PRESCRIPTION FOR CARE?

An exploration of the experiences of nurse and midwife prescribers in the maternity setting

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by

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DEDICATION

This thesis and the research conducted is dedicated to all nurse/midwife prescribers in recognition of the enormous contribution they make to patient care. Their commitment to care and drive to enhance it wherever possible, in what are challenging times, is extraordinary.

I am in awe.

ABSTRACT

Introduction and Background: Nursing/midwifery practice are continually evolving and the introduction of prescriptive authority for nurses/midwives in 2007 is one of the most significant changes in recent years. Nurses/midwives in Ireland can engage in prescribing decision making within their scope of practice following educational preparation and with support from their employer. Though prescriptive authority brings benefits for patients and practitioners, questions have been raised about how caring and nurse/midwife identity may be affected. Given prescribing was once the sole remit of doctors within healthcare, nurse/midwife prescribing raises issues in relation to role boundaries which can affect identity. This research aims to explore the experiences of nurse/midwife prescribers (RNPs) in order to generate practitioner-based knowledge with the potential to inform education and research, policy and practice.

Methodology: This qualitative study is influenced by hermeneutic phenomenology. Ethical approval and permission to access the research sites was obtained and a gatekeeper forwarded study information to potential participants. 16 participants from 2 maternity hospitals participated in one to one semi-structured interviews which were audio-recorded and transcribed. Interviews were coded and codes categorised, allowing themes to emerge.

Results: Findings suggest that the introduction of prescriptive authority was an important point in the professionalisation of nursing/midwifery. Prescriptive authority contributes to the empowerment of nurses/midwives but factors which influence the extent to which this happens have been identified. Prescriptive

authority enhances nursing/midwifery identity and compliments nursing/midwifery practice, facilitating a more agentic practitioner, though challenges to this have also been identified.

Conclusion:

This study provides a rich account of the practice and experiences of RNPs in the maternity setting, developing knowledge directly from those experiences. Findings from this research can inform those with direct responsibility for the regulation of prescribing practice and those responsible for education and research in the context of nurse/midwife prescribing.

ABBREVIATIONS

AMP: Advanced Midwife Practitioner

ANP: Advanced Nurse Practitioner

BD: Twice Daily

BERA: British Educational Research Ethics (Guidelines)

CCA: Constant Comparative Analysis

CNS: Clinical Nurse Specialist

CPA: Collaborative Practice Agreement

CPD: Continuing Professional Development

DMM: Designated Medical Mentor

DOMINO: Domiciliary Care In and Out of hospital

D&T: Drugs and Therapeutic Committee

EWTD: European Working Time Directive

GP: General Practitioner

HIQA: Health Information and Quality Authority

HPRA: Health Products Regulatory Agency

HSE: Health Service Executive

ICM: International Confederation of Midwives

IMC: Irish Medical Council

MDS: Minimum Data Set

NCHD: Non Consultant Hospital Doctor

NICU: Neonatal Intensive Care Unit

NMBI: Nursing and Midwifery Board of Ireland

QDAS: Qualitative Data Analysis Software

REG: Registrar (Junior Medical Doctor)

RGN: Registered General Nurse

RNP: Registered Nurse Prescriber

SHO: Senior House Officer (Junior Medical Doctor)

SIA: Social Identity Approach

SLT: Situated Learning Theory

TDS: Three Times Daily

WHO: World Health Organisation

WISH: World Innovation Summit for Health

GLOSSARY AND DEFINITION OF TERMS

British National Formulary (BNF)

This is a pharmaceutical reference book published twice a year by the British Medical Association and Pharmaceutical Society of Great Britain.

Collaborative Practice Agreement (CPA)

Up until Late 2019, a nurse or midwife wishing to register as a nurse prescriber with NMBI had to have in place a valid collaborative practice agreement within their organisation. The agreement defined the parameters of a nurse or midwife's scope of practice and was established between the nurse/midwife and collaborating medical practitioners. The director of nursing or midwifery signed and approved the CPA on behalf of the organisation.

Designated Medical Mentor (DMM)

Each nurse or midwife wishing to undertake the programme preparing them for prescriptive authority must have the support of a designated medical mentor who is a senior experienced medical practitioner working in the specialist area in which the nurse/midwife is practicing. The mentor's role is to provide the required 12 days/96 hours clinical teaching and learning support over the course of the education programme and to assess the nurse/midwife's clinical competence for prescribing.

Drugs and Therapeutic Committee

The drugs and therapeutic committee is normally an organisational committee which is charged with informing policy in relation to medicines, advising on prescribing practice and reviewing incident reports in relation to medicines use. It is charged with reviewing the list of drugs submitted by a nurse prescriber.

Intern

A junior hospital doctor in their first-year post-graduation from medical school.

Non-Medical Prescribing

This is the prescription of a medicinal product by a health care professional other than a medical practitioner. In the UK pharmacists, podiatrists, physiotherapists along with nurses and midwives can prescribe medicinal products subject to them meeting certain criteria. They are all termed non-medical prescribers.

Off Label

Refers to the prescription of a medicine which has a product authorisation (it is licensed and authorised) but is being prescribed outside of that authorisation for example in a different patient population or for a different condition for which it has the authorisation.

Prescriptive Authority

The legal authority conferred on an individual permitting them to make decisions around the prescribing of medicinal products.

Registered Nurse Prescriber (RNP)

A nurse or midwife who following completion of an approved education programme is registered in the prescribing division of the nursing and midwifery register held by the Nursing and Midwifery Board of Ireland. In order to register as a nurse prescribing the individual must also be registered on one of the other divisions: general, children's, mental health or intellectual disability.

Registration

Registration with the professional body (NMBI) as a nurse/midwife.

Scope of Practice

The expected range of roles, functions, responsibilities and activities that a nurse/midwife registered with the NMBI is educated for and is competent and authorised to perform (NMBI, 2015b).

Triage

Process of determining severity of illness or presenting complaint in order to prioritise care and treatment for those most in need on presentation to hospital.

Unauthorised / Exempt Medicines

An exempt medicinal product (EMP) is a medicinal product that is not authorised or registered in Ireland either by the HPRA or in the case of a centrally authorised medicinal product, by the European Commission (via the European Medicines Agency), but which can be legally supplied to a patient in order to fulfil the needs

of the patient. Up until 2018, legislation prohibited registered nurse/midwife prescribers from prescribing exempt medicines.

CHAPTER 1 INTRODUCTION AND BACKGROUND

1.0 Introduction

Health and illness, birth and death, have always been a part of the circle of life and as such, the practice of nursing and midwifery has always been around. Nursing and midwifery practice though is in a continual state of change due to desires by the professions and individual practitioners, along with the need for the professions to meet the changing needs of society. Many nurses and midwives are taking on new roles which expand their nursing or midwifery practice, some of which have previously fallen within the remit of medical professionals. One such role is the prescription of medicines, introduced in Ireland in 2007 (HSE, 2007). Since then, qualified nurses and midwives, subject to meeting certain criteria, including successful completion of an approved education programme, are authorised to assess patients within their scope of practice, prescribe a medicine, discontinue a medicine or make a decision that a medicine is not warranted in a given situation.

This qualitative study, influenced by hermeneutic phenomenology (Heidegger, 1962), uses semi-structured interviews to explore the experiences of nurse and midwife prescribers (RNPs) working within Irish maternity services. Rather than include a large number of RNPs countrywide, I sought to undertake an in-depth analysis of individual experiences. 16 RNPs (15 female and one male) out of a total of 81 employed in one of two maternity hospitals participated. All participants had experience of prescribing, ranging from four months to nine years. They

worked in a wide variety of clinical areas within maternity services including diabetes, mental health, the emergency department and neonatology. At the time of interview, none were working within antenatal, delivery or postnatal wards and four participants were not actively prescribing.

This study offers insights into their experiences and practices of prescribing in the maternity setting, drawing knowledge directly from those experiences. This research argues that expanding nursing/midwifery practice to include prescriptive authority is a positive development for patients and those who engage with the health service, as well as for the professions themselves. I reveal how prescriptive authority can contribute to a sense of nurse/midwife empowerment. Although it has been suggested that nurse prescribing moves the nurse's role towards a more technical function (While & Biggs, 2004), this research proposes the opposite is in fact the case, as nurse prescribing extends and expands the caring role. This enhances their capacity to act agentically (or independently) and can strengthen their nursing/midwifery identity. The contribution prescriptive authority makes to the professionalisation agenda also emerges. Though largely positive, the research identifies that work needs to be done to maximise the conditions for autonomous practice. This can inform those with direct responsibility for the regulation of prescribing practice and those responsible for education and research in the context of nurse/midwife prescribing. All of this is explored within the context of the political, regulatory, organisational and interprofessional landscape within which nurses and midwives practice.

This thesis will bring you into the world of nursing and midwifery practice in Ireland, a world you may be unfamiliar with and so I regularly provide signposts that both provide context and illuminate this world. To complement the introductory passages thus far, this chapter continues with further background and context for the study, situating the research within the broader arena of nursing and midwifery practice in Ireland. I outline the purpose, rationale and significance of the study and pose the research questions. My perspectives as an educator and researcher unfold throughout the chapter and I outline the standpoint from which I began the research. This chapter concludes with an outline of the organisation of the thesis.

In terms of my own suitability to undertake this study, I am a proud nurse and I am excited at the growth and development of the professions of nursing and midwifery. I trained as a nurse through the apprenticeship model, based in a hospital school rather than in university. My current role is as lecturer and programme director in the School of Nursing and Midwifery at the Royal College of Surgeons in Ireland (RCSI) which focuses exclusively on the delivery of postgraduate nursing and midwifery programmes. I have had a long association with nurse and midwife prescribing in Ireland having served on the multi-stakeholder National Implementation Group established by the Minister for Health and Children in 2006. In my role as programme director I have responsibility for the organisation and delivery of the education programme preparing nurses and midwives for prescriptive authority (decision making around the prescribing of medicines), which includes curriculum development, teaching and assessing.

1.1 Background and context

What are nursing and midwifery? Scholars have over the years, attempted to define nursing including Florence Nightingale with the publication of her book *Notes on Nursing: What it is and What it is Not* (Nightingale, 1860). The practice of nursing encompasses many areas including health promotion, illness prevention, and the care of individuals who are ill, disabled or dying. Nursing also includes advocacy and research, shaping health policy and education (International Council of Nurses, 2002). Traditional definitions have often defined nursing in terms of what nurses do and restricted 'what nursing is' to a task-based role. More recent attempts to define nursing and midwifery have looked beyond this but in my opinion remain quite abstract, an example being the Royal College of Nursing (2014: 3) which defines nursing as:

> The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

Midwifery includes working with women to support them during pregnancy, labour, and the postpartum period, as well as caring for newborns. Midwives also hold an important role in providing and delivering education to women, families and communities (International Confederation of Midwives, 2011). The Nursing and Midwifery Board of Ireland (NMBI) works with the following definition of a midwife adapted from the International Confederation of Midwives' definition (NMBI, 2015a: 9)

> A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.

However, for me, these definitions are not clear as they do not express the essence of what I believe nursing and midwifery to be, which is about caring relationships. My position is supported by Swanson who considered nursing as ‘informed caring for the wellbeing of others’ (Swanson, 1993: 352) and who had previously described caring as ‘a nurturing way of relating to a valued other’ (Swanson, 1991: 165). As well as recognising care as key to nursing, she also established the importance of knowledge in her reference to informed caring. The centrality of caring to nursing was also proposed by Watson, who suggested it was the ‘essence’ or core of nursing (Watson, 2008). The importance of care is something that forms a huge part of nurse-identity. Nursing is about being with the patient through their experiences. This requires nurses, to develop an authentic caring relationship with their patients, acknowledge what the patient is experiencing and enable the patient to reach their desired potential. This may range from maximum independence, to be pain-free, to have a fulfilling birth-experience, or indeed to have a ‘good death’. Amidst an over-riding concern for care, enabling the patient to reach their desired potential requires holistic knowledge gained through both experience and formal education.

The values of caring and patient-centeredness, embedded in nursing (McCormack et al., 2011) are ones I embrace as a teacher. Though I have worked as a nurse educator for many years and longer than I did as a clinically based nurse, it is my years as a nurse which have informed and shaped who I am as an educator. I feel a strong sense of responsibility and accountability to the professions of nursing and midwifery, individual practitioners (students) and most importantly patients whose care I influence through my role as a nurse educator. My thoughts on education are important as they directly link with the research methodology and methods adopted within this study. My goal as a teacher is to guide, facilitate and provide space for students to learn through reflecting on their own knowledge and experience, discovering how they can apply knowledge gained over time in their practice roles. Much of my approach to teaching can be explained from a personal and social constructivist perspective (Rutherford-Hemming, 2012) with students building their own knowledge from personal experience through collaborative and interactive classroom activities such as group work and discussion. I endeavour to foster dialogic education, a phrase coined by Freire to represent a situation in which co-learning and teaching take place; the teacher becomes the teacher and learner as do the students (Freire, 1972). This is very relevant for me as I have been out of clinical practice a long time whilst the students are immersed in it. I therefore rely on students to name their professional world as I do not have current first-hand experience of that world.

In terms of occupational location, nurses and midwives in Ireland are working within a healthcare arena that is experiencing significant change and health service reform (Wall, 2018a). This includes a change in the demographic and epidemiological profile of those using the health service and changing models of care delivery, identified as challenges to health service provision (Begley et al., 2010). Chronic shortages of nurses and midwives over the years have also contributed to challenges (INMO, 2019). The recent adoption of *Sláintecare* (a programme of transformation for the health services in Ireland), will require new ways of working (Government of Ireland, 2018) which will impact all healthcare workers within the health service, adding to the challenges.

The nursing and midwifery professions have been proactive in providing care in a challenging and changing environment by expanding their scope of practice, or the activities which they have the competence and authority to perform (NMBI, 2015b), both at the level of the professions and at an individual practitioner level (Fealy et al., 2014). At the level of the professions, expanding scope of practice has garnered government support (Government of Ireland, 1998; Government of Ireland, 2011; Government of Ireland, 2019) and has included the development of pathways such as advanced practitioner, clinical specialist and RNP. This expansion of practice can be viewed both as a result of, and contributor to, the professionalisation of nursing and midwifery.

Whilst undergraduate (pre-registration) education for nurses and midwives provides the foundation for practice, it does not prepare practitioners for expanded practice roles. Postgraduate education and continuing professional

development (CPD), described by Houle (1980) as the hallmark of a profession, is thus necessary. To become a nurse prescriber, practitioners must complete a specific education programme approved by NMBI for the purposes of registration as an RNP. At RCSI, this is the Certificate in Nursing (Nurse/Midwife Prescribing) which is six months long. The programme is founded on the principles of adult learning (Knowles, 1984) and is delivered collaboratively by the Schools of Nursing and Midwifery, Pharmacy and Medicine, using a blended learning approach. The programme consists of three theoretical modules and a clinical component in which the student is required to have the support of a designated medical mentor (DMM) who in the hospital setting is a medical consultant. The mentor is required to provide 96 hours teaching and learning opportunities over the course of the programme and assess the student's competence to make prescribing decisions at the end of the programme (further details of the course will be provided in Chapter 2).

Though the introduction of nurse/midwife prescribing in Ireland and the model adopted will be further elaborated on in Chapter 2, it is prudent to give a brief description here in order to provide context for the research question. Following the *Report of the Commission on Nursing: A Blueprint for the Future* (Government of Ireland, 1998) a pilot initiative in which a small group of nurses and midwives were permitted to prescribe under protocol commenced. The review of this initiative along with a review of prescribing internationally (An Bord Altranais, 2005) resulted in the establishment of legislation to permit nurses and midwives to prescribe, governance structures to support safe prescribing practices and an

education programme preparing nurses and midwives for the role in 2006/2007. Up until late 2019, in order to register as a prescriber, each RNP had to establish a Collaborative Practice Agreement (CPA). This served as the organisational permission for an RNP to prescribe and listed the drugs specific to an RNP's scope of practice. Importantly, it required the signatures of any doctor who supported the particular RNP in prescribing for their patients.

1.2 Purpose, rationale and significance of the study

This study arose out of my personal interest in, and commitment to, nurse and midwife prescribing and my passion for the contribution the professions make to society. The focus to date within the Certificate in Nursing (Nurse/Midwife Prescribing) has been around supporting nurses and midwives to achieve the competence necessary to take on the role. Little to no emphasis has been placed on exploring what prescriptive authority may mean for their identity as a nurse or midwife or their practice working across traditional role boundaries. As I am not a nurse prescriber myself, this study offers me an insight into the world of RNPs which I can share with current and future prescribing students. I am better informed to prepare RNPs to negotiate challenges associated with their new role and to illuminate how the addition of prescriptive authority can enable them to become more agentic in their practice.

It has been suggested that increasing demands on nursing have shifted the focus of nursing practice from care to cure (Cook & Cullen, 2003). Some researchers argue that when expanded practice roles are undertaken there is potential for the caring focus to be lost (McKenna et al., 2006) and professional identity affected

(Borthwick et al., 2009; Coull et al., 2013; Weiss et al., 2016). The adoption of prescriptive authority by nurses and midwives, which was once restricted to the medical profession may perpetuate this, diluting the integrity of the nursing and midwifery professions and our commitment to a caring focus. Exploring the experiences of RNPs has helped identify barriers, and facilitators, to the expression of this value. Perceptions uncovered will support healthcare leaders and individual practitioners in ensuring that expanded practice and prescriptive authority is not undertaken at the expense of traditional nursing/midwifery roles and that a values-based approach to the provision of nursing and midwifery care continues.

The expertise of and knowledge about nursing work is often unclear (Summers & Summers, 2009; Weston, 2010). This can result in public perception of nursing work not being as valuable as that of doctors (Gordon, 2005). Lack of acknowledgement of diverse roles within nursing and the expertise required to carry them out can lead to a devaluing of nursing work (Weston, 2010). In an attempt to address this, the World Innovation Summit for Health (WISH) recently published a report recognising nurses' expert knowledge and experience and their value in shaping policies, calling for their voices to be heard (Crisp et al., 2018). This study also recognises nurse and midwife expertise and experience and gives voice to those working at the coalface, ensuring that their knowledge is available to inform policy in the future.

Nurse/midwife prescribing can contribute to enhanced patient care. In the past, before a nurse/midwife could administer medication in the absence of a

prescription, both they and the patient had to wait until a doctor became available to write one. By expanding their scope of practice to include prescriptive authority, practitioners are better positioned to assess and respond to the needs of their patient than previously. However, realising the contributions nurse/midwife prescribing can make is not without its challenges. Insights gained from this research have identified these challenges and may help us to maximise the contribution RNPs can make. Insights may also contribute to our understanding of interprofessional relationships in an evolving healthcare sector, where the continued professionalisation of nursing and midwifery is still heavily reliant on the medical profession.

In terms of research supporting the introduction of nurse and midwife prescribing in Ireland, little is available to tell of its success, its challenges or the experiences of RNPs themselves. The most significant piece of work was carried out in 2009 just two years after its implementation (Drennan et al., 2009). Whilst 248 nurses and midwives from 61 different clinical areas had been supported to take on the role, just 58 nurses/midwives from 23 health service providers were registered as RNPs (Health Service Executive, 2009). This study increases our limited understanding of nurse and midwife prescribing which may also influence the preparation of other healthcare practitioners for their roles and working within a multidisciplinary team. This research also addresses the gap identified by Small et al. (2016) in relation to knowledge of prescribing within midwifery practice and Nutall (2018) who suggested insights into the lived experience of nurse

prescribers would further support and motivate nurses to take on the role (Nutall, 2018).

Engaging in this research is significant for me in terms of my own CPD. In carrying out this research, I have embodied my commitment to lifelong learning which is essential to the practice of both nursing and education.

1.3 Research question and introduction to methodology

The aim of this research is to explore the experiences of nurse and midwife prescribers (RNPs) in order to generate practitioner-based knowledge with the potential to inform education and research, policy and practice. The research question is essentially 'what is the experience of being an RNP?' and was guided by the following questions;

> What does it mean to be an RNP?
>
> How does the experience of being an RNP fit with the prescriber's sense of being a nurse or midwife?
>
> What influences the experience of being an RNP?
>
> How does prescribing influence interprofessional relationships and the development of the profession?

Ultimately, the research contemplates what we can learn from these experiences and how this learning can be applied to the education of nurse prescribers and their preparation for the role.

I position myself as a critical researcher, drawing on influences of social constructionism (Crotty, 1998) and inspired by hermeneutic phenomenology. As a teacher of clinical ethics and member of several research ethics committees, I am familiar with, and recognise that individuals interpret things differently. Given my belief that knowledge is constructed through interaction and engagement between teacher and learner, it is appropriate then for me to state that new knowledge generated through research is also constructed in an interaction between researcher and participant.

The topic is explored qualitatively, drawing on hermeneutic phenomenological ideas (Heidegger, 1962) which aims to interpret as well as describe the phenomenon of being an RNP. The methodology will be outlined in greater detail in Chapter 5.

1.4 Contribution of this research

This research makes a significant contribution to what is known about nurse/midwife prescribing. No previously published work has specifically focused on the role of RNP in the maternity setting and the findings go some way towards addressing this gap. The findings provide a rich account of how prescriptive authority can contribute towards the empowerment of practitioners, strengthen their identity through their increased capacity for care and enhance their ability to act agentically. The contribution prescriptive authority makes to the continued professionalisation of nursing and midwifery has also emerged.

This research also contributes to our knowledge about the educational preparation of nurses and midwives for a prescribing role and alerts us to opportunities for reimagining it. The research highlights the educational role RNPs play both at the patient level and that of interdisciplinary colleagues and the role clinical practice plays in informal learning and supporting the continued development of practitioners.

Though I identify strongly as being a nurse I am very conscious that my professional role is that of nurse educator and undertaking a doctorate in education has exposed me to new ways of thinking about education that I may not have had access to otherwise. To date this research has already informed and affected change in my own educational practices. As a more informed educator, I now take time to facilitate discussion on the realities of being an RNP affording reflective spaces for students to contemplate what being a prescriber might mean for their identity as a nurse/midwife and their interprofessional relationships. I am more informed as to the potential challenges, barriers and facilitators to RNP practice which I now share with students. At a broader level, I have changed how I give feedback across all the programmes I am involved in examining.

This research has also contributed to discussion about RNP practice through conference presentations I have given and has enabled me to make more informed and meaningful contributions to relevant draft policy documents circulated by NMBI and the Health Service Executive (HSE) in relation to nurse/midwife prescribing. On foot of these contributions, the research provides

direction for further research and education, practice and policy (which are outlined in Chapter 9).

1.5 Organisation of the dissertation

Following this introductory chapter, I outline the evolution of maternity services in Ireland as this is the area in which this study was carried out. I provide more detailed background about the educational preparation of RNPs in Ireland and the model of prescribing introduced. Chapter 3 situates nurse/midwife prescribing within the context of professionalisation. I propose that professionalisation is a positive endeavour for nursing and midwifery and explore the professionalisation journey undertaken by the professions to date, acknowledging education and expansion of practice in this regard. I suggest ways in which the introduction of nurse/midwife prescribing is both as a result of and contributor to the professionalisation process. In Chapter 4, I recognise the impact expanded practice and in particular prescribing can have on professional identity and the caring role of the nurse/midwife. I propose Swanson's theory of caring (1993) as an appropriate one to guide practice that maintains and enhances caring in new roles, including prescribing. I also consider the intricacies of navigating the new role within the context of team and collaborative working environments. Chapter 5 provides a detailed account of the methodology underpinning the study and the methods used. Chapter 6 and 7 present the results of the study and within Chapter 8, I discuss the findings within the themes of empowerment and agency. Chapter 9 concludes the thesis, discussing the implications of the findings and analysis for, education and research, practice and policy.

1.6 Conclusion

The purpose of this chapter was to introduce the study presented within the thesis and outline the major findings which propose that:

- the expansion of practice to include the prescribing of medicines is a positive development for the nursing and midwife professions as it contributes to their continued professionalisation agenda (Suddaby & Greenwood, 2001)
- through the increased autonomy prescriptive authority affords nurses and midwives (Drennan et al., 2009), they can become more empowered and subsequently more agentic in terms of patient care with a strengthened professional identity. However, factors have been identified which can influence the degree to which RNPs are empowered, subsequently affecting their agentic capacity

Context and background have been outlined setting the scene and establishing the purpose of the research. The research questions have been posed and methodological approach noted. The scope of the research has been framed and my role as researcher along with the assumptions I bring to the research process have unfolded throughout the chapter. The next chapter provides background into the educational preparation for RNPs in Ireland and the model introduced along with briefly charting the evolution of maternity services in Ireland.

CHAPTER 2 MATERNITY SERVICES IN IRELAND AND THE INTRODUCTION OF NURSE/MIDWIFE PRESCRIBING

2.0 Introduction

One of the most significant changes in nursing and midwifery in recent times was the introduction of prescriptive authority which allows nurses and midwives subject to meeting certain criteria, to make decisions around the prescribing of medicines for patients, within their scope of practice. The purpose of this chapter is to provide context for the study that will unfold throughout this thesis. This chapter briefly charts the practice of midwifery over the years and outlines how nurses and midwives can become prescribers (RNPs) and details the model and regulation of nurse/midwife prescribing in Ireland.

2.1 Setting the scene: midwifery practice in Ireland

The current legislation governing nursing and midwifery practice in Ireland, The Nurses and Midwives Act (2011) recognises the two professions as distinct from each other though prior to this they were viewed from a legislative perspective as part of the same profession. Internationally, two social movements, both with roots in the feminist movement contributed to midwifery being differentiated from nursing. The first was the dissatisfaction of women with the birthing experience and the second, the frustration and lack of autonomy of midwives (Reiger, 2001). In some instances midwives found themselves being rotated around specific areas within hospitals inhibiting them from following women throughout pregnancy and delivery. This resulted in a lack of holistic and continuous care required for women-centred care (Minns, 1996). From 1959, midwifery was a

profession only accessible by those who were already qualified nurses. This requirement in effect made midwifery a specialist branch of nursing rather than a specific profession itself. With a biomedical model of care dominating nursing education (Uys & Gwele, 2005; Meleis, 2012), this would seem to jar with the midwifery philosophy of care which sees pregnancy and childbirth as normal physiological processes occurring during the lifecycle (NMBI, 2015a) and women centred care in the context of midwifery as a biopsychosocial model (MacKenzie Bryers & van Teijlingen, 2012; Fontein-Kuipers et al., 2018). In 2000, direct entry to midwifery programmes recommenced as had been recommended by the *Report of the Commission on Nursing: A Blueprint for the Future* (Government of Ireland, 1998). The 1998 report (Government of Ireland, 1998) also called for the establishment of four-year degree programmes which commenced in 2002 for nursing programmes and in 2006 for programmes leading to a midwifery qualification and those combining both a children's and general nursing qualification. The *Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes* (2012), recommended a continuation of distinct points of entry to the professions at degree level (Government of Ireland, 2012).

Alongside the changes within the midwifery profession itself, the way maternity services were being provided also changed. During the first half of the twentieth-century midwifery services in Ireland were mainly provided in the community and whilst ‘home’ was considered the most appropriate place for childbirth a small number of maternity hospitals existed to help mothers who lived in squalid conditions in tenements (Robbins, 2000). During this period however high rates

of infant and maternal mortality were of concern to the medical profession with the shortcomings in midwifery often blamed (Robbins, 2000). However, with many women living with poor sanitation and experiencing malnutrition and other health issues, Robbins (2000) argues laying the blame at the door of midwifery was unfair. In the 1940s there were renewed concerns regarding the health of mothers and babies with the medical profession believing hospitals to be safer than homes for childbirth (Robbins, 2000). Whereas home births accounted for approximately 30% of births in the 1950s, by 2010 they accounted for less than 1% (Kennedy, 2010).

In Ireland, a number of public policy initiatives encouraged the medical, hospital led provision of maternity services, such as the provision of maternity units around the country. The Health Act (1953) facilitated a medical model of childbirth (Kennedy, 2012) with the establishment of the mother and infant care scheme in which most antenatal care is medically led, provided by general practitioners and obstetricians. The change in the provision of maternity services in the 1950s impacted on midwifery training as the number of home births students were required to attend as stipulated by the regulator was difficult to achieve. The result was that training requirements were changed so that the number of home births that had to be attended were reduced. This gave the appearance of the nursing and midwifery regulator adopting the position that hospitals were the most appropriate places to give birth. The availability of private health insurance, which supports maternity care led by obstetricians, has also contributed to medically led maternity care. Though Kennedy (2012) posits that these approaches have in the

past led to the underdevelopment of midwifery provided services, as I outline throughout this thesis, the professional roles of nurses and midwives have evolved and developed significantly in more recent times.

In terms of birth-rates, Ireland has one of the highest fertility rates in the EU (Government of Ireland, 2019). Though there have been slight decreases over the years, in 2018 there were 61,016 live births, a rate of 12.5 per 1000 people, the highest in Europe (Pope, 2019). Hospital-based care, which is led by medical professionals, is what most pregnant women avail of in Ireland. This approach stems from historical perspectives as outlined in the previous paragraph. However, things are changing slowly.

The 2001 *Kinder Report* of the maternity services review group (Kinder, 2001), investigated options available to women in terms of maternity services. This resulted in the provision of a blueprint for women-centred care and led to the establishment of midwifery-led units. These have been positively evaluated with Begley et al. (2009) identifying that midwifery-led care is as safe as obstetrician-led care and reduces the risks of interventions during labour and delivery (Bernitz et al., 2016; Sandall et al., 2016). Though traditionally midwives have been subordinate to medicine (Hunter, 2005), the pivotal role midwives can play in the provision of maternity services has been recognised by a number of further reports such as *'The Future of Maternity and Gynaecology Services in Ireland 2006-2016'*. The report supports the development of new career pathways for midwifery including advanced practice and clinical specialist roles (Institute of Obstetricians and Gynaecologists, 2006). The '*Independent Review of Maternity*

and Gynaecology Services in the Greater Dublin Area (GDA)' (2008) also advocated strengthening community care and expanding the DOMINO scheme. The DOMINO scheme facilitates midwifery-led antenatal care and includes early discharge home and postnatal care provided in the woman's home. The review proposed that all women have access to effective community-based, midwife provided, postnatal care (KPMG, 2008). In 2016, the *National Maternity Strategy* made a large number of recommendations including that a choice of maternity care be available to women based on risk profile and that maternity care be women-centred and provided by the most appropriate professional, based on need (Department of Health, 2016a). Since prescriptive authority increases nurse and midwife autonomy, this development should widen and increase the types of maternity care women can avail of. However, the 2020 Health Information and Quality Authority (HIQA) report on maternity services identified insufficient funding to support implementation of the strategy to date and recommended that a comprehensive, fully costed plan to fully achieve the strategy be developed (HIQA, 2020).

In 2018, an Electronic Health Record (EHR) was introduced to maternity services with the aim of improving communication, enhancing clinical audit mechanisms and reflecting 'best' standards in documentation (eHealthireland, 2018). This changed a previously long-standing practice of doctors (and in more recent times nurses and midwives) hand-writing prescriptions, to a system where medication is now electronically prescribed. EHRs have been found to reduce errors (Bates et al., 1998; Reckmann et al., 2009; Nuckols et al., 2014) and have many

advantages over handwritten prescriptions (Bates et al., 1998; Reckmann et al., 2009; Westbrook et al., 2012; Nuckols et al., 2014) but can also contribute to new issues in relation to functionality and technology design (Koppel et al., 2005; Campbell et al., 2006; Puaar et al., 2018).

2.2 Becoming a nurse/midwife prescriber in Ireland

In 2005, An Bord Altranais evaluated the pilot initiative where nurses and midwives were given the authority to prescribe medications under protocol. From this they recommended that prescriptive authority be extended to nurses and midwives, meeting certain criteria and fulfilling certain educational requirements (An Bord Altranais, 2005: 130). A National Resource and Implementation Group was established by the Minister for Health and Children to oversee the development of legislative, governance and educational requirements for future RNPs. Members included representation from various stakeholders including; the medical, nursing (including myself), midwifery and pharmacy professions, representatives from the main nursing and midwifery unions (Irish Nurses Organisation and Psychiatric Nurses Association) and Department of Health representatives. Three pieces of legislation were required to facilitate the new role; Irish Medicines Board (Miscellaneous Provisions Act) 2006 (Commencement) Order 2007, Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007, Statutory Instruments No. 201 of 2007 and Misuse of Drugs (Amendment) Regulations 2007, Statutory Instruments No. 200 of 2007.

2.2.1 The education programme preparing nurses and midwives for prescriptive authority

The first nurses and midwives commenced their six-month part-time education programme at the Royal College of Surgeons in Ireland (RCSI) and University College Cork (UCC) in 2007 with the first graduates registering on the prescribing division of the nursing and midwifery register in January 2008. Since 2007, the HSE has funded nurses and midwives working in the public sector to undertake the programme and those working in the private sector either self-fund or in some instances are financed by their employer. Eligibility for the programme has not changed over the years and the criteria which must be met include; be qualified three years, have one years' experience in the area they wish to prescribe, have evidence of Continuing Professional Development (CPD), be supported by their nursing or midwifery director and complete a Nursing and Midwifery Board of Ireland (NMBI) approved programme. The programme includes both theoretical and clinical components and prior to commencing the programme, they must have the support of a designated medical mentor (DMM) who will facilitate learning in the clinical environment. This medical mentor is normally a general practitioner (GP) in the primary care setting or a hospital consultant in the acute sector. Their involvement effectively controls the selection of candidates for the programme as they must agree to mentor an individual nurse or midwife for the duration of the education programme.

As well as providing teaching and learning opportunities (96 hours) over the course of the programme (Health Service Executive, 2008), the mentor is required to assess the nurse/midwife's clinical competence in terms of diagnostic

and patient management ability and therefore determines whether the nurse/midwife successfully exits from the programme. Though students view the mentorship aspect of the programme as really important (Latter et al., 2010) there have been reports that mentors give it a low priority (Nettleton & Bray, 2008).

This model, requiring doctors as mentors for the prescribing programme contrasts with some parts of the world such as Sweden and some states in the USA and Australia (Kroezen et al., 2012) where there is no mandatory clinical learning component. Where there is a clinical requirement the mentorship function is often undertaken by nurses working in either an education or supervisory role (Kroezen et al., 2012). As recently as 2019, new standards came into effect in the UK which remove the requirement that a medical professional only, undertake the mentorship role (Nursing and Midwifery Council, 2018). In preparation for the role, those mentoring students undertaking the programme at RCSI receive written material electronically. Although face to face workshops were run for a number of years at the beginning of the initiative, in my experience they were poorly attended by mentors, similarly reported by Campbell (2004) and Ring (2005). I contact mentors by email on three occasions over the course of the programme and they can contact me anytime with concerns or queries.

The theoretical aspect of the programme is delivered through blended learning with students attending class on some days and on others engaging with the programme online. It consists of three modules, Professional Accountability in Nurse/Midwife Prescribing, Pharmacology and Prescribing Science and

Systematic Assessment and Evaluation in Patient Care. The pharmacology module in particular is challenging academically (Lymn et al., 2008). particularly for those working in a specialist practice area. In my experience, whilst students are very knowledgeable about drugs in their specialist area, they are not as well versed in wider pharmacological knowledge. The pharmacology module is broad, requiring students to develop both breadth and depth of knowledge, a lot of which is complex with some students questioning the relevance for their practice, given they are going to prescribe only within their scope.

2.3 Model of nurse/midwife prescribing in Ireland

Different models of nurse and midwife prescribing are in operation throughout the world due to the differences in legislative and regulatory requirements and parameters of practice established within those countries (Creedon et al., 2009). The model introduced in Ireland is seen as quite liberal (Kroezen et al., 2012) and I view it as independent but collaborative. Up until November 2019, RNPs made independent clinical decisions within what was called a 'collaborative practice agreement' (CPA) which was introduced in 2007 as part of the regulatory framework for RNPs. Though the NMBI suggested it remain in place when evaluated in 2015, (NMBI, 2015c) the regulatory requirement to hold a CPA was removed in November 2019. The CPA was a significant tool in the regulation of nurse and midwife prescribing practice, with the medical profession ultimately having the power to control the practice of nurses and midwives. Whilst in some organisations local policy facilitated one senior doctor signing on behalf of a group of doctors, in others, all consultants/GPs who consented to a particular

RNP prescribing for their patients, had to sign it (NMBI, 2016). If a consultant/GP decided they didn't want a particular nurse or midwife prescribing for their patients they didn't sign the agreement, thus constraining the capacity of the RNP to prescribe. RNPs were required to have the list of medicines specific to their scope of practice (which was contained within the CPA) reviewed by their organisations Drugs and Therapeutics Committee (D&T). If a nurse or midwife did not have a valid signed CPA in place, they could not apply to register as a prescriber with the NMBI. Though the regulatory requirement for a CPA has been removed (NMBI, 2019), many hospitals are uncertain as to how the governance of nurse and midwife prescribing will be managed into the future. Whilst organisations await guidance from the HSE, some are continuing the CPA as a local practice agreement.

There are a number of other points to note in relation to nurse/midwife prescribing in Ireland. Though RNPs can prescribe within their scope of practice, legislation restricts the prescription of controlled medications such as morphine to certain settings. Up until late 2018, legislation also prohibited RNPs from prescribing unauthorised or exempt medications. This was a particular challenge in some clinical areas such as neonatology where commonly used medicines are unauthorised or exempt. Similar to other countries, RNPs do not receive any financial reward for taking on the prescribing role. Up until 2015, RNPs were required to enter details of prescriptions they wrote into a database. The idea behind this was that individuals could audit their practice and a national picture of RNP activity could be built up. This proved extremely time-consuming for RNPs

(NMBI, 2015c) and since it only captured prescriptions written, it did not capture all RNP decision making which included decisions not to prescribe or to discontinue a medication (Creedon et al., 2014).

2.4 Benefits and challenges of nurse/midwife prescribing

Almost all research published about non-medical prescribing has been undertaken in nursing and to a lesser extent pharmacy practice and so this thesis draws on the research published within these disciplines. By and large, this research suggests the benefits are numerous for both professionals in terms of professional development (Drennan et al., 2009) and patients who are very accepting of the role (Latter et al., 2010; Maddox et al., 2016). Patient benefits include more seamless and speedy access to effective treatments (Latter & Courtenay, 2004; Carey et al., 2008; Cooper et al., 2008a; Courtenay et al., 2011). As advocacy and empowerment of health service users are central to the role of nurses and midwives, these roles are further enabled through expansion of practice and adoption of prescriptive authority. This view is supported by Latter et al. (2005) who described how patients became more involved in decision making with more choice of options being offered to patients when seen by a prescribing nurse. Ross (2015) also acknowledges more discussion of options by nurse prescribers, thus giving patients more choice. When patients are more involved in decision making around their care and management, greater concordance with management plans can be achieved (Gray et al., 2005).

It is well known that nurses and midwives often direct the prescribing decisions of junior doctors. Indeed from my own experience, during the first days and weeks

of practice for newly qualified doctors, nurses spent significant time advising the interns what to prescribe, the dose and appropriate route. Formalised prescriptive authority for nurses and midwives uses their knowledge and skills more appropriately (Latter & Courtenay, 2004; Kroezen et al., 2011) and legitimises the common practice of experienced nurses directing the prescribing decisions of doctors. It also allows nurses and midwives to take responsibility for their actions which is not facilitated when doctors sign the prescription decided on by a nurse/midwife (Wedgewood, 1995). A further study by Latter et al. (2012) acknowledged that nurse prescribers are as good at clinical decision making as their medical colleagues. Improvements in patient flow and waiting list times have also been attributed to nurse and midwife prescribing (Casey et al., 2020).

Though the adoption of medicinal product prescribing has been generally well-received, some reservations have been expressed and challenges identified. Many researchers suggest the issue of most concern is whether nurse and midwife prescribing is safe (BMA, 2005; Hawkes, 2009; Rana et al., 2009; Stenner et al., 2009; Watterson et al., 2009; Funnell et al., 2014; Kroezen et al., 2014a). Even though Courtenay and Berry (2007) describe how doctors believe nurses have the knowledge levels and ability to prescribe and that academic preparation fulfilled the needs of the prescribing role, others have queried the preparedness of nurses and midwives for the role (Bullock & Manias, 2002; Wilhelmsson & Foldevi, 2003; Banning, 2004; Lockwood & Fealy, 2008; Stenner et al., 2009). In particular, there are concerns over the short pharmacology education compared to that in medical programmes (Bradley et al., 2006; Schön

et al., 2006; Carey & Courtenay, 2010). Moreover, concerns about examination skills and differential diagnostic ability (Courtenay et al., 2009a; Young et al., 2009) have been expressed.

It has been identified that nurses and midwives undertaking the programme preparing them for prescriptive authority have more clinical experience and expertise than junior doctors and yet the same concern regarding safety of prescribing is not expressed in relation to junior doctor prescribing (Pritchard, 2017). This lack of safety concern regarding the prescribing practices of junior doctors is contentious given the reports by junior doctors that they do not feel adequately prepared for prescribing, that the activity is stressful for them (Geoghegan et al., 2017) and the fact that they make the most prescribing errors (Dornan et al., 2009; Ryan et al., 2011).

McBrien (2015) notes that some nurses and midwives undertake the educational programme preparing them for the prescribing role, but do not actually engage in prescribing decision making. This can be due to the heavy administrative burden associated with nurse/midwife prescribing in Ireland (McBrien, 2015) and a perception that prescribing moves the nurse's role into a more technical function (While & Biggs, 2004). The challenge of jurisdictional power and blurring of boundaries have also been expressed (Avery et al., 2004) and these will be addressed in more detail in Chapter 4. None of these challenges were identified in the evaluation carried out by Drennan et al. (2009) in Ireland though this might be because nurse/midwife prescribing was still in its infancy having only commenced in 2007. Participants in Drennan's work were working in healthcare

organisations which were at the forefront of introducing this expanded practice role. There was good support from within the organisations, from healthcare professions such as medicine and pharmacy, and leaders from within those organisations championed the initiative.

2.5 Conclusion

The introduction of nurse and midwife prescribing has been one of the most significant changes to the scope of practice for the professions in recent times. This chapter has sketched the evolution of maternity services in Ireland over time and outlined more comprehensively the educational preparation for prescriptive authority which had been noted in the introductory chapter. The model of nurse/midwife prescribing adopted in Ireland has been outlined and the established benefits, concerns and challenges of nurse/midwife prescribing summarised. Importantly, the role the medical profession plays in both the educational preparation and practice of nurse/midwife prescribing has been illuminated. The next chapter will situate nurse and midwife prescribing within the context of professionalisation of the professions.

CHAPTER 3 PROFESSIONALISATION OF NURSING AND MIDWIFERY: SITUATING NURSE AND MIDWIFE PRESCRIBING

3.0 Introduction

The practice of nursing and midwifery and the contribution they make within the health service is continually evolving and the purpose of this chapter is to situate nurse and midwife prescribing within the broader context of professionalisation. The way in which nursing and midwifery meet the criteria to be considered professional groups is proposed and the influence of other professional groups such as the medical profession in the professionalisation of nursing and midwifery are explored. Throughout this chapter, I will suggest ways in which the introduction of nurse and midwife prescribing is both as a result of professionalisation and a contributor to that continued agenda. I consider professionalisation from the perspectives of power and empowerment, education and expanded practice. This will lead into Chapter 4 which will discuss the issue of professional identity, an important consideration given the potential for prescribing practice to alter identity and the role of other healthcare professionals in identity formation.

3.1 What is a profession?

Given that nursing and midwifery are now considered to be professionalised practices, it is fair to suggest that they must be considered professions. Early studies of professions proposed a set of traits or characteristics against which an ideal occupation could be measured (Wilensky, 1964). So what are these traits and what characteristics do nursing and midwifery hold to make them

recognisable as professions rather than occupations? Does such a difference matter?

According to early scholars in the field of professionalisation such as Greenwood (1957), Wilensky (1964) and Etzioni (1969), these traits are distinct, identifiable knowledge and skills, an altruistic mission, code of ethics, a self-governing body along with controlled entry to the occupation. I propose that nursing and midwifery can legitimately call themselves professions applying the trait approach. Identifiable knowledge and skills relate to those that are required in order for nurses and midwives to care for their patients. An altruistic mission is the desire for nurses and midwives to support and care for their patients. In my own experience, the impetus for many nurses and midwives undertaking the prescribing education programme was because they considered it to be in the best interests of patients. Whilst nursing and midwifery are already governed by a code of professional conduct and ethics, the introduction of specific standards for prescribing practice, further augment this professional trait. The professions of nursing and midwifery have been self-governing through the Nursing and Midwifery Board of Ireland (NMBI), though the board now consists of a lay majority. There is a specific additional requirement that those wishing to prescribe, have their names entered on the prescribing division of the register. Nursing and midwifery meet the trait of controlled entry to the profession by setting minimum standards and competence that must be achieved in order to practice as a registered nurse or midwife. Controlled entry to prescribing practice is maintained through the requirement that nurses and midwives achieve

additional competence through experience and the completion of an approved education programme. This trait approach sees professions as service orientated, knowledge-based occupations that respond to social needs.

Another approach to defining or establishing what constitutes a profession emerged from power theorists who value exclusionary power and the right to monopolise work (Larson, 1977; Abbott, 1988; Friedson, 1994, 2001). The monopolising of work is an important concept within healthcare and in particular nursing and midwifery as new groups of healthcare practitioners emerge such as physician associates and birth attendants who have the potential to displace nurses and midwives from work which was traditionally within their role. In this 'power approach' to defining and creating a need for a profession, the complexity of social problems is often exaggerated in order to provide a space within which professionals can operate. Professions make a claim of competence in a specific area and this is very often supported by the state in terms of legislation and policy. One common element between both approaches is the requirement for specialised knowledge and skill necessary for a professional group to exercise authority (Wilensky, 1964). It is this specialised or abstract knowledge that Abbot (1988) considered distinguishing a trade or craft from a profession. He outlined how professions have abstract knowledge out of which grows practical control with theory therefore, controlling practice. Abbott (1988) also captured the importance of relationships with others and society as a whole as defining of a profession, recognising how professions are unstable entities existing alongside others. He considers that it is through the acceptance by society of self-declared

claims, made by an occupational group that renders them a profession. Davies (1998) recognised the need for additional professional characteristics such as interprofessional collaboration, partnership with users and reflective practice for professional groups which I consider to be very relevant to healthcare practice.

