Heart and Lungs: Education and Agency in the context of a Pandemic.

An exploration of the experiences of Respiratory Clinical Nurse Specialists and Advanced Nurse Practitioners.

Submitted in fulfilment of the requirements of the Doctorate of Higher and Adult Education Degree (EdD)

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Dedication

This thesis and the research conducted are dedicated to all respiratory nurses, CNSs and ANPs of Ireland in recognition of their enormous contribution to patient care and the healthcare environment. Their commitment to patient care and their drive to enhance education, especially during Covid-19, in what was a challenging time, is astonishing.

You are all amazing.

Abbreviations

A/E	Accident and Emergency
ANÁIL	Respiratory Nurses Association of Ireland
ANP	Advanced Nurse Practitioner
AoMRC	Academy of Medical Royal Colleges
BERA	British Educational Research Ethics (Guidelines)
CDC	Centres for Disease Control and Prevention
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
Covid	Coronavirus Disease
CPD	Continuing Professional Development
DoES	Department of Education and Skills
DoH	Department of Health
DoHC	Department of Health and Children
ERS	European Respiratory Society
EU	European Union
GDPR	General Data Protection Regulation
GP	General Practitioner
HCPC	Health and Care Professions Council
HE	Higher Education
HEA	Higher Education Authority
HEI	Higher Education Institution
HIQA	Health Information and Quality Authority
HPSC	Health Protection Surveillance Centre
HSE	Health Service Executive

ICN	International Council of Nurses
ICRN	International Coalition of Respiratory Nurses
ICU	Intensive Care Unit
IT	Information Technology
ITS	Irish Thoracic Society
MAXQDA	Software for Qualitative Data Analysis
MDT	Multidisciplinary Team
NACNS	National Association of Clinical Nurse Specialists
NCHD	Non-Consultant Hospital Doctor
NCPDNM	National Council for the Professional Development of Nursing and Midwifery
NIV	Non-Invasive Ventilation
NMBI	Nursing and Midwifery Board of Ireland
NP	Nurse Practitioner
OT	Occupational Therapist
PHN	Public Health Nurse
PPE	Personal Protective Equipment
QDAS	Qualitative Data Analysis Software
QQI	Quality and Qualifications Ireland
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCSI	Royal College of Surgeons Ireland
REG	Registrar (Junior Medical Doctor)
RGN	Registered General Nurse
UK	United Kingdom
USA	United States of America

WHO	World Health Organisation
WISH	World Innovation Summit for Health

Abstract

This thesis explores how respiratory nursing expanded its scope of practice at a professional level and at an individual practitioner level in recent years. The introduction of the respiratory Clinical Nurse Specialists (CNSs) and Advanced Nursing Practitioners (ANPs) roles are among the most significant changes in recent years. The timing of this study is significant as the first wave of Covid-19 had just occurred as this research was conducted. Hence, it provides insight into the experiences of a group of respiratory nurse specialists in Ireland as they responded to the first wave of a global pandemic.

Respiratory CNS/ANPs are responsible for educating their colleagues and patients under their scope of practice, significantly expanding their role to include activities which were formerly the remit of medical colleagues. While the expanded role benefits patients and consultants, it also raises issues concerning professional identity formation and education. This research explores how respiratory nurse specialists (CNS/ANP) enhance practice development, generate knowledge-based practice, and contribute to learning, education, and research in the sector.

This qualitative study consists of qualitative online interviews with 15 respiratory CNSs/ANPs about their experiences as respiratory nurses during the first wave of Covid-19. The study is based on a hermeneutic phenomenological approach.

Findings reveal that the respiratory CNS/ANP role enhances and complements nursing practice on an individual and sectoral level, enabling a more agentic practitioner professional identity and education for colleagues and patients. The expanded role raises key issues for professionalism and multidisciplinary teamwork in nursing and nurse education, the positioning of advanced practitioner roles in changing healthcare hierarchies, and the nature of education and knowledge formation in practitioner-based professions. These findings can inform those with responsibility for regulating respiratory CNS/ANP nursing practice and those

responsible for education and research in the nurse context, especially in the context of global changes due to Covid-19.

Chapter 1: Introduction and Background – Professional Experiences of Respiratory Nurse Specialists during the First Wave of Covid-19.

1.0 Introduction to Study

This thesis explores how the respiratory nursing profession has expanded its scope of practice at professional and individual practitioner levels in recent years. The timing of this study is significant as the first wave of Covid-19 had just occurred as I conducted my research. So, it provides insight into the experiences of a group of respiratory nurse specialists in Ireland as they responded to the first wave of a global pandemic. The evolution of nursing practice has been in a continual state of change for practitioners as they respond to the profession's obligation to meet society's changing demands. Respiratory nurse specialists have or are taking on newly expanded practice roles, some of which have previously been the responsibility of other healthcare professionals. These significant changes in the nursing profession reflect how the continual development of knowledge and capabilities is being conceived and balanced among other professions within healthcare.

This study adopts a phenomenological perspective to explore the experiences of fifteen respiratory nurse specialists working in respiratory clinical environments across Ireland through a series of one-to-one semi-structured interviews. They currently work as Clinical Nurse Specialists (CNSs) or Advanced Nursing Practitioners (ANPs). Their knowledge and capacity to teach respiratory care became critical for all medical professionals during the Covid-19 pandemic. This was not the initial intention or context of this research; therefore, the methodology chapter explains how the research design and approach were adapted to respond to this changing societal context. Ultimately, the study presents insights into respiratory nursing specialists' experiences and practices during this unique period, analysing these findings to create emergent knowledge directly from those experiences.

There is little existing research regarding respiratory CNS/ANPs in Ireland which tells their story or captures the benefits and challenges of their experiences. This study set out to give an increased understanding of the experiences of respiratory nursing and contribute to the larger body of literature about the impact of shifts in nursing and medical professional roles and identity. It intends to explore the effect of changing clinical practice within the respiratory healthcare profession and trace their changing work relationships and engagements in multidisciplinary teams. It plans to examine the implications of these changes for nursing education and contribute to developing a body of knowledge concerning respiratory CNS/ANP to advise nursing education in the future.

As the research evolved, the changing context of the first wave of Covid-19 dramatically impacted the work and role of respiratory nurse specialists. Internationally, research has been slow to emerge regarding the role of respiratory CNS/ANP during the pandemic. The Covid-19 pandemic has profoundly impacted nursing and nurse education in higher education and clinical healthcare environments because of nursing's central role in the health and care of patients affected by Covid-19. The hope for this research is to contribute to this gap in research regarding healthcare responses in emergency contexts and potentially inform education, research, and practice policy levels in respiratory care and respiratory nurse specialist professionalisation.

1.1 Statement of Problem and Purpose of Research

The practice of nursing is continually evolving, with nurses expanding their scope of practice to include roles previously undertaken by other medical professionals (Nursing and Midwifery Board of Ireland, 2015). However, realising these contributions are not without their challenges. The literature suggests that role identity can be threatened when roles change and core work activities are lost (Borthwick et al., 2009). Cook and Cullen (2003) argue that the change in respiratory CNS/ANP nursing practice runs the risk of diluting the essence of

respiratory CNS/ANP nursing practice by adopting what was once a medical role with a focus on cure rather than care. This is significant because respiratory CNS/ANP roles continue to evolve, especially during the Covid-19 pandemic. This shifting balance between cure and care goes to the heart of the issues raised by this study as the caring role and practice traditionally associated with nursing becomes interwoven with the focus on medication and treatment associated with medicine.

This study explores how respiratory CNS/ANPs view their profession in this changing context and how their professional identity and interprofessional relations may be affected as their practice expands. The themes of power, change, and agency are identified as central in this exploration of the challenges of achieving practice autonomy in respiratory care.

1.2 Research Question

This research aim is to explore how respiratory nurse specialists (CNS/ANP) experiences enhance practice development, generate knowledge-based practice, and contribute to learning, education, and research in the sector. The following research questions guide the research about the practice of respiratory nursing specialists CNS/ANP from practitioners' perspective.

- *How has the role of respiratory CNS/ANP developed in the Irish healthcare field as a profession?*
- *How do the experiences of respiratory nurse specialists (CNS/ANP) enhance practice development, generate knowledge-based practice, and contribute to learning and education?*

These research questions were studied from a phenomenological viewpoint and changed during the study, especially in the emergent context of Covid-19, outlined in greater detail in chapter four.

1.3 Rationale and Significance of this Study

This thesis emerged from my professional and personal interest in understanding how respiratory CNS/ANPs contribute to society and nursing. I have always been interested in respiratory care from an early age because of childhood asthma. When I became a nurse, I saw and experienced the difference respiratory nurse specialists make in patients' lives.

Being a nurse is important to me and a massive part of who I am. Many definitions of nursing have been devised, which will be explored in later chapters, but personally, the values of nursing are crucial and go deeper than those definitions. Nurses offer a unique contribution to health and healthcare, the essence of which is caring relationships. Previous work has cautioned that when expanded practice roles are undertaken, the caring focus can be diffused or lost (McKenna, 2006), and professional identity is affected. Examining this dilemma is core to my research objective. Maintaining the integrity of nursing and our commitment to core nursing values requires that we retain that caring focus. This thesis set out to explore how the experiences of respiratory nurse specialists (CNS/ANP) enhance practice development, generate knowledge-based practice, and contribute to learning and education.

My professional career has focused on this area. I am currently involved in a respiratory nursing educational programme awarding a level 9 qualification in respiratory nursing for respiratory specialists. I am currently a member of ANÁIL (ANÁIL, 2021) committee (Irish Respiratory Nurse Association), the Irish Thoracic Society and the European Thoracic committee (Please see Appendix H for ANÁIL member breakdown in 2021). I am a committee member of the International Coalition of Respiratory Nurses (ICRN), working on a core syllabus and curriculum for respiratory nursing. I have also contributed to developing the educational requirements, legislative provisions and governance structures required to enable nurses to become respiratory nurse specialists. Hence, as an educational practitioner, I hold

key experience and knowledge of the profession and am centrally involved in developing the sector in the Irish context.

As a nurse educator, I am significantly involved in the educational preparation of respiratory nurses who wish to expand their practice and become respiratory CNS/ANPs. This preparation focuses on supporting these nurses to achieve the competence necessary to take on the respiratory CNS/ANP role.

During my professional experiences, I have observed that nurses frequently underplay their skills and experience in their relationships with other medical professionals. This is supported by research findings, with existing literature linking this devaluation of their work to the lower status of nursing in the healthcare field (Weston, 2008).

Nurses' expert knowledge and experience, as well as the importance of including nurses in policy making and implementation, were recognised in a study released by the World Innovation Summit for Health (WISH) calling for greater recognition of their voices (Crisp, Brownie, & Refsum, 2018). I hope this study will give voice to and draw attention to the role and practices of respiratory CNS/ANPs working in the field of respiratory nursing to ensure that their experiences and knowledge can be used in the future to inform professional practice and educational development.

The specialised respiratory nursing roles of Advanced Nursing Practitioner (ANP) and Clinical Nurse Specialist (CNS) have emerged as expert nursing roles that care for respiratory patients with complex health needs throughout their lifespan in multiple healthcare environments. More details on their distinctive roles are expanded further in section 1.4. Their emergence and position as a professional role are explored in more detail in chapter 2.

Participating in this research was paramount for my development as a practitioner-researcher to bring research capacities into my continuing professional development, as discussed further in the methodology chapter.

1.4 Overview of the Role of Respiratory Specialist Nurses

1.4.1 The Role of Respiratory CNS and ANP

The role of respiratory CNS encompasses a primary clinical focus, which comprises assessments, planning, delivery, and evaluation of care given to patients/clients and their families in hospital, community, and outpatient settings. The role of respiratory CNS delivers care in line with five core concepts defined in the Framework for the Establishment of Clinical Nurse/Midwife Specialist (National Council for the Professional Development of Nursing and Midwifery, 2008b). These core concepts include clinical focus, patient/client advocacy, education and training, audit, research, and consultation. Respiratory CNSs work closely with medical and para-medical colleagues and may alter prescribed clinical options along agreed protocol-driven guidelines. Respiratory CNSs participate in and disseminate nursing research and audits and provide education and clinical practice consultancy to nursing colleagues and wider interdisciplinary teams. Respiratory CNSs have specific roles such as education, promoting self-management strategies, supporting early discharge, and long-term care and management of people living with respiratory conditions (Gibson et al., 2013). They are instrumental in guiding self-management in patients and coordinating integrated care pathways that focus on early diagnosis, intervention, and management of chronic respiratory disease (Rafferty & Elborn, 2004). The progression and expansion of respiratory CNS roles in the Irish Health System are related to innovations witnessed in the UK, USA, and Canada. The role of respiratory CNSs has become a key growth area within nursing and aims to develop the profile of nursing, enhance patient care, and improve healthcare delivery and outcomes.

The role of respiratory ANPs is to promote wellness, offer healthcare interventions, and advocate healthy lifestyle choices for patients/clients, their families, and carers in a wide variety of settings in collaboration with other healthcare professionals, according to the agreed scope of practice guidelines as outlined by (Nursing and Midwifery Board of Ireland, 2015). The core concepts of the ANP role are autonomy in clinical practice, expert practice, professional and clinical leadership, and research (National Council for the Professional Development of Nursing and Midwifery, 2008b). Respiratory ANP roles in Ireland have evolved and expanded in recent years in response to Ireland's healthcare service needs. A clear policy framework for advanced practice nursing exists that is responsive to health service needs and aligns with national nursing health policy (Government of Ireland, 2019) and professional nursing regulation (Nursing and Midwifery Board of Ireland, 2017). Drennan et al. (2009) contend that empowering nurses to have more agency in these roles contributes to more effective care.

Respiratory ANPs use advanced critical nursing knowledge and critical thinking skills to independently provide optimum patient care through caseload management of acute and chronic respiratory illnesses. Respiratory ANPs constitute a level of practice which often includes several diverse responsibilities; they are autonomous, experienced practitioners who are competent, accountable, and responsible for their practice.

As the Irish Government is committed to increased development of advanced practice roles (Fealy et al., 2018), I was intrigued to understand the professional role and education remit of the respiratory nurse specialists (CNS/ANP). I was interested in examining how it enhances development in practice, adds to knowledge-based practice, and contributes to learning and education in nursing. According to Furlong and Smith (2005), there is a clear distinction between the core concepts of advanced nurse practice and clinical nurse specialists. The core concepts of respiratory CNS and ANP are explained below and shown in Figure 1.1. While Furlong and Smith (2005) consider their distinction clear, in practice, there is still overlap in

the roles of respiratory CNS/ANPs, as becomes evident throughout this thesis. However, after a thorough review of the current literature, there is no specific published study on the respiratory CNS/ANP roles conducted in Ireland and a lack of international research on exploring the experiences of respiratory nurse specialists (CNS/ANP) education and professionalism in their clinical health environment. What is presented below gives an overview, from limited literature, of what these roles of CNS/ANPs are currently considered in the Irish healthcare field. Respiratory CNS/ANPs play active roles as clinicians, advocates, educators, collaborators, and health promoters (Lit, Lee, & Chow, 2014). They play a crucial role in developing the profile of nursing, enhancing patient care, and improving healthcare delivery.

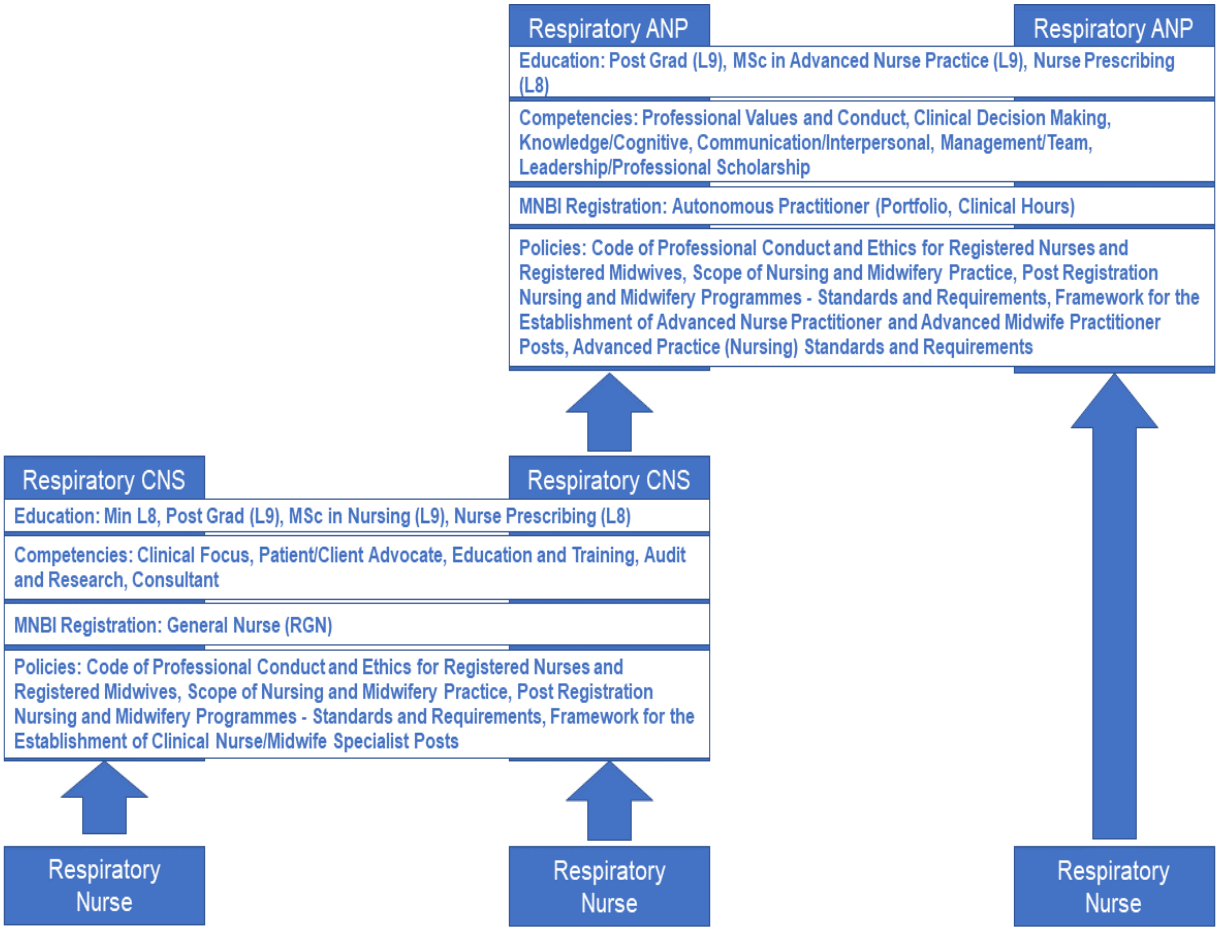

Figure 1.1 Respiratory CNS and ANP Pathways

1.4.1.1 International Perspective

Worldwide, the recognition of respiratory nurses has contributed to improving the quality of patient care outcomes. It is difficult to give a singular overview of the respiratory CNS/ANP role from an international aspect as the role and name differ between countries or regions. European nations have different healthcare systems and nursing laws; therefore, the job of a respiratory CNS/ANP can vary. The European Respiratory Society (ERS) (European Respiratory Society, 2023) provides respiratory nurses and practitioners throughout Europe with educational and research opportunities and gives a good insight into the various terminology of respiratory nurse practice used in Europe. In Spain, respiratory nurses are referred to as rehabilitation nurses; rehabilitation nurses have a different understanding in other European countries. In some European countries, the role differs or does not exist; therefore, it is quite challenging to compare these roles. In Australia, Canada and the USA, the scope and role of respiratory nurses have been well-defined and established. Over the past four decades, specialist and advanced practice roles in nursing and midwifery have expanded rapidly internationally. The ERS documented the involvement of respiratory nurses in the treatment and management of respiratory diseases; however, the roles are not clearly defined. In the European Union (EU), only Denmark, Finland, Iceland, Norway, Portugal, Spain, Sweden, the UK and Ireland have a formal respiratory specialisation for nurses, and the competences and education levels of respiratory nurses vary from one European country to another (Alonso et al., 2020).

The International Council of Nurses (ICN) (International Council of Nurses, 2023) is a global organisation that promotes the nursing profession and offers resources for nurses all around the world. On a global scale, ICN provides useful information on nursing practice and policies in respiratory nursing. In the USA, respiratory CNS and nurse practitioners (NP) are typically the two roles that constitute respiratory advanced nursing practice. The American Association of Critical-Care Nurses (American Association of Critical-Care Nurses, 2023), American

Association of Colleges of Nursing (American Association of Colleges of Nursing, 2023) and the National Association of Clinical Nurse Specialists (NACNS) (National Association of Clinical Nurse Specialists, 2023) work to advance the position of clinical respiratory nurse specialists. The NACNS focuses on promoting and advancing the role of respiratory clinical nurse specialists which is similar to the role of respiratory ANP in Ireland.

World Health Organization (WHO) plays a significant role in shaping the practice of respiratory CNSs and ANPs through its global health policies, guidelines, and recommendations. In 2020, the International Coalition for Respiratory Nursing (ICRN) (International Coalition for Respiratory Nursing, 2023) was formed with the aim to identify disparities in the training and certification of respiratory nurses worldwide and to define a range of minimal educational standards and provision of post-registration training in each country. The ICRN group identified the need to determine the requirement for a respiratory nursing core curriculum. A 39-item survey was sent to 33 respiratory nursing specialists in 27 different countries. Questions were posed regarding present responsibilities, perceived needs, expectations for a core curriculum project, and the presence of respiratory content in each country's nursing curricula. Participants in 30 answers from 25 different countries worked in academia (53.3%) and clinical practice (40%), respectively. Findings revealed that 97% of respondents said that a basic respiratory nursing curriculum is necessary. Internal/medical nursing care is included in post-registration nursing programs at the bachelor's (83.3%) and master's (63.3%) levels; less than half identified discrete respiratory nursing curricula. Respondents to this survey felt that knowledge should make up 70% of the basic educational program, followed by skills at 60% and competences at 50%, with separate content for the respiratory care of children and adults. The survey findings identified significant regional differences in respiratory nursing education, with many countries lacking formal educational initiatives to train nurses to provide higher-quality respiratory care (Šajnić et al., 2022).

1.4.2 Educational Standards and Pathways of Respiratory CNS and ANP

Differences are evident in international practice, specifically regarding the educational standards and pathways for respiratory CNS. In Ireland, respiratory CNS are educated to graduate level 8 and have wide-ranging experience and clinical expertise in the relevant respiratory specialist areas (Health Service Executive, 2011; National Council for the Professional Development of Nursing and Midwifery, 2008b). Many respiratory CNSs continue education to formal specialist post-registration QQI level 9 education programmes in respiratory nursing, generally advertised as entry requirements for respiratory CNS posts in the Health Service Executive (HSE). The postgraduate diploma in respiratory care in nursing is at a level 9 major award educational standard, whereas the prescribing course is a level 8 award. A respiratory CNS will have formally recognised post-registration education relevant to their area of specialist practice at level 8 or above on the NQAI framework (National Council for the Professional Development of Nursing and Midwifery, 2010). The level of education for nurses to be recognised as CNS is a higher/postgraduate diploma, equivalent to a major award at level 8 on the National Qualification Authority of Ireland qualification framework (National Council for the Professional Development of Nursing and Midwifery, 2008b; Quality and Qualifications, 2019). The Nursing and Midwifery Board of Ireland (NMBI) accredit the educational programme.

Such formal education is underpinned by extensive experience and clinical expertise in the relevant specialist area. The Post Graduate Diploma in Respiratory Care in Nursing Practice programme is designed to ensure safe and effective nursing practice by developing the knowledge and competencies necessary for high-level professional practice in respiratory nursing. It integrates theory and practice and completes dedicated learning hours and clinical competencies.

1.4.3 Registration, Specialties and Capabilities of Respiratory CNS and ANP

A respiratory CNS/ANP must be registered on the active register of nurses held by NMBI. While respiratory CNS/ANPs represent the grade of respiratory nurse specialist, a wide range of specialities in different areas define the title and subspecialist title in the field of respiratory nursing care. Respiratory CNS specialise in different areas, for example, integrated care, asthma, cystic fibrosis, emergency respiratory and others. However, currently, this specialism is not the case for the role of respiratory ANP. According to Charbachi, Williams, and McCormack (2012), the CNS role in respiratory nursing remains complex and multidimensional, with many components that can create confusion. They argue that it is crucial to emphasise the role of respiratory CNS and their contribution to practice visibly.

The Nursing and Midwifery Board of Ireland (2017) acknowledges the knowledge, skill and expertise required for respiratory ANPs in caring for respiratory patients with complex health needs throughout their lifespan in multiple healthcare environments. The HEIs provide evidence-based education programmes in line with the standards and requirements that prepare candidate respiratory ANPs with the necessary competencies to register as ANPs (Nursing and Midwifery Board of Ireland, 2017). In 2010, there were many CNSs and comparatively few ANPs in other specialities (Begley, 2010). The first respiratory ANP was registered in 2015. Although there are more respiratory CNSs than respiratory ANPs, there is a drive to advance the number of ANPs in respiratory care in the HSE (Government of Ireland, 2019). Because respiratory CNSs are not on a separate registration division, it was difficult to obtain the number of respiratory CNSs from the NMBI. However, ANPs are registered with the NMBI but not broken down into their specialities; therefore, the current number of ANPs in 2022 was 657 (Nursing and Midwifery Board of Ireland, 2022) across all nursing specialities.

The criteria to become a respiratory ANP requires a nurse to register with NMBI, in the prescriber division, and as an ANP with NMBI. They are experts in clinical practice and

educated to master's level 9, as a minimum, as per the national framework of qualification (National Council for the Professional Development of Nursing and Midwifery, 2007; Nursing and Midwifery Board of Ireland, 2017) with three modules component on the appropriate care (respiratory) advanced practice. An autonomous ANP is accountable and liable for making complex decisions. Alongside other healthcare professionals, ANPs may conduct thorough health assessments and exhibit expert ability in clinical diagnosing and treating acute and chronic illnesses within a collaboratively agreed framework of their scope of practice. Expert practitioners exhibit excellent practical and theoretical knowledge and critical thinking abilities.

Additionally, they exhibit the capacity to explain and defend the idea of advanced practice. ANPs can start and implement improvements in healthcare services in response to patient needs and service demand, making them clinical innovators and leaders. They must be committed to the growth of these areas and have a vision of nursing practice that can be developed outside the current parameters of nursing practice and clinical decision-making (Pirret, 2007), enhancing practice development, generating knowledge-based practice, and contributing to learning.

Nursing audits and research must be initiated and coordinated by ANPs. ANPs identify and incorporate nursing research in healthcare settings where the best evidence-based practice is applied to satisfy patient and service needs. Enhancing the professional status of nursing, such as advanced nursing roles, does not always incorporate the paradigms of nurses from different educational and experiential backgrounds (Keogh, 1997). Hence, the development of advanced roles in nursing to create an advanced contribution to practice, education, research and administration can produce role overlap and confusion (Wall, 2006).

1.5 Impact of Context of the First Wave of the Covid-19 Pandemic on this Research

The Covid-19 pandemic has significantly impacted how things are done in all walks of life since 2020. Because of nursing's central role in the health and care of patients affected by Covid-19 and other illnesses during this time, the pandemic had a particularly profound impact on nursing and nurse education in higher education and clinical healthcare environments. The World Health Organisation (WHO) offered specific guidelines for respiratory treatment and care in response to the Covid-19 pandemic that had to be followed, which were updated and changed regularly. As of March 17, 2020, Covid-19 had been officially declared a pandemic by the WHO. Covid-19 has now spread throughout most countries, causing millions of cases, killing hundreds of thousands of people, impacting health systems and causing socio-economic damage (World Health Organization, 2022). The first case in Ireland was declared on the 29th of February 2020, followed by a rapid increase in reported infections, leading to a peak in daily incidence in the following weeks (Health Service Executive, 2020b).

The Covid-19 pandemic has placed enormous strain on clinical healthcare environments, and nurses working on the frontline have been impacted immensely. Cheng et al. (2020) investigated nurses' emotional responses and coping styles and conducted a comparative study with nursing college students through an online survey questionnaire in February 2020 in China. The results showed heightened anxiety and fear in nursing college students when caring for Covid-19 patients. Cheng et al. (2020) recommended that healthcare organisations focus on providing nurses with psychological support, education, and training in coping strategies. It is also worth noting that the context of this 2020 study was at a time when vaccination programmes were way off in the distant future, and death rates worldwide were increasing daily due to the Covid-19 virus (see Figure 1.2).

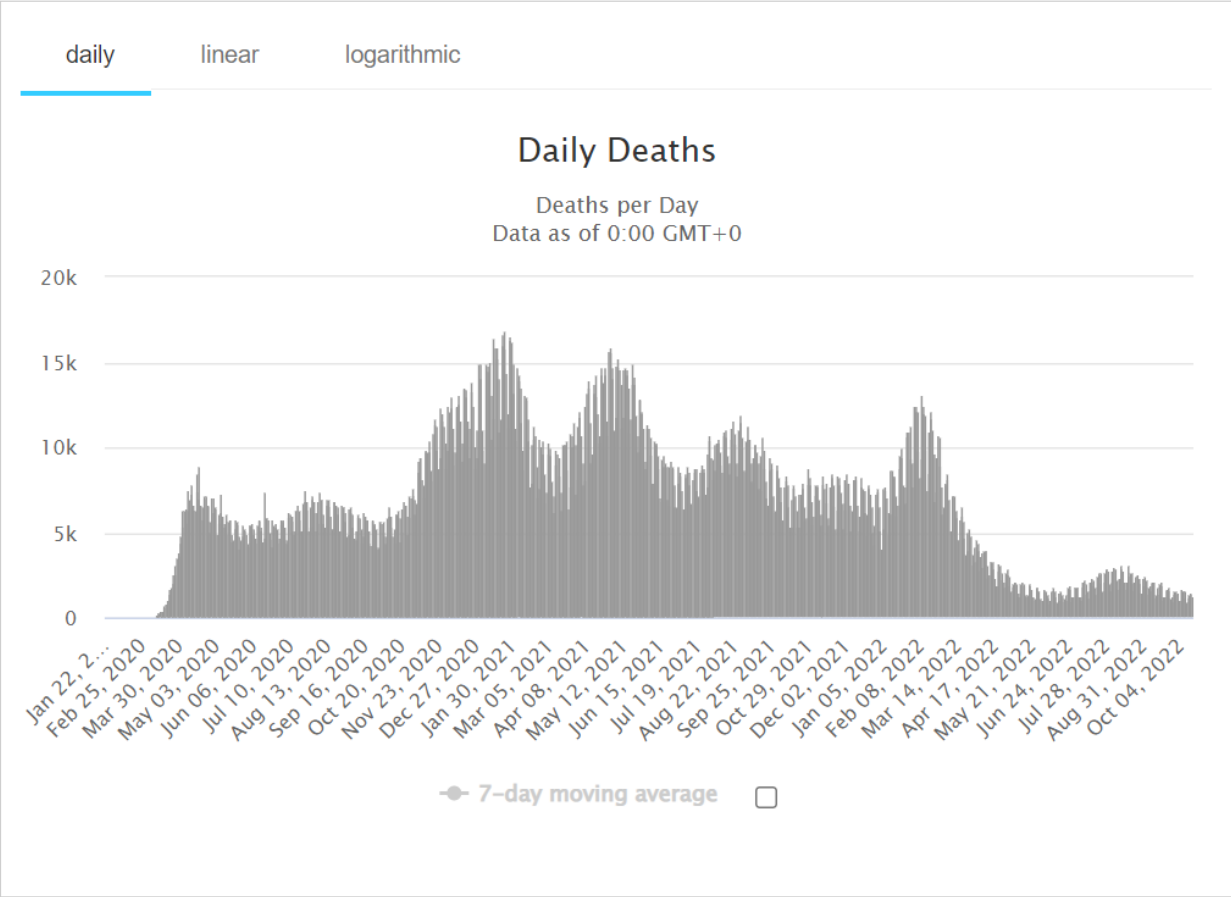

Figure 1.2 Covid-19 Pandemic Worldwide Statistics (Worldometer, 2022)

The Covid-19 pandemic presented a significant and extraordinary public health emergency. This resulted in the need to introduce substantial and strict public health measures to control the pandemic in Ireland and worldwide. The Irish government mandated the closure of all educational settings from 12 March 2020 as part of the government response to contain the spread of Covid-19 (Government of Ireland, 2020). The closures occurred with immediate effect on the day of the government announcement. In Ireland and across the world, Covid-19 epidemic waves, driven by the emergence of new variants of the SARS-CoV-2, have continued their course since then despite various government interventions. Public health interventions continue in their attempts to control the spread as they wait for the planned significant effect of vaccination.

Spring 2020 was a significant period of uncertainty and anxiety in Ireland and worldwide about what would happen next. This was the first major pandemic we, as a society, ever had to deal with in our lifetimes, imposing unusual risks to the physical and mental health and well-being of healthcare workers and the functioning of our healthcare systems. During this crisis, there was a requirement for rapid scaling up of respiratory care and training, while simultaneously, there was the significant impact of Covid-19 restrictions, resulting in a greater need for online and virtual clinics, as well as media input. Cox (2020) noted the media focus on healthcare and the recognition of the degree of personal risk at this time, which exceeds the everyday context of the duty of care for healthcare workers.

Respiratory nurses played a pivotal role in the public health response to the Covid-19 pandemic crisis, delivering direct patient care, educating colleagues, and reducing the risk of exposure to the coronavirus. As a nurse educator in this area, understanding the impact of emergency contexts like Covid-19 on respiratory nursing practice and nurse education is a new concept that had not previously been explored from an Irish perspective. The findings of this research present the responses of respiratory nurse specialists, CNSs and ANPs who were at the frontline of respiratory care and education during this time. The research interviews were conducted during the summer of 2020, towards the end of Ireland's first major societal lockdown.

Many participants were still in an emergency work context when I interviewed them, stretching beyond their normal activities responsible for supporting the respiratory care of their patients and training their colleagues at the same time. The interviews represented the first opportunity many had to reflect and talk about their experiences during this first wave of Covid-19. As such, it means an extraordinary and unique time in Irish healthcare as these respondents experienced and responded to the first major pandemic in their lifetimes and careers. The themes presented in the findings chapters represent the collective experiences and emotions

of these participants working in the immediacy and uncertain context of this first wave of the pandemic in Ireland.

The year 2020 was the 200th anniversary of the birth of Florence Nightingale, whereby the World Health Organisation (WHO) announced 2020 as the year of the nurse and midwifery (Mitchell, 2019). The WHO nominated the year 2020 to celebrate the benefits that nursing and midwifery bring to global health and to highlight the enormous sacrifices and contributions made by all who work and contribute to nursing. The Covid-19 pandemic highlighted the complicated, complex, and demanding work nurses performed in hospitals and the community.

1.6 Organisation of the Dissertation

Following this introductory chapter, chapter 2 reviews the development and current context of respiratory CNS/ANPs' teaching and learning and professionalism. The journey undertaken by the respiratory CNS/ANPs as an emergent profession will be explored along with the relevance of education and expansion of the practice in their roles. The context of the global pandemic of Covid-19 is then outlined, exploring how it impacted expanded practice on the professional identity of respiratory nurse specialists in Ireland during the first wave of Covid-19. My theoretical framework is presented in Chapter 3, drawing on theories of education and professionalism, with elements of different theories incorporated through the thesis as relevant. The theoretical framework gives me a viewing point or lens through which I can view and examine the findings. The theoretical framework helped me interpret the experiences of respiratory CNS/ANPs.

Chapter 4 provides a detailed account of the study's methodology and describes the research design and methods used. The findings and results will be discussed in chapters 5 and 6 according to the two key themes emerging from the research. Chapter 5 explores educational aspects, and chapter 6 presents the study findings concerning professionalism. Chapter 7

discusses my reflections on the findings of this research journey, and chapter 8 concludes the thesis with a discussion on the implications of the findings for education and research, practice and policy and acknowledges the limitations of the research.

1.7 Conclusion

This introductory chapter gives an insight into the research and provides an outline of the role, education, and criteria of respiratory nurse practitioners before discussing the expansion of the practice of respiratory CNS/ANPs that occurred due to the emergence of the Covid-19 pandemic. The research question, including the impact of this changing context, was outlined and followed by a brief explanation of the methodological approach and the rationale for the study. The next chapter, chapter 2, will discuss the respiratory CNS/ANPs in the context of teaching and learning and explore the impact of the pandemic on teaching and learning for respiratory nurse specialists.

Chapter 2: Evolution of Nursing Education and Theories of Teaching and Learning

2.0 Introduction

This chapter explores how the professionalisation of nursing has evolved and opened up new opportunities for nurses to develop the role in which they work (Wall, 2006). It traces the evolution of nursing from being classed as a vocation to its current professional status (Yam, 2004). It explores how the traditional certificate style of nursing education was hospital-based training in practice, where nursing was associated with values of caring and obedience as a vocation, premised in an authoritarian system where the nurses were not to question the knowledge or decisions of doctors and medical staff. This view of nursing hindered the development of the nursing profession from educational, status and financial aspects, where the medical profession had more power and influence than nurses. The following sections of this chapter introduce the nursing career before exploring the historical development of nursing to understand the implication of these shifts in its professional development. This is discussed in various contexts and historical eras to the present Covid-19 pandemic.

Since respiratory CNS/ANPs are the focus of this research, this chapter focuses on their evolution and current practice within this broader nursing field. Professionalisation is seen as enabling respiratory CNS/ANPs to meet the needs of an evolving healthcare service by expanding their scope of practice to include roles previously undertaken by doctors. This is a significant shift in the knowledge and power base of nursing practice as their scope of practice expands to include knowledge and capacities previously considered the sole remit of medical professionals. Carper's (1978) framework of knowing will aid in exploring respiratory CNS/ANP experiences. This integrated, inclusive, and eclectic approach to knowing in the nursing profession reflects the goals of respiratory CNS/ANPs: to provide effective, efficient, and compassionate care while considering individuality, context, and complexity. This chapter

describes the origin and evolution of Carper's (1978) model and applies these 'ways of knowing' as a framework to define and build on what is known relating to respiratory CNS/ANPs. Carper's (1978) fundamental patterns of knowing in nursing have been frequently cited and applied in nursing for over 40 years. This seminal work broadened the understanding of knowledge development in nursing. It offered a framework that recognises and includes the diversity of approaches needed in every aspect of the practice-based discipline of respiratory CNS/ANP. This is combined with insights about knowledge development in education theories.

This chapter explores respiratory CNS/ANPs' professional educational journey undertaken to date to practice on this continuum. It considers the themes of the career and development of nursing, the influence of education and professionalisation in nursing, and the role of practice and power. It also considers the continuing professional development of respiratory nursing, expanding roles and practice. Examining the educational standard of respiratory CNS/ANPs in Ireland gives us a sense of the continuing development of the respiratory CNS/ANP professions through increasing respiratory CNS/ANP knowledge (scientific and theoretical), its practical base and expanding collaborative and reflective practice.

Finally, the context of how the first wave of Covid-19 affected the continuing professional development and education of respiratory CNS/ANPs' expanding practice is explored by drawing on the emergent literature on Covid-19 and healthcare provision literature in emergency contexts.

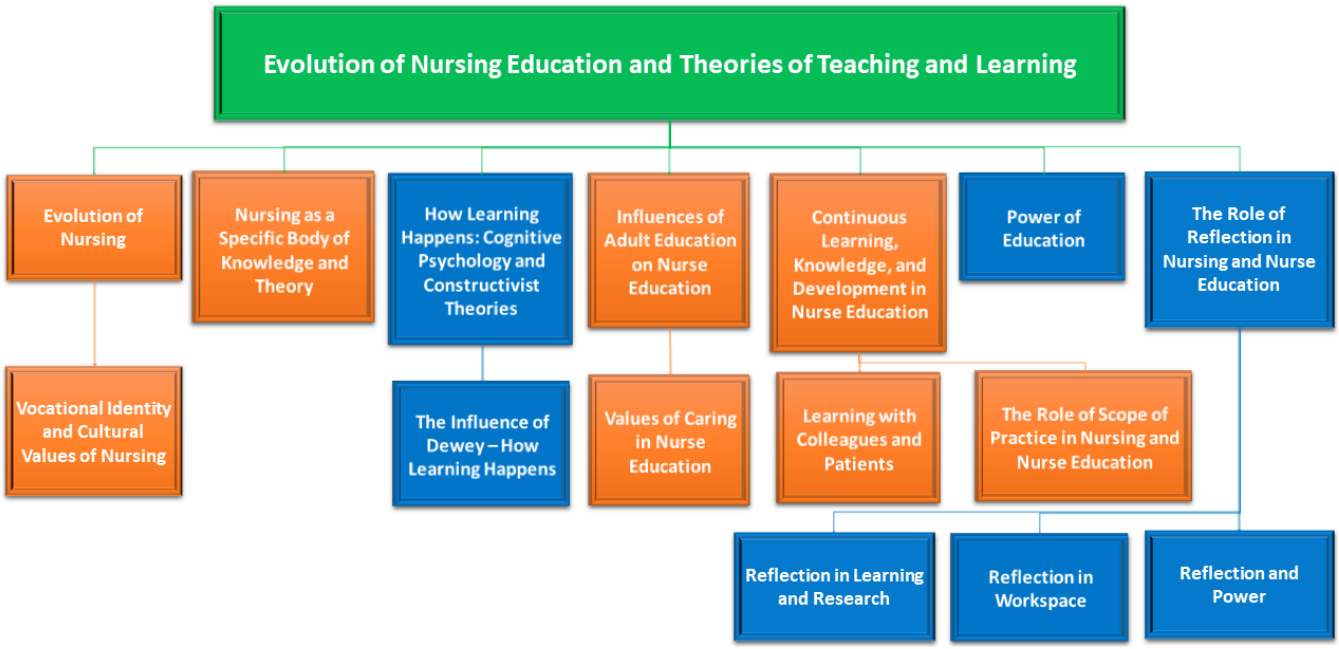

Figure 2.1 Evolution of Nursing Education and Theories of Teaching and Learning

2.1 Evolution of Nursing

When we think of the evolution of nursing, most of us think of Florence Nightingale. Some of us may think of the first African-American nurse, Mary Eliza Mahoney, and here in Ireland, we think of Catherine McCauley. All three women have contributed significantly to the nursing profession. They have all been central in promoting a vision of nursing as a patient-centred and practice-orientated caring profession. Over the years, there have been many attempts to define nursing, from the traditional views of nursing to today's professional nursing definition.

Traditionally, nursing was an apprenticeship-style training program often established by or influenced by a religious institution and mainly attended by young women. Nightingale's (1860) first nursing education book, *Notes on Nursing what it is what it was*, defined nursing as a task-based role with restrictions with a primary focus on sanitation and cleanliness. The curriculum structure was based on learning from experience through nursing practice, tests, and skills. The educators for these nurses were medics, and the education occurred within the

hospital setting and culture. The emphasis on the apprenticeship model focuses on a nurse's on-the-job training rather than university-based education. This model was born from a necessity to provide a workforce for hospitals. However, it has been criticised as curtailing the development of the nursing career as a profession in its own right (Mooney & Nolan, 2006).

In 1904, the National Council of Nurses was established in Ireland from the amalgamation of the Matron's Council of Great Britain and Ireland and the Society for the State Registration of Nurses in Ireland. The Central Midwives Board and the General Nursing Council, founded in 1918 and 1919, were replaced by An Bord Altranais, created by the Nurses Act of 1950. The Nurses Act of 1985 re-established the Board and extended and redefined its duties. The Irish Nurses Union (later to become the Irish Nurses Organisation) was formed in 1919.

Concurrently, in the 1950s, the World Health Organisation formed a nursing education group in Belgium. This group recommended developing an experimental nursing school in each country. This was a significant move that marked the shift of the knowledge and pedagogical basis of nurse education from its own experience and practice-based to an academic and accreditation base in higher education. In the 1960s, the first five-year degree programme was developed in the United Kingdom, and the first educational programme at the degree level commenced in 1974 in Australia. The Irish employment context for women was very different to other countries at this time due to a governmental ban on women working in the public sector and some private companies once they were married, which has existed since 1932 (Foley, 2022). This marriage ban reflected a social and cultural climate at the time that restricted women’s participation in public life, assigning them to the home and (largely unpaid or part-time) caring duties. It was lifted in 1973, significantly later than most other jurisdictions.