Defining an occupational group as a profession would appear to be easily done if certain criteria are met however our evolving healthcare world poses a significant challenge. Larson (1977) proposed that the cognitive dimension of a profession relates to the specific knowledge and skills of a particular profession which sets them apart from others. However, identifying the knowledge and skills specific to nursing and midwifery practice may be challenging when roles are evolving. In order for nurses and midwives to expand their practice and take on new roles, for example, the prescribing of medicines or advanced practice, they must increase their knowledge and skills much of which would have previously resided within the realm of the medical profession. With this sharing of knowledge and skills between professional groups, it may become difficult to see what distinguishes nursing and midwifery from medicine. Another challenge in relation to identifying nursing and midwifery as professions is that much of nursing and midwifery practice remains invisible (Cuxart-Ainaud, 2010). Whilst we can see physical acts of caring, emotional acts of caring may not be as noticeable. Similarly, the decision-making that supports nursing and midwifery practices or the support and advice nurses and midwives provide to their interprofessional colleagues may not be obvious. This invisibility is probably due to how difficult it

is to articulate what nurses and midwives do and their roles and this may become an even more significant issue with the continued expansion of practice.

3.2 Professionalisation and the role of education, state and others

The professionalisation of nursing and midwifery, the process whereby nursing and midwifery practice has moved from what was considered a vocational calling to being recognised as practices carried out by professionals (Yam, 2004) is ongoing. I consider it to be a positive endeavour, not only for patients which will be discussed during this chapter but especially for the professions of nursing and midwifery themselves. It has been a progressive move for what are female-dominated professions (Bourgeault et al., 2004) and has drawn on both science and feminism to further its agenda (Adams & Bourgeault, 2004). Midwifery has drawn on science to contest the claims made by the medical profession that natural childbirth is unsafe (Rushing, 1993) and on cultural feminism, which seeks to increase the value of women and their experiences and promises to attach social value to caring (Adams & Bourgeault, 2004). Fitzsimons (2017) proposes that benefits of professionalisation to a group are due to the achievement of better working conditions, superior standards and the protection of the public. The practice of nursing and midwifery is widely regulated requiring educational preparation for the roles and registration of practitioners. In Ireland, this function is carried out by the NMBI. With registration comes benefits including the right to practice and use of a title, access to work and public trust. The very existence of a register signifies that a community of similar individuals exists with which a practitioner can identify.

Professionalisation to date, has enabled nursing and midwifery to be considered autonomous professional groups though this idea of autonomy is contested and will be discussed in Section 3.4. This autonomy facilitates nurses and midwives in meeting the needs of an evolving healthcare service by expanding their scope of practice to include roles previously undertaken by medical professionals such as the prescribing of medicines. Not only has the professionalisation of nursing and midwifery contributed to the dismantling of traditional power structures within healthcare organisations, in terms of clinical care and enhanced decision-making as outlined above, this is also evident at a corporate level with the appointment of nurses to hospital chief executive officer roles and at a national level in Ireland with the appointment of a chief nurse in the Department of Health (Culliton, 2013).

Historians, who have examined the professions, largely identify a relationship between the emergence of educated professionals and the esteem this afforded them in terms of social status (Kitson-Clarke, 1962; Ringer, 1969; Parsons, 1971). In fact, in the early 1900s in Ireland, nurse training schools had been established in many hospitals in the voluntary sector (Robbins, 2000) with nursing seen as an attractive profession for the middle class. This was due to a number of factors including that medical schools were linked to them, many distinguished doctors practiced there and the boards of management were comprised of members of the influential classes, providing a certain prestige to being employed there (Robbins, 2000). Though nurses and midwives have long been held in high esteem, it was not until the educational preparation for nursing and midwifery

moved to the higher education setting that their professional contribution to patient care has been duly recognised.

The links between education and the professionalisation of nursing have undergone significant examination (Duffield, 1986; Gerrish et al., 2003; Keogh, 2008). Historically, nursing education emphasised the training of nurses rather than the education of nurses. This stemmed from the requirement to provide a workforce for hospitals (Mooney & Nolan, 2006) rather than developing nursing as a profession in its own right. Even with the establishment of the first nurse training school, at St Thomas' Hospital, London, by Florence Nightingale in 1860, this emphasis was maintained. The content delivered in training schools was from the sciences, delivered by doctors with much of the work and knowledge of 'nursing' being learnt 'on the job' and not studied. This approach to training suited the medical profession who following the Flexner (1972) report pushed medical education into medical schools, further separating themselves from nursing.

Many authors (Greenwood, 1957; Bixler & Bixler, 1959; Friedson, 2001; Giddens, 2010) include Larson's cognitive dimension of a profession in their own conceptualisation of a profession. Lack of a university qualification and theory and research within the discipline prompted Etzioni (1969) to consider nursing a semi profession provoking the suggestion that this cognitive dimension be obtained through university education (Abbott, 1988, Evetts, 2003). Though doctors were against this move as they feared insubordination and that nurses might think they knew more than them (Ashley, 1976; Malka, 2007) it had actually begun to happen in the 1950s. This may have been fuelled by nurse leaders

wanting nursing to be recognised as distinct with its own body of 'scientific' knowledge, viewed by others, particularly those in medicine, as the highest form of knowledge. It was a move that also recognised the changing healthcare landscape and the increasing complexity of individuals requiring care. The move to university-educated nurses also supported Friedson's idea that professional work requires judgement which is reliant on theoretical and abstract knowledge in order for the work to be performed competently, with learning taking place in a higher education institute (Friedson, 1977). The requirement for training in special schools meant that a new role now existed, that of teacher/lecturer, which opened up opportunities for scholarship and nursing research. This led to the development of nursing science and the proliferation of nursing theories in the 1960s. Nursing and midwifery's engagement with research is one that continues to grow supporting the control of knowledge that is generated about the professions and the work they do.

Within the Irish context, the first step towards a university education for nurses was at a postgraduate level with the establishment of a nurse tutors diploma in 1960 at University College Dublin. However, it is only since 1994 that education programmes leading to registration as a nurse have been offered at higher education institutes (McCarty & Higgins, 2003) with the first being a diploma qualification offered at the National University of Ireland, Galway (NUIG). This was prompted by a move to a more community model of care and increasing technological advances which required additional knowledge by nurses. By 1997, all pre-registration programmes were offered at diploma level within third level

institutions (Simons et al., 1998) contributing to the professionalisation agenda by rooting nursing in academia (Ryan, 2008). The reform of nursing education was also driven by fiscal and pragmatic reasons (Fealy & McNamara, 2007). Given that the UK had previously moved nurse education into the higher education setting, there was concern that an Irish nursing qualification would not be similarly recognised as one obtained in the UK (Fealy & McNamara, 2007).

Though Duffield (1986) recognises the transfer of nurse education from the apprentice type training to third-level education settings, as the major influence in the professionalisation of nursing, it could be argued that this position diminishes the value of knowledge gained through practice and experience. The move to a university-based preparation for nursing practice was also questioned by Porter, S. (1990; 1992) who was somewhat critical of the drive to professional status for nursing through university education due to the absence of significant exploration of the university education and the professional model. Concerns have also been expressed that the transfer of education to third level removes education from nursing practice (Wakefield, 2000) and Andrew (2012) ponders if academic status has been achieved at the expense of direct patient care. In spite of these concerns, I consider the professionalisation of nursing and midwifery through education to be largely positive which has yielded benefits for patients and society along with the professions themselves. Many nursing and midwifery education programmes around the world, though based in the higher education sector, have integrated clinical placements throughout the programme giving students the opportunity to engage in patient care throughout their education.

Professionalisation and the educational pathway we now undertake prepares us more fully to provide and lead care for our patients with the links between educational attainment of nurses and improved patient outcomes recognised (Aiken et al., 2003; Kendall-Gallagher et al., 2011).

Apart from the very clear role education has played in the professionalisation of nursing and midwifery, the process is very much in keeping with the five stages described by Wilensky (1964). The first stage is the emergence of an occupational group and though this happened initially for nursing and midwifery, a new group, nurse/midwife prescribers (RNPs) have now emerged. The second stage is the establishment of a training and selection programme described above (continuing professional development is addressed in detail in Section 3.5). Formation of a professional association marks the third stage and in the case of nursing and midwifery this is the NMBI. The development of a code of ethics and political activity to recognise and protect professional work are the final stages. Nurses and midwives practice in accordance with a code of ethics developed by NMBI who have also developed additional standards to which RNPs must adhere. Political activity has resulted in the protection of titles such as Registered General Nurse (RGN), Registered Midwife (RM) and Registered Nurse Prescriber (RNP) and the introduction of legislation that enables expanded practice to include prescriptive authority by nurses and midwives.

Abbott (1988) recognised that professional status once achieved needs to be defended, in other words, professionalisation is a continuous process. It is perhaps through Broman's idea that professionalisation is more than the creation

of a new elite and also includes the adaption of a group to new circumstances, that this occurs (Broman, 1995). This is particularly relevant to nursing and midwifery who continue to socialise new students and graduates to the professions whilst at the same time require those currently working as nurses and midwives to continually adapt to a changing landscape and circumstances. Professionalisation now includes both the attempt to attain new privileges (such as prescribing) as well as defending existing ones in light of new professional groups emerging for example physician associates. It is a forward-looking process by members of a group that allows the group itself to determine their future. In this way, the introduction of nurse and midwife prescribing can be seen as being as a result of the professionalisation project to date.

The degree to which professionalisation is achieved is dependent on a number of factors including technical competence and the extent to which client, or in this case patient interests and professional norms are adhered to (Wilensky, 1964). Professionalisation is also highly reliant on the state. Nurses and midwives consider themselves to be self-governing both at an individual level in terms of practicing within a scope of practice and at the level of the professions through the professional regulator. It is important to note though that this self-governance and power to control the professions is granted by the state through legislation. Legislation for practice in Ireland was first enacted in 1918 for midwives and 1919 for nurses. The introduction of nurse and midwife prescribing also required legislative change, facilitated by the government. Many hospitals and healthcare organisations are funded by the state. Though hospitals have always been

bureaucratic, hierarchal organisations, state involvement magnifies this and with bureaucracy, comes an associated lack of autonomy (Turner, 1995). Contra to this I propose that bureaucracy and state intervention can on occasion facilitate autonomy as will be reported in Chapter 6 of this thesis.

Professionalisation also requires a group to be recognised as a professional group by others (Friedson, 1986; Adams, 2003). This is apparent in a very significant way within healthcare which is interactive and multidisciplinary in nature. One potential challenge to the professionalisation of healthcare groups other than medicine, is the role medicine plays in determining the fate of subordinate groups who are seeking professional status (Larkin, 2002). Doctors have been central to the delivery of nurse and midwife education over the years (Faulkner, 1996) giving them a powerful role in dictating the evolution of the nursing and midwifery professions rather than nursing and midwifery directing their own professional futures. This signifies the process as one that does not occur within a silo but occurs within a political and social context.

If professionalisation and recognition as a professional group is so highly reliant on acceptance and recognition by others and on the state, how autonomous can a group, in this case nursing and midwifery, ever be? Though there are positive benefits to the participation of the medical profession in the preparation and support of nurse and midwife prescribers (Bowskill et al., 2014) which will be addressed later on in this chapter, and state involvement can facilitate autonomy, issues of power in relation to the process of professionalisation warrant exploration.

3.3 Power and professionalisation

The journey to professional status for nursing, mirroring that of the women's movement (Castle, 1987), has been arduous and has faced other challenges, one of which is a power imbalance. When we think about power we can tend to think of it as meaning domination, influence or control. It is however, a much broader concept than that and cannot be conceptualised so narrowly. Hawks (1991) speaks of 'power over' and 'power to' and Veneklasen and Miller (2002), 'power within' and 'power with' (Veneklasen & Miller, 2002). Each of these is visible to some extent within nursing and midwifery practice. Hawks (1991) described 'power over' as influence over behaviour and actions. An example of this was the traditional model of nurse and midwife education (outlined in the previous section) which promoted the subservient nature of those roles to medicine. As a female-dominated occupational group, nurses have been open to oppression by virtue of their gender (Roberts et al., 2009; Dubrosky, 2013) with the power imbalance in favour of the mainly male medical profession (Rowen, 2010). Nursing was classed as women's work and considered less valuable (Wuest, 1994; Adams & Miller, 2001) with much of it invisible (Wolf, 1989; Benner, 2001) further decreasing its value, contributing to powerlessness within the profession. Nurses held subordinate positions and thus supported the work of other male healthcare workers (Daiski, 2004). Clothing is also a reminder of a power imbalance (Weiss et al., 2016) with (the mainly female) nurses and midwives wearing hospital stipulated uniforms and doctors wearing white coats or clothes of their own choosing.

Nursing leaders have also contributed to the power imbalance or hierarchal divide between medicine and nursing over the years. Though wanting to enhance the image of nursing, early leaders like Nightingale were more concerned about the moral character of the nurses than their clinical skills (Ashley, 1976; Reverby, 1987). An effort was made to keep nurse training within the hospital setting (Weiss, 1995; Malka, 2007) and with many hospitals, bureaucratic and hierarchal in nature being run by religious organisations which emphasised obedience and duty (Marshall & Wall, 1999), a sense of duty to hospital administrators and doctors was instilled (Ashley, 1976; Reverby, 1987; Malka, 2007). Power was given to nurse leaders to control nursing students with nurse leaders often siding with doctors rather than the nurses (Ballou & Landereau, 2010). Issues related to gender also exist within the professions themselves with male nurses more likely to rise to senior positions and be paid more than female nurses (Brown, 2009). The introduction of new nursing and midwifery roles may also perpetuate a divide within the professions which will be addressed in Section 4.4.

Nurses have experienced ‘power over’ in oppression by organisation and administrative structures (Kuokkanen & Leino - Kilpi, 2000) and it could be argued that power over nursing/midwifery continues in the way prescriptive authority for RNPs is facilitated and regulated. The requirement for a Collaborative Practice Agreement (CPA) could be viewed as a tool to support medical dominance, however this requirement for documented collaboration, along with consultant/GP approval to prescribe and Drugs and Therapeutic (D&T) committee oversight came from within the professions of nursing and midwifery

and not from medicine. Though doctors could exercise their authority in their mentorship role as power over in a negative sense, in my experience, mentors have taken a much more collaborative approach which is more in line with the idea of 'power with' (Veneklasen & Miller, 2002). It is clear that the medical profession play a key role in the development of nursing and midwifery roles and an acknowledgement of the potential benefits of this model is warranted.

No group of healthcare professionals work in isolation from others and a much more collaborative, team-based approach to patient management and care is practised. Afseth and Paterson (2017) found that engagement with a designated medical practitioner resulted in the development of trust between the nurse and doctor and facilitated the ratification of the role of the nurse prescriber within the wider team. They also outlined how the designated medical mentors brought a unique perspective to the situation and supported the generic pharmacological teaching delivered through the education programme, by providing context for the information and discussion of prescribing evidence (Afseth & Paterson, 2017). The authors also suggested that this engagement between nurse and doctor updated the practice of medical practitioners themselves (Afseth & Paterson, 2017). The influence of the medical profession in terms of role development will be further discussed in Chapter 4 on professional identity.

Power as a positive construct has also been recognised (Foucault & Gordon, 1980) and in the case of nursing and midwifery practice in 'power within' and 'power with' (Veneklasen & Miller, 2002) and 'power to' (Hawks, 1991). Power within' is the 'capacity to imagine and have hope' and 'power with' involves

collaboration to promote fair relationships (Veneklasen & Miller, 2002). Both of these are evident in Ireland, firstly in the pursuit of prescriptive authority and secondly in the model of prescribing established in Ireland. 'Power to' facilitates the achievement of organisational goals and 'getting the work done' (Vine, 2004). Rules and procedures are established by management and others within the system are expected to comply with them. 'Power to' is useful in enabling nurses to work effectively with patients and other staff (Katriina et al., 2013) and can be sourced from interpersonal relationships (Hawks, 1991) and the professionalisation process by expanding scope of practice. An example of this 'power to' is prescriptive authority for nurses and midwives which facilitates a better experience for patients (Latter & Courtenay, 2004; Carey et al., 2008; Cooper et al., 2008a; Courtenay et al., 2011). This raises questions though in terms of whether those 'getting the work done' are just following rules or worse being exploited, or at an individual level if this is a positive expression of power?

It would be remiss to speak of power in either its negative or positive forms without acknowledging that nurses and midwives also hold a degree of power over others. This includes colleagues to whom they delegate work such as students, junior staff and support workers and patients and those they care for. Will the increasing knowledge and expertise that nurses and midwives hold arising out of professionalisation create a greater power distance between them and patients? Or, on the other hand, will it enhance their ability to empower patients? I suggest power in its positive form exists as empowerment, a term much more palatable to nurses and midwives which I will now discuss in relation

to nursing and midwifery practice and specifically in relation to prescribing practice.

3.4 Empowerment and autonomy

Nurses and midwives often align themselves with the term empowerment rather than power which may be due to an understanding of power as a masculine construct, in opposition to caring and nurses' identity as women (Rafael, 1996). So what is empowerment and why might it sit more comfortably within professions that are largely determined by their relationship with care? Chandler differentiates between power and empowerment. She claims that empowerment enables individuals 'to feel effective so they can successfully execute their jobs' and thus is an enabler of action (Chandler, 1992 p66). On the other hand, she suggests 'power' is about domination and control (Chandler, 1992). The idea of empowerment, which emerged with the growth of self-help and political awareness (Ryles, 1999) is important. Nurses who perceive themselves as powerless are less satisfied (Manojlovich & Laschinger, 2002), can become burnt out (Leiter & Laschinger, 2006) while those who are empowered are highly motivated and empowering of others (Laschinger & Havens, 1996).

3.4.1 Empowerment and nurse/midwife prescribing

So how does the concept of empowerment relate to nurse and midwife prescribing? Empowered nurses and midwives are those with the authority to act or practice to the full extent of their scope, which may include prescribing, resulting in better patient care. A number of different theories have been developed in relation to how individuals become empowered including a theory

of psychological empowerment (Spreitzer, 1995), structural empowerment (Kanter, 1993) and relational empowerment (Chandler, 1992). I consider that nurses and midwives need to be able to draw on all three sources in order to maximise their level of empowerment. Spreitzer's theory of psychological empowerment suggests empowerment is a motivational construct with four cognitions, meaning, competence, self-determination and impact. In summary these suggest; that an individual's beliefs and standards align with work goals (meaning), belief in one's capacity (competence), an individual's sense of autonomy (self-determination) and the belief that a difference can be made (impact). Kanter's theory of structural empowerment (Kanter, 1993) recognises that opportunity and power within organisations are essential to empowerment. In more detail these are; opportunities for advancement or involvement in activities that are beyond an individual's current job description, access to information about the organisation, access to support for responsibilities and access to resources (Kanter, 1993). In relation to prescribing this includes support to attend classes in preparation for prescribing practice and national, legislative, regulatory and institutional structures and processes that support safe prescribing practice. Laschinger et al. (2001) propose that structural empowerment contributes to psychological empowerment. RNPs draw heavily on relationships as a source of empowerment (Chandler, 1992; Raphael, 1996) both during the education programme preparing them for their role and when practicing as a prescriber. This is due to the model of educational preparation which requires a formal mentor-mentee relationship along with the collaborative

model of prescribing adopted in Ireland. The relational empowerment approach which stemmed from women's experience in relationships contends that relationships are founded on interaction. Strength or power arises out of relationships that are built on dialogue and self-awareness (Fletcher, 2006) and the experience of being empowered arises out of the learning which occurs within relationships. Surrey (1997) recognises that empowerment thrives within relationships that are nurtured which includes a responsibility to participate in the growth of others in the relationship (Fletcher, 1998). This is an important concept in terms of nurse and midwife prescribing given the central part the mentor plays in preparing the nurse/midwife for the role. The power arising out of caring relationships has also been recognised within the nursing literature (Benner, 2001; Fletcher, 2006).

RNPs need to draw on all three sources of empowerment for a number of reasons including the complexity of the healthcare environment and the disruption to the traditional order of things, that prescriptive authority for nurses and midwives brings. Drawing on one or two only may not facilitate autonomous practice. If for example nurses and midwives only draw on empowerment arising out of relationships, if traditions, rules and policies within organisations do not support them (Shirley, 2007; Skar, 2009) their potential for empowerment will not be realised. A nurse or midwife may have the support of a medical mentor to pursue a prescribing qualification but if organisational policy does not support the practice, the individual will not be empowered to actually prescribe. Similarly, despite organisational policy supporting prescribing by nurses and midwives,

unless the individual can be empowered through a supportive mentorship relationship and they possess a belief that they have the capacity to and will make an impact, they will not be empowered sufficiently to be autonomous.

3.4.2 The meaning of autonomy

What does it mean though, to be autonomous? Sociologists describe autonomy in terms of the right to control work free from the influence of others (Friedson, 1970) and nursing scholars have conceptualised it in terms of clinical decision making (Kramer & Schmalenberg, 1993; Keys, 2009). Though autonomy's 'relationship with nursing practice and status has been addressed extensively, it has been poorly defined, operationalised and measured' (Iliopoulou & While, 2010: 2521). Within nursing itself there are variations with some nurses considering autonomy to mean working individually, based on their own decision making and others suggesting it means working within a team context where support and clarification can be accessed (Oshodi, 2019). What resonates with me, is autonomy as authority to act and make decisions (MacDonald, 2002; Weston, 2008; Berndt et al., 2009), but also recognising autonomy as socially constructed and dependent on relationships and structures (MacDonald, 2002). This is one which perhaps sits well with nursing and midwifery practice, recognising practice as interdependent with other professional groups (Shirley, 2007) and one bound within legislation and professional regulation.

Taking into account the conceptualisation of autonomy described above it would appear that yes nurses and midwives are autonomous and those taking on expanded practice roles for example prescribing, are even more so. It is perhaps

though not quite so clear cut. Given the regulation of nursing and midwifery practice described in Chapter 2, are nurses and midwives empowered to be autonomous or is it more an illusion of power (Foucault, 1975; Foucault & Gordon, 1980) that they hold? It could be argued that they are under constant surveillance, under, as what Foucault would suggest is the gaze from the panopticon (Foucault, 1975). In this way nurses and midwives conform to certain behaviours because they are potentially being watched. In terms of nurse and midwife prescribing the role of the D & T committee, the CPA and the role of mentors could be viewed as tools of the panopticon. However, it is possible that it is the professions themselves that exert most power over individual nurses and midwives in terms of their disciplinary power (Foucault, 1975).

The aim of disciplinary power is to mould nurses to conform to professional norms (Cheek & Rudge, 1994). It ensures nurses behave in a way acceptable to the profession and is exercised through three processes. Hierarchal observation is the mechanism by which those at the top can view those below and hospital practices support this. It can be indiscreet where the nurse is aware they are being watched with examples being the requirement for documentation and audit. Discreet hierarchal observation encourages nurses to think that they are practicing autonomously when in fact they are practicing within parameters. Normalising judgement is the second process where practitioners are judged against norms and involves self-monitoring and policing of ourselves. We learn to regulate our behaviour against standards and can do this through different mechanisms for example reflection (Hardin, 2001) and the use of rewards and

punishments. The techniques of hierarchal observation and normalising judgement come together in the third process which is examination. This is a process which identifies deficits (Cheek & Rudge, 1994) and one we are very familiar with in terms of examination of knowledge, skill and competence.

Another view which could suggest nurses and midwives are less autonomous than they think, particularly when talking on expanded practice roles such as prescribing, is that they have been co-opted to do the work of doctors. Gamson (1975) and Piven and Cloward (1977) and have suggested that co-optation is a strategy to get people to work with those who have the power to make decisions, without giving them any of the benefits using co-operative practices. The goals of those in power are achieved with no cost to them. Nurses and midwives taking on expanded practice roles could be seen to be co-opted to do the less desirable work of doctors. This was certainly a fear in the past when nurse leaders hindered the development of advanced practice roles as they were concerned that nurses would be co-opted by doctors and would be led away from nursing (Barnum & Kerfoot, 1995). Given my conceptualisation of autonomy though, expanded practice to include prescriptive authority is not an exercise of co-optation.

In the context of autonomy for healthcare professionals we also need to consider the role organisations may play in inhibiting autonomy. Lewis and Batey (1982) suggests that when an organisation can veto power then autonomy does not exist. This would mean though that nobody is autonomous as we are all, whether doctors, nurses, midwives, physiotherapists of pharmacists, subject to practicing within the parameters of our individual scope of practice and scope of practice of

the profession and to practicing within the parameters of organisational rules and clinical guidelines.

Taking all of the above into consideration, I propose that that there are both areas of, and degrees of autonomy. These areas of autonomy have been described by Manojlovich (2007) as control of the content of practice, the context of practice and competence, recognising that we are talking of nursing/midwifery autonomy and not absolute autonomy over all clinical practice or that provided by doctors. To view nursing/midwifery autonomy with respect to medical autonomy would be to take a very doctor centric position and imply that what doctors do is more important than what nurses/midwives do. Autonomous nursing practice, conceptualised as authority to act (MacDonald, 2002; Weston, 20008) and being socially constructed and dependent on relationships and structures (MacDonald, 2002) can be seen in the following example. Consider the patient post-surgery, who, to the nurse's eye appears to be in some discomfort. The nurse will undertake a patient assessment. They will check intravenous lines, drains, the patient's wound and pressure areas for signs the patient maybe developing a pressure sore. They will perhaps reposition the patient to one which is more comfortable. They will use an evidenced based tool to assess the patient's pain score and seek information from the patient about how their pain/discomfort is presenting and affecting them. The nurse will determine when the patient last received pain relief and will ask the patient how effective it was in addressing their pain. They will also seek to determine if the patient experienced any side effects, particularly those that were unwanted, for example nausea or

drowsiness. Based on these considerations and patient desire, the nurse will then collaborate with the patient as to the best course of action which may include the administration of additional pain relief. If the nurse holds prescriptive authority, he or she may be able to prescribe an alternative medicine, particularly if previous pain relief was ineffective. The nurse then administers or arranges for the pain relief to be administered and reassures the patient that he/she will come by in a while to determine its effectiveness.

This example also highlights two of Manojlovich's (2007) areas of autonomy; control of content of practice which is reliant on nurses and midwives having control over practice, which is based on knowledge and judgement and control over competence of practice which is facilitated though knowledge development (Raphael, 1996) enabled through education and the development of expertise. Manojlovich's (2007) third area of autonomy is control over the context of practice. This can be facilitated or enabled by giving nurses the opportunity to contribute to the running of hospitals and perhaps in the case of prescribers, to contribute to policy development and the introduction of new ways of working. When hospitals support autonomous nursing practice in this way patient outcomes are improved (Aiken et al., 1999; Aiken et al., 2000), patient satisfaction is increased (Aiken et al., 1999) and there are improved levels of recruitment and retention of nurses (Bednash, 2000).

I propose that autonomy as absolute control does not exist in healthcare practice as no one has absolute control. This is recognised by Weston (2008) who suggests that autonomy within nursing is the ability to act according to one's

knowledge and judgement, recognising that this is within the constraints of professional regulation and organisational rules. She also acknowledges though that nurses have increasing opportunities to shape those rules, leading to autonomy over the context of practice (Manojlovich, 2007). It is not enough however to provide input to committees and participants must be actively involved in decision making as engagement only, does not necessarily impact final outcomes (Crowley, 1998; Murray, 2006).

The professions of nursing and midwifery also exert some control over the context of their practice in terms of their authority to self-regulate. This has been enabled by claims that demonstrate value. These include that the tasks to be performed, should they be conducted by others outside the profession, could be detrimental to the public. A second claim demonstrating value is that of expert power (Conger & Kanugo, 1988), knowledge and skill applied by the profession which is beyond the scope of the ordinary person. This expert power arises out of both education and experience. A third claim to value is the characteristics of group members which make them more interested in the good of others than themselves. This last claim is substantiated by a formal code of ethics for nurses and midwives which demonstrates the professions' concern for ethics and their commitment to addressing issues of concern should they arise.

3.5 Caution around professionalisation of nursing and midwifery

Many authors writing about professionalisation and nursing fail to see professionalisation as anything but positive (Miller et al., 1993; Adams & Miller, 2001; Wynd, 2003) and whilst I am overwhelmingly in favour of continued

professionalisation, I am conscious that potential negative consequences have been identified. Given the continued evolution of nursing and midwifery practice and thus its sustained engagement with the professionalisation agenda, it is important to outline these. I disagree with, as did Nelson and Folbre (2006), Heyes' (2005) suggestion that increased wages for nurses, as a result of the professionalisation process could result in a lowering of the quality of people coming forward to nurse. Nurses (Royal College of Nursing, 2010) and midwives (NMBI, 2015a) have embraced the idea of patient empowerment and partnership in care philosophy and earlier in this chapter, I alluded to the idea of power over patients. Professionalisation, where a group has professional status based on factors including expert knowledge, creates a power dynamic and in the case of healthcare, power over the patient or recipient of care. This consequence of professional status could be seen to be a contradiction to our philosophy and begs the question of whether professionalisation has created a distance between nurses and midwives and those they care for or attend to? This question is important for expanded and particularly advanced practice roles for nursing and midwifery when they arise out of the professionalisation project. Do roles, particularly those that were once the responsibility of the medical profession, such as prescribing of medicines, create this distance?

I support the idea that power and knowledge are closely linked (Foucault & Gordon, 1980). It follows then that the incorporation of expanded practice roles to nursing and midwifery practice (which requires additional post qualification knowledge and skills) has contributed to the professionalisation of the

professions and their emergence from the shadows of the medical profession, an example of ‘power to’. The development of the professions of nursing and midwifery is dependent on continuing professional development (CPD) and the following section will outline the connection between these. Expanded practice roles however, can result in fluid boundaries and unstable work jurisdictions and may present challenges with regards to professional identity and professional unease around blurred boundaries and role clarity. These in turn can hinder the advancement of nursing (Laurent et al., 2005; Sidani et al., 2006) and will be addressed further in Chapter 4 on professional identity and reported on in relation to this research in Chapter 7.

3.6 Professionalisation, CPD and nurse/midwife prescribing

I believe that each nurse and midwife is at an individual point on a continuum of learning as described by Benner (1984) who recognised five stages of clinical competence: novice, advanced beginner, competent, proficient and expert during which practitioners develop skills and understanding through experience and education (Benner, 1984). Keeping oneself up to date is both a responsibility and expectation of individuals claiming to belong to a professional group (Houle, 1980). Nursing and midwifery practice is not static and what is known by nurses and midwives at the time of initial registration is not sufficient to sustain a practitioner over the course of a career. With nurses and midwives operating in a changing and more complex environment than previously, they recognise that it is not enough to maintain knowledge and they must continue to develop and advance their own knowledge (Skar, 2010). Engagement in CPD which facilitates

‘changes in life patterns or career lines’ (Houle, 1980: 13) is one way in which this can be facilitated. Engagement with CPD is also acknowledged as necessary in achieving the WHO’s third global patient safety challenge, ‘medication without harm’ (World Health Organisation, 2017). Nurses and midwives have embraced the idea of CPD, necessary to maintain professional status and are willing to expand their scope of practice, recognising how it can improve patient care (Fealy et al., 2014). The contribution of CPD in maintaining competence and facilitating knowledge development is also endorsed by NMBI (NMBI, 2010a).

CPD is also required for expansion of practice (discussed later on in this chapter) which in the main, requires nurses and midwives to engage in postgraduate academic education. Postgraduate education programmes are underpinned by the principles of lifelong learning and are offered in many specialist areas from postgraduate certificate to doctoral level. The pursuit of postgraduate or post-registration education has allowed the professions to ‘further their projects by expanding their knowledge base and jurisdiction’ (Suddaby & Viale, 2011: 431). The value of postgraduate nurse education is immense, linked positively to patient outcomes through improved communication, expanded knowledge and stronger critical thinking skills (Cotterill-Walker, 2012) and the management of chronic health conditions (Higuchi et al., 2006). It is argued that nurses educated to postgraduate level are more likely to use evidence to support their practice (Pelletier et al., 1998), make fewer medication errors, are more accurate in triaging patients in the emergency department and contribute to improved clinical outcomes (Considine et al., 2001; Aiken et al., 2003; Spence, 2004a, 2004b).

Increased credentials can also convince society of the value of nurses (Adams & Miller, 2001).

The CPD programme most relevant to this study is that which qualifies graduates to practice as RNPs. Whilst much CPD is undertaken in formal classroom settings, the power of clinical nursing/midwifery practice itself to facilitate learning and knowledge development cannot be underestimated. This is recognised by the education programme preparing RNPs which includes both theoretical and clinical practice elements. The clinical component is supported by Lave and Wenger's Situated Learning Theory (SLT) (Lave & Wenger, 1991) which proposes that for education to be effective, learning should be embedded in authentic practice. Two important concepts within SLT are communities of practice and legitimate peripheral participation. Wenger (2000) described communities of practice as 'groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly'. Characteristics that distinguish a community of practice are the domain or shared interest of the group, community or people who make up the group and practice or ways of doing things that have been adopted by the group. It is likely that RNPs are members of a number of communities of practice for example their ward or specialist team within which they practice, along with being part of the community of RNPs within their organisation. Legitimate peripheral participation posits that learners move over time, from the edge of a community of practice to being central players within the community as they participate in more complex activities. SLT builds on the idea of modelling within Bandura's Social Learning

Theory and scaffolding within Vygotsky's Social Constructivism (Vygotsky, 1978), encompassing principles of adult education. SLT encourages reflection and focuses on application, with learning occurring through dialogue. The requirement to have a work-based mentor for the nurse and midwife prescribing programme should facilitate this dialogic learning and allow the development of a community of practice between the student, mentor, wider multidisciplinary team and patient. The student prescriber should, through active participation within the community and situated learning space, move from a peripheral position to the centre of the community, developing competence (Benner, 1984; Benner et al., 1996).

The collaborative nature of the prescribing model implemented in Ireland should also facilitate the continuation of the community of practice with RNPs working alongside and learning with and from their colleagues. I believe this model of education and development of RNPs implemented in Ireland should answer the concerns of Wakefield (2000) and Andrew (2012) articulated earlier in this chapter. It does not take into account however the potential that some individuals may not be able to participate meaningfully in activities within their community or indeed that there may be resistance within communities (Fenwick, 2001). This may be particularly relevant when nurses and midwives are knocking on the door of a community of prescribers who, heretofore, were members of the medical profession only. The next section will link expansion of practice and nurse and midwife prescribing which is facilitated by CPD to professionalisation.

Engagement in CPD enables us to address one of the greatest obstacles to achieving the goals of efficient and high-quality patient care in a changing environment, which is the traditional role undertaken by healthcare professionals (Bradley & Nolan, 2007). Upon initial registration as a nurse or midwife, the practitioner is deemed to have achieved certain competencies and is expected to practice within their scope of practice. In order to provide appropriate care though, nurses and midwives must continually adapt their scope of practice which is recognised as being fluid and altering over the course of a career (NMBI, 2015b). It is maintained that broadening practice to include aspects not previously within their individual scope, but which are within the overall scope of the professions, increases the impact nurses and midwives can make (World Innovation Summit for Health, 2018). The Health Service Executive (HSE) requires nurses and midwives to be proactive in recognising areas where expanding their scope of practice would lead to improved outcomes for patients (Health Service Executive, 2012). New policy, outlined in the previous chapter pertaining to the maternity sector is also supportive of expanding roles for nurses and midwives for patient benefit (Department of Health, 2016a).

The introduction of prescriptive authority for nurses and midwives in 2007 has significantly changed how health services and patient care are delivered (Naughton et al., 2013). The narrative around the time of introduction was that patient care would be improved (Luker et al., 1997; Horrocks et al., 2002; An Board Altranais, 2005). The drivers of this new expanded role for nurses and midwives however, are more numerous than that. Bhanbro et al. (2011) and

Weeks et al. (2016) recognise the introduction of non-medical prescribing as an answer to health care challenges in the western world. Internationally the move to facilitate non-medical prescribing has been propelled by a number of internal and external factors (Latter & Courtenay, 2004; Strickland-Hodge, 2008; Kroezen et al., 2011) such as providing more seamless and rapid access to effective treatments (Latter & Courtenay, 2004; Carey et al., 2008; Cooper et al., 2008a; Courtenay et al., 2011) and the desire nursing had to enhance its professional status (James et al., 1999). External factors such as the European Working Time Directive (EWTD) which reduced junior doctors working hours and the requirement to balance public expectation with costs (Culliton, 2011) have also acted as an impetus.

Whilst the benefits to patients when nurses or midwives hold prescriptive authority are laudable, it is imperative to question who else's interests are served by the introduction of nurse/midwife prescribing? Does prescriptive authority for nurses and midwives free doctors from mundane tasks? I argue that the complexity of prescribing decision making means that the activity is anything but mundane. A review of nurse prescribing has shown it to be cost-effective (Venning et al., 2000). If more nurses/midwives with prescriptive authority are employed at a lower salary, there may be potential for the number of doctors in an organisation to be decreased, thus reducing salary costs. The literature suggests that nurses with prescriptive authority prescribe less frequently than doctors, often utilising non-pharmacological treatments (Mahoney, 1994). This may have the potential to reduce the medicines bill for a given organisation or

healthcare provider. If the EWTD had not been introduced, would nurse prescribing have been introduced and would it have had the ministerial backing it did at the time? Was the introduction of nurse and midwife prescribing a strategic approach where the emphasis was on cost reduction and efficiency of services rather than enhanced care?

Despite nurses and midwives embracing new roles, it has been questioned whether professions are vulnerable to pressure and unable to resist change (Kirkpatrick et al., 2005). I believe however that at an individual level, the scope of practice framework provides a defence against pressure to take on roles they are not comfortable with. This is also borne out by the numbers of nurses and midwives prescribing. Though the number of nurses and midwives with active registration to practice is approximately 65,000 and the numbers of RNPs and organisations involved in prescribing are increasing year on year, most recent figures available show that just 1123 RNPs are registered with the NMBI (Health Service Executive, 2018).

I am conscious that developments such as expanding practice within the professions face challenges. The introduction of nurse and midwife prescribing challenges the traditional perspectives of nursing and midwifery being subordinate to medicine and focusing on care whilst medicine focussed on cure. For me, nursing and midwifery are very much values-driven professions, a position supported by two initiatives launched in Ireland in 2016, ‘Values in Action’ by the HSE (Health Service Executive, 2016) and ‘Values of Nursing and Midwifery’ (care, compassion and commitment) launched by the HSE, NMBI and

Department of Health (Department of Health, 2016b). With the development of new and expanded roles for nurses and midwives, which include practice traditionally associated with medical roles, I believe maintaining these values is important in order to safeguard the integrity of the professions.

Further challenges were identified by Fealy et al. (2018) in their discursive paper on developing and sustaining specialist and advanced practice roles. For example, an approach to professional regulation which is legislatively and rule-driven may restrict practice (Fougere, 2016). Similarly, lack of regulation whereby roles lack official recognition may adversely affect the implementation of the role (Carney, 2015). Developing roles are also challenged when practitioners face difficulty in accessing education or in relation to time and costs associated with education (Baxter et al., 2013). Lack of management support (McKenna et al., 2015) can also hinder the full realisation of the leadership aspect to specialist and advanced practice roles (Elliot et al., 2016). Despite these challenges, enabling nurses and midwives, who in many countries, including Ireland make up one-third of the healthcare workforce (Kelly, 2018), to practice to their full potential and expertise will maximise their contribution to healthcare. Nursing and midwifery offer a unique contribution to patient care and we should examine how prescriptive authority is facilitated to ensure that whilst practicing to the full extent of an individual's scope of practice, the nursing or midwifery focus is not lost.

3.7 Conclusion

I consider the professionalisation of nursing and midwifery to be a positive move for the professions and in this chapter have located nurse and midwife prescribing

within this process. Expanding practice to include prescriptive authority, facilitates the advancement of the nursing and midwifery professionalisation project (Suddaby & Greenwood, 2001) and adds to professional standing. The way in which nursing and midwifery meet the criteria to be considered professions and the influence of others including the state and other professional groups in the professionalisation process have been described. Challenges associated with the process have been identified and the significant role education and CPD play in facilitating expansion of practice which contributes to professionalisation have been examined. Concepts relevant to professionalisation, particularly power and empowerment have been explored. This chapter has identified a number of gaps in relation to what we know about nurse and midwife prescribing such as; what separates nursing and midwifery from medicine given the expanded roles of RNPs, does prescriptive authority increase the visibility and value of nursing and midwifery practice, does prescriptive authority create a power distance between nurse/midwife and patient, are RNPs empowered to their maximum capacity and does the educational preparation and model of prescribing introduced for nurses and midwives in Ireland facilitate the development of communities of practice? The following chapter will consider nurse and midwife prescribing within the context of professional identity due to the potential for identity to be altered when practice is expanded and the influence of other healthcare professionals in identity formation.

CHAPTER 4 PROFESSIONAL IDENTITY: SITUATING NURSE AND MIDWIFE PRESCRIBING

4.0 Introduction

Identity is a broad and contested subject but an important one for professionals. This chapter draws on a selection of the literature which helps frame my research questions and what nurse and midwife prescribers (RNPs), the participants in the study, have to say. I discuss and critique different approaches to defining identity including the social identity approach (SIA) which I consider to best connect with my sense of how identity should be framed. I describe the importance of a strong professional identity both for patient care and to enable professions to direct their own future. As this study pertains to practice within maternity services, I explore identity and midwifery, taking cognisance of medicalisation within this field. How identity is constructed is noted as this is of significance for me as an educator preparing nurses and midwives for prescriptive authority. Care, a central value to professional identity for nurses and midwives and its formation is outlined and I propose Swanson's (1993) theory of care as an appropriate theory to guide practice as it maintains and enhances caring in new roles, including prescribing. I also highlight how professional identity, professional boundaries and care can be influenced by changing professional roles.

4.1 Identity

'Being' a nurse is important to me. The core values of nursing and midwifery, (care, compassion and commitment) (Department of Health, 2016b) are values that propelled me to a nursing career and ones that guided my practice when

working as a clinical nurse. There is a saying, once a nurse, always a nurse and I continue to try to live and express the core values of my profession daily both personally and in my professional role as a nurse educator. Nursing is not merely about the tasks I perform but who I am as I perform those tasks, the values and principles that support me in practicing. Identity is not an abstract concept (Ohlén & Segesten, 1998) as it is also something I feel and whilst an intensely personal construct, the formation, scope and protection of professional identity is an important concept both within the academic literature and for professionals themselves. Fagermoen (1997: 435) defines professional identity as 'the values and beliefs held by the nurse that guide his/her thinking, actions and interactions with the patient'. It involves belonging to a recognised group, acting in a way expected of that group, influenced by the accepted values of that group. This identity places me in a specific professional space, cognisant of my education, my professional experience and the management and political structures within the organisation I work.

Ibarra (1999: 764) describes professional identity as a 'relatively stable and enduring constellation of attributes, values, motives and experiences in terms of which people define themselves in a professional role'. Though I have a strong sense of my own professional identity and consider it to be relatively stable, this may be due to the nurse/midwife educator role I find myself in, where the pace of change in the role is not comparable with that in clinically orientated roles. Given the fast rate of change within healthcare generally, the sense of a stable identity may not be universally held by nurses and midwives working in clinical practice.

Mohammed's idea of identity and culture as being 'fluid, complex, historically situated and discursively constructed' (Mohammed, 2006: 98) may be more relevant. With evolving clinical practice at both the professional and individual practitioner levels, identity may well be fluid particularly in light of changes in autonomy that accompany expanded practice roles.

Different theories have been put forward to help us understand our sense of identity including identity theory (Place, 1956), social identity theory (Tajfel & Turner, 1979) and self-categorisation theory (Turner et al., 1987). I consider the social identity approach (SIA), proposed by Kreindler et al. (2012) as an approach that fits best with my understanding of identity. It is sufficiently broad to aid understanding of how group membership affects our sense of self, an important consideration in healthcare where individuals work within teams comprised of different professional groupings. Combining social identity theory with self-categorisation theory (Kreindler et al., 2012), SIA addresses five dimensions which attempt to define or articulate social groups: *social identity* which describes how people perceive themselves as in or out of a group; *social structure* which relates to power and status within a professional setting; *identity content* which recognises how internalisation of group norms guide behaviour; *strength of identification* which accepts that people can be members of many groups but will have a stronger attachment with some more than others and *context* which recognises that how people see each other is influenced by organisational structure and working practices which can affect group interaction. These five dimensions are important considerations when we examine the introduction of

expanded practice roles for nurses and midwives for example nurse and midwife prescribing. How are RNPs perceived within and outside the group? How they are perceived by nursing and midwifery colleagues who do not hold a prescribing qualification? Which group do RNPs belong to? Do they remain within a nursing group or have they moved some way towards a medical group? In a study conducted in the general practice setting (Weiss et al., 2016), prescribing nurses found themselves outside of the nursing space but not yet 'invited' into the space of the GP's, described by Weiss et al. (2016) as being in 'no man's land'. Do they have more status or power within their organisation given their prescriptive authority? Which group norms guide their behaviour? Is it the norms of medicine or the norms of nursing and midwifery to which they are aligned? Do they need to develop new norms? Are they equal members of each group and how are they viewed within their organisation and how has interaction with other professionals changed?

Strong professional identity supports good patient care (Christmas & Cribb, 2017). Christmas and Cribb expand on this by recognising that a commitment by professionals to practice according to standards, is an expression of professional identity (Christmas & Cribb, 2017). Gilburt (2016) suggests a strong professional identity within multidisciplinary teams is necessary for effective integration of healthcare services. However, at a time when a collaborative team-based approach to healthcare is viewed as the ideal, we still have different professional groups, each claiming a unique contribution to patient care and carving out a professional identity for themselves. This pursuit of individual professional identity

can hinder collaborative working and communication difficulties arising out of a tribalist approach to care and increasing demands can hamper interprofessional working (Colyer, 2004). Dingwall and McIntosh (1978) recognise that interprofessional collaboration may be difficult when power differentials between professional groups remain, with effective collaboration requiring equality and respect between professional groups (Crozier, 2003). Conflicting ideologies between the medical and midwifery profession (where midwives view pregnancy and birth as normal and the medical profession view it as something to be managed) also remain (Murray-Davis et al., 2011). These power structures and conflicting ideologies can inhibit effective interprofessional relationships, necessary for good patient care.

As nurses and midwives take on expanded roles, how do they stay true to the core values, care, compassion and commitment in order to safeguard the nursing and midwifery professions into the future? Are we at risk in having other groups impose their identity on us? Given the close collaborative relationship with doctors described in Chapters 2 and 3, this is particularly important for RNPs. The more expansive roles become, especially if at the direction or under the control of the medical profession, the greater chance nursing will be shaped by medicine rather than nursing itself (Callaghan, 2008) and the more nurses and midwives might be open to exploitation and having their professional values eroded. If expanded practice is going to be influenced by the medical profession we need to be mindful of the importance of underpinning expanded practice for nurses and midwives with nursing and midwifery values rather than those of

medicine to ensure professional autonomy is maintained (Brush & Capezuti, 1997; Scott, 1999).