Condell (1998) describes how hospitals were established by nursing-related religious orders like the Irish Sisters of Charity, the Sisters of Mercy, with many Catholic nursing nuns in Ireland who taught nursing techniques during this period. While there were advantages to having

religious orders involved in nursing, there were also drawbacks which shaped the future evolution of nursing. For instance, the engagement of religious groups was cost-effective since nuns were willing to accept lower pay than lay nurses. However, in certain circumstances, nuns without formal training diminished the usefulness of training (Condell, 1998). Church involvement also had enormous significance for nursing regarding women's participation and working careers and the gendered association between nursing and caring roles. The gendered caring practices associated with nursing in Ireland were set within a powerful patriarchal culture with legislative and societal backing from the government and church for many decades (Foley, 2022). This has become Ireland's forerunner of contemporary secular professional nursing comparative to other countries. Nursing education in Ireland was still responding to these changes whilst also trying to become more professionalised during the intervening decades.

Benner's (1984) development model of nursing from novice to expert status is influential in the traditional apprenticeship model of nurse education, including in my nursing. According to Benner (1984), the novice has no prior experience of the situation from which to draw. This applies to students and experienced nurses acquiring new clinical skills and knowledge. It is a model of nursing where clinical expertise is considered paramount to quality patient care. Benner's (1984) continuum gives a map for a nursing educational journey, as one continues to learn on an ongoing basis and may be considered a novice in one specialist area and an expert in another area (e.g., respiratory knowledge).

This model of nurse training has changed significantly in the past two decades. General nurse training has witnessed significant developments, moving from a hospital vocational training model to a higher education training system based on increased academic recognition and pre-registered education (Coburn, 1988). Dreyfus, Dreyfus, and Athanasiou (2000) outline how theory and practice skills are now required in contemporary nursing, with academic-based education combined with a clinical focus to generate clinical expertise within the profession.

The growing emphasis on enhancing the professional status of nurses through education was reflected in the change of nursing qualification from a certificate in the apprenticeship-based system to a degree qualification (QQI level 8) in the higher education system as the requirement for entry to registration as a nurse. Compared to other nursing roles, respiratory CNSs and ANPs are considered specialised nurses with an obligation to obtain higher-level education via defined specialised modules in their specialised area of respiratory care, along with desirable modules to prescribe medicinal products and medical ionising radiation (such as x-rays).

The Commission of Nursing (Government of Ireland, 1998) brought the issues of the professionalisation of nursing to the forefront in its emphasis on enhancing the professional status of nurses through education. This report had a significant influence on the professionalisation of nursing, recognising the power of transferring nurse education from apprentice-style training to a degree in Higher Education Institutions (HEI). This has been informed by numerous publications and reports from agencies such as the Nursing and Midwifery Board of Ireland (NMBI) and the Department of Health and Children (DoHC), focusing on professionalisation in nursing. Key reports include The Commission of Nursing (Government of Ireland, 1998), Hanly Report (Government of Ireland, 2003), Brennan Report (Brennan, 2003), a report from the monitoring group on the implementation of the recommendations from the report of the Review of Undergraduate Nursing and Midwifery Degree Programmes (Government of Ireland, 2012), Code of Professional Conduct and Ethics (Nursing and Midwifery Board of Ireland, 2021a) and Scope of Practice (Nursing and Midwifery Board of Ireland, 2015). All nursing degrees are conferred as a Bachelor of Science located in the academy of scientific disciplines.

Nurses' initial training includes placement and vocational requirements. They are also required to engage in continual professional development throughout their careers (see section 2.9), as well as preceptorship and mentorship that help identify and achieve their long-term and

short-term career goals. Nurse education has developed from the vocational apprenticeship model to its current consolidation within the structure of higher education provision. There is now a lifelong professional development pathway where nurses are encouraged to improve their nursing practice within their working environment and organisation at each career stage.

2.2.1 Vocational Identity and Cultural Values of Nursing

The vocational origins of nursing continue to influence nursing identity through the cultural and societal conventions which portray nurses as conscientious, obedient, kind, and subservient (Nelson & Rafferty, 2012). Nursing was idealised to represent society's past values and views about femininity and social class, with these characteristics related to gender and social status. The primarily female and working-class nursing workforce in Ireland was subjected historically to quasi-religious and military-style indoctrination to instil these supposed characteristics through the Catholic church-managed hospital system that has dominated Irish healthcare (Rafferty, 2002). As a result, character, rather than information or academic capacity, has come to be regarded as the most important aspect of nursing training as a vocation. This has had a significant impact on the development of nurse education.

This positioning of academic and intellectual ability as negatively correlated against vocational approaches and caring values is a particular feature of how nursing evolved as a profession. It is not unique to Ireland, although its intensity in the Catholic-dominated healthcare models in Ireland is distinctive (Rafferty, 2018). While nursing is undeniably about caring and compassion, these qualities should not be negated or placed in polarity to the importance of academic knowledge and education (Gordon & Nelson, 2005). Indeed, it has been suggested that nurses continue to gain from identifying with their vocational and caring sense of the profession since it fosters a strong sense of moral identity from which desire can be generated (Traynor & Evans, 2014). The Nursing and Midwifery Board of Ireland (2015) continue the nature versus nurture debate about whether nurses are born or made, reflecting the ongoing

association of care with nursing's vocational identity in contemporary nursing. Price et al. (2013) find that research reveals the primary motivations for nurses to pursue a career in nursing are altruistic and related to their vocational issues and aspirations, stating that 'career choice is an altruistic decision and portray[s] nursing as a 'helping' career' (Price et al., 2013, p. 308). Altruism, or the desire to serve others, was listed as the most important element influencing nursing students' career decisions (Wu et al., 2015), reflecting its ongoing importance as a value in nursing.

These changes have raised crucial questions for nurse education and the nature of nursing itself. The debate over nursing as a vocation, an art or a science continues. Including both the art and the science provides a holistic lens that describes the complexity of nursing care and education (Peplau, 1988). It highlights a fundamental shift in the epistemological and ontological basis of nursing from the experiences and learning practices of the traditional apprenticeship vocational form of training to an emphasis on professionally accredited and theoretical learning in the academy. These echo the tensions within the profession between practice and theory, where vocational practice is associated with nursing as a female-gendered caring service and theory is associated with professionalised knowledge and the academy. This shift is significant when viewed in terms of power and authority. Historically, nurses were viewed as docile or compliant to the impulses of others in the traditional model, particularly in relation to their medical colleagues. For this reason, the continued growth of nursing education towards a university-based model became an important part of nursing identity and culture, which is considered throughout this thesis.

2.2 Nursing as a Specific Body of Knowledge and Theory

Nursing has developed a specific body of knowledge as it became a profession. Nursing theories outlined a view of nursing as a body of knowledge grounded in the sense of practice, care-orientated, and a holistic sense of the patient. McKenna (2006) described it as an

alternative to practising solely by tradition or intuition, which had been associated with nursing as a vocational practice. This provided a framework for nurse education that had a focus and a structure for its curriculum and research activities and gave a basis of practice that supported the professionalisation of nursing.

According to Mantzoukas and Jasper (2008), there have been three significant movements in nursing knowledge development concerning education. The first movement in nursing knowledge was in the 19th century; nurses were expected to follow a set of rules and skills developed from the evidence of practice in the field and learnt through a vocational apprenticeship model (Bradshaw, 2000). The second movement in nursing knowledge happened in the 1950s with the promotion of theories and models for nursing practice and knowledge and marked the shift towards integrating nursing education into formalised education systems and pedagogies still influential today (Benner, 1984; Carper, 1978). The third movement in nursing knowledge happened since 1995 with the advancement of nursing knowledge through reflection, which encouraged nurses to critically reflect and build capacity-building, experience- and practice-based learning approaches that blend practical and theoretical learning. Hence, we can see how nurse education and its knowledge basis have continued to evolve.

The role of research has been influential in the development of nursing science with a proliferation of nursing theories in the 1960s (Bixler & Bixler, 1959), which fostered the conceptualisation of the profession. This theorising about nursing knowledge included seminal work by Carper (1978), who identified patterns of knowing in nursing through four fundamental patterns: a) empirics or the science of nursing, b) aesthetic or the art of nursing, c) personal knowledge in nursing and the d) ethics component of moral knowledge in nursing. Carper (1978) describes knowing as an individual's perceptual awareness of the complications of a specific situation and that knowledge contributes to a collective body known as nursing education knowledge. The science of empirics of knowing is described as the critical need for

knowledge in the empirical world, law theories, describing, explaining and predicting phenomena (Andrist et al., 2006). Aesthetic is the art of knowing relates to empathy, the gaining of knowledge from another person's perspective with integrity in the personal encounter or intuition (Benner & Tanner, 1987). Personal knowledge in nursing is self-knowledge, therapeutic relationships, wholeness and integrity (Chinn & Kramer, 2015). Ethical development involves the capacity to know and use the code of professional conduct and ethics (Nursing and Midwifery Board of Ireland, 2021a), facilitating the refinement and development of one's moral code. Gaining an understanding of the four fundamental patterns in nursing knowledge acknowledges the complexity and diversity of knowledge in the profession.

The science of nursing includes scientific research methods and theoretical models intended to guide nurse practice based on the positivist traditions of medical science (Bixler & Bixler, 1959). It is associated with pedagogical approaches of memorisation, conceptualisation, stimulation, experimentation and theoretical problem-solving (Kolb, 1984). This scientific and positivist orientation to nursing education is significant, given its different orientations to the requirements of the nurse practice in experience-based and relational learning.

The practice or art of nursing highlights qualities of creativity, skills, and relational and emotional learning (Henry, 2018) associated with social science post-positivistic disciplines. These qualities are also associated with the vocational or apprenticeship elements of nurse training, which are based on learning from experience and practice, working alongside and learning from experienced others in the field (Skår, 2010). Working with experienced nurses in the learning environment involves having the opportunity to confirm, obtain access to, or develop practical and professional knowledge (Skår, 2010). It is a form of work-based experiential learning which focuses on acquiring new skills and knowledge for implementing learning in everyday life. This involves several steps of self-examination, critical assessment of assumptions, exploring ideas or options, planning a course of action, acquiring new

knowledge and skills for implementing plans, and provisionally trying out new roles and relationships that fit the experiential learning profile (Fenwick, 2001). The balance between these different approaches to learning is essential in nurse education, with empirical knowing allowing scientific evidence to guide practice. At the same time, the experiential and aesthetic ways of knowing embrace the art of nursing in Carper's (1978) description of the value and belief for professional nursing practice.

The 'ways of knowing' expressed above are associated with different ontological ways of relating to one's sense of being a nurse as a vocational or academic practice. 'Nursing knowledge' has shifted from intuitive practices or knowing as a vocation to an academic basis, which is associated more with the curriculum or formal body of knowledge about nursing that is officially recognised and professionalised, as well as critical reflective approaches that blend theoretical insights with learning from clinical and practical experience.

Bernstein and Solomon (1999) differentiate between two types of knowledge discourse associated with these 'ways of knowing'. The first is horizontal discourses, which reflect the common-sense, experiential knowledge that people will acquire as they go about their everyday social activities (reflecting the vocational model in nursing). The second is vertical discourses, which contain the coherent knowledge base of an academic discipline, organised through "specialised symbolic structures of explicit knowledge" (Bernstein, 2000, p. 160). This is reflected in the growing professionalism of nursing education from the 1960s onwards. Allais (2014, p. 247) describes the significance of theoretical knowledge in systematic bodies of knowledge or curriculum. Such bodies of knowledge allow us to move intellectually across different everyday contexts in which concepts, principles, and facts are organised in structured relationships with each other (that enable us to step in and out of situations, reflect on them, compare them, and analyse them).

The specificity of how knowledge is formed within nursing as a defined discipline is worth considering. Visintainer (1986) argues that nursing does not have its own unique knowledge base and contends that nurses' knowledge is borrowed from other disciplines. This raises questions about the basis of the knowledge field of nursing and nurse education, particularly in terms of reliance on knowledge borrowed from other disciplines. How can knowledge borrowed from other disciplines that have been developed specifically within that disciplinary field then be applied to nursing practice? For example, nursing uses knowledge from pharmacology to understand drugs, drug interactions, and drug treatments. It uses knowledge about the body developed by physiotherapists on movement and breathing techniques. Crucially, nursing combines this knowledge in the specific context and practice of nursing, creating a new and equally valid knowledge base and discipline developed through its knowledge base in practice.

This capacity to consider how different bodies of theoretical knowledge can be applied in and through the experience and practice-basis of patient care allows nurse education to create unique ‘epistemologies of practice’ (Carlgren, 2020). This can be placed within the contemporary education debate about the power of different knowledge types. Young and Muller (2013) describe ‘powerful knowledge’ as a propositional model of knowledge that privileges Cartesian rational modes of thinking to neglect other ‘ways of knowing’ (Hordern, 2022). Wrigley (2018, p. 10) argues that Young’s emphasis on propositional knowledge over experiential modes of learning separates ‘cognitive from ethical/political and aesthetic aspects of knowledge’ and gives a ‘reductive understanding of “pedagogy”’ (2018, p. 10). Carlgren (2020, p. 326) argues for greater recognition of epistemologies of practice to return our attention to ‘tacit dimensions of knowledge…embeddedness in action’, which are core within nursing practice and ways of knowing.

This debate about different epistemologies and ‘ways of knowing’ in contemporary curriculum studies echoes Carper’s (1978) seminal model and allows us to explore nurses’ ‘ways of

knowing' in more depth. As outlined previously, the science of empirics of knowing is associated with theoretical spheres of knowledge in the empirical world, law theories, describing, explaining and predicting phenomena (Andrist et al., 2006). Empiric knowledge is focused on the science of nursing and evidence-based practice (Chinn & Kramer, 1995). The science of empiric knowledge helps us understand the consequences of any given clinical situation, providing meaning to facts and our isolated observations to inform nursing practice (Chinn & Kramer, 2015). Both are a core part of the formation of disciplinary knowledge of a curriculum (Young, 2008).

Given this knowledge base in and through practice, the act of knowing in nursing can be distinguished from the knowledge of nursing. Knowing is an individual's perceptual awareness of the complications of a specific situation and, with that knowledge, contributes to a collective body known as nursing education knowledge (Carper, 1978). It is an actively engaged form of knowing in and from practice, which gives a specific form of knowledge from practice.

Aesthetic is the art of knowing, which relates to empathy and intuition, gaining knowledge from another person's perspective (Benner & Tanner, 1987). Aesthetic knowing in nursing is expressed in practice in transformative acts that reveal the meaning and significance of the human experience and emotion, such as grief, joy, anxiety, fear, and love (Chinn & Kramer, 2015). Personal knowledge in nursing is self-knowledge, therapeutic relationships, wholeness and integrity (Chinn & Kramer, 2015), while ethical development using codes of professional conduct and ethics (Nursing and Midwifery Board of Ireland, 2021a) facilitates the refinement and development of our moral code. These 'ways of knowing' are associated with vocational nursing models and are very prominent in the beliefs and values that reinforce who we are as nursing professionals and nurse educators.

There is a necessity for this combination of different ways of knowing and knowledge and frames for the individual to grow to be an expert and for the profession to understand how

education works (McHugh & Lake, 2010). Wheelahan (2015, p. 752) argues that students need 'the specialised knowledge that underpins practice in their occupational field' to understand and address the challenges about the 'nature of the practice, ethical issues and dilemmas, and different perspectives in their discipline'. A framework for understanding and theorising nursing education is required for the researcher's learning and what needs to happen in the classroom and the researcher's educational institutions and systems.

2.3 How Learning Happens: Cognitive Psychology and Constructivist Theories

Nursing education in the classroom and clinical learning environment is primarily guided by learning theories. Knowing the general principles of these theories allows the nurse educator to apply their knowledge more successfully in varied learning circumstances (Aliakbari et al., 2015). Cognitive psychology and constructivist learning theories are most evident in nurse education (Aliakbari et al., 2015; O'Donnell et al., 2015).

Cognitive psychologists argue that learning is an internal process that involves thinking, comprehending, organizing, and consciousness (Aliakbari et al., 2015). These learning theories attempt to explain how individual learners learn and apply what they have learned. Rather than giving a single theory, educational psychology provides a diversity of theories and viewpoints on how learning occurs and what motivates people to learn and change (Aliakbari et al., 2015). Understanding learning theories, which are at the heart of educational psychology, is critical in education since it aids in creating a conducive learning environment, boosting educational efficiency, and achieving educational harmony.

Constructivist theory is employed in nursing education as a highly effective way of allowing nurses to actively participate in and reflecting on action and experiences, presenting nurses with different perspectives against a subject and surveying them (Aliakbari et al., 2015). The basic philosophy of constructive theory differs from the underlying philosophy of earlier theories, particularly behaviourism and information processing theories. The constructivist

theory emphasises the learner's involvement during knowledge development in an educational strategy learning moment, often by learning in and from experience. While these approaches have been very influential in nursing education, cognitive psychology and constructivist theory both focus on the individual's cognitive processes and experiences of learning.

The broader social context of learning and knowledge formation remains veiled in these theoretical approaches. Social theories of knowledge highlight the politics of knowledge and learning, while Young and Muller (2013) argue that we need to consider theoretical knowledge as 'powerful knowledge' that provides us with objective structures and epistemic access to aspects of the world we are exploring, even though that knowledge is always incomplete, fallible, and revisable in the light of new evidence. Specialized communities socially produce theoretical knowledge, and these communities develop the rules and criteria we use to frame our research questions and guide our exploration (Wheelahan, 2015, p. 753).

This highlights debates about the nature and balance of personal cognitive processes of learning that occur through our practice and experiences, which cognitive psychology and social constructivism highlight and the political and epistemological basis of learning through the theoretical knowledge formed in disciplines and subjects. Nurse education's capacity to draw on theoretical knowledge and processes from different disciplines of pharmacology, physiotherapy, and other areas mentioned earlier helps to 'develop the rules and criteria' of the discipline (Wheelahan, 2015, p. 753), which can be applied through critical reflective practices to the patient's holistic care within their social context. This gives it a specific type of experience-based knowledge base for nursing education, which is more profound than individualised explanations.

2.3.1 The Influence of Dewey - How Learning Happens

Dewey (1933) believes that humans have the ability to construct knowledge in their own minds through a process of problem-solving and discovery based on their experiences in practice. This is an approach to learning which resonates strongly with me as I consider how I learned throughout my professional nursing experience. As a student nurse, the realities of a busy ward were worlds apart from the experimental and experiential learning process in the classroom. I learned about patient-centred care and the importance of making things better for your patients in the hospital. I later discovered the name for this learning as exploratory learning, which emphasises a constructivist-based teaching method where learners are encouraged to find out the concepts and principles through their own experiences and practices rather than relying on the teacher's explanations and descriptions. Teachers are discouraged from influencing learners with an expert-dominated or accumulative approach to knowledge, and instead, educators facilitate learning under Dewey's learning approach, which emphasises activity and experience (Quinn & Hughes, 2007). This practice-orientated approach to learning from and through experience has influenced nursing education. It is often described as standing in some tension to the theoretical or powerful knowledge that Bernstein, Young and others in the realist tradition describe. While they focus on the socio-political dynamics of how knowledge develops within curricula, Dewey's pragmatism did note the need for continuity of learning from a curriculum but emphasised the processes of how we actively engage with learning through inquiry, making sense of knowledge in terms of how it relates to our own experiences. Dewey's pragmatic approach to nurse education has been evident in using observational learning theory to train nurses in numerous skills and areas. This was the approach used by many respiratory CNS/ANPs in the first and second waves of Covid-19. This focuses on the processes for teaching new practices and competencies, encouraging and influencing previously taught actions, attracting learners' attention, eliciting solid and emotional responses, and decreasing the effect of deterrents (Spiegler, 2015). The social

learning theory is acknowledged as a powerful tool for nursing education with a wide range of applications (Aliakbari et al., 2015).

One of the most significant components of nursing education is that all nurses learn continuously within their professional role as part of their ongoing practice. Nursing colleagues can learn about the work of respiratory CNS/ANP by allowing them to watch professional nursing procedures. The nurses observe the specialist respiratory nurses' performance and learn in the context of the relationships between the patient and the wider multidisciplinary team involved in the respiratory procedures. This is a rich form of learning which attempts to merge theoretical knowledge and learning in the practical context of their occurrence within the practice of everyday knowledge. It is seen in the development of conceptual frameworks in nursing, such as the influential model by Roper, Logan, and Tierney (2000), who categorised the reporting of nursing care in 12 main activities of daily living on a continuum of dependency to independence (see Appendix F). This conceptual framework enhances nurses' knowledge and links theory to practice but has been criticised for the relevance and scope of its categorisation of daily activities.

Developing a greater understanding of the theoretical basis of knowledge emerging from practice is key. Wheelahan (2015); Young and Muller (2013), and others emphasise the role of theoretical knowledge as specialised knowledge in and through academic disciplines which produces and defines knowledge through conceptual frameworks. They emphasise the role of theoretical knowledge more than the pragmatic approach of Dewey's learning through inquiry and experiential model (Roper, Logan, & Tierney, 2000). Wheelahan (2015) holds that students learn to apply theoretical knowledge in the context of their everyday lives, developing the capacity to know when and how to move between different types of theoretical and everyday knowledge in different contexts. It is this which is the key to the capacities of a professional, who can move between different types of knowledge as is appropriate to the context and need. However, these forms of knowledge and their status are mediated by the

structures, cultures and processes of learning institutions and the systems in which this learning is applied – in this instance, the context of healthcare. This is explored in the following sections in terms of the role of power in and through education in healthcare professions such as nursing.

2.4 Power in Education

Power within nursing and nurse education is complex and somewhat diverse when we consider broader issues of control, domination and influence in healthcare and education. Exploring power in relation to historical, theoretical, and practical aspects within contemporary education systems is vital. This section explores how power works in and through education by examining what has changed in nurse education and what is shaping and driving policy and practices in recent years. This involves exploring how power has evolved as a multifaceted element in education, transformed by and shaping the system.

Foucault contends that “power, while pervasive, comes from everywhere and is everywhere” (Foucault, 1998, p. 63). It constantly changes and can have negative and positive meanings (Foucault, 1980). Power exists everywhere in healthcare and education and takes specific forms shaped by the context and culture of nursing. Epistemological differences and tensions between the caring discourses of nursing on the one hand and scientific expert-led discourses of medical science on the other in nurse education have a significant influence (as discussed earlier in terms of the historical evolution of nursing and nurse education). The tensions between these discourses continue to impact today in different ways throughout the work life and education of respiratory nurses, as explored below.

Noddings (1984) described knowledge as a source of power that allows people opportunities to develop and flourish. Noddings refers to knowledge as a source of power that allows people opportunities. She notes that "privileged knowledge" often expresses the hegemony of the dominant class and becomes institutionalised through curricula and disciplines. Rather than

leading to democratic flourishing, following “privileged knowledge can leave people with less freedom and choice”, especially when it intersects with gender, race and class inequalities (Noddings, 2006, p. 238).

In the traditional certification style of nursing education, students were not to question the doctor; the knowledge and status of the doctor were supreme, with the role of nurses to serve (Sirota, 2007; Stein, Watts, & Howell, 1990). This consensual view of nursing hindered the nursing profession from both a knowledge and educational aspect. Active democratic learning through engagement was not encouraged in the traditional learning mode in nurse education. While it is encouraged in the reflective mode of learning in contemporary nurse education at a personal learning level, the political and social context of knowledge and curriculum formation in nurse education has rarely been questioned. Whose knowledge and experience are being taught? How is it presented in the curriculum? Foucault (1980) examines the validity of reflection and its unquestionable acceptance in work and education contexts, reminding us to consider the influence of power in the co-option of concepts like reflection into our working structures and cultures.

Power, in this case, could be viewed as the capacity to direct or influence others and is experienced at macro, meso and micro-levels. According to (Foucault, 1984), although power produces knowledge, nevertheless, power and knowledge are directly implicated with one another. As explored in section 2.1, power relationships in healthcare are often described as hierarchical, with control given to medics as the dominant experts in hierarchical structures within healthcare within Ireland and internationally. This was evident through the medical model and curriculum, which dominated healthcare, including nurse education.

This hierarchical model did not mean an entirely one-way flow of power. As Foucault recognises, power flows are multiple, overlapping, and complex. Nurses hold power over patients, the power to relate information to other multidisciplinary team members and the

power to withhold information regarding the best outcome. VeneKlasen and Miller's (2002) model of empowerment and power discusses the flows of power over, power with, power to and power within, which recognise these complex flows of power. Educators must be aware of the political hierarchy of knowledge in these relationships, where some knowledge is given more power/weight over others in disciplines. As discussed in the previous section, Bernstein, Young, Wheelahan, and others explore this through their analysis of how "powerful knowledge" is formed through education curricula and disciplines. Analysis of power flows must also acknowledge that change is slow to happen as political power often does not seek to change traditional practices, so students are not encouraged to question the dominant authority and discourses in society. Hence, the impetus is often towards status, and the political state of our educational system is slow to change, with existing political powers maintaining their authority and control. The link between the political establishment and the educational system needs more thought and reflection. It is an area that nursing and nurse education have been slow to consider. Still, it is crucial given the dominant ideology of the medicalised model and authority of medics, which has traditionally dominated the caring and patient-centred ethos of nursing.

Foucault's (1984) understanding of disciplinary power is central to his work on discipline and punishment. He likened this concept to medical power. Foucault (2012) discussed docility-utility, which is disciplinary power imposing control over others, a controlling power. The subject of the relative dominance of the medical profession is one that Friedson (1994) considers.

Docility-utility can be challenged, as is evident in Friedson's (1994) discussion of the '*zone of discretion'* and micro-level power in medicine. At this level, a professional power monopoly over specific abilities guarantees that even clerical doctors can keep a significant degree of discretion in their day-to-day work compared to other healthcare professionals. These discretionary powers typically allow doctors to fend off attempts to interfere with their clinical

autonomy, whether those attempts come from managerial attempts to oversee their performance or from the nursing/other professions taking on tasks doctors view as being within their prerogative (as is the case with respiratory CNS/ANPs performing aspects of work which doctors regard as being within their medical profession). Friedson (1994) contends that the profession's strength is increased if it is viewed as a "corporate entity" as opposed to solely in terms of the work habits of individual practitioners' power.

Inglis (1997) discusses individual empowerment and emancipation, arguing that "empowerment involves people developing capacities to act successfully with the existing system and structures of power while emancipation concerns critically analysing resisting and challenging structure of power" (Inglis, 1997, p. 4). This raises key questions about the nature of power evident in the status and agency of respiratory ANPs and respiratory CNSs. In many instances, there are systemic and institutional barriers that influence the ability of respiratory CNS/ANPs to be agentic, such as the requirement for clinical learning agreement and healthcare individuals in a position of power (e.g., Consultant or Director of Nursing) signing off on the number of clinical hours. The behaviour shows how professional standards and requirements result in doctors and senior management in clinical learning environments still having the power to determine the opportunities for empowerment of respiratory CNS and ANP roles.

Foucault's (1980) work explains how power and agency are intertwined in complex and dynamic ways. In nursing and nurse education, Foucault's conception of power as agentic is evident through a person's power to control their own goals, destiny, and actions. This is visible in the growing level of professional control evident in the expanded scope of practice of respiratory nursing specialists.

Foucault (1980) argues that power is exercised not by denying an individual's agency but by socialising them as actors who voluntarily operate in the best interests of others, defined as a

disciplinary practice. Relations of power do not abolish individuals' freedoms but control and direct those freedoms. Foucault (1998) discussed agency of all those who subject themselves to the modern power/knowledge regime, not just as subjected to power relations but also as ‘relays’ in power relations. According to Foucault, although power produces knowledge, nevertheless, power and knowledge are directly implicated with one another in the power-knowledge relationship. This has been very evident historically in the cultural practices and disciplinary norms of nursing, which are dominated by the expert-led medical model to the denigration of the relational, holistic, and experience-based orientation of nursing practices.

Hodgson (2004) discussed agency in terms of how an individual is influenced by their surroundings and structures within their organisation. The social sciences have long recognised the conflict between (social) order and change or, more precisely, between structure and agency. They also contend that one should not discount the existence of social institutions or structures (Hodgson, 2004). These contributions, which come from the domains of economics, sociology, political science, and management, do not give a crucial account of the conceptual tension of how structure and agency interact and interrelate (Dolfsma & Verburg, 2005). The same may be true of nursing, where there is a tendency to stress either structure or agency and miss out on how they interact.

Complex power flows between structure and agency are evident in the interprofessional relationships which exist in the multidisciplinary team-working context of respiratory care. Interprofessional relationships between and within professions substantially impact job acceptance (Maxwell et al., 2013). Respiratory CNS/ANPs' interpersonal and interprofessional relationships influence their experiences within their clinical environments, with varying power flows evident across and within these teams. However, the later findings reveal that whether their job enables empowerment or emancipation depends on the different levels of recognition and agency of respiratory CNSs and ANPs. There are obstacles to the autonomy of nursing education, such as different multidisciplinary team working contexts, the type of clinical

learning agreements and the number of clinical hours that may need to be approved by health professionals in positions of authority and power, such as consultants and directors of nursing. Before exploring these power dynamics in more depth, it is useful to look at the specifics of education within nurse education, firstly in terms of the influences of adult education, followed by a discussion of the values of caring in nurse education.

2.5 Influences of Adult Education on Nurse Education

There are influences between adult education and nursing in terms of their people-centred nature, whether this is a patient or learner, and the strong emphasis on care and transformative action. Benner (2001) has described qualities of power associated with care provided by nurses, such as transformative and healing power, which is central to nurse education. Respiratory nurses are adult learners working and studying part-time, bringing their experience and expertise from different clinical respiratory backgrounds into their learning. A vital component of nursing education is clinical experience; you cannot become a respiratory specialist nurse without participating in practical learning environments. Accredited nursing programmes demand new knowledge and skills to prepare respiratory nurses working in respiratory care and hands-on patient care experience.

It has been described as a paradigm shift from a teacher-centric approach to a student-centred educational approach within many disciplines where students exercise greater choice over learning methods (Keating, 2014). This emphasis on learning from practical experience and a student-centred approach has been heavily influenced by Dewey's educational philosophy (1925). This shift is evident in the changing discipline of nurse education, with the development of a constructivist student-centred approach that focuses more on students learning through inquiry than on teachers teaching. This was seen as providing healthcare staff with the necessary skills to think creatively, make moral decisions, analyse research critically, update their skill sets and evaluate practice (Adam, 2004; Twomey, 2004). The role

of the educator also changes, increasingly viewed as a facilitator of learning rather than the expert depositing banks of knowledge. This is vital for nursing, where the capacity to act and engage in practice is crucial. An inquiry-based approach is essential, as Dewey (1925) outlined.

Dewey and Creed (1897) saw education as a continued reconstruction of experiences whereby the process of education and the goal of education are considered the same thing. Dewey (1925) believes that individuals can construct knowledge in their own minds through a process of problem-solving and discovery. This inquiry-based approach emphasises the importance of seeking a form of education which is the basis to support learning over the individual's lifetime.

For Dewey (1925), education and science are united by the centrality of experience and the importance of inquiry. The uniting of education and science in Dewey's model through experience and inquiry-based learning is vital for nurse education, as it recognises the significance of learning from and through experience. It gives a knowledgebase for the care and relational work of nurses.

As adult learners, nurse educators build on existing knowledge, skills, and experiences, continually improving their teaching practice by learning from every educational opportunity. As educators in nursing education, there is a need to reflect on situations and discover again what nursing means to nurse educators as individuals through the exploration of nursing education and nursing knowledge (O'Shea, 2003). While this is a feature of many experiential and reflective approaches to learning, which Dewey's inquiry-based model of education inspired, nurse education is also marked by its disciplinary norms based on the values of holistic patient care.

2.5.1 Values of Caring in Nurse Education

The values of caring and patient-centeredness implicit in nursing, as noted by McCormack, Dewing, and McCance (2011), are embraced by nurse educators, upholding the values of kindness and person-centeredness by showing an interest in and concern for students, acting without prejudice, spending time with each student individually, respecting cultural sensitivity and diversity, and creating and offering educational opportunities that are both relevant and stimulating for students.

The context of practice in nursing is essential to consider as its focus on patient care requires a specific practice and pedagogical approach. Noddings (2005) explores the nature of caring in education, with the relationship between teacher and student considered a foundation for pedagogical activity. Given the centrality of emotional care in nursing education, it is worth further exploring these relationships and their dichotomies and contradictions. High solidarity and care levels in society generally enhance people's ability to flourish (Wilkinson, Pickett, & Cato, 2009). The nurse's role is to care for and restore people to good health, and the teacher's role is to facilitate people's education to new goals and levels. Both involve relationships of doing and learning, which happen through caring relations of interdependency (Cantillon & Lynch, 2017). The value of caring knowledge is understood in nursing as a fundamental principle underpinning actions and relationships. According to Noddings (2002), there are three elements to a caring encounter: the connection between the carer and the cared, the degree of exchange they both gain from the encounter in different ways and how both give and gain knowledge from the encounter. Noddings (2002) distinguished between "caring for," which refers to direct care for another person, and "caring about," which refers to having concern for others and wanting to do something about it or a specific aspect of it. Watson (2008) suggests caring is the philosophical foundation for contemporary nursing practice and is the essence of nursing and the foundational disciplinary core of the profession. This basis in care is profoundly relational and agentic, with theorists highlighting how care involves

freedom, responsibilities, and knowledge of self and others in these relationships. Ehrenberg and Häggblom (2007) highlight that with freedom comes a greater responsibility for students to reach their learning goals. Palmer (1998) notes that educators' ability to connect with students and to connect them to the subject depends less on the methods used than the degree to which they know and trust their self-hood and willingness to make it available and vulnerable in the service of learning. Nurse education has a deep sense of the significance and complexity of caring relationships in care and educational contexts. This is worth considering regarding the agency and relationality it reveals about learners as they mediate between the practice-based knowledge from the lived experience of caring and theoretical knowledge of the healthcare disciplines they draw on in their work as nurses. This is explored further in the following sections in terms of the continuous learning of nursing professionals.

2.6 Continuous Learning, Knowledge, and Development in Nurse Education

In health care and nursing professionals, identities are formed in various environments and interactions, from formal education and training to clinical practice and patient care, as well as mentoring and supervision (Academy of Medical Royal Colleges, 2020). The transition from studying to practising is a crucial achievement. Still, it is recognised that professional and occupational identities of respiratory CNS/ANP are not simply acquired in training but are capacities that continue to develop over time. The expansion of nursing respiratory CNS/ANP roles through the advancement of their professional level and individual level of knowledge is facilitated by continuous professional development (CPD), including education, learning, knowledge, and development.

Essential elements in the professionalism of nursing include the formalisation of its knowledge and values through professional standards, frameworks, and curricula. These recognise and build on its unique knowledge base, theoretical knowledge, values, and practices. This is explored in the following section regarding the continuous development of nurse education.

Ireland's first framework to support the professional development of those who teach across the HE sector was published by the National Forum in 2016 (Higher Education Authority, 2016). It is underpinned by a set of core values and provides a structured outline of professional development activities for teaching and learning within HE. The National Forum coordinates many initiatives and national-level activities focusing on enhancing teaching and learning. The principles of professional development in nursing were designated to a professional body known as the National Council for the Professional Development of Nursing and Midwifery (NCPDNM). However, the Government at the time felt it was no longer a cost-effective venture. This NCPDNM was subsequently dissolved under part 12 of the Nurses and Midwives Act of 2011. Its assets were transferred to An Bord Altranais, indicative of the power the government held as a form of political technology that controls the nursing professions (Government of Ireland, 2011). Clinical Nurse Specialist roles and clinical midwife specialist records were now under the authority of An Bord Altranais (Nursing and Midwifery Board of Ireland, 2012), whose name was changed to the Nursing and Midwifery Bord of Ireland in the same act.

While these frameworks and standards exist, the individual registrant must maintain professional competence through CPD programmes and opportunities as a self-regulated profession. The role of CPD is viewed as a partnership between the nurse and their employer through the Code of Professional Conduct and Ethics (Nursing and Midwifery Board of Ireland, 2021b) and Scope of Practice (Nursing and Midwifery Board of Ireland, 2015). This has implications for how nurse education in HE is positioned and viewed both by professions and more widely by the broader medical field and professional bodies, as will be explored later in this thesis.

Since 2001, this framework has promoted the development and expansion of the CNS's career pathway in Ireland. It opens new opportunities for nurses to develop their role, one of which is the respiratory ANP role. The development of the respiratory ANP role aims to make an

advanced contribution to education, administration, research, and practice. While the potential contributions of this extended nursing role of the respiratory ANP are recognised, successful implementation of this role is hindered by confusion with the current role of the respiratory CNS, with patient and care teams unable to differentiate the relationship between both nursing qualifications and roles. This confusion plays out in different ways, as evident in later findings chapters.

For nurses entering respiratory academic programs in the future, they will begin their studies with challenges and concerns arising from the context of the Covid-19 pandemic that no other cohort could have anticipated with regard to the interruptions in nursing education, clinical learning and prospects (Dewart et al., 2020). They need to be responsive to the changing contexts as they occur, both in terms of the care of individual patients and the wider changes in healthcare and society. The educational needs and pathways of nurses entering respiratory care are considered in the following sections.

Health and Care Professions Council in the UK discusses the importance of the acknowledgement of other professions for recognition processes (Health and Care Professions Council, 2014). For any nurse to apply for a postgraduate education programme, they must have documented evidence from their director of nursing. For several postgraduate programmes, nurses require elected medical practitioners to provide them with learning and teaching opportunities when undertaking educational programme (Government of Ireland, 2019). Hence, the learning journey and experiences of respiratory CNSs and ANPs are in the hands of these individuals from other cognate disciplines. Miller (2008) describes this as ‘power over’, the power to determine if one is successful; it is now diffused through the multidisciplinary healthcare contexts in which respiratory nurses practice. We are beginning to recognise the forms of power by which one group of people controls the development of other groups and seduces us all to cooperate and collude (Miller, 2008, p. 159). Hawks (1991) speaks of ‘power over’ and ‘power to’, which are visible in nursing practice and influence

behaviour and actions. Nurses have experienced ‘power over’ at an organisational level in terms of the dominance of medical professionals (Kuokkanen & Leino-Kilpi, 2000). This is shifting significantly in terms of the changing roles and contexts of contemporary nursing practice. This research must reflect on who this power is given to, their positioning and recognition processes, the epistemological implications of their knowledge base, and how they bring it to nurse education.

2.6.1 Learning with Colleagues and Patients

Respiratory nurse specialists have responsibilities under their scope of practice from the Nursing and Midwifery Board of Ireland (2015) to contribute to educating their colleagues and patients, ensuring continued workplace competency. Hence, they are continually involved in relationships and learning with other professions and colleagues. The clinical environment offers a specific opportunity for this learning to take place, which can contribute to CPD. The breath of this educational role towards others signifies the importance of ongoing education for respiratory nurses.

Working and learning from multidisciplinary teams of professionals is vital throughout a nurse’s career. It is emphasised in undergraduate and postgraduate nursing education but remains a feature and developmental need throughout a nurse’s career. Bringing together professionals from different disciplines for training on cross-cutting topics like domestic violence, safeguarding, or quality improvement also provides an opportunity for team development. Multi-professional teams need resources to ensure that they can develop effectively as a group and as individuals.

Respiratory nursing specialisations and specialised courses are available but not consistently across Europe (Alonso et al., 2020). Professional learning and education are about the advancement of the individual as a professional. The educational programme preparing nurses to practice in specialist respiratory care enables them to engage in CPD with an

approach to expanding an individual nurse's scope of practice. Hence, they are continually involved in relationships and learning with other professions and colleagues.

Patients with respiratory conditions working with specialist colleagues in respiratory care formulate and develop the learning, knowledge, and skills in assessment and therapeutic interventions. As discussed earlier, respiratory nurse specialists undertake a specific postgraduate diploma in respiratory care, educating them to deal with acute and chronic respiratory illnesses. While collaborating with other healthcare team members, respiratory nurses provide patients with lung disorders with comprehensive treatment while upholding the highest nursing standards. In addition to providing patient care, specialist nurses frequently participate in preventive programs such as smoking cessation and other patient education forms while working in various clinical environments.

2.6.2 The Role of Scope of Practice in Nursing and Nurse Education

In relation to professional development, the Nursing and Midwifery Board of Ireland (NMBI) play an important quality assurance and development role. NMBI's primary role is maintaining an accurate register of nurses and midwives in Ireland. To complete registration, an applicant must meet specific standards and requirements for the nursing division under European Union directives and Irish legislation. NMBI ensures that nurses' practice is maintained at a standard for individuals to achieve registration and protects the public through the provision of fitness to practice and accreditation of education programmes (Nursing and Midwifery Board of Ireland, 2021a). Power operates through regulation, such as a nursing register, which enables formal and informal sanctions over what is and is not permissible in a profession.

The benefit to nurses' professional development as a member of this register is it entitles an applicant to use the title "Nurse", provides a right to practice and entrance to a working environment and maintains public recognition and trust in the profession. From an educational professional development, the Nursing and Midwifery Board of Ireland (2021a) accredits all

nursing programmes and sets standards for HEIs, providing the programmes and competency standards that nurses must achieve before completion. While this is a formally stated regulation process, it assumes specific parameters and discourses about regulation that are explored below.

This scope of practice framework was created with the intention of giving nurses expert advice and support on issues pertaining to the range of their clinical practice, including a flowchart to assist nurses in defining and choosing their areas of expertise (Nursing and Midwifery Board of Ireland, 2015). This is significant as it reveals how the nursing profession defined its knowledge base and disciplinary scope. One way the nursing profession embraces the challenges it faces is by expanding the scope of practice both at a professional level and at an individual practitioner level. The education programme preparing nurses to practice in specialist respiratory care enables them to engage in CPD with an approach to expanding a nurse's scope of practice.

Improved patient outcomes and increased practitioner autonomy were intended to result from expanding nurses' scope of practice (Begley, 2010; Health Service Executive, 2011). As nurses take on expanded tasks and increase their scope of practice, they are now adopting functions that were once the unique purview of the medical profession, such as intravenous cannulation and X-ray prescribing (Fealy et al., 2018). Engagement in education, learning skills and CPD activities is necessary to take advantage of chances to broaden practice areas and develop as more autonomous practitioners.

The respiratory CNSs and ANPs are now practising skills and knowledge that doctors solely practised in the past. This is a crucial power shift and development in the nursing profession and reflects how the continual development of knowledge and capabilities is being conceived between these professions. Gerrish et al. (2011) articulated that ANPs recognise how knowledge can be developed through experience, reflecting the Deweyan emphasis on

practice and inquiry-based learning. Roy and Obloy (1978) elaborate on those to describe how nursing knowledge had been built through practice with the development of nursing as a distinct “scientific discipline”. This is significant in terms of developing the theoretical knowledge of nursing as a discipline in its own right with practice-based knowledge that developed over the course of a nurse’s career (Benner, 1984). While some of this learning is produced through formal CPD activities, the importance of clinical practice and critical reflection to enable this learning and knowledge development cannot be understated. It is anticipated that advanced nursing practice will not only enhance the professional status of nursing but also improve the quality of healthcare (Fealy et al., 2018).

A significant element in this shift has been the increased emphasis placed on reflectivity and critical thinking. Critical thinking is described as the disciplined, intellectual process of applying skilful reasoning as a guide to belief or action. It requires reflective and reasonable thinking focused on deciding what to believe or do (Paul, 1991). Critical thinking as a practice is disciplined, comprehensive, based on intellectual standards, and, as a result, well-reasoned. Scenarios within the healthcare environment present respiratory CNS/ANPs with a level of complexity that requires critical thinking and responsible decision-making. Reflectivity and critical thinking are core elements which contribute to the development of a theoretical discipline (Allais, 2014; Young & Muller, 2014), although the type of reflective thinking and level of abstraction of knowledge demands will differ according to the specificity of each sector (Muller, 2009). This is explored below in terms of the role of reflection in nursing.

2.7 The Role of Reflection in Nursing and Nurse Education

Reflection is a vital concept within contemporary nursing practice and education. Carper (1978) and Benner (1984) acknowledge the importance of reflection in the workplace and its impact on the intellectual position and practice-orientated epistemological commitments of nursing as theoretical knowledge. In my own practice, I have engaged in reflection as a student

and educator and continue to do so as an ongoing part of my practice. From a humanistic perspective, the reflective diary experience asserts the learner's rights to autonomy, provides the learner with a legitimate learning experience and allows for reflection and inquiry (Beattie, 1987; Blidi, 2017). Critical reflection processes enable educators to attend to their personal development or 'inner work' (Palmer, 2007). Reflection on one's practice opens one's professionalism to scrutiny and opinions, which can positively affect individuals to grow professionally as a method of learning from practice (Rolfe, Freshwater, & Jasper, 2001). Reflection is encouraged among professionals so they can adapt critically in the professional role (Schön, 1983).

Reflectivity as a process focuses on the frame of reference that defines an individual, with the two dimensions of a habit of mind and point of view (Mezirow, 2000). The frame of reference can be transformed through critical reflection on these assumptions, habits, and beliefs, leading to significant personal transformation. Being reflective of one's own assumptions is essential for transforming one's taken-for-granted frame of reference (Mezirow, 2000). To gain a deeper understanding and develop new views that inform their actions, nurse educators urge their students to use reflective processes to challenge presumptions and expectations. Reflection on the growth of competence and self-assurance in new roles and relationships that bring about change in the learning and working settings is essential (Tsimane & Downing, 2020). It is part of a transformative learning process that encourages nurses to independently develop their ability to think so they may use the knowledge they have gained from life experience as an active part of their learning (Tsimane & Downing, 2020). This reflective process of learning from experience and practice is an essential part of the knowledge basis of nursing as a discipline and how they process the knowledge from other disciplines into nursing practices.

Respiratory nurse specialists played a crucial role in educating about the Covid-19 pandemic worldwide, extending and expanding their roles to teach colleagues and patients and adopting

new ways of working across clinical specialities (Dewart et al., 2020). Respiratory postgraduate education and critically reflective practice supported nurses in the continually evolving clinical healthcare environment and in maintaining competence in providing patient care. Postgraduate nursing education enhanced patient outcomes due to critically reflective thinking skills, evidence-based practice and expanded knowledge (Cotterill-Walker, 2012).

The pandemic has altered the higher education scene and the capacity to adapt to teaching strategies, such as online, hybrid, and blended learning techniques, necessary as academic institutions around the world address the global health crisis (Singh, Steele, & Singh, 2021). From a learner's viewpoint, the pandemic endorsed new and innovative ideas for delivering education (Watson et al., 2020). Online education, while being a reactionary response to the pandemic, happened swiftly due to the pandemic, and all classroom-based content went online, the scale of which was a new and unplanned event and method of learning. Student educational content transfer and sensemaking occurred both asynchronously online and synchronously during face-to-face online tutorials, flipping the standard classroom style on its head to which all educators and students had become accustomed (Watson et al., 2020).

Marks, Edwards, and Jerge (2021) conducted a study on education focusing on what was understood at the time about the management of Covid-19 patients using a traditional didactic approach and incorporating experienced nursing support staff at the patient’s bedside. To prepare for a potentially devastating demand of critical care patients due to Covid-19, nurses in the health system received a rapid training course. The didactic educational session was performed using a massed practice model, and analysis showed that the distributed practice may have been more actual (Marks, Edwards, & Jerge, 2021). This educational training was delivered in two parts: a single 4-hour didactic session and clinical support for inexperienced intensive care unit (ICU) nurses in the form of an experienced buddy. Nurses were then interviewed about the education program's strengths and weaknesses and their perceptions of the additional clinical support. The results of this qualitative inquiry sought to understand

the perceptions of nurses related to the value of education and bedside support by nurses. Marks, Edwards and Jerge's (2021) analysis discovered that distributed practice would have been more effective by using a distributed learning model with small groups attending numerous training. However, the educators who provided the didactic instruction were described as very knowledgeable by the participants, which was the core strength of the training programme. Marks, Edwards, and Jerge (2021) stated that due to the emergency of the Covid-19 pandemic, there was no time to create and implement a didactic training program using the distributed practice model.

During this research, there was uncertainty regarding the end of the Covid-19 pandemic and the possibility of new strains of the virus emerging all the time, so face-to-face teaching and learning were quickly switched to virtual remote learning modes, with little to no training for educators or students. The capacity for critical reflection became vital in this process as online learning and teaching emerged as a response to completing a nursing curriculum during a crisis. However, the practicum clinical component that needs to occur in person remains challenging (Agu et al., 2021). This identified another important impact of Covid-19 on nursing education and the management of the clinical practicum, which requires a specific type of reflection-in-action (Schön, 1983), discussed in the following section.

The nursing curriculum has been adapted to an online format; however, the long-term significance of this change has yet to be established or evaluated. Poon (2013) acknowledges that nursing educationalists need to keep up with changing technology, learning theories and the changing educational needs of learners. This was particularly evident in Covid-19, where there has been a rapid change to how education is delivered and continually evolving. The educational system must respond rapidly to facilitate education during the pandemic in the form of immediate nursing education/upskilling for care delivery while maintaining existing educational programmes at all levels.

The effect of Covid-19 on nursing education in Ireland and across the world has demonstrated that if sufficient measures are established for future crises, there will be less impact on nursing education. Nurse education systems must adapt to withstand these future crises and unexpected events and recover rapidly from them (Agu et al., 2021). The Covid-19 pandemic has proven to educators a need for disaster planning and preparation in nursing education. Healthcare organisations, nursing regulatory bodies, and Higher Education Institutions write and develop policies to help cope and recover quickly from future disaster occurrences (World Health Organization, 2021). Before the pandemic, education programmes must respond to changing service needs; however, disaster planning is a new element for future planning in all healthcare environments (Sundararaman, Muraleedharan, & Ranjan, 2021).

2.7.1 Reflection in Learning and Research

Reflection in the context of learning refers to those intellectual and affective activities in which individuals explore their experiences and lead to new understandings and appreciation of practice (Boud, Keogh, & Walker, 2013). Reflective models entice practitioners to become researchers in their practice (Rolfe, Freshwater, & Jasper, 2001). A reflective position has many functions; it challenges us to be conscious of the culture, politics and ideology of those we have as an audience and those we study (Hertz, 1997). In the qualitative research methodology, the researcher continually engages in the process of reflection, empowering agentic capacity through reflection and enhancing teaching practices. Throughout this thesis, critical reflection will be significant; continuing to develop critical reflection as a researcher enables me to clarify my research position and relationship within the relevant field of professional practice (Ryan, 2006).

Reflection is beneficial for more efficient learning in a cyclical process, as Kolb's (1984) model demonstrates. Schön (1983) conception of reflection has been very influential in educational theory, describing the process of reflection through two elements: reflection-in-action and

reflection-on-action. Reflection-in-action is a process of reflecting on a particular situation as it occurs. At the same time, reflection-on-action deals with analysing and discussing a situation after the event has taken place. Greenwood et al. (2001) describe reflection-on-action as a 'cognitive post-mortem' in which the practitioner revisits an experience to learn from an activity. Schön (1983) argues that reflection-in-action contributes to developing epistemology of practice. Instead of separating theory from practice, this acknowledges how nurses actively learn from their daily work and use knowledge from nursing, which is core to the theoretical knowledge of nursing as a distinctive discipline (Powell, 1989).

The reflection process allows one to examine one's beliefs, assumptions and strategies for teaching and learning. Reflection opens one's professionalism to scrutiny and opinions, which can have a positive effect and enable individuals to grow professionally.

Theorists of education acknowledge the importance of the role of reflection in education. Schön's (1983) and Kolb's (1984) models explore how reflection works in active learning processes, as discussed above. Bourdieu (2000) acknowledges reflection on self, the research context and the academic field in his analysis of power and reproduction (Wacquant, 1993). Freire (2005) asks all who teach to reflect critically on the meaning of learning and the act of teaching as an integral part of their pedagogical processes, embedding this in processes of power and conscientization. Javis' (2006) notion of disjuncture and Mezirow's concept of disorientating dilemmas gives a framework to understand how we manage disjunctions, new ideas and changes in our reflective learning processes. This acknowledges how people's experience of the world and how we understand it shapes transformation and learning. The learner looks back on lived experience and then analyses and generalizes this experience to develop mental structures, or 'meaning perspectives', as Mezirow (1990) describes it through reflective thinking. Different types of experiences, such as disorienting dilemmas (Mezirow, 1978) or 'critical occurrences' during practice, can prompt reflective learning processes (Cope & Watts, 2000). When examining lived experience in the process of constructing meaning,

positive and negative emotions play a role. Kolb (1984) views reflection as a circular process characterized by tension, conflict, and different emotions, beginning with a concrete experience and progressing through reflective observation, abstract conceptualization, and active experimentation. Kolb (1984) describes how emotions may be perceived as influencing the constructivist process, and the individual to reflect upon and regulate their emotions as they go forward with conceptual thinking.

This points to the distinction or binary between emotions and conceptual thinking that is evident in educational theory. It is a point of tension for nursing education where care, interdependency and emotions are central to their ontology. In the constructivist perspective, contemplation can lead to meaning creation or perception shifts, and reflection is the perceptive process through which we change our ideas, literally and figuratively (Mezirow, 1990). Schön (1983) places the practitioner at the centre of the reflective thinking process. He describes how reflective practitioners ask about and experiment with solutions by detecting and defining problems of interest like power and positionality. Hierarchies play a role when looking at different degrees of reflection; premise reflection (Mezirow, 1990) or double-loop learning (Argyris & Schön, 1974) are considered superior reflection levels. Notably absent in many of these reflective models is a consideration of the role of emotions and care. It is an element which returned to chapter 3 regarding the role of care in nursing as part of the "inner work" that nurses do as part of their practice (Palmer, 2007).

2.7.2 Reflection in Workplace

Reflection in the workplace is increasingly important as a form of learning from and through experience. Adult learning in the workplace is frequently articulated in a constructivist view as occurring in the setting of single one-off experiences or over time through a series of interactions. Individuals are acknowledged as bringing their prior life and work meanings, knowledge, skills, beliefs, interests, and drive to each learning moment in either instance

(Marsick, Watkins, & O'Connor, 2011). Learning can be structured formally through training or education to access known knowledge in a classroom setting, or it can happen in the workplace context when solving issues, seeking challenges, or exploring possibilities in the workplace as informal or incidental learning (Marsick & Watkins, 2001). Informal learning at work refers to the interactions of humans and their behaviours with norms, tools, and texts, as well as their work's cultural and material contexts. The constructivist perspective emphasises reflection as a crucial component of individual and group learning. The process of reflection before, during, and after action is critical to learn from and through action at work. Gill (2000) notes that when applied to professional learning and development in this instance, tacit knowledge can only be learned by doing in practice. Learning does not come from experience alone but through the processes of reflection and action upon it. As discussed in the previous section, the idea that meaning is built gradually over time and experiences was proposed by Dewey (1925) and further developed in the education theories by Schön (1983), Kolb (1984) and Mezirow (1991) as crucial to changing experience into learning through reflection processes. Reflection aids in identifying issues, developing solutions, and participating in collective inquiry (Fenwick, 2010). Reflection is an intentional and explicit process aimed at autonomously creating meaning in a learning situation separate from metacognitive processes. Cognitive learning theories focus on the ability of students to guide their learning using mental strategies (Shuell, 1986). Concrete experiences and cognitive reflection on these experiences have been utilised to understand learning from experience in education (Fenwick, 2001). The reflective practices of respiratory CNS/ANP with the theoretical knowledge and relational capacities learnt during their educational programmes can be viewed as a learning self within a system, representing the space in which the learner develops as an independent and autonomous practitioner (Fenwick, 2000). As discussed in the next section, this must be set within the broader context of workplace and educational structures and power dynamics.

2.7.3 Reflection and Power

Questions of power are at the centre of the reflective process. Power dynamics are socially built and historically established, influencing what is valued. Power is crucial in determining what individuals include and exclude in perceptions and how people conceive agency, role, stance, or position negotiation. Increasingly reflective processes are packaged in learning and employment as goals or outputs that are economically and socially valued, such as stated competencies, achievement gaps, career ladders, and other practical objectives.

The constructions of reflection discussed in previous sections can be deconstructed by the critical-cultural viewpoint to highlight some constraints and limitations of current formulations of reflection in work and learning. Fenwick (2000, p. 257) highlights how “learning in a particular cultural space is shaped by the discourses and their semiotics (signs, codes, and texts) that are most visible and accorded most authority by different groups”. This points to the importance of power dynamics and ideological values within social structures. Through the ideological processes valued in current educational methods, individuals believe they can and should manage or influence their own lives, diverting focus away from the changes that are needed in the more extensive repressive system where they are subjected to norms, institutions, practices, and where poor communication is not openly discussed in favour of a belief in the power of individual action and transformative capacity (Fenwick, 2008a).

2.8 Conclusion

This overview of the education of respiratory CNS/ANPs indicates that respiratory specialist nurses’ contribution is an essential resource in the present and future healthcare delivery. The most important aspect of nursing training is the shift from nursing education as a vocation to an academic approach; however, the literature highlights the continued importance of the vocational characteristics of teaching, e.g., caring and compassion. This has had a significant impact on the development of nurse education.

This reflected changes in the discipline of nurse education, with the development of a constructivist student-centred approach focusing more on student learning through inquiry rather than teaching. Frameworks for nurse education had a focus and a structure for its curriculum and research activities and gave a basis of practice that supported the professionalisation of nursing. Cognitive psychology and constructivist learning theories are most evident in nurse education, while social theories of knowledge highlight the politics of knowledge and learning.

The literature examined how power operates in and through education by studying how nursing education has changed. Additionally, there was a noticeable transition in nurse education from practice- and experience-based to academic-based in higher education. The literature discussed how critical reflection plays a key role in modern nursing practice and nurse education and that it significantly impacts one's position intellectually and professionally.

The following chapter explores professionalism and professionalisation within respiratory CNSs/ANPs nursing practice, nursing, multidisciplinary teams, and a healthcare environment. It then identifies a thematic framework within which to situate this study.

Chapter 3: Professional Identity and Professionalism for Respiratory CNSs and ANPs

3.0 Introduction

Nursing practice within the healthcare service is continually evolving. This chapter explores respiratory CNSs and ANPs' experiences of professional identity and professionalism in this changing context. This is situated within broader historical, political, and social contexts. From a policy perspective, there was a concerted push in the past decade in Irish healthcare for more respiratory CNSs and ANPs. The goal was a 2% target to be in line with Europe, including respiratory roles (Government of Ireland, 2019). The first respiratory ANP was registered in 2015.

From my initial exploration of respiratory CNS/ANP roles in practice and their clinical field, I was aware of issues regarding the status and level of respect in the broader healthcare context and tensions within their roles. This initial exploration and my practitioner knowledge gave me a sense that respiratory CNS/ANPs were not well positioned and were not always very visible in their field. This was the origin of my doctoral study and the focus of my initial research questions (see chapter 4).

This marginal position of the respiratory CNS/ANPs changed very rapidly with the arrival of the pandemic, where their role became central. The Covid-19 pandemic highlighted the significant contribution of respiratory nurses to frontline care, leadership, education, and continuation of care for vulnerable patients with acute and chronic lung diseases. Covid-19 substantially impacts respiratory morbidity and mortality, with respiratory nurse practices being essential to the immediate response, planning of later stages of Covid-19 recovery, and the management of future pandemics. In response to the pandemic, respiratory nurses' expertise has been deployed to train and upskill the wider medical workforce and to develop

management guidelines and protocols at local and national levels. Many new strategies, initiatives and practices developed during this pandemic will leave a legacy for innovation in clinical care, enhancement of standards, efficiency, and improved patient outcomes in the future. It also offers learning for the processes of professional learning and the value of interprofessional education programmes, which are a focus of this chapter.

The Covid-19 pandemic provided an added particular focus to the research; however, the research remained true to its original research questions. This chapter draws on different approaches to defining the profession, and identity will be used in later chapters to discuss how the professional identity of respiratory specialist nurses (CNS/ANPs) is constructed and recognised in healthcare contexts.

Professional identity and professionalism are often used without a clear definition or conflicting definitions (Fitzgerald, 2020). Reviewing the concepts of professionalism and professional identity helps provide a common language and understanding for research and practice in this healthcare setting. While definitions of professionalism and professional identity are explored in later sections of this chapter, initial definitions are outlined here to guide the reader. A profession is viewed as a set of attributes (specific skills and knowledge, a mission, a code of ethics, and a self-governing body alongside a controlled entry to the occupation) that define and set boundaries on practice in a field of work (Etzioni, 1969). Professional identity is understood as a complex construct, an ongoing, self-reflective process of how individual conceives themselves (Wilson et al., 2013, p. 370). Professional identity is the enduring constellation of attributes, beliefs, values, motives, and experiences in which people define themselves in professional roles (Schein, 1978). It involves the ‘integration of personal values, morals, and attributes with the norms of the profession’ (Rabow et al., 2010, p. 312).

Educational theories have been influential in exploring how professional identity and learning become intertwined in the context of rapid change during the Covid-19 pandemic. This

massive reshaping of context through the catastrophe and immediate nature of a global pandemic alters learning and identity in what transpired for the respiratory CNS/ANP practices. Initially, this explored the formation of professional identity, which can be viewed through the lens of positioning theory in the following section, followed by exploration of social identity and professionalism theories.

Figure 3.1 Professional Identity and Professionalism for Respiratory CNSs and ANPs

3.1 Positioning Theory

Positioning theory was developed by Davies and Harré (1990), understanding identity as influenced by the relationships and interactions that individuals develop within broader social, historical, political and cultural contexts. The concept underpins that individuals and groups are positioned by themselves, others, and wider society.

Positioning theory explores how identity is formed through people's development and organisation, with narrative plotlines giving meaning to people's lives (Harré et al., 2009). These narratives are robust social tools or devices we employ to establish an identity for ourselves in the world in terms of who we are, who we were, and who we desire to be (Monrouxe, 2010). Georgakopoulou (2013) highlights the flows and connections between the narratives people tell themselves and others within local contexts and the broader social, cultural, historical, and political discourses (dubbed master narratives) as a significant analysis element within positioning theory. For example, the public notion of what it means to be a nurse could be considered a master narrative, whilst individuals' narratives of their identity as respiratory CNS/ANP may differ. Individuals use master narratives to position themselves and others within stories in order to claim rights and responsibilities for themselves, as well as to attribute and contest rights and responsibilities to others (Harré et al., 2009).

In terms of interaction, positioning theory is helpful because it can be applied to micro-level interactions as well as macro-level scale positioning (Harré et al., 2009). It can be used, for example, to frame interaction and identity work within small teams or to understand how professional groups and organisations position themselves in relation to others on a larger scale. It has also been used in conflict resolution to analyse power, conflict exacerbation and alliance creation on a macro level (Harré et al., 2009). Chulach and Gagnon (2016) found that master narratives are typically unspoken and uncontested. As a result, using positioning theory for analytical purposes brings narratives to a conscious level, allowing assumptions to be probed and questioned. Examining narratives provides a framework for learning about how social interaction during our daily practices gives insights into how we shape and negotiate identity in professional contexts.

Bamberg (1997) examines three positioning levels; firstly, examining the narrator as a character in relation to other characters in the story and how this relates to other social categories. Secondly, the narrator's position in connection to the subjects to whom they are

conveying their account is examined, revealing culturally rooted identity narratives. The narrator's position in terms of past events and pre-existing master narratives is examined finally to reveal people's sense of self and identity. Identity can thus be investigated as an interacting, cognitive, social, and structural process over time. Positioning theory raises and addresses the conscious level, tacit beliefs and behaviours situated within what are often invisible social structures (Chulach & Gagnon, 2016).

While positioning theory's concentration on the story might be considered a weakness of the theory (Czarniawska, 2013), it can be expanded with observations to explore how individuals position themselves and others within formal and informal workplace connections. Hence, it can make visible how workplace positioning and professional identity are exhibited in various ways, including naming, workspace allocation, presence and placement on websites or staff information boards, and being invited to meetings and uniforms. It has the power to address and bring hidden beliefs and behaviours inside social institutions to the surface (Chulach & Gagnon, 2016; Currie, Finn, & Martin, 2010). These elements offer the potential for this research to reveal and gain a comprehensive understanding of how, why, and what role identity and positioning have developed for respiratory CNS & ANPs.

Understanding how professional identity becomes evident in practice, it is required to investigate all three levels of identity from a social viewpoint: individual (micro), relational/interactional (meso), and social (macro) (Currie, Finn, & Martin, 2010). Although its usage in healthcare research has been relatively new, social identity theory can be used as a complementary model to positioning theory, as it enables us to conceptualise how individuals create group identity and the subsequent impact on behaviours (Burford, 2012).

3.2 Social Identity Theory

Social identity focuses on the concept that individuals identify with a social group to which they feel they belong. This focuses on how people form group alliances, adopt or standardise group

behaviour and develop individual and group self-worth (Burford, 2012). Social identity theory is an explanatory framework which focuses on the individual as part of a collective or group context (Willetts & Clarke, 2014). It integrates both social and individual levels of analysis. It provides a valuable framework for comprehending the impact of identity on the behaviours of professional groups operating in multi-professional settings, as occurs in this research. Burford (2012) argues its strength as a theoretical framework is its ability to explain, understand and clarify social identity in an analytical group-based process that acknowledges social settings' dynamic and complex nature.

Tajfel and Turner (1986) initially conceptualised social identity theory to examine the motivations underlying group behaviour that were not fully clarified by interpersonal relationships or personality trait theories of the time (Hogg, 2020). The principles of social identity theory emphasise how belonging to a group is very significant, and emotionally valuing group membership is acknowledged as necessary. It highlights the individual's status within the group and explores how self-worth is developed through self-esteem and perceived group status (Hogg, 2020; Willetts & Clarke, 2014).

A more contingent understanding of professional identity relevant to workplace settings, including healthcare, has been developed by extending social identity theory through the work of McNeil, Mitchell, and Parker (2013). They expand on social identity theory by using it to underpin the concept of professional identity threat. They contend, in concept analysis, that professional identity is essential for teamwork and that threats to established professional identities and hierarchies are often to blame for difficulties in engaging in effective collaborative work. Based on this theory, respiratory ANPs may be regarded as a potential threat to the professional identity of others in the setting due to their extended role and scope of practice in what was previously defined and held within other medical roles.

Critics of social identity theory argue that the framework is limited, as it theorises the relationship between the individual (at the micro level) and the group (at the macro level); however, only to the extent that each group member is regarded as interchangeable and that given the same function, any group member would behave predictably similarly (Currie, Finn, & Martin, 2010). Hence, individuals inside the collective are viewed as interchangeable prototypes based on role, according to the core principle of social identity theory (Hogg, 2020), so that if one member departs the community, they are replaced by another prototype individual, ensuring the group equilibrium. As a result, rather than person-based individual characteristics, a person's roles are prioritised. This was important for this study as social identity theory gives an explanatory framework to investigate group behaviours as roles shifted for respiratory CNS/ANPs. It has particular relevance in understanding tensions between groups that are perceived as competing for group status, as becomes evident in the later discussion chapter for this research (Fiol, Pratt, & O'Connor, 2009).

Currie, Finn, and Martin (2010) and Monrouxe (2010) claim that identities are developed not only because of roles played but also because of an individual’s qualities and interactions with other group members. Personal meanings and cognition influence individual values and standards at the micro (individual/cognitive) level. By combining micro and macro levels in this theory, we can argue that nursing identity can be influenced by how a person sees themselves as a nurse (micro) and how well it aligns with their awareness of the larger (macro) picture of nursing. The interactional (meso) level of professional identity is referred to as "relational identity" (Sluss & Ashforth, 2007). This concerns not only the individual and the collective but also the relationships and interactions among group members and members of different groups in a team and client context. Role-based and person-based attributes must be seen positively by others to function successfully in the workplace. Professional associations, academic environments, workforce culture, and broader societal discourses and structures all impact public image, status, and ethical obligations at the macro institutional or group level of

professional identity (Chulach & Gagnon, 2016; McNeil, Mitchell, & Parker, 2013). This gives a detailed framework to examine the changes in specialist respiratory nursing roles, which are the focus of the next section.

3.3 Professionalisation for Respiratory CNSs and ANPs

Professionalisation has enabled respiratory CNS and ANP nurses to meet the demands of a changing healthcare service. The respiratory nurse specialist diversification and expansion of roles are essential for the delivery of twenty-first-century care, with new ways of working acknowledged as important in maintaining the highest standards of professional education and training (Sundararaman, Muraleedharan, & Ranjan, 2021). This has included the significant step of expanding their scope of practice to include roles previously undertaken by medical professionals. The extended relationship with patients and their embeddedness in people's lives and communities is a notable feature of respiratory CNS and ANPs' work through their nursing care, educational role in managing respiratory conditions and patient advocacy in a multidisciplinary team context. The significance of these features and their role became particularly relevant during the Covid-19 pandemic, as discussed in later chapters. Respiratory CNS/ANPs are crucial in educational preparation and practice, supporting the nursing profession's continuing development and professionalisation. The professionalisation journey undertaken by respiratory CNS/ANPs was discussed in chapter 2 by reviewing the historical moments in the development of nursing in Ireland.

The practice of respiratory CNS/ANP must be placed in the social, cultural, and political contexts emphasised by social positioning and social identity theories. The previous chapter discussed how the medical profession and the multidisciplinary team relationships influenced the professionalisation of the roles of respiratory CNS and ANP nurses. A review of the history of nursing demonstrates the movement to raise the status of the discipline through the development of greater professionalisation (Coburn, 1988).

A specific feature of professionalisation within respiratory CNS/ANPs that has increased both on an individual and group basis is increased collaborative and reflective practice in nursing and multidisciplinary team settings. Interprofessional training offers opportunities for collaborative practice and team building and can help construct mutual respect, trust and understanding (Academy of Medical Royal Colleges, 2020). Professional identity and career progression are interlinked, and all health and care staff must feel reassured about the opportunities for further development. A culture of curiosity and learning that values reflection and improvement can enhance individual and group identities (Academy of Medical Royal Colleges, 2020).

The aim of professionalising the respiratory ANP was to make an advanced contribution to patient care, education, administration, research, and practice. As discussed in chapter 2, patient and multidisciplinary teams struggle to differentiate between respiratory nursing qualifications and roles, especially surrounding the competencies and professional responsibilities of the respiratory CNS. This confusion about the respiratory CNS role further complicates the successful implementation of the extended nursing role for respiratory ANP. It points to the complexities of professional identity formation and interactions within and across professional roles, which will be explored further in the findings chapters.

3.3.1 Gender and Knowledge Base of Nursing

Positioning theory allows us to view respiratory nurses within the context of their relationships with other medical professions and broader social contexts. This highlights the influences of the master narrative of the dominant nursing discourses in society. The impact of these dominant discourses shapes the norms, interactions, and dynamics of nursing as a profession, as is explored in this section.

Nursing has been predominantly gendered as a profession and continues to be dominated by female participants. Currently, 89% of female versus 11% of male nurses internationally,

according to Organisation for Economic Co-operation and Development (2019). A gendered master narrative shapes this based on the assumption that caring is a natural feminine trait and a suitable role for females in society. This does not translate into leadership positions in the profession, where females still do not occupy positions of power in senior roles (Hauser, 2014). Clayton-Hathway et al. (2020) and Ud Din, Cheng, and Nazneen (2018) contend that a lack of representation in positions of power in this female profession is not due to ability or education levels but more to do with personal and family situations, for example, many nurses work part-time, take career breaks and are mainly family caretakers. This is linked to the broader cultural and societal norms where women are perceived as having a 'moral imperative' to care and associated with caring roles in private and public life (Lynch, 2021; O'Brien, 2007). This moral imperative also positions the responsibility for care with the individual rather than as a core part of the interdependency of humans in their system and culture. It ignores the fact that caring is a human capability, meeting all people's fundamental human needs. The focus on the individual as a 'carer' and as 'cared for' systemically undervalues the roles of those who care in society (Cantillon & Lynch, 2017; Nussbaum & Glover, 1995, pp. 360-395). Hence, master narratives or dominant discourses orientate females towards these hegemonic feminised and caring roles (Cantillon & Lynch, 2017; Lynch, 2021), which have historically been given a subordinate status in relation to the medical field (Badgett, 1999). In nursing, professional recognition and the progression of professionalisation have been problematic when nursing is viewed as a job with little value, and its knowledge base is perceived as having a subordinate status in the medical field (Daiski, 2004). This reflects the broader debate about the relationships between care production and the gendered distribution of care work as critical concerns in the philosophical and egalitarian discussions of care and emotions (O'Brien, 2007).

Finlay (2000) suggests that it is incompatible to view nursing through the lens of professionalisation as motivated solely by power and authority. Nursing theories acknowledge

the specific body of knowledge for nurses, which combines the theoretical knowledge from health sciences with clinical-based, experiential learning from and with patients and colleagues, recognising this holistic knowledge base as a critical part of its status as a profession. Nursing theories create a view of nursing that addresses the mission, goals, and nature of nursing care hence designating a body of knowledge that is practice-based, care-orientated, with a holistic sense and orientation towards the patient. According to O'Brien (2007), individuals who provide emotional care labour often do it at unique costs to their well-being without recognition and reward. McKenna (2006) contends that this recognition gives nursing an alternative to its previous status as practised solely by tradition or intuition. Significantly, this knowledge base provides nursing with a framework for its education by suggesting a defined focus, curriculum structure, and a basis of practice, as explored in the previous chapter.

There have been phenomenal developments in the healthcare system regarding the professionalisation of nursing in the last two decades. As discussed in chapter 2, general nurse training in Ireland has seen much development and increased academic recognition, with pre-registered education and the report by the Commission of Nursing (Government of Ireland, 1998) having a significant influence on the professionalisation of nursing.

Features of and ways we can characterise a profession are discussed in the next section, exploring what has happened through the professionalism of this respiratory nursing role.

3.4 Defining Profession and Professionalism

Wilensky and Lebeaux (1958) describe a profession as a set of traits and characteristics against which an ideal occupation can be measured. This set of attributes recommends specific skills and knowledge, a mission, a code of ethics, and a self-governing body alongside a controlled entry to the occupation as the best characteristics of a profession (Etzioni, 1969). Etzioni (1969) considered nursing semi-professional due to the lack of a university degree and

the theory and research in the field at the time, suggesting that this cognitive dimension be acquired through university education. This can be linked to the 'vertical discourses', which Bernstein (2000) describes as containing the specialised knowledge base of a discipline, which was discussed in the previous chapter. Recognition of the importance of theoretical knowledge specialised to each discipline (Allais, 2014; Wheelahan, 2015; Young, 2008) is evident in the shift of nurse education into higher education documented in chapter 2. It is also evident in the ongoing emphasis in nursing practice on participation in CPD as part of professional requirements.

In the traditional model of nursing training, where nursing was viewed as a vocation rather than a profession, it was characterised as a consensual view of nursing where students were to follow the authority and expertise of the medical profession, assumed not to have specialised knowledge of their own, and nurses were not to question the doctors. This hindered the nursing profession from recognition and educational aspects. Power was taken or given to medics as the dominant experts in hierarchical structures within healthcare in Ireland and internationally (Willis, 2020). Foucault (2012) referred to this in the concept of docility-utility, discussed in section 3.5, which is disciplinary power imposing control over others, a controlling power.

In the process of nursing professionalism, the significance of its recognition of the specific practice-orientated knowledge that emerges tacitly during the care of patients discussed in the previous chapter is evident. While nurse education draws on theoretical knowledge from other disciplines, it integrates them into a new clinically based, practice-based form of nurse education through this lens of practice-based care. This is at the basis of nursing as a discipline and is evident in the development of advanced specialist roles such as respiratory CNS/ANPs. The expanded role of respiratory CNS/ANPs gives them greater capacity to make choices and decisions in their practice; hence, control and power negotiations on a professional level have become important (Lundgren et al., 2017), as discussed later.

The regulation of the profession, its practice and power is a key feature of professionalism, revealing the controls and boundaries set on knowledge and practice by profession. Nurses can be self-governing both at an individual level, in terms of practising within a scope of practice (Nursing and Midwifery Board of Ireland, 2015), and at the professional level, through the professional regulator. Like any profession, nursing must have clear regulatory principles so that registered nurses know what is required of them. These principles, outlined in table 3.1, are set down in the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (Nursing and Midwifery Board of Ireland, 2021a). They are essential tools in safeguarding the health and well-being of the public. These elements and aspects of the code of professional conduct and ethics are evident in the findings and discussion chapters below.

Table 3.1 Five Principles of the Code of Professional Conducts and Ethics for Registered Nurses and Registered Midwives (Nursing and Midwifery Board of Ireland, 2021a)

Expanding the scope of practice both at a professional level and at an individual practitioner level is a critical stage in the professionalisation of nursing. The respiratory CNS/ANPs are practising skills and knowledge that doctors only practised in the past. This is a significant shift

in development in the nursing profession and reflects how the continual development of knowledge and capabilities shifts positions and power dynamics for and between these groups.

Advancing the knowledge basis and scope of practice of respiratory CNS/ANPs requires regulation and CPD (as discussed in section 2.8). Compared to other nursing roles, CNS/ANPs are considered specialised nurses with a requirement for higher-level education with defined specialised modules in their specialised area of respiratory care, along with desirable modules to prescribe medicinal products and medical ionising radiation (x-rays). Through NMBI governance and regulation of nursing in the Republic of Ireland, the ANP role undergoes a registration process to accredit its practitioners. In contrast, the respiratory CNSs undergo an approval process (Begley et al., 2014), the implications of which are discussed in section 1.4. Respiratory CNS/ANP work in a health service where patients' demographic and epidemiological profiles change. The respiratory CNS/ANPs have responsibilities under their scope of practice (Nursing and Midwifery Board of Ireland, 2015) to contribute to the education of their colleagues and patients. These are discussed in greater detail in section 2.8.2 but are essential to note here as part of the professionalisation of the sector.

3.4.1 Recognition of Status and Power in Nursing

Nursing struggles to assert their professional power and autonomy relative to other, more established professions. This is evident in recognition of their professionalisation that has yet to be fully translated into financial reward through its pay structures and conditions. Lack of financial recognition has been reported when nurses have expanded their role (Ross, Barr, & Stevens, 2013). Lennon and Fallon (2018) found that respiratory CNS/ANPs felt they warranted additional financial recognition for their role, as their role produced cost savings for the organisation where they worked. Respiratory CNS/ANPs in Lennon and Fallon’s (2018) study also reported that they were conflicted on an emotional level about wanting additional

payment and recognition. This conflict seems to stem back to the culture where nursing is viewed as a vocation (see chapter 2) rather than a profession, with the desire for financial recognition or reward not deemed valid in the emotional commitment associated with a vocation. Respiratory CNS/ANP roles provide several strategic advantages, such as improved service delivery, faster throughput, reduced costs and a transparent governance and accreditation structure. Challenges exist in successfully implementing expanded practice roles due to internal and external factors such as peer support, organisational issues and cost (Fealy et al., 2018).

Professional structures such as medical power and administration conservatism are seen as hampering nurses' entry into roles as respiratory nurse specialists, as well as their establishment and progression from those roles (Powell & Davies, 2012). The notion that professional-level impediments to practice overrode person-based interactions (Powell & Davies, 2012) was an interesting conclusion; for example, a medic claiming to be knowledgeable with the objective of dominating nurses and the service, thus seriously impeding the practice of expert nurses. As a result, an individual nurse's competency had less impact on role acceptance than long-held beliefs about professional identities. Trapani, Scholes, and Cassar (2016) highlight that nurses' interactions with medical practitioners were marked by power imbalances of which they were acutely aware, which obliged them to include doctors in their clinical judgments. When nurses decide to consult a medical practitioner, they must consider several occasionally competing motivations, striking a balance between their moral duty to protect patients' interests and the need to accept authority (Trapani, Scholes, & Cassar, 2016). Subsequently, as agents for both patients and medical practitioners, nurses find themselves positioned in a situation of dual agency where nurses ultimately feel morally obligated to act as their patient's agents. At the same time, several other factors influence practice because of the others involved in patient care.

According to Currie, Finn, and Martin (2010), active but unseen labour is carried out to safeguard established identities and hierarchies amongst professions, which impacts the ability of nurses working in new roles to attain their full potential. In nursing, the development of therapeutic relationships, emotional care, and social interaction, like holding a patient's hand, can be regarded as unseen labour, and work related to care is often invisible. The significance of holding a patient's hand expresses several of the capacities of nursing: to emotionally connect with the patient, to communicate in an embodied manner through touch, and to monitor the quality of health evident in a patient's pulse and skin condition. The cost of this unseen labour is not reimbursed and can impact nurses' emotions, affecting one's mental, social, and physical health (Lynch, 2021). This adds to the discussion over professional identity and border work by proposing that new nursing positions should be viewed as 'less bounded' or 'differently bounded' rather than 'boundaryless'.

Organisational and professional barriers continue to limit new working models for respiratory nurse specialists, as the traditional cultures where nurses were subservient in comparison to their medical colleagues still exist. This is significant because the efficacy of advanced practice positions is jeopardised if the impact of this lack of recognition of their professional identity in the healthcare field is not considered. Powell and Davies (2012) agree with Currie, Finn, and Martin (2010) that there is a link between changing professional identity, positioning and cross-border cooperation with colleagues. Powell and Davies (2012) discovered that health professionals resistant to role transformation and the development of working practice hampered professional boundaries. This was accomplished through tactics such as doctors claiming knowledge to gain jurisdictional authority over the service and other nurses who significantly impeded specialist nurses' practice to ensure that the status quo was maintained. Maxwell et al. (2013) investigated how specialist nursing roles gained jurisdiction, or the legal right to engage in specific workplace practices. This study discovered four social identities: professional, speciality, relational, and organisational. These social identities influenced the

types of roles established (new roles are ambiguous until they are established), role acceptance (to gain acceptance from others and with the group), and jurisdictional mandate (to gain trust, confidence, express and authority).

Maxwell's et al. (2013) study discovered that interprofessional relationships between and within professions substantially impacted job acceptance, with personal traits garnering greater support than technical expertise. However, this was frequently in the form of medical patronage, which can be interpreted as demonstrating a medically dominated healthcare hierarchy. Power is infused throughout such a hierarchical structure, with the position of expert nurses potentially in jeopardy because patronage might be removed. It is also a deeply divisive system on an individual level, placing staff in competition with each other for patronage. Hence, other nurses appear to obstruct the development of any functions (such as the expanded scope of practice), as rivalry and ambition are advantageous to the organisation (Cleary et al., 2016). It is also highly contingent on professional negotiations within the sector. 'The professional identity of the fixer roles as "a response to the need to comply with national performance targets" (Maxwell et al., 2013, p. 626) also had an impact on their relationship with other nurses within the organisation who had not been party to agreeing with the new jurisdiction' of changed roles or practices (Maxwell et al., 2013, p. 627). Hence, multidisciplinary and good interprofessional relationships help define a speciality social identity.

Healthcare professionals are typically recognised by their professional identification or by their clinical specialities (Maxwell et al., 2013). Although relational social identities do not grant the receiver membership in the group, it draws attention to the power dynamics of the relationships in the group and how recipients of new roles engage with both members of the group and those who would like to ally with the group. Organisational social identities, the professional/managerial identity continuum, and the speciality/generalist identity continuum are intimately related to the role's content. The relationship between organisational identity

and its values and culture, or ‘the way things are done’, according to Maxwell et al. (2013, p. 628), appears to be the foundation of social identities.

As individuals, we all hold multiple identities, including our personal and professional selves as nurses and educators. In this context, people are likely to identify as part of a greater whole, whether as employees of an organisation or a professional body. As part of their professional identity, individuals often assume the values, skills and behaviours of their occupational group, ‘thinking, acting, and feeling’ part of a group (Cruess et al., 2014), whether that be a nurse, respiratory CNS, respiratory ANP, physiotherapist, doctor. Professional identity enables respiratory CNS/ANPs to connect with their job and develop a sense of self and perception of belonging.

Individuals shape their professional identity concerning the perceptions and expectations of those around them, including colleagues, patients, employers, regulators, and those outside their working life and broader society. In the last twenty years, the tasks and skills that were traditionally the preserve of one clinical team, the medical, have become the responsibility of other team members like specialist nurses and respiratory CNS/ANPs. Respiratory CNS/ANPs encounter, engage with and sometimes challenge other team members who question their changing professional identity.

3.5 Professional Identity

Professional identity is a complex construct, ‘an ongoing, self-reflective process involving habits of thinking, feeling, and acting’ (Wear & Castellani, 2000, p. 603). Professional identity ‘requires the integration of personal values, morals, and attributes with the norms of the profession, that is, of the individual’s identity with the professional self’ (Rabow et al., 2010, p. 312). Wackerhausen (2009) agrees, discussing professional identity as embodying norms, beliefs, and practices similar to those of a profession. As nursing practice is continually

evolving, with nurses expanding their scope of practice to include roles previously undertaken by professionals, defining professional identity is very relevant to this research.

As people adopt forms of professional identity, they internalise their professional behaviours and ethics and develop self-regulation and adherence to appropriate behavioural norms of their profession (Hamilton, 2008). Professional identity allows the presentation of proper actions and demeanour to society, thereby instilling confidence and respect for the profession. Extensive literature identifies professional identity as a sound theoretical framework to explore how professional values are formed, changed and developed, and this is explored in the following section in terms of suitability for analysis in this study (Chulach & Gagnon, 2016; Currie, Finn, & Martin, 2010; Monrouxe, 2010).

As this study relates to the role of respiratory CNS/ANPs, the emergent context of Covid-19 had an enormous influence and significance within this field. A significant portion of this chapter will explore professional identity concerning the development of respiratory CNS/ANP roles before the Covid-19 pandemic and the changes that occurred because of Covid-19.

As mentioned in section 3.1, a positioning theory is helpful to understanding the identity processes at individual, interactional, broader institutional and social levels. It is helpful in the study of professional identity within healthcare environments, as it considers identity construction at micro, meso, and macro levels, the interaction of which is poorly understood in today's healthcare settings (Currie, Finn, & Martin, 2010). It allows us to consider how respiratory CNS/ANPs are influenced by their given positions in how they view themselves, how others perceive them, and how they act.

3.6 Professional Identity Construction

Professional identity encompasses the area of one's professional self-perception (Best & Williams, 2019). Schein (1978) recognises professional identity as the relatively stable and

enduring constellation of attributes, beliefs, values, motives, and experiences in which people define themselves in professional roles. Professional identity is a construction that changes over people's careers and is seen as emergent and more flexible in the initial phases of the professional career (Ibarra, 1999). Professional identity is constructed by drivers such as gender and professional culture and recognises that professional identity is further modified by working experience (Best & Williams, 2019). Pratt and Corley (2007) describe professional identity as centring on two parts. Firstly, role identity with different professions, individual skills, and knowledge where individuals are doing what they can do, which results in their actions being seen as unique and specific in the eyes of colleagues and patients, as they are only seen in that role. Secondly, the feeling of individualism explores how people develop and retain a sense of uniqueness in their work identities (Pratt & Corley, 2007). In the case of respiratory CNS/ANPs, their recognised work or professional social identity is constructed as an individual who identifies as belonging to the profession of nursing or perhaps the specialist identity of respiratory nurse with other individuals who engage in the same approach to a form of work (as explored in later findings chapters). Professional identity is constructed in how an individual makes meaning from their daily work, how these experiences influence and express what is meaningful in a situation, creating a sense of trust and furthering a feeling of security.

Siebert and Siebert (2005) claim that an individual's professional identity, both the role and work identity, is essential not only for the unique sense of identity it gives people but also because it determines behaviours and working attributes. Vitally, the construction of one's identity is highly significant for those providing care; for example, deciding on how the respiratory services are delivered ultimately depends on the respiratory CNS/ANP nurse's behaviour, establishing the quality of respiratory care received. Mitchell and Boyle (2015) note that this type of professional identity within healthcare is focused on single professions and the education of those professions, highlighting that more needs to be known about

professional identities within the advancing world of interprofessional teams, which characterises much of the work of respiratory nurse specialists today (Mitchell & Boyle, 2015).

The literature has identified four interconnected methods for achieving and constructing professional identity: performance, reflectivity, narrative, and socialisation/social identity.