4.2 Identity, midwifery and medicalisation

The introduction of prescribing to the midwife role poses some interesting questions in relation to midwife identity given midwifery's commitment to pregnancy and childbirth as normal physiological processes and the connection between medicine and medicalisation. Though the health professions literature is brimming with discussion of professional identity in nursing and medicine (Fagermoen, 1997; Andrew, 2012; Wilson et al., 2013; Wong & Trollope-Kumar, 2014; Olive & Abercrombie, 2017), literature on midwifery and identity is less proliferous. This is perhaps because midwifery remains in some countries a sub-specialty of nursing and is underdeveloped as a discipline in its own right. Workforce shortages in the midwifery setting are well recognised and this has been attributed to poor access to education, workload, stress, lack of promotional opportunities and burn out (Buscher et al., 2009; Hildingsson et al., 2013; Jordan et al., 2013; Mollart et al., 2013; Newton et al., 2014). This has led to the introduction of midwifery support workers or care assistants in some jurisdictions, including Ireland, which can alter professional identity within the profession (Smith, 2014) as certain midwifery tasks are delegated to this new group of staff. Though many individuals are entering the midwifery profession through the direct entry route (NMBI, 2020), many more practicing midwives have practised as nurses first. But what exactly is identity in midwifery? Larsson et al. (2009: 377) defined it 'as a combination of thinking, reflection and handcraft'. Midwifery

identity was reported by Hunter and Warren (2014) as a sense of belonging and an interweaving of personal and professional identities, what someone was, rather than what they do. Midwifery identity though could be considered to be under threat with Larsson et al. (2009) reporting it as diminished. This is accounted for due to the increased use of medical technology which is now informing decisions midwives used to make and midwives' decreased influence during childbirth as a result of the greater number of doctors. They also reported increased workload and transfer of work to other healthcare workers which resulted in a decrease in the handcraft element of their practice which they considered important to their identity as midwives (Larsson et al., 2009). Research by Curtis et al. (2006), Rayment (2011) and Sidebotham and Ahern (2011) found that changes to professional identity that limits professional autonomy were reasons why midwives did not want to continue practicing midwifery. This is driven by a sense that their professional autonomy is being overridden by the medical profession (Greve, 2009; Shaban et al., 2012; Sidebotham et al., 2015) and fear of litigation which promotes a culture of medical hegemony (Savage & Francome, 2007; Karlstrom et al., 2009; Hood et al., 2010). The introduction of prescribing in midwifery poses some interesting questions. Will the prescription of medicines, previously a medical task alienate midwives from their identity as a midwife or will this expanded role which increases their autonomy, facilitate them in providing more holistic women-centred care and thus strengthen their identity as a midwife?

‘Medicalisation’ describes a process by which human problems become defined and treated as medical problems’ (Sadler et al., 2009) and has been the source of much debate and discussion in the literature. The term ‘medicalisation’ was first used by Zola (1972), a sociologist who recognised the influential nature of medicine and its use as social control. Brubaker and Dillaway (2009) also recognised it as a tool for social control using medical gaze and surveillance. Many view medicalisation entirely as a negative use of power over patients with Foucault (1976) and Illich (1976) proposing that it involves removal of power from the people the profession seeks to serve, for its own ends. Feminists argue that medical gaze undermines women’s sense of authority and control of their bodies (Martin, 1987). Others, including Conrad et al. (2010) consider it neutral, neither positive nor negative, rather recognition that a condition has come under the jurisdiction of the medical profession. It is my view that though medicalisation has in some respects exerted inappropriate power over individuals, many of the advancements in healthcare we seek and take for granted, are as a result of medicalisation. Given that prescriptive authority has traditionally been seen as a medical task and falling within the remit of the doctor, an examination of medicalisation and how prescriptive authority for nurses and midwives may influence or perhaps contribute to the medicalisation of maternity care, through increased gaze and surveillance, is warranted.

Childbirth sits between two worlds, one of nature and one of culture (Oakley, 1979). It is natural because of the biological process of birthing but cultural because of the influence science, technology and politics have on the process.

Midwifery means to be with a woman and promotes a model of care that is in partnership with women and women-centred. However, pregnancy and childbirth have been fertile areas for medicalisation to take root for a number of reasons. Versluysen (1977) interpreted the hospital movement of the 18th century as a male ploy for gaining control over female health care. There is a certain acceptance that when women enter hospital for birth they lose the ability to challenge medical authority and decision-making responsibility is transferred to hospital personnel (Jordan, 1980: 33). As a mother of three, I have my own experience of pregnancy and childbirth with my eldest born 20 years ago. Whilst I chose consultant-led antenatal care and hospital delivery, my experiences were that even within the hospital environment, I was given choice, my care was collaborative, with midwives delivering all three babies. Birth in hospital facilitates the use of technology not available within the home which again could facilitate medicalisation. Obstetrics is closely aligned with gynaecology rather than paediatrics and as gynaecology treats conditions of the female reproductive system, it is easy to see how the medical profession has exerted their power in this realm. Whereas midwifery is geared towards women allowing their body to do the work of labour, medicine sees pregnancy and birth as physiological actions with scientific knowledge and medical technology having become unquestioned and championed (Loe, 2004: 12). Scientific knowledge, supported by government policy has allowed the medical establishment to oversee the delivery of obstetric care. The influence of this scientific knowledge and medical technology is evident

in the caesarean rate in Ireland of over 30% (National Women and Infants Health Programme, 2018).

The medical profession's attitudes and justification for the medicalisation of pregnancy and childbirth are rooted in what they consider clinical concerns, with pregnancy and childbirth deemed to be risky (Zadoroznyj, 1999; Behruzi et al., 2010). Kohler Reissman (1998) states that obstetricians have exploited this sense of risk associated with complicated pregnancies and deliveries in order to maintain hegemonic control over childbirth. Though policies around childbirth have allowed an ‘almost complete medicalisation of pregnancy’ (Cahill, 2000) recent ones are more receptive to management of pregnancy and birth outside the hospital setting by midwives (Department of Health, 2016a). However, as soon as a pregnancy or delivery becomes ‘risky’ the obstetrician is called in thus elevating the obstetrician to a position above that of the midwife. When something is deemed risky, usually determined by the meeting of certain criteria established by the medical profession, technological intervention is warranted (Zadoroznyj, 1999: 268) effectively removing women’s control over their body and disempowering midwives. When offered choice within a hospital setting this is often couched in terms of a safe birth or possible death of baby or mother. Crossley (2007) in discussing her own experience of childbirth contends that this is no choice at all. When childbirth is medicalised women have to turn to ‘medical experts’ to understand the experience that previously women had understood better (Oakley, 1984; Davis-Floyd, 1992; Kitzinger, 2006). When it is recommended to women that an intervention is necessary based on safety

concerns for her or her baby, women do not have the knowledge to know if the situation is a medical emergency and whether there is no other choice, but intervention. The decline in maternal and infant mortality has also been attributed to hospitalisation though this fails to take into account other factors such as improved nutrition and hygiene and education. If other factors have had an impact then Cahill (2000) argues then that we cannot enforce hospitalisation on safety grounds.

Opposition to the medicalisation of pregnancy and childbirth is often articulated in terms of a natural or normal birth. However, there is no consensus on what constitutes a normal birth (Wagner, 1994) and their meanings have changed over time. Dillaway and Brubaker (2006) contend that women themselves distinguish between a natural or medicalised birth based on one criterion, that of pain relief. The natural birth movement recognises the importance of pain in the birthing process and encourages women to embrace the pain of childbirth rather than claim it doesn't exist. This natural approach is often viewed as 'good' (Conrad, 2007). Oakley (1979) viewed natural childbirth as challenging of the hospitalisation of childbirth, technology and pharmacological methods to relieve pain. It requires consciousness and control and the active role of the pregnant women. However, if there is an emphasis on minimal or no pain relief, a situation arises in which women feel prevented from asking for pain relief (Porter, M., 1990). In other words, it could be said that natural childbirth denies women choice (Brubaker & Dillaway, 2009).

In her work in 1992, Davis-Floyd (1992) identified three types of birthing mother; one who accepts medicalisation, one who views birth as a natural or spiritual process and one in between who make their own choices within a hospital setting and view acceptance of pain relief as personal choice. This idea of women determining whether a birth is medicalised or not, was recognised by MacDonald (2006) who reported birth as a natural event even if it involved medical intervention if the woman chose that intervention. However, whether choice really exists in the hospital setting is questioned (Jordan, 1980: 33). Rather than viewing birth as either normal or medicalised, viewing it on a continuum scale, is advocated for by Brubaker and Dillaway (2008). It is likely too, that there are nurses and midwives working in the maternity setting who view medicalisation on a continuum. Where they position themselves on this continuum may influence whether they consider prescribing contradicts a midwifery approach to care and thus negatively impacts their identity as a nurse/midwife.

Though medicalisation of pregnancy and childbirth can be viewed as negatively impacting women by reducing women's control over their body, Parens (2013) proposes and I agree that it is only a problem if it oversteps what is appropriate. The use of medical intervention and medicalisation is a positive move when the situation warrants it, decided within a collaborative framework taking into consideration the wishes of the woman and the expertise of those involved in delivering care. Green and Baston (2007) report that women don't always see a medical approach in a negative light. This was certainly the case in my own experience, when my second daughter was born 18 years ago and required

intensive care for a short period. This was provided collaboratively between doctors and nurses/midwives. Not all women who avail of a medically led or technocratic birth are passive; some may actively choose this approach for reasons of convenience or to introduce an aspect of predictability to their labour, freedom from pain (Kohler Reissman, 1998: 52) and their fear of risk (de Vries et al., 2009). Some choice can be available to women within the constraints of this model of care. Campbell and Porter (1997) question however if this choice based on safety concerns reflects real choice or if it reflects the grasp of medical rhetoric around the risks of childbirth coupled with the promise of safer childbirth with the use of technology? Medicalisation of midwifery and maternity services has had positive consequences for women who choose to avail of birth control and abortion (Ehrenreich & English, 1973) and has contributed to women who previously wouldn't have been able to become or stay pregnant, to do so. Careful monitoring during pregnancy of women with conditions such as epilepsy and diabetes contributes to the safety of women and the safe delivery of healthy babies. Whereas in the past it was the medical profession engaged in monitoring these women, this role is very often undertaken by nurses or midwives working in specialist or advanced practice. Women seek medical advice when they want to know what is happening. They also seek advice from others who have experienced pregnancy and childbirth and use their own experiences to filter and organise the information, including medical knowledge. This empowers women to make decisions. When maternity services were provided in the community, knowledge was held by women and their midwives. With the move of maternity

services to the hospital setting, knowledge was held by medical staff. I suggest that the introduction of specialist and advanced practice roles along with prescriptive authority returns this knowledge to the nursing and midwifery professions.

As this study looks at the experiences of RNPs in the maternity setting it is important to acknowledge the role medicines play in medicalisation. The pharmaceutical industry plays a role in medicalisation by virtue of the fact that it develops and seeks licences for medicines. Illich (1976) suggested that the pharmaceutical industry was working secretively with the medical profession and though McCartney et al. (1999) disagreed with the extent of this argument they did highlight the power of and political dimension of access to medicinal products. This is of particular importance for RNPs who now have the power to prescribe and therefore provide access to medicines. Do they view prescriptive authority as congruent with midwifery practice and as a way of ensuring more women-centered care through offering choice and quicker access to medicines? Conversely, do they view prescriptive authority as undermining their midwifery practice by leaning towards a more medical led model of care?

4.3 Constructing identity

Now that I have shared what I consider professional identity to be, it is important to appreciate how that identity is constructed and how it may continue to be constructed for RNPs. Formation of professional identity begins during an individual's time as a student (MacIntosh, 2003) and it is expected that following completion of nurse education programmes students will have developed at least

partly, a professional identity through the professional socialisation process (Mooney, 2007; Ajjawh & Higgs, 2008). As a nurse/midwife educator I have a role in ensuring this happens within the context of RNPs. I acknowledge the construction of identity as conceived in relation to organisations, colleagues, patients and families (Watson, 2008; Helmich et al., 2010). The impact encounters with patients, colleagues and mentors had on professional identity development were reiterated more recently by Wong and Trollope-Kumar (2014). Wenger's (1998) assertion that identities are constructed through participatory engagement and by becoming a member of a professional group is important within the context of professional identity for RNPs given they are taking on what was traditionally a medical role. It is also important given the role the medical mentor plays in the educational preparation of the RNP and the expectation that the student prescriber will move from a position on the periphery of the community of practice to an expert within it.

Responsibility is also viewed as important in the development of professional identity (Moss & McManus, 1992; Radcliffe & Lester, 2003; Hayes et al. 2004; Miskelly & Duncan, 2014) and important to acknowledge within the context of this research given the additional responsibility prescriptive authority confers on an individual nurse or midwife. This is recognised in the regulation and registration requirements which support not only the professionalisation of nursing and midwifery but also play a role in the development of professional identity (Christmas & Cribb, 2017), positively affecting it (Wiles, 2013). Nursing and midwifery legislation provides for the protection of professional titles and so can

act as a protector of identity. The NMBI is the regulating body for nurses and midwives in Ireland and has statutory responsibility for the registration of nursing and midwifery practitioners. Whilst the objectives of the NMBI are to protect the public and ensure the integrity of nursing and midwifery practices (NMBI, 2014), the specific functions of NMBI, include specifying standards for practice and for specialist posts. Codes of ethics such as the *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (NMBI, 2014) guide the daily practice of nurses and midwives in caring for patients in an effective, safe and ethical way and are recognised as vehicles for professional identity. The prescription of minimum practice standards can enable professional identity through the upholding of those standards (Christmas & Cribb, 2017). Where minimum standards are deemed not to have been met the NMBI can inquire into complaints and make decisions in relation to the imposition of sanctions on registered nurses and midwives. With the introduction of nurse and midwife prescribing in Ireland the NMBI published requirements and standards for education programmes preparing nurses and midwives for prescriptive authority and additional practice standards with respect to prescribing practice. Once qualified as an RNP, the individual is required, prior to enacting their new role to have their name entered on the prescribing division of the register. This sets them apart from other nurses and midwives without the qualification.

Values (Asquith et al., 2005) are also recognised as important in the development of professional identity. The idea of values being a factor is timely given that this research is being conducted when there is a renewed focus on the values of care,

compassion and commitment in nursing and midwifery in Ireland (Department of Health, 2016b). Care as a value, is one that is entwined with the idea of identity and what it means to be a nurse or midwife. Therefore, how care may be affected when new roles are introduced warrants exploration.

4.4 Care

Care as a concept has received much attention in the literature across a number of disciplines including psychology (Gilligan, 1982), political science (Tronto, 1993), education (Noddings, 1984; 2002) and of course nursing and midwifery (Watson, 1979; Benner, 1984; Swanson, 1993; Leninger, 2002). Noddings differentiated caring into 'caring for' (face to face encounters where one cares for another) and 'caring about' (where one has concern for others and wants to do something about it) (Noddings, 2002). Tronto (1998) described four phases of care 'caring about' (a recognition that someone needs care), 'taking care of' (where an individual assumes responsibility to respond to the need for care), 'caregiving' (the physical work of caring) and 'care receiving' (involving collaboration by the recipient of care).

Despite a number of caring theories being developed within nursing and midwifery including Watson (1979), Swanson (1993) and Leninger (2002), Adams (2016) acknowledges that nursing struggles to clarify the essence of caring in a way that is acceptable to everyone and which represents all of nursing. Though Leininger (2002) and Sargent (2012) proclaim that caring is what makes nursing distinctive from other professions, Barker et al. (1995) suggest it is not essential to the profession. I disagree however and suggest caring is the essence

of nursing and midwifery practice, an ontological position and one that is central to my role as a nurse. I find it impossible to separate as Noddings (2002) did, care into 'caring about' and 'caring for' as, as with many practitioners, I am motivated in my work by the emotional aspects of my work (Waerness, 1984). It is thus an ongoing and integrative process. For me, caring encompasses listening to the patient, advocating for the patient, doing for the patient if necessary, but most importantly, relating to and being with the patient. This sense of 'being with' is the core of midwifery too with the term midwife meaning to be 'with woman'. The importance of caring for nursing is supported by Davis (2005) who reported that a caring presence positively impacts patient experience and a non-caring environment or culture leads to issues around quality and safety (Watson, 2009: 468).

One of the first scholars to develop a caring science within nursing and midwifery between 1975 and 1979, based on her own professional experiences, was the renowned nurse scholar, Jean Watson. Watson's theory of caring was and is an evolving one. In 1999 she suggested that caring is 'the moral ideal of nursing whereby the end is protection, enhancement and preservation of human dignity' (Watson, 1999: 29). She went on to describe caring as a science and the philosophical foundation for contemporary nursing practice which 'is the essence of nursing and the foundational disciplinary core of the profession' Watson (2008: 17). Whilst acknowledging the importance of Watson's contribution to nursing practice, it is Swanson's Theory of Caring (Swanson, 1993) which I relate most to.

Swanson described caring as ‘a nurturing way of relating to a valued other and toward whom one has a personal sense of commitment and responsibility’ (Swanson, 1993: 354). It is perhaps not surprising that this theory of caring resonates as it has its foundation within phenomenology. In addition, Swanson’s theory developed out of her work with three groups; women who had miscarried, health care professionals working in neonatal intensive care units and socially at-risk mothers and as such has a midwifery and maternity focus. Swanson (1993) promotes a practical application of caring theory to practice and identified five spheres of caring. These are (1) knowing, which includes assessing and seeking cues to understand the person; (2) being with, which means being present (including emotionally present) to others, acknowledging individuals experience as significant; (3) doing for, including doing for others in a competent manner what they would do for themselves if they were able; (4) empowering by explaining, informing and advocating; and (5) maintaining belief through offering realistic optimism. Swanson’s theory provides a framework for incorporating a nursing or midwifery perspective into every encounter, thus supporting nurses and midwives in maintaining or enhancing their caring focus whilst undertaking new expanded practice roles such as prescribing.

If we view the RNP role through the lens of Swanson’s theory, the caring role is enhanced. RNPs ‘know more’ by virtue of their pharmacological knowledge and their knowledge of the patient through their patient assessment required for prescribing decision-making. Moreover, RNPs are ‘with patients’ more as they can provide a holistic experience for the patient, rather than having to go and find

a doctor to write a prescription. They can ‘do more’ in a practical sense in that they make prescribing decisions and prescribe if required. RNPs can empower patients more through patient education as a result of their pharmacological knowledge. During the process of assessment, prescribing and ultimate administration of certain medications, there is increased engagement between RNP and patient. This facilitates the development of a relationship in which the RNP can offer realistic expectations to the patient and support them in seeing meaning in their experience. Viewing nursing and midwifery practice through Swanson’s lens supports the idea that expanding practice to include prescriptive authority should enhance the care role of the nurse/midwife. In this way expanded practice strengthens the essence of the professions and grounds practice in nursing and midwifery values despite the influence of other professional groups in new role development.

4.4.1 Care, identity and new roles

As noted previously, nurses and midwives are working in a changing healthcare environment which sees them taking on many new roles, some of which, such as the prescribing of medicines would have traditionally been viewed as the responsibility of doctors. So what becomes of identity and care (both of which are inextricably linked in my view) when nurses and midwives expand their practice, taking on roles traditionally the responsibility of doctors? Other researchers have suggested that when nurses and midwives expand their practice, new professional expertise develops (Dezalay & Garth, 1996), sometimes in a specific specialist area for example diabetes. This can result in a broadening of their professional practice (Anand et al., 2007). Specific positive

effects of enhanced practice related to autonomy and independence (Rodden, 2001; George et al., 2006; Cooper et al., 2008b; Piil et al., 2012) and professional development (Drennan et al., 2009) have also been noted. Nancarrow and Borthwick (2005) claim however that diversification, specialism and substitution are threatening nursing roles.

The effect of expanded practice on identity was noted by Piil et al. (2012) who suggested that when practice is expanded there is a transition in perception of identity. The literature around expansion of practice and identity within the nursing and midwifery professions is contradictory. Petrakaki et al. (2014) recognise that expanded roles can lead to intensified professional identity. Cuxart-Ainaud, (2006), Cousins and Donnell, (2012) and Romero-Collado et al. (2014) attribute the improvement and strengthening of nursing's professional identity which nurse prescribing brings, to the increased autonomy it affords. Conversely, Coull et al. (2013) recognise the risk of nursing identity being eroded when nurses take on roles traditionally associated with doctors' responsibilities.

In the past, medicine has focused on cure with nursing focusing on compassionate caring but the introduction of prescribing and expanding nursing practice challenges this notion (Tye & Ross, 2000; Piil et al., 2012). Given the role doctors play in mentoring students during the course of the education programme, do RNPs become more like or adopt the attributes of the medical profession? By taking on a prescribing role are nurses and midwives contributing to the discourse which elevates the biomedical model of care above that of others? Concern about loss of caring focus was noted by Larkin (1983) in relation

to specialist practice. He suggested that in the acquisition of higher status roles for example specialist practice, some roles are discarded and occupational imperialism arises where professions discard or delegate less desirable jobs to others.

In other words, specialists discard roles or tasks which would be seen to dilute their new higher status, specialist tasks. This idea of loss of core work has also been discussed by Borthwick et al. (2009) who suggest whilst expanding scope of practice can enhance status, loss of core work which may become delegated to other professional groups could threaten identity. This could result in practitioners potentially seeing themselves as having lost their nursing or midwifery identity but not acquired a new identity (Weiss et al., 2016). This may be explained by a loss of caring focus when nurses take on some roles previously undertaken by doctors (McKenna et al., 2006) but is the caring focus actually lost when nurses and midwives take on prescriptive authority?

The idea that a caring focus may be lost has certainly been of concern to some researchers (Ohlén & Segesten 1998; Scott, 1999; Callaghan, 2008) in relation to advanced practitioners and the impact expanded practice can have in altering the values underpinning practice. One of the proposed benefits of nurse/midwife prescribing is that practitioners can provide a full cycle of care (An Bord Altranais, 2005). If caring duties are delegated or lost to other healthcare professionals, the argument that nurses and midwives are best placed to provide holistic care is void and so prescriptive authority must not be undertaken at the expense of other traditional nursing/midwifery roles or responsibilities. If nurses and midwives are

seen to becoming more ‘like doctors’ will nursing/midwifery become invisible, underrepresented and underutilised?

Concerns in relation to the loss of caring are not confined to expansion of practice though. There is unease with an increasingly technology-driven healthcare environment that the philosophy of caring may fade from nursing/midwifery (Adams, 2016). Though technological advances have greatly improved the outcomes for many patients, technology doesn’t attend to all patient needs and therefore nothing can replace hands-on interpersonal care.

As noted above, there are concerns about expanded and advanced practice contributing to a loss of caring and Tye and Ross (2000) expressed concerns about the shift from care to cure when nurses take on a prescribing role. However, I am more drawn to subsequent work by Ross (2015) that described how prescriptive authority made nurse prescribers feel more caring. Participants attributed this to the already holistic approach to care by nurses which was enhanced by prescriptive authority. They also considered the additional time invested in patients by virtue of them writing the prescription as contributing to enhanced caring. Role expansion within nursing and midwifery will continue particularly in advanced practice given the government's agenda in this area (Government of Ireland, 2017) and how this may effect professional boundaries will now be addressed.

4.5 Boundaries

Professions exist in an interdependent environment, none more so than those professions operating within healthcare. Previously, different professional groups focused on different aspects of patient management based on their philosophical backgrounds. In the past, doctors gave instructions and orders to other healthcare staff who carried them out. These traditional roles and professional boundaries contributed to a sense of professional identity (Allen, 1997). Traditional boundaries are now being challenged on a number of fronts. They are informally crossed on a daily basis due to differing work practices, with this informal flexibility leading to blurring (Foster & Flanders, 2014). Role development can also result in organisational, professional and legal issues occurring at the boundary between professional groups (Tye & Ross, 2000). As nurses and midwives take on expanded roles, they 'change the landscape' (Hwang & Powell, 2009: 182) and challenge (Mantzoukas & Watkinson, 2007) and shift traditional boundaries of practice (Piil, 2012).

Nolan (1995) considers that blurring of professional boundaries is required in order to provide interprofessional care. When boundaries are blurred and a professional group encroaches on the territory of another, occupational territory is expanded (Hunter & Segrott, 2008). The development of new nursing roles (and subsequent encroachment into what was traditionally medical territory) is significantly influenced by relationships with medical staff (Tye & Ross, 2000; McGarvey et al., 2004; Griffen & Melby, 2006; Reay et al., 2006; Willard & Luker, 2007). This is very much the case with RNPs who require a medical practitioner mentor during their training period (see Chapter 2) and who up until late 2019

required a CPA with collaborating doctors. Support from doctors for new roles has been lacking where it is thought these roles intrude on medical practice (Wilson et al., 2002) and medical associations in many countries have opposed the introduction of nurse/midwife prescribing (McCann & Baker, 2002; Plonczynski et al., 2003; Ball, 2009).

Control over roles ensures longevity for a profession with ownership of roles supported by an individual or a professionals group's expertise in a particular area, for example prescribing, which can convey status and power (McLaughlin & Webster, 1998). To stay successful professional groups try to maintain their jurisdiction through control over access to education, training and labour markets (MacDonald, 1995; McDonald, 1999) through professional accreditation (Daniels & Johansen, 1985) and the direction of career paths (Daniels & Johansen, 1985). Abbott (1988) identified that undertaking roles and responsibilities which were once the remit of the medical profession can result in competition for jurisdictional power. An example of this is the prescription of medicines, by other non-medical professionals. There have been mixed reports though as to whether non-medical prescribing is a threat to the power of the medical profession. Weiss and Fitzpatrick (1997), Britten (2001), Nancarrow and Borthwick (2005), Lloyd and Hughes (2007) and Weiss (2011) suggest it might challenge medical superiority and professional boundaries. This may be due to prescribing being viewed as an expression of professional autonomy, core to professional identity and dominance of the medical profession (Friedson, 1970, 1985; Willis, 2006). Though a study by Weiss and Sutton (2009) suggested it did not, it is important

to note that this was in relation to supplementary prescribing in which the doctor maintains control of diagnosis. This differs to the model of nurse/midwife prescribing in Ireland in which the prescriber takes responsibility for diagnosis (NMBI, 2019). Berg (1997) also cautions that other professionals may become deskilled when nurses and midwives expand their practice resulting in hostility within the working environment.

Though Nardi and Diallo (2014) maintains that the medical profession is continuing to try and control nursing by retaining a model of doctor-led teams and clinical authority, others suggest medical dominance is decreasing (Coburn, 2006; French & Emed, 2009). It is important to note however that challenges to the dominance of medicine are not just due to the development of new roles for other healthcare professionals. Other factors such as more informed, questioning and less passive patients, developments in self-help and a desire to reduce healthcare costs (Coulter, 1999; Bury, 2005) have also been recognised as playing a part.

Another challenge to professional boundaries lies in the fact that the exact function of new roles can be unclear until they become embedded within an organisation (Martin & Hitchinson, 1999). This can impact professional identity (Lowe et al., 2012) and lead to difficulties in developing role distinctions and boundaries (Read et al., 2001; Guest et al., 2004; Griffin & Melby, 2006; Lathlean, 2007). Furthermore, it is claimed that overlapping roles in turn make identity less clear (Ewens, 2003; Deppoliti, 2008; Machin, 2012; Piil et al. 2012).

Though nurses and midwives actively embrace new roles and are keen to do so, the ability to do so can be influenced by their nursing colleagues. Conflict between nurses working in expanded roles versus those who were not was noted by Tye and Ross (2000) who indicated that some nurses do not want to take instruction from other nurses practicing in an expanded role. Nurse practitioners have spoken about being 'othered' perceived as different and isolated from their own profession (Reay et al., 2003) and it is possible that this might also be the case for prescribers.

Given the challenges identified above, how are new roles introduced successfully? Maxwell et al. (2013) outlined how innovations such as new roles are adopted and suggest when roles are imposed it is more difficult to establish shared identities which would enable increased levels of interaction, supporting good patient care. When new roles are founded and facilitated through local agreements, establishing parameters of practice is more easily done. This would indicate that local agreements such as the CPA should facilitate the new role of RNP and their practice, and contribute to a shared identity. This does not mean that the RNP would lose their nursing/midwifery identity more that they are enabled to adopt a shared identity with others on the multidisciplinary team. The idea that identity is changed when boundaries are blurred has also been recognised by Berg, (1997) and Barnes (2000). Furthermore, when boundaries are blurred, distinctive identities of individual professional groupings may be diminished (Elston & Holloway, 2001) and occupational identity can become

vulnerable which ‘risks undermining the values which hold professional communities together’ (Pinder et al., 2005: 776).

So, given the challenges faced when introducing new roles from within and outside nursing and midwifery and the challenges this brings for professional identity, how can the collaborative working environment be navigated? To deliver healthcare more effectively, Allen (1997), Bechky (2003a, 2003b) and Murray-Davis et al. (2011) acknowledge the importance of professionals having knowledge of the responsibilities of other professions. Gardner et al. (2007) also saw the importance of other professionals and the public knowing what to expect of nursing roles as confusion of role titles along with confusion of role functions feeds role conflict which can impact on interprofessional working. However, with nursing and midwifery practice expanding so quickly, this can be difficult. Sterrett (2015) acknowledges that improved collaboration necessary for caring for patients in today’s world will result from the creation of healthcare professionals who have professional and interprofessional identities and where the skills and knowledge of different team members are equally valued (Institute of Medicine, 2011). Weiss et al. (2016) went further in stating that where there are respect and recognition, of different professional identities, a shared identity can be formed which contributes to multidisciplinary patient care. Within midwifery, this shared identity would allow the dismantling of professional barriers, enabling the adoption of a more woman-centered approach to care where power may be minimised and collaboration promoted (Murray-Davis, 2008). What is important, is rather than controlling who does what, we should ensure that the needs of

people using the health service are met in an appropriate way within an appropriate timeframe by an appropriately qualified and competent person, from whichever profession that may be.

4.6 Conclusion

While broad patient needs such as diagnosis, treatment and care have not changed, the specifics of those activities and importantly, who is carrying out those activities has. This raises issues in relation to professional identity and care and this chapter has explored both with respect to expanded practice roles and prescribing of medicines by nurses and midwives. In exploring these, a number of questions are raised including; how is professional identity impacted when nurses and midwives working in the maternity setting take on a prescribing role, does prescriptive authority impact on the caring focus of nurses and midwives working in the maternity setting, are nursing and midwifery becoming more or less visible when practitioners hold prescriptive authority and how are interprofessional relationships and the multidisciplinary landscape navigated when boundaries are blurred? The following chapter will outline the methodological approach taken in the study and methods employed to explore the experiences of RNPs in the maternity setting.

CHAPTER 5 METHODOLOGY

5.0 Introduction

This chapter presents the methodological underpinnings and subsequent methods used in the study which explored the experiences of nurse and midwife prescribers (RNPs) in the maternity setting. The research was undertaken in order to generate practitioner-based knowledge with the potential to inform education and research, policy and practice. The research was conceptualised, designed and conducted from a critical researcher perspective drawing on constructionist ideas (Crotty, 1998) and heavily influenced by hermeneutic phenomenology (Heidegger, 1962).

Research is a messy affair and the cleanly presented reports of research found in peer-reviewed journals usually do little to acknowledge this fact. This research was not a linear process and required much toing and froing. Decisions and choices were made and changed, sometimes reverting back to their original state following reflection and engagement with the literature. The decisions I made about the research, in particular around the theoretical framework, design and methodology have emerged through intuition, reasoning and weighing up alternatives. This was summed up well by Bargar and Duncan (1982: 2) who spoke of the hidden 'inner drama' of research that has an 'intuitive base' a 'halting timeline' with 'extensive recycling of concepts and perspectives'. An account of how I came to adopt certain positions and justification for the approach adopted is outlined. I express my thoughts around ethics as a process versus the reality of procedural ethics requirements. The process of obtaining access to

participants along with ethical approval to conduct the study is described. Data collection methods are described in detail along with how the findings were analysed. The chapter concludes by summarising the methodological approach and the methods used, acting as a signpost for the subsequent chapters which present the findings.

'Research is a formalised curiosity. It is poking and prying with a purpose' (Hurston, 1942: 143). This poking and prying can be approached from different paradigmatic standpoints, a paradigm being a 'set of beliefs and feelings about the work and how it should be understood and studied' (Denzin & Lincoln, 2013: 26). There are considered to be three major approaches to research; quantitative, qualitative and more recently mixed methods and while each attempt to make sense of the world, they do so in a different way. With quantitative research concerning itself with objectively knowing something exists, qualitative research is more concerned with why and how circumstances occur (Mills et al., 2014).

The origins of what we now consider to be scientific research date back to the time of Bacon, Galileo and Newton in the 17th century. However, Bacon and Galileo would have called themselves natural philosophers rather than scientists as the word science at the time meant knowledge and didn't come into its present use until the 19th century (Okasha, 2002). Bacon's method of induction involved the collection of facts and observations which allowed predictions to be made and this is recognised as the start of modern-day science. Physical sciences or natural sciences argue that there is an objective truth than can be known and draw on a realist concept of knowledge (Guba, 1990) recognising that it is

possible to know through objective methods. Comte, a French philosopher, was the first to apply this method of science to the social sciences in the 18th century and so the term positivism emerged. Though hypothesis testing is present to some degree across the spectrum of epistemological positions, learning about reality through testing hypothesis and control variables is a key component within positivism (Mack, 2010). This position is widely accepted within the healthcare field within which I have been immersed for much of my adult life. This chapter unearths why I do not consider we can know social reality in this way and so it is important to establish my positioning at this stage to demonstrate how my methodological approach and methods are congruent with my philosophical position.

5.1 Ontology/epistemology

Ontology, epistemology, methodology and methods are the 'building blocks' of research (Grix, 2002; 2010). By considering what I consider to be knowledge (ontology), how I know it (epistemology) and the process for studying it (methodology), I will highlight how my methods are congruent with my philosophical position. What I consider to be knowledge is hugely influential in the type of research and methodological approaches adopted and relies on what I see as my relationship to reality. Ontology is the study of reality. Epistemology is concerned with how we know what we know, in other words, how do we gain knowledge of reality, what do we consider an acceptable way of knowing reality? I consider ontological and epistemological positioning as on a spectrum. In viewing the spectrum of ontology from realist at one end to constructivist at the

other, I find myself leaning towards the realist end of the spectrum. In terms of the spectrum of epistemology, with positivism at one end and interpretivism at the other, I locate myself at neither one end nor the other, but somewhere in the middle. I consider that there is one reality but there can be multiple perspectives of that reality. I also identify as being a critical researcher. Using a critical lens enables me to better understand the experiences of RNPs. This approach requires me to attend to power structures that could influence RNP experience and in this way seeks to generate knowledge with the potential to inform policy, practice, research and education.

The journey towards this positionality has been fraught with internal turmoil and the notion of what reality is and how we gain knowledge of it has been one of the most challenging aspects of undertaking this doctorate. Though as a nurse I would have been familiar with Carper's different ways of knowing (Carper, 1978), this familiarity was just an awareness. This was quite difficult to acknowledge during the doctorate as I felt a sort of embarrassment about my lack of understanding given I have been a nurse for many years. I found the language around positionality difficult to comprehend at the beginning of the doctoral journey and something I had not had exposure to before, having undertaken my post graduate education within a School of Medicine. Additionally, for a significant part of my professional life I was involved in the conduct of clinical trials and surrounded by medical colleagues both of which adopted a realist and positivist positionality. My positionality though, influenced heavily by my role as educator of RNPs, has gained clarity as the doctorate and research process unfolded,

assisted by reflexivity and engagement in discussion with others. Whereas previously I tried to put myself in a specific box established by others, I am now more comfortable embracing a position which more accurately reflects my thoughts and ideas. I don't necessarily consider my broad preconceptions of the nature of reality and knowledge to have been challenged as I had not taken a particular stance prior to the doctorate. What has occurred though is more of an awakening, a greater curiosity has emerged, one that is open to other possibilities and so my position is one which draws from the perspectives of different positions, one advocated by Lincoln and Guba (2000) when such an activity is useful or enriches the process.

The terms constructivism and constructionism are often used interchangeably and in this way considered by some to mean the same thing (Bryman, 2012). This is by no means a universal view with others suggesting there are differences (Charmaz, 2006; Savin-Badin & Major, 2013). In viewing these terms as having different meanings, it has become clear to me that my position is influenced by elements of both. I consider that our minds actively process data they are confronted with to construct knowledge (constructivism). I subscribe to the idea that our perspectives or interpretation of things do not happen in a vacuum but are influenced by the social, political, cultural and environmental context of where we find ourselves (constructionism). I recognise that different people can have different perspectives on reality rather than multiple realities being possible. I believe that knowledge is constructed in our interpretation of the world around us as proposed by Crotty (1998) and that sense is made of the world based on our

historical and social perspectives. I also acknowledge that knowledge can arise out of a process of interaction with others, a position described by Crotty (1998) in his account of social constructionism. This position of accepting that there are different ways of knowing is one well established within nursing and midwifery and articulated by Barbara Carper in her ways of knowing (Carper, 1978).

But what does my positionality mean in terms of the conduct of the research? Acknowledgement of positionality in qualitative research is important and influences all aspects of the research from formulation of the research question, to methods used, to analysis of findings. As I mentioned earlier, I am a proud nurse and excited by developments experienced by the professions of nursing and midwifery. This means that I approached the research with the view that expansion of practice to include prescribing was a positive move for the professions. I also hold the view that nursing and midwifery are values based professions and that this should continue when expanded practice roles are undertaken. This research has enabled me to reconnect with the values underpinning nursing practice and is in a way an exercise in me affirming my commitment to them and to nursing itself. My role as an educator preparing nurses and midwives for this new role means that I had a particular interest, both personal and professional, in finding out how their educational preparation was perceived. My views on continuing professional development (CPD) as a requirement for professional nursing and midwifery practice means that engagement in this activity was something I expected to see. My approach to teaching in which I facilitate learning constructed out of the interaction of learners

with learners and learners with teacher, informed my research approach in which I engaged in dialogic exchange with participants in order to generate knowledge. My involvement in policy development at a national level with multiple stakeholders and my positive experience of it means that I came to the research with the assumption that collaboration though challenging at times is the most effective way of enabling change.

All of these assumptions and my positionality influenced how I both conducted and interpreted the research. Indeed, they influenced my decision to undertake this research in the first place. Rather than try to bracket these assumptions to reduce their influence as would be the case in a descriptive phenomenological approach (Husserl, 1931; 1982), I acknowledge that as a qualitative researcher I am an integral part of the process with it being both impossible and undesirable to separate the two (Galdas, 2017). I have negotiated the influence of my positionality by being transparent and reflexive as I outline in Section 5.2 which is in keeping with an interpretive phenomenological approach. This has also enabled me to be open to the possibility of my assumptions about nursing, expanded practice and education being challenged and altering over the course of the research. The values of and subjectivity of me as a researcher are also addressed in Section 5.5.4 which attends to the quality of the research.

5.2 Reflexivity

I acknowledge methodology as a framework or model that guides how a research study is conducted or the lens through which phenomena are explored. My methodological assumptions reflect my ontological and epistemological positions

and therefore follow as being ‘ideographic, dialectical and hermeneutical in nature’ (Waring, 2017: 16). This means that within my approach I recognise the importance of individual experience, I engage with that experience through discussion with participants and that meaning derives from interpretation. Reflection, which Boud et al. (1985: 19) suggest is ‘an important human activity in which people recapture their experience, think about it, mull over and evaluate it. It is this working with experience that is important in learning’, is well noted as an important aspect of nursing practice. It is recognised within the work of both Carper (1978) and Benner (1984) and a practice I have engaged with throughout my professional life. Since I see this research as an extension of my personal nursing practice, keeping a reflective journal throughout this research process was not an unusual nor undesired undertaking and an important aspect of my methodological approach. It is also an important element of the critical approach I bring to the research. I acknowledge its importance and value in this chapter with the inclusion of a number of journal extracts and again in Chapter 9 where I reflect on the research process as a whole. Within a research context, Berger (2015: 220) views reflexivity ‘as the process of a continual internal dialogue and critical self-evaluation of researcher’s positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome’. Research memos have a long history in qualitative research (Miles et al., 2014; Ravitch & Carl, 2016) allowing the creation of conscious reflection on the process. My reflective journaling took place at structured times such as following individual and group supervision

sessions and after each research interview took place, along with *ad hoc* times when questions or thoughts about the research process crossed my mind. Though this process was challenging due to time constraints, it provided me with opportunities to commit to paper my unstructured thinking and to delve more deeply into areas of concern or thoughts that I was struggling with.

As proposed in the introduction to this chapter, research is a messy affair. One of the things I found difficult was having an open flexible approach. This was probably due to my professional history of having previously worked in the area of clinical trials where the underpinning methodology is one of positivism. Acknowledging that research questions and design may alter during the research process was unnerving. Devising my research question was not something that came easy. It was crafted and recrafted, tweaked and retweaked, evolving over a period of time. My overall question that orientated my research within the qualitative paradigm went through many iterations. Sub questions, related to the broad master question identified specific elements I wanted to explore. I was careful not to inadvertently introduce an element of causation, which could direct the research in a certain way (Aurini et al., 2016).

I explored a number of methodologies before deciding which was the most appropriate for my research. Ethnography (Bryman, 2012) was considered, as how an individual experiences their role may in fact be determined by the environment and culture in which they find themselves. Ethnography would have provided an insight into the patterns of working as an RNP and whether and how the culture of an organisation facilitates or hinders the work of the prescriber.

However, observation, central to ethnography would have opened up additional ethical and practical issues within a healthcare environment. A grounded theory approach would have illuminated the process of acting as an RNP. Discourse analysis would have provided an alternative insight into nurse prescribing but not of the individual experience of being a prescriber. Analysis of various texts like professional guidelines, legislation and organisational policy would have outlined the scope of the nurse prescribers practice. Ultimately my question became 'what does it mean to be a prescriber?' Linking my research question to a philosophy, in other words linking what I wanted to know to and how it could be known ensured that data collected could answer my questions. Thus a qualitative approach, drawing on hermeneutic phenomenological ideas facilitated me in exploring the experiences of RNPs in the maternity setting, in order to generate practitioner-based knowledge with the potential to inform education and research, policy and practice.

5.3 Phenomenology

This study was phenomenologically inspired and strongly influenced by the work of Heidegger (1962), Gadamer (1976) and van Manen (1990, 1997, 2014) so an exploration of phenomenology and what I understand it to be is warranted at this juncture. The word phenomenon has its origins in the Greek *phaenesthai* meaning to flare up or be shown (Moustakas, 1994). Merriam (2002: 7) describes phenomenology as 'an attempt to deal with inner experiences unprobed in everyday life'. Wertz (2005: 175) describes 'phenomenology as a low hovering, in-dwelling, mediative philosophy that glories in the concreteness of person-world

relations and accords lived experience with all its indeterminacy and ambiguity, primacy over the known'. It is recognised as a philosophy, methodology and method (Maykut & Morehouse, 1994; Sloan & Bowe, 2014) and has been used widely in the research endeavours of the disciplines of sociology, psychology, health sciences and education (Creswell, 1998). Two major ideas support a phenomenological approach to research, that the world exists as it is lived and that human experience is meaningful and of interest to the world. Dowling (2007) recognises it as the dominant means of knowledge development within nursing, employed to explore and understand the everyday experience of people (Polit & Beck, 2014; Grbich, 2012). Nursing's use of phenomenology has been criticised though with Crotty (1996) arguing that nurses have adopted a hybrid form of phenomenology, 'new phenomenology' which is both subjective and lacking critique with nurses focusing on the experience and not seeking to describe the essential essences of a phenomenon. However, this critique is only relevant if one considers phenomenology to only exist if Husserl's epistemological position is adopted (Crotty, 1996); in other words, that we can only know if we distil down to the essence of a phenomenon. Furthermore, Paley cautions against the use of phenomenology within nursing, suggesting that nurses have misinterpreted the central philosophical ideas within phenomenology (Paley, 1997). Not only does Paley criticise the use of phenomenology within nursing research to date but is in fact critical of the central tenet of Husserl's phenomenology and suggests that 'the idea that it is possible to identify the 'essence' … of phenomena must be judged unintelligible" (Paley, 1997: 192). He is also critical of the

phenomenological approach adopted by Giorgi, Smith and van Manen themselves (Paley, 2017). In Paley's view, explaining, theorising and testing are more important than 'just' describing and interpreting (Paley, 2017), suggesting in my view that phenomenology doesn't sit well with his epistemological position.

Edmund Husserl (1931) is credited with being the founder of phenomenology and this new way of knowing arose out of his questioning of western philosophical ideas and his feeling that psychology was wrong in trying to apply the natural sciences to the human sciences (Laverty, 2003: 4). Husserl's phenomenology is located within the positivist perspective and as his work was developed by other philosophers and psychologists, variations arose situated within the postpositive (Merleau-Ponty), interpretivist (Heidegger) and constructivist (Gadamer) perspectives (Racher & Robinson, 2003). All phenomenologists reject the idea that an objective approach to discovery is possible, however there are distinct differences between the variants of phenomenology which have implications for the conduct of research both in terms of data collection and analysis. While Husserl was hugely influential in the work of Heidegger, Heidegger, more concerned with the relationship of being within the world (Spurling, 1977; Valle et al., 1989) adopted an ontological rather than epistemological stance. It is this sense of phenomenology, drawing on the work of Heidegger (1962) and van Manen (1990, 1997, 2014) which influenced this study. Furthermore, my commitment to recognising the importance of locating experiences within a cultural context (Benner, 2000) was also influential.

Though phenomenology can be broadly categorised as either descriptive or interpretative, Langdridge (2008: 1131) suggests that hard and fast boundaries between description and interpretation are inappropriate as 'such boundaries would be antithetical to the spirit of the phenomenological tradition that prizes individuality and reality'. Finlay (2009) further proposes that description and interpretation are on a continuum, with specific work being more or less interpretative. I align myself with the thoughts of Matua and van Der Wal (2015) who suggest that the main differences between descriptive and interpretative phenomenology seem to centre around the focus of the research, role of previous knowledge, outcome of the research and value of context. Descriptive phenomenology aims to describe as truthfully as possible first-hand experience of the phenomenon without taking into account social, political or cultural contexts (van Manen, 1997; Dowling, 2007; Reiners, 2012). In fact researchers employing a descriptive phenomenological approach consider that people's environment does not impact on their experiences (Wojnar & Swanson, 2007). On the other hand, phenomenologists that lean towards interpretative frameworks, recognise that experience is very much influenced by the cultural context people find themselves in (Mackey, 2005; Flood, 2010) and look to see how individuals interpret their world (Orne, 1995). They seek to gain a deep understanding of experience by perhaps uncovering hidden meanings in the experience (Spiegelberg, 1975; Streubert & Carpenter, 2011) by entering the world of the participants. I believe that description of something is necessary in order to

interpret it, mirroring the consideration by Heidegger (1962: 37) that meaning exists in description, only when it is interpreted.

Phenomenologists employing a descriptive approach seek to distance themselves from previous knowledge of the phenomenon under exploration (Tufford & Newman, 2012). This has prompted a proposal that researchers avoid extensive literature reviews prior to conducting research, to prevent them from being tainted by prior knowledge (Wojnar & Swanson, 2007). Within the interpretative field, prior knowledge is embraced and becomes an integral part of the research (Lopez & Willis, 2004; Humble & Cross, 2010). In the analysis of descriptive phenomenological studies, the researcher stays close to the data as it is presented rather than providing and presenting an interpretation of the data. With descriptive phenomenology, disciplinary knowledge is built through the description of experience and identification of general structures of a phenomenon. On the other hand, the end product of interpretative phenomenology has been described by Flood (2010) as co-constitutionality, whereby meaning that is arrived at, comprises of meanings of both participant and researcher, and Streubert and Carpenter (2011) as the hermeneutic circle of understanding. These imply that meaning is derived through shared activity and knowledge between the researcher and participant. This is also consistent with Gadamer's suggestion that understanding comes from engagement in a reciprocal arrangement of interpretation with participants. I engaged in this dialogic process with participants, seeking feedback from them and becoming involved in further discussion with them (Fleming et al., 2003).

One common element within both descriptive and hermeneutic branches of phenomenology is the process of reduction which Husserl devised as a way a way of holding preconceptions aloft so that the essence of a phenomenon could emerge (Racher & Robinson, 2003) or 'the process of coming to know the phenomenon as it shows itself as described by participants' (Parse, 2001: 79). The manner in which phenomenologists approach reduction however, differs depending on their alignment to either descriptive or interpretative phenomenology.

Given my leanings towards hermeneutic phenomenology, I reject the notion of bracketing, seen as the process of setting aside a 'natural attitude' (Husserl, 1931; 1982) or preconceptions so as to describe what individuals are saying, in order to get to the essence of a phenomenon. Halling et al. (2006) suggest bracketing is neither possible nor desirable and Dahlberg and Dahlberg (2004: 272) argue it implies an exactness. They propose the use of the term bridling which 'invokes the thought of being respectful, or humble, to that which it bridled in order not to dominate, violate it or swallow it as bracketing seems to do' (Dahlberg & Dahlberg, 2004: 272). Even though I entered into this research with an open mind, it would be naïve and disingenuous to claim that I did not hold certain assumptions. For example, I believed and continue to do so that the introduction of nurse and midwife prescribing is beneficial not only to patients but to the professions of nursing and midwifery and healthcare organisations. As an educator who prepared many of the participants in the study for their new role as RNPs I was too close to the phenomenon to put aside completely my

preconceptions. Bracketing would have been both undesirable given that I value my own knowledge and unattainable given my close relationship to the phenomenon under exploration. I also considered that it would have been counterproductive to try and distance myself from the knowledge that prompted me to undertake the study in the first place (Koch, 1995).

In adopting an approach which aimed to interpret rather than just describe the phenomenon of prescribing, I engaged in the process of reduction through reflexivity. I became aware of how questions, methods and position may impact on knowledge created within the study (Langdridge, 2007), recognising that my subjectivity as a researcher could not be eliminated (Giorgi, 1994) and acknowledging how assumptions and prior knowledge may influence the research process. This was a continuous rather than a one-off event (Koch & Harrington, 1998) but I was cautious not to fall into the trap of navel-gazing (Merleau-Ponty, 1968) or becoming self-absorbed and embraced the relationship between the participants and myself rather than becoming consumed with myself. Engaging in the process of reduction enabled me to enter a state of 'epoche', meaning to withhold judgement (Moustakas, 1994). The phenomenological approach I adopted supported my positionality as a critical researcher. With phenomenology focusing on the individual, the critical lens permitted me to also focus on context. The critical researcher approach allowed me to examine the data arising out of the study in a holistic way, as "parts in relation to the whole and the whole in relation to parts" (Kincheloe & McLaren, 2005: 312). This also compliments the idea of Heidegger's hermeneutic circle (Heidegger, 1962).

5.4 Ethics

Ensuring the ethical conduct of this research study is something I was committed to from the conceptualisation of the research right through to the submission of this thesis and dissemination of the findings through presentation and publication. Research ethics can be explained in different ways but I think that Hammersley's definition fits well with how I view research ethics, as 'values that ought to inform the work of researchers' (Hammersley, 2017: 58). This identifies ethics as a process rather than a once-off event or decision to be made. It positions ethics within the researcher rather than something external to be checked off a list. Conducting ethical research was and continues to be about me being ethical in my judgement and decisions. Sitting alongside this idea of ethics as a process is the reality that governance of research is very procedural. I was required to follow the *Maynooth University Research Ethics Policies* along with the *British Educational Research Ethics Guidelines* (BERA, 2011) and as a nurse, I was also guided by my *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (NMBI, 2014) and NMBI's *Professional Guidance for the Ethical Conduct of Research* (NMBI, 2015d). These required amongst other things that permission to access a research site and research ethics approval be obtained prior to conducting fieldwork involving human participants. Individual informed consent was to be sought and confidentiality be maintained. Though Frank (2004) suggests that engaging with the procedural aspects named above can inhibit the development of an ethical culture, I propose that engaging in these activities can open the door to discussion about being ethical with colleagues, students, fellow researchers and potential participants. Engaging with

procedures gave me an opportunity to ‘check in’ with myself and reflect on the process of being ethical and conducting ethical research. However, engaging with the procedural aspect of obtaining research ethics approval from four different committees; at both hospitals from which participants were recruited, from Maynooth University where this doctorate was conducted and from my workplace, did little in my opinion to ensure the ethical conduct of the research and in fact, served to reinforce the notion of ethics as a tick box exercise. A huge challenge emerged in trying to get each of the research ethics committees to approve the same version of the study. Two of the committees had conflicting requirements in terms of data storage and how participant confidentiality would be maintained. The following journal extract was written on the day that ethics approval to conduct the study at one hospital was revoked due to requirements from another committee who had reviewed the study.

Journal Extract

I can’t believe it . . . I am devastated . . . I am so frustrated . . . I cannot believe what has happened. I have no idea how to fix this, how to conduct this research. All I want to do is give nurse prescribers an opportunity to be heard. They are competent individuals . . . I have safeguards in place so they don’t feel as if they have to take part. I will give them all the time in the world to decide on whether they want to take part, I’ll answer all their questions. Part of me feels it’s too difficult to do this but on the other hand, I am so close . . . I really want to hear what RNPs have to say. This is such an important and exciting time for nursing and midwifery, things are changing and rather than be dictated to I want those whom changes will effect to be part of that decision or at least to inform it. I feel claustrophobic . . . I can’t breathe

It seems in following institutional requirements, the bigger picture of whether this research was ethically conceived and designed and whether it looked as if it was going to be carried out by an ethical researcher had been lost. A collaborative approach involving myself, my supervisor and course director was used to engage with the committees and in the end all agreed to the requirements established by the hospital sites and ethics approval was granted by all four committees.

Though Pollock (2012) suggests that application of the principles of ethics is formulaic and bureaucratic, I consider them to be useful as a frame through which I can illustrate how I adhered to the requirements of the ethics committees as well as ensuring that ethics was a process within this research which was continually negotiated.

5.4.1 Autonomy

Autonomy includes the right to self-determination. In the context of the research presented in this thesis, it meant that potential participants had the right to decide whether or not they wished to participate in the research study. They were advised both verbally and in the participant information leaflet that they were under no obligation to take part and that they could decline participation or withdraw their consent at any stage, without negative consequence to them and without giving a reason, up to the point of publication of the thesis. Voluntary informed consent, defined in the guidelines as (BERA, 2011: 5)

> the condition in which participants understand and agree to their participation without any duress, prior to the research getting underway

was obtained. Though not a staff member of either research sites I was known by many of the potential participants in my role as lecturer at RCSI, as most would have been previous students of the college. I recognised that some potential participants may have felt obliged to participate and so a number of measures were put in place to ensure voluntary informed consent occurred. The offices of the nursing and midwifery directors agreed to act as a gatekeeper for the study. In this role, they stood between me as the researcher and potential participants. Gatekeepers control 'avenues of opportunity' (Hammersley & Atkinson, 1983: 38) and can protect potentially vulnerable individuals (Holloway & Wheeler, 2002) through their ability to control who has access and when to participants. In the context of this research, another role they held was to disseminate brief information about the study and my contact details to nursing and midwifery staff, who could then decide to contact me for further information and to participate if they wished. It was also possible that some RNPs were undertaking further programmes of study at RCSI on which I taught and examined. No nurse/midwife who was undertaking any education programme at RCSI, or waiting for results from RCSI at the time of data collection was included in the study due to the unequal relationship which would exist between me and the student. This measure was put in place to ensure that there was no feeling of obligation on their side. It also ensured that individuals would not feel that either participation

or lack of participation would impact their results in any way. As this was not a time-sensitive study, potential participants had time to decide whether to participate or not, therefore removing any pressure to give an answer straight away.

Providing sufficient information about the study to potential participants was another important step in ensuring that they were adequately informed and therefore could provide informed consent if they wished to participate. A detailed information leaflet was provided and within this and through discussion, potential participants were advised that even though their organisation (workplace) has agreed for the organisation to participate, that their individual participation remained at their discretion. They were also informed that their identity and data collected about them would be kept confidential within the limits of the law and that nursing and midwifery managers within the research sites would not be informed as to who had or had not participated in the study. Participants were also advised about the process to be undertaken in relation to dissemination of findings.

5.4.2 Beneficence and non-maleficence

Beneficence means to do good and non-maleficence to do no harm (Beauchamp & Childress, 2001). Whilst it is recognised that risk or harm may result from participation in any research study, the risks attached to this study were low. Two areas that warranted detailed consideration were that of privacy and confidentiality and a number of approaches were adopted to ensure that individual participant privacy was maintained in so far as possible. To promote

privacy and confidentiality of participants, audio-recorded interviews (which will be discussed in detail in the next section) were held in a quiet private area, either in their workplace or mine. It was recognised that in this study as all participants were from one of two organisations, some participants may become known. This was particularly the case if they are the only nurse/midwife prescriber on a particular ward or specific clinical setting. For this reason, descriptions of individuals in the presentation of findings are kept to a minimum. Each participant was assigned a code and matching of participant with the code was only possible by myself who held the key. All data was encrypted and securely stored in line with relevant legislation and according to local policy. Once transcription (which will be discussed in the next section) had taken place, the audio recordings were destroyed. No individual was referred to by name at any stage of the reporting or presentation of results though no guarantee of anonymity could be made due to the fact that all participants were from one of two organisations. Personal and possessive pronouns were not used in the reporting of findings as this would have identified the one male participant.

There is the potential in nursing or midwifery research, that the researcher may become aware of risk or actual risk (Hammersely, 2017) associated with poor clinical practice. Participants were advised within the participant information leaflet that if I were to become aware of any safety concerns that the relevant authorities within their organisation would be informed. This approach was in keeping with my professional responsibilities set out in the *Code of Professional Conduct and Ethics for Nurses and Midwives* (NMBI, 2014).

5.4.3 Justice

The principle of justice relates to fairness (Beauchamp & Childress, 2001). All potential and actual participants have the right to be treated fairly and equitably before, during and after participation in a study. In upholding this principle, all eligible individuals were afforded the opportunity to find out more information about the study and participate if they wished and those undertaking any education programme or waiting for results at RCSI were excluded from the study. Following transcription of the audio recorded interviews, participants were provided with the transcript of their interview to review. This allowed participants to verify, clarify or redact anything they wished in the transcript.

This discussion has focused on protecting individual participants from risk and historically, viewing risk in research from participants' perspective only, was the norm (Dickson-Swift et al., 2008). With qualitative research carrying different types of risk, it is important to recognise that the ethical conduct of research also requires us to examine potential adverse situations for the researcher (Shaw & Barrett, 2006). In preparation for this study and in developing good research practices The Social Research Association's *Staying Safe: A Code of Practice for the Safety of Social Researchers* (Social Research Association, 2005) was reviewed and I undertook a risk assessment from my perspective as researcher. This included an assessment of the environment in which the research would take place and characteristics of participants. I was familiar with the locations in which the interviews would take place and I always informed another individual where I was going and roughly how long I would be. Though there is an emotional impact associated with working with data generated by people, I considered the

data not to be sensitive and therefore the emotional burden to myself, low. Though interviewing can be considered stressful (Johnson & MacLeod-Clarke, 2003) particularly for novice researchers (Coles & Mudaly, 2010) and repeated exposure to data overwhelming (Campbell, 2002), I felt that personally and professionally I was well equipped to cope with these concerns. As suggested by Connolly and Reilly (2007) I built alliances with a couple of people in my class with whom I could reflect and debrief, not on content, but on the processes associated with qualitative research.

5.5 Research methods

Though the terms methodology and methods are sometimes used interchangeably, Straus and Corbin (1998: 3) offer a good distinction: methodology is ‘a way of thinking about and studying social reality’ and methods are a ‘set of procedures and techniques for gathering and analysing data’. This section will outline the methods used throughout the study including participant profile, accessing the research site and data collection and analysis. Issues relating to the quality of the study will also be addressed.

5.5.1 Sample

As the aim of the study was to explore the experiences RNPs in the maternity setting, the criteria for inclusion was that participants must be registered nurses or midwives holding prescriptive authority who have prescribing experience in the maternity setting in Ireland. Details in relation to the participants are provided in Chapter 6, Section 6.1.

5.5.2 Accessing the site and recruitment

Initially, I considered conducting the study at one maternity hospital given the large number of desired participants (RNPs). However, due to slow recruitment, I decided to include a second site. This decision proved beneficial in the long term as I recruited participants working in different specialist areas within the maternity services, adding further depth to the research. Both hospitals have had long term involvement with the introduction of RNPs. One had been involved in the pilot programme in 2003 and the other was one of the main drivers of the initiative in 2006/2007. Permission to access each site where participants were working was granted by the Directors of Nursing and Midwifery. I emailed the directors, introducing myself and outlining briefly the study I wished to conduct. I indicated that I was in the first instance contacting them and if they were supportive, would then go on to seek ethical approval from the sites. Both directors were delighted to facilitate the study, recognising that it was an area undeveloped in terms of research and advised that their offices would be happy to act as a gatekeeper.

Participants in the study were self-selecting and measures to safeguard them such as the use of a gatekeeper, obtaining approval to conduct the study and individual informed consent, as outlined in the previous section, were put in place. The gatekeeper hung posters at strategic points around each hospital such as coffee rooms and common areas to advertise the study and contacted the desired population via email, introducing me as the researcher and briefly outlining the study. The email invited potential participants to contact me directly if they required more information or wished to participate. The following journal extract illustrates some of my thoughts around the recruitment process.

Extracts from journal

I am gutted at how difficult it has been to recruit participants. Given the number of nurse and midwife prescribers in the maternity setting I thought they would be more forthcoming. I am not surprised really that 12 of the participants are practicing at advanced and specialist level because of how useful and desirable prescriptive authority is in these roles. It is interesting though that no midwives working in the delivery setting at the time of interviews took part. This could be due to the busyness of their practice area and also the regulation around prescribing especially assessment and documentation and lack of staff which I heard about from the first few participants. Midwives in general settings are also working 12/13 hour shifts and so staying behind after work or meeting me on days off may not have been of interest to them. Nurses and midwives working in specialist/advanced practice have a little more flexibility in terms of managing their workday and probably see taking part in research as fulfilling the requirement for research engagement. It was good to get one male participant though maintaining confidentiality may prove challenging when presenting findings.

5.5.2 Data collection and sampling

My research approach sought to 'understand, explain and demystify social reality through the eyes of different participants' (Cohen et al., 2007: 19). In other words, I sought to understand, interpret and make clear, through engaging with RNPs, what being an RNP meant. To this end, a process of qualitative interviewing was employed. This method is in keeping with my ontological position which recognises that an individual's knowledge, understanding and experiences are meaningful elements of social reality that can be understood and my epistemological position that recognises social interaction and interpretation as a valid way of constructing knowledge.

Silverman (2000) recognises interviews as the gold standard in qualitative research and semi-structured interviews were used to gain the perspectives of the participants. They were guided by my reading of the literature, my own experience of interaction with RNPs and were in-depth in nature, allowing exploration of a range of ideas (Rubin & Rubin, 2012: 3). Being in-depth, experiences, behaviours and feelings were explored allowing a detailed rich picture of what it means to be a prescriber to emerge. Data were collected between June 2018 and October 2018. Interviews were scheduled for a time and place that was convenient to both participants and myself with the majority of these occurring either in the hospital itself or at my workplace. I was conscious that staff I wished to interview were busy health professionals and that I needed to be flexible in how I approached the timing of interviews and considered the option of telephone interviews. I did not need to use this approach though and was more comfortable with face to face interviews, knowing that face to face would facilitate my acknowledgment of nonverbal clues (Dearnley, 2005) and enable the development of a more immediate rapport with participants. Interviews lasted between 35 and 75 minutes with the average length being 50 minutes.

As a nurse I have a lot of experience in interviewing patients. However, interviewing for the purpose of research is not quite the same as having a common conversation and preparation and attention to detail were required in order to be able to draw findings which could be analysed and defended (Mears, 2017: 183). Prior to conducting the research interviews, I engaged in role-play with colleagues acting as both researcher and participant to try and get a feel for

what it would be like, a useful technique when other forms of pilot testing are unavailable (Chenail, 2011). One of my colleagues was previously an RNP and had some useful insights to bring to the process. This process was also useful in determining the scope of the interview guide and whether it was adequate in drawing out the experiences of RNPs. No changes were made as a result of this process to the interview guide and when I actually went into the field to collect the data, participants readily addressed all the questions in the guide, often without prompting.

Though all interviewing should be viewed purposefully, I approached the interviews as 'conversations with a purpose' (Burgess, 1984: 102), recognising the construction of knowledge collaboratively between the participant and myself. The conversations required preparation on my behalf prior to them taking part and attentive listening during the conversation, so that appropriate analysis could be undertaken that would generate defensible findings (Mears, 2017). I took notice of what participants said, allowing me to follow up with what was important to them and uncover issues which I had not anticipated. A number of different probing techniques were used to enable expansion of and deeper exploration of issues as they emerged from the interviews. Active silence (Gorden, 1992) on my part allowed the participant to take the topic in the direction they wished. Request for elaboration (Oksenberg et al., 1991), such as 'can you tell me a little more about . . . ' indicated both that I was listening to the participant but also that I was interested to hear more about something specific they had mentioned. Summarising and paraphrasing what the participant had shared also served to

enhance the quality and depth of the conversation as it encouraged clarification when information was unclear. Audio recording of the interviews using an iPhone enabled me to concentrate on the interview and what participants were saying. Following transcription (which will be addressed in the section on data analysis) and participant verification, audio recordings were deleted.

When reviewing the transcripts myself it became apparent that I could have asked a number of additional questions during the interviews. This was the case particularly in the early interviews, possibly due to my relative inexperience in conducting research interviews. Participants were invited to answer these additional questions either during a phone conversation or via email. Anyone contacted about additional questions chose to answer via email and these additional questions and answers were added to the individual's transcript. No changes to transcripts were requested by participants. This suggests that they were comfortable with what they had shared during our conversations and that I had accurately and truthfully represented their experiences of being RNPs.

There is inconsistency in terms of what are considered appropriate sample sizes in qualitative research and how they are determined. It is important therefore to outline some of the issues associated with sample size. Ritchie et al. (2003: 84) outlines no fewer than seven factors that might affect the potential size of a sample: "the heterogeneity of the population; the number of selection criteria; the extent to which 'nesting' of criteria is needed; groups of special interest that require intensive study; multiple samples within one study; types of data collection methods use; and the budget and resources available". Charmaz

(2006: 114) proposes that the aims of a study are the driver of the project design, and therefore the sample size. Data saturation, when no new ideas are emerging from the interviews (Grady, 1998), is another criterion often used to determine sample size in qualitative research and the one which influenced my decision to cease interviewing additional participants once I had interviewed the 16th participant. However, the literature in relation to the point at which saturation can be deemed to have been achieved or indeed the relevance at all of saturation varies.

Though Charmaz (2006: 114) proposes that saturation may be achieved more quickly in a small study with "modest claims" and Guest et al. (2006) at around 12 participants in homogenous groups, Dey (1999) has argued that the idea of saturation is inappropriate as categories of data may be closed early in the data collection and analysis process, when data is only partially coded. Furthermore, Strauss and Corbin (1998) consider saturation as being along a continuum and propose continued review and familiarisation with data will always offer the potential for new insights to emerge. They posit that researchers should be concerned with reaching a point at which data becomes "counter-productive" and that the new that is found doesn't add anything to the overall story the research is telling. I found myself at the point identified by Strauss and Corbin (1998) when I interviewed the 16th participant and ceased interviewing new participants at that stage. Given the homogenous nature of the research participants, reaching this point at the 16th participant was not surprising.

5.5.3 Data analysis

Once each interview had been completed, I took some time to reflect on the interview, how I felt it went, whether anything surprised me and what I had learnt from that interview that could inform subsequent interviews. These reflections were recorded in my journal that I had been keeping throughout this research. During these reflections I also noted non-verbal moments during the interview which I considered significant such as a silence or tone of voice or laughter. As soon as possible after each interview took place, I transcribed the interviews verbatim. Transcription was an iterative process involving me typing out the text of the conversation while listening to the audio recording on a slow setting. I then read the transcript, correcting spelling, highlighting sections or sentences that did not seem to make sense or which stood out for me. As I listened to the recording again, I read the transcript, making any corrections necessary and taking notes of additional questions I would go back to the participant with, or which I wanted them to clarify. Following interview and transcription, participants were afforded the opportunity to review the transcript of their individual interview and make amendments if they wished. Also known as a member check, this allowed the accuracy and completeness of data to be confirmed (Lincoln & Guba, 1985).

The value and appropriateness of returning transcripts to participants however, is questioned by some (Giorgi, 2008; Hagens et al., 2009). Giorgi (2008) argues against the process though as he believes participants cannot confirm the meaning of their experiences, nor do they have sufficient phenomenological skill to judge the analysis. It could also be argued that participants may have a different experience of the phenomenon at the member checking stage and so

would ‘change their story’. Hagens et al. (2009) found that returning transcripts to participants did not add to the accuracy of the transcripts and suggested bias may occur if participants chose to delete or remove information, which the researcher thought to be valuable. However, I consider the interpretation of data to be a constant process of revision, therefore the potential for participants to revise what they had initially told me was not unduly upsetting to me. By embracing the relationship between researcher and those researched, the data emerged out of the relationship and was as it were, co-created. New data that emerged out of the clarification process were then incorporated into the transcripts. This fostered collaboration and included participants in the analysis of their data and is congruent with my constructivist and constructionist perspectives of knowledge development.

Data arising from qualitative research can be managed and analysed in a number of ways though most include some element of coding. This is the process by which words or short phrases that represent content and meaning of data, are assigned to passages of interview transcripts. The coding process was very much a journey for me and one during which I learnt and grew as a researcher more than I ever thought I would. Though I am quite an organised person, my organisational skills were put to the test. My commitment to the process was tried and I developed a level of perseverance I had not known previously. I felt a huge responsibility around the coding of data gathered during this study. Such was my anxiety around the process and coding in a way which remained true to what participants had shared, it was an activity I ‘put off’ rather than formally engaging

with at an early stage. I had a very useful discussion though with my supervisor when I was about two-thirds way through the fieldwork. I was able to discuss what I could see coming from the stories I had already gathered. I had, as I transcribed, made notes in the margins about what struck me or words that stood out. Without even realising it I had started to assign codes. Some of the notes I made in the margins of the interview transcripts became codes and others ended up fitting a description of a theme. As well as using an open coding procedure, derived from grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998) as outlined above, in which codes emerged from the interview transcripts, I used apriori coding (codes decided in advance). Due to my engagement with the literature and my professional knowledge in the area of nurse and midwife prescribing, I had a predetermined idea of what codes I might use to draw meaning from the text (Blair, 2015). Using both meant I availed of the advantages of both. Apriori coding gave me a structure within which to commence coding and open coding allowed me to be open to other ideas that emerged and ensured that I didn't leave out rich data just because it didn't fit a code.

During the coding process I became immersed in the data, in the voices of the participants. I engaged in 'dwelling' (von Eckartsberg, 1998) during which I made room for the phenomenon of the experience of being an RNP to make itself known. Wertz (2005: 172) describes that what is involved is 'an extreme form of care that savours the situations described in a slow meditative way and attends to, even magnifies, all the details'. This idea of care, attending to and magnifying

details, complements my sense of what it means to be a nurse and a nurse educator.

The development of a codebook to support the process was quite a comforting exercise for me and alleviated some of the anxiety I had about coding. Being able to define what was meant by each code, gave me a boundary which was supportive in the process. I could see progress in my identification of codes and labelling of transcripts. Though often seen as 'behind the scenes work' the development of a codebook was central to being able to carry out the analysis. The codebook itself though evolved over time. Additional codes were added, codes merged and redefined. Coding was a cyclical process and as Abbott (2004: 125) describes like 'decorating a room; you try it, step back, move a few things, step back again, try a serious reorganisation and so on'. What was happening was that I was coding and analysing simultaneously, an approach linked to constant comparison analysis (CCA) which derives from grounded theory (Glaser & Strauss, 1967). An important aspect of CCA is keeping a coding memo which was invaluable to me from a practical level in that it very clearly set out how I came about codes, the meaning I ascribed to each code, as well as being useful for reflection on the process (Birks et al., 2008).

Analysis of each individual interview involved moving back and forth between parts of the text and the full text, illustrative of Heidegger's hermeneutic circle (Heidegger, 1962). The first loop involved managing the data by creating and organising files. The second stage involved reading and making notes to form initial codes. This enabled me to keep track of my ideas as they presented

themselves. I also reread the transcripts a number of times, each time becoming more familiar with them (Agar, 1980). The third stage involved describing and classifying codes and gathering them into themes. This is the essence of qualitative data analysis. Developing significant statements and grouping them into significant meanings became the fourth stage. I compared data both within individual interviews and across the interviews ensuring that 'all data was systematically compared to all other data in the data set' (O'Conner et al., 2008: 41) another characteristic of CCA. This resulted in categories changing as understanding of relationships between categories emerged. Finally, the fifth stage required me to represent the data which I have done in the next two chapters. This also created some tension as initially I felt uncomfortable in choosing which direct quotes to present. All of the contributions made by participants in the study were in my mind, important and significant. Familiarisation with and reflection on the data enabled me to reach a point at which I was able to make those decisions. I also used the existential themes identified by van Manen (1997), spatiality (lived space), corporeality (lived body), temporality (lived time) relationality (lived human relation) and materiality (lived things and technology) to guide reflection on data collected.

An important question that I had to address before coding and analysis commenced was whether I would code manually or use qualitative data analysis software (QDAS). The following journal extract sums up my thoughts at the time.

Journal extract

I think I should be using software, it might make my analysis more complete. If I don't use it will it be viewed as a shortcoming? The thoughts of it though . . . not only do I not really like technology and it will take time to learn, there is something about it not sitting right with me. On the other hand, if I don't embrace it now, at what other stage in my career will I have the opportunity and take it up?

The decision I made in the end was to manually code the data rather than using QDAS. Though recognising that technology can make things easier and can 'extend our reach' (Flusser, 2013), the idea of using it in this research didn't sit well with me, it didn't seem right. I was concerned it would separate me from the research and present obstacles to insight, concerns previously articulated by Goble et al. (2012) who also suppose that 'through our use of technology, we become functions of it (Goble et al., 2012). I felt that using the QDAS would dehumanise (Heidegger, 2008: 319) and mechanise what should be a creative and immersive personal experience (Cross, 2011). I was also wary of falling into a 'coding trap' (Gilbert, 2002: 218) where I might become guided by what the technology could do rather than what was appropriate for my study (Garcia-Horta & Gerra-Ramos, 2009: 163). Finally, whether the use of QDAS is compatible with phenomenologically inspired research is questionable given van Manen's (2014: 319) thoughts on its use that 'these are not the ways of doing phenomenology'.

Once I had agreed to code manually and felt it was justifiable to approach it in this way I felt a sort of liberation. Much to my teenage daughters' distress, I took over their den for this activity. It resembled an untidy playschool room . . . papers, sticky labels, highlighters and coloured markers decorated the floor and walls. My

youngest thoughtfully made signs saying do not enter . . . I had not realised that when they regained their territory at the end of the coding process they intended the sign to stay. The process, though tedious and time-consuming, was fascinating. I became one with the data, living and breathing it. It consumed me and was always present. I relived each interview time and time again, I felt as if I was walking in the shoes of the participants once more.

5.5.4 Quality of the research

Good research design can contribute to credibility of findings and conclusions. Whilst the terms reliability and validity are terms often used when speaking of credibility in quantitative research, there is some discussion in the literature as to whether the same terms are appropriate or applicable to qualitative research. (Sandelowski, 1993; Long & Johnson, 2000; Rolfe, 2006). Whereas Mason (1996) aligns closely with the meanings ascribed to the terms within quantitative research, Le Compte and Goetz (1982) and Kirk and Miller (1986) apply different meanings to the terms. Another approach and one which I adopted was to attend to the quality of the research under the terms trustworthiness and authenticity (Lincoln & Guba, 1985).

Credibility, transferability, dependability, and confirmability are the four criteria within the element of trustworthiness. Within this framework, research is credible when another researcher can recognise an experience when faced with it. Establishing credibility involved my adherence to good research practice and engagement in the process of member checking outlined previously. Research is transferable if a sufficiently detailed description is provided by the researcher so

that others can judge for themselves if findings are transferable to a different situation and context. Research is dependable if the research process is documented and logical and I have kept appropriate records throughout the research process including transcripts, journal entries and decisions around data analysis. This allows auditing, to ensure that conclusions I have drawn have been done so appropriately and with sufficient data to support the conclusions. Though Bryman (2012) interprets confirmability as the researcher not overly allowing personal values to influence the conduct of the research, I interpret it more as my responsibility to acknowledge my immersion in the nurse and midwife prescribing experience since 2007 and my subjectivity as a researcher. I engaged with this process through reflective journaling which gave me time and space to understand how my views and assumptions could influence or impact this qualitative research. Authenticity is the other element which Lincoln and Guba (1985) suggest the quality of research should be assessed against. It concerns itself with criteria such as whether the research represents different views of the research population and whether it helps members reach a better understanding of their world. It also concerns itself with whether the members of the population come to a better understanding of the views of others, whether the research has empowered members to engage in action for change. The quality of this research will also be judged through the examination process this thesis will undergo and during the process of peer review when it is submitted for publication.

5.6 Conclusion

Arriving at my research question has been a challenge and this is noted in the literature (Khankeh et al., 2015). Though I was always certain about the broad area I wished to explore, arriving at the final research questions was a process of discussion and thoughtful reflection. It was important to engage in this process as it enabled me to explore and dig deep into qualitative research methodology. In this chapter I have outlined my philosophical underpinnings and how they supported the methodological approach and methods used in exploring the experiences of RNPs in the maternity setting. The approach to seeking participants, collecting and analysing data, and issues relating to the quality of the research have been addressed. Challenges associated with the methodological and practical aspects of the study and how they were managed have been outlined. A detailed account of the ethical considerations associated with the study has been provided and the facilitative nature of my research journal outlined. The next two chapters will present the findings of the research undertaken.

CHAPTER 6 STUDY FINDINGS (PART 1)

> *'If you meet me outside and you ask me what am I doing I say I'm a midwife. If I talk to the patient I don't say I am a midwife, I say I am a specialist . . . nobody ever asks me if I am prescriber or not unless I prescribe and they say . . . oh you prescribe. Yeah I'm a prescriber'* (P9)

6.0 Introduction

Both Chapter 6 and Chapter 7 present the findings from the research which explored the experiences of 16 nurse and midwife prescribers (RNPs) in the maternity setting. The participants came from a range of clinical areas within the maternity services, had varying degrees of experience prescribing and worked at different grades, from staff midwife to advanced practice grade. The professionalisation journey undertaken by the professions of nursing and midwifery and their current status was explored in Chapter 3 and this theme emerged strongly during my conversations with the participants. This was particularly evident when they spoke of their level of empowerment and factors which influenced their empowerment and their enhanced status within their organisation. This chapter begins with an overview of the participants and presents findings under the two themes of Empowerment and Professionalisation. Findings in relation to the other major themes of Identity and Agency will be presented in Chapter 7 and all four themes will be discussed in Chapter 8. The role education plays in the life of RNPs is threaded throughout the themes of empowerment, professionalisation, identity and agency. Though four major themes were identified, none stands alone and there is an interconnectedness between them, for example processes leading to

professionalisation lead to empowerment and agency. Similarly, agency in the form of caring is very much tied into participants' identity of being a nurse or midwife. What is immediately noteworthy from the findings is that participants articulated their experiences of being an RNP very much through the lens of what it meant for the patients or women in their care, in keeping with a values-based approach to delivering patient or woman-centred care. Though I have specified in many cases throughout the chapter the number of participants who had a particular experience this is only to give a flavour of how extensive their experience was. It is in no way an attempt to quantify, diminish or elevate the relevance or importance of the experience. The fact that an experience was reported by a participant means it was meaningful for that participant and therefore important.

6.1 Overview of participants

Sixteen RNPs from a total potential of eighty-one, from across two hospitals providing maternity care services participated in this research. Detail in relation to the recruitment of participants can be found in Chapter 5, Section 5.5. In the interests of maintaining confidentiality as far as possible, individual profiles of participants are not outlined. Many of the participants in this study were working in specialist areas in which there were only a small number in the entire country. Profiling each participant individually may make identification of the participants more likely. Participants consisted of fifteen female and one male RNP. Where the words 'his/her/he/she' would read easier they have been replaced with 'their' to maintain confidentiality as far as possible. Additionally, where words or

phrases within the quotations used would identify participants, these have been replaced with XX.

The first participant in the study was part of the inaugural class of nurses and midwives to be educationally prepared for prescriptive authority and was one of the first prescribers in the country. Two participants held nursing only qualifications, one held a midwifery only qualification and thirteen held dual nursing and midwifery qualifications. Participants had between four months and nine years' experience prescribing medications. Four participants, who had extensive experience of prescribing prior to our interview were not actively prescribing and the reasons for this will be identified later on in Chapter 7. Eight participants had worked outside Ireland but only one had experience of prescribing in another country. Two participants had undertaken the pilot prescribing initiative established in 2003 which was the precursor to legislation being passed permitting nurses and midwives to prescribe medicines. Eight of the participants were practicing and prescribing at an advanced level (having undertaken continuing professional development (CPD) and clinical supervision and practicing as expert practitioners, demonstrating exemplary clinical leadership), four were practicing and prescribing in specialist roles (having undertaken CPD and practicing in a specialist field with extensive experience and clinical expertise) and four were practicing and prescribing in clinical manager roles. Out of those practicing at an advanced level, four were RNPs before becoming advanced practitioners, two were practicing as advanced practitioners

before taking on the prescribing role and two became RNPs and advanced practitioners simultaneously. The is further addressed in Section 6.2.

The clinical areas in which participants had experience of prescribing were antenatal care, urodynamics, haematology, labour, perinatal mental health, diabetes, infection control, neonatology, community and the obstetric emergency department. Two participants had experience prescribing in two of the above areas. All participants had undertaken Level 9 study which would be the minimum educational criteria for specialist or advanced practice posts. Eleven participants had completed a master's degree.

6.2 Empowerment of nurses and midwives through prescriptive authority

6.2.1 Educational preparation and its role in empowering RNPs

'things made sense to me' (P8)

Participants viewed educational preparation leading to prescriptive authority as a factor in influencing the degree to which they could become empowered. Indeed, one participant, recognising the importance of pharmacology knowledge, undertook the programme with a specific aim of increasing their knowledge in this area as they '*thought it was lacking, the knowledge in pharmacology in midwifery training'* (P11).

Overall participants were happy with the educational preparation received for their prescribing role, though differences were expressed. Two participants suggested that the timeframe for the programme, given the breadth of content to

be covered, was quite short. One participant spoke of their intimidation in the classroom setting. They felt others in the class were more knowledgeable. This was something that caught me by surprise and so I have included their quote here:

> *P3: I used to find sometimes coming into the class . . . a little bit intimidating from the girls who worked in, there were a lot of cardio or CCU women or girls and they seemed to know everything and all I thought was all I want to know is about my Heparin (name of drug). But they sat up here in the corner, they weren't loud but always very vocal and they always had the questions and answers and I thought dear God I know nothing compared to them.*

The pharmacology module was the one which generated most discussion by participants due to its generic nature and the specific nature of participants' practice. This was a particular issue for those working in neonatology. It was felt the course was very adult orientated and therefore four participants felt they weren't adequately prepared for the drugs they would be prescribing. The contribution the education programme made to RNPs ability to care is further expanded in Chapter 7. The following participant who had completed the pilot programme in 2003 felt the programme still didn't meet their needs. It was the assessment of the pharmacological knowledge which this participant considered to be irrelevant for practice, that was particularly frustrating:

> *P14: I felt very wrong . . . to be assessed in areas of nursing and medicine that did not relate at all to our care or the care of the mothers let alone the babies we look after . . . I feel quite sore about it as you can see . . . it was a waste of a lot of energy and time studying things that had no relevance*

Another participant felt it was more important to be able to use resources and a recognised medicines formulary such as the BNF effectively rather than having knowledge of a wide range of drugs they would never use. Ten participants spoke

about how tough the course was and the stress of having to study medications they were never going to prescribe. Fifteen participants, though recognising the difficulty of the programme and how much of what was covered from a pharmacological perspective was more geared to the general adult population, acknowledged that there were many positive aspects to the course:

> *P8: It gave me greater understanding and for the first time, I understood why things would happen. It's a bit like when you start your nursing. You think why are they talking to me about red blood cells but you need it. It's building blocks. It certainly gave me a lot more confidence and understanding and how drugs worked and even the terminology . . . things made sense to me now . . . and I could understand why that blood pressure tablet would work as opposed to this one*

The course, though difficult was a bit of a 'wakeup call' for one participant who felt that the pharmacology covered was something they should know anyway. This was further reiterated by another participant who recognised that the population they are caring for had evolved and therefore different types of knowledge are required:

> *P11: I can tell you we resented the amount that was done on cardiology and psychiatry with so little being done in maternity, but saying that more and more you have women that have very complex cardiac problem and it's really important for us to know but you only realise that when you think about it. Years ago women with very complex cardiac problems didn't have babies or they died when they got pregnant. Nowadays they survive very well. The knowledge of pharmacology and cardiology is really important for midwifery.*

One participant, though working in a specialist role recognised the importance of knowing about a wider range of drugs because many women presenting to the diabetes maternity services have hypertension or complicated renal disease. However, another prescriber working in the same area had a different perspective and felt that knowing the basics was fine, such as interactions and suggested a

separate module on ‘drug-drug’ interactions followed by the specifics required for practice in diabetes.

Students also take a module during which issues such as professional accountability and ethical prescribing are covered. Ten participants viewed this positively and students felt prepared from a regulatory and legislative point of view. Another suggested audit of practice was still an area in which responsibilities were unclear. One participant spoke of the practical nature of the assignment work and the impact the course co-ordinator had on the whole experience, which contributed positively to the experience of being a prescriber in practice:

> *P7: The assignments were structured around the CPA. You know a lot of the course was really geared towards helping you with what you had to do. The course coordinator was really, she was very empowering . . . from the time we started we were quite nervous and then towards the end we all knew that we would be okay . . . I think it was just a really supportive environment to study in so I think it actually transferred over to the prescribing.*

The theoretical aspect of the health assessment module was viewed very positively by all as suggested by the following participant:

> *P7: The health assessment associated with the prescribing, definitely enhances your practice . . . like I never ever knew what percussion was for . . . And all of a sudden I knew why they were doing that and I knew more about drug reactions and I looked at people on polypharmacy. So I think it did change my practice, it made me see things slightly differently . . . more comprehensive hat on.*

This module also includes a mentorship aspect with the Nursing and Midwifery Board of Ireland (NMBI) stipulating that mentorship be provided by a designated medical mentor, usually a hospital consultant or general practitioner (depending on the setting) with whom the student prescriber works closely. This study has

shown that for some, the experiences of being mentored may have been less than ideal. One participant outlined how the consultant mentor didn't engage in much prescribing activity themselves and so questioned the appropriateness of this person as a mentor. Five participants felt that mentors saw the process more as a tick box exercise and viewed some mentors as easier than others '*It was kind of a hands off kind of thing . . . he did the signing off but it was sort of a tick box exercise I felt which is why we chose him to do it . . . I don't think it really served much for me anyway'* (P8).

One participant acknowledged that whilst you might get away with someone being less 'hands-on' that this was not appropriate as at the end of the day nurses and midwives need to be able to make safe and appropriate prescribing decisions. They also recognised that opportunities for learning were missed and not utilised. Another participant who had a positive experience themselves described how a mentor could make life difficult for student prescribers:

> *P1: I know one person finished her night shift and she lived in Meath and she finished at 8 am and he couldn't meet her until 11 so she had to hang around . . . and she was under pressure because she had to get x y and z done for her CPA . . . both consultants were very busy, one was very straight forward and easy, you know he was very supportive . . . the other one had a similar workload and it was just more difficult.*

Anxiety in relation to performance in front of the medical mentor was acknowledged only once. Ten participants considered their mentorship experience to be positive overall despite in some instances it being a tick box exercise. Three participants spoke of the encouragement of the consultant during the mentorship process, however the challenge associated with obtaining medical mentors was also noted.

Nine participants questioned the need or even appropriateness of the mentor having to be a doctor. One participant who worked alongside an advanced practitioner recognised both the practicality of having an advanced practitioner as mentor but also the wealth of knowledge that person had to offer as described below:

> *P7: Someone like (AMP Colleague) could have mentored me or partly mentored me I think that would have been brilliant. I don't understand why if you have an advanced practitioner why they can't be your mentor. Particularly if they have been prescribing for a certain length of time. My mentor was here for half a morning a week you know but (AMP colleague), I worked with five days a week so I think, I don't understand why we allow, medics but not an advanced practitioner. I think it's a crying shame that we don't use the talents that we have within the nursing and midwifery profession.*

Another participant recognised how they were already involved in mentoring candidate advanced practitioners and mentoring as part of the prescribing programme would be an extension of that professional relationship on a more formal footing. All but one participant believed that if not yet, in the future they would be happy to take on that mentorship role and saw this as a really important part of the course. Two participants considered that their role in auditing their own and others prescribing ideally placed them to take on that mentorship role and ensure best practice.

6.2.2 The role of relationships with others and organisational support and structures in empowerment

> '*Everybody thought gosh this is brilliant and I felt really I suppose respected in my role, I felt you know really empowered and very well supported (from management)'* (P1)

A significant contributor to the empowerment of RNPs was the support they received from within their organisation which ranged from collegiality to an organisational culture of support and strong leadership. There were overwhelming reports of how individual pharmacists supported RNPs. In one setting the newly appointed chief pharmacist was very proactive in their support of nurse and midwife prescribing. Participant 16 recognised the trust between pharmacists and midwives in the following extract:

> *P16: So he (the new chief pharmacist) knows, he's well-tuned in. The previous pharmacist, it was no way, no way, you were only a midwife, don't be above your station like you know he wouldn't have . . . XX is quite pro midwives and I think he is someone who trusts our profession.*

The chief pharmacist was described by Participant 13 as *'he'd be my go to he's fantastic'* (P13). Three participants in the study recognised the proactive approach of pharmacists in bringing newly authorised drugs to the attention of RNPs, further enhancing the autonomy of the RNP. A pharmacist was also supportive as reported by one participant in how they encouraged RNPs to future proof their practice, by ensuring that a range of medication doses were listed on their Collaborative Practice Agreement (CPA). Though many participants identified the collaborative nature of their professional relationship with

pharmacists who were proactive in supporting RNPs, a small number identified the role the pharmacist played in controlling their prescribing practice. One participant spoke about how the pharmacist didn't want nurse prescribers continuing medications the patient was already on. Given that the prescriber had successfully passed the education programme, this really annoyed them as they felt it was none of their business. A participant who had a similar experience felt it might be due to the fact that nurses and midwives could prescribe but pharmacists couldn't. The pharmacist wasn't challenged on this as the prescriber didn't *'want to get myself in trouble'* (P1).

What became noticeable during the conversations with participants was how influential the medical profession is in promoting expanded or advanced practice roles for nurses and midwives. This was evident at a national level as described by Participant 12, in the face of opposition from within nursing and midwifery:

> *P12: When Professor xx and Professor xx suggested having ANPs in the hospital . . . they went to the Royal College meeting and they said this is happening (introduction of ANPs) and they were told they were stark raving mad . . . they told Professor xx he was stark raving mad. And he said well we're doing it.*

It was also articulated at an individual level and the quote from Participant 10 gives a sense of this*: 'Dr XX was very encouraging . . . it was Dr XX who kind of put me forward to do the ANP course . . . I have to say and she was extremely encouraging . . . Like she would always have information to share which was fantastic'* (P10). Ten participants described how their collaborative relationship continued with their mentors once the course finished and the formal requirements for mentorship were over.

The support of colleague RNPs was also of huge importance. This happened in both formal ways such as managing the CPA approval process and informally. This informal support was vital for those in specialist roles whose consultants were working offsite for large portions of the week, as captured by Participant 7 '*sometimes specialists are isolating roles in the sense that you are kind of you're not on a ward . . . that massive family do you know. I would be quite friendly with the other specialist ANPs around the hospital. At least once a day one of the other girls pops into the office and says P7, come look at this'* (P7). Participant 7 also acknowledged the encouragement of the course coordinator suggesting that a supportive educational environment supported the transition from a nervous student to a confident prescriber.