3.6.1 Professional Identity and Performance

It has been hypothesized that professional identity evolves from performance (Willetts & Clarke, 2014). Monrouxe (2010) argue that, when adopting a professional identity, individuals first act as if they are one and then begin to internalise that identity to become one. As a result, professional identity is the embodiment of the profession's habitual habits, which have become normalised over time and often accepted without reflection or inquiry. Internalised values become subconscious and tacit in this way (Wackerhausen, 2009). The study of social performances and habitual practices may thus give a better knowledge of underlying attitudes and behaviours, allowing for a better comprehension of professional identity.

3.6.2 Reflectivity in the Formation of the Professional Self

Recognising that the person is active in forming their professional self is vital (Wilson et al., 2013). Individuals learn to reflect on how their professional group reflects, think in how the group thinks, and value what the group values through a process of enculturation from the profession's perspective (Wackerhausen, 2009). A respiratory CNS/ANP may reach different outcomes regarding the patient's condition than other team members, and this distinction may denote their identity, thinking processes and disciplinary discourses. Clarifying what one is not may play a significant role in defining who one is (Fiol, Pratt, & O'Connor, 2009). However, when the profession's perspective is so established that team members lack the awareness to reflect from the perspective of others, this can become an issue due to a risk of professional

identity conflict (McNeil, Mitchell, & Parker, 2013; Wackerhausen, 2009). The narratives or discourses that professions tell are one way they set themselves apart from other professions.

3.6.3 Narratives of Professional Identities

Frank (2010) described how, as we narrate our story, it becomes indisputable due to the sense of emotional engagement with it. When this occurs in a professional setting, cultures and identities emerge. When there is no standardising narrative framework through which to understand events, disruption ensues, which can lead to emotions of professional confusion, imbalance, and threat. Furthermore, group members are supposed to share a common understanding of the shared story; if they do not, conflict may arise (Frank, 2010). Multidisciplinary team members tell narratives about themselves as members of the group and the group to which they belong, as well as narratives that indicate the group's typicality to distinguish their distinctive disciplinary professional identity and to create a common team or identity (Wackerhausen, 2009). Hence, identity development is influenced by how narratives are delivered, what is included, excluded and deleted, and the meanings, intentions, and characterisations assigned to the narratives we create (Garcia & Hardy, 2007). Positioning oneself concerning others or a professional group in reference to other professional groups is a part of narratives (Garcia & Hardy, 2007; Wackerhausen, 2009). Narratives are used internally in the tales people tell themselves, and externally in the stories, they tell others to construct identities (Garcia & Hardy, 2007). At a team level, coherent narratives are realised through socialisation and interactions between different groups and group members, which has been the focus of research in and around healthcare.

3.6.4 Socialisation Through the Professional Lifespan

Socialisation is fluid and continuous, developing throughout a professional lifespan (Lai & Lim, 2012). Prescribed norms, such as policies, formal hierarchies, and job descriptions, are structural components of socialisation. In contrast, cultural elements refer to language and

symbols that express ideas and values of the profession, according to Lai and Lim (2012). Cultural and structural components of socialisation influence professional identity and behaviour. Formal socialisation processes primarily investigate structural socialisation, whereas cultural influences are frequently informal or hidden; these cultural practices are mainly responsible for professional identity assimilation (Hafferty & Franks, 1994) (Wackerhausen, 2009). There can be dissonance between structure and culture, which could help explain why role implementation is not always successful despite organisational support (Currie, Finn, & Martin, 2010).

Formal socialisation refers to institutional practices such as classroom instruction and overt professional practices aimed at instilling professional identity and, as a result, professionalism. Formal directives are converted into practical applications through the informal socialisation processes of learning from colleagues. The transference of cultural practices unrelated to formal educational and professional goals is called hidden socialisation. For example, the enculturation of gallows humour among healthcare professionals is a culturally recognised coping technique which is kept hidden from formally institutionalised socialisation agendas. Formal socialisation methods are thought to have a higher impact on professional identity than informal and covert socialisation processes (Hafferty & Franks, 1994). Socialisation and the interactional processes of performance, reflectivity, and narrative-telling are fundamental to developing professional identity and enculturation into professional education and practices.

3.7 Professional Identity within Multidisciplinary Teams

Professional identity within multidisciplinary teams is acknowledged as a complex process correlated with higher levels of perceived integration (Gilburt, 2016). Professional identities are sustained, nurtured, and developed, reflecting identity formation's dynamic and ongoing process (Academy of Medical Royal Colleges, 2020). However, respiratory CNS/ANP identities will be shaped and reshaped as the professional landscape changes. Although some

core characteristics and values will remain constant, others will evolve. In emergencies and disasters like Covid-19, one's professional identity must be flexible and withstand changes in the professional environment. It must adapt to new ways of working, which was the case for respiratory CNS/ANPs. The Covid-19 pandemic and our response have demonstrated the importance of multi-professional working amid unprecedented service pressures, working together as part of a new single team in the face of this catastrophic and devastating pandemic.

Literature on multi-professional teams reveals that if professional teams are to thrive in practice, members should be encouraged to build their professional and collective team identities. Without blurring the lines between distinct professional groups, a shared team identity recognises and honours the unique talents of all members. Teams should recognise how each member contributes to the patient's care and how they can collaborate efficiently.

Multi-professional team-working relies upon appropriate and supportive supervision. Healthcare professionals should be supervised by the most appropriate colleague, whether this is someone from the same or a different professional group. Supervisors must understand the roles and responsibilities of those working under their supervision. They must also recognise that other professional groups have different approaches to and cultures of supervision. Effective multidisciplinary professional teamwork requires collaboration and mutual respect without protectionism of specific practices or roles (which can lead to the associated perpetuation of silos), as was evident in the first and second wave of the Covid-19 pandemic (Butler et al., 2021).

Teams must recognise that members possess multiple layered 'identities', including their identity as a healthcare professional and their shared identities as part of a team, an organisation, and a professional group, as explored in previous sections. Practitioners may have a pre-existing identity from an earlier clinical role as a nurse and then develop a different

identity in their new advanced role. Some will move between these identities, reconciling and integrating them to create a blended or hybrid identity, but others may struggle to combine them (Brown et al., 2020). Holding multiple identities without conflict may help individuals integrate better into multi-professional teams and settings. In this environment, people need to be confident in their professional and personal identities and those of their colleagues (Edmondson, 1999). Multi-professional teams must foster a supportive environment where hierarchies are flattened and feedback encouraged. A potential conflict may include concerns about or resistance to changes in the team's constitution; therefore, teams must develop strategies to manage and resolve conflict to facilitate an inclusive culture (Whitehead, Dittman, & McNulty, 2017). Team members may be less likely to feel anxious about changes if they have a forum to express concerns, and if their concerns are adequately addressed, communicating different roles and responsibilities helps to tackle uncertainty (Whitehead, Dittman, & McNulty, 2017). Members are also less likely to feel threatened if they have a confident sense of their professional identity and are reassured about available opportunities.

The team members must understand their duties, the roles of others, and how their skill sets complement one another. A common understanding of an individual's scope of practice, skills, and lines of accountability and governance should exist (Nursing and Midwifery Board of Ireland, 2015). These difficulties must also be fully understood by administrative and management personnel. In more fluid or transitory teams, or if professional boundaries are compromised, such clarity can be challenging to achieve and impact professional identity. During times of crisis and continual change, multidisciplinary teams have limited time or space to create relationships or develop individual and group identities as becomes relevant during Covid-19, as later findings discuss. Byram et al. (2022) view the development of learning identities in changing social contexts, such as a pandemic, as contributing to the expansion of nurses' knowledge and identities.

As respiratory CNS/ANPs' role expands and diversifies, multidisciplinary teams and patients need support to navigate the changing landscape. In practice, roles and responsibilities should reflect all team members' recognised knowledge, learning, training, skills, and qualifications. Smith et al. (2022) view changes in everyday life as having consequences for an individual's sense of self and one's learning identity. Respiratory CNS/ANPs must clearly explain their role to patients and families and, most importantly, clarify their professional identity and learning identity to colleagues in their multidisciplinary teams. Role recognition is vital for building professional identity; however, healthcare professionals have reported being introduced incorrectly or mislabelled (Brown et al., 2020). A better understanding of the role of the patient helps in managing and informing expectations (Halter et al., 2017).

3.8 Professional Identity and Complexity of Power

Clark (2014) discusses the dominant narratives in interprofessional practice and education, noting where the generation of an individual's professional identity is explored in three main aspects: the self, the relationship with patients and the relationship with others on the team. This approach allows awareness of the diversity of the numerous levels/grades of professionals and recognises the interplay of various influences in building a professional identity (Clark, 2014). Payne (2006) looks at identity politics and argues that identity construction is changing. Historically, roles have been attributed to people within well-established power dynamics and contexts where their role was clearly understood. Payne (2006) argues that with the advent of professional teams working across multiple disciplines, roles now need to be negotiated due to the boundaries being more complex. The different skills and resources required within the team and beyond suggest that communities of practice are fundamental as they help construct the identities of fellow professionals and support the development of a shared identity and history (Payne, 2006).

Payne identifies a sub-theme within the construction of professional identity as power, as the previously stable power dynamics between professionals now shift within the growth of professional teams (Payne, 2006). Creating a solid professional identity is necessary for recognising other people's professional identities and negotiating one's professional identity while establishing those of other professions. Trust is critical when dealing with professional identity in nursing and during times of change, such as during the Covid-19 pandemic (Best & Williams, 2019). However, some may see the use of power as having a negative impact on other colleagues' perceptions of their professional identity. Pate, Fischbacher, and Mackinnon (2010) mention the fight for professional identity is not new, with the concept of professional identity being long-standing and highly valued by health professionals. This constructionist view of professional identity acknowledges it as requiring active engagement and management, which cannot be ignored, particularly during periods of uncertainty. The idea of a static and single professional identity in nursing that was popular in the past is now outdated and unfit for purpose, with a shift towards this multi-layered and responsive view of professional identity as a dynamic and complex construct.

3.9 Professional Identity and Struggles over Recognition

Identities are shaped through an individual's participation in or engagement with different 'communities of practice', learning through interactions with different groups. People manage their multiple identities in different ways, learning to navigate and reconcile the many layers of their identities. Research suggests that a robust professional identity has positive and negative consequences for individuals and their colleagues (Monrouxe & Rees, 2017).

On the positive front, it has been linked to autonomy and resilience (Ralph, 2015), well-being and the ability to mitigate burnout (Monrouxe & Rees, 2017), ethical decision-making in difficult situations (Ralph, 2015) and patient care, adherence to standards and interpersonal communication. Research suggests that a solid professional identity within multidisciplinary

teams is associated with higher levels of perceived integration in the group (Gilburt, 2016). The significance of these themes becomes evident throughout the findings chapters later in this thesis. A study commissioned by the Professional Standards Authority in the UK found that it was 'the commitment of individuals to practise in line with the standards that follow from their own professional identities that drive good patient care' (Christmas & Cribb, 2017).

However, if an individual has an overly rigid professional identity, this may lead to poor teamworking and resistance to change. A strict identity might also fail to equip the individual for changes in their working patterns, practices, or professional environment. Introducing new roles or ways of working can be perceived as a challenge or threat to pre-existing professional identities. Hence, colleagues need to retain a sense of their unique qualities, contributions, and professional identity while working closely with others from different occupational groups. 'Identity dissonance' can occur when individuals struggle to reconcile the various aspects of their identities (Costello, 2005). These positive and negative aspects of identity formation are explored in later chapters regarding its implications for respiratory CNS/ANPs, specifically within the context of rapid changes during the Covid-19 pandemic.

3.10 Professionalism and Professionalisation during the Covid-19 Pandemic

The media covering the pandemic recognised nurses as everyday heroes who were unwavering in their commitment to patients and their profession. This acknowledged how nursing was described in 'martyr' terms, which explained how nurses worked with many critically ill patients in poorly resourced conditions and often without personal protective equipment (PPE) in the early months of the pandemic (Mason, 2020). The extensive range and type of imagery used by media and the public to describe respiratory nursing have impacted the profession.

The term heroism is often linked to fictional characters such as superheroes or ancient Greek mythology. During the Covid-19 pandemic, this term was increasingly used to describe

healthcare and essential workers. It is, therefore, useful to explore the contextual circumstances and features of discourses on heroism in the literature. MacDonald et al. (2018) examined the use of heroism in nursing as the inspired act of the courageous and questioned what defines a hero and what is heroic. Their review of the literature reveals a broader understanding of heroism, with the role of nurses in everyday heroism evident in their work in extraordinary contexts such as

> ‘Nurses who work in first-response situations, pandemics, and humanitarian and disaster relief work are also often acting heroically because they continue in their efforts, despite the personal risk. Such personal risk obviously includes the risks of contagion, illness or injury…[and] a lack of recognition’ (MacDonald et al. (2018, p. 139).

MacDonald et al. (2018, p. 139) discuss how ‘everyday heroism equates with moral courage…justice values and compassion…[and] the ability to act ethically and creatively’. It is a contextual understanding of heroism imposed by extraordinary situations that are different to the traditional view of the heroic individual, the inspiring figure with exceptional characteristics. The emergent literature on Covid-19 identifies that healthcare professionals, including respiratory nurse specialists (CNS/ANPs), recognise the risks of their occupation in a pandemic situation; some perceive those risks as not worth taking for themselves and their families (Koh, Hegney, & Drury, 2012). Heroism in nursing is a term that became very popular in current literature linked to the Covid-19 pandemic. Cox (2020) discussed the difficulties following the media focusing on ‘healthcare heroes’ and acknowledged the degree of personal risk exceeding the duty of care. It fails to recognise the importance of reciprocity, and by implying that all healthcare workers must be heroic, it can have adverse psychological effects on workers (Cox, 2020, p. 510).

The Covid-19 pandemic had an emotional effect on respiratory nurse specialists, and their coping mechanisms have endured a transformation due to the stress experienced during this time. The literature on coping mechanisms is helpful to revisit, considering the impact of this pandemic. Folkman et al. (1987) describe the thoughts and actions of individuals dealing with stressful incidents as coping. There are two general coping strategies; problem-focused coping, which is finding a solution and taking action, and emotion-focused coping, which involves finding a way to reduce emotional stress connected with a stressful situation (Folkman et al., 1987). During the Covid-19 pandemic, respiratory CNSs and ANPs were utilising both problem-focused and emotion-focused coping skills to deal with the uncertainty of not knowing what would happen next.

Emotions are supposed to have properties that stimulate certain behaviours, like fear, anger, disgust and happiness (Ekman & Davidson, 1994; Fredrickson, 2001). Evidence from international literature indicates that the typical emotions experienced during a pandemic include fear of themselves and colleagues becoming sick from the Covid-19 virus, desire to protect themselves and their families from Covid-19 (e.g., using PPE), anger related to information and resource void, concern with a lack of vaccinations, forlornly related to when the Covid-19 pandemic would end, secure in their jobs and need to support each other as nursing and multidisciplinary teams (Renström & Bäck, 2021), all of which are evident in the findings chapters.

Coping strategies and emotions are closely linked. Charles, Reynolds, and Gatz (2001) describe how individuals who experience anger and fear regarding a situation or event ask questions and use active orientation coping strategies. In contrast, individuals who experience sadness are silent and more likely to accept or avoid the issues/situations and use passive coping strategies. These are a complex of secondary traumatic stress reactions, including occupational stress and burnout, which face individuals working in high-pressure and intense contact working contexts (Sinclair et al., 2017).

3.11 Conclusion

Changing work habits can cause anxiety, stress, resentment, and hostility at any time, let alone in the uncertainty and immediacy of a global pandemic. These challenges must be addressed honestly to create a healthy environment where respiratory CNSs, respiratory ANPs and all team members can thrive. Professional identity and career development are inextricably linked, and all healthcare workers must be confident in their ability to advance their careers. A culture of curiosity and learning that places a value on reflection and self-reflection improves and enhances individual and group identities.

Little research focuses on the professional identities of respiratory CNS/ANPs in multidisciplinary healthcare teams concerning their practice. This research aims to explore the education experience of respiratory nurse specialists (CNS/ANP) to understand how knowledge and learning are used in their clinical health environment to enhance practice development and generate knowledge-based practice. It seeks to explore the professional identities of respiratory CNS/ANPs, how professional boundaries and the relationships and roles within multidisciplinary healthcare teams are formed (Matykiewicz, 2011). Exploring at this micro level intends to develop a deeper insight into how respiratory CNS/ANPs experience and practice within respiratory nursing care.

The frameworks discussed in this chapter will underpin the research process with the intention of gaining a more in-depth and explanatory understanding of the relationship between professional identity and professionalism and how they have evolved in nursing than would be gained from utilising a single framework. Chapter four will describe the methodology and methods relating to the research process before the findings are explored and discussed.

Chapter 4: Methodology

4.0 Introduction

This chapter outlines the methodological design of this research. It discusses the subsequent research processes and methods used in the study to explore the educational experiences of respiratory clinical nurse specialists and advanced nurse practitioners in nursing. The qualitative research approaches of the exploratory study are influenced by hermeneutic phenomenology (Heidegger, 1962) and Dewey's (1925) constructionist emphasis on the inquiry into real-world experiences. This research was undertaken to generate a practitioner knowledge base about nurse education with the potential to inform education research and policy in this area.

This methodology chapter initially discusses the development of my research position and question, followed by the study's aims. It then explains the research approach, discussing the different research designs. It explores the origins of qualitative research and highlights Heideggerian phenomenology's central tenets before outlining the rationale for choosing this approach. I discuss my research positioning and how my methodological approach and methods correspond with my philosophical position. The research participants, sample, and sampling methods are then outlined. This is followed by a discussion of the methods of data collection, research ethics considerations, and the data analysis undertaken.

4.1 Choosing a Research Paradigm: Quantitative or Qualitative?

Research can be chaotic and curious but offers a chance to learn about something. Research pries and pokes to uncover different perspectives and, in doing so, find different paradigm approaches (Hurston, 1942). Paradigms, qualitative or quantitative, are seen as a 'set of beliefs and feelings about the world and how it should be understood and studied' (Denzin & Lincoln, 2012, p. 26). The conception of the research approach and design must go beyond

the steps of an outlined research pathway to represent the researcher's vision and beliefs (Parahoo, 2014)

Research can be categorised into two broad methodological approaches from the quantitative and qualitative paradigms (Polit & Beck, 2017a). Quantitative research emphasises measuring and using figures to capture, measure, and compare aspects of the social world. In contrast, qualitative research concentrates on the meanings of the world conveyed by people in the conduct of their reality of practice (Ingham-Broomfield, 2015). Quantitative research is primarily designed before commencing data collection and seldom shifts from this framework. This stands in contrast to qualitative research, where the researcher uses an evolving research design that usually evolves over the course of the research study (Polit & Beck, 2017a). The world of quantitative healthcare research has led to evidence-based practice for decades, investigating a specific phenomenon using a rigorous process and statistical analysis (Polit & Beck, 2017a).

For this research study, qualitative methods offer a form of research that is naturalistic and inductive. It provides an opportunity to understand the educational experiences of respiratory nurses as they give voice to their experiences and perspectives. Qualitative research focuses on the in-depth understanding of the phenomenon under investigation and its subjective nature, enabling the researcher to comprehend individuals' beliefs, interactions, and experiences. This is important for this study because it intends to focus on how respiratory CNS/ANP nurses experience their nurse education and practice. The focus of qualitative research approaches people's everyday experiences in their naturalistic setting, providing a platform to voice and giving visibility to an area of nurse education that is trying to gain greater recognition for the changes in its practices, knowledge base, and capacities.

This was completed through the qualitative research method of in-depth interviews. This form of 'interviewing involves asking open-ended questions, listening to and recording the answers,

and following up with additional relevant questions. On the surface, this appears to require no more than knowing how to talk and listen. Beneath the surface, however, interviewing becomes an art and science requiring skill and sensitivity, concentration, interpersonal understanding, insight, mental activity and discipline' (Patton, 1987, p. 108). Interviews offer a flexible, participant-focused, and naturalist form of research. Interviews allow participants to give an inner perspective about their behaviour and context, which is very important for this research's focus on recognising respiratory CNS/ANP practitioners' work. Given the in-depth focus on people's experiences, qualitative interviews usually involve a limited number of semi-structured conversational-style interviews between the researcher and the participants.

An in-depth analysis of the recorded conversations allows the researcher to construct narratives. This method of analysis acknowledges the role and impact of the researcher in co-constructing the knowledge flow through the research process and relationship. In qualitative research, we 'learn about what we may or may not expect of the product or theme as well as the actual content and the context in practice' (May, 2002, p. 6).

The intention of adopting a qualitative interviewing research design and methodology for this research thesis was to ensure that its methodology is consistent with the practitioner-orientated and practice-based learning at the heart of this research. Establishing my positioning and demonstrating how the philosophical approach is congruent with the methodological design and methods used is essential.

4.2 Ontology and Epistemology

Engaging in research is impossible without the researcher committing to clear ontological and epistemological positions (Scotland, 2012). In discussing my research positioning, it is vital to be critically aware and reflective about how research and knowledge are constructed, interpreted, and used throughout the research journey. Ontology explores the assumptions and fundamental conceptions of knowledge (Bentz & Shapiro, 1998). It critically considers the

knowledge of being and explores beliefs about the nature of being, which are often left unquestioned. Therefore, ontology can be described as the nature of being in the world and what can be known about that reality and the social world that exists. The most common ontological positions are realism (the notion that something is real) and relativism (that 'reality' is filtered through your relationship with reality). Epistemology is the study of the nature and scope of knowledge and justified belief about that knowledge. Bentz and Shapiro (1998) explain epistemology as knowledge of the outside world and how the mind comes to objective knowledge. My understanding of ontology and epistemology emerged in my conversations with my fellow students, acknowledging that 'there is no better place to start than with the building blocks of research: ontology, epistemology, methodology, methods, and sources' (Grix, 2018, p. 69). I have been guided by the mantra of what I consider knowledge as ontology, how I know it as epistemology and the process for studying it as methodology.

Ontological claims are claims and assumptions that are made about the nature of reality, and epistemology is about how we come to know what we know (Grix, 2002). Constructivism can be cognitive; ontological constructivism claims that the knower makes the world. Considering ontological and epistemological positioning as a spectrum (see Figure 4.1), viewing ontology from a realist stance at one end to a constructivist stance at the other, I currently position myself towards the realist end of the spectrum. Using the same spectrum, viewing epistemology from positivism at one end and interpretivism at the other, I position myself somewhere in the middle. Two contrasting epistemological positions are those contained within the perspectives of "positivism" and "interpretivism". Positivism as an epistemology is associated with an objectivist ontology, which implies independence between social phenomena, their meanings, and social actors (Grix, 2002). In contrast, interpretivism explores the social world of the people being studied, focusing on their meaning and interpretations; the social actors construct meanings in a particular context (Grix, 2002).

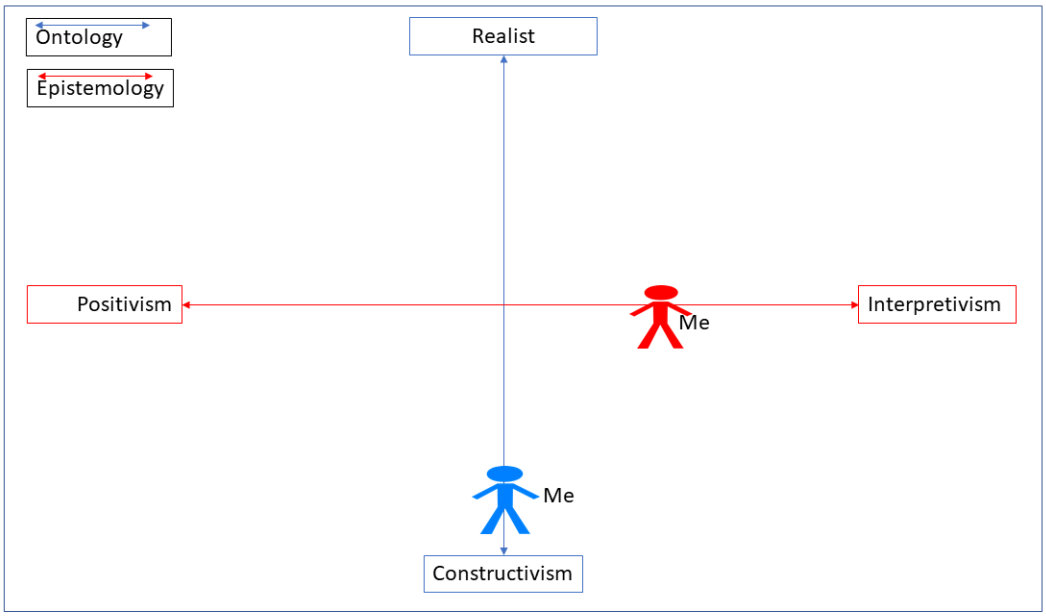

Figure 4.1 My Ontology and Epistemology Stance (adapted from (Grix, 2018))

I struggle with the positivist concept that knowledge exists independently of individuals 'out there', and those individuals can objectively know it, which is the dominant approach in the specific and medical fields. I continually question whether we can know our realities influenced by an interpretivist approach. As the researcher, I have integrated my thinking about ontology within my emergent researcher identity, which I feel influences the research process. I understand my research engagements with participants as being processed through the personal and professional lens of understanding embodied experiences and reflections as the 'evolving nexus (personal and professional) that constitute life and converge in the mystery of self' (Palmer, 2007, p. 18). My social reality exists as individuals experience it. As many different people exist, there will be or may be many realities, which permits me to encompass a constructivist ontological stance.

As a researcher becoming familiar with social science methodologies, I navigated the different meanings of constructivism and constructionism and how others use the terms (Bryman, 2016). I see my position as influenced by components of both constructivism and

constructionism. In constructing knowledge, the mind actively processes the data we are confronted with (constructivism); however, the interpretation of these experiences is influenced by our social, cultural, and environmental context (constructionism).

Epistemology is involved with how individuals know and what individuals know. So how do individuals achieve knowledge of reality, and what do individuals consider a usable way of knowing reality? Assisting myself to recognise if my methods and philosophical positions match, I align with an interpretivist epistemology which strives to understand and describe people's lived experiences (Higgs et al., 2008). This is influenced by the work of Carper's (1978) patterns of knowing and Benner's (1984) novice-to-expert framework in the nursing field, along with Vygotsky (1978) in the educational arena. In interpretivism, you are asking core questions about the nature of knowledge and interpretivism, which values aesthetic, personal, and ethical 'ways of knowing' as integral parts of knowledge (Carper, 1999). This position recognises a social world that is created by individuals who continually try to make sense of it. In other words, this acknowledges that knowledge is gained through interpreting observations and accounts of participants and critically reflecting and integrating this in our understanding of the world.

Both Carper (1978) and Benner (1984) acknowledge the importance of reflection in the workplace and its impact on intellectual position and epistemological commitments and is a crucial cognitive practice that supports practice (Karin, Nyström, & Dahlberg, 2007). Grix (2002) notes that ontological and epistemological assumptions are linked to the researcher, not the research. An interpretivist approach seeks to understand, explain, and demystify social reality (Cohen, Manion, & Morrison, 2002), recognising that a social world constructed by us, which we continually need to make sense of (Milburn et al., 1995). While clarifying and critically reflecting on my methodological approach, keeping a reflective journal supports my ontological

and epistemological position as part of the interpretivist research process as a reflective practitioner.

The choice and use of methodology, and its plan of action, are carefully chosen and designed to answer the research question (Creswell & Creswell, 2017). Tuli (2010) suggests that to solve a research problem; no universal methodology can be used; the methodology selected is the best fit for the research question at hand. The methods chosen must be determined for their capacity to facilitate research participants to interpret and re-tell their perspectives of their learning experiences. This study aims to explore how respiratory nurse specialists in CNS and ANP roles understand their knowledge and learning within their specific health environment; therefore, the capacity of qualitative research approaches to contextualising research is vital to reveal how the environment impacts participants' experiences. This attention to how meaning is formed and interpreted in participants' accounts during qualitative interviews is informed by Heidegger's sense of phenomenology. The use of interpretative phenomenology can be defensible in relation to describing and interpreting individual experiences.

A qualitative approach was used, which centres on the meaning of human experiences that are unique to an individual and acknowledges the environment in which the experience occurs. Galdas (2017) states that as a qualitative researcher, you are an integral part of the process, making it impossible to separate. Therefore, a descriptive phenomenological approach would not work where I would have to bracket my assumptions that influence my education and nursing education (Husserl, 1931). Heidegger's phenomenology rejects the notion of bracketing. Therefore, for those reasons discussed previously, I am drawing on hermeneutic phenomenological ideas to explore the participants' experiences in this study.

4.3 The Context of Phenomenology in Nursing

A hermeneutic phenomenology is a well-established philosophy and methodology within nursing research and an approach that enabled me to explore the participants' experiences.

Phenomenology is not a singular body of thought but has been adapted and developed by several key individuals, including Husserl and Heidegger (Langdridge, 2007). Phenomenological philosophy was a movement that began in the early 1900s with founder father Edmund Husserl (1859 -1938) and was further developed by Martin Heidegger (1859-1938).

Phenomenology as a philosophy and methodology within nursing research is employed to explore and understand the everyday experience of people (Polit & Beck, 2017a). The word phenomenon originates in the Greek *phainesthai,* meaning to flare up or be shown (Moustakas, 1994). Phenomenology has been used widely in the research endeavours of sociology, psychology, health sciences, and education (Creswell & Poth, 2017). I feel phenomenology is the right approach to base this exploratory qualitative study of respiratory CNSs and ANPs' experiences of knowledge and learning they have developed in their areas of nursing practice. This thesis study is strongly influenced and inspired by the phenomenological work of Heidegger, Gadamar and van Manem. Phenomenology is described as probing into life to find inner experience. Interpretive phenomenology tries to illuminate the experiences of individuals by listening carefully to and interpreting what they say. Phenomenological assumptions demonstrate that the world exists not as thought but as how it is lived. It views the human experience as meaningful and of interest to the world, recognised as a philosophy, methodology, and method. Phenomenology falls under the constructivist interpretivist canopy, with its research outcomes being knowledge of the lived experience of the phenomena under review (Sloan & Bowe, 2014).

4.4 Background to Phenomenology

While Edmund Husserl is credited with being the founder of phenomenology, many philosophers and psychologists have further developed the philosophy and methodology. Husserl's version of phenomenology is located within the positivist perspective. Husserl's

approach was purely descriptive, and he believed that the essential essence of phenomena could be identified through the description of that experience by individuals. Hence, 'Transcendental Phenomenology' aims to understand by uncovering the essence of an individual's experience. Husserl believed that 'knowledge based on intuition and essence precedes empirical knowledge' and considered experience the ultimate source of knowledge (Moustakas, 1994, p. 26). Hence, Heideggerian phenomenology seeks to go beyond describing the experiences of individuals and looks to understand how individuals interpret their world (Orne, 1995).

Therefore, phenomenology can be divided into these two strands: descriptive and interpretive. The main differences between descriptive and interpretative phenomenology centre around the focus of the research, the role of previous knowledge, the research's outcome, and the context's value (Matua & Van Der Wal, 2015). Descriptive phenomenology aims to describe as truthfully as possible the first-hand experience of the phenomenon without taking into account their social, political or cultural contexts (Van Manen, 2016). Phenomenologists employing a descriptive approach seek to distance themselves from previous knowledge of the phenomenon. The goal of descriptive phenomenology is to describe as put forward by individuals experiencing a phenomenon.

Interpretative phenomenology invites the researcher to enter the participants' world, identifying the meaning that individuals ascribe to the experience of a phenomenon. Interpretative phenomenology seeks to gain a deep understanding of an experience by uncovering hidden meanings in the experience (Speziale, Streubert, & Carpenter, 2011). The interpretative approach embraces prior knowledge and becomes an integral part of the research. The goal of interpretative phenomenology has been described by Speziale, Streubert, and Carpenter (2011) as the hermeneutic circle of understanding. This implies that meaning is derived through the shared activity and knowledge of the researcher and research participant. The main difference between the two phenomenological approaches is that descriptive

phenomenology builds disciplinary knowledge to identify a phenomenon's essential structures or essence. Interpretative phenomenology not only describes the experience but integrates the meaning of that experience for an individual, as explored below.

4.5 Interpretive Phenomenology

An interpretative phenomenological approach is suited to knowledge development, with interpretivist phenomenologists recognising that experience is very much influenced by the cultural context in which they exist (Flood, 2010). Though I came into this research with an open mind, it would be immature to think that I do not hold certain assumptions given my years of professional experience and commitment to this field. This sense of professional values and commitment is key for me as a researcher, as I would find it difficult to distance myself from the knowledge that drove me to undertake this study. For this reason, a descriptive phenomenological approach using bracketing would not work for me, with Heidegger's interpretivist approach matching my practitioner position more readily. Heidegger contended that bracketing is impossible, claiming that an individual's assumptions or prior knowledge should be acknowledged and critically reflected on, particularly how those assumptions and prior knowledge may influence the research process.

Heidegger moved the thinking behind phenomenology and recognised phenomenology as being more concerned with the relationship of being within the world (Valle, King, & Halling, 1989). Heidegger focused on interpreting interactions 'to better understand the political, historical and sociocultural context in which it occurs' (Crabtree & Miller, 1999, p. 28). Heidegger focused on the meaning of being in the world and had an ontological rather than an epistemological orientation. Heidegger considered that there was already an element of interpretation in describing something. Proponents of hermeneutics believe that 'phenomenology without hermeneutics can become shallow' (Todres & Wheeler, 2001). My understanding of hermeneutics is orientated towards historical and relative meanings and

interpretations. Bentz and Shapiro (1998) suggest that hermeneutics is the study of texts and related theories for their “interpretation”.

Merleau-Ponty, Gadamer, and van Manen further developed Husserl and Heidegger's work. Gadamer (2013) aligned himself with Heidegger's work and suggested that to understand, the researcher must engage in a reciprocal arrangement of interpretation with participants, aligning more closely with Heidegger’s approach. Gadamer (2013) also believes that knowledge always involves self-knowledge. Language is inextricably linked with understanding and interpretation (Langdridge, 2007). I engaged reflectively with knowledge by adopting an approach that interprets rather than describes the phenomenon. Van Manen (2016) explores interpretative phenomenology using five lifeworld existential themes described in the following table.

Table 4.1 Five Existential Themes (Van Manen, 2016)

Spatiality	Lived space
Corporality	Lived body
Temporality	Lived time
Relationality	Lived human relation
Materiality	Lived things and technology

Van Manen (2016) defines spatiality as the lived space that affects our experience of the world; corporeality as we are always a living body in the world; temporality that fosters the appreciation of the movement of time (lived time) concerning the experiences of the phenomenon; relationality as the lived relation individuals maintain with others in the interpersonal space that they share; and materiality as the ‘*thriving with technology’* theme related to growth and development of wellness.

4.6 Reflection in Research

As Boud, Keogh, and Walker (2013, p. 43) suggested, reflection 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’. Reflection is a strong concept in nursing, recognised within the seminal works of both Carper (1978) and Benner (1984), as discussed in Chapter 2. Processes of critical reflection can assist individuals in learning from their experiences (Jarvis, 2006; Schön, 1983). Reflection entails critically reviewing experiences from practice so that it can inform and change future practice in a positive way (Bulman, Lathlean, & Gobbi, 2012). In qualitative research, there is a history of research journalling that aids the creation of the development of reflection (Ravitch & Carl, 2016) and acknowledges that openly examining one’s practice requires courage, open-mindedness, and a willingness to accept and act on, criticism (Dewey, 1933).

I have engaged in and seen reflection as a critical component of my nursing practice in my professional life for many years and, more recently, for research purposes during this doctoral study. My reflective journaling initially occurred at unscheduled times when questions or thoughts about the research process crossed my mind (my little blue book). As time went on, I started to use the reflective journal at structured times, like after individual and group supervision sessions. It was my opportunity to commit to writing my emergent thoughts on paper and to probe more intensely into issues causing me concerns. I found this reflective journaling process stimulating in supporting me in exploring issues about several methodologies before deciding which was the most appropriate for my research. As Lay and McGuire (2010, p. 540) describe, ‘our efforts to move from reflection which utilizes intellectual standards for critical thinking to reflexivity relies on critical social theory’. I kept revisiting my research question, and during my pondering and reflecting, I found my question developing.

My reflective journal was also an essential aspect of my methodological approach. Following each interview and when I had challenges, my reflective journal gave me the space and opportunity to ponder and write my unstructured thinking onto paper, where I could dive more deeply into my thoughts and begin to formulate meanings. This fits the qualitative research history of taking research memos and notes to aid the interpretive process (Miles, Huberman, & Saldana, 2014).

Carper (1978) and Benner (1984) recognise and acknowledge the central role that reflection plays in nursing as staff continue their journey through their practice and experience. Carper (1978) and Benner (1984) tend to assume reflection is an unproblematic process, whereas sociologists like Foucault and Rabinow (1997) point to the influence of power within reflective processes. This problematising of reflection in terms of considering the power dynamics of its context is important, as the hierarchy between medical staff plays a significant role in clinical healthcare environments, as explored in later chapters. As I progressed in my doctoral research, my reflection enabled me to consider these issues and other research dynamics more deeply.

4.7 Ethical Considerations in Research

Wellington (2015) refers to the term ethics as the moral principle and guiding conduct that a group holds. Iphofen and Tolich (2018) consider ethics in research to be the extent to which the research adheres to moral standards in a field, including professional, legal, cultural, and social accountability issues. These occur in two intertwined processes: the formal ethical review processes and the lived practices of the researcher. Ethical approval was formally obtained before commencing the research as a requirement of Maynooth University, where this Doctorate of Higher and Adult Education was undertaken and from my place of employment in the Royal College of Surgeons, Ireland (see Appendix A and Appendix B).

These processes enabled me to carefully consider the ethical implications and potential responses of my research before engaging in the research process.

Throughout the process, I was guided by research codes of conduct from the British Educational Research Association (2011) and the professional code of conduct and ethics for Registered Nurses and Registered Midwives (Nursing and Midwifery Board of Ireland, 2021b). The ethical guidelines from the British Educational Research Association (2011) highlight the significance of a process of informed consent for the participant's decision to engage in the research based on precise, clear, and in-depth information in the form of leaflets, information sheets, pre-interview discussions, and consent forms. It also explores the nature of confidentiality, with pseudonyms and the removal of identifying markers used throughout this research in the interview transcripts to protect participants' identities and maintain confidentiality.

They also highlight how ethical dilemmas can occur at any stage when conducting a research study; therefore, ethical adherence is required as a living process throughout the research process (Bickman, Rog, & Hedrick, 2009). To maintain ethical integrity, each of the ethical principles of autonomy, beneficence, non-maleficence, and justice, which incorporate respect, confidentiality/consent, must be considered at every stage of the research process, as discussed in the following sections below. These principles prompted open discussion about research ethics with fellow researchers, colleagues, and participants. Participating in these discussions and procedures was a time of reflection for me, ensuring that the ethical considerations became an intensely felt and living part of the process throughout the research.

I wrote the following journal extract when I obtained approval to conduct my study from Maynooth and RCSI.

Journal Extract

Have I got ethical approval, I am checking the email from Maynooth but not 100% sure, will email my supervisor to double check but it looks like I have approval? I can't believe it I am in shock, why am I crying, this is good a happy time. I can start my research once I obtained RCSI approval, one hurdle achieved one step nearer to exploring experiences of the respiratory CNSs and ANPs in practice. Happy Days.

4.8 Autonomy and Anonymity in Research

Autonomy is related to people's freedom to determine their actions, which includes rights to the protection of anonymity and confidentiality in research (Beauchamp & Childress, 2001). Throughout this research, participants' autonomy was respected, and participants had the right to decide to partake or not to partake in this research study and could withdraw at any time up until analysis. All participants were given sufficient information verbally and in the form of a leaflet to facilitate an informed decision for study participation and the opportunity to contact me at any stage to discuss the research. There was no obligation to partake; participants could decline or withdraw their consent at any stage without being given a reason, and there would be no consequences to them. In terms of ethical considerations, several participants in respiratory nursing have undertaken the educational respiratory programme in the RCSI, of which I was the programme director at the time of this research. I feared some might feel compelled to participate in this research, and I wished to ensure that no participant was obligated to participate. Therefore, I used a gatekeeper for this research (a CNS in respiratory care who was secretary for the Irish Respiratory Nursing Association (ANÁIL) at the time of this research). The gatekeeper posted announcements about the study on the ANÁIL website and at the Irish Thoracic Society (Irish Thoracic Society, 2019) conferences in 2020 in the form of leaflets strategically placed on tables explaining the study (Appendix E) that included my contact details. The gatekeeper also emailed members of ANÁIL. This meant participants could decide if they wished to partake in this study by contacting me directly rather than by any direct invitation from me. I would have been known by many of the participants

due to my previous role as programme director. Respiratory CNSs or ANPs undertaking or waiting on a result from the respiratory programme in the RCSI were excluded from the study to ensure that there was no obligation or unequal relationship between student and teacher at the time of data collection. The exclusion also ensured that students would not think or feel that if an individual participated or did not participate in the study, it might impact their result.

Respect for the participants' anonymity and privacy was paramount throughout the research. According to Behi and Nolan (1995), guaranteeing confidentiality involves the researcher ensuring that the participant's information will be used so that no one other than the researcher knows the source of the data. I had to respect the confidentiality and anonymity of all participants' information. Confidentiality was ensured for all participants by withholding names and identifying markers while transcribing and coding all data. The identity of all participants was only known to the researcher. Each participant was given a coded link, for example, “Participant 1” or “P1”, to ensure confidentiality. Participants were informed that their identity and data collected would be kept confidential within the law's limits and informed about the process of disseminating the findings. To protect participant identity (British Educational Research Association, 2011), as outlined in the information sheet and consent form, in line with legislation and general data protection regulation policy (GDPR) (European Union, 2016), all participant data was anonymised, encrypted, and stored securely throughout the interview process,

4.9 Beneficence

According to Beauchamp and Childress (2001), a research study's benefit must outweigh the potential for harm. The beneficence principle means to do good in or by your research by promoting good practice with the intention to create more significant outcomes (Polit & Beck, 2017b). Part of this was in maintaining the confidentiality and privacy of individual participants in this research study, as discussed above. It also necessitated research consideration in the

setting and environment of the research. The research interviews were conducted between July and November 2020 as originally planned. What was unknown at the time of planning was the emergence and rapid spread of the global Covid-19 pandemic. Conducting research interviews during a pandemic provided unprecedented insights into qualitative research approaches (Dodds & Hess, 2020). The context of Covid-19 also offered an opportunity to gain significant new perceptions through online interviewing with research participants. These participants would have been considered a high-risk category. Due to government-enforced social distancing rules and lockdowns during the research period, what was initially planned to be conducted as face-to-face interviews would now have to be transferred to an online medium platform (discussed later in this chapter).

All interviews were conducted at a date and time suitable to participants with a location of their choosing, either home or work. A secure e-link was sent to the participant to ensure privacy and confidentiality. The face-to-face interview took place online so that we could see each other during the interview. However, only the audio version of the interview was recorded and transcribed for use by the researcher.

As all the participants are respiratory CNSs and ANPs in a specialist area of nursing, those working in this area could potentially recognise details about each other's practice, for example, identifying a participant if a region of Ireland was identified. In keeping with the beneficence principle, descriptions that could potentially identify people, such as place of work, regions, and other individual features, are presented anonymously in the findings chapter. As discussed in the autonomy and anonymity section above, each participant was assigned a code, and I, the researcher, was the only one aware of the matching participants to these codes. No participant was referred to by name at any stage of reporting or results/findings presentation. After transcribing the interviews, all data was encrypted and securely stored in line with relevant legislation and general data protection regulation policy (European Union, 2016) and was outlined in the information sheet (Appendix C) and consent form (Appendix D).

Hammersley and Traianou (2014) note there is a potential that the researcher may be made aware of a risk in nursing research linked to poor clinical practice. This is an essential aspect of the beneficence principle. In keeping with the principles of the code of professional conduct and ethics for nurses (Nursing and Midwifery Board of Ireland, 2021b), I was responsible for making relevant authorities within the organisation aware of safety or risk concerns. The information sheet and consent form had all this information for the participants, and none required such assistance.

4.10 Non-Maleficence

The principle of non-maleficence relates to the researcher aiming to minimise risk to the participant. In qualitative research, as the participants discuss their experiences, this potentially could expose them to emotional distress. The researcher was aware that the discussion about their experience of respiratory CNS and ANP amidst the middle of a Covid-19 pandemic might be a sensitive and potentially traumatic topic to participants because of incidents over the previous few months before starting the research. Participants were informed that they could withdraw from the interview at any time to reduce such a risk. All participants were made aware at the start of the interview and understood that if they became emotionally distressed, we would stop the interview immediately. Furthermore, participants were informed they could receive counselling, and details of this were included in the information sheet (see Appendix C). After each interview, I contacted each participant for a debriefing session to ensure all was well. I was aware that if a participant talked to me after the interview and exhibited any emotional distress, such as tears or laughter, it would be an emotional release for them but potentially distressing.

As I had previously worked as an ICU and respiratory nurse, along with the knowledge I gained from my current role, I felt equipped to address the emotional distress experienced by any participant and had the resources to transfer participants to support services if required. I know

this professional nursing role differs from a researcher's role. Still, it gives me a unique insight into the types of pressures, work cultures, and conditions of these participants. However, if participants continued to experience any emotional distress following the interview, participants were referred to HSE Employee Assistance and Counselling Service (Health Service Executive, 2022), which offered additional support. My supervisor's contact details were offered to the participants if they felt the research was not carried out as described in the information sheet and consent form each participant had signed.

I was also aware of the emotional toll of eliciting and responding to these stories and my own need for self-care. As a social science researcher, repeated exposure to data during the analysis and writing process can be overwhelming (Connolly & Reilly, 2007). An emotional aspect is always present in data generated for people's lived experiences, especially as this data was collected during a pandemic where respiratory CNSs and ANPs were working with Covid-19. I found the data analysis overwhelming and highly sensitive at times and reflected on this in my journal to reduce my emotional burden. I also discussed its impact with my research supervision group and supervisor, with whom I could reflect and debrief about the research process without revealing any of the content. These alliances supported me both personally and professionally to cope and, when needed, take time out to manage the emotional burden of this research.

4.11 Justice

The principle of justice requires that people be treated fairly (Beauchamp & Childress, 2001). All participants were treated the same way; all had the complete information needed to participate in the study and were given time to decide. Furthermore, all participants were treated equally during the interview phase and shown respect and dignity throughout all stages of the research. Respect is a finely tuned process that was embodied in the relationship between my participants throughout all stages of the study and me and required that I was

respectful of what interviewees say during an interview and used this data carefully and respectfully throughout analysis and findings. Respect was also part of the ethos and culture through which I conducted this research. I was attuned to the power relations and context of this research. Both in terms of respecting and maintaining confidentiality about the details of the participants' professional context and the power dynamics of the interviews. While I was not working with current students, I may have existing relationships with some participants in terms of being former students working in respiratory care or colleagues I now meet at conferences and meetings in relation to respiratory care in nursing. As explained earlier, participants undertaking the respiratory programme or awaiting results at RCSI were excluded from the study.

4.12 Profile of Research Participants

Fifteen respiratory CNS/ANP nurse specialists out of 113 respiratory nurse specialists who were members of ANÁIL (Appendix H) in 2020 from across Ireland participated in this research. Participants worked in respiratory care, from acute and integrated care to community care settings. As all the participants in this study work in specialist areas within respiratory care, it may have been easy to identify them if the study included detailed profiling. With that in mind, individual profiles of the participants were not outlined to maintain confidentiality. Instead, a general profile is presented below. Additionally, to preserve anonymity and confidentiality, "x" was substituted in any quotation where it might have been possible to identify participants, for example, place names or geographical names.

In terms of their general profile as a group, participants had seven to thirty years of experience in respiratory care nursing. The participants had significant levels of respiratory experience; 13% had between 5 to 10 years, and 87% had over 10 years of experience. Of the fifteen participants, thirteen had respiratory education qualifications recognised by the Nursing and Midwifery Board of Ireland (NMBI). All participants who worked in respiratory care in Irish

Healthcare settings were female, with a minimal level 8 educational degree. All participants had undertaken a level 9 study, which is the minimum educational training for specialists and advanced respiratory practice, while twelve participants had completed a master's degree. Fourteen participants had worked outside of Ireland at one time or another, and all participants had been interested in respiratory care from the early stages of their careers. Other profile details are included throughout the findings chapters where relevant.

4.13 Research Methods and Sampling

Corbin and Strauss (2014) explain research methods in the social sciences as the established procedures and techniques for gathering and analysing data. The interpretivist approach described in a previous section grounded my methodological approach of discovering, understanding, and explaining different participants' sense of social reality from their point of view. The following sections will outline the methods used within the study, the locations of research sites, the data collection and analysis process, and issues related to the quality of the study.

As the aim of this study was to explore the experience of respiratory nurse specialists (CNS/ANP) in their clinical environment, a purposive sampling strategy was used with the criteria for inclusion that participants were currently registered with the Nursing and Midwifery Board of Ireland and working as respiratory nurse specialists (CNS/ANP) in a clinical environment.

Given the national context of the Covid-19 pandemic and the intense working conditions for respiratory nurses at the time of this research in 2020, I was concerned about the response rate to the call for participants. The journal extracts below give an insight into my thoughts during that period.

Journal Extract

I am surprised, in the first week of recruitment for participants, I had received 4 emails expressing interest.

Journal Extract

Given the timing and these nurses working and caring for individuals in the middle of the pandemic, I didn't expect the outcome to be so positive for me. It's great that all 15 of my participants practising at advanced and specialist levels took the time in this present environment to partake in this study. I feel the participants didn't mind doing any interview because there could do it face-to-face online without leaving their homes or places of work. In a funny way, Covid-19 may have worked to my benefit, as participants had less going on outside of work, with events and travel being cancelled due to the pandemic. Every cloud has a silver lining.

Once the participants contacted me, arrangements for the interview were established and conducted between July and November 2020. Informed consent was obtained before the interview, starting via email, and instructions on signing and returning the informed consent form electronically. A copy of the signed informed consent form was provided to each participant, and the researcher kept a copy. At the start of the interview, the participant was informed that they could withdraw at any time, without any ramification, and the information leaflet that participants received had information about withdrawing from the study, emailed to participants at the same time the consent form was provided.

In qualitative research, data collection is often undertaken within their natural environment to create a familiar and non-threatening atmosphere for participants. However, this was impossible as the participants were all considered frontline workers in the middle of a Covid-19 pandemic. I overcame this hurdle with the use of modern technology and thus in keeping with the ethos of qualitative research methodology, as described in the next section. Semi-

structured qualitative interviews were used to gain insights from the participants flexibly and responsively guided by the themes of the research (Silverman, 2015).

4.14 Location and Process of Interviewing

Respiratory nurse specialists participating in this research came from many healthcare clinical settings all over Ireland working in respiratory care contexts. This research was conducted via a face-to-face online interview, given the context of the national restrictions at the time.

Collecting data from participants working in many different healthcare environments across the country facilitated the collection of in-depth information from various contexts and experiences in respiratory nursing. Circulating the research information among participants in a countrywide organisation like ANÁIL (2021) brought participants with a breadth of experience to the research rather than focusing on one or two clinical environments that may end up too insular or specific.

Interviews were conducted at a time suitable for each participant, and most were from the participant's home location. I was aware and conscious that the interview process is time-consuming both for the researcher and the participant. I needed to be mindful of this during the interviews because all my participants work full-time. Many may be working twelve-hour day shifts. I was also aware that interviews occurred when the world was dealing with a pandemic, and restrictions were still in place. As the researcher, I needed to show care and accommodate the participants as best as possible.

At a technical level, an e-link was forwarded to each participant before the scheduled interview time started. The e-link was accessed by the researcher and participant simultaneously, where the participant and researcher could see and hear each other over the digital medium. The interview process required the researcher to perform a lot of technical preparation and

attentive listening throughout the interview. All interview audio was recorded and saved post-interview on the Maynooth University secure cloud drive.

An inductive approach was used where I was open to ideas emerging through the interview process. What kept repeating itself was the immediacy of the Covid-19 context and the amount of education happening in a short time. I took careful note of what participants were saying, which provided me with the necessary information to follow up with the participants to reaffirm and confirm what was said and that their important concerns were articulated as they wished. Audio recordings allowed me to concentrate more on the interviews and what the participants said. I used phatic communication to build the relationship and encourage conversation by nodding my head and expressing '*ok'* and '*hmmm'* to note to the participant that I was listening carefully. I also used verbal probing to enable participants to expand and explore any issues that were emerging from the participant interview. While two participants experienced technical difficulties, most described their interview experience as highly satisfactory. Those technical difficulties were overcome by providing the time and space to allow the participants to reschedule the interview at a time when they would feel comfortable that their internet connectivity would be satisfactory.

During my years as a nurse, I gained experience interviewing patients about their condition while admitting patients to the hospital and engaging with students and qualified nurses as an educator. However, this was a very different experience. A research interview is very different from other ordinary conversations. As a researcher, you must be mentally and physically prepared, and deep listening, relationship building and attention to detail skills are critical. Before my first interview date, I was very nervous for two reasons, as evident in my journal extract below, firstly about conducting a research interview and secondly about using a digital medium platform for interviewing. To prepare myself, I ran a pilot test interview with a colleague. Engaging in this role-play was very useful in ironing out any teething problems and giving me a feel for the interview process. A pilot trial run in research can identify any required

adaption to the research method and avoid limitations to the larger scale study (Polit & Beck, 2017a). I also spoke to previous colleagues who had experiences conducting qualitative research interviews, and they gave me helpful insight into the process. The interview process was also guided by literature I had read and from my past experiences interacting with CNSs and ANPs in respiratory care.

> *Journal Extract*
>
> *Reflection on first interview.*
>
> *I'm about to conduct my first interview for my research project. I am very excited and very nervous, there's a range of emotions going through me. Actually, I feel a little bit sick in my stomach and I know it's going to be OK, but there still that feeling. I've checked my videos I've checked my recordings equipment; I've double-checked it, I checked that the participant has agreed to accept a call, and I have a list of questions or sample questions that I might ask the participant. I'm excited that I'm getting a start on this project. But expect to do the interview this way. I think it's just to make sure the equipment works right and that I have everything done right and everything will be ok*

I conducted the interviews with an inductive approach, aware that ideas would emerge in this interview process. An open approach, with active listening and probing, was used to explain and explore emerging ideas. I took cues from the participants and asked them to expand or say something more about their interesting points. In this exploratory approach, I was open to finding new content that I may not have considered before, especially relating to this global Covid-19 pandemic.

In qualitative research, data collection will discontinue once a point of saturation has been reached; this occurs when a range of views has been obtained, with no new perspectives emerging (Braun & Clarke, 2021). I ceased interviewing new participants when I reached 15 interviews. It was at this point that I considered data saturation had occurred.

4.15 Data Analysis

According to Banonis (1989), qualitative data analysis enables the meaning of the phenomenon to be understood while preserving the individuality of each participant's experience. This research is conducted within the framework of interpretivist phenomenology. Data analysis in qualitative research is a process that begins with data collection. The qualitative data collection involves transcribing *verbatim* from the recordings of each interview (described below). Immediately after each interview was completed, I took time to reflect on the interview, how I felt, what surprised me, and why it went down the path it did. What I learned from each interview helped inform the following interview. I wrote my thoughts in my reflective diary and surprised myself with what I had learned from each interview. The journal extract below is an insight into my thoughts during that period.

> *Journal Extract*
>
> *When building a rapport with the participants and from the reading I knew I had to set the scene make sure that they feel comfortable inform them they could take a break anytime as technology can be draining. I was conscious of my tone and facial expressions. To my surprise, building rapport was letting the participants see the researcher and see the researcher in her environment (no false background on the screen). So, there wasn't this sense of evilness/ power (that the researcher is not in her ivory tower). What do I mean by this? I think one of my participants summed it up at the end of the interview when he/she commented on my background and that it wasn't a false background. It was where I was working from, and he/she commented on the toy tractor and asked if this was my home and thanked me for conducting the interview from my home. Another example of rapport was when participants used my name in the interviews. I only realised how many times one participant used my name in the middle of the interview when I was transcribing.*

During the transcribing of the interviews, I noted an emotional moment, or some would say behavioural moment, that silence for 15 seconds when the participants are thinking about what they are going to say, how the tone of voice changes, and that nervous laugh. As soon as possible, I transcribed the interview and ensured each was transcribed in full before I began another transcription. I transcribed the interviews verbatim, which is a difficult task in general. With my dyslexia, I found this process overwhelming; therefore, I engaged digital software to assist me, but it still took time, however, with fewer spelling errors. Transcription is considered part of the analytical research process, with some analysis occurring then regarding how to represent transcription, even perhaps subconsciously through the listening and transcribing process. After listening to the audio, correcting errors, and typing out text with the help of the software, each interview took between three to four hours to ensure an accurately transcribed version of a sixty-minute interview. This involved listening and slowing down the recordings to ensure everything was captured. I then reviewed the transcript and made corrections while listening to the audio version. I also used this time to highlight sections that stood out or did not make sense and added additional notes and questions so the researcher could revert to the participant to seek clarification when returning the transcripts[1]. I took note of additional questions that I would revert to the participant to seek clarification when returning the transcripts.

The transcript was emailed to the participants, allowing them to review the transcription and make amendments or add to the transcription with the material they did not remember at the time of the interview. This is known as member checking, which allows for the correctness of data to be confirmed (Lincoln & Guba, 1985). Houser (2016) suggests that the researchers meet the participants a second time to seek further meaning-making and interpretation of the

[1] To enhance the readability missing words or text is indicated by (….) Dots are the beginning, or the end of extract show that the participant was talking prior to and after the extract. Sometimes brackets are included where I have explained what a participant is referring to.

participant's interview if needed. Post-interview, as I went through and reflected on the themes, I pondered whether a reconnection with the participant was required. However, other researchers would question the significance and relevance of returning the transcripts to the participants. Hagens, Dobrow, and Chafe (2009) found that returning transcripts to participants did not add to the accuracy of the transcript and found that bias may occur if participants removed information that the researcher found valuable. Giorgi (2010) believes participants can not verify the meaning of their experiences and may not have adequate phenomenological talent to judge the analysis. Giorgi (2010) also suggests that participants may have different experiences of the phenomenon between the interview and the checking stages.

As a researcher, I believe collaboration with the participants in the analysis of the data from their interview is congruent with the constructivist perspective in developing knowledge for this research. The data emerged from the participant, and the researcher reviewing the transcript embraced the ongoing co-created research relationship. I was not displeased or upset if a participant revised what they told me at the interview, as this can potentially occur with time and interpretation, acknowledging that qualitative data is a process of constant revision. Given the sensitivity of the experiences shared by the participants, I wanted to ensure that they were satisfied with what was potentially used in the analysis process and written version of the thesis.

The analysis involves a careful reading of interview transcripts alongside highlighting critical comments and themes. Core to this process was an ongoing critical reflection on the study's ethical considerations, supported using my reflective research journal. I believe as an educator that knowledge gained through interaction and engagement between researcher and participant can apply to the analysis of transcript where new learning occurs through research because of synergy between researcher and their participants. Only one participant made changes to their interview transcript, specifically a clarification surrounding experience in the

field of respiratory nursing. Overall, it would suggest that the participants were happy with what they had shared during our interviews, and I had accurately represented their experiences.

Each interview analysis involved moving from a focus on participant interviews to a more shared understanding of the emergent themes, moving from a descriptive to an interpretative level. The iterative repetitious process of analysis, cross-checking, and re-analysis is intended to draw out and respect the divergences and convergences across all participants' accounts of their experiences[2]. What is significant is that the participants articulate their experiences as respiratory CNS/ANP nurse specialists using the lens of what it meant for them, the patients in their care, and their colleagues' eyes. Experiences reported by the participants are taken as meaningful and important to them. There was a lot of toing and froing with text, involving full text and a section of the text. The analysis was a cyclical process, following Heidegger's hermeneutic circle approach (Heidegger, 1962). This process approach considered how each theme relates to people's experiences and how meaning is derived through shared activity and knowledge between the researcher and participant, enabling the researcher to understand 'the whole through grasping its parts and comprehending the meaning of the parts divining the whole' (Crotty, 1998, p. 92). Heidegger's hermeneutic circle (see Figure 4.2) involved moving back and forth between parts of the text and the full text.

[2] All identifying information has been removed and participant are known as P1- P15 to ensure anonymity.

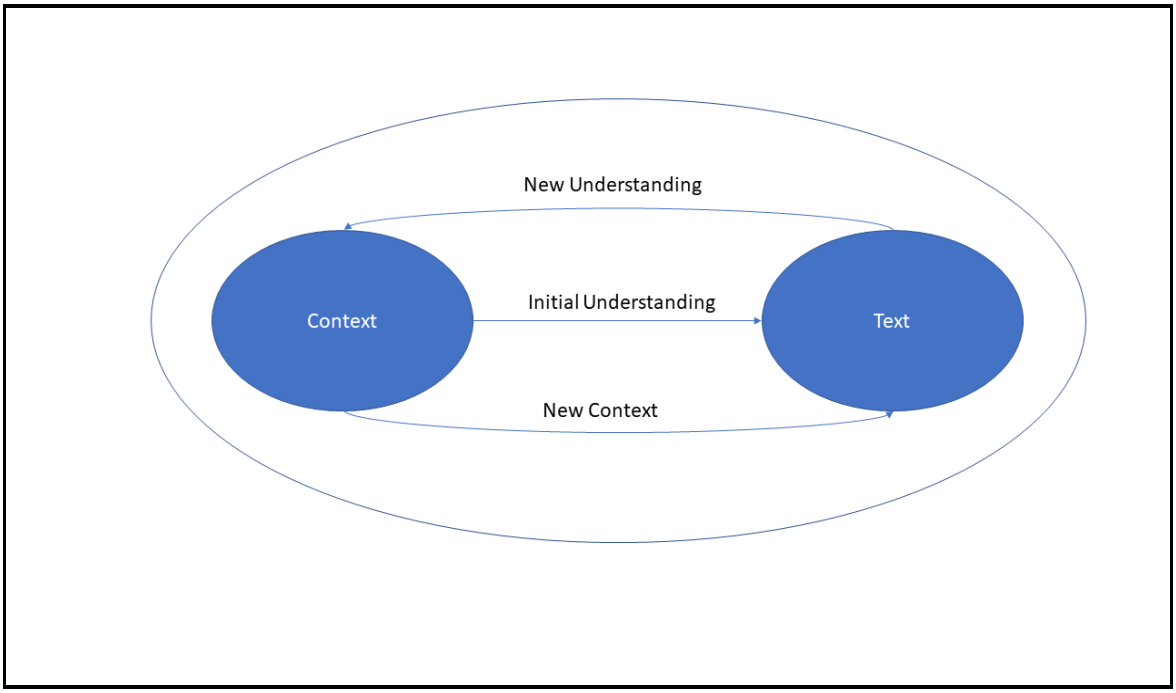

Figure 4.2 Hermeneutic Circle

The data analysis was broken up into the following stages (see Table 4.2). The first stage involved managing the data by creating and organising files, followed by the second stage, which involved deep familiarisation through reading and making notes from initial codes. The third stage involved deep reading towards describing and classifying codes and distilling them into themes. Developing significant statements and grouping them into important meanings became the fourth stage as phenomenology deals with the specific. The fifth and final stage required representing the data I outlined in the following chapters.

Table 4.2 Stages Involved in the Data Analysis

Stages	Activity
Organisation	Managing the data by creating files and organising your interview files
Reading and re-reading	The process started with reading and examining the scripts. While reading, I also listen to the audio recording to hear the experience. This process occurred several times, it gives me a recollection of the interview, and I started to make initial comments
Exploratory commenting	Noting and examining context at an exploratory level. Trying to capture the meaning of the documented topics in the interviews. Focusing on content, reflecting on language, and as a researcher asking a question about the data that was emerging
Developing of emergent theme	Keeping track of ideas as they present themselves, focusing on chunks of text, and recalling what you have learned through exploratory commenting, emergent themes, reflecting and exploring the understanding.
Looking at connections across themes	Introducing structure to your analysis as the emerging themes are drawn together. Producing several subordinate themes with emerging themes. Developing statements and grouping them together.
Patterns	Comparing data with individual interviews across the data in all the interviews so that all data was compared systemically. This resulted in categories changing as an understanding of relationship categories emerged. Grouping meaning together

The hermeneutic process acknowledges the interpretative process whereby the themes presented through this analysis process are one possible account of respiratory CNS/ANP nurse specialist experiences based on my interpretation of the participants' accounts. The analytical process of the hermeneutic circle enabled the researcher to keep track of ideas as they presented themselves in the interviews, as I, as the researcher, deeply re-read the

transcripts, repeatedly becoming ever more familiar (Agar, 1980). I compared data within individual interviews and across interviews, ensuring that all data was systematically compared to all other data in the data set (O'Connor, Netting, & Thomas, 2008). What emerged from this process were the category themes and relationships between category themes and subthemes. Transcript extracts in the form of quotations present the phenomenological process from which my (researcher) interpretations developed, transcribed as evidence to illustrate how the participants spoke during interview.

Though I have indicated throughout the findings chapter the number of participants who had similar experiences, this is intended to demonstrate how extensive the participants' experiences were amongst this group of respiratory nurse specialists. It is not my intention to attempt to quantify or assess participants' experiences but to interpret their qualitative experiences and perspectives guided by my research questions.

The final stage was the presentation of findings from the data analysis, as outlined in chapters 5 and 6. As a researcher, I found the presentation of findings challenging when deciding what quotes to include, as I felt all the contributions made by the participants in this study were imperative. The reflective research process of memoing and my research journaling helped me decide what quotes to include to illustrate each point in the data presented.

The next decision I had to ask myself in the research process was how I would code the data. I decided to use the analytical method of thematic coding (Braun & Clarke, 2006, 2012), which is a recursive method of analysis that seeks to identify patterns of meaning in the data through 'a constant moving back and forward between the entire data set, the coded extracts of data that you are analysing, and the analysis of the data that you are producing' (Braun & Clarke, 2006, p. 86).

I also needed to determine whether to do this analysis electronically using Qualitative Data Analysis Software (QDAS) or manually using line-by-line and colour coding. This part I was

not looking forward to this because of my dyslexia. There was excitement about what themes would emerge, but fear was the primary emotion. The below journal extract gives insight into my thoughts at that period.

> *Journal Extract*
>
> *I think I am going to be using QDAS MaxQDA software package. I had an introduction class with my supervisor and some classmates, and I feel it will suit me and make my analysis more complete. With my dyslexia this software would stop words and themes moving, which would be a problem on paper if I were to do it manually. Also, I feel with qualitative research used a package is new to me and technology in to be embraced. If I do use this package, I will be able to manage it, I know it will take time and every minute counts. If I don't use it will it be viewed as I am not interested in learning a new skill that could be added to my research portfolio. The thoughts of it, the fear … I don't know what to think. …. Look it's now or never, go for it girl, take the bull by the horns I can do this... when in my career will I get this opportunity again…*

After researching both coding methods, I decided to code electronically using a qualitative data analysis (QDAS) software package called MAXQDA. I felt the technology would make data coding and analysis more manageable for me to 'extend [the] research' (Flusser, 2013). Hence, using technology in the research felt suitable for me and my research. Van Manen (2016) questions the compatibility of using QDAS as an appropriate tool for phenomenological research. However, phenomenologists seldom refer to how phenomenology is to be done: pencil, paper, and computer (Sohn, 2017). di Gregorio (2011) supports the use of technology and encourages phenomenologists to join the digital world and overcome their methodological loyalties, arguing that whatever their qualitative research methodology, QDAS can aid the performance processes.

Each of the fifteen interview transcripts was uploaded to MAXQDA and saved. The next stage was to use this tool to assist in data coding and subsequent analysis. When I finally decided on QDAS coding and justified its approach, I felt a sort of freedom to start the next research phase.

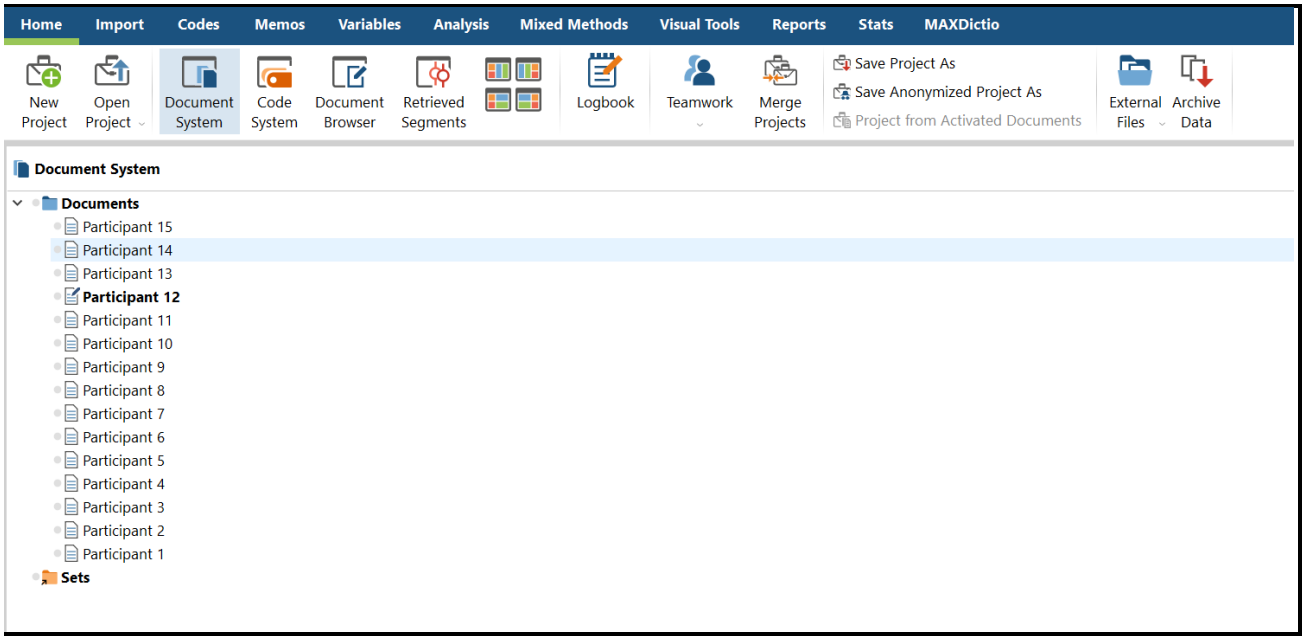

Figure 4.3 Transcripts uploaded to MAXqda

The inductive coding process, as described by Gibbs et al. (2019), systematically scrutinizes the data for ideas and uses a coded label to show similar text passages. Similar processes of inductive coding can be used in both QDAS and manual coding, where text is highlighted, and different colours are given to emergent codes:

- *Open coding allows you to create a new code and associate this with an existing quotation or selected text segment. Remember that the text may be related to more than one code.*
- *Code-by-list allows you to assign an existing code to a segment of text or quotation.*
- *In-vivo coding is helpful if the selected text is an appropriate code name.*

- *In later stages of coding, these codes are analysed to identify the research themes and categories.*

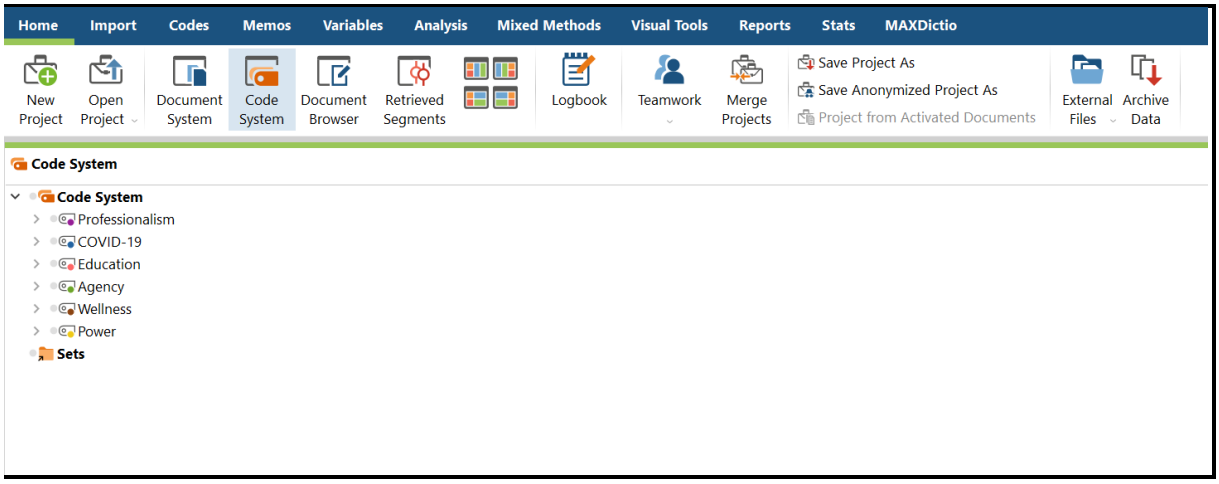

Figure 4.4 Coding System with Main Themes

The coding process resulted in transcripts overlaid with a coding scheme of the main themes and associated with highlighted text segments. The codes identified emerged from the data and reflected the essence of the discussion within the transcripts, reflecting the hermeneutic phenomenological research approach. Coding rules help keep choice consistent and focus on the research question. 'Any researcher who wishes to become proficient at doing qualitative analysis must learn to code well and easily. The excellence of the research rests in large part on the excellence of the coding' (Strauss, 1987, p. 27).

It takes time to develop a solid codebook, whether working with deductive or inductive approaches. It requires a comprehensive method of analysing qualitative data that immerses you in the data (Azungah, 2018). I used an inductive approach when coding, observing an emerging pattern of codes/themes. The value and quality considered for the integrity of the codebook examined validity, the credibility of the coder and codebook developer, practical

usability, and technical alignment with technology support (McLellan-Lemal & Macqueen, 2008).

With coding, I felt I was re-living each interview repeatedly. I was becoming one with the participant, taking each step with them as they relived their experiences. It reminds me of the beautiful poem 'footsteps in the sand'. The coding process was time-consuming and monotonous but simultaneously captivating with the emerging themes. Night and day, I was eating, drinking, and living the data, the data becoming part of my thinking process. At this stage, two important information points emerged, as I had to recognise that not all the data would be coded, and some text segments had more than one code. Each theme was being read and re-read, coded, and re-coded, resulting in the creation of code families with relationships between the codes. This approach allowed the various subthemes to be identified within each main theme.

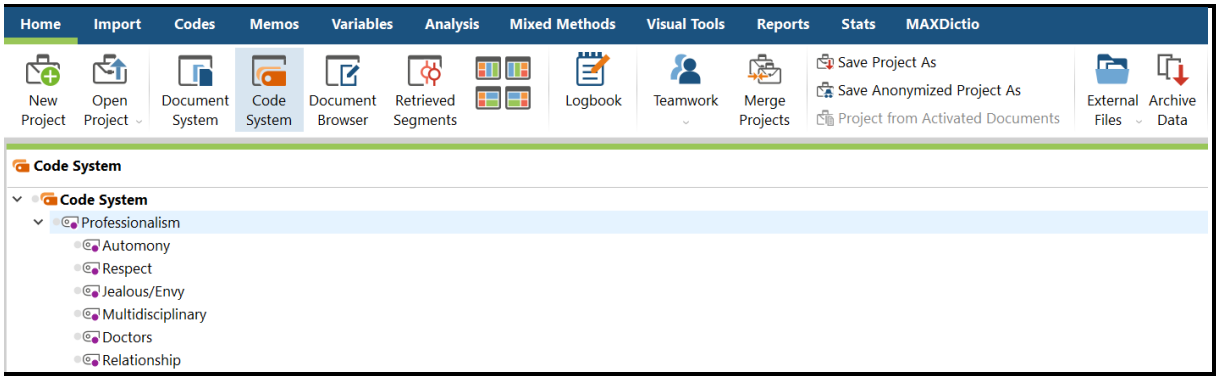

Figure 4.5 Example of Sub Themes within Main Theme

One major advantage of the MAXQDA software was storing each coded segment (quotation) separately from the primary documents through the retrieved segment option and maintaining a library of codes and their linkages to the quotations. You could highlight and colour-mark the content in each transcript. MAXQDA facilitated the coding process by automatically recording the codes into the software's coding system, ready for later sorting. The retrieval of coded text,

which remained linked with the individual transcript, allowed for checking back and forth between analysis and transcript data to ensure the rigour of the analysis process and the intersections between codes. MAXQDA also offers a visualisation tool to see and display your data, such as models, charts, and tree mapping.

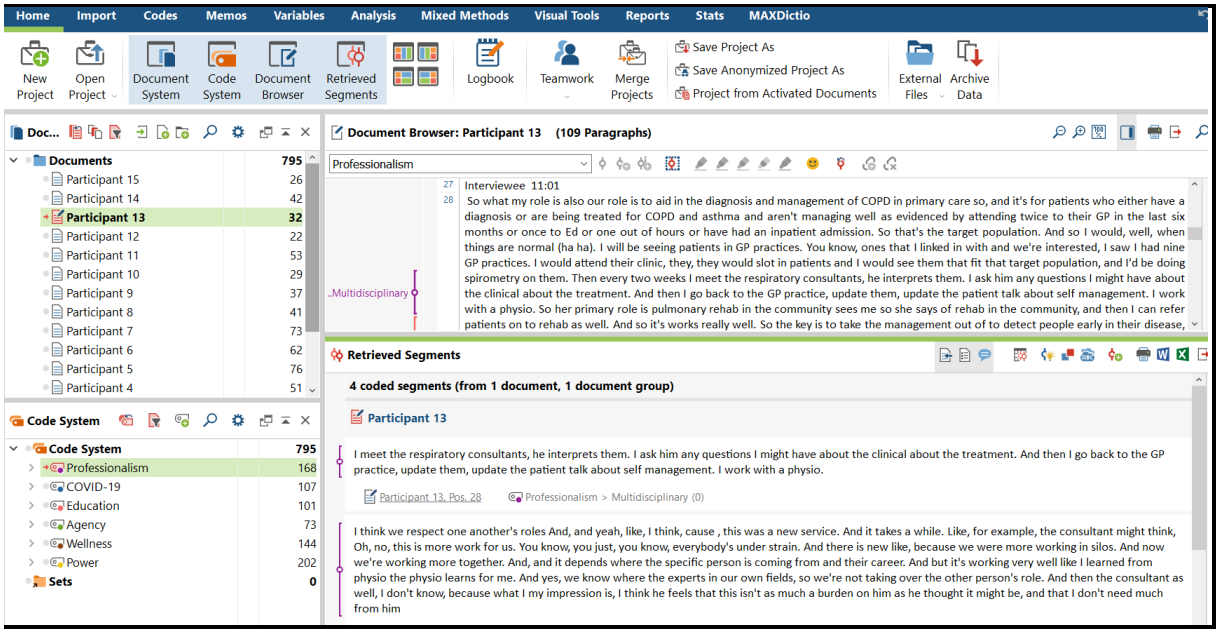

Figure 4.6 Overview of Full Coding Analysis in MAXqda

4.16 Quality of the Research

Truth value, consistency, and applicability are terms used in qualitative research when discussing research credibility and quality, compared to quantitative research, where measurement, validity, and reliability are used. There are ongoing debates about whether terms such as validity, reliability, and generalisability are appropriate to evaluate qualitative research (Rolfe, 2006; Sandelowski, 2010). Truth value focuses on the clarity and accuracy of the data from the participant's perspective, recognises all realities, and outlines your experiences to reduce bias (Noble & Smith, 2015). Consistency in qualitative research comprises the trustworthiness of the method used, the researcher's understanding, and the

clarity of the decision-making process, and other researchers would arrive at similar findings (Noble & Smith, 2015). This also acknowledges the hermeneutic circle process that recognises each participant's specific interpretations in their interview accounts and seeks to explore and move between the parts and the whole (Crotty, 1998).

The trustworthiness of a study is established if the reader can audit the events of the study (Polit & Beck, 2017a). The quality of the research study should be assessed against its authenticity (Guba & Lincoln, 1994). This element of authenticity is concerned with standards, such as if the research represents different views of the research population, with the research assisting a member of the population in having an improved understanding of the views of others and that the research had empowered individuals to participate in action for change. Applicability in qualitative research suggests that a finding can be applied to other groups and settings (Noble & Smith, 2015). The results and analysis of the findings will be incorporated into my dissertation and presented and judged for examination at Maynooth University. This thesis will undergo a process of peer review when submitted for publication.

Credibility, transferability, dependability, and confirmability are the four criteria within the element of trustworthiness (Guba & Lincoln, 1994). These terms maintain that a study is credible when it represents authentic descriptions and when researchers or readers confronted with the experiences can recognise it. A researcher must demonstrate rigour throughout a qualitative study by establishing trustworthiness (Clayton & Thorne, 2000). Credibility is when other researchers can recognise an experience when faced with it. There are techniques that a researcher finds helpful in maintaining credibility, such as peer reviews, reflection, and journaling (Clayton & Thorne, 2000; Creswell & Poth, 2017; Guba & Lincoln, 1994). All these techniques were used throughout this research process. As previously noted, member/peer checking can establish credibility to ensure that you adhere to good research practice, which in this research included a discussion with my supervisor and my research support group, as well as with current debates and literature in the field. Transferability is

evident when the research findings can be applied to other settings or populations (Polit & Beck, 2017a). Others judge the use of transferability if the research process can be transferable to other situations. The use of purposive sampling can inform the transferability of the study by providing a solid description and robust data set with a possible range of information (Cypress, 2021).

Research is considered dependable based on how the research process is documented. I, as the researcher, have recorded the research journey and process, including journal passages, interview transcripts, and all analysis decisions. If auditing were to occur, I would have sufficient data and documentation of the process to support my established conclusions. I was aware that I was conducting research in an area where I had experience and knowledge as a practitioner and educator. Hence, as a researcher, I may bring my own beliefs and values, which could arise as biases. I overcame this challenge by engaging in discussion with my supervisor and my peer supervision group and through critical reflection about the nature of researcher bias as a practitioner-researcher.

Confirmability in research requires the researcher to show how interpretation has occurred. The self-awareness of the researcher is essential in interpreting confirmability and revealing the study's credibility. I kept a research journal noting the content, research interactions and analytical processes. I continually reflected on various events throughout the research process, making the journal entries as things or events that happened throughout the study. The journal entries used throughout this chapter included the challenges of interviewing, the use of technology, the Covid-19 context, data analysis and other research experiences. My academic supervisor was always there to discuss any problem or barrier I encountered. The journaling or interaction with my academic supervisor could be considered part of maintaining an audit trail.

4.17 Conclusion

As an experienced respiratory nurse and educator, I was always sure about the research area I wanted to explore and the participants who would be involved in the study. Focusing on the research question was a testing process with numerous drafting of research questions. To arrive at the final research question was a journey of critical reflection, reading, discussion, and more in-depth reflection. This research is far from straightforward and involves a lot of toing and froing. I decided that research is a muddled business and that the neatly presented evidence of research found in peer-reviewed journals does not reflect reality. Arriving at my research question was somewhat of a struggle and something I had to write and rewrite numerous times, as is also evident in the research literature (Kellehear, 2020). Exploring qualitative research enabled me to excavate and refine my research question.

To support the methodology and methods employed, I outlined my philosophical underpinnings to explore my research question, which was to explore respiratory nurse specialists (CNS/ANP) experiences to enhance practice development, generate knowledge-based practice, and contribute to learning, education, and research in the sector. This process enabled me to explore and dive deep into qualitative research methodology.

My challenge with the methodological approach and the management of the practical aspect of this study was outlined in previous sections in terms of the way the participants were sampled, the interview process, and the online data collection context. The associated ethical study considerations were discussed and provided, and the data analysis process, validity and reliability were outlined. The following chapter will present the findings of this research study.

Chapter 5: Findings 1 – Education

5.0 Introduction

The following findings chapters (chapters 5 and 6) present the findings that emerged from the interviews conducted with respiratory nurse practitioners in CNS and ANP positions during the summer of 2020. As described in the previous chapter, the interview transcripts were analysed using thematic analysis (Braun & Clarke, 2006, 2012), and the data was broken down into superordinate themes. Each superordinate theme has several related subordinate themes. Though these superordinate themes were identified, there was an interconnection between the themes, as will become apparent throughout these findings' chapters.

Education is a fundamental element of the roles of Clinical Nurse Specialists and Advanced Nursing Practitioners (Furlong & Smith, 2005). While Furlong and Smith (2005) identify clear distinctions between the respiratory CNS and ANP roles, in practice, there is still an overlap in the roles and education of respiratory CNS/ANPs that becomes evident in this findings chapter. Therefore, both roles are discussed together throughout the thesis. The core elements of the respiratory CNS/ANP roles are discussed in section 1.4 and reviewed below.

Respiratory CNS/ANPs play active roles as clinicians, advocates, educators, collaborators, and health promoters (Lit, Lee, & Chow, 2014). They offer expert guidance and are highly skilled in respiratory nursing, such as non-invasive ventilation, pulmonary rehabilitation, and management of chronic respiratory diseases (Rafferty & Elborn, 2004). Respiratory CNS/ANPs enact the specialist role by performing nurse-led respiratory clinics (Lit, Lee, & Chow, 2014), harnessing their education role for the improvement of respiratory patient self-care management. During the Covid-19 pandemic, these nurse-led clinics had to segway to a virtual environment where information and education had to be shared virtually, thus changing the respiratory CNS/ANP education role in the community. These elements are discussed in

the following sections according to the subordinate themes of teaching, learning and career pathways.

This chapter will present the findings for the first of two major themes of this research: the theme of Education, including general experiences of education in nursing and education during the Covid-19 pandemic. Three subordinate themes of education are presented in turn in the following subsections.

Table 5.1 Education - Superordinate Theme and Subordinate themes

Superordinate Theme	• Education
Subordinate Themes (Sub Themes)	• Educational Teaching • Educational Learning • Educational Career Pathways

5.1 Educational Teaching

This theme focuses on the responsibility of a respiratory CNS/ANP to teach the skills and learning needed for respiratory nursing to the next generation of students and staff, along with innovative teaching methods to enhance patient education (Good & Kirkwood, 2017). This is key for patient care by developing the capacity for self-care. For example, teaching is fundamental in the use of inhaler techniques in respiratory treatments. This includes a 'train the trainer' approach to upskill existing staff and the 'teach back' method to show patients how to use inhaler treatments. Teaching methods for respiratory care became vitally important during the Covid-19 pandemic, where respiratory problems became common side effects, and these skills became essential for all medical staff. The teaching role of respiratory CNS/ANPs expanded to all hospital staff in other critical respiratory care activities of mask-wearing use of

different machines and respiratory techniques. Hence, participants spoke about how successful respiratory CNS/ANPs must have a love of teaching and a drive to develop new teaching methods and courses.

> *P1: I suppose there's a big bit of me that loves the teaching side of us. And, you know, whether you're teaching nurses or teaching patients, I enjoy kind of people learning.*
>
> *P7: So, a lot of it is education. That's huge.*
>
> *P11: I think like a major role of CNS is education. I think, like, master's thesis finishing has proven to me like we just do need it, it has been the focus of ours, keep educating our colleagues and keep educating ourselves as well.*

Over three-quarters of the participants in this study discussed the role of teaching and how they felt that education and teaching were part of their core competencies.

> *P6: Well, I suppose the whole time you, we, I am aware of the core competencies of the clinical nurse specialist … and your role as an educator, working with other members of the multidisciplinary team, … it has an educational component.*

They acknowledged this was especially important during this research due to the constant ongoing changes with the Covid-19 pandemic.

> *P15: let's share what we know, and I think with more respiratory knowledge and studies for the ward nurses*

All participants outlined how teaching and training sessions increased because of the Covid-19 pandemic.

> *P11: The hospital did put on training sessions. Upskilling sessions. When we gave some, but we didn't get to attend, I didn't get to attend any other than because we were too busy.*
>
> *P9: Going around education and training in the ED department for patients that might present with Covid-19 and underlying respiratory conditions.*
>
> *P2: And I kind of assumed the role of educator myself because I always had an interest in student nurses on helping them along and teaching.*

All participants mentioned the importance of teaching the correct inhaler techniques to patients and staff.

P1: teaching nurses or you're teaching patients… big challenge … and it's everywhere, … administration of inhaled therapies.