Without patient acceptance, RNPs wouldn't be able to practice to the extent of their scope and patients were generally very accepting of the RNP role and did not question it. Participants considered this could be due to the fact there is greater public awareness of the role, given there are so many RNPs in general settings or due to the complex interactions and procedures they were already conducting as proposed by Participant 2:

> *P2: When you say I can prescribe something for you now, you know I would have thought they would have been 'oh can you really?' so it was taken completely as part of the service really. Maybe because the test itself seems quite complex, it seems more high faluting than it actually is, so it sort of is a follow on from that, it's no big deal that you can prescribe then.*

One participant talked about the additional trust and confidence patients had in the nurse/midwife because of the prescribing role. All of the RNPs whilst undertaking the education programme preparing them for the role were practicing

and working clinically at the time. The following extract describes an interaction between student nurse prescriber and patient which sums up the esteem in which these healthcare professionals are held:

> *P5: They . . . have been pleased for me, like they would have been how does it feel? I'll never forget, there was one woman who . . . was very tricky, very unwell during pregnancy and I worked a lot with her and she knew I was doing the course because I had to miss some days and I wasn't expecting anything . . . but she brought me a lovely cross pen and she goes 'I thought of you now for your prescribing'. It was very special.*

Participants working in the emergency department had a slightly different experience, often being questioned by patients as to why they were not seeing a doctor.

Nursing and medical leadership were identified as facilitators of empowerment by one participant who commented '*I think, the organisation was probably the biggest facilitator. I think the organisational support and the leadership within the organisation really, really embraces midwife prescribing and makes the process easier'* (P7). Different committees such as medication safety groups and drugs and therapeutics committees (D&T) were viewed by three participants to be supportive, as commented on by Participant 12 who asserted that they were *'supportive and facilitative rather than limiting'* (P12). Support from the director of nursing and midwifery was also evident in their facilitation of attendance at study days once the participants were prescribing. The following extract from Participant 2 sums up the supportive nature of the environments *'I felt like I suppose respected which I suppose enhanced my confidence in my role and like there's a really good culture in (hospital name), you know it's a good working environment. I think interdisciplinary roles kind of blend well together'* (P2). Of

note is that seven participants talked about being lucky in terms of the support they received from different sectors, rather than thinking it was something that should be expected.

The introduction of an electronic health record and associated electronic prescribing was viewed by participants in this study as having an impact on RNP empowerment. Access into the system was a challenge for two of the participants and three others who could get into it, admitted they did not know if they were able to generate a report of their own prescribing practice. Two participants outlined how they preferred the original paper-based chart and prescription as they had an immediate visual. Participant 6 felt that electronic prescribing slowed things down as '*It is a little bit longer time consuming than before'* (P6). Correcting a prescription on the electronic system was also reported as challenging as the prescription must be cancelled and the process started again from scratch. It was also reported that the system was not set up for every dose of every drug that could be used. A participant working in the neonatal unit where dosing of medicines is of paramount importance had this to say:

> *P10: I am rolling my eyes because we had a big meeting about this . . . it's more difficult I think in that you, you're, it's so much easier to write down what you want but now you have to check with the order sentence check that the order sentence is correct. I think I'm nearly more nervous now in getting it wrong because of the process of prescribing . . . it's to pick the right thing on the system.*

Because the electronic system is set up with doses and frequency of administration, two participants expressed concern that they may lose some pharmacological knowledge because they are not having to actively think about what they are prescribing as once you put in the first two letters of a drug a list

comes up. One of the participants though confident in their prescribing felt that with the electronic record there was a bigger scope for mistakes and described it like this:

> *P15: I can see how errors can occur and will occur from electronic charting, and yes its deskilling yes definitely . . . as prescribers you nearly have a bit of a reliance on the computer now whereas before you know you would look at the baby and do the assessment and go into your BNF or whatever neonatal drug formulary we'd have here . . . now it's all built into the chart.*

In contrast nine participants felt that the provision of set orders within the system made life easier and possibly safer if it was set up right. Participant 16 suggested that rather than '*people would come up and say give us a signature there now . . . with the electronic chart you have to be there both of you have to be checking it you have to sign it and you have to log on and log off*' (P16).

The electronic chart and prescription was viewed by two participants as being the main detractor from care. One considered eye contact to be really important during the interaction between healthcare practitioner and patient, and having to concentrate on inputting information to a computer meant they were distracted from the patient. Another participant gave a specific example of being more removed from the patient. As they were in a more advisory role, the participant could review test results online from their office and cancel antibiotic prescriptions if needed without ever having to see the patient.

6.2.3 Regulation and legislation: facilitators and barriers to empowerment

'It is restrictive in one sense . . . but for me it is working' (P6)

As noted earlier in this thesis, the professions of nursing and midwifery are highly regulated with RNP practice governed through a dual framework of legislation and professional regulation. Both elements featured heavily in the participants account of being an RNP. All of the participants in the study raised the issue of the CPA (described in detail in Chapter 2) themselves without prompting from me. The CPA was viewed as unnecessary and restrictive by some participants and facilitative of a safe and expanded practice by others. The grade or practice level of an individual participant was not indicative of the position they held on it.

Most participants reported that devising the CPA was very much a collaborative exercise between the participant and other RNP colleagues, their mentor and/or pharmacist. Well established RNPs were reported as very willing to share their list of drugs and advise new RNPs. The remaining seven participants based their CPA drug list on the medications they normally had to ask the doctors to prescribe. In 11 instances the consultant mentor was heavily involved in devising the CPA with the student prescriber whereas in other instances it was driven by the student prescriber themselves. Eleven participants actively engaged with a pharmacist when devising their CPA as demonstrated below:

> *P10: Yes, before it went to drugs and therapeutics . . . I would have sent it (to the pharmacist) as a courtesy more than anything else but also so she can check it. She would come back and say to me 'listen you use this on the unit it's now licensed so you can add it to your list'.*

The participant who had prescribing experience outside of Ireland considered their involvement in developing their CPA as quite liberal and was concerned about the power or autonomy given to prescribers in this country in devising their CPA. The participant felt that without someone checking everything, the RNP could have free reign as to what they prescribed and how they practiced. The requirement to have one or more senior doctors sign the CPA in order to permit an RNP to prescribe for their patients elicited mixed reviews. Two participants didn't have very strong feelings on the matter at the time they began prescribing. They were some of the first in the country and given the seismic change happening within nursing and midwifery they didn't give it much thought. Neither were prescribing at the time of interview. One participant considered the CPA to be collaborative as outlined below:

> *P12: We sign it as well, so if you look at it that it's a kind of an agreement between two people it's like both of us sign the consent for the research, it's not like they're giving me permission . . . What they're doing, they're agreeing to say I'm happy for P12 to prescribe, that she has full authority to prescribe those and I'm happy with that. I much prefer that than having my CPA in isolation, something happens and someone says 'well I was never happy that you could prescribe that' . . . it can be used to control, but our experience has not been like that.*

Another participant felt it was offensive to their experience and expertise and articulated this as *'a bit insulting'* (P16), to have the master of the hospital sign the CPA when they didn't work closely with the participant.

Participants held strong, though differing views on the value of the CPA for practice. Ten felt it significantly impacted on nurse and midwife autonomy and questioned its rationale given they have successfully completed the course and

were deemed safe to prescribe. The following participant articulated these frustrations well:

> *P7: I definitely think the CPA takes autonomy away from nurses and midwives. I don't understand why sometimes we disempower ourselves in nursing and midwifery and why we have to prescribe under the regulation of medics. I feel the CPA is slightly redundant.*

Ten participants felt that the CPA was limiting of practice in some respects but useful in others. The following participant gives a sense of this:

> *P6: Having a CPA does kind of limit our prescribing because we only can prescribe the drugs from our CPA but it's good to have CPA because as I said for the course we know what we are prescribing and we can keep ourselves up to date on those drugs . . . It is restrictive in one sense . . . but for me it is working, I am happy with it. It is better to have it from the legal point of view so you have that boundary.*

Another participant viewed the CPA as supportive and particularly when first practicing as a prescriber as it gave a sense of security, but held strong views about the autonomy of nurses. Some questioned its appropriateness as the prescriber became experienced though this was challenged by one prescriber who had a number of years prescribing experience and felt they wouldn't be able to remember all the drugs on their list. In this respect, the CPA was useful. and being used as a reference tool and not as a strategy to control practice. One participant suggested that the CPA was valuable in delineating between roles where there were nurses and midwives of different grade or scope working in a particular area. This was elaborated on by the following participant who contemplated the CPA requirement for nurses and midwives working at different levels and suggested there should be a different mechanism for those working in advanced practice:

> *P14: I think that there should be a different pathway for people in advanced practice. I think it depends if you are staff nurse/midwife, yes I think a CPA is important and I don't mean to sound elitist about this and I really don't mean to sound elitist, but we are practicing, I'm practicing in advanced practice and therefore I have the authority to care for these babies and make diagnosis and make treatment plans, and treatment plans and diagnosis depend on medications. If I'm approved and supported to be an advanced nurse practitioner, part of my practice should be prescription of these medications without these hurdles.*

11 participants viewed the CPA as a protective mechanism for practice, focusing the practice of the prescriber. It provided participants with a defence against pressure to prescribe a medicine outside of their scope. This was explained as, if the drug is not on their list they can't prescribe it and the CPA provides evidence of that. The professional requirement to practice within the confines of a CPA was noted as a challenge for eight RNPs. This was the case in which a slightly different dose of drug was required for a specific patient which was not captured within the CPA 'w*ith some of the benzodiazepines the way it had been decided I can prescribe it, 5 mg BD but then you might have somebody who needs it TDS'* (P5).

Thirteen participants spoke about the requirement to amend their CPA**.** Nine reported being quite proactive in amending it in relation to patient and practice needs and applied to have new drugs included on or removed from the CPA when appropriate. Four, though recognising a need for amendments felt that it wasn't really worth the effort, particularly if it was for a drug that whilst useful, they would not prescribe that frequently. Time was also a factor in determining whether prescribers continued to make amendments as necessary, and six participants identified that lack of time or time constraints prevented them from seeking amendments. One participant considered the requirement to establish a new

CPA on changing jobs or hospitals as a way of the medical staff controlling practice and another, as the *'rigmarole of bureaucracy'* (P8). The extract provided below from Participant 3 is an example of why this was deemed unnecessary:

> *P3: I think if you are comfortable prescribing pain killers it doesn't matter where you are . . . pregnancy is pregnancy until 6 weeks postnatal so even things you can't have in pregnancy you can't have them in postnatal.*

Practice standards guiding nurse and midwife prescribing practice were also raised as an issue. One in particular, the separation of prescribing activities was deemed impractical by two participants, particularly when working in isolation. It was deemed by them to take away from one of the proposed benefits of nurse and midwife prescribing which was for one practitioner to deliver a full cycle of care. This practice standard was also deemed by one participant to be excessive and not required as '*by administering it I'm still checking it with somebody . . . we do check things, we are very thorough . . . they should give us a bit more trust . . . don't make it harder than it actually is . . . let us do our job'* (P16).

Nine participants felt very strongly that there were different rules in place for the recording of prescribing activity by RNPs and doctors with RNPs required to enter details of prescriptions they had written to a database. Fifteen participants were frustrated with the amount of work entering the prescription details entailed, with one describing the requirement as a *'nightmare'* (P8). This sometimes resulted in RNPs not using their prescriptive authority and getting the doctor to write the prescription. The rationale for this database was unclear as the information inputted was never used locally as described by Participant 4: *'putting it into the database seemed to be only, what will I say, you go to meetings and the senior*

people were able to produce their reports from what we put in . . . the doctors, they didn't have to constantly prove themselves (P4). It was also unclear as to how diligent participants were in fulfilling this administrative requirement with some recognising that it didn't always happen. In addition to this it was considered to be a flawed method of recording activity by ten participants, who explained how not every prescribing decision results in the generation of a prescription. Decisions to offer lifestyle advice instead of pharmacological agents or a decision to discontinue a medication were not captured by the database and this acknowledgement is captured by the RNP quoted below:

> *P9: And then strange enough they weren't interested at all about cancellation of prescriptions. So huge amount of my patients that I was cancelling, de-escalating, I was doing it in the capacity of a prescriber but I couldn't document it within the database.*

Participant 16 felt that the regulation of RNP practice was extreme and became quite frustrated with this. The participant captured the general feeling around regulation of RNP practice:

> *P16: I do think sometime its overkill. I see doctors here writing scripts and they don't even (see the patient) . . . it's given . . . for nurses and midwives it's double checking, double checking, double checking and I shouldn't have to double check and triple check I just feel that the trust isn't there whereas for our medical colleagues it is.*

The practice of all prescribers regardless of profession is governed by legislation. The amendment of this legislation along with the development of new legislation was required in order to provide a legal framework for RNP practice. The legislation up until the end of 2018 permitted different practices for nurses/midwives and doctors. The prohibition on prescribing unauthorised medicines was expressed as a huge impediment to the delivery of normal care

by six participants working in neonatology and antenatal care where some medicines which are used routinely, are unauthorised. This was highlighted as a matter of life and death which could result in unsafe prescribing practices as reported by this participant:

> *P12: If a baby seizes I can't treat it. There was one night it was so bad the SHO was at a caesarean section or at a delivery, I couldn't get anyone to prescribe phenobarbitone (drug name), I went down to the labour ward and got a consultant obstetrician to chart phenobarbitone for a baby that was seizing in the ICU. It only happened once, but I needed it in a hurry, it needed to be done and I had no alternative.*

Not being legally allowed to prescribe unauthorised medicines exposed differences in the provision of services to patients across different hospitals. For example, one participant reported how decisions on which brand or brands of a specific drug to stock in a particular hospital, are often made on financial grounds. They went on to explain that one hospital may stock a brand of a product that is authorised and another may stock an unauthorised brand of the product. This means that an RNP in one hospital may be able to prescribe treatment for a patient whereas a similarly educated and experienced RNP working within the same scope of practice in another hospital, may not. The example of Caffeine was given by Participant 12. Caffeine which is routinely used in neonatology is available as an oral medicine or an intravenous one. Only the intravenous one is authorised but it is more expensive and thus not stocked by all hospitals.

The prohibition on prescribing unauthorised medicines also impacted in a practical way on day to day practice. A number of examples were given whereby the RNP would prescribe a generic product (as stipulated by the regulator) but the only version of it available in the hospital pharmacy was an unauthorised

brand. This was very disconcerting for one participant. They queried where they stood legally, or where the administrator of an unauthorised drug stood, when they were administering an unauthorised brand on foot of a medicine prescribed by an RNP. The participant outlined how persistence on their part in negotiating with the regulator, meant that regulatory guidance was amended in order to allow the prescription of a brand name in some instances.

Three participants in the study considered that the legislation prohibiting RNPs prescribing unauthorised medicines was not required and that there were enough other safeguards in place to ensure safe care such as the CPA, D&T Committee review and HSE guidelines that would '*stop reckless prescribing of unlicensed medications'* (P12). It was felt by one advanced practitioner that the prohibition of prescribing unauthorised medicines disproportionally affected those working in an advanced capacity as they are caring for patients with more complex conditions and need to prescribe '*drugs that you wouldn't necessarily expect a staff nurse to be prescribing'* (P12). The significance of being able to prescribe unauthorised medicines in the future was articulated as to finally be able to provide truly holistic care.

6.3 Professionalistion: issues relating to nurse/midwife prescribing

6.3.1 Enhancing professional status and continuing professional development

> '*I think I get, what's the word, kudos from the medical staff since I'm prescribing'* (P3).

Five participants felt that having prescriptive authority meant consultants had a higher opinion of them, possibly due to their increased knowledge. Participant three captured this as *'I think I get, what's the word, kudos from the medical staff since I'm prescribing'* (P3). The colour of the uniform worn by advanced practitioners (who are all prescribing) signaled them out as having a much broader scope than other staff, but sometimes this could lead to misunderstanding in relation to the scope of drugs that can be prescribed by the individual:

> *P15: They see us I suppose in the (colour), they know what we do we do a lot of, you know, acute resuscitations and we do a lot of the, you know medical kind of procedures and we teach a lot of the medics when they come on rotation . . . they assume we can prescribe pretty much anything.*

The impact of uniform was also mentioned by another participant in relation to speaking to doctors and letting them know the extent of the RNP's scope. The participant experienced that the higher the grade, for example indicated by a particular coloured uniform, the more accepted they were. Two participants reported that the professions of nursing and midwifery were perceived by medical staff as being very thorough in their approach to governance and regulation of RNP practice.

One way in which participants considered their enhanced professional status to be recognised, was through their teaching activities and they were involved in teaching nursing/midwifery and medical students, junior nursing and medical colleagues and pharmacists. In some instances, it was difficult for the participant to identify whether their teaching role evolved out of their prescriptive authority or if it was more linked to their grade, such as advanced practitioner. Three participants described being involved at a national level in directing the education of specialist practitioners and informally assessing their competence. With junior doctors moving positions every six or twelve months, participants also saw their role in bringing new doctors to their unit or hospital, up to speed in the correct practice in the new setting. One participant outlined how policy around prescribing antimicrobials differs from hospital to hospital and their role in informing and educating doctors about guidelines. A couple of participants recollected practical ways, guided by their experience in which they supported the learning of their colleagues in practice. Another participant spoke about the need to teach medical colleagues by giving them opportunities to develop skills but at the same time not becoming deskilled themselves. The participant recognised that being part of this educational activity facilitated maintenance of their own skills. The actual act of prescribing was also seen as a teaching opportunity with teaching sessions being given to students around why particular drugs were being given and how they worked. Five participants outlined how given their prescriptive authority they were seen as a general medications resource within their clinical areas, with colleagues from a cross disciplines

seeking their advice. Though all recognised the importance of themselves as teachers and supporting the practice of others, the time required to do this was identified as a challenge by two participants.

All nurses and midwives have a professional responsibility to engage in continuing professional development (CPD). Participating in the education of others as outlined above and undertaking the prescribing education programme were some ways identified by participants as contributing to this requirement. Engaging in the practice of prescribing decision making was also seen as a vehicle for learning on the part of the prescriber. This was particularly the case for those who undertook advanced practice courses subsequently. Two participants were prescribing before undertaking the advanced practice programme and recognised that actively prescribing supported the transition to becoming an advanced practitioner. Participant 16 recalled how prescribing supported the transition period well as outlined below:

> *P16: Definitely it was a bonus having prescriptive authority . . . and using that in community . . . it was so invaluable to me. As a practitioner in the community I was making the decisions so it wasn't as if I was protected by the hospital walls all my career and that all of a sudden I was branching out into a new position . . . Prescribing in the community has definitely helped in that transition to ANP even though the list (of drugs) grew.*

One of the practice standards associated with having prescriptive authority is that of maintaining competence. It is also required under the professional code of conduct for all nurses and midwives. Though the lack of clear guidance from NMBI as to appropriate CPD in order to achieve this practice standard was articulated by one participant, the activities engaged in by others, were wide-ranging. These included reading the literature, attendance at specialty

conferences and following updates on Twitter from the Irish Medicines Formulary and Health Product Regulatory Agency (HPRA). Four participants outlined how elements of their practice were in fact activities of professional development indicating maintenance of competence to prescribe. The following extract from the interview with Participant 9 provides a good example of this '*Automatically I'm involved in writing antimicrobial stewardship every year . . . my CPA is coming from antimicrobial stewardship so therefore in order to change anything I have to have the knowledge so in a way I'm quite up to date about my CPA because of that role'* (P9).

Engagement in audit was also seen as a mechanism to maintain competence though how this was operationalised differed between organisation and practitioner. One described the audit process as *'(it's going) slowly, I genuinely do really like looking at that type of thing and to think myself and reflect on it . . . What does it mean, why am I prescribing that more, what is behind my decision'* (P5), recognising the importance of it and how it could inform practice. Seven prescribers self-audited and two participants stated they audited each other. They reported this practice was more frequent in the early days but seemed to have died out for many participants in more recent years. Previously, many prescribers used the compulsory database as a mechanism for audit but because this was no longer mandatory, the practice of auditing their prescribing activity had fallen by the wayside as suggested by Participant 15 '*Since the electronic charting has come in I do feel that has kind of gone now. Slipped, it has yeah'* (P15). Though it is expected that auditing can be performed using the electronic health record it

appeared that this was not the case or at least not for individual prescribers. Whereas one participant felt that not much direction was given in relation to the auditing practices another played a significant role in designing audit processes. Regardless of the manner in which participants engaged in CPD activities, one issue that was raised by five participants was the time required to engage in activities to maintain competence.

6.3.2 Prescriptive authority for everyone?

> *'I think it's (prescribing) probably best kept to a more advanced role maybe'* (P10)

Participants were quite vocal on whether prescriptive authority is something all nurses and midwives should hold. Views ranged from those who thought it should be compulsory (eight participants) to those who thought it should be reserved for those in advanced practice roles (four participants). Participant 7 cautioned that no one should be forced into the role as it is not like medicine or veterinary, where individuals going into those roles know that prescribing is part and parcel of it. It was considered though that those who would be comfortable should be encouraged and supported. One participant who had experience of prescribing in another jurisdiction felt it should be part and parcel of midwife's repertoire '*I was kind of delighted that we have this facility because I believe the midwives should be able to prescribe . . . I always thought it should come as part of a package for midwife'* (P9) and therefore compulsory. Many participants recognised that much of which they wished to prescribe were over the counter

medicines or very basic fluids and felt that there should be a way that all midwives and nurses should be able to prescribe them. This was outlined by the following participant who suggested in doing so would protect the baby:

> *P12: I think there are certain things that could be (prescribed by everybody) . . . what we do and always did in neonatal units, if the baby comes in and needs IV fluids, the nurse will put up the IV, long before nurses were cannulating it was always done in neonates. If a baby came in with an unreportable blood sugar, that drip went in, the IV was hung before the doctor was even bleeped. That has always been the way even though it is not technically correct to do it . . . but the baby was protected at all costs.*

Three participants in favour of prescribing across maternity settings held certain caveats such as the need for the nurse or midwife to be clinically active. The benefit of experience when taking on the prescribing role was recognised and it was suggested by Participant 16 that *'I don't think it should be incorporated into undergraduate, that would be too much . . . maybe when you are 2 years qualified that it should be made compulsory'* (P16). Another participant suggested that a different pathway should be available for those working in specialist or advanced practice roles, as opposed to those in staff positions. The participant comments:

> *P14: Yes, I think it should be needs based . . . not every nurse needs it but I think if you are in an area where there is a need a patient need yes and there should be the pathways that are appropriate be it advanced practice . . . CNS.*

A participant though advocating for prescribing in the wider maternity setting to enable pain relief to be prescribed, suggested in the NICU the prescribing role be restricted to those in advanced practice offering the following rationale for this opinion:

> *P10: I think my hesitation is, I suppose, because it's such a specialised area and there is such a scope for error, realistically because it's all about,*

> *its done, it's not just a standard dose for everybody like it is in an adult. It's a calculated dose . . . I think for in our unit, I think it's probably best kept to a more advanced role maybe.*

Most participants suggested that undertaking the prescribing role was not something to be taken on lightly and made a number of suggestions. Preparation for the role was mentioned by eight participants. This is nicely summarised by Participant 10 who outlined how important it was to take time to prepare for the role:

> *P10: Take your time. Just because you're allowed to prescribe doesn't mean you come bucking out the gate . . . start out with things that you're very confident with and comfortable with . . . you don't have to go out and prescribe the most high-tech thing on your list in the first week.*

Two suggested that the potential candidate think long and hard about how it was going to benefit their own career. Participant 8 felt quite strongly about this as can be seen below and suggested potential candidates think selfishly:

> *P8: I'd say do it, but do it for yourself. Do it because you believe it will enhance your career, don't do it because you're thinking I want to be helping the women. It's a difficult course . . . you don't get all the study leave…it is a tough job and also it's going to increase your workload so I would be saying think about it for yourself . . . so very selfish.*

The importance of being comfortable with drug calculations was mentioned by one participant who noted that before you calculate drug doses for prescribing, you must be confident calculating them for administration purposes. All participants recognised the effort required though for the course. They stipulated, and it was particularly important for those working in specialist areas to understand that they would be trying to relearn drugs and conditions from years previous and playing catch up. The importance of having good support such as

line manager support and a good mentor to whom you can go with questions, prior to commencing the education programme was emphasised by two participants. Cautionary notes were also reiterated by others such as keeping your CPA focused and not a 'mile long'. The following quote by Participant 4 gives a sense of this caution ' *I'd just say keep themselves safe . . . if you are unsure about something don't stretch yourself . . . your registration is on the line'* (P4).

6.3.3 Promotional opportunities and financial recognition

'it could actually be prescribing that could propel you forward (to other roles)' (P7)

One participant working in specialist practice, though recognising a certain level of autonomous practice in their specialist role, could foresee that prescriptive authority would enhance that further. Education was the key to this and there was no doubt in the minds of participants that prescriptive authority contributed to their professional development. One participant wanted to advance professionally but in an area that was relevant to the specific practice area they were working in and felt that a prescribing qualification would meet this criterion. It was seen as a stepping stone to promotion within the healthcare system by six participants with one viewing it as particularly relevant if you wished to move to a community-based role '*it was always for the more junior midwives considered what will I say, a step to promotion, being interested and having prescribing done if you were going to the community, it would be seen as something good'* (P4). Another

participant outlined how this career progression motivated junior staff. Though many nurses and midwives work part-time, only one of the participants in the study had this working arrangement. This participant felt disadvantaged when it came to promotions and seeking other positions. The participant viewed a prescribing qualification as a way to mitigate against this:

> *P8: I was job sharing at the time, or part-time and I suppose, at the back of my mind I did want something to make me more valuable say if I was going for something and competing against other people . . . at the back of my mind thinking, good for the CV!*

One participant acknowledged the benefit of having prescriptive authority in moving from a staff to a specialist role but how it was not making a difference in the argument for an advanced practice role. The participant had achieved all the other criteria required for advanced practice but this further progression was not being supported by the hospital. The participant described this as very frustrating as they felt they were operating at an advanced level already.

Seven participants identified that undertaking the prescribing programme was specifically linked to their advanced practice role and indeed prescriptive authority is often a prerequisite for anyone wishing to work at this level. An additional participant, in planning for advanced practice had undertaken the prescribing programme in order to be prepared when an advanced practice position became available '*It's kind of a pre requisite of some of the career pathways so I suppose in that sense it could actually be prescribing that could propel you forward . . . I'm succession planning for when (colleague) finishes. I kind of wanted all the study done so if I had a family or something I wouldn't have to* (P7). Many nurses and midwives strive for advanced practice and an advanced

practice role was *'dangled as a carrot'* (P5) in front of another participant if they undertook the programme. Two participants had undertaken the pilot programme in 2003 and had no other choice but to undertake the new education programme if they wanted to prescribe, despite having completed the course and assessments years previously as outlined below:

> *P14: Well prescribing is a bit of a thorny issue actually because we did the pilot project . . . in 2003, it was a 6 month project we did all of the exams, the assessments, it was all done and in the end of it all we got no recognition for it bar a certificate or something because then when it became available as the full course we had to go back and do the whole thing yet again.*

Nine participants felt that being a nurse or midwife with prescriptive authority was different to being one without and that this difference should be recognised, given the high stakes nature of prescribing. Desire for financial recognition amongst participants in this study was often linked to the fact that nurses with prescriptive authority were in themselves a cost-saving asset. Whereas some participants felt that the prescribing role warranted financial recognition as described by Participant 7, '*you do take on increased responsibility . . . I would often work over hours and things like that in order to make sure to get everything done . . . I do think that nurses deserve more pay for taking on that added responsibility'* (P7), three participants felt conflicted because they had wanted to take on the role themselves. One participant went onto compare the situation with other professional groups who:

> P7: *Often when they do more, higher education or they add things to their practice or to their registrations they tend to see that they do go up . . . your money might go up, your promotion opportunities might go up which might result in you being paid a bit more.*

Five participants could not understand why more nurses and midwives who held prescriptive authority did not embrace the role more wholeheartedly given the time savings it produced, though lack of financial recognition was viewed by two of these participants as a possible reason. Given that prescribing was considered at one point the sole remit of the medical professions, some participants didn't want to be seen to be doing the doctors work for nothing extra. Two further participants wondered if a financial payment as reward for the added responsibility, would incentivise people to undertake prescribing for financial gain rather than for patient need. Despite the lack of financial recognition for the role, nine participants were of the opinion that they would encourage anybody thinking of it to become a prescriber with one saying '*It's the best course that I have done'* (P7).

6.4 Conclusion

This chapter has presented the findings of the research which explored the experiences of 16 RNPs in the maternity setting, under the headings of Empowerment and Professionalisation. It is clear that prescriptive authority can contribute towards the empowerment of nurses and midwives, resulting in more autonomous practice and a number of factors which determine the extent to which they can be empowered were identified. The education programme preparing nurses and midwives for prescribing practice was viewed as empowering though some concerns were expressed in terms of the mentorship model and the appropriateness of only allowing doctors to mentor student prescribers. Interprofessional relationships for the most part, along with patient

trust were widely noted as facilitative of empowerment. Legislation and regulation was seen on a continuum from being facilitative and empowering to at the other end, restrictive and prohibitive of allowing RNPs practice to the full extent of their scope. Institutional processes and structures, imposed by the nursing/midwifery hierarchy, created an additional workload sometimes leading to RNPs not using their prescriptive authority.

Findings suggest that prescriptive authority contributes to the professionalisation of nursing and midwifery through the enhanced status it affords nurses and midwives. The expanded scope of RNP practice has resulted in greater recognition of their knowledge and expertise by other professional groups. The practice of prescribing also generates new practice-based knowledge for the professions and prescriptive authority was noted as having a positive impact on an individual's chances of promotion. Concerns were expressed in terms of the lack of guidance and the *ad hoc* nature of CPD activity. Lack of financial recognition for the additional responsibility prescribing entailed was also of concern from a professionalisation perspective. Chapter 7 will continue the presentation of findings from the research under the themes of Identity and Agency.

CHAPTER 7 STUDY FINDINGS (PART 2)

7.0 Introduction

Chapter 6 presented the findings of the research which explored the experiences of 16 nurse/midwife prescribers (RNPs) in the maternity setting under the themes Empowerment and Professionalisation. In this chapter, I continue with the presentation of findings under the themes of Identity (discussed in Chapter 4) and Agency which I consider to be the ability to act independently. RNP perspectives on what it means to be a prescriber came to the fore during our conversations and most were keen to ensure that their commitment to nursing and midwifery was emphasised. Relationships with other professional groups were also identified by participants as a factor which could impact the extent to which they could fulfil their role. The role prescriptive authority played in enhancing participants' ability to be agentic was also highlighted and expressed in terms of care and advocacy. Factors positively and negatively affecting their agentic capacity were acknowledged.

7.1 Identity: Practicing as an RNP

7.1.1 I am a nurse . . . I am a midwife

'I am still, I'm a nurse in an advanced role but I am a nurse' (P10)

Though just one participant (P9) commented on how they held a number of identities, all equally, most identified as being a nurse or midwife and that holding onto that identity was important. There was also a sense that their identity, despite role changes was strong and stable. This type of information was very

forthcoming when I asked broad and open questions like ‘tell me about your practice since you became an RNP?’ or ‘what is it like to be an RNP?’ Six participants felt that with prescribing, they were straddling both the worlds of medicine and nursing/midwifery. One participant considered they were a bridge between nursing and medicine, but this was more due to their advanced practice role. There was an acknowledgement that the demographics of women presenting to maternity services are changing. Six participants recognised that they are seeing women with more complex health problems, older women, multiple births, a high rate of epidurals and more caesarean sections. Though roles and responsibilities have changed to meet the requirements of women and babies using maternity and midwifery services, participants articulated how care remained a central tenet of all patient interactions. There was an overwhelming view that the addition of prescriptive authority to the repertoire of nurses and midwives’ skills, significantly enhanced their ability to care for women and babies, more detail of which will be presented in Section 7.2.

Despite the fact that many participants were taking on an increasing number of medically orientated tasks, most were keen to point out they were not doctors. One participant spoke about how it is part of nursing development to take on new roles, and own them as nurses and midwives. Roles such as inserting intravenous cannulas, suturing and administering first dose antibiotics are now all being performed by nurses and midwives, whereas in the past they were medical roles. RNPs spoke about not being ‘too medical’ because they weren’t

doctors and what was important was the care of babies regardless of who provided that care. The following extract from Participant 10 described it like this:

> *P10: I think I try not to go too medical. I do try to keep my roots in nursing . . . because I'm a nurse. I'm not a doctor. If I wanted to be a doctor, I would have gone that way. But I like the fact that I'm more autonomous as a nurse now. But I am still a nurse . . . yes I can do some of the things that the medics can do but I can also do some of the things from a nursing point of view that they can't. And I don't ever want to lose that.*

Maintaining a nursing/midwifery focus in light of required role changes was important for many participants due to the unique contribution nurses and midwives make to patient care. This unique contribution was captured well by Participant 12, as the particular set of skills and clinical focus brought to the bedside by nurses and midwives:

> *P12: The parents would say, anytime I have spoken to them that we have a way, the nurse practitioner's way of explaining to them that the doctors don't necessarily have. Because we have got it from the nursing perspective so we know how to explain it maybe in a slightly different way and we can draw their attention to their behavioural and developmental effects and how their baby behaves when they are in the incubator. The nursing stuff, that the doctors don't take notice of necessarily.*

Seven participants recognised that rooting their practice in nursing and midwifery whilst taking on an expanded role was challenging, but it could be achieved in a number of ways. Bedside teaching and more formalised teaching on postgraduate programmes were frequently mentioned. Some reported stepping aside from their specialist or advanced practice role and caring for patients at the bedside, whilst the assigned nurse or midwife took a coffee or lunch break. This enabled medical colleagues to continue to view the RNP as a nurse/midwife despite the advanced role undertaken as described by Participant 10:

> *P10: That's the one thing that I have tried to keep is that ultimately my grounding is nursing. So that's why I do like to do the odd nursing shift and see what's going on on the floor with the nurses . . . my colleagues from a medical point of view realize that I am still, I'm a nurse in an advanced role, but I am a nurse.*

Developing guidelines as part of specialist or advanced practice was also seen to root practice in nursing and midwifery and contribute to the development of quality nursing/midwifery care. Providing the nursing/midwifery perspective on ward rounds and engaging in and providing feedback on audit, also helped reinforce their nursing/midwifery focus. Two participants spoke about maintaining a nursing or midwifery focus through the lens of the patient. This included *'being a voice for the woman, educating them'* (P16*).* In contrast, one participant proposed that as Advanced Nurse Practitioners (ANPs) '*we have given up so much of what made nursing what it was . . . I think ANPs are (replacement doctors). It's using my skill, it's using my knowledge, and at the end of the day it's whatever is best for the baby'* (P12).

One participant acknowledged that different grades and roles of healthcare professionals can be confusing for patients. The participant suggested that they are often mistaken for doctors, due to the wide range of activities undertaken by them such as scanning, assessing, diagnosing and prescribing. Though this participant would correct a patient stating they were an advanced midwife practitioner (AMP) the patient would often leave the consultation saying *'thanks doctor'* (P3). This participant was passionate about making sure the patient knew they were a midwife:

> *P13: Always (I correct them). I say 'no I'm a midwife', always, because you have to . . . especially to promote our role as advanced midwife*

practitioners, for people to be going home and saying 'that was the advanced midwife practitioner, I went and I saw her, she was great' rather than 'the doctor was great' so I think it is important . . . Important I suppose for promoting nursing.

7.1.2 Relationships with others in a hospital setting

'midwives are . . . very hard on midwives and nurses very hard on nurses' (P16)

Participants recognised that transitioning to an advanced practice or prescribing role could be challenging and a time of tension. Some negotiated it more easily than others and some, despite years of practicing in advanced roles with prescriptive authority, felt caught in the middle. Five advanced practitioners felt that prescriptive authority was an element of advanced practice which was a hybrid role and therefore it was difficult to separate the two and attribute certain experiences to either the RNP or advanced practice role.

Participant 12 in the extract below sheds light on their own experience of the transition from a staff nurse position to that of advanced practitioner and commented that many people don't realise '*that was still a huge transition, a huge transition. And people sometimes, you know on the outside looking in at the role, don't actually see that* (P12). This same participant recognised that this did not only apply to them and recalled how at '*our conference last year the candidates that did speak said they kind of felt a little bit lost. And you do feel a little bit lost in the role first because you are given this new role and you don't know where to go or where to start sometimes'* (P12).

Participants had mixed experiences in relation to how they were perceived by other nurses and midwives with whom they worked. Three participants experienced tension between themselves and nurses/midwives who did not hold prescriptive authority. The following participant understood the challenges of being seen more like a doctor which resulted in a lack of support from nursing/midwifery colleagues making it '*difficult to walk that line . . . we're still very much a little bit in the middle which is where the ANP role is. I don't think anyone ever looked at how difficult that line is to walk . . . Because your nursing colleagues sometimes do not like it and can give you a lot of hassle' (P12).* The effect on this particular participant was that they were often excluded and not given information others knew. This feeling of exclusion was further amplified within clinical practice when they were 'left to it', to do both their ANP role and the bedside nurse role as outlined below:

> *P12: I remember in the beginning when I would be on call, I would get a call to go down to a preterm delivery and the unit manager might say to me 'well you can manage that on your own' . . . if it was a registrar, the nurse had to go with them. But I would be off down there on my own. I would be trying to do everything on my own, I would come back up with this baby, I would have my work to do to admit the baby. Order the tests, take the bloods, get the drip up, but no I would have to weigh the baby, get the baby on the monitor, do the observations, fill in the observations chart.*

The participant suggested that the reason could be a bit of jealousy or *'who does (P12) think they are?'* (P12).

Participant 12 considered the ANP/RNP role to be all-encompassing and felt that nurses and midwives might resent when the RNP picks up on errors or omissions. Though this participant acknowledged that their role was different, and

expectations of their role were different, this culminated in a lot of frustration for this RNP as *'sometimes the girls would say . . . 'well you're not part of the senior staff'. And I would say 'hang on a minute, what part of nurse do you not get'? That is my title, nurse practitioner, it is advanced nurse practitioner not anything else. I'm still (a) nurse, I'm (a) registered nurse, my role is more expansive . . . but I'm still a nurse'* (P12). Another participant described how they were questioned by other nurses and midwives if they were doing the doctor's job. This RNP's frustration in having to defend what the role is, was palpable:

> *P16: I'd say 'no, I'm not doing the doctors job, I've all this experience as a midwife all around the hospital, in all areas, in the community, I've been, I'm, all the courses I've done, I've scanning done, I can put that all together and give the woman 100% midwifery care but at an advanced level' . . . trying to convince the midwives was actually harder . . . I don't know, midwives are more, they are very hard on midwives and nurses very hard on nurses.*

So riled was this participant, that they continued to defend their role and outlined how they had much more experience and could do a much better job than a junior doctor and ended by saying *'I've gone beyond worrying about what people or midwifery colleagues think'* (P16). One participant who worked at an advanced practice level described how their assessment of the baby prior to making a decision around prescribing, might slow up care and this might not always be appreciated by staff. Negative attitudes from other nursing and midwifery staff were also keenly acknowledged. Participant 7 gave an account of how the attitude of nurses and midwives who held prescriptive authority themselves but didn't use it, put them off using their prescriptive authority:

> *P7: I am put off by people saying 'are you really going to prescribe for . . . ?' that has knocked my confidence slightly from the very beginning, more senior staff saying to me 'are you really going to prescribe that, get a*

> *doctor to do it'. I can do it, and I have done it but it does kind of make you a bit nervous*

Another participant expressed that other nurses and midwives thought they were a fool because of the extra responsibility associated with prescribing and the fact that they received no extra pay. The participant went on to say '*as time went on I thought they might be right'* (P4).

Eleven participants believed they were viewed positively and very much seen as being able to offer something of value to the nurses and midwives without prescriptive authority. Six participants acknowledged that having RNPs practicing in their clinical area when they were starting, made their lives easier as they had paved the way for the new RNP. Participant 15 described this as '*setting that foundation'* (P15). Another participant reported how nursing and midwifery colleagues really appreciated the participant's role when there was no doctor around, seeing the RNP as a 'gap filler' rather than being an autonomous practitioner with prescriptive authority. On a day-to-day basis, participants reported that staff 'loved' when there was an RNP on duty because it made their lives a little bit easier '*The girls actually love it . . . I might be around more than the doctor on call you know. Like they appreciate the fact that you're more accessible I think sometimes, more so than some of the NCHDs* (P10). This availability though meant that in some instances RNPs found it difficult to say no and this could result in them being taken advantage of, saying 's*ometimes I'd wish they'd go away'* (P8). Another prescriber spoke of how '*I think people knew that . . . I very seldom said no. See I have always thought that person in the bed*

could be my mother or could be my sister, my sister in law, somebody that I really love, so how do I want to treat her' (P11).

One participant described how despite being advised not to undertake the prescribing programme by colleagues they did and in fact prescriptive authority actually made them feel more accepted by nursing and midwifery colleagues on a daily basis. The participant worked in infection prevention and control, mostly as an advisor and described how previously they could be seen to *'not get their hands dirty'* (P9). By actively engaging in clinical decision making in the prescribing role the RNP was seen to be making a more substantial contribution to patient care.

RNPs work with a broad range of other healthcare professionals and participants felt that the introduction of nurse prescribing was broadly welcomed by other staff. They remembered how the introduction of nurse/midwife prescribing was met with much fanfare within the health service and within individual hospitals, signifying the huge significance of the occasion. One of the first prescribers in the country recalled a huge media scene around it. Another participant who was only recently prescribing at the time we spoke, suggested that prescriptive authority was so embedded within the organisation at that stage that holding it was not an extraordinary thing, '*you're not special, everyone else has it' (P7).*

Doctors, from the most junior to the most senior, were mostly reported as widely supportive of nurse/midwife prescribing. The role of the RNP was appreciated by junior doctors who were thankful at not having to keep returning to the labour

ward to write up pain relief every five minutes. The role of the RNP had become so expected that one participant reported that when doctors were asked to prescribe something, their automatic reaction was to ask was there no RNP on duty. Despite the role being generally well understood, three participants were of the opinion that there seemed to be some assumption by junior doctors that a nurse prescriber could prescribe anything. Participants outlined how consultants, rather than feeling threatened when working alongside a nurse or midwife prescriber asked the RNP to write prescriptions. One participant felt a little perturbed about how easy having prescriptive authority made the life of the doctors, but at the same time, recognised the enhanced level of care they were able to give. One of the participants who had undertaken the pilot programme indicated that medical staff were amused they had to do the programme again:

> *P12: When we did the pilot project and then we came to do the actual . . . the guys that were SHOs when we did the pilot were now the regs and they were fascinated. 'You're doing another prescribing course?' They couldn't get their heads around this. They really couldn't get their heads around this. And the consultants, 'sure you did all that in xx', 'yeah but we have to do it all again'. Yeah. And they view us as being, nursing as being much more about ticking the boxes and making sure everything is done correctly.*

Just one senior medical doctor was reported as having concerns about the introduction of nurse and midwife prescribing. Once he was made aware of the processes around nurse/midwife prescribing he was reassured and comfortable with the initiative. One participant in this study was a member of the Drugs and Therapeutics Committee (D & T). The participant saw how some RNPs and the prescribing role were viewed by medical staff through the work of the committee.

It was not plain sailing for all especially if they were junior. It was explained like this '*I'm now on the Drugs and Therapeutics committee so I do see . . . some of the CPA's that come through from people that might be more junior . . . you can see it being questioned quite a lot and they're sent off to write up more or to take a drug off or whatever'* (P14).

Another participant spoke of how they were seen as a hidden resource within the hospital. The RNP indicated that non-medical staff approached them once they knew of their prescriptive authority despite it not being broadcast. This was usually in relation to their own medical conditions as the participant describes here:

> *P7: Actually like a lot of the household staff and the porters a lot of them have type one diabetes and as soon as I started prescribing they would come and say P7 tell me about the Novorapid (drug name) again.*

Only one participant directly referenced how they felt they were perceived by a pharmacist. The participant felt that they were viewed positively with the pharmacist suggesting to the participant '*you probably know more about the drugs anyway'* (P8).

Participants in this study were reflective of what their role might mean for others with whom they work. It was acknowledged that when the ANP role was introduced there were concerns that doctors could become deskilled in certain areas as when procedures are carried out less frequently there are less opportunities for practicing. Participant 12 captured this well:

> *P12: I have probably the most practice at intubating a preterm baby in the country, because I am doing it so long. And we're doing less and less of*

> *it now. So I would have the skill from before whereas the newer ones (ANPs and doctors) are finding it hard to get the opportunities to learn the skill.*

Six participants felt that nurses and midwives taking on a prescribing role did not negatively impact medical practice and that junior doctors had plenty to do anyway. One gave a specific example regarding the completion of repeated tasks for example pain relief on the labour ward and suggested this activity did not result in any learning for doctors and so doctors' opportunities for learning were not negatively impacted.