Participant 8 highlighted how some staff had poor skills in teaching inhaler techniques as it is a skill set that must be continually used, noting, '*we did an audit, and the staff was poor, you know they lost their skill quite easily, so there were all up skilled on it, and yes, we were still being called to do inhaler techniques' (P8).* Participants explained how effective inhaler teaching and education could make a big difference in disease control for the patient, and good communication is vital if this is to be achieved successfully. Ongoing teaching workshops were required for all multidisciplinary team members as techniques changed, with numerous more inhalers coming onto the market with specific delivery methods and instructions.

P8: I would have done a lot of education on inhaler technique.

We're going to workshops … with physios, doctors and pharmacists … showing the different inhalers or instruct them how to use them.

P7: There's been huge changes over the years … when I started, there was really only three or four commonly used inhalers on the market today there are many different inhalers.

Eight participants in this study referred explicitly to the increased teaching in pulmonary rehabilitation care to help improve the quality of life for patients with chronic obstructive pulmonary disease. Respiratory CNSs and ANPs are increasingly partaking in educational programmes for patients, providing additional support and teaching them new skills. These teaching activities enhance the core competencies of the respiratory CNSs and ANP role. Traditionally, this training was primarily provided by a physiotherapist, but now they are shared between both disciplines, physiotherapists and respiratory CNS/ANPs. Respiratory CNS and ANP specialists bring their profession's unique knowledge and attributes by partaking in these roles.

P6: we have pulmonary rehab classes for patients, so they attend twice a week. So that was run jointly with a physiotherapist and a clinical nurse specialist. So, our role there was to educate the patient on the exercise program.

P6: So, it was a 16-week, sorry, 16 classes, but it was run twice weekly, over eight weeks. And it had a one-hour component of exercise and about half an hour to 40 minutes component of education from a member of the MDT. And about three of those tasks would be led by the clinical nurse specialist.

Integral in these skills, participants discussed the teach-back methods as a technique respiratory CNS and ANPs used to ensure that they have explained inhaler information and skill clearly so that patients understand what is communicated to them.

P7: So, the teach-back method is [when] I showed the patient how to use the inhaler. And then they also have one, and they show me back how they use it.

Using teach-back methods ensures that a respiratory care teacher and patient both see what a patient is doing and can identify what steps need improvement or what information you need to emphasise with the patient. This teaching method also gives the respiratory nurse specialist a greater understanding of patient knowledge, and there are documented records of patients' understanding before leaving the educational sessions.

P7: I'm providing the education, but I'm also learning all the time. There have been huge, huge changes over the years.

This form of teaching in and through practice is a vital part of the teaching approach. It involves taking technical and medical knowledge of the issue and applying this in practice as they observe and assess patients' and colleagues' capacities to enhance their self-care.

Respiratory CNS/ANPs also identified ongoing informal teaching moments within their clinical areas with their medical colleagues as an effective method for increased learning. These impromptu teaching moments are linked to providing optimum patient care, which can influence and shape learning for patients and staff. Participant 6 outlined the importance of impromptu teaching and giving some power back to the patient and nursing staff.

P6: you know, in terms of … the education of the nurse. So, it's important that you just don't ask a nurse to do something for a patient without, you know, giving some website number, giving current literature on this, or providing some like impromptu education.

Impromptu or practice-based teaching occurs in clinical settings all the time. Participants described how effective clinical teaching had increased for respiratory CNS/ANPs and even became more important during uncertain times, like during a pandemic, with all staff transforming into potential learners and educators.

> *P5: Covid-19 … was really all-around learning and teaching and medics, nurses, physiotherapists, we've had speech and language therapists, … all around using the machines… additional precautions that were required in the setting of Covid.*

Much of this cascading approach to teaching was made by respiratory CNS/ANPs, supporting nurses and other staff to build on their knowledge from personal experiences through their collaborative and interactive work in clinical areas. Respiratory CNS/ANPs spoke about how they felt this teaching role was a crucial part of their capacity and one to which they could contribute.

> *P9: I had that respiratory and knowledge, and from a speciality point of view, it was kind of looked for a little bit more.*

Respiratory CNS/ANPs are a vast educational resource for colleagues within the clinical areas, and all spoke of being involved in teaching practices. This ranged from formal arrangements, such as part of a specialist programme, to using more informal daily teaching opportunities.

> *P5: I love teaching, and it's something I would spend quite a bit of time doing and so probably that that is something that might come more into my role.*

The personnel involved in these teaching contexts included nursing and medical students, junior nursing, medical colleagues, pharmacists and most importantly, patients.

Teaching is a core competency for a respiratory CNS/ANPs framework. In some instances, it was difficult for the participants to identify whether their teaching role evolved out of a need to know this information or if it was more expected from their role due to their high level of education and experience. However, it has become a core element of their role.

P5: I make time for teaching … I could have won the lotto (Laugh+++). I open up a respiratory institution; you can all come and work with me.

P2: the staff, nurses… are very supportive of the role, and they would look for to you for education, as it is part of your role.

5.1.1 Patient Education

Patient education for CNS/ANPs in respiratory care comes in the form of communicating health promotion, supporting patient adherence to their treatment, and ongoing training for staff and patients. Recently, it has also involved a supportive role during a very stressful Covid-19 pandemic, reassuring patients about respiratory issues. For staff, it has involved adapting to new ways of education, using online methods, virtual clinics, and consultations. As respiratory nurse specialists, all participants were aware of their roles in patient care and as nurse educators.

P9: you are doing a lot of education and training on the ground and trying to advance your knowledge and general care for respiratory patients on the ward.

Health promotion is one of the respiratory CNS/ANP's clinical core competencies. Health promotion is necessary for patient self-care to make patients more aware of their condition, support them to self-manage their care, and know when their condition is deteriorating and may need medical intervention.

P13: [for] people early in their disease, [we] give them a diagnosis, gives them the tools to look after themselves, and have a better quality of life and reduce costs on the secondary care on the whole health system.

Respiratory CNS/ANPs promote this critical self-awareness as part of patient education. Educating patients gives them the tools required to help manage their condition. They identify the building of good relationships of learning with patients as key.

P14: a lot of our work is health promotion because, you know, you are talking about diet, exercise, smoking cessation, you know, and I suppose you're trying to give people the tools to be able to manage their conditions at home… were always trying to get patients on boards, so that and build up that good relationship.

Participants described how patients could only learn when they were ready to hear what had been explained. They felt that the power was always in the hands of the patient when it came to the patient taking ownership of their condition. Excellent patient education was finding a way for a patient to understand while taking satisfaction from their knowledge breakthroughs.

> *P14: I would say most of the learning happens because you learn how to manage people's conditions or to help them manage their own conditions.*

For respiratory CNS/ANPs to improve and maintain respiratory patients' health, education is of utmost importance for better health outcomes. Providing patient education improves patients' quality of life with underlying respiratory conditions. It is vital to teach and educate respiratory patients on respiratory protocols to improve their respiratory health and skills, like deep breathing exercises. Patient learning deep breathing exercises may improve a patient's ability to clear mucus from the lungs and increase the amount of oxygen that gets deeper into the lungs.

> *P13: we're giving them tools like talking about self-management about their symptoms, and about taking their inhalers and about doing exercise. And then if they've a lot of phlegm, learning how to clear that phlegm to drink a lot of water, you know, to have a good diet and what a good diet is and how important it is. If you've COPD [Chronic Obstructive Pulmonary Disease], even more so because just breathing they use calories. And then you know, making them aware of that if they have a lot of exacerbations and what an exacerbation is, and it's worse for their lungs.*

It is crucial to good patient care to educate the patients about the risk factors associated with their specific respiratory condition. Respiratory CNS/ANP education includes checking people's level of understanding, arming them with the tools and, most importantly, listening to and responding to the patient. Education occurs at the care receiver and the caregiver level as an active process of understanding and capacity building.

> *P13: reflect back on what they're saying, so you're telling me they make you feel worse? Yeah, they do. And I think I'm going to give off. And then I could say, well, so how do you plan to do that? So, it's more coming from them than me saying you need to give off. You shouldn't do this. They say that. So, it's a it's more effective in them coming to the conclusion.*

P1: But I've often been told by patients, you know, it's never been explained to me like that before I understand it much better now and thanks for explaining it the way you did and thanks for being so patient and repeating it and or making it simple or so.

P12: So, we usually have one of the CNS is attending that. So they will be, there in case somebody is starting on a new inhaler. They need education, right management, their asthma, peak flow diaries, and peak flow monitoring, symptom management, that kind of thing. Our COPD, new diagnosis provides, education, and support. And it's always important to give them your contact details as well. So that they if they go home and have a think about it or if they have any worries or concerns that they can give you a call.

Respiratory CNS/ANPs can reassure patients by removing or decreasing their fears and concerns about their respiratory conditions. For respiratory CNS/ANPs, reassurance for non-specific conditions, where a diagnosis is unclear or unavailable, is complex and can have unexpected results for the patient. High distress can cause patients to consult more with respiratory CNS/ANPs for reassurance. To reduce distress and offer support, respiratory CNS/ANPs provide structured education, virtual telephone clinics and support skills, which can be effective in the short- and long-term.

P9: And it was very stressful for them because they didn't know whether it was going to continue, whether it was going to stop or what we could do [during Covid Restrictions and Lockdown]. And I suppose it was trying to reassure them and look and say for now we have to stop. And but that they had the telephone link that if there were any issues, and, you know, we gave them an education, or like a physical program that they could work on.

P6: you're also focusing on patient education, making sure that they're using their baseline therapy like inhalers because the biological therapies are quite expensive. So, the key thing there would be you're checking things like patient adherence and making sure that they're there. Do this in a stepwise approach.

Participants described how Covid-19 had mixed impacts on respiratory patients. Due to the fear of Covid-19, respiratory CNS/ANPs described how many patients with underlying respiratory conditions followed their medication instructions and cocooned for the first time. The stress, fear and anxiety of Covid-19 resulted in a dramatic increase in patient adherence to medication. However, due to pandemic restrictions, patients' general well-being deteriorated. Webinars and virtual clinics where respiratory CNS/ANPs spoke to patients were essential to good medication adherence.

P1: was doing the virtual clinic, my God to see the patients were obeying their inhalers (laughing). You know, it was actually a very pleasant surprise, you know, for the ones who come in and they couldn't tell you what colour inhaler they were on or whatever, but all of a sudden, they know their inhalers which is no bad thing.

This global pandemic seemed to impact the patients significantly, and any information provided to patients was taken onboard.

P7: So, one good thing that's coming into the pandemic, I'm hoping ... will continue when patients can see improvement due to adherence of medication, I hope it will continue.

Participants described how, as the patient self-knowledge within this cohort increased, they became more aware of the benefits of good medication adherence for their health, leading to lower hospital admissions during Covid-19.

P6: we also see some patients all the time in the emergency department, although it's less so now with Covid, due to adherence. I had to explain about Covid..., and because of the risk of infection.

P7: did a few telephone reviews over the phone. Everybody seems to be really, well at the moment I started talking to patients, pharmacists, consultants we've done a few webinars, and that that adherence seems to have improved dramatically.

5.1.2 Virtual Clinics

Due to Covid-19, virtual clinics became a norm overnight and a necessity for respiratory CNS/ANPs, as a method to assess and keep their patients monitored. Respiratory CNS/ANPs were very involved in setting up virtual respiratory clinics.

P13: in the setting of Covid and then we were very heavily involved in all the virtual clinics. And we did a huge amount of work to help with the virtual clinics.

P5: but certainly, the phone calls in, which was already very busy in our service went through the roof. And so, a huge amount of time spent on the phone.

Virtual clinics were set up with patients and medical team members, such as consultants to GPs and for multidisciplinary team meetings. Participants described the success of these virtual clinics.

P11: The consultants are very happy with the virtual clinic program.

P7: started virtual meetings from talking to patients, pharmacists, we've done a few webinars, and you know, with consultants.

Virtual clinics were done using face-to-face online calls or telephoning individuals with respiratory conditions. This allowed respiratory patients to remain cocooned, reducing the risk of infection. As normal clinics reopened, many patients were afraid to attend clinics in person.

P11: in relation to our patients, we're all in the cocooning group… So we didn't do face to face clinics during that time … we did virtual clinics.

Nurse-led clinics tended to be more telephone virtual clinics. The age demographic of the patients involved having respiratory conditions like COPD and asthma tended to prefer telephone to computers '*and we have developed a knack for the telephone consults' (P15)*. Seven participants in this study described the virtual clinic as mostly telephone-based.

P13: because of Covid-19. I am seeing people virtually but again, it's all nurse lead Yeah, virtually so I'm following it up on patients or referrals that I'm getting I'm still, I can ring them virtually.

P11: So, we didn't do face to face clinics during that time we did what we call it virtual clinics, but they weren't, we phoned patients to see how they were getting on.

P9: So, my nurse clinics, more like telephone based at the moment because of Covid. And so yeah, that's like a snapshot of what the service provides. And then I'm linked with my consultant who has an interest in respiratory. And I attend his clinics as well. So, it's very, very busy service.

Virtual clinics focused on the patient's conditions and became important advice channels on how one could or should manage their conditions and their life during the lockdown. Participants recounted how patients presented differently and with different concerns due to their changed lifestyle while cocooning; for example, participant 12 *'noticed…, the people that have come back to clinic seem to be very, deconditioned as a result of cocoon'.*

P11: We had patients who thought that cocooning meant they had to stay in the four walls, and we had to provide advice on you know how they could access services like even shopping.

P5: you know, you'd be ringing out for the virtual clinics and patients would be everybody was actually most people were quite stable for the simple reason they were cocooning, and there were no bugs and whatever. So, a lot was just actually having a chat with somebody, you know, who hadn't spoken to another person in three weeks, you know, that kind of thing. So, and emotionally, it was a very different job.

Performing a lot of video-based virtual clinics is a significant change in practice for the respiratory CNS/ANPs and did have its challenges. These included challenges like limited video-based technology in the clinical practice area, patients' homes, and the older age cohort of patients unfamiliar with online and computer-based technology. Several patients had no access to computers or laptops, and many didn't know how to use this technology, so the telephone was the only option.

P5: it depends on your patients, and your cohorts of patients and how many will you actually reach with the technology if they're not familiar with it, everybody has a phone but having, there is nothing like seeing your patients physically.

This was further exacerbated by the fact that these patients did not have their families or friends to aid them with any technical issues with IT because of the national lockdown restrictions. Participants described how these challenges and the time participants spent on the phone or looking at computer screens were very challenging.

P5: I'd rather see 1000 patients (in person), its very draining been on the phone and looking at computer screens all the time for your information.

Many participants found benefits in the virtual clinics and felt that it would become part of nursing practice for respiratory CNS/ANPs going into the future.

P7: going to be doing a lot of video clinics. So that will change our practice.

P8: you're dealing with patients with asthma and COPD in different conditions. I found it quite easy to just do the virtual clinic and you know, it came second nature to me.

However, many participants felt respiratory CNS/ANPs missed face-to-face interaction during Covid-19.

P6: online clinic for patients to prevent, I suppose, reduce the risk of infection and coming into hospital, you just missing that face, you know face to face contact.

P1: I mean, we've never said this would replace our clinic for good … it would be great…to move to 50% virtual and 50% based.

Participants were also conscious that several respiratory tests and procedures had to be rescheduled or cancelled because of the pandemic.

P13: I can ring them virtually, but I can't do spirometry at the moment because there's controversy over whether its aerosol generating in which case, we need a dedicated room to do spirometry.

P4: a lot of them really needed face to face consultations, you know, things like inhaler technique for repeat, spirometry, stuff like that. So, they're all now waiting on those as soon as I can get back as on the ground I will be. With no direction as to when we can go.

Five participants felt it would be great to balance virtual and non-virtual clinics for different purposes.

P4: did virtual clinics for a bit of March, April, and a bit of May for any patients who were due a review, so the majority of my patients would get two assessments, they've got their initial assessments and then a follow usually six weeks later, though, everyone got a phone call?

P1: virtual clinic… , the phone calls … sufficed for patients we knew well, but for the new patients that are new to the service, it wasn't really good you actually do need to see them in person.

However, five participants also noted that virtual clinics reduced the personal contact and the visual clues that patients expressed to them in private communication. This was a cause for concern as they learned a lot from the general chat.

P5: we couldn't say virtual completely forever some patients needed to be seen. So, we had to coordinate I suppose the safe running of the clinics.

less face-to-face patient contacts, which I missed a lot, and especially with the patients who are more vulnerable than ever with what was happening.

P7: just missing that face. I know it's a face-to-face contact, really. Like here in the hospital, they are doing face-to-face clinics. And I've been covering for the CNS this week and last week, and we have seen a small amount again of, you know, limited face-to-face contacts. So much nicer than over the phone or due to video.

With experience, the respiratory CNS/ANPs can see how virtual clinics are now becoming less onerous on consultants' time and for other multidisciplinary team members.

P11: This has become much less onerous now because the consultants are very happy with the virtual clinic program, but we attend five consultant clinics a week as well.

P8: I found it quite easy to just be doing the virtual clinic and you know; it came second nature to me.

The world of virtual communications became increasingly crucial during Covid-19, and technology made a significant impact on respiratory CNS/ANPs in a brief period. Respiratory CNS/ANPs had to learn new skills with very little training.

P7: video consultation… so different and I suppose we're very hands-on as well. It's strange doing it or not having the patient sitting in front of you.

Participants described the challenges of digital communications for diagnosis where 'it'll take us a little bit longer maybe to get that diagnosis right …maybe not efficiently' (P7).

P5: it's your gut when you look at somebody and say, oh, person doesn't look right. There's something that not right, you can't do that over the phone.

Timewise assessing patients for respiratory CNS/ANPs took longer as assessments were now performed using a computer screen. Tools traditionally used to diagnose patients, such as spirometry, could no longer be used due to Covid-19 restrictions and the risk of spreading infection. Participants also described the depersonalising effect of engaging with patients online and the challenges of sourcing IT equipment.

P2: I struggled with it was the disconnect with the patient. All you knew was a patient's name and an age. Very little information about the patient I was so focused on the machines (computer) and that I'd forget about a patient I'm really distressed going home thinking … like was really so focused on just all the numbers on getting everything in every hour on that big chart.

There was a high scale of video consultations, using technology from telephone to zoom meetings to keep in contact with patients.

P11: we spent a lot of time sourcing equipment, because as we found out, and at the time that while there was equipment (computers) in, there wouldn't have been enough. So, we did a lot sourcing of IT equipment.

Some respiratory CNS/ANPs felt they became an image on the screen to their patients; there was a disconnect while losing that personal touch *'it was new technology...just incredibly stressful and then facetiming people/patient, I was not psychologically prepared' (P2)*.

> *P7: So, I'm going to my plan during the video consultation already have posted some placebos inhalers out to them. So, it is different, and I suppose we're very hands on ... It's … strange doing it not having the patient sitting in front of you ... it a new way of working.*

> *P9: when we're all trying to really catch up with what was happening across the world ... So, for them, I suppose it was a matter of trying to reassure the patient and it was really important that we had that telephone link.*

The respiratory CNS/ANPs faced the challenge of education of technical respiratory equipment to staff as a high speed of learning was required across all areas of healthcare, which was unprecedented.

> *P1: Do that telephone assessment. And I suppose if we'd had triage training, maybe You know, we talked about in that it was an interesting outcome of Covid-19 and virtual clinic in that, you know, the phone calls.*

5.2 Educational Learning

Ongoing professional learning and education are crucial in nursing, especially in a technical arena like respiratory care, which combines specific respiratory knowledge and skills with a practitioner's general nursing capacity. While academic learning is essential, learning on the job and the practical day-to-day learning and experience of respiratory nursing are equally vital, especially in a changing healthcare context.

The Covid-19 pandemic developed an unanticipated learning curve in nursing, where learning and education in respiratory care had to be accelerated across all areas. This type of learning and form of education was unusual in its broad scale and rapid pace, which was necessary due to the circumstances. Existing knowledge about respiratory conditions from the formal learning in educational programmes that many healthcare staff had was insufficient.

Participants acknowledged the lack of knowledge among nurses working on respiratory wards in a respiratory care setting for this type of context. One of the reasons for the knowledge gaps highlighted by participants was that many nursing managers do not always have a respiratory nursing background. It raises the question of whether the presence of respiratory CNS/ANPs on respiratory wards deskills the general nurse as they feel they do not need this learning or knowledge themselves as they can call on the respiratory nurse specialist.

> *P15: the lack of knowledge of some of the nurses, you know, and they're working on a respiratory unit, they still don't get the NIV [Non-Invasive Ventilation]. I just find that quite scary.*
>
> *I find it quite scary that the CMNs get a job on a respiratory unit. And they didn't have the post-grad course, or they didn't have any respiratory knowledge.*

Professional learning allows respiratory nurse specialists to gain excellent knowledge and develop professional autonomy in these specialist areas. Respiratory nurse specialists are aware of their specialist capacity, clearly stating their area of expertise. They can attain and maintain professional autonomy and influence respiratory care for other nurses and multidisciplinary team members.

> *P15: Wow, actually, I know a lot. And some really want to boast, I don't mean, boast at all, but it does frighten me a bit. Actually, the lack of knowledge.*

The Covid-19 pandemic posed a considerable challenge to this education, as learning had to take place at an unprecedented scale and force.

> *P15: That's one thing I didn't mention in Covid. We've done loads and loads of Covid respiratory education on oxygen, NIV and Airvo[3] and all that. So that's been really good. And it's been really appreciated.*

Though respectful and supportive of academic education and learning, participants in this study expressed experiences of a gap between academic knowledge and practice-based

[3] Airvo, (Heated Humidified High Flow Therapy) https://irishthoracicsociety.com/wp-content/uploads/2017/12/O2-Guidelines-Final.pdf

learning. This highlights an essential theory-practice gap that became evident when this knowledge and capacity was needed in an immediate and vast scale of Covid-19.

> *P14: I think a lot of the time with the academic courses, there's still such a huge gap between you know, what you're doing in college, and you know, actual practice your day-to-day practice.*
>
> *And I think, you learn so much, and I would say that you learn so much on the job. I would say, over the past few years if you learn from the person that's sitting opposite you.*
>
> *P7: I'm not saying I didn't learn anything from the course. But it was to kind of further my knowledge on I would be good, I would say at the practical, everyday stuff. But I needed to learn more about research, research methods, all that kind of stuff. If I was going to further my career on it, like I did learn a lot with the asthma and COPD module.*
>
> *P13: I learned loads on the job. I think, yes, I started the diploma, higher diploma in respiratory before I got that job. I was in the middle of doing it. And when I got that job, I finished this by learning, you know, I learned on the job basically.*

An interesting consideration is that over half of the participants started their education before or at the beginning of taking up their role as respiratory CNS/ANPs, so their experience combined work practice and postgraduate learning simultaneously. It raises critical questions about the interaction between and sequencing of work-based practical and academic-based learning linked to the balance between theoretical knowledge and experimental-based clinical learning discussed in Chapter 3.

Participants spoke about the ongoing and continuous nature of their professional learning, describing every day as a school day, with the spark of learning as authentic and valuable in their professional lives. Learning brings immediate achievement and the opportunity to apply what they are learning to their nursing practice for the patient's benefit. It is a deeply intertwined form of theoretical and applied knowledge**.**

> *P7: I'm still learning every day on the job.*

Participants also acknowledged the academic content of the postgraduate course as key. The respiratory nursing course, though difficult was described as a 'wake-up call' for two

participants who felt the content covered in the programme was something they should know but did not. It emerged the postgraduate course was seen as a vehicle for learning, especially for those who undertook advanced practice roles.

> *P9: from that advanced learning, I've looked at how I suppose again, when I was reviewing the policies, procedures and guidelines around caring for patients with specific respiratory conditions, and there was part of the modules … different respiratory conditions and treatments and guidance around the care for those patients or looking internationally at the guidelines and trying to bring them to what would be practical at a local level.*

Respiratory CNS/ANPs must maintain and improve their knowledge, skills, and competence through continuing professional development (CPD). CPD is central to respiratory CNS/ANPs' lifelong learning and is vital for keeping nurses' knowledge and skills up to date while increasing confidence levels.

> *P8: I suppose one thing I ensure that I have done every year I attend the Irish Thoracic Society meeting I mean, those are very beneficial. Not only from educational point of view, with regard to workshops, … wanting to update and upskill.*
>
> *P9: to practice as a CNS, it's really important that you have that educational background, and that's why it's mandatory when I applied for the job either completed or in the process of completing the respiratory course.*
>
> *P13: I've increased my confidence by the learning that I've done, you know, increasing my knowledge, listening to webinars doing it… So I know that I can do it, I know that I have all the knowledge from doing the role. And all the learnings that I have.*

As respiratory CNS/ANPs, learning and broadening their knowledge is continuous and never-ending. Participant 5 used the expression '*don't let the grass grow*' regarding career learning.

> *P5: like it's a long career we're going to be nursing for a long time. You need to feel challenged and encouraged and build your knowledge and find your niche.*
>
> *It's really important. So, I think that's the only that's the biggest thing I've learned from all of this is just keep going.*
>
> *P6: So, we found that we got we have a lot of the patients with respiratory failure were admitted to the wards … who required noninvasive ventilation … So, I had update myself, you know, as other team members with a lot of learning to do*

Participants spoke about the balance between clinical judgement and the theoretical knowledge they learn in their formal education to develop a 'store of knowledge' that is their professional knowledge. All participants use clinical eye or judgement in using this 'store of knowledge' to care appropriately for patients. They spoke of how these clinical judgement skills were supported by their extensive practice-based experience and theoretical education to give the unique intuition of each respiratory nurse specialist in nursing practice.

> *P2: I think it's observation, it's, and it's learning on the job, that we acquire the skills and we, we develop a clinical eye that and it's very easy to say that that's intuition, but I don't think it is, I think it's actually a whole big store of knowledge from observations and from reading that we that we have within us*

As discussed in Chapter 3, this deep sense of learning encompasses reflection in action and reflection on action processes (Schön, 1991), which uses the '*whole big store of knowledge from observations*' and theoretical readings.

Covid-19 brought issues about learning that had not been experienced before in respiratory nursing, impacting participants' learning. They spoke of the intense scale of new learning needed to know the basics of looking after a Covid-19 patient. Participants spoke of an initial lack of experience and knowledge regarding the impact of a new disease like Covid-19 on the respiratory system and the consequent steep learning curve. This learning occurred in active clinical conditions, as they were being redeployed as nurses in wards to help in respiratory areas.

Participants also spoke of the need to bring this new learning to their colleagues across multiple areas of healthcare at the same time as they were self-learning. The timing and demand for this immediate upskilling for which respiratory CNSs and ANPs were responsible was another unique feature of the impact of Covid-19. The net result was a dramatic increase in teaching and education provided by respiratory CNS/ANPs to nurses, doctors, and healthcare professionals.

P15: We've done loads of loads of Covid-19 Respiratory education on oxygen NIV and Airvo and all that.

P11: you know, is education of both our colleagues and nursing, our medical. And we also find ourselves doing GP talks and all sorts of, so a big part of our role was education. So, we needed to educate people on the use of non-invasive ventilation.

P11: we did information sessions where we, you know, we did a bit of Covid-19 we spoke about the various therapies and why you would use them … from junior staff nurses right up to consultants attended.

Participants spoke about how this learning has rejuvenated the respiratory CNS/ANPs and improved their practice by proving the need for increased and continual knowledge and studies on the wards. They became very aware of the impact of this practice-based knowledge on nurses on wards and could see the longer-term implications of this in their work.

P15: I think with more knowledge and studies for the ward nurses (that are really going through hell at the moment, with Covid and everything) … think they will enjoy their job more as well.

They were also cognisant of the development and preparation work needed to ensure that learning was being applied. They spoke of their new learning skills regarding sourcing equipment and oxygen supply and ensuring it was adequate to fulfil the demand for it.

P11: we spent a lot of time sourcing equipment, because as we found out, and at the time that while there was equipment in there, it was it wouldn't have been enough. So we did a lot sourcing of equipment.

Participants discussed the struggle to continue their structured learning through educational programmes while working during the pandemic.

P8: Covid-19... different times and challenging times… it definitely has improved my practice get more involved as well.

P5: Learning at a rate that hadn't happen before, what you need to know to look after a Covid patient… Trying to continue your own structured education programme and working in pandemic. Make education sources available and learning how this could be done in limited time.

Making educational resources available and learning how this could be done within a limited timeframe and supplies became part of the respiratory CNS/ANP role.

The participants also spoke of the highly responsive nature of this knowledge and education, where it needed to be applied immediately in a changing context. They could not think too far ahead as the guidelines and policies on the Covid-19 pandemic were constantly being updated, making it a very challenging time, '*Covid-19 had taught me not to think too far ahead… because basically plans change and all that' (P8).*

As practice changed, new educational resources were required; for example, aerosol generation procedure tests were suspended due to the risk of spreading Covid-19, *'there is going to be no diagnostic testing in the community, we would normally do spirometry, reversibility testing' (P7)*.

5.3 Educational Career Pathways

Chapter 2 reveals that the educational pathway to becoming a respiratory CNS/ANP in Ireland was unclear for a long time. Although the clarity of these pathways has improved for respiratory ANPs, it is still an issue for respiratory CNSs. Respiratory CNS/ANPs have many pathways within their roles, as evident from all fifteen interviews.

> *P11: I had identified courses and signed up for myself, you know, I did spirometry course I did pulmonary rehab course… but I thought my point of view, there was no defined pathway. So, then the opportunity came for me to be an accredited CNS.*
>
> *P3: I had my nursing; I had my management courses. I've done a few courses … I have my degree done as well. So, I said I did a bit of research and postgraduate in respiratory.*

Four participants discussed how they worked as respiratory nurses for a long time and were unsure how to progress their careers from an educational perspective, as they had different components and modules in various programmes. Participant 11 described their educational pathway by using the analogy of shopping in a supermarket where you pick this and that in terms of the different programme modules but are still unsure if you have all the necessary ingredients for a successful meal.

P11: a lot of us who've been in job for a while… there was no defined pathway, we have a lot of the stuff, educational but don't have everything done …, it's like, you go shopping in … and you're going to cook[for a], dinner party, but have no idea what you're cooking. So, you pick this up, you take that and then you get home, and you realize. I have gone to supermarket again because I've forgotten about that.

I think it's getting better now, one of our colleagues actually did a two-year study he/she did his/her master's in advanced health and all that so, he's/she's on a straighter path than I am.

P7: And then there's Advanced Practice modules where I'm like, oh my god, I need to do all that education to get the role. There still a lot more to do, that's my stumbling block.

It was evident that several respiratory CNSs did not meet the educational criteria for becoming a respiratory ANP. Despite having undertaken several educational programmes, they were missing required modules or had to revert to undertake more education to meet the ANP pathway. Consequently, professional tensions and feelings of jealousy between respiratory CNSs or between respiratory CNSs and ANPs can manifest because of this uncertainty in clarity regarding career pathways and development.

P3: there's a lot of jealousy there… some of my colleagues have done courses on things now, he's/she's ANP that he's/she's all the qualifications, he/she doesn't have a master's and so that's his/her knowledge of the ANP role. He/she thinks because he/she got her advanced assessment and prescribing that he/she can be ANP … but he/she needs to go off and do her master's. [he/she] doesn't understand the education component. There's a lot of line blurring. People don't understand what an ANP does and what CNS does.

P2: ANPs … I would say there's a little bit of friction is with Clinical Nurse Specialists.

The level of education set for nurses to be recognised as CNSs and ANPs, including their registration, was discussed previously in section 1.4. Several respiratory CNSs in this study have both level 8 prescribing and level 9 respiratory qualifications.

P7: there was a higher diploma in respiratory nursing. I did the asthma and COPD module. So, I did that. And then I think it was the following year… I got a job as a respiratory CNS.

P6: do my higher diploma in respiratory… And I went for interview … I was successful. So that was my official post as a Clinical Nurse Specialist, and yeah.

Some participants discussed how respiratory CNS/ANPs were not always actively supported by their management in their organisation when it came to facilitating their professional education and learning pathways.

> *P8: Education wise, we wouldn't be supported that well in the past, it wasn't that they didn't support us they probably didn't feel the need*
>
> *on different occasions to be supported to do study at nine times out of 10 wouldn't have been acceptable, they couldn't just release us to go. So that probably was a stumbling block to ours as well*
>
> *P3: very tough, said working full time and gave me only 10 days leave so that I could take unpaid leave work hours, and so that was very difficult.*

Two participants expressed concerns for nurses applying for the respiratory CNS and ANP role who have little clinical experience, especially considering the current educational pathway they will have to develop. In the past, respiratory nurse specialists had good levels of clinical experience but often lacked the education component.

> *P5: I don't know what that seems to be the way they're looking forward is that really, our nurses won't be very long qualified before they're able to apply for these jobs now because they are a lot more progressive by continuing their education than what my gang would have been you know.*
>
> *I had the experience behind me … and … education that was required [to] … carry out the role … but I think looking at the way things might go forward that you could be three or four years qualified going into an ANP job I couldn't imagine having been three- or four-years qualified progressing that quickly onto ANP, I suppose the encouragement is different now.*
>
> *P11: whether it was NMBI or whether it was the college's … recommended pathway you take; I just feel and I'm conscious of the fact that … student nurses now and they're all going to be ANPs straight out.*
>
> *I suppose I don't regret experience I that I had along the way.*

Continuous nursing education is an expectation when pursuing a career in nursing. Participants identified how educating themselves and others is a significant role of being a respiratory CNS/ANP. Nursing education varies from postgraduate diplomas in higher education institutions (HEI) to on-the-job education in the clinical practice of respiratory CNSs and ANPs in respiratory care. They spoke of the importance of nursing education being

supported and encouraged by management and nurtured in a way that can provide more opportunities for nursing education within clinical settings. Nursing education builds the capacity to make nurses more confident to take on more roles and responsibilities and complements their professional experiences.

Participants who are respiratory ANPs or wish to pursue respiratory advanced nurse practice must undertake a master's educational programme and a postgraduate programme in respiratory nursing, as outlined in section 1.4. All participants in this study had a minimal level 8 qualification; apart from 2 participants, most had level 9 postgraduate qualifications, whether in the form of a master's or postgraduate diploma.

> *P14: I had done a postgraduate diploma in respiratory, and I did then I went and trained in spirometry and that sort of thing. So … I did my masters, and I did my I became an ANP candidate … I did a postgraduate diploma and then an advanced practice.*

> *P3: And then with the Advanced Practice masters, that was an eye opener, and, you know, as in doing the clinical practice that the doing the advanced health assessment, it was actually really good.*

The participants in this study understood they must keep themselves self-educated on relevant updates on the Covid-19 pandemic, which became a significant part of their role during this time. As described in the previous section, their education role was a specific type of upskilling in the clinical area. It was then delivered to doctors, nurses, and other members of the multidisciplinary teams. Participants acknowledged that this education was very specific and purposeful, happening in practice whenever and wherever suited clinical staff or as an issue or query occurred.

> *P13: I did two long days this week, Covid-19 swabbing, … part of the other part of my role, of course, is on education, like I'm doing education. I'm doing a GP session.*

> *P6: we have our educational role … main one would be on non-invasive ventilation. be educating the nurses on the wards on … evidence-based practice … how to put on a mask for an NIV and how to monitor the therapy ... assess the patient and assess the nurse in her clinic and competency.*

Given this practice and the applied nature of this education, participants noted that establishing the existing knowledge and skills basis of their peers is a crucial element in the teaching process. As educators, they do not ask staff to do a skill or task without finding out their current level of understanding and then provide the staff with the required information and skills capacities.

Participants spoke about the challenges of progressing on this education and career development pathway in the broader context of their lives. They described how nursing education is challenging at level 9 regarding juggling family and job. Participant 5 discussed the sudden loss of a parent as they were going back into a college education and taking up the role of respiratory ANP.

> *P5: I'm never going to survive. But you do and that but so there is never a right time for education or doing a course.*

Professional education is part of their career and so must be balanced with the other work and family commitments of their lives as mature students.

> *P3: I did the master's in advanced practice prescribing pathway … very tough, stayed working full time and gave me only 10 days leave so that I could take unpaid leave work hours, and so that was very difficult.*
>
> *P1: I'm doing my further studies with a view to do ANP… huge task and there is an appreciation there, why bother, as your part time, but it's important.*

Participants spoke of how education can be very stressful when working full-time, especially during a pandemic. All the participants were working in respiratory care, so they spoke of the timeliness of learning about Covid-19 respiratory care as paramount. The immediate need for this type of specialist respiratory knowledge and skills meant that education and learning were very focused. There could be no delay in updating the relevant information and skills at speed and putting them into practice immediately. All participants remarked on the pressure that this created on learning.

P2: And so that was incredibly stressful. And then we hadn't really had maybe two hours of training before we were sent in, [to] … covid intensive care.

keeping up with CPD was a big NO[4] this year, has been a non-year, I miss all the conferences.

All participants recognised the importance of their ongoing education as nursing policies and guidelines change and update; you need to be continuously learning.

P2: And I always had an interest in education. That was just something I think that was kind of in me so I always if there was any course going, I'd always put my hand up to go and do the course.

Participants acknowledged that there are many forms of learning in this ongoing education, which reflects the different forms and dimensions of learning from practice discussed in Chapter 3. Of relevance for their work, they recognised experience-based learning from day to day on the job, practice-based learning by applying something new like skill-based learning, developing the capacity to assess colleagues and patients' learning needs and relational learning from social interaction with colleagues and multidisciplinary teams. There were also professional learning opportunities from participating in conferences, learning from policies and guidelines, and learning by thinking about work experiences, which was described as reflecting on practice, deepening conceptual reflection in workplace learning from and through experience. This professional workplace learning can be referred to as increasing human capacities for flexible and creative activity in work situations (Fenwick, 2008b).

P1: I think I suppose a little bit of it's that I'd have to say I learned on the job, okay. And now, you know, okay, I've done all the core stuff on, asthma, COPD.

So, you know, there's been a lot of learning along the way and attending conferences and keeping up to date with new guidelines and that and I'd have to say you learn a lot from the patients as well.

[4] The participant spelled out the word NO to show impact of not being able to keep up with CPD

P8: like even going to ITS conferences and other … study days.

It became clear from the participant interviews that they spoke of two forms of respiratory nursing education: ongoing education in practice and structured formal education processes. As discussed in Chapter 2, participants have to learn to apply the theoretical knowledge learnt in formal education in the context of their everyday practices, developing the capacity to know when and how to move between different types of theoretical and everyday knowledge in different contexts (Wheelahan, 2015).

5.4 Conclusion

Respiratory CNS/ANPs hold a crucial role in nursing education, and this has never been more in focus than during the COVID-19 pandemic. The findings show that learning occurred for both patients and members of the multidisciplinary teams. The findings chapter on education presents the educational experiences of the respiratory CNS/ANPs study participants. Continuous nursing education is expected, and participants identified education as a significant role of being a respiratory CNS/ANP in fostering more confidence to take on more roles and responsibilities and complement their professional experiences. Nursing education varies from postgraduate diplomas to on-the-job education in clinical practice. They spoke of the importance of management supporting and encouraging nursing education and the need for more opportunities for nursing education within clinical settings.

Participants identified self-education and the education of others as significant roles of being a respiratory CNS/ANP. For example, they understood they needed to stay self-educated during the Covid-19 pandemic to ensure they all had up-to-date information. Participants acknowledged how the teaching methods/skills of respiratory care became vitally important during the COVID-19 pandemic. Respiratory problems manifested as a common side effect of the virus. These teaching methods/skills became essential for respiratory CNS/ANPs daily in educating patients, nurses, and all medical staff. Participants noted how their education varies

from postgraduate diplomas in higher education institutions (HEI) to on-the-job education and that the pathway to becoming a respiratory CNS or ANP must always expect the involvement of continuous nurse education. However, there are challenges in progressing in education and career development pathways at level 9, especially when juggling a job, family, and other commitments. Chapter 2 reveals that the educational pathway to becoming a respiratory CNS/ANP in Ireland was unclear for a long time. Although the clarity of these pathways has improved for respiratory ANPs, it is still an issue for respiratory CNSs. Respiratory CNS/ANPs have many pathways within their roles, as evident from all fifteen interviews.

Participants considered professional learning crucial in nurse education, especially in technical areas requiring specific knowledge and skills and a practitioner's general nursing capabilities. However, the respiratory CNS/ANPs participants see learning academically as very important but equally note the practical day-to-day learning on the job as invaluable in building valuable nursing experience. Educational development can be a slow process. Respiratory CNS/ANPs are a vast educational resource for colleagues within the clinical areas. This ranged from specialist programmes to more informal daily teaching. Teaching is a core competency for a respiratory CNS/ANPs framework.

Participants recognised experience-based learning from day to day on the job, practice-based learning by applying something new like skill-based learning, developing the capacity to assess colleagues' and patients' learning needs and relational learning from social interaction with colleagues and multidisciplinary teams. There were also professional learning opportunities from participating in conferences, learning from policies and guidelines, and learning by thinking about work experiences, which was described as reflecting on practice, deepening theoretical knowledge and conceptual reflection in workplace learning from and through experience.

Participants also identified how, in a short period, communication technology platforms and virtual clinics became an overnight requirement for respiratory CNS/ANPs. This involved a lot of video-based virtual clinics, which was a significant change for the respiratory CNS/ANPs practice and did not come without its challenges. Challenges like limited video-based technology in the clinical practice area, patients' homes, and the older age cohort of patients unfamiliar with online and computer-based technology. This developed into a new assessment in keeping their patients monitored. Participants acknowledged their difference-making role in people's lives and felt appreciated for their work and effort, which contributed to reasonable job satisfaction. They note that one of the surprising benefits of being fearful of Covid-19 was the increased patient adherence to medication instruction and information.

Respiratory CNS/ANP participants describe how the Covid-19 pandemic created a sense of collective action across all areas and teams where everyone pulled together (e.g., team staff, consultants, doctors, etc.). In the next Chapter 6, I will present the findings of professionalism.

Chapter 6: Findings 2 – Professionalism

6.0 Introduction

This chapter will present the findings for the second of this research's major themes, Professionalism. Four subordinate themes of professionalism are presented in the following subsections.

Table 6.1 Professionalism - Superordinate Theme and Subordinate themes

Superordinate Theme	•Professionalism
Subordinate Themes (Sub Themes)	•Professional Role •Professional Emotional Regulation •Professional Multidisciplinary Teams •Professional Relationships

Professionalism in nursing is highly regulated; the power to control professionalism in nursing is granted through legislation but realised through everyday nursing practices, as the following sections reveal.

6.1 Professional Role

As part of their professional role, respiratory CNS/ANPs respect and maintain their dignity and that of patients in their professional practice. Under the code of professional conduct and ethics, principle one discusses respect for the patient's dignity, requiring that all people are treated equally without discriminating on the ground, age, gender, race, etc. (Nursing and Midwifery Board of Ireland, 2021a). Respect is essential to a healthcare organisation, creating an atmosphere where members of healthcare teams engage and collaborate to care for

patients as individuals. Responsibility and trust emerge from the respect created during the interaction between respiratory CNS/ANPs and consultants/other teams. At the same time, NMBI principles state that there must never be a lack of respect within a working environment from colleagues or management, but under pressure, it may not always be the case in practice.

Participants discussed how they felt that respect manifests from positive and challenging aspects of their role. Participant 7 contended that respect came from the role progression of the respiratory nurse specialist, including the recognition from multidisciplinary professional colleagues. Participant 5 linked respect with the responsibility or the extra responsibility that comes with the role of a respiratory CNS/ANP as an advanced specialist practitioner. There was the desire to grow and expand professional knowledge to continue gaining that respect and maintain the confidence of colleagues in the professional area and team.

> *P5: The biggest thing I suppose is the level of responsibility was always there, we've always been treated extremely well. And in our team and our, I suppose our knowledge and our ability to make decisions has always been really well respected. And that's something that's been very consistent … your opinion was always respected and that was really important to help you I think, grow and expand your knowledge and feel confident.*

All participants felt professional respect among multidisciplinary colleagues '*I have some brilliant colleagues, and they really respect and appreciate us*' (P15). Participant 4 felt great respect for respiratory CNS/ANPs within the multidisciplinary teams when discussing respect between physiotherapists, social workers and occupational therapists when liaising with respiratory CNS/ANPs.

Participant 4 also highlights that Covid-19 has increased the levels of respect and trust '*I do think there's a respect, for specialist respiratory nursing. ….. with Covid-19 they properly trust and respect us as much as ever, if not more*' (P4).

Participant 7 discussed the diversity on the job in the nurse-led clinics where they see complex cases of numerous respiratory conditions, including asthma, COPD, pulmonary fibrosis, bronchitis and other conditions. The respiratory nurse must manage these problematic and diverse conditions, gaining professional respect and acknowledgement from all involved.

> *P11: we run a nurse lead clinic, we have asthma, severe asthma, COPD bronchiectasis, interstitial lung disease, we run an oxygen assessment clinic, and as well as that we see patients, both inpatient and patients who attend ED.*
>
> *P7: I spend 80% doing clinics in the community, 20% in the hospital, so I spend one day a week in the hospital.*
>
> *P1: different focuses… some people you know, want to focus on maybe one specific disease or condition, and for others, they may tend to prefer and kind of auditing and collating information.*

One significant aspect of recognition for any professional is the financial reward or recognition of the professional role through salary and work conditions. This is an issue which is highlighted as problematic by participants. The prestige and financial recognition of respiratory CNSs and ANPs as a profession have not kept up with their growth. In 2016, the Irish Government aimed to increase the number of ANPs by 2% to be in line with the European, which included respiratory roles (Government of Ireland, 2019). With this new pathway, incentives (including financial and educational) did not materialise; consequently, fewer nurses are becoming respiratory CNSs. Participant 15 discussed the lack of respect respiratory CNSs receive '*I think that we deserve the recognition and respect … we deserve to have an academic qualification to back up the the job, you know, the job description'* (P15). Participants felt their position should be similar to their colleagues on multidisciplinary teams, such as occupational therapists, physiotherapists, and other healthcare professions. They noted that they are required to have equivalent third-level qualifications at levels 8 and 9 as colleagues, but their wages do not reflect their input *'I don't know, we're not getting the same respect, we still don't get that same respect. And it starts with our wages not being matched at exit of when they finish the degrees'* (P15). Participant 15 continues to outline why this

respect is deserved, locating this within the broader debate about the recognition of nursing as a profession.

> *P15: I know there's a lot of debate at the time was nursing really a profession, and a lot of people took issue with the fact that nursing was going to third level, but I think it has its own very specific body of knowledge [which is] one of the criteria for what constitutes a profession… so, I definitely think we're, we're deserving of it and financial award.*

This reflects the history of nursing's development from a vocation to a professional sense of identity as outlined in Chapter 2, with educational qualifications and theoretical knowledge base cited as crucial elements in its professional development.

Several participants who worked in hospitals, communities, and integrated care as respiratory CNSs and ANPs acknowledge that their workload may not always be visible to managers at more senior levels, which contributes to the lack of visibility and recognition of respiratory CNSs and ANPs. They also recognise that their workload visibility depends on the participant's clinical setting, which ranges across different services and work styles, meaning that their contribution is not always apparent. Management at times showed a lack of respect by not being aware of the depth of their job, with many participants describing how they go over and above their job description.

> *P4: sometimes there's actually not enough hours in the day to do all that work.*
>
> *If you set up a great service, it's going well, like there's no feedback and the managers write reports or compile a report of all the services.*
>
> *I know what's working for patients. I know the feedback I get from patients is good. I thought it would be nice to know the senior management are happy with you.*
>
> *P10: …it's just completely different levels of workload it's not a one person busy one person it's not, it as hard as you know some days as the wards but like we have our own levels of stress, and we have our own levels of busy it just isn't the same.*
>
> *P8: logistics and management… And that's why I say own workload is massive. Yeah, it's very difficult to just come in the morning and just it's something to do with respiratory care, you can't just walk out and leave, it has to be done today.*

> *P1: I heard you've got a great policy on this. And I'm about to start it, would you mind sharing for me? And I said, No, of course not. I share with you. But you know, I suppose and it's great to do that, and you get great feedback from it. But there is this sense in your core that, you know, this is frustrating, you know, that, that there's a total lack of appreciation of what we do, in our centre in our specialty, and all over our hospital there are advanced nurse practitioners. I mean, it's not hospital wide. You know, it's that we are not really on the radar of our manager.*

This lack of visibility of their work highlights the broader issue of the lack of recognition of care work and interdependency in society (Nussbaum, 2006). This is a vital issue for all areas of nursing where a caring ethos is central to professional identity. If caring and interdependency are not visible or recognised at a professional level, it denigrates the role of caring in society (Lynch, 2021). This is an issue that is considered further in the discussion chapter.

Participant 2 discussed respect as knowing your practice and others recognising your practice and capabilities. Building professional respect with consultants and multidisciplinary teams involves awareness of your professional competency. Participants emphasised the importance of regular meetings where you can outline what you are doing in the role and gain greater visibility.

> *P10: at the start of my ANP role, referral [by consultant] wasn't being made but over time the referrals started coming directly to ANP from consultant.*

Time also plays an essential aspect in the development of professional respect. Individual respiratory CNSs and ANPs have different working patterns that allow them to slowly build up professional contacts and networks to advance professional recognition from consultants and other colleagues on multidisciplinary teams over time.

> *P6: we can do things as nurse specialists, like you can, you know, access HSE land or, and network with other team members of the MDT, you know, in order to advance your practice.*

Participants 4 and 13 discussed the respect within the role and the mutual understanding and respect for each other's roles amongst respiratory CNSs and ANPs. However, in many cases, when a service is new in an area, it can take time for colleagues from other disciplines to understand the role. Participants described how some colleagues might initially see the role

of respiratory CNSs and ANPs as extra work or a burden for them, so it can take time to acquire that professional respect.

Professional respect can also differ between disciplines, for example, the differing types of respect offered by consultants and physiotherapists.

> *P13: think we respect one another's roles … it takes a while. Like, for example, the consultant might think, oh, no, this is more work for us… but we're working more together.*
>
> *my impression is, I think they feel that this isn't as much a burden on us as we thought it might be, and that I don't need much from them. (Them being consultants)*
>
> *And yes, we know we're the experts in our own fields, so we're not taking over the other person's role.*

This type of mutual recognition and respect were crucial elements of what works in multidisciplinary teams and were vital to professional recognition. Where there is respect and recognition of different professional identities, a shared practice identity can be formed, contributing to multidisciplinary patient care (Weiss et al., 2016), and every team member is equally valued (Shalala et al., 2011).

6.1.1 Role Autonomy

Professional autonomy means having the expertise and specialist skills to make decisions and the liberty to act following their professional knowledge base, which is significant to clinical practice (Wade, 1999). A respiratory CNS/ANP must be competent and have the courage to take charge and self-manage in circumstances where they are in authority to satisfy the role of an autonomous professional practitioner, as was highlighted by the participants in this study.

> *P15: I'm constantly having to check myself is this within my scope of practice… but I started being more confident, I think.*
>
> *P14: you work maybe a little bit more autonomously as an ANP.*

Participants viewed their respiratory nursing role as a specialist role where they have expertise and autonomy in the field of practice. Respiratory ANPs considered themselves autonomous practitioners where the need for medical colleagues' assistance was sometimes reduced or limited. This was a significant shift for nursing practitioners from when nurses were traditionally answerable and taking orders from medical colleagues, especially those in higher ranks, such as consultants, with nurses having little autonomy over their own professional decisions.

> *P13: my role … [as an] ANP, I'll have to do that. … then you wouldn't need the consultant so much. But I will, would do all the self-management and education. I mean, I'll be kept busy anyway, with self-managed education, oxygen clinics, they'll be coming out and I'd be involved in that.*

All participants recognised that their nursing colleagues viewed respiratory CNS/ANPs as having autonomy in their roles. They regarded the ability to make independent decisions in their role as having benefits for both health outcomes and patient experiences.

> *P11: I think they see me as an experienced practitioner and we do all kind of maintain a certain autonomy in our role So, you know, I would have an inpatient caseload. And the only reason I would hand that off is if I had patients with, still had something to do or I was going away on leave.*

Regarding the autonomy of respiratory CNSs, participants expressed mixed understandings between respiratory CNS autonomy and respiratory ANP autonomy. Ten participants reflected on a blurring or amalgamation of both roles and a diverse understanding of autonomy within and between CNS and ANP roles, as outlined by Participant 7.

> *P7: as CNS you're assisting the diagnosis, you're doing the diagnostic testing, you're doing the treatment planning, you're a nurse prescriber, you come back and review the patient. To me, I personally feel my role at the moment is an ANP role.*

They noted that it is a requirement for all respiratory ANPs to have level 9 qualification (Nursing and Midwifery Board of Ireland, 2017); however, many respiratory CNSs (while not strictly a requirement) have attained level 9 qualification as part of their professional development.

Participants described that when it comes to professional autonomy, there was a lack of knowledge or awareness from nurses and other healthcare professionals about the difference between the role of a respiratory CNS and ANP.

> *P14: what was the difference with me as a respiratory CNS, and me as respiratory ANP and they would say, there's no difference*

Four participants recognised the difficulties of outlining autonomy within roles and felt autonomy was beyond their formal job description. Participants were stepping up to a higher level of autonomy while still positioned in their current role and questioned whether this was to the detriment of their personal and professional career development. This raises the question of the potential negative impacts of autonomy on career progression, highlighting the shifts between and significance of role experience and autonomy over the job description, which P4 noted.

> *P4: you are quite an autonomous practitioner and thus maybe these posts should always have been either ANP or senior CNS level if there was such a thing, and I don't think respiratory integrated care, is CNS post, I suppose it's not a post you could do as your first CNS post. You're very autonomous, you know, you're making decisions with GPs there.*

One participant spoke very clearly about the practice aspect, where teamwork and learning from one another and by doing so advance your practice, thus developing your autonomy. This highlights the significance of learning from practice together in collaborative teams and being able to act autonomously as core parts of the professionalism that these specialist respiratory nurses have developed.

6.1.2 Role Satisfaction and Appreciation

Participants described how job satisfaction for respiratory CNS/ANP was knowing and feeling that their role was making a difference in people's lives, what they described as going the extra mile in work and getting appreciated or noticed for that work. Knowing that the

educational message they were communicating to the respiratory patient and their family was making a difference.

> *P13: I think because we're experts in our fields with the knowledge to give the patients so they're feeling better because they're getting the exact gold standard treatments, …been advised anyway and then it's up to them whether they want to carry through in it, but the ones that do are feeling better as a result.*

Job satisfaction fosters a sense of wellness that breeds the confidence to take on new jobs, roles, and tasks.

> *P13: in my own role, I'm feeling, job satisfaction that you're, you're helping the people and you know, and you're learning all the time, … you know, to empower people to look after themselves to motivate.*

The Covid-19 pandemic brought lots of opportunities to work and interact with different hospital staff and in different environments. This gave many participants more confidence and motivation *'it gives me confidence to go ahead and to apply for the jobs…to kind of give me the push, I was thinking, just go for and see how you get on' (P12).*

During the Covid-19 pandemic, the role of respiratory CNS/ANP became very interesting and fostered a new sense of job satisfaction and recognition for some participants.

> *P4: I certainly at times during redeployment did feel a little bit more appreciated, like they certainly looked for expertise in relation to setting up the hub as respiratory specialist and at the beginning and did certainly feel like there was an appreciation for our skill.*

Even during stressful times, participants described the impact of recognition and appreciation where everyone pulled together, and respiratory CNS/ANPs got acknowledged for their roles.

> *P1: Like I love this job as was I'm, I'm almost ** years in the post. I absolutely love what I do.*

> *P12: because of Covid-19, we were heavily involved in a lot of stuff going on in the hospital, and we got to meet and interact with a lot of people. …they did see acknowledge that we did lots of lots of lots of hard work, … we got feedback from people [public and patients] as well that they were really happy that service we provided.*

As the Covid-19 pandemic was such a new and momentous occasion within the public health system, it did bring a sense of collective effort where everyone pulled together as a team (staff, consultants, doctors). There was an outpouring of appreciation among hospital staff for their job and a sense of collective teamwork in which everyone played a role. However, staff also spoke about how they missed the usual rituals and opportunities to personally show appreciation to each other, such as during informal occasions such as staff nights out. They felt it was impossible to show colleagues appreciation for their lifesaving efforts and personal sacrifices on the frontline during Covid-19 due to the social restrictions. They spoke of how this was affecting staff morale.

> *P5: we'd always try and do something at Christmas for nurses, the doctors, the physios, I really missed it this year, we didn't get to do it. And it was something I felt was nearly should have been like our reward for surviving this long and surviving the months we survived, and we couldn't have it. And I definitely missed that I felt like it would have been the boost we needed to, … actually pat ourselves on the backs and say, you know… good job now and best foot forward for the next round.*

From a public perception, it brought to light an acknowledgement of how much nurses were needed. In the media, the public showed appreciation by clapping for the nurses (Hilliard, Falvey, & O'Halloran, 2020). Patients and patient families also showed great appreciation for what nurses were doing. Participants discussed how they felt appreciated within their team during Covid-19.

> *P5: there's awful lot of teamwork within the hospital…, we actually all appreciate each other.*

> *P8: Covid19 has brought that to light as well like how much we are needed*

However, the participants also acknowledged that teamwork could be taken for granted during normal times.

> *P5: I think over Covid-19, everyone was kind of much more of a team, that everyone appreciated what everyone did … it was more, it was a complete team.*

Participants also highlighted how the media contributed to appreciating nursing and respiratory nurse specialists' roles during this time. They described how comforting it was that the public appreciated and valued their services.

> *P10: even the clapping, like, it's nice to know that people actually appreciate what you do on a normal day.*

Even with all this goodwill, participants discussed how they felt this appreciation would disappear once things got back to normal. Issues like waiting lists, conditions and pay would remain on the agenda.

> *P10: we have our bad days and everyone's giving out about the waiting list, … other what a terrible health service … and salary.*
>
> *P9: it's been hard for my patients like my waiting lists have gotten longer… because of the restrictions that happened around Covid.*

Other participants recognised how Covid-19 shone a light on respiratory CNS/ANPs and the tremendously expanding service they provide.

> *P10: Covid has brought that to light as well like how much we are needed… and its huge service and the one that expanding.*

6.2 Professional Emotional Regulation in the Context of Covid-19

Stress and anxiety significantly impacted respiratory CNS/ANPs professionally and personally during the Covid-19 pandemic. Participants expressed, in this study, the daily battle they faced during the first wave of the Covid-19 pandemic. This gives a key insight into how emotional regulation and relational care was essential element of the professional identity and culture of respiratory CNS/ANPs. Participants were very passionate about their jobs, but they spoke of how emotions related to stress and anxiety significantly impacted them professionally and personally during the Covid-19 pandemic.

P1: what was very stressful time, staff were redeployed.

P2: we're so stressed trying to manage… patients and manage the safety … probably didn't realize the impact it was having on us psychologically, like how traumatized we were.

P14: I suppose I'm very aware. When I get really tired, and I need to be because I don't want to get burned out, I'm very aware at the moment that this is going to go on for a long, long time.

P11: I know that this hospital and all the hospitals have come out of what was very stressful time staff were redeployed. People were working in areas they weren't sure, and people are tired and worried.

Participants spoke of the multiple pressures they were experiencing, including the stress of redeployment to wards and intensive care with high death rates.

P12: It was just really difficult for everyone to get their head around the whole Covid-19 thing and the death rate on the ward was through the roof.

P2: I was redeployed to intensive care. So, I was in the covid intensive care for nearly three months. And so that was incredibly stressful. … learning curve was vertical.

Many respiratory CNS/ANPs felt the stress and guilt of redeployment, not being there for their cohort of patients and feelings of patient abandonment; Participant 7 noted, '*it was difficult being redeployed. I felt like I was abandoning my patients' (P7).*

The lack of routine, structure and feelings of constant changes significantly impacted participants. Respiratory CNS/ANP participants spoke about how they were unsure where they would be the next day they came into work, consistently moving from their current roles to areas like ICU or swabbing.

P15: Now, it's terrible…, there's no structure to the day… there's no planning and it's quite stressful that way.

P11: were redeployed… working in areas ... weren't sure of and people are tired and worried.

Participants spoke about their intense tiredness and stress due to the change in work schedules and patterns, the long hours, the lack of structure to their working day, and the feeling that planning and power were taken away from them.

P14: I do find that I do extra hours all the time, I frequently come in, ……and I frequently run back in for an hour.

P4: quite difficult…constant changing of shifts times to be in work … to finish work. you're told to work the weekend on Thursday. … we all find that extremely difficult.

All participants outlined how their workload, stress, and anxiety levels had increased because of the Covid-19 pandemic.

P11: we're all a lot more stressed I am anyway I'm a bit more stressed and more anxious. I actually I'm a bit more tired.

P10: the reality, of Covid …We are heading towards serious burn out for all these doctors and nurses and everybody in general Health Service.

P11: Every night, I hear the number that they're going up again, and I think oh, my God I know that the hospitals very stressful.

Another serious stressful situation during Covid-19 was when one's colleagues got sick or broke down due to the demand and emotional impact of the pandemic on them and their families.

P7: there were. days … you could easily find somebody having a little cry in the corner, one of us would be having a little cry …now, best foot forward.

P11: Nurses are tired and worried, and you know (nurse) who contracted Covid-19 and are really still not better but they're back in work.

Participants also spoke of the psychological changes between staff members due to the continual stream of pressures, as they witnessed their colleagues getting infected, the impact of having minimal downtime due to prolonged and continual work schedules and the exhaustion of this continual pressure. Participants 2 and 11 noted not remembering anything apart from the pandemic during the first wave of Covid-19.

P2: I really have very little recollection of any day off. And other people will say the same that I don't remember the sunshine and I don't remember.

P11: I'm awake before the alarm but certainly over the last few months there more times the alarm had woken me and that's because you know, I go to bed, I am tired, I just can't get into that sleep mode, and I might wake a couple of times at night. And the only thing really change in my life is the fact that we're living through Covid-19

Participants carried a burden of future occurrence, what would we do if this happens again, another lockdown, and more waves of Covid-19.

> *P11: People are really frustrated and feels really unfair, … have to go into lockdown again, from … my point of view, found it extremely stressful.*
>
> *P5: thoughts of facing into it again, now. I can't imagine what it's going to be like by Christmas if it all does surge in a significant way going into the winter.*

The participants discussed fear of getting Covid-19 or bringing Covid-19 home to their families. Respiratory CNS/ANPs risked their health and lives to help those patients with Covid-19.

> *P5: there was this fear of you bringing home Covid and where was your appreciation of family?*
>
> *P10: no one obviously wants to be at work, and no one wants to get Covid-19, and everyone was afraid.*
>
> *They often sacrificing time with their family and the fear of bringing Covid-19 home.*
>
> *P6: I came back to respiratory for two days a week ... because of childcare ...I do one day at the weekend on the wards, … it meant I [had] ... days off during the week.*

The stress of potentially getting ill themselves, working in a frontline environment or bringing the virus back to your family and loved ones caused a feeling of anxiety and being overwhelmed.

> *P7: first started having Covid-19 anxiety, because … young kids and a husband at home …And childcare anxiety ... to find childcare in the middle of a pandemic.*
>
> *P5: like no one obviously wants to be at work and no one wants to get Covid-19 and everyone was afraid of, you know, bring it home to your family or whatever.*
>
> *P3: it affected, trying to maintain a relationship, trying to maintain family connections, trying to maintain friendships very, very difficult. I find very, very hard… the whole Covid.*

Some participants were the family breadwinners, *'I'm the only breadwinner, the only person bringing in income' (P11),* while their partners may be out of work. So they had to cope with the additional worry of family, paying bills, and coping emotionally with the stress.

They also spoke of the stress from the healthcare context of what they were experiencing onwards with the increasing death rate and policies of no visitors allowed on wards, which were very tough for some participants.

> *P2: I found that really hard to reconcile. I, it was just incredibly stressful ... facetiming people, I was not psychologically prepared to see children and wives and husbands on iPads.*

> *P3; trying to maintain family connections… very difficult...very hard, with the whole Covid thing.*

As respiratory nurse specialists, participants said they were not getting a good night's sleep. They were dreaming about the job and feeling traumatised by its psychological impact on them.

> *P5: there's a lot of nights I definitely didn't sleep well, since all this kicked off … you're on heightened alert all the time.*

> *P11: I go to bed I am tired I just can't get into that sleep mode, and I might wake a couple of times at night. And the really change in my life.*

> *P2: I had to go back, resume in my own clinics and I just didn't really have time to deal with that. But over time at home, eventually the nightmares go away, you start to be able to sleep again, you can kind of switch off.*

All participants discussed how their respiratory patients became very anxious due to their respiratory illness, which only escalated during the Covid-19 pandemic. Respiratory CNS/ANPs participants dealing with chronic diseases noted increased anxiety and depression among their patients and immediate families.

> *P8: In respiratory patient, anxiety and depression is huge probably more so now after covid because there's so much anxiety out there regarding it.*

> *P11: difficulties… they're wearing a face mask because they're frightened and concerned.*

> *P5: you can imagine how lonely it must be for people/patient that have been on their own for months now.*

> *P2: I found really, really difficult and I struggled with it was the disconnect with the patient.*

Half of the participants felt guilty and stressed for not being there for their respiratory patients.

> *P5: thinking about certain patients, thinking, God I wonder now are they sitting up at night worrying, you know, and things like that.*

> *P9: patients, education ... physical programmes ... it was very stressful for them because they didn't know whether it was going to continue whether it was going to stop or what.*

Several participants in the study talked about how they availed of hospital counselling or some form of counselling to cope. In some cases, this was formal counselling; in other instances, it was what they described as informal counselling, like a chat with a friend to help them cope.

> *P3: I was very overwhelmed with everything. So, I took on the counselling … that has been very helpful.*

> *P5: So, a lot was just actually having a chat with somebody, you know, who hadn't spoken to another person you know, that kind of thing. Emotionally, it was a very different job.*

Two participants expressed how exercise helps them cope with their stress and anxiety from Covid-19 '*exercise help[s] me deal with Covid-19' (P4).*

> *P3: studying full time trying to maintain a relationship, trying to maintain family connections, trying to maintain friendships very, very difficult. I find it very, very hard, and then the whole COVID thing. So, exercise is very important to me*

A significant learning from Covid-19 was the emotional and physiological impact a pandemic had on respiratory CNS/ANPs (and nurses in general) that should guide learning into the future on how to manage wellness during a pandemic.

Showing compassion to your patients was a characteristic which was very present and evident in the work and role of respiratory CNS/ANPs during the Covid-19 pandemic, which was evident through the findings below.

> *P14: You know, and so I suppose that that compassion I'm not saying that our medical colleagues don't have that, but I suppose we as respiratory nurses specialist, we were very invested in the patient, what we do it's caring for a person…no matter what their need.*

P3: I am very passionate for patient… with any chronic lung condition with lower life expectancy, So I've developed a good links with them in the community.

It can be attributed more to the fact that respiratory CNS/ANPs are in a relationship with their patients. Participants described the longer-term relationship they have with patients: you know them for longer, and compassion grows organically over time as they begin to care deeply for patients and their progression.

P4: I think that is different you know; you do carry a piece with you. You know your remember patients longer I think you know they're with you and they're in your lives for years on end. And you see them get older, get worse, get better, die all that.

P10: you're turning your phone on at nine o'clock in the evening, you might answer their call, I'm answering their calls on my day off, which isn't my job, but at the end of the day they're my patients, so I'm not going to let them go…. you've been in relationship with these people.

Participants spoke of how they took action to connect with and actively support people to cope with what they were experiencing.

P5: and you discuss this, and they will either be a particular person you spoke to on the phone, and they would just be so down and so lonely. And so, what I started doing then was I got some cards, and then I'm sending a little card, so it was lovely to talk to them on Wednesday and or Tuesday or whatever and to keep the faith keep going.

The Covid-19 pandemic extracted a lot of emotions from staff and colleagues. Participants described how sometimes emotions impact them and how it is critical to show compassion.

P2: a lot of the times especially now with Covid, we take on patients' sadness, and we take on their illness, and you know, you get very connected to patients. And I think it's nice to have somebody to say, oh god that was just so sad or that went really well or that went really badly.

P4: you can't switch off and it hard to switch off from work…as a specialist nurse ...you know your remember patients longer I think you know they're with you and they're in your lives for years on end and the impact Covid-19 had on them, its emotional.

Having compassion for yourself and switching off from the job is a necessary form of wellness, as well as using mindfulness. This was challenging for all the participants in this study during and living through the Covid-19 pandemic. Respiratory CNS/ANPs discussed how

compassion plays a role for them from a professional perspective which can be traced back to the caring and relational nature of the nursing role.

> *P2: I think it was nice to be able to marry the two together. … there is this idea that we are a vocation, and I don't agree with that... we're professional... It wasn't based on a calling, that drove me. Doesn't mean that I don't care that I'm not compassionate I 100% compassionate and care probably too much sometimes.*

6.3 Professional Multidisciplinary Teams

A key aspect of respiratory CNS/ANPs' role is the capacity to work with a broad set of multidisciplinary teams. This gives them opportunities to develop their professional identity, knowledge, skills, and leadership capacities in and through these multidisciplinary relationships. The very essence of the respiratory CNS/ANP role requires support and interaction from broad multidisciplinary teams and their disparate knowledge basis. Hence, this requires a learning disposition within their role as they continually engage and learn from and with colleagues in other disciplines. This was accelerated in the context of rapid change in Covid-19. Participants acknowledged the importance of developing a shared practice identity and working practices that contribute to the multidisciplinary team and patient care. Over half of the participants acknowledged the significance of establishing their role and place in the multidisciplinary team, with participant 13 noting that '*we respect one another's roles…, I think, cause, this was a newest/role service… it takes a while'.*

> *P13: for example, the consultant might think, oh, no, this is more work for us… is new like because we were more working in silos. And now we're working more together.*
>
> *I learned from physio, the physio learns for me. And yes, we know where the experts in our own fields, so we're not taking over the other person's role.*
>
> *P5: in our team and our, I suppose our knowledge and our ability to make decisions has always been really well respected. And that's something that's been very consistent.*

P4: you know, there is great respect for nursing among MDT whether that be, the physios or physiologist or social worker or OT or whatever? I do think there's a respect, especially for specialist nursing.

In the past, professional disciplines concentrated on particular aspects of patient care; therefore, multidisciplinary teamwork was not prioritised. The emphasis has shifted to a holistic and patient-orientated approach, with different disciplines working together in patient care and treatment. The addition of services and collaborative or team working now required within the multidisciplinary team means that respiratory CNS/ANPs must have a clear sense of their own professional identity and the other groups with whom they engage:

P11: We have a very wide and, you know, so not only are we interacting with this hospital as a group of us, but we also interact with our respiratory consultants.

On the wider hospital we're interacting because we're caring for patients or consulting on patients who are admitted to the hospital.

We're also interacting with, you know, members of the MDT in particular, physiotherapists, we're interacting with NCHDs. And we're interacting with non-respiratory consultants.

And, you know, it's actually quite broad, you know, we interact I've actually done home visits with some occupational therapists. And, you know, we do actually am we've computerized referral system here in the hospital, and we often as CNS will identify gaps, we may have found referred to social worker before the patient needs it.

P9: And that required a lot of interdisciplinary links, you know, we linked with the ED department, and we'll link with nursing management and link for the ward level staff. And we'll link with pharmacy so there were lots of different multidisciplinary teams apart, that's what suppose it's a learning process as well, as much as anything, but I think the part of the CNS was really important in that and yeah, I think it has been valued that would be my opinion, anyway.

This continues to evolve with different disciplines joining the team and working group structure emerging in some instances.

P6: respiratory consultants and we also have an advanced nurse practitioner in respiratory …. also with the multidisciplinary team we have physiotherapist, senior physiotherapy in respiratory and we have a respiratory care working group … the whole team has changed and evolved in last 5 years and … enhanced and supported my role.

Participants described how their experiences in respiratory care as CNS/ANPs allowed them to contribute to preparing other healthcare practitioners for their roles and working within multidisciplinary teams.

> *P5: So, we had to coordinate I suppose the safe and running up the clinics that we had triage who was coming we looked at the timings we kept it all very safe and we saw lots of patients ourselves in the clinics and with support from our consultants in the teams.*
>
> *P7: GP rang …" I haven't a clue what inhalers to prescribe. There's so many on the market now. And I really value your advice".*

Covid-19 highlighted the importance of teamwork among staff. Once they may have taken each other for granted, they started to embrace a greater appreciation for everyone's role. This became even more evident as pandemic deaths began to rise.

> *P5: Covid had highlighted the important of teamwork, … Decision that had to be make as team caring for living and dying patient.*
>
> *P12: And here in the hospital … Covid ward … previously been cardio thoracic ward. … in the previous six months, they had only two deaths. And then in one weekend, for example, there was four patients that died. So, it was really difficult for them to get their head around, understandably.*

Despite the pressures, participants described a strong sense of teamwork prevailing where everyone knew they were making a difference and going through the same experiences together.

> *P10: over Covid-19, everyone was kind of much more of a team, that everyone appreciated what everyone did, whether it was the cleaner, whether it was porter, or whether is consultant.*

Participants also spoke of how there was a greater sense of knowing each other's work and role within the team as a shared reality became evident. Their work became much more visible to each other as everyone saw each other's roles and points of view. There was a collective sense that they were all living through this terrible pandemic simultaneously, and '*it did bring out a lot of goodness in people and the teamwork. I think it actually was really evident during that time' (P2).*

However, on the flip side, Covid-19 sometimes highlighted some evidence of a lack of teamwork when decisions were made rapidly, and respiratory CNS/ANPs and the broader teams were not informed in a timely fashion. Healthcare professionals had to make decisions under extraordinary pressures and decisions that have had significant consequences as the Covid-19 pandemic was stretching current resources (Guidolin et al., 2021).

> *P3: the whole Covid-19 thing, you know, a lot of decisions were made. They weren't made as the team, you're told by them afterwards.*

The value of teamwork became very evident when respiratory CNS/ANPs were redeployed during Covid-19 to wards, with medics taking on the role that respiratory CNS/ANPs previously performed to help with their patient load. The existing multidisciplinary teamwork and shared knowledge allowed consultants to ensure the respiratory CNS/ANPs' virtual respiratory clinics were conducted to maintain the continuation of service for the patients.

> *P2: (the consultant) divided up my patients between himself and the registrars and gave them all a virtual call and went through things …. prescriptions or anything, and they were just a bit of reassurance, and they did letters, so I hadn't a big bunch of clinic letters waiting for me…. they were supporting the fact that I was in ICU.*

Some respiratory CNS/ANPs described their appreciation when a member of the medic team followed up with their patients once the respiratory CNS/ANPs had informed them of their concerns. Others were not as fortunate when it came to teamwork and had to continue to follow up with their patients on their days off, showing substantial personal commitment to them.

> *P8: those patients I've been trying to ring them on days off.*

However, participants were very conscious that this type of teamwork and stepping in to support each other did not cover the entirety of their workload. Over a third of the participants in the study were concerned about the consequences for non-Covid-19 respiratory patients. They asked when their regular respiratory clinics would resume. They expressed a feeling of neglecting their patients who did not have Covid-19 but still had respiratory health issues. As

all the attention and resources switched to fighting the Covid-19 pandemic, many procedures were cancelled, and many patients were terrified for their health.

> *P2: some of them had transplant assessments cancelled or the routine stuff was cancelled, diagnostics were cancelled, their blood tests were cancelled. So, they felt very shafted by the health system.*

6.3.1 The Impact of Redeployment

All participants commented on the impact of their redeployment due to Covid-19 and discussed the impact of being redeployed on the service. Many respiratory CNS and ANPs described how they were redeployed or volunteered to work in acute respiratory care or Covid-19 wards. *'we were deployed, we did actually do some volunteer shifts on the Covid ward' (P11)*. During the Covid-19 pandemic, over a third of the respiratory CNS/ANP study participants were redeployed to swabbing centres.

> *P7: email came ... to say all face-to-face clinics were to cease. And so, I got redeployed from around the middle of March ... I was doing swabbing. ... for about a month.*
>
> *P4: so, my last clinic was on the 12th of March... on the sixth of April I was redeployed two days a week to the Covid assessment hub.*
>
> *P6: we were redeployed as clinical nurse specialists, we were classed as essential workers, and we were all redeployed and back to the ward level.*

In most cases, staff were redeployed without any choice, although in some cases, participants volunteered or were called upon for their expertise '*I suppose you just, do it, don't you, I find that I do extra hours all the time' (P14).*

> *P13: I was swabbing. So now we're, I was back in my original role for three months, I had been gone for swabbing worked in the Covid hub ... back in my original role three months, but now we're back, as to swab. So long days…swabbing, and then doing what I can, other part of my role education, like I'm doing education. I'm doing a GP session.*

Participants described how part of this redeployment involved becoming educators in respiratory care as other nurses in other areas were redeployed to care for patients with Covid-19. The role of respiratory CNS and ANP became more focused on education and teaching respiratory therapies and multidisciplinary education to a wide range of staff, from junior nurses to senior consultants.

> *P11: redeployed was big part of our role, was education of both our colleagues and nursing our medical. And we also find ourselves doing GP talks and all sorts, big part of our role was education. So, we needed to educate people on the use of particular and non-invasive ventilation ... everybody from junior staff nurses right up to consultants attended these sessions.*

For some, the experience of redeployment had both a positive aspect in terms of greater recognition of their work and gaining additional experience in other healthcare settings.

> *P4: during redeployment did feel a little bit more appreciated, like they certainly looked for expertise in relation to setting up the hub as respiratory specialist and at the beginning and did certainly feel like there was an appreciation for our skill.*
>
> *P6: I became ICU nurse, but it was it was good, great learning. I had my own patients. And, and again, it was patients who had Covid-19 who are Covid-19 positive, and they were ventilated.*

For some, there were also negative and stressful learning impacts on the respiratory CNS and ANP roles, including a lack of time and leave and the personal stress involved in healthcare in this setting.

> *P2: I was redeployed to intensive care. So, I was in the covid intensive care for nearly three months. And so that was incredibly stressful.*
>
> *P4: I was redeployed ... there's been no patient contact at all. Just between redeployment and lack of holidays and all that stuff- just need to take a break.*

Also, respiratory CNS/ANP participants were conscious that they were one of the few groups who were redeployed, their roles changed, and expectations increased '*during Covid, we were probably one of the few groups who ... redeployed' (P11).*

Transitioning between roles as they were redeployed was challenging. One participant described going back to a respiratory CNS role for one day, then redeployed, and then back to a respiratory CNS role the next day. All this occurred while carrying out a significant work burden and ensuring that other people's workload within the team was covered.

6.3.2 The Impact of Multitasking in Changing Contexts

The pressure of Covid-19 and dealing with staff becoming sick resulted in respiratory CNS/ANPs assuming multitasking roles to a level they had not experienced before. Respiratory CNS/ANPs spoke of working in unfamiliar environments as staff on Covid wards, in ICU, and swabbing centres while expected to maintain some of their existing responsibilities with their patients simultaneously. This placed enormous stress across the healthcare system as staff struggled to cover the escalating pressures brought on by Covid-19. They spoke about how their work changed enormously and was stretched to cover many more responsibilities, with the following section exploring the implications for their work practices.

> *P10: your kind of expected to do some of your CNS role, even though you're technically a staff person on the ward, you expected to do two jobs at the same time and use the same responsibilities.*
>
> *There is a girl (staff) that was pregnant ... she was sick which diminished the service. Covid-19 was quite hard.*

Not only were respiratory CNS/ANPs dealing with multitasking in a pandemic context, but they were also coping with many other pressures. They described the combination of the emotional stress of dealing with ill colleagues and the anxiety of covering their roles, having to rush from one service area to another and doing training with many different groups of healthcare staff across the systems. During this time, participants had to deal with the uncertainty of not knowing when they would return to their jobs/role and their patients. They described how their everyday work context was *'turned into Covid ward, it was just hard going... working in an environment, you're not used to' (P10)*.

Nurses were also under pressure within their work context, with a high risk of infection, insufficient rest time, and continued working with intensity under challenging circumstances (Zhou et al., 2021). Due to Covid-19, nurses were more prone to work interruptions due to negative experiences, lengthy shifts, and a lack of emergency public incident training (Zhou et al., 2021). Participants, in some cases, were expected to work in clinical environments that were unfamiliar to them and an additional aspect to their regular responsibilities. For example, respiratory CNS/ANPs were working as staff nurses but were still expected to continue carrying out their roles.

P6: I worked there (wards)…. and then I came back to respiratory for two days a week.

Due to the emergency context and unknowable qualities of Covid-19, changes were happening rapidly in public and medical care. Participants remarked how decisions were made quickly and were unaware of them.

> *P10: Decisions made, and you are not aware of them, you just had to go and do it, we were in the middle of pandemic. Say that people make the best of it and worked the best they could in the team.*

This differed from how participants were used to working, where the multidisciplinary teams made decisions in discussion with each other in clinical healthcare environments. The normal processes of ensuring clear communication, collaboration, and trust at all levels to enable effective decision-making (Donley, 2021) were not occurring.

Three participants highlighted that decisions were now being made within the respiratory nursing team with little or no discussion and continual change.

> *P3: there was no group decision, it was one or two individuals run off. And then those individuals then were sick. So, it fell on everyone else… communication was very poor.*

Communication was a big issue, and this is a vital component of managing during a crisis time. Respiratory CNS/ANPs had to make the best of it and work the best they could, often without knowing the timing, context, or content themselves.

> *P3: You're told you doing training and doing it for the whole entire hospital … and some of the training I've never even received, and I had to give this training to other….when is this train[ing], today? ... what are we training?*

The scale and types of multitasking were significant because they occurred during an emergency where the respiratory CNS/ANPs had little or no control or knowledge over what was happening within their roles. They often performed double roles as ward nurses and respiratory specialists, combined with the unknown quality of the pandemic and consequent public response during this time.

6.4 Professional Relationships in a Teamwork Context

In respiratory CNS/ANP nursing, the working relationship is based on professionalism and care, involving members of the healthcare team, such as doctors and nurses, working together, respecting and promoting the rights of all colleagues. There is a solid professional relationship between respiratory CNSs, ANPs and the patient because of the numerous interactions that occur over time. A good professional relationship is described as one where everyone in the team is approachable, complementing each other, bringing unique skills and trusting each other (Mark, Salyer, & Wan, 2003). Although communication and collaboration are vitally important, there are occasions when someone does not want to participate, and some people find it hard to build a relationship within a team.

> *P1: I often find, to be honest, sometimes it actually boils down to the personalities in an individual role at a time... we do work more closely, I suppose you'd say what the physiotherapists with the, you know, respiratory physios, with the respiratory physiologists who do the breathing tests, and with the consultants and senior doctor.*

We must remember the different healthcare contexts of many multidisciplinary members, such as respiratory physiotherapists and respiratory consultants. Respiratory physiotherapists specialise in treating patients with respiratory disease using respiratory exercises, muscle physiology, exercise training and behaviour change (Troosters et al., 2015). A respiratory consultant is a medical professional specialising in respiratory care, diagnosing, treating and preventing diseases and conditions affecting the respiratory system (Royal College of

Physicians, 2017). Inevitably, there will be situations where personalities differ, and clashes of personalities occur, thus making communication difficult. It can also be expected that there may be a conflict between team members since their professional judgment and outcomes may differ. However, once the personalities of individuals are recognised, firm professional relationships can develop. Participants identified how dialogue and discussion were key to these positive working relationships.

> *P1: Consultant and registrar, I had a very good working relationship with them ... we would always discuss the patients and I think.*
>
> *I appreciate this that I've been so fortunate where I'm working, that I've always worked with consultants that are approachable, that you can go and discuss the case or see what you're thinking.*
>
> *P13: I meet the respiratory consultants, ... I ask the [consultants] any questions I might have about the clinical, about the treatment.*
>
> *P9: I suppose with interdisciplinary links, like we were talking ...I would have a lot more links with our colleagues I would have gotten calls from them a little bit more than before.*
>
> *P14: I suppose in terms of interpersonal relationships, I would have had a good working relationship with other disciplines.*

It is also worth noting that the relationship between respiratory nurse practitioners CNS and ANPs is different to their relationship with those from other disciplines, as both are nurses.

> *P7: Supporting nursing roles, whether that's respiratory CNS or ANP.*
>
> *P15: I have some brilliant colleagues, and I really respect them and appreciate them... We are nurses, can never step away and nurse at the bedside, have to stay there until the next one comes and helps.*

Participant 2 outlines how the relationship between respiratory CNS/ANPs with each role complements each other.

> *P2: Now I have a good relationship with CNS, and I think they see the value in the role, they see how we can actually complement each other rather than be opposing forces and how he/she [CNS] can refer into me with we're opening up new pathways for patients.*

Participant 15 outlines how there can be relationship tension between respiratory CNSs and Respiratory ANPs (as discussed previously).

P15: my direct CNS colleagues, I find that relationship very difficult.

Ideally, the relationship between staff nurses and respiratory CNS/ANPs forms where there is effective communication and information-sharing. This will establish a professional relationship where the staff nurse understands the respiratory CNS/ANPs' preferences for treatment, enabling them (staff nurses) to ask questions, gain knowledge, and value the expertise of respiratory CNS/ANPs, forming a strong professional relationship. Participants emphasised that when undertaking the role of CNSs or ANPs, there was a need for the support of their nursing colleagues.

P6: I think the CNS role is, you know, there's good reception here, you know, other nurses, I think they value our and our role, but it's important that you what we work, like you interact positively with nurses and, and obviously, every scenario can be different.

So, it's, it's how you approach each scenario and on each patient care, but I think it's important… to make sure that there's something in it for the nurse like, you know… in terms of our professionalism.

P7: you need support. I certainly have talking to other CNS or ANP I think that's how you get on that pathway is having a good, good relationship with them, but the support for nursing from them.

I certainly think a lot more coming on board now, supporting nursing roles.

Communicating is critical in any professional relationship, and the development of trust is a core concept of this. Any professional relationship with consultants, nurses, or respiratory CNS/ANPs can take time to build this trust. When new roles were developing or members joined a team, participants described how this trust could be slow to develop or become diluted. You can feel vulnerable and fearful of saying the wrong thing, which can negatively affect communication and relationships.

Participants acknowledged that good communication could assist in performing an accurate, consistent, and more manageable workload, ensuring the multidisciplinary team's satisfaction and enhancing professional relationships with respiratory nurse specialists.

> *P2: So eventually, I suppose a trusting relationship, forms like you can't expect that to have that overnight. But I've been doing it now for two, two years… it's going well, it takes a good six months to settle into anything new, I think.*
>
> *people know what I'm doing, there's a much clearer idea about what I'm doing, you get an opportunity to talk at grand rounds and meet with a whole new team.*
>
> *So, it's very important, communication is key and at the beginning, that your key communicating over and over again, and the biggest mistake is to assume that a communication has happened … be sure that people understand your role*
>
> *P7: Talking I certainly have talked to other CNS or ANP I think that's how you get on and having a good relationship with them (MDT)*

Participants highlighted how trust is one of those factors in a professional relationship that is important and very time-consuming to build and sustain. It is paramount that respiratory CNS/ANPs have satisfying professional relationships with each other, between themselves and with other professions, and dare to speak up and confront any fears to build a solid professional relationship.

However, this is not always the case, as every team may have difficulties at some point. Participants spoke about how there can be difficulties between respiratory CNSs on a team, where there was a lack of a professional relationship built over time, leading to possible repercussions.

> *P4: we've had staff come on to the team that didn't become part of the team and didn't stay very long because for whatever reason, they didn't want to become involved in that debrief and that relationship that we have as a team.*
>
> *we're certainly not a clique by any means, like we welcome everyone new into our team, but we find one particular staff member and… he/she finds it really hard to gel in the group, even though we would have made huge efforts to include him/her.*

Four participants discussed how it had been difficult to form relationships with new staff members and that there was this sense of an invisible guard or a barrier.

P4: I would often come up with the barrier of Oh, well, you don't take any referrals from the PHN or the RGNs … There be a sense of begrudgery.

P11: I had a concern, you know, there are members of my group that relationship would be tighter.

Reasons for this were due to previously established relationships within the team, the knowledge base of this new individual joining the team or a fear that the knowledge of the current respiratory CNS/ANPs might be questioned or brought into question.

6.4.1 Intense Emotions in Professional Work

For respiratory CNS/ANPs, intense emotions can be engendered by the demands for high productivity and fierce competition for limited resources and jobs in the area. Understanding how these impact the working environment, workplace relationships, and individual/team performance needs to be explored. Intense emotions such as professional jealousy may not be acknowledged or may not be understood by either side. Professional jealousy can disrupt the working environment. Colleagues may recognise others' educational achievements and see themselves as comparable in their role function, but this may not be reflected in role status. Differences in nursing experiences and colleagues trying to work to the best of their abilities can breed disruptive jealousy from others.