7.2 Agency as a nurse or midwife prescriber

7.2.1 Patient care and decision making

> *'It was dextrous 10%. The baby came up to be admitted. And the girls said oh the baby needs IV fluids and I said grand I'll write that and they said oh you can write that and I said yeah I can, 10% dextrous and put my name on it. They were all looking at this and saying you can sign that, I said yeah, and they said this baby needs antibiotics can you do that. And I said I will examine the baby and if he needs them then I can do that'* (P12)

Fourteen participants vividly remembered the first prescription they wrote. They smiled when recalling the time and recollected the prescription, the patient and the condition for which they prescribed with great clarity. Some became a little bit emotional and it was clearly a big deal for them. Despite the prescriptions being for quite basic formulations, the act of prescribing and being able to 'do this' for the patient was exciting and gave a great sense of achievement. Participant 1 recalled their first prescription written for a woman in labour '*it was a lovely feeling . . . it was quite a proud moment. I remember feeling quiet proud* '(P1). Participant

5 spoke of the great sense of achievement felt when prescribing for a woman who had not wanted to take medicine during pregnancy:

> *P5: it was for Citalopram for a postnatal lady who was highly anxious . . . she had been very reluctant to consider taking medication . . . it was something I had been working on both in pregnancy and postnatally and I remember when she said, 'now I think you're right, I think it's time, I need to start medication' and I thought oh I can do this [laugh], you know and writing the prescription with a very shaky hand. There was a sense of achievement.*

Three participants spoke of not only personal excitement about that first prescription but the excitement in the ward generally. Seven participants talked about how cautious they were with that first prescription and spent some time thinking about what they were actually going to do. They didn't want to make a mistake or for '*the pharmacy to come back and say for how many days? You forgot to write for how many days, or you forgot to write your registration number*' (P9). Another spoke about how they got the consultant to check what they were writing. More careful practice also came from the enhanced knowledge and awareness practitioners had. One participant working in a specialist area outlined their concern about the first few prescriptions being benzodiazepines, and how they could be viewed by others:

> *P5: I had such a run of people in need of them (benzodiazepines) and I kept going into the consultant asking 'can you write the prescription' but he said 'but you can prescribe now'. Well I don't want my first few prescriptions being benzodiazepines, that'd be like my God who's your one, she going gung ho with the benzos . . . but the women actually did really need them.*

Despite these concerns the predicted contribution to clinical care which prompted 12 participants to undertake the programme in the first place was realised. The vast majority of participants in this study were of the opinion that prescriptive

authority enhanced the care they provided to women and babies. Rather than viewing the prescription of medicines as medicalising pregnancy and childbirth, it was considered to be an important part of care when a woman's clinical condition or for example desire for pain relief, warranted it. Twelve participants highlighted that midwifery practice was about caring for pregnant women in a woman-centred way. The following example demonstrates how the prescriber used their enhanced knowledge, coupled with the nursing/midwifery focus to deliver person centred unique care, in what was an emotionally challenging situation for both nurse and patient. A patient who was on a new anticoagulant drug announced she was pregnant and that she had taken herself off the drug. When the RNP was taking a history and assessing the woman they felt something wasn't right so another pregnancy test was performed which was negative:

> *P3: So I came into the room and told her the news and she was not having it and she showed me 12 pregnancy tests, but they were all negative, but she said 'if you stare at them long enough you will see 2 lines' . . . And I'm looking at her thinking oh God, oh God, what do you say to someone . . . she wasn't hyper, it was just she was too calm…it wasn't that there was no emotion there, she was upset but she really wasn't, it wasn't sinking in. I needed to get her back on her oral anticoagulants . . . So I said 'I tell you what we will do, come into me on Saturday and I'll do a blood test on you today and I'll do another one on Saturday and it will tell me if your levels are going up and we can take it from there . . . is that fair?' so she said 'yes' and went off and I actually prayed that she'd get her period. I prayed so hard last night, I didn't sleep thinking about her and she rang me this morning and her period came so she's gone back on her own medications. I was like 'the next time you think you're pregnant you come into me and we'll go through everything'.*

It was recognised by four participants that caring appropriately for women involves giving them choice and empowering them. This includes the choice for example, as to whether to avail of pain relief in labour. Facilitating that choice at

the earliest possible time was also considered caring. This idea of early choice is captured well by Participant 4:

> *P4: If you're giving woman-centered care . . . If she chooses to have pain relief if you're waiting for a doctor to come and prescribe it, isn't that worse? You have a delay in care then and she's waiting in pain when she's chosen to have pain relief and you can't give it to her.*

Being in a position to be responsive to women's changing requirements or desires, was also important for two participants. Caring means being open to what women want as captured by Participant 1 who outlined so '*If someone asks for analgesia even though she has documented in her birth plan, 'I don't want anything' . . . I'm going to respect that, regardless of what she might have wanted last week'* (P1).

The idea of being able to provide a more holistic caring experience for women or patients was reiterated by all 16 participants. Participants reported how clinical specialists and advanced practitioners with prescriptive authority offer a one-stop-shop for patients, with the RNP assessing, diagnosing and commencing treatment all at one visit, thereby cutting back on hospital visits. All participants identified how prescriptive authority enabled more timely treatment as '*I never have to turn to anyone, it's brilliant . . . you can treat them from the minute they come in the door. The girls will triage them and say to me (P13) 'I think she's a mastitis' so you're getting an antibiotic in straight away. They're prescribed, they're given within, she could be here 10 mins and she has her antibiotics going'* (P13). Timeliness of treatment also meant in some instances the amount of time a woman was suffering was reduced which was important for participants.

Timeliness of treatment was also preventing life-changing complications as outlined by Participant 15:

> *P15: A lot of our patients would have hypoglycaemia, that's one of the big reasons for admission to our unit so you don't want to delay that in any way . . . can have detrimental effects neurologically you know so being able to prescribe glucose, yeah, can obviously save the baby you know.*

With many consultants in specialist practice working across different settings geographically, 14 participants recognised their ability to provide enhanced care through continuity of care. In the absence of a doctor at a clinic, nurses/midwives were able to manage the vast majority of patients. Three participants acknowledged that prescriptive authority changed their interaction with patients '*we are more in touch with patients. We have more interactions with the patients, we have a telehealth service as well so the patients are phoning us everyday . . . before I did the prescription course, I had to think and take advice from the consultant and then get back to the patient. There is no break, we can look and make decisions'* (P6). Continuity of care was also expressed by those working in advanced practice who facilitated continuity of safe care following periods of junior doctor transition, as outlined by Participant 12:

> *P12: One of the big advantages over the years that has come across is you have a consistent level of care. If you have got ANPs . . . You don't get that dip that you used to get 30 years ago for July and August where everything went hay ways . . . we spend the whole month July, August and the beginning of September supporting our junior medical colleagues until they get their feet under them and they're up and running.*

Continuity of care also means that patients are dealing with one health professional with whom they can make direct contact, rather than perhaps speaking to a different doctor any time they call looking for advice. In what can

be an intimate experience, having a midwife be able to provide all care was viewed as important and captured well by Participant 1:

> *P1: Where I worked there was an awful lot of quick turn over. You know they (women) didn't need to meet 5 or 6 different people while they were in . . . met me and I admitted her and I assessed her for whatever her clinical thing was, you know I'm the one prescribing her medication, they just don't have to involve anyone else.*

Continuity of care led to additional benefits such as greater concordance and adherence. Three participants acknowledged that consultations with medical doctors can be very quick, often leaving the patient with unanswered questions. The additional knowledge the RNP held with respect to pharmacology of specific drugs, enabled them to give more detailed explanations and empower the patients to weigh up the advantages and disadvantages of medication use in pregnancy. Three participants outlined how prescriptive authority changed not only how they taught patients but also the focus of that teaching. Being able to prescribe was considered to be more than just having pharmacological knowledge. It also included taking into account practicalities such as timing and route of administration and how these fit in with the woman's lifestyle.

Four participants reported on concordance with Participant 7 saying '*I think that (we) probably might see a slightly higher adherence to medication regimes just because of time' (P7).* Three participants were very aware though of treatment costs for women and the implications that had for their health and their lifestyle. High medication cost was reported as resulting in some women not taking their medication. One participant described how continuity of care allowed a trusting relationship to develop. Women felt comfortable acknowledging financial

challenges which placed the RNP in a position whereby alternative arrangements with pharmacies could be explored. Three participants reported how they gave practical suggestions to their patients such as, instead of having friends buy baby presents, that they contribute to the costs of the woman's medications in order to keep the woman well during pregnancy. Concordance was not always easy to achieve and this participant outlined how sometimes striking while the 'iron was hot' and not having to say *'hold off now, wait and I'll go and talk to the psychiatrist',* (P5) is important. The participant stated they were listening more to patients because of the role they had in making prescribing decisions:

> *P5: I suppose because when you're really listening to somebody particularly say a pregnant women and making a very difficult decision for them whether to stay or come off medication because they think it is the right or wrong thing to do, a big part of that work is being able to tease out their relationship with the medication, with the drug and how it is, how it has been for them. It's a big thing, it's like I'm listening on a deeper level . . . because I'm writing the prescription!*

The participant went on to explain how there was huge misinformation out there in relation to medication use during pregnancy and they described how having prescriptive authority added '*to an honesty because I think there's something about when you write a prescription for somebody and you spend the time discussing it, particularly in my area that's not necessarily done in one session'* (P5). This participant went on to describe how due to nervousness on a patient's behalf about medication use in pregnancy it was agreed to start on the recommended daily dose every second day for a week to build up to the full dose, minimising any side effects.

Two participants suggested that being able to prescribe, also increased the amount of time a nurse or midwife could spend with a woman as the RNP wasn't running off to find a doctor, thus increasing opportunities for caring. This idea of time with patients was very important for the participant working in perinatal mental health who recognised that women want to do what is best for their baby and can often delay making decisions about medication. A significant part of this RNP's time is spent reassuring women, supporting them, having a clear discussion about early warning signs and having a plan which takes time to establish.

Nurses and midwives with prescriptive authority work within a widened scope of practice and this enabled, as one participant suggested, their caring focus and caring relationship with patients to start earlier. An example of this was in relation to patients who are on anticoagulants. Once the participant working in this area obtained prescriptive authority, they began to engage with patients' preconception, offering advice. The participant explained that sometimes these prospective patients need a little bit of extra time and reassurance.

Having the additional knowledge that came with prescriptive authority was reported by five participants and enhanced their ability to care in terms of them being able to evaluate treatment in a more informed manner. Participant 15 captured it as '*you know you have a better understanding, I suppose it improves your assessment of the baby, you know why would I give this antibiotic over the other and it all comes back to pharmacology teaching in the beginning you know'* (P15).

The addition of prescriptive authority to an individual nurse or midwives practice also enabled them to prevent complications, thus adding to the caring role. One participant gave an example of a woman who post normal delivery had quite a lot of bleeding. The participant was able to prescribe three drugs, one for pain, one to stop her being sick and one to stop the bleeding, preventing the woman from having a huge postpartum haemorrhage.

Participants in this study who had experience prescribing in the community worked with little or no medical cover on a day to day basis and recognised the huge benefits prescriptive authority brought in terms of safer patient care. This was captured by Participant 16 who said:

> *P16: In the community . . . as a prescriber it was vital to have it . . . when you are out and about and away from the hospital and you're assessing women and they are showing signs of a urinary tract infection or perineal infection if they've just had a baby . . . it was beyond your scope to prescribe so you'd be traveling all the way back in to get a prescription from a doctor who hadn't seen the patient, who hadn't assessed her . . . it just wasn't right*.

Safer practice within the hospital setting was also acknowledged when nurses and midwives held prescriptive authority. Participant 5 in the following quote outlined practice prior to being awarded prescriptive authority '*They'd have to wait till he was back or I could liaise with their GP or sometimes I might liaise with him over the phone and he might fax through a prescription from the other hospital that he was working in at the time. Sometimes I'd go down to outpatients and speak to a very friendly registrar and say 'can you sign this, what do you think, could you prescribe this'?* (P5). These outpatient doctors were obstetric trainees rather than mental health trainees and so not only were they prescribing

medications without having assessed the woman but were doing so without current, relevant, clinical mental health experience.

Though most participants enthusiastically articulated how their caring role was enhanced with prescriptive authority, one participant recognised that their caring focus could be lost, particularly as '*the higher your clinical decision-making ability is, possibly the more you are taken over by, not the person sitting in front of you, but the things that are going on, the processes and the things that you are thinking through in your mind'* (P7). One ANP participant was adamant that the caring role was diminished. This was more to do with the transition into advanced practice rather than just the ability to prescribe. The participant described how other carers were taking on some of what made nursing what it was:

> *P12: We did a bed bath with a patient but it wasn't a bed bath, you were assessing their skin, you were assessing their activities of daily . . . you were assessing their motor skills. You were finding their social history, their family history and things you learned in conversation were often very important to treatment but they never thought to mention it to a doctor . . . now it's the healthcare assistant that's doing that. So the nurse doesn't have that same relationship with the patient.*

The participant mentioned this as a general observation rather than being directly linked to their own role, recognising that as their role has changed they are not on duty as the clinical nurse '*I'm there as the reg (medical doctor) when I'm there (P12).*

The scope of caring practices was broadened by participants' enhanced autonomous decision making. This was facilitated by, amongst other things, knowledge, including pharmacological knowledge. Different views were expressed as to whether a broad pharmacological knowledge base, delivered

during the education programme preparing nurses and midwives for prescriptive authority, was of benefit to this process. One participant, whilst working in the neonatal setting acknowledged that though the education programme was more focused on an adult patient population, much of the pharmacological knowledge gained around areas such as renal failure was also useful in the neonatal setting. This acknowledgement was not just confined to the neonatal setting and participant eight's words capture this sentiment well '*it gave me greater understanding and for the first time, I understood why things would happen . . . it certainly gave me a lot more confidence and understanding and how drugs worked and even the terminology'* (P8).

Being aware of pharmacology broader than their particular practice was deemed by two participants as it caused them to pause and reflect on their scope. Participant 11 describes this well '*I especially used it when you had a woman that had really complex cardiologic element and I was actually out of my depth . . . so it really helped me to stop prescribing . . . it made me more aware of multi medication and what effect it would have on the mom and the baby. It kind of made me more careful'* (P11). Participants in this study who cared for women with chronic diseases also felt that their overall practice was enhanced by having a broader pharmacological knowledge base than just those medications related to their specialist area, with participant two adding *'it is so important to be aware of possible interactions. I would value the knowledge I gained regularly'* (P2). Another participant gave an example of how prescriptive authority and the knowledge that came with that gave them greater scope to problem solve.

This opinion of the usefulness of wider pharmacological knowledge was not held by all though. One participant recognised where the knowledge was interesting, being examined on pharmacology that they were never going to use was inappropriate. Two others could not identify times when it was useful in their practice. This may have been, as suggested by one participant, due to the fact they did not using the wider pharmacological knowledge routinely and so forgot it.

Thirteen participants were of the opinion that their decision making differed to that of doctors. These differences ranged from being more thorough and more cautious, to more holistic. The following participant described their cautious practice when prescribing Pethidine, a strong pain killer, similar to morphine, often used during labour. Whereas many prescribers would write the prescription as a continual one, this participant wrote it as a stat dose (once-off). Participant 8 stated that it wasn't because they didn't trust their colleagues but that '*Say I was going off duty . . . I nearly didn't want that prescription floating around for someone else to make the decision'* (P8). This made things more difficult for the person wishing to administer the drug because they had to go again and get someone else to prescribe it. Six participants outlined the main difference in their prescribing decision-making and practice and that was around the assessment of the woman. Ten participants recounted situations of doctor prescribing and their lack of thoroughness and attention to interactions and allergies. Four participants described how doctors often prescribed on the 'say so' of a nurse/midwife without ever having set eyes on the patient. In the experiences of

participants, this never happened when an RNP prescribed and so contributed to them being safer prescribers, through undertaking 'a *more thorough process*' (P8). The rigorous assessment and documentation process undertaken by RNPs however, did add to the RNP workload. The following participant articulates the nursing and midwifery focus that RNPs bring to the decision-making process:

> *P1: I think you're going in more holistically . . . you're looking at the woman as a whole, you're thinking what did she take at home or what did she have earlier. I feel the doctors, in my experience anyway, I really felt that for doctors it (prescribing), was a chore, they had results therefore this was the medication and they're not really looking at the woman.*

Participant 8 spoke about how starting on or continuing a medication whilst pregnant, is a huge challenge and decision for both prescriber and pregnant woman and recounted how important collaboration with women around medication use during pregnancy is. This participant recounted how some doctors started patients on high dose antidepressants quite quickly with subsequent severe side effects resulting in women not taking their medication. On the other hand, the RNP assessed women holistically and in collaboration with them, sometimes started them on a lower dose, building up to the recommended dose. Another participant recalled a time when a GP took a patient of Venlafaxine (a drug that should not be stopped suddenly) when she became pregnant. The woman had been taking it 13 years and ended up being hospitalised because of significant discontinuation syndrome.

RNP decision making also involved making non-pharmacological decisions as described by those working in diabetes. Rather than automatically titrating a

patient's insulin dose (which they considered a doctor might do) due to a patient's blood sugar levels, the RNPs look at their diet and exercise first.

One participant felt that whilst their prescribing decision making did not differ to that of doctors, they felt RNPs were better prepared for the prescribing role than doctors, again looking at the baby holistically, monitoring all aspects of the baby's wellbeing, prior to making prescribing decisions.

Medicines Management including decision making around prescribing is a complex activity. There was a very clear indication that decision making around patient care, though autonomous on the part of the RNP was collaborative when necessary. Though most expressed confidence in their own decision making, participants demonstrated frequent use of a referral pathway to other clinicians. I saw this first hand when I was about to start the interview with Participant 16. A microbiologist came to meet with the participant in relation to a prescribing decision. This participant was confident and had many years prescribing experience but acknowledged '*if I'm questioning something that I'm not 110%, then I will go to the consultant microbiologist who came over . . . if I'm not happy . . . I will go and speak to someone more senior to me'* (P16). 12 participants outlined that as soon as a patient presented with issues outside the participant's scope of practice, they referred the patient immediately to another healthcare practitioner, which could be a doctor or other RNP. Referral to a doctor was often only undertaken when a drug was rarely prescribed and so wasn't listed on a participants CPA as reported by Participant 10:

> *P10: some of the weird and wonderful antibiotics that we would use really infrequently here I would refer that either to one of my NCHD colleagues because they don't have limitations or to the consultant depending who's beside me. I don't pick and choose, I'd say it as quickly to (Consultant name) as I would to one of the doctors.*

Referring clinical decision making to others and particularly consultants was not viewed in a negative light and participants did not see it as a restriction to their autonomous practice as outlined by Participant 12 '*to me it's (referral onwards), it's the correct way to do it because the reg wouldn't necessarily prescribe it either without discussing it with the consultant'* (P12). Sometimes rather than formally referring a patient onto another prescriber nine participants felt very comfortable with 'running things by them' (medical colleagues).

Just one participant outlined how the responsibility of prescribing generally weighed heavily on them and this would result in referral onwards even when not particularly required '*women who need Pethidine who are getting contractions and had previous caesarean section, now there was no reason why I couldn't but I would also want to have that run behind a senior doctor because there is the risk of problems in that woman'* (P8). Another participant found themselves in a unique situation and saw their role as more advisory in the role of infection control which meant that referral onwards was not unusual as they did not belong to a team as such. This participant's situation was also unique in that much of their decision making centred around discontinuation of antibiotics.

Up until the end of 2019, the parameters of practice for an RNP were set within their CPA and it was clear from chatting with participants that all worked within a specific scope of practice and undertook clinical decision making within that

scope. The range of drugs that participants in the study talked about prescribing were wide-ranging, indicative of the broad range of specialisms in which participants worked. Antibiotics featured heavily in the prescribing practice of eight prescribers. This was linked to their area of practice and their patient population though they often wondered what people might say as described by Participant 12; '*if anyone looked at it they might say oh my God . . . antimicrobial stewardship . . . most of what we prescribed is antibiotics . . . They're relevant to our practice'* (P12). Four participants also had supplies such as catheters included on their CPA. The rate of prescribing was also very prescriber specific. Some reported writing six or seven prescriptions routinely every day. Others prescribed a couple of times a week. One participant stated that a lot of prescribing decisions were around discontinuing prescriptions. Seven also indicated that practice had changed over time as captured by Participant 15:

> *P15:* '*There is some ones like Vancomycin, you're probably using it more nowadays but when I started we wouldn't have used a lot of Vancomycin and I suppose now there's VRE resistance and you don't want that to get into neonatal units of course.*

7.2.2 Advocacy

> *'I don't think I would have had the confidence to put her point forward before doing the course'* (P1)

All participants in this study provided accounts in which their advocacy role was enhanced through prescriptive authority. Seven participants gave examples of an increased ability to advocate for patients. One described the case of a woman who presented on a hot summer day, dehydrated with some back pain and painful

urination. An assumption was made by the medical team that the woman had a kidney infection, but she did not want to take antibiotics. The participant advocated on the patient's behalf, suggesting that since the urine was clear, to wait until the laboratory report came back. When it came back clear and the woman did not need treatment '*I remember thinking yay! I don't think I would have had the confidence to put her point forward before doing the course and I remember ringing her and saying you know your urine is clear, you didn't need it. She was really grateful*' (P1).

Prescriptive authority was reported by six participants as having given them a louder voice within the organisation with respect to patient care. Four participants in the study had been appointed to committees in which their new pharmacological knowledge and the practice of prescribing was of benefit, such as the D&T committee or the Neonatal Safety Committee. Another participant outlined how they were working alongside the hospital pharmacist to further develop the electronic system which was recently introduced. This participant felt that nursing/midwifery brought a holistic approach to problem-solving and a pragmatic approach to what would work in practice.

Seven participants gave examples of how they were more aware, given their prescriptive authority, of safe prescribing practice. They recounted times when they questioned the prescribing practices of others and acted as patient safety champions. The elements they questioned mostly concerned incorrect dosages of drugs, but occasionally, the actual drug prescribed, was queried. This was often during the first few weeks following the rotation of junior doctors. RNPs

approach to correcting inaccurate prescriptions varied. One described how they just informed the original prescriber that they had had to change it, whereas others tried to elicit if there was a particular reason why perhaps, a higher dose than expected, was prescribed.

Being used as a 'messenger' when an incorrect prescription was noticed by bedside staff was reported by three participants. Participant 12 described such a scenario in which a staff midwife said *'the reg prescribed this and it's not the right dose . . . would you mind?'* (P12). This participant went on to say *'they tend to come to us as the nurse practitioners to liaise and negotiate, if that makes sense. So we are a little bit like a conduit. We would go and say 'did you really intend that dose?''* (P12). Nine participants stated that the response from others to being questioned about the incorrect prescribing was generally positive. Most were happy to have had an error noticed and rectified before any harm occurred. Participants did identify though that this positive response was a result of their non-combative approach. Participant 11 outlined how the culture within their organisation and unit facilitated a positive exchange between professionals, when faced with an incorrect prescription:

> *P11: I didn't have to challenge that many but . . . because of the interaction you have with the doctors . . . it's very, its more jovial you know and it is kind of honest it's actually a great a relationship that you have with the doctors. And they kind of would take what you say, if it's said nicely and in the right place and you're not sort of saying 'excuse me' in front of the patient.*

Two participants outlined that they could spot inaccurate prescriptions more easily, now that they were prescribing themselves. Participants were very

conscious of the need for nurses and midwives to be administering correct prescriptions, which provided additional motivation to correcting incorrect ones.

Advocacy at a national level was also reported by participants in this study. One participant took it upon on themselves to contact the Health Product Regulatory Agency (HPRA) for clarification in relation to whether it was brand or generic formulations of medicines which were authorised. This action by an RNP resulted in a change in the regulatory guidance in relation to prescription of medicines by RNPs, allowing the prescribing of a brand name medicine in some circumstances. Advocacy for both patients and the nursing and midwifery professions at a national level was articulated by the advanced practitioners in this study. This was in relation to being able to prescribe medicines which were off label or unauthorised. Years of lobbying had resulted in permission to prescribe medicines off label, but frustration in relation to unauthorised medicines remained. This was captured well by Participant 12 who outlined how many advanced practitioners had been fighting since the early days to have the legislation on prescribing unauthorised medicines changed. '*It's a real nightmare. I have been bringing it up . . . we have been banging that drum consistently and nothing is happening . . . about four years ago a group got together and we sat, we put together a briefing document . . . it sat on the minister's desk. It's still sitting there' (P12).* This participant was delighted to hear at the time of our conversation that publication of the new legislation was imminent. This was enacted in December 2018, though practice standards which facilitated the prescription of unauthorised medications were not published until late 2019.

Practice standards established by the nursing and midwifery regulator for RNPs set out that their clinical decision making must not be influenced by the pharmaceutical industry. Two participants reported that industry representatives often have difficulty accessing staff within hospitals, with another two identifying that they do have interactions with the pharma industry. These latter two participants outlined how the pharmaceutical industry contributes to the educational and professional development of prescribers by coming in and speaking about new products that are being launched. Three participants spoke of the costs associated with being on medicines, with two of these engaging with the pharmaceutical industry in an attempt to support patients in reducing costs by sourcing the most competitive products.

Extensive contact with the pharmaceutical industry was reported by Participant 3. They outlined that the patients seen were generally prescribed one of two drugs for their condition. One drug, in particular, was prescribed most frequently because it was easier to teach the patients how to administer it. The difficulty with the alternative was in relation to markings on the syringe and the RNP's safety concerns with that. The participant had contacted the second company to see if the syringes could be changed in order to provide choice to women but they had not been forthcoming. Participants worked in collaboration with the pharmaceutical industry in other ways such as the generation of patient education materials and instructional videos. One particular company was reported as facilitative in developing guidelines and acting as a go-between for the clinical site and community pharmacists. One participant also had experience of patients

being supplied with incorrect medicine doses by the community pharmacist. In this instance the RNP contacted the pharmaceutical representatives who acted as an intermediary between the hospital and the community pharmacists, by sending letters and updates, drawing attention to specifics of a drug. This prescriber had also been in contact with the pharmaceutical society in an attempt to promote safe practice. The pharmaceutical journal agreed to include a section outlining dose adjustment calculations which would be relevant to all prescribers of a specific drug. Participants who did have contact with the pharmaceutical industry did not consider that they benefited personally from this interaction and were keen to point out how they were treated differently from doctors as captured by Participant 3 '*I do feel that when it comes to say conferences and things like that, say the consultants would get it first and I have to ask, they'll get it given to them, I'll have to ask and pay for it myself then they'll reimburse'* (P3).

7.2.3 Barriers and facilitators to agency

> *'unless I felt that I was clinically able to give at the time, I didn't prescribe'* (P4)

Twelve participants recognised the impact their knowledge, as a result of experience and their educational preparation for the prescribing role had for practice. One described their knowledge as empowering and another describing how the years of experience as a midwife enabled them to *'eyeball'* (P6) a woman and see if anything was amiss. The following extract demonstrates how a prescriber put both of these elements together which enabled problem-solving:

> *P6: We have one lady who was allergic to all insulins bar 1, Novorapid (drug name) which was the rapid-acting insulin. She was gestational diabetes and unless she takes the insulin 24hrs there is no background insulin . . . so that was very challenging It (Knowledge and experience) made it less challenging from that point of view because I could see, foresee what's happening and what can I do with this patient for the best care.*

Confidence in prescribing ability was cited frequently by participants as a facilitator of prescribing practice. Fourteen participants expressed confidence in their prescribing ability arising out of the practice of prescribing, their past experience of administering the drugs and from previous practice of telling medical staff what and how much to prescribe as reported by this participant:

> *P1: I might have been a bit nervy the first few because it was something new, but like I always felt confident I was giving them the right thing. I spent so many years saying to doctors 'can you prescribe this, can you prescribe that', they're saying 'what's the dose of Labetalol, are you sure it's 100mgs bd' and I'd say 'absolutely'.*

One participant who was newly qualified as a prescriber had this to say about their confidence '*Getting there, wouldn't say confident, but getting there. I suppose just the time . . . I'm only, July, August, September, I'm checking back and coming in the next day and checking back to make sure'* (P13). Participant 4 suggested confidence came from being thorough in '*assessment and documentation . . . I would be very by the book'* (P4). Despite this confidence, they recognised the immense responsibility associated with the authority to prescribe. This sense of responsibility contributed to RNPs becoming more careful and aware of their practice as presented by Participant 6:

> *P6: I think what it means to me, I feel more confident, I know the drugs very well. Before I knew the drugs as well but because I know I'm prescribing, I have to be very careful and very aware of the patients . . . drug interactions and any allergies and how patients are getting on . . .*

> *teach the patient about allergic reactions so, it gives me in-depth insight and understanding and makes my practice more careful, safe practice.*

Perceiving themselves as confident, safer, more careful nurses and midwives resulted in them expressing a sense of empowerment and autonomy. This sense of autonomy to provide holistic care resulted in great personal satisfaction. Participant 16 summed up this sense of self as *'I'm a better midwife'* (P16) due to being able to provide more immediate care.

Autonomous practice as an RNP though was not without its challenges and those challenges could prevent RNPs practicing to the full extent of their scope. In the main these stemmed from organisational issues such as workload and physical barriers. Other challenges such as working within the confines of the CPA and separation of the tasks of prescribing and administration of medicines, have been addressed in Section 6.2 as they are challenges that arise out of elements of professional regulation.

Nine participants in the study outlined how the addition of prescriptive authority to their practice increased their workload. This was reported as often due to the additional workload associated with entering data into the minimum data set (MDS) but also the very fact that assessing the patient took time. One participant acknowledged that sometimes patients don't tell you all the information that is necessary to make safe and appropriate prescribing decisions and it takes time to get that out of them. The RNPs who had experience prescribing in the general settings for example labour ward or antenatal wards spoke of the interruptions they experienced whilst prescribing. These were often due to a midwifery or

medical colleague needed help with a procedure. These could be numerous during the course of writing one prescription. The following participant outlines how this was managed:

> *P4: I was interrupted a good few times while I was writing the prescription and when I looked down I had written my own name instead of the actual drug name in that section. Obviously just completely absent you know, not concentrating on what I was doing and it gave me a fright . . . so from then on I made a decision that unless I felt that I was clinically able to give at the time I didn't prescribe.*

Five participants spoke of the impact having prescriptive authority had on them when nursing and midwifery colleagues who they were working alongside, did not. This is summarised well by Participant 4:

> *P4: I suppose the biggest thing with the workload once your colleagues learned you could prescribe they were sticking drug charts in front of you all the time. If you were the only one prescribing on shift you ended up with a big workload and I suppose they weren't prepared to take on prescribing themselves but they were quite happy to put the drug chart in front of you. Which was particularly annoying . . . it was an extra workload for sure*.

This had a knock-on effect in that time spent prescribing for a midwifery colleague's patient meant that the prescriber was taken away from their own patient group. These time pressures and workload resulted in four participants indicating that they reduced the times they actually used their prescriptive authority. The general workload also contributed to the following participant's burnout '*Time, time pressure . . . I just found it was easier to get the doctor to do it if he or she was there. You know you've so much time demands, we get so many complicated high-risk patients from around the country and I found as time went on maybe I was getting a bit burnt out in my role'* (P1). Participant 4 recalled how staffing issues and time became more of a barrier during the recession with

staff numbers reducing and increasingly complex patients requiring care. Another challenge which presented itself from a workload perspective was that four of the participants in this study who worked in advanced practice roles, found themselves required to relieve breaks for bedside staff. This resulted in them being taken away from their own role. Whilst the issue of increased workload was raised by many it was also acknowledged by ten participants that prescriptive authority *'probably streamlined my working day more . . . you're not fragmenting what you're doing, and you can walk away knowing that everything has been done as a package by you for that patient . . . So it does mean that you can kind of complete the care you give to'* (P10). Two participants outlined how their workload had reduced in recent times. This was due to the addition of more RNPs in certain areas and the requirement to enter prescriptions into a database being removed. Individual prescribers also noted that they reduced their prescribing workload by focusing on a more restricted list of drugs.

Three participants identified physical barriers preventing them from being able to exercise their prescriptive authority in a way in which they preferred. One participant outlined the challenge of not having *'dedicated place to review our patients . . . We have no privacy for the patient, it is an open area, other people are listening and patients might be upset'* (P6). The participant went on to explain that they run a teleservice and with three people sharing the office *'we can't hear the patient so the others have to go out in the corridor so it's not a good situation'* (P6). With the introduction of electronic prescribing came another challenge; lack of printers, which meant that RNPs had to revert back to prescribing on paper.

Ten participants found themselves in positions where they were asked to prescribe but didn't. The reasons for this varied from being asked to prescribe outside their scope of practice to being asked to prescribe outside professional guidance. Requests for prescriptions came from both staff and patients. Often requests came from a ward within the hospital asking for a prescriber to prescribe a medicine for a patient they had no therapeutic relationship with. One participant outlined a situation where they were asked to prescribe for a patient on another ward who happened to be their sister. In all of these instances, the RNP refused. Participants also reported requests for prescriptions that fell outside their scope of practice when it came to discharging patients. If one out of three required medicines was outside the scope of an RNP's practice and not listed on their CPA, they could not prescribe it. All decisions not to prescribe were reported as usually accepted without any negative effects, though those requesting the prescription were often surprised that nurse and midwife prescriptive authority is not as extensive and liberal as that of doctors. Two participants reported not prescribing on some occasions because there was a doctor beside them and it was easier to let them do it rather than having to undertake a full patient assessment and documentation as required when an RNP prescribes.

One prescriber spoke about how errors in medical staff prescribing were more frequent when there were a number of RNPs undertaking a lot of the prescribing work during the day, which made the NCHD's less familiar with regimes. Participant 7 outlined how '*Once or twice I said 'you know no I'm not going to prescribe that, maybe ask the SHO who is around who's asking for it to prescribe*

it'. That probably didn't go down quite as well but it was a decision kind of taken between ourselves and pharmacy . . . so people are still used to the drugs and used to how the new system is run' (P7).

Despite participants' narrative of empowerment and prescriptive authority, there was an element for some of their prescribing authority being used in a task-orientated way or they were in a sense 'picking up the pieces' from the medical profession. One participant spoke about babies in the NICU having their eyes tested each Friday and the body of work that was required prior to that. It was *'just easier for me to sit down and physically prescribe the eye drops for all of those babies'* (P10). Another participant spoke about how during clinics that were doctor-led, the consultant would often ask the RNP to write the prescriptions for the consultant. The participant said '*She's not using me . . . it speeds her up a bit if she's seeing the patients…if we're in the room I'll do it, the printer is there, it's all the same thing'* (P3).

One participant working in the area of diabetes outlined how some doctors write up the insulin regime but fail to write up the associated steroids. This participant keeps *'an eye on that and I prescribe that (steroids) or my other colleague who prescribes'* (P6). One participant who talked about how 'after hours' they were involved in picking up where doctors had left off, felt the action was warranted as at the end of the day what was required was speedy discharge. Prescribing in these instances also met their own needs, which was to use their prescriptive authority as outlined by Participant 15:

> *P15: When you got that certificate, you wanted to get out there and actively use your qualification . . . there was a bit of that, primarily I wanted to utilize time spent educating myself on this course but also yes I suppose from a practical point of view . . . you did need the prompt discharge of babies and it sped up that process.*

Four participants in the research, though having a significant number of years prescribing experience behind them were no longer prescribing. All of these participants had worked within the antenatal services or delivery ward areas rather than working within specialist areas of practice when they gained their prescriptive authority. The reasons for not using their prescriptive authority varied, though each mentioned in addition, the challenges associated with prescribing in areas such as delivery and antenatal services, where workload added to burnout. The impact of building capacity of RNPs within a setting was recognised by six participants who acknowledged that having more RNPs in a particular area would cut down on patient waiting times and potential burnout of RNPs. One participant, due to health reasons moved from the labour ward to a more administrative role with no clinical focus thus there is no opportunity for them to prescribe. Another participant, after seven years prescribing, wanted a change as due to a new managerial approach within the ward area, their job was changing, with little opportunity for autonomous practice. This participant had not given any thought to opportunities for prescribing in their new role due to the new job and subsequent studies undertaken. During our conversation however, they recognised that there may be potential for them to begin prescribing again. A participant who moved from one area to another recognised that it would be outside their scope, given the population attending the department but as time goes on and they ‘grow into’ their new area, this may become a possibility. A

further participant felt that the opportunities to prescribe were minimal and would only add to their workload.

7.2.4 Institutional and organisational issues and agency

> *'it was the introduction of nurse prescribing that influenced their (doctors) practice'* (P12)

Institutional and organisational issues in relation to agency were also addressed during conversations with ten participants. Reported organisational benefits arising out of nurse and midwife prescribing were wide-ranging. These included enabling a more efficient and streamlined discharge from the NICU which freed up cots, facilitating new admissions. Participant 4 recognised how timely pain relief for women in the labour ward '*was helpful in my workload because obviously, if someone was in pain and you could get it sorted then the sooner she could go to the postnatal ward'* (P4). Though continuity of care was outlined from an individual patient perspective, it also accrued benefits for the organisation as described by Participant 14:

> *P14: I think that from a hospital point of view . . . the continuity of care is probably the biggest thing . . . we maintain standards, so when a new doctor comes in, new staff come in, we insist on that standard, that's the standard that's acceptable here in the hospital so continuity of care is probably the biggest thing in our role.*

Efficiencies reported by participants, enabled by having nurses and midwives with prescriptive authority, resulted in cost savings as participants reported patients needed fewer hospital visits. RNPs also reported more efficient use of

junior doctor time, as they didn't have to go to the ward to prescribe pain relief very often.

The introduction of nurse and midwife prescribing and all of the checking and professional guidance around what information needed to be put on a prescription changed organisational practices in other ways such as how doctors prescribed. This was described well by Participant 12 who said it '*prompted the doctors having to put their medical council number on prescriptions . . . our drug Kardex was subsequently redesigned with a section NMBI/IMC. Every prescription had to have a number so it was the introduction of nurse prescribing that influenced their practice'* (P12). Another change that nurse/midwife prescribing brought in was the prescription of medicines by generic name which was a regulatory requirement for RNPs and noticed by Participant 9 who commented '*the last few years I can say that it is, the practice is changing so people are getting more familiar with generic names and prescribe more in line with that'* (P9).

7.3 Conclusion

This research explored the experiences of 16 RNPs in the maternity setting. Participants came from a range of clinical areas in the maternity services, worked at different grades from staff midwife/staff nurse to advanced practitioner grade and had different lengths of prescribing experience. This chapter presented findings under the themes of Identity and Agency. Findings suggest that RNP identity as a nurse or midwife is strengthened when they hold prescriptive authority. Though some felt they were straddling the worlds of medicine and

nursing/midwifery, they were unable to determine if this was solely due to their prescribing role or due to their specialist or advanced practice role. They considered nursing and midwifery practice to offer a unique contribution to patient care and were committed to ensuring that their practice maintained a nursing/midwifery focus. Participant experience also highlights that holding prescriptive authority enhances their overall capacity to act agentically which was articulated as care that was more timely, more women centred, more holistic and offered more choice to women. Participants considered their clinical decision making to be enhanced and superior to that of some doctors as it was more cautious and more thorough. Participants' capability for advocacy was also enhanced and this was reported in terms of advocating at a patient level, raising concerns about poor prescribing, at an institutional and national level and with the pharmaceutical industry. Agency was facilitated by practitioners' confidence but numerous challenges to agency were described including workload, interruptions, burnout, physical barriers such as lack of space and the fear of doctors becoming deskilled. In the next chapter I will discuss the findings presented in Chapter 6 and 7.

CHAPTER 8 PRESCRIPTIVE AUTHORITY: TOWARDS MORE EMPOWERED AND AGENTIC PRACTITIONERS

8.0 Introduction

The previous two chapters presented the findings of the research which explored the experiences of nurse and midwife prescribers (RNPs) in the maternity setting. Findings arose out of one to one, semi-structured interviews that aimed to generate practitioner-based knowledge, with the potential to inform education and research, policy and practice. In this chapter, I will analyse and discuss the findings. In summary, findings suggest that prescriptive authority can empower nurses and midwives. A number of factors were identified however, that determine the extent to which RNPs can be empowered such as education, interprofessional relationships, legislation and regulation. Participants claimed that their identity as a nurse/midwife is strengthened when they hold prescriptive authority. They are committed to ensuring their practice maintains a nursing/midwifery focus ensuring the unique contribution nurses and midwives make to patient care is upheld. Findings suggest that prescriptive authority contributes to the professionalisation of nursing and midwifery through the enhanced status it affords practitioners. Participant experience also highlights that holding prescriptive authority enhances their overall capacity to act agentically or independently. This was articulated as enhanced care and increased capability for advocacy, though numerous challenges to this were described. Though a largely positive development for the professions of nursing and midwifery, less positive aspects are considered such as whether nurses and midwives are exploited. Many of the findings incorporate aspects related to

education and though they are present throughout the analysis discussion, given the substantial contribution this research makes to education and learning these aspects are drawn together towards the close of the chapter highlighting their significance. The limitations to the research have also been acknowledged.

8.1 Empowerment

Though nursing in the past has experienced oppression (Witz, 1992) the experience of participants in this study would suggest that nursing and midwifery, particularly for those who hold prescriptive authority, have moved largely beyond that position. The role of prescribing, whilst bound within professional and legal parameters, is largely dictated by patient need rather than by doctors or organisations, supporting the idea that medical dominance does not retain the hold it once did over nursing/midwifery practice.

The introduction of nurse/midwife prescribing has contributed to a process of empowering both individual practitioners and the professions themselves. It was clear from this research that RNPs draw on three sources of empowerment, structural (Kanter, 1993) relational (Chandler, 1992), and psychological (Spreitzer, 1995), described in Chapter 3. The empowerment experienced by RNPs arises out of increased professional autonomy afforded them by prescriptive authority (Rodden, 2001; George et al., 2006; Cooper et al., 2008b). When speaking of their newly acquired prescriptive authority, overwhelmingly participants in the study were uncomfortable with the term power and much preferred the term empowerment. Women, (as the vast majority of nurses and midwives are), prefer power as relationally negotiated (Ceci, 2004), arising out of

relationships that are interactive, with power arising out of those dialogic relationships (Fletcher, 2006). Judging by this research, the main factors influencing empowerment are education, relationships with others and professional regulation, legislation and organisational structures.

8.1.1 The role of education in empowering nurses and midwives

Educational preparation can be seen as an element of structural empowerment (Kanter, 1993) as it facilitates the development of knowledge required by RNPs to carry out their role competently. It can also appear as an element of relational empowerment in that knowledge and power arise out of the dialogic interactions (Fletcher, 2006) which occur specifically between mentor and prescribing student. Though education is central to empowering individuals who wish to expand their practice, care is needed to ensure that all opportunities that present themselves are taken to enhance empowerment.

The medical profession has determined the fate of nursing and midwifery and education in the past (Larkin, 2002) and has continued to play a part in the development of nurse/midwife prescribing as outlined in earlier chapters. Participants placed huge importance on being mentored, reiterating findings from Latter et al. (2010). Many participants in this study had positive experiences, which helped contextualise the theory delivered in the classroom (Afseth & Paterson, 2017). At an individual level, the interaction provided by mentors, rather than being controlling (for the most part), is supportive and facilitative of an expanded scope of practice for RNPs. This may well be due to the collegial and professional relationships that now exist between the professions of

nursing/midwifery and medicine and between individuals across those professional groups. However, with some reports of mentorship being less than ideal, the degree to which RNPs can avail of learning that is embedded within authentic practice (Lave & Wenger, 1991) is uncertain. How students can move from a position of peripheral participation within a community of practice to one that is central within the community is questionable. The findings in relation to mentorship echo those previously reported by Campbell (2004), Nolan et al. (2004), Ryan-Woolley et al. (2007) and Ross and Kettles (2012).

Whom the student RNP had as a mentor, determined how effective the process was for learning. With one participant outlining how the consultant mentor did not engage in much prescribing activity themselves, how can the student prescriber model the behaviour of the mentor? Other participants' experiences concerned the mentors treating the mentorship role as a tick box exercise. This may be because they were very familiar with the working practice and competence of the student prescriber. However, this is concerning given previous reports by Cooper et al. (2008a) who reported than mentors can sometimes overestimate the knowledge base of a student prescriber. Similarly, it could have been due to the low priority given to the role by mentors themselves due to other demands on their time (Nettleton & Bray, 2008) or due to lack of knowledge of their role. However, the mentorship aspect is an important part of the course to which mentors formally sign up. If a student prescriber is not appropriately mentored and we recognise the importance of relationships in empowering individuals

(Chandler, 1992; Rafael, 1996), then it is likely the level of empowerment they attain will be less than that of those who have had the expected experience.

Though the medical mentorship model was appropriate initially when the only people prescribing, who worked closely with nurses and midwives were doctors, I propose this model be revisited. One way of addressing the challenges associated with less than ideal mentorship approaches is to widen our view of who can act as mentor. Rather than require it to be a medical doctor, I suggest it be the most appropriate professional, taking cognisance of their experience and prescribing practice. It may, in fact, be an RNP and whilst most participants in this study revealed they would be happy to take on the role, interestingly in a study by Courtenay et al. (2009b) students felt that a doctor would be the most appropriate person to mentor them. This points to the importance of a collaborative approach in establishing mentor/student arrangements, to ensure that both parties are happy with the arrangement. In some countries, either nursing supervisors or educators take on the mentorship role (Kroezen et al., 2012) and the UK Department of Health (2006) and Earle et al. (2011) have identified having non-medical prescribers as mentors, as desirable. This new model was piloted successfully in the UK with benefits for both students and practicing non-medical prescribers identified (Bowskill et al., 2014). This resulted in a change to requirements and standards for educational programmes preparing non-medical prescribers in the UK in 2019. Now, non-medical prescribers are permitted to act as mentors, where appropriate.

Broadening the base from where mentors can be drawn would also help address the challenge nurses and midwives might experience in obtaining a mentor, a point raised by participants in this study. However, this change should be driven by appropriateness, ensuring that appropriate learning and support take place, rather than by convenience. Permitting experienced RNPs to act as mentors would also contribute further to the professionalisation agenda in having the knowledge and expertise of RNPs further acknowledged. Though participants in this study did not raise it, Miles (2008) suggested that mentors want students to adopt the same values as them. Adopting a model whereby RNPs act as a mentor should enable prescribing by nurses and midwives to be infused with nursing and midwifery values. We must be conscious though that in pursuing a non-medical mentorship model that resistance may be experienced from different quarters with an interest in this area. Ultimately, the Nursing and Midwifery Board of Ireland (NMBI) will make the decision and a less radical model or a position of compromise might be the way forward. In adopting a co-mentorship model, the benefits of medical mentorship (Lafleur & White, 2010; Afseth & Paterson, 2017) would be recognised and acknowledged. Removing all medical professionals from the mentorship model may also reduce the opportunities to further develop collaborative working relationships. This may affect the development of interprofessional communities of practice and therefore a co-mentorship model may be more appropriate.

The NMBI has recently invited consultation on new draft requirements and standards for prescribing. In my view, one of the glaring omissions is the lack of

engagement or discussion around mentorship. Removing the absolute requirement for medical mentors would further empower nurses and midwives to direct the learning amongst their own members and further recognise their knowledge and expertise. This move would support disciplinary power (Foucault, 1975) over practice rather than the medical profession maintaining control over which nurses/midwives could become prescribers. It is only through engagement with the regulator that we will gain an understanding of why the opportunity to alter the mentorship requirements was not embraced. Does the regulator privilege the status of doctors and view medical knowledge as superior to that of nurses and midwives or are they fearful that support for nurse/midwife prescribing will be withdrawn by doctors if the requirement for a medical mentor is removed?

Empowerment contributes to an individual's ability for autonomous decision making within a prescribing role. This decision-making is facilitated by experience and knowledge, including pharmacological knowledge. A broad pharmacological base is an important part of the education programme preparing nurses and midwives for prescriptive authority. Some participants in this study disagreed however and queried the relevance of it, mirroring findings by Jones et al. (2007) in a study amongst mental health nurses. This suggests to me that perhaps some consider in-depth expertise and knowledge in a specific area to be more valuable than general knowledge. The relevance of a broad generic educational base is rightly questioned as some participants in the study described how not using the knowledge on a day to day basis meant it was forgotten, reiterating work by Abuzour et al. (2018). Despite this consideration, this study suggests many RNPs

appreciate the pharmacological knowledge gained from the education programme confirming findings by Boreham et al. (2013), citing the increasing complexity of women presenting to maternity services (Smith et al., 2009) as the reason. What emerged from this research was that awareness of the importance of broader pharmacological knowledge often arose out of a process of reflection on their scope of practice, one of the core responsibilities of registered nurses and midwives (NMBI, 2014) and as a result of their prescribing practice.

Maintaining a robust broad pharmacological approach within the education programme also protects the professions of nursing/midwifery from potential criticism by the medical profession in relation to knowledge. Though there was no substantial evidence in this study to suggest that nursing/midwifery (in the context of prescribing) continues to be dominated by the medical profession, de Raeve (2002) suggests that domination in the past arose out of an assumption that nurses had less knowledge. Though there were no suggestions from the findings in this study that the medical profession in Ireland has concerns about the preparedness of nurses and midwives for the role, concerns of this nature have been raised before (Bullock & Manias, 2002; Wilhelmsson & Foldevi, 2003; Banning, 2004; Lockwood & Fealy, 2008; Stenner et al., 2009; Kroezen et al., 2013). If we are to alleviate the concerns of insufficient pharmacological training, education and knowledge raised in Bradley et al. (2006), Skingsley et al. (2006), and Carey and Courtenay (2010), then we need to maintain the current broad approach to the education of RNPs.

Though the course content and clinical setting are important for learning, so too is the classroom environment. As a nurse educator and having prepared most of the participants for the prescribing role, I was both shocked and disappointed to hear one participant speak of their intimidation in the classroom setting arising out of their lack of confidence in areas outside their expertise. Though a broad representation from different clinical areas provides a rich learning environment, specialisation whilst enhancing knowledge and expertise in one particular area may reduce confidence in another. Ensuring that all students feel comfortable within the classroom setting is something I can act on immediately by acknowledging and emphasising within each class group, all students, regardless of clinical area, have a unique perspective to bring. This will optimise the learning experience for students and contribute to their empowerment through education.

8.1.2 The role of relationships in empowering nurses and midwives

The experiences of participants in this study illuminate the role relationships play in empowering RNPs. In speaking of relational empowerment (Chandler, 1992; Rafael, 1996), Fletcher (2006) suggests that power arises out of relationships that are built on dialogue and the extent to which RNPs feel empowered was very much linked to the interactions and relationships they have with other healthcare professionals and patients themselves. What emerges as part of this research is how the RNP role, which was introduced with consultation and collaboration (outlined in Chapter 2), was introduced successfully. The findings also support those presented by Maxwell et al. (2013) who equally suggest collaboration leads to the development of trust between professions and wider acceptance of new roles (Afseth & Paterson, 2017). This trust was likely supported by the inclusion

of other professional groups in Ireland such as the Irish Medical Council and Pharmaceutical Society of Ireland on the National Resource and Implementation Group (Health Service Executive, 2008) which steered the development of governance, legislative and educational requirements for the role. Though the Collaborative Practice Agreement (CPA) (outlined in chapter 2) was introduced from a regulatory perspective, the requirement to have doctor sign off could also be viewed as having instilled trust between nursing/midwifery professions and medicine. The findings of this study suggest that even though the introduction of the RNP role, through consultation and collaboration was widely accepted, individual nurses or midwives may have more difficulty accessing this acceptance. This was the case with more junior staff who may not have developed sufficiently strong professional relationships with colleagues. It may also be due to concerns regarding patient safety (BMA, 2005; Watterson et al., 2009; Funnell et al., 2014) though as acknowledged earlier this does not seem to have been an issue in Ireland.

Pharmacists also play a role in the empowerment of RNPs. Collegiality between RNPs and pharmacists along with the medical profession was highlighted in this study, lending credence to the work of Boreham et al. (2013) which suggested prescribing results in improved working relationships with other healthcare professionals. Where RNPs met resistance to their new role from pharmacists, they attributed this to the fact that pharmacists themselves did not have prescriptive authority. This study shows that strong professional relationships

were established with the professions of medicine and pharmacy and power arose out of those relationships (Fletcher, 2006).

The support provided by these groups could be due to a shared vision for patients to receive the right care at the right time by the right practitioner regardless of their professional background. It could also be due to the culture within the organisations, which supports collaborative and collegial relationships, important in supporting practice (Padgett, 2013). Hopia et al. (2017) have also recognised how networking with prescribing colleagues is important for competence. The collegial and confident professional relationship that exists between RNPs and medical staff was also demonstrated by the informal 'running things by' the doctor if seeking clarification rather than formally referring the patient onwards. This type of collaborative practice results in good decision making (Clarke & Glendon, 2015) and extends the knowledge base of practitioners (Morgan, 2017), ultimately improving patient outcomes (Schmalenberg et al., 2005).

This idea of support as contributing to empowerment and acceptance of new roles is not new (McKenna et al., 2006; Fealy et al., 2015; Elliot et al., 2016; Small et al., 2016) with a lack of support linked to disempowerment (Daiski, 2004). Change is not always easy and the introduction of RNPs results in a shift in professional boundaries of practice (Ben-Natan et al., 2013; Bowskill et al., 2013; Kroezen et al., 2013; Kroezen et al., 2014b). Though the literature suggests mixed reports in terms of whether non-medical prescribing is a threat to medical dominance (Weiss & Fitzpatrick, 1997; Britten, 2001; Nancarrow & Borthwick, 2005; Lloyd & Hughes, 2007; Weiss & Sutton, 2009; Weiss, 2011), as a whole,

doctors in Ireland do not seem to have been perturbed by the initiative. The important role leadership plays in introducing change (Senior & Fleming, 2006) and its role in introducing nurse/midwife prescribing was acknowledged by RNPs. The introduction of a collaborative model of nurse/midwife prescribing in Ireland resulted in a sense of shared power, supporting the position of Foucault and Rabinow (1984) who suggested that just because someone gains power, it does not mean someone else loses it. Professionals, regardless of occupational grouping worked together in order to benefit the patient, echoing previous findings from Boreham et al. (2013) which claimed that non-medical prescribing enhanced collaborative working. Equally, we could view, as did Bryers and van Teijlingen (2010) the provision of care as on a continuum, with nurses, midwives or doctors the most appropriate professional to deliver care at a particular point.

It was fascinating to hear RNPs talk about being 'lucky' in the support they received. This could be due to nursing's history of being subservient to the medical profession (Ashley, 1976; Witz, 1992) and a perception that they should not really be entitled to it and so were lucky to have it. I am also mindful that the RNPs I spoke to were ones who were supported by colleagues. It may be that there are other nurses/midwives who would have liked to pursue prescriptive authority but were not supported for one reason or another. An example of support being less forthcoming was given by one participant who reported how more junior staff could find getting their drug list approved by the Drugs and Therapeutics Committee (D&T) challenging. The idea of being lucky in the support RNPs received could also arise out of how nurses and midwives

generally feel about their position within the hierarchy of healthcare organisations and healthcare professionals.

Relationships with patients and the trust they place in their healthcare provider are also important for empowerment. The findings from this study and previous work by Archibald and Frazer (2013) support this. Though there has been some reporting of wariness on behalf of patients (Hobson et al., 2010) when nurses prescribe, participants in this study did not think this was an issue and would seem to support earlier work by Latter et al. (2010), Drennan et al. (2011) and Maddox et al. (2016) which claim the prescribing role is generally welcomed by patients. Though one participant reported being asked by patients why they were not seeing the doctor, it is important to note that patients with this question were attending the emergency department and may have been extremely anxious and worried that they may be losing their baby. If this is the case, it is possible, that some people view members of the medical profession, regardless of grade or experience, as a higher authority than nurses or midwives. On the other hand, some patients seemed not to notice it was the nurse/midwife who prescribed their medications. In these situations, it could be argued that in the eyes of patients, it does not matter to them who provides care so long as the care that is needed is provided, a position proposed by Tye and Ross (2000). It is however only by asking patients directly that we will be able to determine their level of acceptance/wariness with the RNP role.

8.1.3 The role of regulation in empowering nurses and midwives

The professions of nursing and midwifery are tightly regulated, the purpose of which is to protect the public (International Council of Nurses, 1997). Foucault and Gordon (1980) recognise that change is possible when structures change and structures that changed significantly which facilitated the introduction of nurse/midwife prescribing were the regulatory and legislative frameworks supporting practice. These can be viewed through the lens of Kanter's theory of structural empowerment (Kanter, 1993) as sources of empowerment in that they provide the power or authority for the RNP role and provide support for responsibilities (Kanter, 1993).

The findings of this study, somewhat mirroring those of Small et al. (2016), suggest that for some RNPs, the regulatory framework restricts their practice, impacting their ability to do their job to their full potential. On the other hand, others perceive the regulatory mechanisms as a protective and supportive feature for practice and enabling of expanded practice to an extent not seen before. Perhaps the most significant tool in the regulation and control of RNP practice is the CPA which plays a central role in perceived autonomy and which was described in Chapter 2. Though prescriptive authority has been reported to increase and enhance professional autonomy in other jurisdictions (Rodden, 2001; George et al., 2006; Cooper et al., 2008b) and recently in Ireland (Casey et al., 2020), some participants felt strongly that the requirement to have a CPA took away from the autonomy prescriptive authority was meant to bestow on them. Specifically, this included the requirement for collaborating doctors to sign the CPA, the technical detail required in relation to medicines listed within the

CPA and the bureaucracy associated with amending the CPA. The result was that there were some instances whereby an RNP had the authority to prescribe a drug but not at the specific dose or frequency required by a particular patient, thus restricting their autonomy. Given the changing nature of clinical practice, the introduction of new medicines and evolving scope of RNPs, some deemed the CPA not reflective of practice needs due to the rigmarole around updating it, which thus restricted autonomy. This mirrors findings by Casey et al. (2020) who also identified the CPA as a barrier to practice.

Nurses and midwives practice at many different levels, staff nurse/midwife, clinical manager, specialist and advanced practitioner and though mindful of how the CPA could impact autonomy, some participants found it useful on a number of levels. It provided clarity on their role, important for professional identity and professional boundaries. Participants reported the CPA as useful in acting as a defence against pressure to prescribe outside their scope of practice, previously acknowledged by Stenner and Courtenay (2008a) and Pritchard (2018) as a challenge prescribers face. In cases where participants refused to prescribe, the CPA provided evidence to support their refusal and was seen as a supportive mechanism. This alternative perspective on the CPA can be explained through Weston's (2008) conceptualisation of autonomy as freedom to make choices based on one's knowledge and judgement but within professional and organisational rules. Though Lennon and Fallon (2018) reported conflict when an RNP refused to prescribe, the findings in this study run counter to that.

Though it was acknowledged that the model of CPA introduced as part of the regulatory framework supporting RNPs in practice could be used as power over a nurse or midwife, it is interesting that the requirement for a CPA initially came from within nursing/midwifery and not from the medical profession and so can be viewed as a form of or tool of disciplinary power (Foucault, 1975). Given the role our professional values play in the regulation of practice anyway I consider the CPA to have been an unnecessary additional tool. The requirement may be a legacy issue reflecting back to times when the medical profession directed the practice of nursing and midwifery. It could equally reflect a lack of confidence within the NMBI that nursing/midwifery could advance without the support of the medical profession. Alternatively, it could have been introduced in the true spirit of collaboration. Rather than being dictated to by the medical profession, the development of individual RNP CPA's was seen as collaborative with both mentors and pharmacists providing valuable input. One participant felt slight unease at the power conferred on the prescriber themselves to determine what drugs went on their CPA. This may well be due to the fact that in the countries the participant had previously practised, little autonomy is conferred on individual nurses or midwives. The removal of the CPA from the regulatory framework in 2019 is to be welcomed, though it will be interesting to see how prescribing practice is governed at a local level and if governance practices are comparable across the health sector. There is the possibility that removal of the CPA may in fact move practice from one that is governed by disciplinary power to one governed externally to nursing and midwifery. Whether those who considered the

CPA as supportive of practice continue to feel supported within the new arrangements, remains to be seen.

Another component of the professional regulation is the requirement to adhere to specific practice standards for prescribing (NMBI, 2007; 2010b; 2018; 2019), applicable only to nurses/midwives with no similar framework in place for other prescribers such as doctors. Though devised to ensure safe practice, findings from this research suggest some practice standards are disempowering. One of these standards that is challenging for practice is the requirement if at all possible to separate the prescribing of medicines from the administration of medicines. Considered 'best practice' (NMBI, 2018), it means that if the RNP prescribes a medicine, another nurse or midwife should administer it. Where RNPs work in isolation, this is practically impossible. The reason for this standard is to maximise safe medicines management and the safety role played by the medication administrator when an error is made by a prescriber was acknowledged by Sutherland et al. (2019). Having a different person administer medicine to the one prescribing it will more likely result in the identification of an error if it has occurred. However, if a nurse or midwife who assesses a patient and prescribes a medicine prior to a procedure, must then seek out another to administer it, one of the proposed benefits of nurse/midwife prescribing which is that it allows the practitioner to provide a full cycle of care (An Bord Altranais, 2005) is lost. The CPA did, however, allow for a deviation from this practice standard in specific circumstances so long as it was documented and approved within the organisation (NMBI, 2018).

Different rules and expectations exist around nurse/midwife prescribing in comparison to doctor prescribing, instigated by the NMBI and the HSE. Findings from this study illuminated these different rules and expectations, which are far more stringent for nurses/midwives, resulting in frustration for RNPs. This led to a feeling amongst participants that RNPs were not trusted as much as doctors by the healthcare hierarchy including nursing and midwifery. This is despite the nurse/midwife potentially having significantly more clinical experience than the junior doctor. Some participants in this study had little trust in the professional and organisational structures in turn, believing as did participants in a study by Maddox et al. (2016) that they would more likely than a doctor to be struck of the register for making an error. Given that most nurses and midwives are female, there may be a gendered element to this also as Sarsons (2017) found female surgeons to be treated more unfairly than their male surgical colleagues when similar errors were made by male and female surgeons.

Emerging from this research is that the requirement from the HSE to enter prescriptions into a database from which statistical information could be drawn could disempower RNPs, resulting in them not prescribing. This data entry was a significant time burden and the value of it was not visible to those who were contributing to it. Participants welcomed the removal of the mandatory requirement to use the database in 2015, because decisions which did not result in a prescription were not captured, thus giving an incomplete picture of RNP decision making. Creedon et al. (2014) had previously highlighted this issue with the set-up of the database seeming to imply that decisions not to prescribe were

less valued than decisions to prescribe. This is despite the fact that one of the advantages of nurse/midwife prescribing is that they tend to prescribe less often and use non-pharmacological methods (Mahoney, 1994; Rowbotham et al., 2012) where appropriate. Therefore, a system established to capture RNP activity did not capture the breadth of RNP decision making or scope and in fact, served to disempower and potentially devalue the practice of RNPs.

The introduction of additional rules and expectations on the prescribing practice of RNPs as compared to doctors warrants further exploration. If introduced as part of 'best practice', then they should have been introduced for everyone who prescribes. Fear that doctors would not trust RNPs given previously identified lack of support from doctors (McCann & Baker, 2002; Wilson, 2002; Plonczynski et al., 2003; Ball, 2009) may also have been a factor, though findings from this study do not support this claim. In fact, respondents in this study acknowledged the huge support doctors provided, enabling the role out of nurse/midwife prescribing. Lack of trust within nursing and midwifery, as suggested by one participant may also have contributed to the additional rules for RNPs.

Though most participants viewed prescriptive authority as empowering for their own practice and care of patients, there was a certain element of task-orientated practice expressed by a small number of participants in this study. This included picking up the pieces of doctors' practice, 'doing' the work of prescribing for them and completing treatment regimens when doctors had been incomplete in their prescribing. This could be viewed negatively and as a return to a time when nurses were considered the handmaiden of the doctor (McGregor-Roberston,

1902; Ashley, 1976) or indeed as a strategy of co-optation (Gamson, 1975; Piven & Cloward, 1977) by doctors. However, participants were driven to this action by their commitment to patients and making sure they received what they needed when they needed it. Confidence also played a part in empowering participants in this study with a suggestion that confidence arose out of prescribing practice. Whilst most participants in this study stated they were very confident in their prescribing ability, supporting recent findings by Casey et al. (2020), some identified being nervous on commencement as an RNP, mirroring findings by Luker et al. (1997). Findings from this study suggest that actively making prescribing decisions contributed to RNP confidence, echoing previous findings (Granby, 2003; While & Biggs, 2004; Hopia et al., 2017). With this in mind, we could view this so-called task-orientated practice as a way of RNPs consolidating and gaining confidence in their practice, leading to greater empowerment.

Some RNPs expressed concern over their prescription of Antibiotics and Benzodiazepines despite these drugs being completely appropriate for their patient population and scope of practice. They were worried about what people would say given the emphasis on antibiotic stewardship (SARI, 2009) and concern regarding what is considered the over-prescription of benzodiazepines (Cadogan & Ryder, 2015). Despite the literature demonstrating that nurses prescribe pharmacological agents less often than their medical colleagues (Avorn et al., 1991; Sutcliff, 1996) and are more likely to try non-pharmacological management of conditions when appropriate (Rowbotham et al., 2012), these fears may reflect back to concerns expressed by the medical profession with

regards to safe prescribing practice (BMA, 2005; Watterson et al., 2009; Funnell et al., 2014). Nurses and midwives are very conscious of their scope of practice and those I spoke with were careful to ensure that they did not practice outside it.

Changes in legislation were also required to facilitate the RNP role and were empowering of RNP practice. However, legislation that restricted RNPs from prescribing unauthorised medicines as outlined earlier in this thesis is disempowering for practitioners. Findings from this study highlight how the legislative restriction to RNPs prescribing unauthorised drugs, impacted on their ability to care as fully as they wished, supporting earlier work which found that legal parameters of practice constrained individual RNPs practicing to their full scope (Sangster Gormley et al., 2011; Heale & Rick Buckley, 2015; Fougère et al., 2016). Situations arose whereby the RNP prescribed a drug but the one stocked in the hospital pharmacy was an unauthorised brand. This was hugely concerning for some prescribers as they felt that their prescription was invalid which meant that the nurse/midwife administering the drug, was administering a medicine that did not have a valid prescription. The lack of a legal framework to support the prescribing of unauthorised medicines by RNPs also resulted in unsafe practices. RNPs, fully competent to make prescribing decisions had to ask a doctor who may not have had time to see a patient, to prescribe an unauthorised medicine. RNPs practicing at an advanced level also felt that the restriction on prescribing unauthorised drugs disproportionally affected them as they were generally looking after more complex patients, who required

unauthorised drugs. The introduction of new practice standards (NMBI, 2019) following amendment to prescribing legislation which now permits RNPs to prescribe unauthorised medicines is significant and should alleviate these challenges.

Disciplinary power plays a role in the regulation of nursing and midwifery practice including participants' adherence to their scope of practice and self-policing through a process of professional accountability which limits their prescribing decisions (Goswell & Siefers, 2009). Is all this additional regulation over prescribing practice necessary? There is concern that too tight a control over practice may result in practitioners not practicing to the full extent of their education and training (AANP, 2013), not being as effective as they could be, prescribing less often than they could and therefore failing to accomplish the patient and service benefits they set out to achieve in the first instance.

Another element of structural empowerment (Kanter, 1993) was the development of policy at a national and organisational level, along with structures around audit and risk management. Additionally, individual RNPs were given opportunities; they were put forward and supported by their directors of nursing/midwifery, they were appointed to committees based on their prescribing role and were supported by a prescribing site co-ordinator. There are concerns however that unless organisational structures are enhanced such as increasing opportunities and access to continuing professional development (CPD) along with increasing the numbers of RNPs practicing to prevent burnout, that RNPs may become disempowered.

The introduction of the Electronic Health Record (EHR) across the maternity services was also an influencing factor in the empowerment of RNPs. Though the EHR can be a hugely positive initiative (Bates et al., 1998; Nuckols et al., 2014; Reckmann et al., 2009; Westbrook et al., 2012), participants in this study expressed some reservations. It was acknowledged that the EHR had the potential to remove the caring focus of their practice, a finding previously reported by Watson (2001). Optimum use of EHR is dependent on a number of key issues including user competence (Bates et al., 1998; 1999; Nuchols et al., 2014). A multidisciplinary approach to the design of the system was undertaken with input from RNPs and even so, the design of the system itself was reported to create challenges, signifying the complexity of marrying technology to clinical practice. Participants in this study described either not being able to 'get into the system' or not being able to generate an audit of their own prescribing activity. Audit is an important tool in improving the quality of care provided (Esposito & Dal Canton, 2014). With the reported disengagement with the audit process by participants in this study to date, additional challenges such as not being able to access the electronic system will not improve this situation. Lack of training and education is considered a barrier to innovation (Pontefract & Wilson, 2019) and given that the rollout of the EHR is in its infancy, greater exposure to and training in its use may address these issues. Electronic prescribing was seen in some cases to slow down and add to the already heavy workload of RNPs but most worryingly many were concerned with safety issues they perceived to be attached to electronic prescribing. Some participants felt there was greater scope for error rather than

if they had to handwrite the drug name, dose etc. Apprehension was also expressed in relation to the EHR and the potential for knowledge to be lost, signifying implications for providers of CPD related to prescribing. We must ensure that in the adoption of technology that we do not disempower practitioners.

8.2 Identity and professionalisation

Being a nurse or midwife is an important part of who we are and maintaining a strong nursing or midwifery identity when taking on new roles is important for patient care (Christmas & Cribb, 2017). It was important to participants in this study due to the pride they took in their profession. Being recognised as a doctor, rather than a nurse/midwife was troubling for some participants. They recognised taking on activities that are more complex may have contributed to patients thinking they were doctors. Judging by the findings from this research however, prescriptive authority enhances an individual's nursing or midwifery identity, confirming claims by Borthwick et al. (2009) and Petrakaki et al. (2014) that nursing identity is intensified when roles are expanded. Though loss of core work has been suggested as having the potential to weaken professional identity (Borthwick et al. 2009), this was not the case in this study as participants made conscious efforts to ground their practice in nursing/midwifery and maintain a strong emphasis on care. Nursing and midwifery are values-based professions and participants gave accounts of activities they undertook to ensure their practice remained rooted in and guided by nursing and midwifery ideals. Not only is rooting practice in nursing and midwifery important for professional identity it is

also important to protect the unique contribution nursing and midwifery make to patient care. The unique contribution nurses and midwives make to care was recognised by participants in the work carried out by Tye and Ross (2000) and reiterated by participants in this study as a holistic approach to care.

Socialisation to professional roles is important for identity (Mooney, 2007) and with the role of educators in socialising students to a profession well known (Weis, 2002; Zarshenas et al., 2014) the role of programme directors in socialising nurses and midwives to their new prescribing role cannot be underestimated. Using Kreindler et al.'s (2012) approach would suggest that nursing/midwifery identity could be enhanced by encouraging more group interaction with other RNPs. Informal support provided on an *ad hoc* basis between RNPs was reported by participants in this study but the development of more formalised support or a buddy system (Lennon & Fallon, 2018) may enhance the RNP's nursing/midwifery identity within a team identity and within a community of practice (Wenger, 2000). Otherwise, RNPs may become susceptible to adopting some of the behaviours of the medical profession, diluting the nursing and midwifery focus and identity.

My own experience of being a nurse in a non-traditional nursing role (research nurse) is that nursing colleagues can view you as something else and 'not a real nurse'. This experience of being set aside was articulated by some participants in this study with an acknowledgement of being 'othered' or isolated by nursing and midwifery colleagues. Exclusion of nurses and midwives who were deemed not to be doing nursing work was previously reported by Cummings et al. (2003),

Reay et al. (2003) and Dunphy et al. (2009) and in the case of the research presented in this thesis, may stem from prescribing being considered the work of doctors rather than that of nurses/midwives. However, participants in this study did not consider they were doing doctors' work, echoing previous findings by Lockwood and Fealy (2008). In fact, they saw themselves as nurses/midwives working to the limits of their scope of practice or in the words of one participant, a better midwife. It is important to point out though that any participant who articulated these experiences of being 'othered' was working in a specialist or advanced practice role and it was difficult for them to determine whether the experience was due to their role overall or due specifically to their prescribing role. This reaction from nursing and midwifery colleagues may be due to a perceived or real two-tiered system within the professions of nursing and midwifery that contributes to an internal hierarchal system (Weiss et al., 2016); those that hold prescriptive authority and those that do not. Conflict may also exist when one nurse/midwife is giving another instruction, a factor previously recognised by Tye and Ross (2000). Findings from this study also suggest that nursing and midwifery colleagues do not truly value the additional knowledge and scope of RNP practice, as colleagues viewed them as a gap filler in their workplace rather than as autonomous professionals working within an expanded scope of practice. The role of the RNP was seen to make life easier for the 'floor staff' and this emphasis on 'getting the job of prescribing done' may indicate that these nurses and midwives remained in a task-orientated mind-set which can

dominate in workplaces where there is an emphasis on efficiency (Sharp et al., 2018).

In contrast to this position was the experience of one participant who felt that prescriptive authority allowed increased respect and acceptance by nursing and midwifery colleagues. This participant was working in infection control and prior to obtaining prescriptive authority held an advisory role. As a prescriber, they were seen as getting their hands dirtier, having a more hands-on clinical role than previously and as such were more accepted.

Blurring of boundaries when nurses hold prescriptive authority has previously been identified (Ben-Natan et al., 2013; Bowskill et al., 2013; Kroezen et al., 2013; Kroezen et al., 2014a). This was acknowledged by participants in this study but not reported as negatively affecting their practice nor their professional relationships with medical colleagues. This may be due to the fact that medical dominance and its monopoly over healthcare delivery is decreasing due to a number of factors such as a more informed public, roll out of clinical guidelines and legislation which allows for the creation of new grades of healthcare professions and the expanded practice of others (Tousijn, 2002; Coburn, 2006; Tousijn, 2006; Bury & Taylor, 2008). Doctors' claim to authority over nurses in the past stemmed from them having greater knowledge (Royal Australasian College of Surgeons, 1987; Brown & Seddon, 1996). Nursing and midwifery knowledge, as a result of their educational preparation for the prescribing role, disrupts this claim and takes away the professional monopoly doctors had on prescribing and access to treatment. Given the high regard in which

nurses/midwives are held by medical colleagues, it appears that the hierarchal structure in which the medical profession was dominant over nursing (Friedson, 1970; Abbott, 1988; Adamson et al., 1995) which would have existed previously, is levelling out. The experiences of the participants in this research substantiate this as does work by Ross (2015) which suggested that nurses who hold prescriptive authority were on a more equal footing with their medical colleagues. The support participants received from their medical colleagues is perhaps not surprising since the consultants with whom the RNPs worked would already have agreed to act as mentor during the education programme preparing them for the role. It could be argued that acceptance may also be due to RNPs taking on what the medical profession considers routine tasks, therefore, giving doctors the space to undertake more acute work (Stewart et al., 2009; Watterson et al., 2009). This could in itself be viewed as enhancing their own professional role and the subordination of nursing (Abbott, 1988). However, classifying prescribing work as routine fails to take into account the complexity of decision-making around prescribing and the expert knowledge needed to ensure safe prescribing practices.

It is rare that prescribing of medication by any health care professional happens in isolation. Prescribing of a medicine or indeed a decision not to prescribe any medication should happen through a collaborative process. This may be in collaboration with other healthcare professionals such as nurses, microbiologists and pathologists but also patients themselves to facilitate concordance. Given the encouragement that consultants gave to RNPs in terms of progressing to

advanced practice as outlined by participants in this study, I would suggest that they are motivated jointly by improving patient care and a genuine desire to see their nursing/midwifery colleagues develop professionally. The involvement of a medical mentor in other studies has been shown to help establish trust and the role of the RNP within the wider healthcare team (Afseth & Paterson, 2017). There is no doubt that improved collaboration, necessary to care for patients in today's world will result from the creation of healthcare professionals who have both a professional and interprofessional identity (Sterrett, 2015) where the skills and knowledge of different team members are equally valued (Institute of Medicine, 2011). Weiss et al. (2016) went further in stating that where there is respect and recognition of different professional identities a shared practice identity can be formed which contributes to multidisciplinary patient care.

A number of findings emerged out of this research which suggests that prescriptive authority contributes to the professionalisation of nursing and midwifery and elements of Wilensky's five-stage process (discussed in Chapter 3) are seen (Wilensky, 1964). Though the professional groups of nursing and midwifery previously existed, a new group emerged, RNPs. An education programme was established to prepare this new group for their role and whilst a professional association and code of ethics already existed for nursing and midwifery practice, this was augmented by specific practice standards for RNPs. The final stage of Wilensky's process of professionalisation is political activity and numerous examples of this both at a national level and by individual RNPs were reported by participants and highlighted in Chapter 7.

It is clear that engaging in the education programme preparing for prescriptive authority and the practice of prescribing contributes to enabling nurses and midwives to meet the professional requirement to engage in CPD and maintain competence. Engagement with CPD is a requirement for modern-day nursing and midwifery practice and most participants acknowledged clinical need as what motivated them to undertake the education programme preparing them for prescriptive authority. This motivation is in keeping with a trait approach to professionalisation one of whose attributes is an altruistic mission (Greenwood, 1957; Wilensky, 1964; Etzioni 1969). Undertaking the education programme for the role demonstrates participants' clear commitment to lifelong learning and embracement of CPD, a commitment previously reported by Fealy et al. (2014). Findings from this study suggest not only does the education programme help maintain competence, but adds to the skills and knowledge required to care in an evolving sector (Gopee, 2001; Ross et al., 2013), contributing to and increasing the knowledge base of the professions. It also enabled them to meet their professional responsibilities as registered nurses and midwives (NMBI, 2014). However, the engagement of participants in this study with further CPD activities is of concern. Despite the professional requirement for RNPs to undertake specific CPD in relation to their prescribing activity (NMBI, 2018), not all were proactive, echoing previous findings from Ireland (Drennan et al., 2009; Condell et al., 2014; Casey et al., 2020). Though lack of time, previously reported by Courtenay and Gordon (2009) and lack of guidance from the regulator (Courtenay et al. 2007; Drennan et al., 2009) were the only reasons identified by

the participants in this study, previous work has identified cost and workload (Courtenay & Gordon, 2009) and employer support (Weglicki et al., 2015) as contributing factors. The implication of poor engagement with CPD is that full development of the participants' expanded role may be inhibited (Baxter et al., 2013; McKenna et al., 2015) thus hindering further professionalisation of the professions. With engagement in CPD necessary for continued learning (Illich, 1976; Friedson, 2001) and considered a hallmark of a professional group (Houle, 1980), RNPs and those supporting them such as the regulator and educators, must explore ways in which relevant CPD can be undertaken so that the position of being professionals is not questioned and patient care is not compromised.

Another finding, which emerged from this study, is that the visibility of nursing and midwifery is increased when nurses/midwives hold prescriptive authority. The clinical environment is one in which teaching and learning activities are undertaken regularly and participants' knowledge and experience arising out of their prescriptive authority enhanced their capacity for teaching activities across the healthcare organisation. They reported themselves as being a huge educational resource for colleagues, a finding previously noted by Stenner and Courtenay (2008b) and Ross (2015).

Nurses and midwives working in specialist practice often run nurse-led clinics and have taken on many expanded practice roles. Prescriptive authority for these practitioners allows them to assess, diagnose and treat, leading to a more efficient service for the patient and more holistic care. Eaton and Webb (1979) identified how increasing clinical activities such as history taking in the pharmacy

profession was a strategy of professionalisation and this model easily translates to the professions of nursing and midwifery. The increased visibility of nursing and midwifery amongst RNPs is as a result of practitioners engaging in this work and actually putting their name to a prescription. In the past, though nurses and midwives were undertaking assessments and making clinical decisions, they asked the doctor to prescribe a particular drug (Cope et al., 2016). The doctor's name appeared on the prescription and so nursing/midwifery knowledge and expertise, which informed the prescription, was hidden. The signing of a prescription by a nurse or midwife highlights their knowledge, contributing to an enhanced status for the professions. The visibility of nursing and midwifery was also raised through advocacy work reported and discussed in Section 8.3.

Emerging from this research is that a prescribing qualification enhances the marketability of an individual practitioner and is a useful tool in their pursuit of promotional positions. This is possibly due to the enhanced autonomy the qualification bestows on nurses and midwives, as previously described by Rodden (2001), George et al. (2006) and Cooper et al. (2008b). Prescribing allowed participants in this study to engage in clinical decision making at a higher level than they would have done previously. This decision-making was particularly important for those wishing to further their development into advanced practice roles. Given the Irish Governments commitment to increasing the number of advanced practice roles (Government of Ireland, 2017) this research is timely as findings suggest that for individuals wishing to go forward to advanced practice, prior to undertaking the educational preparation for that role they should

already be practicing as a prescriber. Not only does the qualification make the RNP more marketable but from an organisational perspective, they become more flexible in terms of the setting in which they can work autonomously.

This increased contribution RNPs make to patient care and therefore added value to they bring to the health service raises another question as to whether individuals who hold prescriptive authority should be financially rewarded for the additional responsibility they undertake. Though participants articulated having an enhanced status within their organisation, paying RNPs would also be a recognition of their status. Nurses and midwives already expand their practice taking on new roles such as cannulation without extra pay. Other professions do likewise, for example teachers supporting their classroom activities with online material and activities. Thoughts by the participants in this study are inconclusive. Though practitioners working in some specialist areas such as ICU are paid an additional allowance in recognition of their specialist qualification, there is no additional payment for RNPs, despite the added responsibility associated with prescriptive authority. Is failure to financially reward RNPs exploitative of their goodwill? On the one hand, some participants in this study felt that additional financial recognition of their role was warranted echoing previous findings by Lennon and Fallon (2018) as prescribers themselves produced cost savings for their employer. Figures from the UK suggest the cost-saving contribution by non-medical prescribers within the NHS to be £777million (NHS Health Education North West, 2015). Other participants had mixed feelings in relation to financial reward for the prescribing role and ‘felt bad’ about wanting additional payment.

This may well reflect back to days when nursing and midwifery were seen as vocations. The concerns with not financially rewarding RNPs have been reported in the literature such as leading to dissatisfaction amongst prescribers (Ross & Kettles, 2012) and as a deterrent to nurses contemplating a prescribing role (Nolan et al., 2004; Hall et al., 2006; Kelly et al., 2010; Creedon et al., 2015). This question of financial reward for prescribing though sits within the broader issue of pay for nurses and midwives generally. This issue was very much to the fore during the course of this doctoral work as nurses and midwives took industrial action in an attempt to gain pay parity with other degree qualified healthcare professionals (Wall & Clarke, 2019). NMBI (2015b) states that expansion of practice should only be undertaken when there is potential for patient benefit. Would financial benefit for RNPs incentivise nurses and midwives to undertake a prescribing role for 'the wrong reasons'? However, given the 'hoops' they have to go through in having their organisation and medical mentor formally endorse their application (Health Service Executive, 2008) I consider there to be sufficient safeguards in place to ensure that only those within whose practice there is a clinical need and who are themselves deemed to have the potential competence to carry out the role, are supported. Would paying nurses and midwives extra for taking on a prescribing role contribute to a hierarchy within the professions? It could be viewed that though RNPs are not being forced to take on the role, they in fact being co-opted (Gamson, 1975; Piven & Cloward, 1977) to undertake what was traditionally a medical task by appealing to their altruistic nature and commitment to enhanced nursing/midwifery care. Participants in this study

however did not express this view and considered prescriptive authority to be an expansion of their practice rather than taking on a new specialism for example, intensive care nursing.

Though prescriptive authority is good for patients and good for the professions, what emerged in this study were strong feelings that the role should not be undertaken lightly and that practitioners should be adequately prepared. It was also suggested by some that it was not for everyone and by others that it should be restricted in some instances to those working in advanced practice roles. Though it might be considered, given the experiences of participants in this study, that the NMBI exerted what some would consider excess power and restriction over the practice of RNPs in terms of regulation, it was interesting that some RNPs themselves also wished to exert their power over who was permitted to hold prescriptive authority. Though they mentioned that this was not an elitist perspective it would appear to me to be one and an example of nurses restricting others from within their own profession expanding their practice in a manner appropriate and required for their practice area. This idea of ring-fencing certain work is an example of marking of professional territory described by Abbott (1988) in relation to medical work. Whilst the literature does not generally endorse this perspective, Scrafton et al. (2012) found that nurse prescribers did not think junior nurses should hold prescriptive authority, as they did not have the clinical knowledge and skills necessary to make prescribing decisions. This position regarding prescriptive authority risks the creation of new hierarchies within the professions (Weiss et al., 2016) though perhaps this exists already because of

specialist and advanced practice roles. This position of restricting prescriptive authority to those working at a more advanced level is in contrast to the position adopted by the NMBI and HSE. When setting the entry criteria for the programme, they consciously took an inclusive approach where any grade of nurse or midwife (subject to meeting certain criteria) could undertake the programme preparing them for prescriptive authority (Health Service Executive, 2008). A contrasting view, expressed by other participants in this study, suggests that prescriptive authority should be afforded to all nurses and midwives, with some even believing it should be a compulsory part of practice. Making the qualification compulsory would result in building capacity, which may mitigate against some of the issues experienced by RNPs such as burnout and fatigue when they are constantly being asked to prescribe for patients other than those within their caseload. However, just because someone has prescriptive authority does not mean that they will actually use it and the extra work involved in assessment and documentation of prescribing decision making may remain an impediment to prescribing by nurses/midwives. Though there are no immediate moves to introduce widespread prescriptive authority for all nurses and midwives in Ireland, draft proposals in the UK suggest limited prescriptive authority should be extended to all newly qualified nurses (Dean, 2017). Additionally, the idea has been mooted in Ireland with the Department of Health's publication on graduate to advanced practice policy (Department of Health, 2019). The idea of some nurses being uncomfortable with prescribing has been raised previously, along with the idea that prescriptive authority could lead to exploitation of staff (McCann

& Baker, 2002). Given that nurses and midwives working in the public sector do not have to seek funding to undertake the programme as they would with other postgraduate education, this may put pressure on nurses and midwives to undertake the programme when in fact they might not choose to do it themselves. However, I consider prescriptive authority, once an individual nurse or midwife has sufficient experience and is adequately prepared educationally and supported within their organisation, to be a requirement for practice.

Oakley (1986) and Salvage (1988) previously suggested professionalisation within nursing might lead to a more dramatic power differential between nurses and patients, similar to that which exists between doctors and patients. Though one participant acknowledged that as the level of clinical decision-making increases such as with advanced practice the ability to care might decrease, this sentiment was not broadly reported. In fact, it was suggested that prescriptive authority, as a tool and outcome of professionalisation created more of a connection between nurse/midwife and patient as will become clear in the next section.

8.3 Agency

This research also suggests that a nurse/midwife's capacity to be agentic, which I understand to be the capacity to act independently, is inextricably linked to the level of empowerment prescriptive authority enables. Foucault describes power as existing to be used and it is by examining how it is used (Bradbury-Jones et al., 2008) that agency can be best understood. This study argues that prescriptive authority, rather than taking away the caring focus of nursing/midwifery practice,

actually enhances it and reiterates findings from previous work in relation to care (Latter & Courtenay, 2004; Gray et al., 2005; Berry et al., 2008; Carey et al., 2008; Cooper et al., 2008a; Lockwood & Fealy, 2008; Drennan et al., 2009; Courtenay et al., 2011; Casey et al., 2020).

Nursing acts and in particular caring nursing acts can sometimes be hidden (Reverby, 1987). Prescribing decision-making, viewed as a behaviour of caring, illuminates nursing/midwifery care and moves caring from the margins of healthcare to the centre of healthcare (Watson, 1995). The caring that participants in this study described was very much in keeping with Swanson's idea of it being 'a nurturing way of relating to a valued other and toward whom one has a personal sense of commitment and responsibility' (Swanson, 1993: 354). RNPs become more expert (Benner, 1984) with a 'broader scope of caring practices' (Swanson, 1993). Swanson's five spheres of caring which were outlined in Chapter 4 (Swanson, 1993) are an appropriate frame within which to view this broader scope. Applying these five spheres of caring to RNP practice, RNPs 'know' through their enhanced knowledge and competence as prescribers and their ability to undertake assessment relevant to prescribing decisions. They 'are with' patients in a way they were not able to be before they held prescriptive authority. They 'do for' patients in an enhanced way due to their increased competence. They have a greater ability to empower patients which will be further addressed later on in this chapter in terms of advocacy and they maintain belief and encourage patients. This encouragement and time spent with women (Venning et al., 2000) and the manner in which information was relayed to women

(Ross, 2015) resulted in greater concordance. Participants articulated examples within each of these spheres. Prescriptive authority results in RNPs being able to offer more choice, to be flexible in meeting women's needs and provide a variety of care that is holistic, timely and continuous.

Though the addition of prescriptive authority could be viewed as contributing to the medicalisation of pregnancy and childbirth, I consider caring to be about being with the patient in the way the patient needs at a given time (Adams, 2016). Prescriptive authority enables the nurse/midwife to fulfil that care to a greater extent. Prescriptive authority expressed in collaborative decision making with women reported in this study and by Latter et al. (2005), supports midwifery's partnership with women approach to care. The changing demographics of women presenting to maternity services, partly as a result of medical advancements, means women who would have previously been advised not to become pregnant due to underlying health problems, can now safely do so and carry a baby to term. The use and increasing success of IVF, older first-time mothers and a more women-centered approach to care, that both offers and facilitates women's choice have also contributed to changing demographics. Therefore, the roles of nurses and midwives and what they can offer needs to change. The prescription of pharmaceutical agents is an integral part of providing the care to women outlined above and integral to the role of specialists nurses in particular (Bowskill, 2009; Carey et al., 2014). I suggest that not only is prescriptive authority compatible with nursing and midwifery practice in the maternity setting but is a requirement, once a nurse or midwife has sufficient

experience and is prepared and supported, to fulfil the values associated with nursing and midwifery practice.

Nurse and midwife prescribing leads to safer patient care and this is supported by the findings of this study and previous work by Retchin (2008) and Lennon and Fallon (2018). Nurse and midwife prescribing leads to greater continuity of care, leading to care that is less fragmented. With fragmented care linked to medication errors (Retchin, 2008) it follows that less fragmented care will be safer. Nursing leadership is a critical component of the delivery of effective healthcare (Swearingen, 2009) and leading on patient safety was one motivating factor for a participant, working in the community who was troubled by the fact that doctors were writing prescriptions for patients they had not seen, based on the participant's request. The writing of prescriptions by doctors for patients they hadn't seen, also exists in specialist practice with many consultants working within maternity services appointed to two hospitals meaning they are not always at the maternity hospital when needed. This requires the nurse or midwife to call the consultant to prescribe 'over the phone'. Having prescriptive authority and adhering to the practice standards set out for nurse and midwife prescribers (NMBI, 2018) allows practitioners to take responsibility and be accountable for prescribing decisions, allowing for safer care.

Participants in this study believed their decision-making was superior to that of doctors. Though the literature to date has not reported on whether this is the case, others suggest RNP decision making is at least as safe and appropriate as that of their medical counterparts (Venning et al., 2000; Miles et al., 2002; Carey

et al., 2008; Drennan et al., 2009; Jones et al., 2011). Participants in this study linked their perceived superior decision making to their approach, which was more holistic, thorough and cautious as previously outlined by Funnell et al. (2014). Examples were given to substantiate this including starting lower doses of drugs during pregnancy and building up to a therapeutic dose, rather than starting with the full dose. This reduced the potential that women might stop their medicine due to side effects. The numerous accounts of medical practitioners prescribing on the 'say so' of a nurse or midwife without ever having seen or assessed the woman (Cope et al., 2016) also validated their opinion that their decision-making was superior. This more holistic, cautious and thorough approach to decision making stemmed, they believed from their educational preparation for the role which was viewed positively and previously reported by Drennan et al. (2009). This may well be true. Whereas nurses and midwives feel well prepared for a prescribing role a number of reports indicate the lack of preparedness of medical graduates in relation to prescribing activities (Rothwell et al., 2012; Burford et al., 2014; Miles et al., 2017). It is also likely that the practice and philosophy of nursing/midwifery which places the patient at the centre of what we do, permeates as it should do (NMBI, 2015b), the expanded practice role.

Nurses and midwives are reflective practitioners and this emerged during our conversations as both reflection in action and reflection on action (Schön, 1983). Decisions were measured and often a decision was made not to prescribe for a variety of reasons or to refer the patient onto another healthcare professional, be that medical doctor or other RNP. Referral onwards was not viewed negatively,

rather an appropriate collaborative approach to care. There was no evidence within this study that nurses and midwives with prescriptive authority would operate as a 'loose cannon', a concern within the medical profession reported previously (Stenner et al., 2009).

'Patient advocacy appears to be embedded in the DNA of good nurses, rooted in their ability to listen actively, observe keenly, analyse and process various types of information, and communicate skillfully' (Rowen, 2010: 46). Advocacy has always been a core role for nurses and midwives and their ability to advocate is enhanced when they hold prescriptive authority. The findings of this study corroborate this. Patients can find themselves caught up in a healthcare system in which their voice holds little or no influence. Prescriptive authority gave nurses/midwives and patients a voice. RNPs gave examples of advocating on patients' behalf indicating the confidence emerging out of their empowered status and experience in prescribing that prescriptive authority provided them echoing previous work (Stenner & Courtenay, 2008a; Carey et al., 2014; Lim et al., 2018).

Nurses and midwives have a moral obligation to 'call out' poor practice. This is enshrined in our *Code of Professional Conduct and Ethics* (NMBI, 2014). Poor prescribing practice needs to be challenged to enable safety (Dornan et al., 2009) and RNPs are not afraid to do this. Participants in this study demonstrated awareness of the complexity of interprofessional relationships and their role in implementing safe practice, by questioning or debating the prescribing decision making of other healthcare professionals. This required overcoming 'a historically entrenched power differential to speak words of dissension' (Pijl-Zieber, 2013:

143). Their ability to do this arose out of their increased confidence they gained as a result of their prescribing practice (Bradley et al., 2007) and the increased sense of empowerment they held (Ross, 2015). It also suggests that a traditional hierarchal environment, which obstructed assertiveness has largely been dismantled, at least for RNPs. The manner in which RNPs approached a colleague who may have incorrectly prescribed a dose of a drug was non-confrontational and respectful. The positive culture within the organisations described by participants and previously recognised by Nutall (2018) which enabled nurse prescribing to flourish, facilitated honest exchange, meaning that identification of prescribing errors was not taken personally. This is another example of how nurses and midwives have moved beyond that of oppressed groups as one of Young's (1990) criteria for an oppressed group was fear of violence including verbal abuse.

Engagement with the pharmaceutical industry for the benefit of patients is an important activity for RNPs. Though mindful of the professional and ethical imperative to make prescribing decisions without influence of the pharmaceutical industry (NMBI, 2018), there were examples of engagement in order to enhance care provided to patients. These engagements often centred on sourcing the most cost-effective supplies or medicines for patients and developing patient education materials. With little in the way of funding for this activity within the hospital, participants justified this engagement.

As the largest professional group providing healthcare, we must contribute to policy in order to shape how healthcare is delivered in the future. Healthcare staff

can make a significant contribution to policy (Matthews, 2017) and opportunities for nurses to do this is increasing (Weston, 2008). Participants in this study appear to have answered the call of Rafferty (2018) who invited nurses to enhance their participation in policy design and embraced those opportunities identified by Weston (2008). Participants' appointment to hospital committees was an acknowledgement of their enhanced knowledge, expertise and the contribution they can make at an organisational and policy level.

Participation at committee level though is not sufficient to impact outcomes (Crowley, 1998; Murray, 2006). These nurses highlighted they are more than mere participants on committees and have impacted both practice and parameters of practice, acting as agents for change at an individual level and at the level of the professions. Notwithstanding earlier reservations about the limitations of autonomy (see Section 3.4), being agents for change suggests that nurses/midwives are no longer working in an environment in which the cultural imperialism (Young, 1990) of medicine continues to exist as strongly as it did before. The introduction of RNPs to an organisation prompted organisations to revamp and update their prescribing policy for all prescribers. Measures to overhaul the prescribing practices of doctors were introduced as a result of the standards RNPs were required to adhere to. These measures included the requirement to include the doctors' medical registration number on all prescriptions and to prescribe medicines by generic rather than brand name. There still remains a gap though with additional measures in place for nurses. RNPs have also engaged in acts of resistance (Foucault, 1976) with the NMBI

and Department of Health, pushing the boundaries of practice. These have resulted in RNPs being permitted to prescribe brand names drugs in some circumstances. A change in legislation allowing RNPs to prescribe unauthorised medications late in 2018 also challenged the structures in place which restricted practice. As agents for change, participants also contributed to healthcare efficiency, an advantage of nurse prescribing previously reported by Courtenay et al. (2011) and Casey et al. (2020). This sense of contribution to a wider agenda suggests that nurses and midwives recognise the immense value they bring to an organisation, enabled by facilitating them to work to the full extent of their education, training and scope. Through this added value, they are contributing to the enhanced status of the professions and thus contributing to the professionalisation agenda as well as contributing to greater control over the content of nursing and midwifery practice, an element of autonomous practice (Manojlovich, 2007).

Barriers exist to nurses and midwives being fully agentic and both the findings of this study and research published previously confirm this. Situations were highlighted that suggested the hospitals involved did not always operate in a way that facilitated agency and the ability to act freely (Kangon, 2014). Prescribing is a complex activity with Sutherland (2019) identifying 30 subtasks involved in one episode of prescribing in a paediatric intensive care unit. This complexity and subsequent cognitive burden can lead to prescribing errors which are quite prevalent in hospital settings (Simpson et al., 2004; Lewis et al., 2009; Franklin et al., 2011). Difficulties around administering drugs and interruptions are well

cited (Westbrook et al., 2010; Raban & Westbrook, 2014; Bower et al., 2015; Blignaut et al., 2017). Interruptions are also linked to prescribing errors (Sevdalis et al., 2014) and these were also a factor for some participants in this study who experienced interruptions from colleagues. Given the potential for error due to interruptions and in the case of prescribing for these errors to be potentially catastrophic, the use of non-interruption zones (Anthony et al., 2010) or the sterile cockpit (Federwisch et al., 2014) are advocated. In this study, unless the RNP felt they could prescribe safely then they didn't. Whilst nobody could dispute that this is the correct course of action, we must look at why the interruptions occur.

For years, inadequate levels of staffing have received national attention (Irish Nurses and Midwives Organisation, 2012; Cullen, 2016; Wall, 2018b) with the recognition that staffing levels within Irish hospitals are insufficient. Added to this challenge is that not every nurse or midwife on duty holds prescriptive authority. Another burden on the workload of RNPs was when they were asked to prescribe for a colleague's patient and felt unable to say no. Though this may have been a result of fear of conflict (Lennon & Fallon, 2018) one participant reported that it was because they put themselves in the shoes of the patient that they felt unable to say no. This resulted in time away from their own patient group. With safe staffing levels linked to mortality and morbidity (Aiken et al., 2014) if we continue to increase the workload on RNPs, it may become unsafe for RNPs to exercise their role. These elements of poor staffing and interruptions resulted in increased burnout, which resulted in RNPs not using their prescriptive authority. Though the role out nationally of the safe staffing framework (Department of Health, 2018)

should create a safer environment, RNPs will only be able to provide an enhanced level of care using their prescriptive authority if the numbers of RNPs are increased. Participants noted that when the numbers of RNPs in a given area increased, the workload of individual RNPs decreased. Workload and the associated documentation and assessment did not seem to be such an issue for those RNPs working in a specialist or advanced practice capacity and in fact, served to streamline their work. This may be because they were already undertaking this level of assessment and documentation as part of their role. As specialists, they are working within a narrow scope of practice and therefore are not being called on to prescribe for colleagues. This indicates that more effort needs to be made in supporting the agency of those working in general areas for whom workload, interruptions and burnout were an issue.

Participants in this study also identified physical challenges associated with the work of prescribing which they considered important (Hobson et al., 2010). Lack of sufficient computers or printers and lack of physical space to conduct consultations limited or hindered RNPs ability to engage in prescribing decision making in the manner, which they believed to be appropriate. Though Lockwood and Fealy (2008) identified fear of litigation as a barrier to prescribing in previous work in Ireland, this issue was not raised within this study. However, given that some participants explained how they referred patients onto their medical mentor even when there was no absolute need due to their fear of making a mistake (Maddox et al., 2016), fear of litigation may have been in their minds.

The significant increase in workload (Lockwood & Fealy, 2008; Watterson et al., 2009; Lennon & Fallon, 2018), particularly for those practicing in general areas such as antenatal and delivery, resulted in a reduced number of prescribing decisions actually undertaken by RNPs. The additional workload was expressed in terms of assessment and documentation and though it would not be considered safe practice, it was often quicker for the RNP to ask a doctor, who would not necessarily assess the woman or document the decision other than in a drug Kardex, to prescribe a certain drug. Though Creedon et al. (2014) outlined similar 'workarounds' the experiences of the majority of participants in this study do not mirror those of Creedon et al. (2014: 599) who suggested that RNPs were a 'disenfranchised, overworked and undervalued group of staff'. In fact, participants in this study expressed feelings of pride in holding prescriptive authority, affirming previous findings (Romero-Collado et al., 2014; Lennon & Fallon, 2018). They recognised their prescriptive authority as momentous for patients in terms of care they could receive from RNPs and for themselves as practitioners in terms of empowerment and responsibility. Other challenges in relation to maintaining competence have been addressed in the section on empowerment and the influence of other nurses and midwives, in the section on identity.

8.4 Highlighting the educational contribution of the research

Education is a prevalent theme throughout the findings but given the interwovenness of education and nursing it made sense to analyse the findings in relation to education through the other major themes. In the interest of

highlighting how important it is though and what this research adds in terms of our knowledge about nursing education and in particular about education and nurse/midwife prescribing, I will bring together the main points with regards to education here.

Firstly, postgraduate education facilitates the development of the professions of nursing and midwifery and individual practitioners through broadening scope of practice. Education can empower individuals to be more autonomous in their practice, reducing the monopoly held by the medical profession over certain activities such as patient assessment, prescribing and discharge. This in turn can lead to increased status within organisations and can increase the promotional opportunities for individuals.

Secondly, educational preparation for the prescribing role is important and valued by participants. Postgraduate educators play a role in the socialisation of nurses and midwives to the prescribing role and situated learning theory (Lave & Wenger, 1991) is an appropriate model for postgraduate nursing/midwifery education. However, the way in which it is facilitated and who may be the most appropriate professional to support learning in practice needs to be considered. Opportunities facilitating CPD are *ad hoc* in nature and a more formalised approach addressing the CPD needs identified by participants needs to be undertaken.

Finally, nurse/midwife prescribing is both facilitated through interdisciplinary learning but also acts as a facilitator of interdisciplinary learning. The practice of

nursing/midwifery is a continuous learning opportunity but also prepares practitioners for both informal and formal teaching roles.

8.5 Limitations of the research

All research has limitations. These may be in relation to the scope of the research or to methodological issues. They may also be in relation to the power relationship between participants and researcher. Naming these limitations reveals my understanding that no universal truths can be claimed to arise out of the research.

A small research sample and a single or limited number of participating sites (16 and two respectively in this study) could be viewed as a limitation to this work. However, the aim of this research was never to make generalisations. Engaging with participants in different settings with experience of the same phenomenon (prescribing) could expand the insights through which to understand the experiences (Polkinghorne, 2005). Beven (2014) acknowledges that research in the phenomenological vein often involves multiple interviews with each participant with each interview having a different focus. It could also be argued that since I only interviewed participants on one occasion that I was only obtaining their experience at a particular time. Had I met with participants again, I would perhaps have gained greater insight into their experiences and developed a more collaborative relationship with them. However, lack of time and availability of participants did not permit additional interviewing but I countered this by providing an opportunity for participants to review their transcripts for accuracy and completeness (Lincoln & Guba, 1985) and amend if necessary. I also took this

engagement as an opportunity to ask any additional questions I had omitted to ask during the interview or to seek clarification or expansion on a point made by the participant during our conversation.

An ethical concern in research and in particular qualitative research, is the power differential between researcher and participant. This is most often viewed as the researcher having power over the participant. Very often in qualitative research, and it was the case during the conduct of this study that the researcher asks participants to reveal experiences from their life, but reveals little of their own. Inherent within the privileged position of the researcher is the capacity for the researcher to abuse their position in many realms such as selection and recruitment of participants, data collection and reporting of data. A number of processes were put in place throughout the conduct of the study to minimise the potential for power influence and these have been detailed within this chapter. 15 of the participants knew me in my role of programme director for the nurse prescribing education programme. My style of teaching and facilitation is one in which not only do I encourage sharing of information by students but I also share aspects of my life with students lending authenticity to our interactions, potentially decreasing the power differential (Dickson-Swift et al., 2006). Therefore, I was not a stranger to them and feel that they knew some of who I was. It is likely that the information participants shared with me was influenced by their previous interactions with me and their perception of me (Richards & Emslie, 2000). Equally the existence of the pre-existing relationship between myself and participants may have influenced their decision to participate and may have

facilitated sharing of their experiences in a way which would not have happened had they not known me (McConnell-Henry et al., 2010).

It is important too to look at this power differential from the opposite perspective. Though the research was initially guided by my own interest in the field, the interview approach which was semi-structured allowed the issues of concern or interest to the participants to be made known. I felt myself to be very much the outsider, studying up (Nader, 1972), immersing myself in the lives as told by the participants, of which I have no first-hand knowledge. This effectively put the research participants in charge. Another noteworthy point to make in terms of limitations is that even though this research concerned nurses and midwives' experiences of prescribing, the vast majority of participants were practicing as midwives and not nurses. With little written specifically about midwife prescribers in the literature, apart from Small et al. (2016), the literature review and discussion reflect on and draw from the nursing literature.

8.5 Conclusion

In this chapter, I have discussed the findings of the research, which explored the experiences of RNPs in the maternity setting. These findings have been examined and discussed in the context of empowerment, identity, professionalisation and agency. In summary I have argued that empowering nurses and midwives to enhance their practice is a positive move for the professions. Prescriptive authority plays a role in empowering practitioners to be more autonomous however, work needs to be done which creates the conditions which maximise autonomous practice. Some critics may disagree with this

perspective though as some findings suggest that when nurses and midwives take on prescriptive authority they may in fact be co-opted to do the work of doctors rather than becoming autonomous. The CPA has been considered with respect to disciplinary power and its recent removal from a regulatory perspective is be welcomed given nurses and midwives' self-regulation and existing mechanisms for monitoring practice. Prescriptive authority can contribute to enhanced agentic capacity, an improved professional identity and the professionalisation of nursing and midwifery. A number of factors that influence the degree to which each of these can be achieved have been identified and discussed. These factors suggest that further work needs to be done in terms of recognising the contribution nurses and midwives make in an enhanced role whilst at the same time ensuring safe conditions for practice. The limitations of the research have also been acknowledged. In the next chapter, I will summarise this thesis and reflect on my own journey of continuing professional development as a researcher. I will outline the implications of my findings for research, education and policy development in the area of expanded practice for nurses and midwives and make a number of recommendations in these areas.

CHAPTER 9 REFLECTION, CONCLUSION AND RECOMMENDATIONS

9.0 Introduction

This qualitative research study explored the experiences of nurse and midwife prescribers (RNPs) in the maternity setting with the aim of generating practitioner-based knowledge with the potential to inform education and research, policy and practice. The research was guided by the following questions:

What does it mean to be a nurse/midwife prescriber?

How does the experience of being an RNP fit with the prescriber's sense of being a nurse or midwife?

What influences the experience of being an RNP?

How does prescribing influence interprofessional relationships and the development of the profession?

16 RNPs from two maternity hospitals working across a variety of clinical settings participated in one to one semi-structured interviews. Participants' prescribing experience ranged from four months to nine years and they were practicing at manager, specialist or advanced levels. Four were not prescribing at the time of interview. Exploration of the experiences of RNPs was guided by hermeneutic phenomenology which aimed to interpret rather than describe the phenomenon of being an RNP. Data were coded and thematically analysed. The research suggests that prescriptive authority can contribute to the empowerment of nurses and midwives, though a number of factors that determine the extent to which they can be empowered were identified. Findings also propose that professional

identity is enhanced when nurses and midwives can prescribe and that prescriptive authority contributes to the professionalisation of nursing and midwifery through the enhanced status it affords practitioners. Participant experience also highlights that holding prescriptive authority increases their overall capacity to act agentically which was expressed in different ways, including enhanced care and advocacy. However, numerous challenges to this were described including; workload, interruptions, burnout and physical barriers such as lack of space. Though findings mirror some of those previously published within nursing settings, this research is the first known to address the experiences of prescribers working solely in the maternity setting. This chapter outlines the implications of the study for research and education, practice and policy and recommendations in each of these areas are proposed. This chapter and dissertation draw to a close with a personal reflection on the doctoral path I have undertaken and I articulate how my practice has changed as a result of this work.

9.1 Implications and recommendations arising out of the research

In my opinion, the findings which emerged from the research have significant implications for research and education, practice and policy and I propose a number of recommendations. Not only does learning arising out of the research have implications for nurse/midwife prescribing but it may also assist educators, managers and policymakers preparing individuals and organisations for the adoption of other new roles within healthcare settings.

9.1.1 Research and education

This research explored in-depth, the experiences of RNPs in two maternity settings. Though learning from this research may be transferable to other settings, the organisations in which this research was conducted were small in nature with a unique focus. Both organisations have a long-standing interest in nurse/midwife prescribing with one involved in the pilot programme in 2003 and the other at the forefront of driving the initiative in 2006/2007. These factors may significantly influence the experience of RNPs and extending this research countrywide to all clinical settings in which RNPs are practising would provide a national and clinically wide view of their experiences. Dissemination of this additional insight could facilitate the introduction of RNPs at an organisational level and facilitate the establishment of specific structures and processes required in individual practice settings, to support RNPs in practice. Though this research sought to explore the experiences of RNPs only, no healthcare practitioner acts within a silo. Additional layers of understanding of the role of RNP may also be unveiled if the experiences of doctors, pharmacists, hospital managers and women being cared for by RNPs are sought. The experiences of nurses/midwives undertaking the education programme preparing them for prescriptive authority has implications for the delivery of the programme in the future. I have already instigated changes at a classroom level with respect to teaching approaches and allow exploration of the realities of the new role of prescriber. These are addressed in more detail in the reflective section of this chapter. Providing space for students to consider the nature of professional practice and supporting them in developing their capacity is an approach

recommended by Wilson (2000). Given the recognition by some participants of the benefit of having a wide pharmacological knowledge that extends outside their immediate scope of practice, the delivery of a broad generic pharmacology module should be continued. The findings of this study have major implications for the future of the mentorship aspect of the programme. All participants considered this to be an important aspect of the programme but their experiences of it as an effective learning mechanism varied. Consideration should be given to alternative models of mentorship. One approach would be to identify the most appropriate person to mentor a student prescriber on an individual case by case basis…this may well be a doctor or it may be an RNP. Another approach would be to have when appropriate and feasible, a co-mentorship approach in which a student prescriber is mentored by both a doctor and practicing RNP. Adopting either of these approaches would contribute to meeting the clinical learning requirements of the programme.

The research also suggests areas in which those of us planning continuing professional development (CPD) activities for RNPs should concentrate on. The provision of refresher courses on pharmacology should be considered. This will counter the experience of practitioners forgetting certain knowledge when they are not using it. It will also go some way to addressing the concerns expressed by those who felt that the use of the electronic health record (EHR) held significant safety concerns. Audit was another area in which participants outlined less than ideal practices. The theoretical and practical aspects of auditing need reinforcement during initial preparation for the prescribing role. Subsequent CPD

activities in relation to auditing should be available to RNPs, so they are able to fulfil their professional responsibility to audit their practice and subsequently use the insights gained for learning and professional development.

9.1.2 Practice

Participating in research can be a transformative process. Whilst engaging with participants allowed them to tell their stories, the dialogic exchange during our conversations allowed participants who were not currently prescribing, to become aware of the potential for prescribing within their new role. Though I am not aware if any have actually re-engaged with prescribing, the first step to that is becoming aware of the potential. Nursing and midwifery practice is continually evolving, the introduction of nurse/midwife prescribing being testament to that. The findings of the research presented within this thesis point to significant implications for practice. It was clear that the standard of prescribing practice in terms of assessment and documentation were superior amongst RNPs than other prescribers. Organisations introducing nurse/midwife prescribing should embrace the opportunity nurse/midwife prescribing brings to upskill and ensure adherence to good prescribing practices by all prescribers. Participants in the study recognised the informal support they sought and provided within the RNP community within their organisation. Given the importance of this peer support and the noted benefits of a community of practice (Wenger, 2000) more formal processes should be put in place to ensure that all RNPs have access to this support mechanism. Though many colleagues and patients are aware of the role and scope of the RNP there are some who are not or who actively discourage

the prescribing practice of RNPs. Activities should be undertaken which clearly demonstrate the RNP as an expanded practice role of nurses/midwives and not that of a mini doctor. The information gained about the empowerment and agency that prescriptive authority affords may also encourage more nurses and midwives to take on the prescribing role. The importance of auditing prescribing practice should be reinforced at an organisational level and supports put in place to ensure that adequate auditing occurs.

9.1.3 Policy

Much of what we as healthcare practitioners practice or teach is driven by policy. Certainly, some of the implications and recommendations identified above such as reviewing the mentorship model would need to be supported by a policy change at a regulatory level. The insights gained from RNPs can contribute to policy changes at national and organisational levels, that are well informed.

Engaging in the practice of prescribing decision making was viewed as a vehicle for learning on the part of the prescriber. Given the Government's commitment to increasing the number of advanced practitioners (Government of Ireland, 2017) consideration should be given to making prescriptive authority and prescribing experience a prerequisite to undertaking an advanced practice role or the educational preparation for advanced practice. A number of challenges to prescribing practice have been identified in this research such as interrupted care and burnout and excessive workloads leading to non-use of prescriptive authority. Though increasing the numbers of RNPs has always been an agenda item for the HSE at a national level, the numbers of RNPs at an organisational

level are increasing slowly. During the recession Directors of Nursing and Midwifery were engaged in a firefighting exercise with inadequate staffing levels and poor staff morale. Though nurse/midwife prescribing continued to be promoted, it was perhaps not top of their agenda. In light of an improved economy and the safe staffing framework (Department of Health, 2018) increasing the numbers of RNPs needs to be revisited and promoted at an organisational level as this research found that increased numbers of RNPs result in less interrupted care and decreases the workload of RNPs. With the increasing knowledge that is emerging about nurse/midwife prescribing, it may also be prudent for developing countries, where resources are limited, to explore the introduction of nurse prescribing (Badnapurkar et al., 2018).

Mixed views in relation to the value and appropriateness of the Collaborative Practice Agreement (CPA) were expressed by participants. Those who felt that it was excessive and an insult to their autonomy are probably quite pleased that the regulatory requirement to hold a CPA has been removed. Individual organisations are now responsible for putting in place local arrangements for governance. It is unclear how onerous or restrictive these will be and whether they will be sufficiently supportive for RNPs who valued the original CPA in terms of focusing practice and acting as a protective mechanism. Guidance from the HSE in terms of policy is expected and should go some way to alleviate concerns and standardise practice.

9.2 Contribution of the research

In addition to providing direction for further research and education, practice and policy, this research makes a significant contribution to what is known about nurse/midwife prescribing. No previously published work has specifically focused on the role of nurse/midwife prescribing in the maternity setting and the findings go some way towards addressing this gap. The findings provide a rich account of how prescriptive authority can empower practitioners, enhance their identity and their capacity for agency. The contribution prescriptive authority makes to the continued professionalisation of nursing and midwifery has also emerged. What is particularly illuminating though are the factors that can influence the extent to which empowerment, identity and agency can be achieved and these have significant implications for the continued roll-out of the initiative.

Dissemination of work undertaken as part of this Doctorate has already begun. A number of presentations have been made at various nursing and education conferences including the RCSI International Education Forum, 2018 and RCSI Faculty of Nursing and Midwifery Annual Research and Education Conference 2019. Findings from the thesis have also been accepted for presentation at the Nurse Education Conference, NETNEP 2020, to be held in Barcelona in December of this year and a paper focusing on prescriptive authority and care has been accepted for publication in the Journal of Prescribing Practice. Further publications are planned with one focusing on empowerment and another on educational preparation for the role and CPD.

9.3 Reflections on the research process

During the Summer of 2017, following completion of the first year of this doctorate, I walked part of the Camino de Santiago with my husband. This was a celebratory event as we wanted to recognise 20 years of marriage by doing something symbolic. The more I think about it, the more that trip has become a symbol of my undertaking this doctorate. Great planning was initiated. Choosing the best route for us, one that was both challenging but doable was akin to the research I embarked on when deciding where I would undertake my doctorate. My fascination with online forums and the tips and tricks provided by others who had previously walked the same route as we planned, was in ways similar to how I felt when seeking out others who had undertaken doctoral work at Maynooth University and particularly those in education. Packing and repacking of rucksacks (which we were going to carry ourselves for the duration), the doubts that crept in about whether we were carrying too much or too little and whether the boots 'would hold', were comparable to the feelings I had when I was accepted onto the doctoral programme and began to wonder whether I 'would hold'!

Despite all our research before the trip, nothing, neither the insights gained from others who had gone before nor the agonising I undertook with regards to the packing would have prepared me for the experience itself. The beauty and lushness of the Pyrenees though previously seen in photos and online videos was overwhelming and something to be experienced rather than spoken about. The inner peace and calmness that came from walking companionably for hours on end, sometimes in silence, again is something that cannot really be described

but experienced. The conversations with strangers from New Zealand, Croatia, Australia, America, France and many more places were illuminating. The stories they told and the experiences they shared added another layer to our 'experience' of the Camino. Similarly, the research I embarked on before commencing my doctorate, whilst useful to a degree, did little to prepare me for the doctoral experience. Rallis and Rossman (2012) speak of the capacities required for the journey to becoming inquiry minded as learning the craft of qualitative research, learning the language and practical wisdom. My experience as a nurse and clinical reasoning which Benner (1984) suggests is a form of practical wisdom, along with my experience on research ethics committees probably helped in this regard. It was perhaps the challenge of learning the language which was one of the most difficult times. The intense head wrecking frustrations whilst trying to 'position' myself were new to me as someone who normally felt quite 'in control'. Little did I know at the beginning that they were to become my constant companions! The joy of the light bulb moments when I wanted everyone to know I had a breakthrough! The friendships that emerged from shared experiences was not something I had given much thought to prior to the doctorate but realise now were always going to be key to my completion. I have come to realise and understand both through the Camino and throughout this doctorate, how important experience is. How interaction builds and influences experience and that it is how we experience that brings meaning to us.

This doctoral undertaking has had a profound experience on me as a nurse researcher and nurse educator. It has forced me out of my comfort zone. Initially,

I didn't feel it necessary to write about power and agency but through the learning arising out of the reflexive processes undertaken throughout the course of this doctorate, I came to realise how they were central themes of the work. My eyes have become open to new research opportunities and ways of undertaking research. Though the journey of this particular piece of work has come to an end, it is likely as it was with our Camino de Santiago trip that I will revisit elements of it as time goes by. Certain parts will require revisiting in order to seek additional experiences and understanding. Once I have been satiated by the French Way of the Camino I expect I will use the knowledge and experiences gained to embark on other Camino paths, just as I will use my research experiences to date for future research work.

My role as a nurse educator has also been impacted. I am much more attuned to classroom dynamics as a result of one of the participants describing their intimidation in the classroom. I am more proactive in asking students to name their professional world within the classroom setting and in having other students and myself acknowledge those different professional worlds and the richness they bring to the learning environment. Whereby I would always have encouraged and facilitated a collaborative classroom, I realise now that this was tokenism. The exposure I have had to the teaching and facilitative style of the Department of Adult Education at Maynooth University has allowed me to become a more confident teacher and facilitator within my own professional role. Rather than filling the classroom time with content to be covered and discussed, I allow more time and space for true dialogic education to take place (Freire, 1972). My

experience of being supervised has also impacted on the type and way in which I provide feedback to students I encounter in my professional role. In the past when providing feedback to students it was very much in the vein of this is what you need to do to improve this piece of writing or this is what you need to do to pass a failed assignment next time round. I am now much more inclined to stay true to the principles of adult education (Knowles, 1984) and pose questions, facilitating students' own examination of the work and ownership of it.

Of course the findings of this research have impacted hugely on the teaching of prescribing students. Issues of professional identity and collaborative practice are actively discussed in the classroom setting. The challenges within practice identified by the participants are explored enabling students to be more prepared when they find themselves in their new prescribing roles. I am also now more aware of the potential for prescriptive authority to contribute to the ability to act agentically and have included time within the education programme to explore how barriers to agency can be overcome and how agency itself can be maximised.

The process of conducting this research has been an act of CPD for me and my personal contribution to the continued professionalisation of nursing and midwifery. My methodological approach, supported by Vygotsky's social development theory (Vygotsky, 1978) where both I and the participants collaborated to develop meaning out of the activity was in congruence with a social constructionist position. This social, collaborative and interactive approach

is also an expression of learning through active participation supported by Lave and Wenger's situated learning theories (Lave & Wenger, 1991).

9.4 Conclusion

This doctoral thesis has mapped the research which explored the experiences of 16 RNPs in the maternity setting in order to generate practitioner-based knowledge with the potential to inform education and research, policy and practice. What has emerged from this phenomenologically inspired study is a rich account of the practice and experiences of RNPs in the maternity setting. The introduction of prescriptive authority was an important point in the professionalisation of nursing and midwifery, being both as a result of and a contributor to this process. It is clear from the accounts of practice articulated by the participants in the study that they are practicing in a collaborative interdependent way with other healthcare professionals such as doctors and pharmacists. Rather than these relationships being hierarchal with one profession dominant over another, these relationships are empowering for individual nurses and midwives and the professions themselves. Empowerment is also influenced by educational preparation and legislative and regulatory provisions. Prescriptive authority also enhances professional nursing/midwifery identity within this interprofessional environment. Though prescriptive authority has enhanced and complimented the practice of nurses and midwives, facilitating a more agentic practitioner, challenges have been identified. These challenges can be addressed through the recommendations made within the thesis for research and education, practice and policy. The research 'Camino' I have

undertaken has, like the Camino de Santiago been full of rich experiences. The experiences have been shaped by my interaction with others and the environment in which I found myself. I am emerging with a sense of self which now includes researcher, with a more finely tuned awareness of myself and others.

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APPENDIX A RESEARCH ETHICS COMMITTEE APPROVALS

Royal College of Surgeons in Ireland
The Research Ethics Committee
121 St. Stephens Green, Dublin 2, Ireland.
Tel: +353 1 4022205 Email: recadmin@rcsi.ie

RCSI
ROYAL COLLEGE OF SURGEONS IN IRELAND
COLÁISTE RÍOGA NA MÁINLEÁ IN ÉIRINN

21st February 2018

Ms Chanel Watson
RCSI School of Nursing and Midwifery,
123 St Stephen's green,
Dublin 2

Ethics Reference No:	REC1522 (accepted from Hospital,)
Project Title:	Exploring the experiences of nurse/midwife prescribers in the maternity setting
Researchers Name (lead applicant & PI):	Ms Chanel Watson (RCSI School of Nursing and Midwifery).
Other Individuals Involved:	Dr Camilla Fitzsimons (School of Education, Maynooth University).

Dear Ms Watson,
Thank you for your Research Ethics Committee (REC) application. The RCSI HREC accepts the ethical approval granted by the Hospital, for the research study (details above).

This letter provides approval for data collection for the time requested in your application and for an additional 6 months. This is to allow for any unexpected delays in proceeding with data collection. Therefore this research ethics approval will expire on **9th April 2019.**

Where data collection is necessary beyond this point, approval for an extension must be sought from the Research Ethics Committee.

This ethical approval is given on the understanding that:

- All personnel listed in the approved application have read, understand and are thoroughly familiar with all aspects of the study.
- Any significant change which occurs in connection with this study and/or which may alter its ethical consideration must be reported immediately to the REC, and an ethical amendment submitted where appropriate.
- **A final report will be submitted to the REC upon completion of the project.**

We wish you all the best with your research.

Yours sincerely,

PRIVATE AND CONFIDENTIAL

Ms. Chanel Watson,
Lecturer / Programme Director,
RCSI School of Nursing & Midwifery,
Royal College of Surgeons in Ireland,
123 St. Stephen's Green,
Dublin 2.

08th January 2018

Our ref: **EC 32.2017**

Re: **Exploring the experiences of nurse / midwife prescribers in the maternity setting.**

Dear Chanel,

Just a note to say that the above study has received ethical approval.

Kind regards,
Yours sincerely,

Chairman,
Ethics Research Committee.

10th September, 2018.

Ms. Chanel Watson
School of Nursing and Midwifery,
Royal College of Surgeons in Ireland,
123 St Stephen's Green,
Dublin 2.

Our ref: REC-2018-018 *(please quote this reference on all correspondence)*
Re: Exploring the experiences of nurse/midwife prescribers in the maternity setting

Dear Chanel,

Many thanks for the amended documentation received in relation to the above research. I am pleased to advise that the requirements set out by the Committee in respect of your study have now been met. This being the case, ethical approval for the research is granted and it may now commence.

You are requested to submit a progress report to the Committee in twelve months, and annually thereafter as applicable.
Please advise us by email to when you have completed your research.
We would also like to know when and where you publish or present your results. Please be aware of your responsibilities with respect to the good research practice policies and guidelines, copies of which are available on the Q-Pulse system.

Yours sincerely,

Chairman,
Research Ethics Committee.

MAYNOOTH UNIVERSITY RESEARCH ETHICS COMMITTEE
MAYNOOTH UNIVERSITY,
MAYNOOTH, CO. KILDARE, IRELAND

Maynooth University
National University of Ireland Maynooth

Dr Carol Barrett
Secretary to Maynooth University Research Ethics Committee

28 March 2018

Chanel Watson
Department of Adult and Community Education
Maynooth University

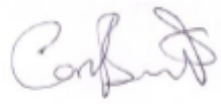
Re: Application for Ethical Approval for a project entitled: Exploring the experiences of nurse/midwife prescribers in the maternity setting

Dear Chanel,

The above project has been evaluated under Tier 2 process, Expedited review and we would like to inform you that ethical approval has been granted.

Any deviations from the project details submitted to the ethics committee will require further evaluation. This ethical approval will expire on 31 March 2019.

Kind Regards,



Dr Carol Barrett
Secretary,
Maynooth University Research Ethics Committee

C.c. Dr Camilla Fitzsimons, Department of Adult and Community Education,

APPENDIX B INTERVIEW SCHEDULE

'Exploring the experiences of nurse/midwife prescribers in the maternity setting'

Interview Guideline

These are the general areas to be explored. It is expected that participant responses will result in some of these areas being explored more deeply. As is the nature of qualitative research, topic areas which I have not identified below may emerge during the interviews which participants which to discuss.

- Tell me about your nursing and midwifery career
- Tell me about how you came to undertake the nurse prescribing course
- Can you tell me about one of the earliest prescriptions you wrote?
- Tell me about your practice since you registered with NMBI as an RNP
- Has your new role impacted on interprofessional relationships in any way?
- Where do you see yourself in 5 years?
- Is there anything else you would like to tell me about being a prescriber?

APPENDIX C INFORMATION LEAFELT AND CONSENT FORMS

PARTICIPANT INFORMATION LEAFLET (Site one)

(Version:1 Date: October 31st 2017)

Study title: Exploring the experiences of nurse/midwife prescribers in the maternity setting

Principal investigator's name:Ms Chanel Watson

Principal investigator's title: Lecturer/Programme Director

Telephone number of principal investigator: 01 402 2706

You are being invited to take part in a research study which is being carried out by me (Chanel Watson) to explore the impact of nurse and midwife prescribing in the midwifery setting.

Before you decide whether or not you wish to take part, you should read the information provided below carefully and, if you wish, discuss it with your family, colleagues or friends. Take time to ask questions – do not feel rushed or under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'.

You do not have to take part in this study and a decision not to take part will not negatively affect you in any way.

You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out and any information you have provided will be destroyed. You do not have to give us a reason. If you do opt out, it will not affect you negatively in any way.

Why is this study being done?

Nurse and Midwife Prescribing was introduced in 2007 and currently there are more than 1000 registered nurses and midwives in Ireland. Much has been written internationally about prescriptive authority in nursing, in specific clinical areas such as dermatology and mental health but no research has looked at the role in the maternity setting. This has resulted in calls to develop a body of knowledge concerning midwife prescribing to advise midwifery education into the future. Additionally, very little is known about the experiences of nurse/midwife prescribers and their practice. Within an Irish context, it has been documented that nurse prescribing positively impacts on the professional development of nurses and midwives but has not articulated how or if this extends beyond an individual's own professional development.

This study aims to explore and examine the experiences of nurse and midwife prescribers in the maternity setting, addressing these gaps.

Who is organising and funding this study?

This study is being conducted by me (Chanel Watson, Lecturer/Programme Director at RCSI) as part of my Doctorate in Higher and Adult Education which I am undertaking at Maynooth University.

Why am I being asked to take part?

All nurses and midwives who are registered nurse prescribers employed at the XXXX Hospital are being invited to participate in this research study.

How will the study be carried out?

I am hoping that approximately 20 nurses/midwives from the organisation will participate in the study which will require each participant to engage in a one to one semi structured interview with me, the researcher. The interviews will take place at a time and place convenient to you and will last no longer than 1 hr. With your consent, the interviews will be audio recorded. Once the interview is over I will transcribe the interview and provide you with a copy of the transcript. At this stage you may review, amend or clarify anything in the transcript.

What are the benefits?

No benefit will accrue to you as a result of your participation in the study. However, your knowledge and experience of how nurse and midwife prescribing has impacted the midwifery setting will be valuable in developing a body of knowledge in relation to nurse and midwife prescribing in practice and advising on midwifery education into the future. I will benefit from the inclusion of the results of this research into my dissertation.

What are the risks?

It is not expected that any harm will occur to you as a result of your participation in the study. You will be required though to make time for the interview.

Is the study confidential?

Data collected will be kept confidential within the limits of current legislation. If during the course of the interviews disclosures of poor practice are made, I will be obliged to bring these to the attention of the hospital administration. Each participant will be assigned a code and only I, (Chanel Watson) will be able to link an individual with a specific code. The code key will be encrypted and stored securely on the shared drive of the RCSI computer system separate from the transcripts. Only I will have access to the audio recordings of interviews. Each interview will be audio recorded and transcribed. You will have an opportunity to review the transcript of your interview to verify accuracy. Once this verification has been completed the audio recording will be destroyed. Transcripts of interviews will also be encrypted and stored securely on the shared drive of the RCSI computer system for 5 years following completion of the doctorate. Only I and my academic supervisor, Dr Camilla Fitzsimons will be able to view the transcripts. Once data collection and transcription of interviews has ceased, all transcripts will be reviewed and thematic analysis undertaken. Following this extensive process the results and subsequent discussion will be incorporated into the dissertation and presented for examination at Maynooth University. Results and discussion may also be presented at national and international meetings and published in peer reviewed journals.

Where can I get further information?

If you have any further questions about the study or if you want to opt out of the study, you can rest assured it won't negatively affect you in any way.

If you need any further information now or at any time in the future, please contact:

Name: Chanel Watson

Address : School of Nursing and Midwifery, RCSI, 123 St Stephen's Green, Dublin 2

Phone No: 01 402 2706 (office hours)

Email: chanelwatson@rcsi.ie

PARTICIPANT CONSENT FORM (Version: 1 Date: October 2017)

Title of Study: Exploring the experiences of nurse/midwife prescribers in the maternity setting

I have read and understood the Information Leaflet about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	*Yes* ☐	*No* ☐
I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I don't have to give a reason for opting out and I understand that opting out won't affect me in any way.	*Yes* ☐	*No* ☐
I am aware of the potential risks of this research study.	*Yes* ☐	*No* ☐
I have been assured that information about me will be kept private and confidential.	*Yes* ☐	*No* ☐
I understand that an audio recording will be made and that I have the right to review and edit any transcripts to which I have contributed.	*Yes* ☐	*No* ☐

I have been given a copy of the Information Leaflet and this completed consent form for my records.	*Yes* ☐	*No* ☐
Storage and future use of information:		
I give permission for data to be stored for possible future research:	*Yes* ☐	*No* ☐
related to the current study subject to research ethics committee approval	*Yes* ☐	*No* ☐
related to the current study only if consent is obtained at the time of the future research subject to research ethics committee approval	*Yes* ☐	*No* ☐
unrelated to the current study subject to research ethics committee approval	*Yes* ☐	*No* ☐
unrelated to the current study only if consent is obtained at the time of the future research subject to research ethics committee approval.	*Yes* ☐	*No* ☐

Participant Name (Block Capitals): _____

Participant Signature: _____ *Date:* _____

To be completed by the Principal Investigator or his nominee.

I the undersigned have taken the time to fully explain to the above participant the nature and purpose of this study in a manner that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

Name & Qualifications (Block Capitals): _____

_____

Signature: _____ Date: _____

2 copies to be made: 1 for participant, 1 for researcher.

Participant Information Leaflet (Site 2)

Study title: Exploring the experiences of nurse and midwife prescribers in the maternity setting

Principal investigator's name: Chanel Watson

Principal investigator's title: Lecturer and Programme Director RCSI

Doctoral student Maynooth University

Telephone number of principal investigator: 01 402 2706

Hospital Contact name: XXXX

Hospital Contact's title: Director of Nursing and Midwifery

Data Controller's/joint Controller's Identity: Ms Chanel Watson

Data Controller's Contact Details:

chanelwatson@rcsi.ie/014022706

Data Protection Officer's Identity: XXXX

Data Protection Officer's Contact Details: XXXX

You are being invited to take part in a research study which is being carried out by me (Chanel Watson) to explore the experiences of nurse and midwife prescribers in the maternity setting.

Before you decide whether or not you wish to take part, you should read the information provided below carefully and, if you wish, discuss it with your family, colleagues or friends. Take time to ask questions – do not feel rushed or under pressure to make a quick decision.

You should clearly understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. This process is known as 'Informed Consent'.

You do not have to take part in this study and a decision not to take part will not negatively affect you in any way.

You can change your mind about taking part in the study any time you like. Even if the study has started, you can still opt out and any information you have provided will be destroyed. You do not have to give us a reason. If you do opt out, it will not affect you negatively in any way.

Why is this study being done?

Nurse and Midwife Prescribing was introduced in 2007 and currently there are more than 1000 registered nurses and midwives in Ireland. Much has been written internationally about prescriptive authority in nursing, in specific clinical areas such as dermatology and mental health but no research has looked at the role in the maternity setting. This has resulted in calls to develop a body of knowledge concerning midwife prescribing to advise midwifery education into the future. Additionally, very little is known about the experiences of nurse/midwife prescribers and their practice. Within an Irish context, it has been documented that nurse prescribing positively impacts on the professional development of nurses and midwives but has not articulated how or if this extends beyond an individual's own professional development.

This study aims to explore and examine the experiences of nurse and midwife prescribers in the maternity setting, addressing these gaps.

Who is organising and funding this study?

This study is being conducted by me (Chanel Watson, Lecturer/Programme Director at RCSI) as part of my Doctorate in Higher and Adult Education which I am undertaking at Maynooth University. No funding to conduct the research has been obtained.

Why am I being asked to take part?

You are being invited to participate in this study as you are a registered nurse prescriber. Nurses and midwives who are registered nurse prescribers employed within a maternity setting are being invited to participate in this research study.

How will the study be carried out?

I am hoping that approximately 20 nurses/midwives from across different organisations will participate in the study which will require each participant to engage in a one to one semi structured interview with me, the researcher. The interviews will take place at a time and place convenient to you.

What will happen to me if I agree to take part?

If you agree to take part, I will schedule a one to one semi structured interview which will take place at a time and venue convenient to you. Each interview will last no longer than 1 hour. With your consent, the interviews will be audio recorded. Once the interview is over I will transcribe the interview and provide you with a copy of the transcript. At this stage you may review, amend or clarify anything in the transcript.

What are the benefits?

No benefit will accrue to you as a result of your participation in the study. However, your knowledge and experience of how nurse and midwife prescribing has impacted the midwifery setting and your practice will be valuable in developing a body of knowledge in relation to nurse and midwife prescribing in practice and advising on midwifery education into the future. I will benefit from the inclusion of the results of this research into my dissertation.

What are the risks?

It is not expected that any harm will occur to you as a result of your participation in the study. You will be required though to make time for the interview which will take no more than 1 hour.

Is the study confidential?

Data collected will be kept confidential within the limits of current legislation. If during the course of the interviews disclosures of poor practice are made, I will be obliged to bring these to the attention of the hospital administration. Each participant will be assigned a code and only I, (Chanel Watson) will be able to link an individual with a specific code. The code key will be encrypted and stored securely on the shared drive of the RCSI computer system separate from the transcripts. Once data collection and transcription of interviews has ceased, all transcripts will be reviewed and thematic analysis undertaken. Following this extensive process the results and subsequent discussion will be incorporated into the dissertation and presented for examination at Maynooth University. Results and discussion may also be presented at national and international meetings and published in peer reviewed journals. Information gathered will not be used in further studies but future research may be informed by the results of this study.

Data Protection

The following points apply to the protection of the data collected from you during this study:

Personal data collected about you will pertain to your experiences of being a prescriber. The legal basis under which your data will be processed is Article 6(1)(f) Legitimate Interests and Article 9 (2)(j) Scientific Research Purposes.

The only person who will have access to the audio recordings and be able to link them and the transcripts to individual participants is me. My supervisor (Dr Camilla Fitzsimons) may also view the transcripts of our interviews but will not be able to link the transcript to an individual participant.

Audio recording of interviews will be destroyed once you have had an opportunity to review the transcript. Transcripts of interviews will be encrypted and stored securely on the shared drive of the RCSI computer system for 5 years following completion of the doctorate.

You have a right to withdraw from the study at any point up until submission of the thesis which is expected to be in February 2020.

If you feel that your data has not been processed in accordance with the legislation you have the right to lodge a complaint with the Data Protection Commissioner.

You have a right to request access to your data and a copy of it

You have a right to restrict or object to processing your data at any stage up until submission of the thesis expected to be in February 2020

You have a right to have any inaccurate information about you corrected or deleted, and this will be facilitated by providing you with the transcript of our interview

You have a right to have your personal data deleted, up until the submission of the thesis expected to be in February 2020

You have a right to move your data from one controller to another in a readable format

No automated decision making or profiling of your data will be undertaken

Your personal data will not be processed beyond the purposes of this study.

Your data will not be transferred to another country.

Where can I get further information?

If you have any further questions about the study or if you want to opt out of the study, you can rest assured it won't negatively affect you in any way.

If you need any further information now or at any time in the future, please contact:

Name: Chanel Watson

Address : School of Nursing and Midwifery, RCSI, 123 St Stephen's Green, Dublin 2

Phone No: 01 402 2706 (office hours)

Email: chanelwatson@rcsi.ie

PARTICIPANT CONSENT FORM

Study title: Exploring the experiences of nurse and midwife prescribers in the maternity setting

Researcher: Ms Chanel Watson Tel: 01 402 2706 E-mail: chanelwatson@rcsi.ie

I have read and understood the Information Leaflet about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	Yes ϒ	No ϒ
I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I don't have to give a reason for opting out and I understand that opting out won't affect me in any way.	Yes ϒ	No ϒ
I am aware of the potential risks, benefits and alternatives of this research study.	Yes ϒ	No ϒ
I have been assured that information about me will be kept private and confidential.	Yes ϒ	No ϒ
I understand that an audio recording will be made and that I have the right to review and edit any transcripts to which I have contributed.	Yes ϒ	No ϒ
I have been given a copy of the Information Leaflet and this completed consent form for my records.	Yes ϒ	No ϒ
I consent to take part in this research study having been fully informed of the risks, benefits and alternatives.	Yes ϒ	No ϒ

I give informed consent to have my data processed as part of this research study.	Yes ϒ	No ϒ

STORAGE AND FUTURE USE OF INFORMATION		
I give permission for material/data to be stored for ***possible future research related*** to the current study ***only if consent is obtained*** at the time of the future research but only if the research is approved by a Research Ethics Committee.	Yes ϒ	No ϒ
I give permission for material/data to be stored for ***possible future research related*** to the current study ***without further consent being required*** but only if the research is approved by a Research Ethics Committee.	Yes ϒ	No ϒ
I give permission for material/data to be stored for ***possible future research unrelated*** to the current study ***only if consent is obtained*** at the time of the future research but only if the research is approved by a Research Ethics Committee.	Yes ϒ	No ϒ
I give permission for material/data to be stored for ***possible future research unrelated*** to the current study ***without further consent*** being required but only if the research is approved by a Research Ethics Committee.	Yes ϒ	No ϒ
I agree that some future research projects may be carried out by researchers working for commercial/pharmaceutical companies.	Yes ϒ	No ϒ
I understand I will not be entitled to a share of any profits that may arise from the future use of my material/data or products derived from it.	Yes ϒ	No ϒ

_____

Participant Name (Block Capitals) Participant Signature Date

To be completed by the Principal Investigator or nominee.

I, the undersigned, have taken the time to fully explain to the above patient the nature and purpose of this study in a way that they could understand. I have explained the risks involved as well as the possible benefits. I have invited them to ask questions on any aspect of the study that concerned them.

_____

Name (Block Capitals) (Qualifications) Signature Date

2 copies to be made: 1 for participant, 1 for PI