P2: I'm doing this and let them know what I was doing to give them a better understanding of my capabilities, I suppose, or my competence.

P3: …there is competition inside and a lot of jealousy that I have the course done, people have bits [of], the course done, or you're going to be ANP first but ANP it's not promotion, it's focusing on a different aspect where they see it as promotion.

It was interesting that over half of the participants discussed professional jealousy among their fellow peers within their experiences of the respiratory CNS/ANP nursing role. This raises the issue of the diverse perceptions of the role, the power of professional jealousy and how it could impact workplace environments.

Participants spoke of how misunderstandings of the academic and practice requirements of the role caused an aspect of this intense emotion between respiratory CNSs and ANPs.

> *P2: So, the friction, basically is it is clinical nurse specialists who feel that they're already doing the ANP role. So, people that are, but they don't have the academic qualification to back it up. And that's fair enough, there are definitely CNS working and beyond the CNS level, they've a lot of experience behind them.*
>
> *P15: I would like to mention that I feel there was a professional jealousy with my colleague, my direct CNS colleague, … that relationship was very difficult.*

Participants described how professional jealousy was closely allied to the lack of professional recognition. Individuals unsure of their professional role can often express intense emotions like professional jealousy.

> *P14: You know, and I don't really feel that there is that much of a difference myself, possibly, that you, you know, you work maybe a little bit more autonomously as ANP, but, you know, you do that as a CNS anyway, you know, I really don't see that there's a huge difference between the roles.*
>
> *P4: as a group of integrated care nurses, we have spoken about that, but a lot of our role is quite advanced. And you are quite an autonomous practitioner and thus maybe these posts should always have been either ANP or senior CNS level.*

Participant 3 described a time struggling to find a chair and a space in an office shared with other respiratory CNS/ANPs, noting that '*It wasn't like I should have a special seat or anything … It's crazy' (P3)*. This was an example of professional jealousy over the participant's new specialist role. Some respondents described how sometimes they did not tell their colleagues if they were going back to college, undertaking a new course, or pursuing another respiratory CNS/ANP job as they worried it would breed some professional envy or jealousy.

> *P3: Okay, ...they see ANP role, I just went off and did the course because … say I'll do it if you do it, and sure, as I said didn't have a breeze what I was signing up to, … ignorance is bliss. For now, a lot of competition inside and a lot of jealousy that I have the course done.*

Professional jealousy is caused by the intense competition for specialist respiratory CNSs and ANPs posts, preferences for a particular position and opportunities for promotions. When these emotions are present and part of everyday working situations, competition and conflict

can lead to benefits and challenges within the workplace. Participant 2 described how some '*people want honorary ANP position'.*

> *P2: You know, you have to do the academic bit. And so, I think part of it was professional envy and you know, few people wanted like nearly an honorary ANP position without the clinical supervision and without the portfolio and all that went with it.*
>
> *P3: there's a lot of jealousy there.*

However, jealousy can have serious consequences, including damaged relationships and communication and undermining colleagues' performance. Resentfulness and hostility between respiratory CNS/ANP respiratory nurse specialists can undermine and damage relationships. The requirements for educational qualifications were crucial points of distinction, with CNSs having practical experience but not necessarily the same academic qualifications as ANPs.

> *P2: there are definitely CNS working and beyond to CNS level, they've a lot of experience behind them.*
>
> *they're still working with all this experience and doing fabulous work and audits, presentations and research and everything else, but yet, they're not ANPs, you just can't get a title overnight.*

This points to the balance and tension between practitioner experience, expertise on the job, and academic accredited knowledge discussed in Chapter 2. It has repercussions across professional fields, including interpersonal relationships and emotions between the two roles. For each role, there is an image that the grass is always greener on the other side.

> *P10: That CNSs is land of the golden honey, you know that. They're really busy in the world, which they are in, but like, it's just a completely different level of busy. And it's completely different stress. But I think until you're in a role, you don't understand what another person's doing.*

Understanding each other's role and status is critical, as P10 emphasised above. Participants discussed how professional jealousy can affect relationships, individual and team performance, and workplace environments.

P7: somebody said to me, I'm a CNS, he's/she's an ANP and doesn't know how to use inhalers. You know, so I suppose they feel, and I feel they have the education, but I would say little clinical experiences… God, I've been at this for 15 years.

6.4.2 Changing Relationships with Professional Healthcare Staff

The changing relationship with doctors has been a fundamental shift in the professionalisation of the respiratory nurse specialist role. Doctors and consultants collaborate with respiratory CNS/ANPs to improve patient service in these multidisciplinary teams. This is a significant shift from the past, where doctors and consultants as medical personnel had positions of authority over nursing staff. Today's emphasis is on the collaborative relationship and interdependency between healthcare staff in team contexts. Respiratory ANPs cannot undertake their specialised role without ongoing support from consultants. Consultants see the value of supporting respiratory CNS/ANPs as the net effect is reduced consultant workload over time. Junior doctors move posts every six months, whereby respiratory CNS/ANP will remain over more extended periods alongside consultants, giving increased continuity of care to the patient. From a professional aspect, consultants benefited from ongoing support, trust and working relationships with respiratory CNS/ANPs and were vital in taking on mentoring roles for staff development.

P4: it was her/him that kind of urged me to do the ANP. And so, he/she, became my supervisor and I kind of went through the whole, you know, the whole process with her/him. He's/she's, you know, he's/she's just he's/she's a fantastic consultant.

Given that respiratory CNSs and especially respiratory ANPs have taken on a role traditionally associated with respiratory medical staff, the question arises if they are taking on the values, ethos, and ways of working of the medical profession. This is particularly relevant given the respiratory consultants' role in mentoring respiratory ANP students during the education programme. During the educational preparation for respiratory ANPs, respiratory consultants share their expertise and knowledge in respiratory matters. They are formal mentors, meaning consultants have power over whether candidates are successful. Consultants are heavily involved in clinical areas with clinical supervision and evaluating candidate respiratory ANPs

(Nursing and Midwifery Board of Ireland, 2017). Clinical supervision can be provided by a registered respiratory ANP where appropriate to the area of practice and patient caseload; however, the consultant remains heavily involved. The director of nursing or designated person has overall responsibility and authority for the governance of all aspects of CNS and ANP practitioner services. This also raises issues about the patient knowledge and expertise of junior doctors in these teams, with some of the roles of respiratory ANPs potentially providing the same expertise and capacities as junior doctors.

> *P5: in the hospitals with the doctors changed over or whatever and that but some of them had never really had much exposure… to respiratory ANPs/ CNSs… I'm actually an independent autonomous practitioner and but I'm here to support you the way you're here to support me.*

This highlighted the development of professionalism in this area, where the roles of respiratory CNSs and ANPs were adopting the professional qualities and practices of the medical profession and developing a new form of professional roles in the nursing profession.

> *P4: I suppose [Consultant] really seeing the value of the specialist nurse within the service. And so, he/she is actually putting through the third ANP now.*
>
> *because [Consultant] sees the value of having that, I suppose, gosh, those people (respiratory ANPs) that are there on the team all the time as opposed to the medical team, coming, and going all the time. You know?*
>
> *P12: We were at meetings with their intensivists, the A/E doctors' respiratory consultants, those kinds of meetings, and we're involved, and we were asked for input on our opinions.*
>
> *and for what we thought was appropriate is to introduce certain measures and we're also involved in developing algorithms in terms of your plan for your patients.*

The building of trust between respiratory ANPs and consultants was key. Participants did not see it as a restriction to their autonomous practice, as outlined by Participant 2 below.

> *P2: So, I think that the consultants in particular value the role and once they have trust in you, and I think that it's really important for ANPs and they are probably aware what we do.*

P14: having a really good mentor and getting that encouragement, and, you know, having that, I suppose that support and that guidance with you all along, that really, you know, and I can see it now with the consultant I work with,

All participants acknowledged the professionalism of the respiratory consultant and felt the consultant recognised and valued their input. Respiratory CNSs and ANPs recognised their ability to provide enhanced care through continuity of care in the absence of a doctor at a clinic, with respiratory nurse specialists able to manage the vast majority of patients.

P4: So, like, [Consultant] would often say that he/she trusted us more than he/ she might trust his/her NCHDs, you know that we have a better skill set because we're so specialised, that we can focus in on the respiratory stuff.

Consultants supporting the role of respiratory CNS/ANPs could also be viewed as instrumental in developing trust between the different professional groups. Noteworthy is the reference to the judgement basis for this trust, which is the specialised skill sets that respiratory nurse specialists have developed because of their respiratory experience. It points to the importance of this specialised knowledge and skills basis.

As this growing trust develops, respiratory CNS/ANPs are described as being seen by the consultants to act in roles formerly held by doctors. However, this raises questions for respiratory nursing, which will be addressed in the discussion chapter regarding recognition of the status of these advanced practitioner roles and where these roles fit in the healthcare structures.

P14: I can see it now with the consultant I work with, because I've worked with consultant for XX years, you know, you build up that professional trust.

P10: That's of the role you kind of trust your colleagues more and you spend more time with senior doctors, like I've been more time with senior consultants.

As a consequence of these shifting perceptions and relationships, respiratory CNS/ANPs in these roles can sometimes find themselves 'othered' or isolated by fellow nursing colleagues, and certainly, this is how some of the participants felt by asking the question, '*where do we belong?*' (P4).

6.5 Conclusion

The research findings presented in Chapter 6 discussed the experiences of the study's respiratory CNS/ANPs participants concerning professionalism. The findings suggest that professionalism in a specialist area like respiratory CNS/ANP is highly regulated. Respiratory CNS/ANPs' practice contributes to patient care and is committed to ensuring that their practice maintains a nursing focus.

The participants highlighted autonomy as enhancing their overall capacity and duty of care to the patient and respect as an essential component of a healthcare organisation, fostering a prosperous working environment where members of healthcare teams interact and work together, and patients are treated as unique persons. A respiratory CNS/ANP must be competent and have the courage to take charge and self-manage to satisfy the role of an autonomous professional practitioner. The findings suggested that respiratory CNS/ANPs are viewed as having autonomy in their roles and the ability to make independent decisions benefiting both health outcomes and patient experiences. Participants described job satisfaction as knowing and feeling that their role was making a difference in people’s lives or going the extra mile, getting appreciated or noticed for their work.

The participants acknowledged that the role of respiratory CNS/ANPs’ revolves around the capacity to work with a broad set of multidisciplinary teams. An important lesson learned was regarding teamwork in that everyone had the same worries and concerns and how practice rapidly had to deal with the constant changing of new information published by the WHO during the Covid-19 pandemic. During the Covid-19 pandemic, the participants described a strong sense of teamwork prevailing where everyone knew they were making a difference and going through the same experiences together. At the same time, there was some evidence of a lack of teamwork when decisions were made rapidly, especially where healthcare

professionals had to make rapid decisions under extraordinary circumstances where resources were stretched.

The respiratory CNS/ANPs participants discussed how difficult it was to regulate their emotions, especially during the difficult time of the Covid-19 pandemic and, the demands for high productivity and intense competition for limited resources and the multiple and changing roles they undertook. Having compassion for yourself and switching off from the job is a necessary form of wellness, as well as using mindfulness and exercise. This was challenging for all the participants in this study during and living through the Covid-19 pandemic.

The findings suggest that the Covid-19 pandemic increased the pressures on respiratory CNS/ANPs, assuming multitasking roles to a level they had not experienced before and dealing with staff becoming sick from the virus. Redeployment to Covid-19 wards and clinics became the norm for many participants. They acknowledged experiencing stress levels because of the changed routine, environment, and emotions of being redeployed to other wards and the enormous anxiety of not being available to support their respiratory patient cohort. Transitioning between roles during redeployment was challenging. One participant described going back to a respiratory CNS role for one day, then redeployed, and then back to a respiratory CNS role the next day while carrying out a significant work burden and ensuring that other people's team workload was covered. Several participants acknowledged that their workload may not always be visible to managers at more senior levels and recognised that their workload visibility differs depending on the participant's clinical setting.

Participants expressed their fears of Covid-19 and its impact on patients with underlying respiratory conditions, especially with the solitary nature of cocooning. The critical challenge instead became the patient's overall mental condition deterioration due to the isolated nature of cocooning. Over a third of the participants in the study also spoke of concerns about the

fallout for non Covid-19 respiratory patients, expressing a feeling of patient neglect for those who didn’t have Covid-19 but still had respiratory health issues.

The findings also highlighted challenges of intense negative emotions such as professional jealousy for their roles. This is created by the demands for high productivity, fierce competition for particular positions and promotion opportunities, as noted in the findings. The participants stressed that when these emotions are present and part of everyday working situations, competition and conflict lead to benefits and challenges within the workplace. The tension between practitioners regarding experience and expertise on the job and academic accredited knowledge can arise. It has repercussions for the participants, including in interpersonal relationships and emotions.

The developing relationship with doctors and consultants has gone through a fundamental shift in the professionalisation of the respiratory nurse specialist role regarding collaboration for improving the service delivered to patients in multidisciplinary teams. This is a significant shift from the past; doctors and consultants had positions of authority over nursing staff; however, while consultants still have regulatory power over clinical supervision for candidate ANPs, the emphasis moved towards a collaborative relationship and interdependency between staff.

The findings' results have been presented under the following major themes: Education and Professionalism. In the next chapter, I will discuss the significance and implications of these findings.

Chapter 7: Discussion

7.0 Introduction

The previous chapters presented the research findings, exploring the experiences of respiratory nurse specialists (CNS/ANP) in terms of their education, professionalism, and professional identity. In this chapter, I will analyse and discuss the implications of these findings. What became evident during the analysis of the experiences of respiratory nurse specialists (CNS/ANP) was that while their experiences are exclusive to the individual, all participants discuss issues of power, change and agency related to their professional identity in the context of the first wave of Covid-19 pandemic.

The healthcare environment places staff at risk due to the stressful situations they face daily (Donley, 2021). The global pandemic of Covid-19 overwhelmed many healthcare systems worldwide, including Ireland, and significantly impacted respiratory specialist nurses on the frontline, whose job is to care for and educate about respiratory care in order to protect the lives of their patients. All participants in this study articulated that in a pandemic, all healthcare professionals are tasked with providing appropriate, safe care to the patient, themselves and the healthcare system while contributing to the efficient running of the health service. Section 2.0 introduced educational theories where (Quinn & Hughes, 2007) note how Dewey's learning approach emphasises activity and experience, and this has been influential in exploring how professional identity and learning become intertwined. The role of theoretical knowledge as specialised knowledge in and through academic disciplines produces and defines knowledge through conceptual frameworks (Wheelahan, 2015; Young & Muller, 2013). Rapid change during the Covid-19 pandemic altered learning and identity in what transpired for the respiratory CNS/ANP practices.

Participants identified as nurses with a special interest in respiratory care and education, placing them in a position of authority in healthcare, especially while dealing with the Covid-19 pandemic. The respiratory CNS/ANPs are committed to the practice and ensuring that respiratory nursing's unique influence is focused on upholding patient care. Section 2.5.1 discusses a similar theme where nurse education has a deep sense of the significance and complexity of caring relationships in care and educational contexts regarding the agency and relationality it reveals. The elements of a caring encounter identified by Noddings (2002) of a connection between the carer and the cared, the degree of exchange they both gain from the encounter in different ways and how both give and gain knowledge from the encounter are evident from the participants' accounts of care in these findings. Participants highlight that their qualifications and current roles in respiratory nursing enhance their overall capacity to act independently or agentically to ensure increased capability for advocacy and enhanced patient care, as articulated by participants, through numerous challenges described before and during Covid-19.

Watson (2008) argues that caring is the philosophical disciplinary foundation for contemporary nursing practice. Participants' training and role enable them to act agentically to fulfil these different elements of the caring encounter that Noddings describes. Ehrenberg and Häggblom (2007) highlight the greater responsibility that these advanced practitioner roles require of students as they reach their learning goals in their nursing education. This research demonstrates how caring changes and is deepened when nurses move into advanced practitioner roles with additional responsibilities and powers. As care theorists highlight, caring work is profoundly relational and agentic, and it involves freedom, responsibilities, and knowledge of self and others in these relationships, which these advanced practitioners are now negotiating. Nurse education has a deep sense of the significance and complexity of caring relationships in care and educational contexts in terms of how nurse practitioners

mediate between the practice-based knowledge from the lived experience of caring and theoretical knowledge of the healthcare disciplines they draw on in their work as nurses.

These experiences are set within the context of the medical field where respiratory nurse specialists in trans- and multidisciplinary care operate. Findings reveal that the regulation of practice through professional guidance and legislation and the influence of other professional groups can enhance and restrict the practice of respiratory CNS/ANPs, affecting their capacity to do their role to their full potential. This resulted in both a positive and negative interpretation of the reality of power as experienced through their practice, as is discussed in this chapter.

The findings reveal that professional regulation and legal parameters are enabling and expanding practice but also causing confusion and tensions at certain points for these nurse practitioners. As Chapter 2 documented, these roles and relationships exist within a context where medical doctors and consultants in the field of respiratory care still maintain a powerful position. How nurse practitioners negotiate these changing power dynamics throughout these encounters and relationships with patients, colleagues, and multidisciplinary team contexts and where it is positioned within their disciplinary knowledge base is a key theme within this chapter.

The findings reveal that education and professionalism empower respiratory CNS/ANPs to be more agentic practitioners, enabling them to use their theoretical knowledge and clinical capacities to care in a holistic and patient-oriented way that defines the professional knowledge basis of respiratory nursing. Furthermore, it becomes apparent that respiratory CNS/ANPs' interpersonal and interprofessional relationships impact their experiences within their clinical environments and in a multidisciplinary context, but also through institutional processes such as educational provision and regulation. This gives them a very specific and unique knowledge basis and professional identity.

Participants articulate this through numerous challenges experienced before and during Covid-19 times, including an increased capability for advocacy, professional training of colleagues and enhanced patient care. The findings suggest that respiratory CNS/ANPs contribute to the professionalisation of nursing as the role of respiratory CNS/ANPs enhances their position as respiratory specialists within their multidisciplinary teams working across many different settings and groups in the clinical context. This is a perceived positive development for respiratory CNS/ANP nurses; however, power and its operation emerged as a meta-theme throughout all the themes emerging from the analysis. This is discussed in this chapter in terms of the themes of teaching and learning, changing professional roles and implications for their professional identity and status.

7.1 Participant Profile

The scope of this research is important to note, as participants for this study came from all over Ireland, working in respiratory care environments as CNSs or ANPs. This proved to be very beneficial as the participants were working in many different respiratory specialist areas (e.g., acute to primary care), adding depth, range, and complexity to the research. Participants were working and caring for patients during the first wave of the Covid-19 pandemic in 2020; therefore, the timing of this research was significant. Participants had spent several months working twelve-hour shifts managing the pressure of the first wave of the Covid-19 pandemic and were still operating under government Covid-19 restrictions when the interviews were completed. The interviews explored how respiratory nurse specialists use their education, skills, and knowledge to respond to a crisis like the Covid-19 pandemic and offer potential learning that is discussed in these final two chapters for how this can inform the development of any crisis plans for major pandemic incidents (Sundararaman, Muraleedharan, & Ranjan, 2021).

Fifteen participants participated in in-depth qualitative interviews in this study. While this is a small number, it enabled rich exploratory conversations with participants about their experiences during this time and their perceptions of their education and professionalism (May, 2002). All research participants were female, although the research was open to both male and female nurses. All participants had level 8 qualifications, and fourteen had undertaken level 9 postgraduate education, indicating their engagement with learning and continuous professional development (CPD).

Participants gave a sense of their understanding of their current role. Respiratory ANPs described how they promote wellness, offer healthcare interventions, and advocate healthy lifestyle choices for patients. They have advanced knowledge in their field, critical thinking skills, patient caseload and collaboration with other healthcare professionals, all according to the agreed scope of practice guidelines and have a level 9 qualification on the NQAI framework (Government of Ireland, 2019; National Council for the Professional Development of Nursing and Midwifery, 2010; Nursing and Midwifery Board of Ireland, 2015, 2017).

Respiratory CNSs describe how they focus on specialist knowledge and skills to improve the quality of patient care, with a clinical focus comprising of assessments, planning, delivery, and evaluation of care given to patients/clients and their families. Respiratory CNSs work closely with medical colleagues, drive guidelines, disseminate research and audits, provide education and work with colleagues and broader interdisciplinary teams, with education at level 8 or above on the NQAI framework (National Council for the Professional Development of Nursing and Midwifery, 2008a, 2010; Nursing and Midwifery Board of Ireland, 2015).

7.2 Teaching and Learning

The role of respiratory CNS/ANPs as nurse educators is to communicate knowledge about respiratory care. The findings reveal the holistic nature and extent of this teaching and learning role. Respiratory CNS/ANPs guide, facilitate and provide space for their colleagues across all

areas of healthcare to learn through reflecting on their knowledge and experiences. This role became vital during the Covid-19 pandemic. Participants discussed in findings section 5.1 how their existing teaching and learning methods had to be adapted during the pandemic with new ways of teaching, like virtual online nurse-led clinics, being developed as a necessity, which brought about pedagogical, patient care and technical challenges and revealed the pedagogical skills of these advanced practitioners in responding to rapidly changing needs and contexts. Nursing knowledge had to be updated and changed rapidly to meet the emerging public health demands. Participants were keenly aware of the importance of respiratory nurse specialists as educators embracing changes and adopting different ways of knowing in their teaching to support changes to meet public health demands. The effect of Covid-19 on nursing education in Ireland and across the world has demonstrated that if sufficient measures are established for future crises, nursing education will be better prepared. Nurse education systems must adapt to withstand these future crises and unexpected events and recover rapidly from them (Agu et al., 2021). The Covid-19 pandemic has proven to educators that education programmes must not only respond to changing service needs but also to future disaster planning and preparation in nursing education and all healthcare environments (Sundararaman, Muraleedharan, & Ranjan, 2021). Healthcare organisations, nursing regulatory bodies, and Higher Educational Institutions (HEI) write and develop policies to help cope and recover quickly from future disaster occurrences (World Health Organization, 2021).

7.2.1 Patient Education

Maintaining a patient-centred rationale in their work is a core value expressed by participants in this study. Their continual relationships with patients and their holistic knowledge of their health condition, life impact and connection with others involved in their care give them a unique body of experience-based knowledge about the patient and their condition rooted in how they live with the respiratory condition. As discussed in section 3.6.2, respiratory

CNS/ANPs may reach different outcomes regarding the patient's condition than other team members, and this distinction may denote their professional identity, format their professional self, thinking processes and disciplinary discourses, setting themselves apart from other professions.

The respiratory CNS/ANPs know this profoundly and holistically and can share and communicate this across the multidisciplinary healthcare team as the patient advocate. This is particularly important when patients may have less capacity to express themselves due to their condition. During the Covid-19 pandemic, findings in section 6.1 identify the appreciation of this knowledge that other multidisciplinary teams showed to the respiratory CNS/ANPs in their holistic approach to patients.

Valuing inter-relational aspects of the work is key to the continuing motivation of CNSs and ANPs as they become educators to patients, families and colleagues (O'Brien & Furlong, 2015). Even during times of Covid-19 redeployment in section 6.3.1, participants continued to care for their respiratory patients, describing how they went the extra mile to make sure patients were well mentally and physically and ensuring they were keeping up their medical adherence, with an overall reduction in-patient admission amongst the participants' respiratory patient cohort as described in section 5.1. It does reveal some of the unanticipated learning consequences of the changing patient behaviours due to Covid-19.

7.2.2 Adaption of Teaching Methods

Respiratory nurse specialists played a crucial role in educating about the Covid-19 pandemic worldwide, extending and expanding their roles to teach colleagues and patients and adopting new ways of working across clinical specialities (Dewart et al., 2020). Respiratory postgraduate education supported nurses in the continually evolving clinical healthcare environment and in maintaining competence in providing patient care. Postgraduate nursing education enhanced patient outcomes due to more critical thinking skills, evidence-based

practice and expanded knowledge (Cotterill-Walker, 2012). Young and Muller (2014) highlight reflectivity and critical thinking as core elements that contribute to the development of a theoretical discipline, and their significance is clear in the enhanced teaching and learning capacity of advanced nurse practitioners.

The pandemic has altered the higher education scene, further developing various teaching strategies, such as online, hybrid, and blended learning techniques necessitated as academic institutions around the world addressed the global health crisis (Singh, Steele, & Singh, 2021). From a learner's viewpoint, the pandemic required new and innovative ideas for delivering education (Watson et al., 2020). This is particularly important for professional healthcare education, where learning has an immediate need and impact. Section 2.7 discusses how online education, while being a reactionary response to the pandemic, happened swiftly due to the pandemic, and all classroom-based content went online, the scale of which was a new and unplanned event and method of learning. Student learning and sensemaking occurred both asynchronously online and synchronously during face-to-face online tutorials, flipping the standard classroom style on its head to which all educators and students had become accustomed (Watson et al., 2020).

The challenges to established ways of education were evident in international healthcare literature with Marks, Edwards, and Jerge (2021) study of the educational provision during Covid-19 assessing the effectiveness of the traditional didactic approach and clinical engagement processes with the experienced nursing support staff at the patient's bedside. Its findings reveal that the didactic instruction mode was beneficial; participants in this study identified time limits in the traditional didactic approach to create and implement it in practice. This points to the challenges of developing and providing education in a rapidly changing pandemic context where the preferred education modes may not be possible, and learning which prioritises engaged practices is preferable. This was evident within this study, where

participants described how they had to respond to evolving contexts and to changing guidelines continually, so they adapted their clinical teaching continually.

During this research, there was uncertainty regarding the end of the Covid-19 pandemic and the possibility of new strains of the virus emerging all the time, so face-to-face teaching quickly switched to virtual remote learning, with little to no time for training or development for educators or students. Online learning and teaching emerged as a response to completing a nursing curriculum during a crisis.

The long-term significance of this change to online and blended modes in nurse education is still emerging. Poon (2013) acknowledges that nursing educationalists need to keep up with changing technology, learning theories and the changing educational needs of learners. This was particularly evident during the Covid-19 pandemic, where section 2.7 discussed how the educational system must respond rapidly in the form of immediate nursing education and upskilling for care delivery while maintaining existing educational programmes at all levels.

The significance of the clinical environment where learning and teaching were undertaken frequently became even more evident during the Covid-19 pandemic. Informal learning involves the interconnections of humans and their actions, culture, and environments. It encompasses the interactions and dynamics between individual learners and group learning, frequently ingrained in everyday practice (Fenwick, 2008b). The enhanced experience and knowledge of the respiratory CNS/ANP empowered them further in the field of respiratory nursing, resulting in a vital offering as educational resources for their multidisciplinary colleagues (Ross, Barr, & Stevens, 2013). They developed and engaged in online education, blended learning and facilitating new learning environments such as virtual clinics and online assessments in a very responsive manner driven by the immediate contexts and needs for respiratory learning required by patients and colleagues. Possessing a qualification in respiratory nursing and autonomy allowed the participants to engage in clinical decision-

making at a higher level (Pirret, 2007) than they would have typically done, especially during the Covid-19 pandemic. This qualification was essential for those wishing to further their development, expand and enhance their roles.

7.2.3 Changes to Learning Identities

Learning was occurring during the context of Covid-19, with new ways of interacting and new practices for educator “self” establishing new worlds and identities (Smyth et al., 2017). Changes in the learning identity of respiratory CNS/ANPs via their everyday interactions and practices can be viewed through the lens of social identity theory (Jenkins, 2014) as a source of new demands that necessitate self-reflection and improvisation. As a result, these forced improvisations led to fresh perspectives on oneself and created motivation to establish a new sense of self in the work environment. Reflecting on fresh experiences, respiratory CNS/ANPs, seek sources of new possibilities and identities that help them to improve educational processes, promote well-being, and encourage autonomy, intrinsic drive, and academic engagement.

Reflecting on the changes to learning identities during the pandemic can help us as nurse educators to understand more about the subject of respiratory care and lead to new research areas in the cognitive, emotional, and relational aspects of learning in nursing education. Because of the Covid-19 pandemic, the respiratory CNS/ANPs participating in this research described how they experience themselves as learners, how they relate to themselves as agents and each other, their expectations regarding how to be a practitioner, how they seek and engage in learning experiences, and their attitude towards learning and their ability to learn have changed. Self-perceptions are known to be influenced by social background, previous learning experiences, and learning crises. Developing learning identities in changing social contexts such as the pandemic contributes to expanding nurses’ knowledge and identities (Byram et al., 2022).

Smith et al. (2022) view changes in everyday life as having consequences for an individual's sense of self and one's learning identity. Following a significant change in teaching practice, this phenomenon reconstructs or disputes your learning identity, consolidating a new sense of an academic self. To deal with Covid-19, the participants had to learn and teach other colleagues about new techniques and technologies rapidly, potentially affecting their learning identity. This research presents an initial insight into participants' reflections on these in the wake of the first wave of Covid-19.

7.3 Continuous Educational and Professional Learning

Empowering respiratory nurse specialists to develop more agentic capacity through ongoing reflection and enhancing teaching practices is essential for their advocacy role. As discussed in section 2.7.1, reflection allows respiratory nurses to examine their beliefs, assumptions and strategies for teaching and learning, opening one's professionalism to scrutiny and opinions, which can have a positive effect professionally. Palmer (2007) notes that educators need to attend to their personal development, or 'inner work', to reflect critically, appreciate their learning, and find how to apply the knowledge gained over time in their practice. Participants highlighted the critical importance of on-the-job experience and continuous professional learning in findings section 5.2 for a respiratory CNS/ANP to bring their professional competencies and skills to a high level. As discussed in section 2.7.2, learning does not come from experience alone but through the processes of reflection and action upon it. Schön (1983), Kolb (1984) and Mezirow (1991) see the reflection process as crucial to changing experience into learning.

Participants identified how dialogic learning and discussion based on their own areas of specialised knowledge and capacity are critical to these positive working relationships '*I learned from physio the physio learns for me. And yes, we know where the experts in our own fields' (P13)*. The participants shied away from the notion of giving learner knowledge through

traditional didactic or ‘banking’ processes, as Freire termed it, and engaged in the form of dialogical education where co-learning and teaching take place; the teacher becomes the teacher and learner as do the students (Freire, 1972). As educators, they build on existing knowledge, skills, and experiences, continually improving their teaching practice by learning from every educational opportunity.

Interestingly, participants spoke about education as involving increased educator and learner knowledge and more democratic flows of learning and teaching as colleagues learn from and with each other. Participants spoke about how education can build people’s knowledge and skills and bring more professional satisfaction in their role *‘I think with more knowledge and studies for the ward nurses (that are really going through hell at the moment, with covid and everything)…. think they will enjoy their job more as well’ (P15)*. Covid-19 brought the importance of respiratory knowledge to the fore of the healthcare sector. In findings section 5.1, participants spoke about how their educational role became increasingly important and how they were asked to give respiratory training and upskilling to various healthcare professionals and areas.

In this educational work, they acknowledged the importance of questioning their awareness of the different levels of expertise and experiences in particular areas and how this can impact a lack of confidence in the learning environment. The healthcare professionals they were educating have extensive experience and confidence in different clinical areas, which gives them a rich enhancing knowledge and expertise in particular clinical areas. Still, they may lack capacities and confidence in other nursing areas, such as respiratory care. Appreciating these different levels of knowledge and carefully crafting a pedagogical response that can identify gaps in knowledge and add these to existing capacities is a crucial part of CNS/ANP’s teaching role. As participants expressed in the findings, respiratory education for healthcare professionals is a highly specialised form of continuous professional development which must build on the specific knowledge and scope of practice of the different roles and knowledge

bases. Appreciating the particularities of highly specialised forms of continuous professional development is vital for healthcare education.

7.3.1 Nursing Policies and Frameworks

The impact of the broader organisational structure on developing the role of respiratory CNS and ANPs also needs to be considered (Kanter, 1993). Chapter 2 reviews the changing policy and regulatory context in healthcare organisations locally, nationally, and internationally. These have significantly impacted the development and expansion of advanced respiratory roles as described by the participants within this study in findings section 5.3.

As an educator in this area, I have held a lot of faith in the power of policy to effect change through implementation. The regulation of the profession, its practice and power is a key feature of professionalism, revealing the controls and boundaries set on knowledge and practice by profession (Bevir, 1999). However, I am mindful of the need to consider the wider environment to make sense of how policy interacts and impacts professional practice, considering policy as the complex process by which individuals exercise power or influence over one another. Policy is a 'law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions' (Centers for Disease Control and Prevention, 2015). How policy is developed and implemented becomes crucial regarding its impact on the healthcare sector. The participants express concerns in section 5.3 of the findings that unless organisations improve with increasing opportunities to access continuous professional development, education, and policy development, it may lead to participants and the profession becoming disempowered. They also highlighted how intra-professional relations are a key element, with good clinical supervision and access to mentors playing a key role in regulating and developing the profession.

Fleming, Loxley, and Finnegan (2017) discuss how enacting policy aimed at significant change is not a straightforward or linear process in higher education. At an institutional level, following

a policy which dictates specific priorities means that autonomy can be limited. An institutional policy is ‘maintained, sustained and changed through the agency of powerful actors at the centre of the system and, less visibly, by dissidence at the margins’ (Fleming, Loxley, & Finnegan, 2017, p. 8). As discussed in section 3.6.3, traditionally, in the healthcare sector, the powerful centre was based within the master narratives of the medical profession, with less visibility and power given to the caring and patient-centred narratives of nursing. Garcia and Hardy (2007) view narratives as used internally in the tales people tell themselves, and externally in the stories they tell others to construct professional identities. Using positioning theory allows me to bring the policy narrative of nurse education, and specifically respiratory nurse education, to a conscious level, allowing assumptions of practitioners, nurse educators and others in the field to be probed and questioned.

In the Irish context, Ireland’s first framework to support the professional development of those who teach nursing across the HE sector was published by the National Forum in 2016 (Higher Education Authority, 2016). This gave clearer policy status and recognition for nurse education. As section 2.8 outlined, this framework for nurse education is underpinned by a set of core values and provides a structured outline of professional development activities for teaching and learning within HE. Nursing is a self-regulated profession, so the registrant must maintain professional competence through continuous professional development (CPD) programmes and opportunities. Hence, the role of CPD is a partnership between the nurse and their employer through the Code of Professional Conduct and Ethics (Nursing and Midwifery Board of Ireland, 2021a) and Scope of Practice (Nursing and Midwifery Board of Ireland, 2015).

Drennan et al. (2009) argue that empowering nurses to have more agency contributes to increased effective care. This is evident in the Irish Government’s commitment to increasing the development of advanced practice roles (Fealy et al., 2018). Section 5.3 outlines that individuals striving for or encouraged by consultants to become respiratory ANPs are required

to undertake a level 9 postgraduate educational programme and are already practising in respiratory care. This type of postgraduate nursing education gives the nurse the capacity to transform the scope and autonomy of their role. Power over and power to discussed in section 2.6 (Noddings, 2002) are visible through this professional accreditation process, which also carries through into advanced practice in nursing and influences behaviour and actions by enhancing clinical practice and patient care and developing learner capabilities within the workforce. The development of the postgraduate level of education has facilitated this expanded scope of practice and enhanced the expressions of explicit professional identities of respiratory CNS/ANPs. Ideally, in a clearly defined profession, this gives a distinctive role and identity and helps to avoid misunderstandings and challenges from other professional groups in healthcare.

However, this clarity does not exist as the findings chapter revealed in the confusion about CNS's role, which was highlighted by participants in terms of the lack of clarity about educational requirements and career progression in section 5.3 and the extent of autonomy given in the role in section 6.1. This raises questions about the rules governing and distinguishing respiratory CNSs and ANPs' roles, given the scope of practice identified for their role. This is defined by the criteria of their qualifications and their skills (Zukin, 1996) and regulated by the process of professional liability.

The recognition and regulation of nursing education are embedded in existing relationships and hierarchies of power within medical and academic fields, privileging expertise, evidence-based practice, and continuous professional development knowledge. Currently, post-registration education opportunities for registered nurses enable the nurses to register on an additional division of the nurse register. Post-registration programmes are designed, established, and directed regarding a specific body of knowledge and experience in nursing. The NMBI authorises post-registration programmes and courses that lead to minor awards, additional awards, and special intention awards. The participants in section 5.1 of the findings

viewed the educational preparation for the roles of respiratory CNS/ANPs as being particularly positive. However, some participants highlighted differences in the content, usefulness, and appropriateness of some material in their course modules regarding the clinical learning environment. This involves revision of course modules, integrating technologies, interprofessional collaboration, and updating the curriculum by emphasizing clinical decision-making and critical thinking for best patient care outcomes and supporting continuous professional development.

Participants acknowledged the value of their respiratory qualifications and education for their organisations in such areas as nurse-led clinics, decreasing waiting lists, adding cost reduction, and making more efficient use of other multidisciplinary team members. With specialist qualifications in respiratory nursing, participants articulated how they felt they contributed to a wider agenda, suggesting that doctors, physiotherapists, and nurses recognised the immense value they brought to their organisation. This enabled and facilitated the respiratory CNS/ANPs to work to the full extent of their education, training, and practice scope. This added value contributes to the enhanced status of the respiratory CNS/ANP profession and the professionalisation agenda.

7.3.2 Professional Education Pathways and Role Identities

There is an increased expectation for respiratory ANPs to demonstrate competence in delivering respiratory care to patients through educational standards and regulations. Respiratory ANPs are educated to a master's level, where consultants are heavily involved in the clinical supervision of the candidate ANPs in the advanced nursing practice master's programme (Nursing and Midwifery Board of Ireland, 2017). This differs from the respiratory CNSs who continue to do general nursing masters for their continuous professional development (CPD). Both are awarded a level 9 qualification; however, the ANP master's seems to be perceived as more specialised. The Government of Ireland (2019) proposes that

the number of ANP positions will expand significantly by 2% within the next five years to match international norms.

Despite regulation and standardisation of education (Nursing and Midwifery Board of Ireland, 2017), the findings reveal that nursing CNSs and ANPs continue to strive for professional position. Respiratory ANPs have found that they are located not necessarily outside the traditionally understood role of the nurse but rather at the intersection of medical and nursing domains (Lowe, 2017). This tenuous or border position can affect relationships and the interplay of nurses with other nurses and health professionals within the healthcare system (Willetts & Clarke, 2014). This was partly due to the educational level of respiratory CNS/ANPs being on a similar level but not similar emphasis, and consequently, roles overlapping and recognition between the two roles can lead to professional jealousy and envy, as noted by participants in section 6.4 of the findings. The confusion on how one navigates to becoming a CNS/ANP, as well as pathways from CNS to ANP and the support provided in this area, were noted by participants in section 5.3 as needing attention.

While the respiratory CNSs and ANPs are busily expanding and extending their roles, their roles have lost sight of their different competencies and the consequent impact on their interprofessional relationships. Respiratory ANPs have an autonomous expert clinical practice, professional, clinical leadership and research educated to a master's level with core competencies. Respiratory CNSs have competencies and are known for being specialists in clinical practice, patient advocacy, consultation, education, and research, and are educated to a higher diploma level; however, most do go on to the master's level available as another academic year. This could explain why there could be a blurring of boundaries and confusion about pathways, with both now reaching level 9 qualification, as participants described. Still, significantly, level 9 qualifications are not a registration requirement for the role of respiratory CNS as a career post and so distinguish them from ANP roles.

This blurring of boundaries and recognition of these two roles is significant, as discussed later in relation to findings about professionalism in the sector. Despite the continued development of respiratory CNSs and ANPs, the scope of practice, legislation and educational standards of those performing this advanced role, there is still a lack of clarity between these respiratory roles in this study, especially for respiratory CNSs (Wong & Farrally, 2013). From the research, there are several areas where participants noted a similar lack of clarity, for example, in section 5.3 regarding educational requirements and career progression and section 6.1 regarding the amount of autonomy given, expected, and allowed within the role. Participants expressed a concern that the practice of respiratory CNS/ANP is restricted if there is too tight an external regulatory control. This results in the education and training of CNSs not being fully utilised for patient care and service (Kopanos, 2014).

The findings revealed that the interprofessional relationships between respiratory CNSs and ANPs had changed during new work conditions that developed during Covid-19. In section 6.1, participants noted where non-autonomous career posts are unavailable or not facilitated for respiratory nurse specialists with specialist qualifications; they questioned the role postings against the reality of having to step up their autonomy. Where power is imposed externally, it leaves little room for autonomy within an individual's position (Bevir, 1999). In this case, the personal expressions of power amongst respiratory CNSs or ANPs in section 6.1, where participants see an overlap between their roles in practice; however, competencies and regulation continue to expand based on an identified role difference. Participants' responses in section 6.1 revealed that the outcomes are more likely to be negatively focused if a gap exists between practices and externally imposed boundaries through regulation, with practitioners using agency as a means of resistance or rejection rather than exploring new positions of possibilities (Bevir, 1999).

While specialist nursing roles like respiratory CNS/ANPs have enhanced professional autonomy, two participants expressed the opinion that the autonomy of specialist nursing roles

can deskill from other nursing staff in clinical practice, and one participant expressed concerns about the unexpected requests or questions they received from the staff. The respiratory nurse specialist must be mindful of the nurse's autonomy in making decisions within their professional scope and responsibility to act accordingly (Varjus, Leino-Kilpi, & Suominen, 2011). This highlights the ongoing complex tensions which occur between roles. As discussed in section 3.2, social identity theory gives an explanatory framework to investigate group behaviours as roles shift for respiratory CNS/ANPs and have relevance in understanding tensions that are perceived as competing for group status. Hogg (2020) emphasises belonging to a group as a very significant aspect of social identity theory, and valuing group membership is emotionally necessary. Social theory identifies the individual's status within the group and then explores how self-worth is developed through self-esteem and perceived group status (Hogg, 2020; Willetts & Clarke, 2014).

7.3.3 Motivations and Supports for Continuous Development of Professionalisation

The power of respiratory nursing postgraduate education and its qualification was acknowledged by many of the participants in the findings chapter. When outlining their rationale for undertaking the respiratory nursing education programme, some participants consider it as preparing them and demonstrating their commitment to improving respiratory health service delivery, taking on the requirement that nurses identify ways to expand their practice (Ellis, 2019).

The respiratory CNS/ANPs in this study embraced the idea of continuous professional learning and expanded practice. They recognised that what was known at the start of their career as a general nurse no longer sufficed at a time when respiratory health and healthcare were more complex. Undertaking the respiratory education programme, master's programmes and other programmes prepared the participants for their current roles (Fealy et al., 2018). Participants

highlighted that they and other staff nurses in the clinical area considered a respiratory nursing qualification a pathway to career development and a stepping stone to promotion or current role expansion. As discussed in section 3.6, professional identity and career development are inextricably linked, and all healthcare workers must be confident in their ability to advance their careers. Ibarra (1999) highlights how professional identity changes throughout individuals' professional career pathways and is more flexible in the initial phases of the professional career. This was particularly evident in the move from a nurse staff position to a specialist position, while some opted for a specialist practice pathway instead of a pathway into management.

What was interesting was the influence respiratory consultants played in encouraging respiratory CNS/ANPs, to progress their careers further through advanced practice. Participants recounted how individual consultants encouraged and supported them to engage in further qualifications and, in several instances, formally mentored and signed off on their clinical supervision in section 5.3. Currently, in Ireland, respiratory ANP is the highest level a nurse can practice in the clinical environment. Eight participants in this study described how they had to move to another organisation to obtain their post as a respiratory CNS, especially for respiratory ANPs.

7.4 Changing Aspects of the Professional Role of Respiratory Nurses

This section explores how participants experience their professional roles and explore the implications of how they developed professional roles. This analysis is guided by social identity and positioning theoretical frame as explored in Chapter 3. These theories acknowledge how individuals internalise their occupational group's values, standards, abilities, and behaviours as they develop their professional identity roles. Because of this, individuals think, behave, and feel like a participant in their professional role identity group, whether they be nurses, respiratory CNS/ANPs or medical staff. The professional role identity enables respiratory

CNS/ANPs to articulate their work purpose and grow in terms of self-awareness and a sense of community. Currie, Finn, and Martin (2010) note the importance of understanding identity from a social viewpoint on three levels: individual (micro), relational/interactional (meso), and social (macro). While the individual and relational/interactional levels are evident in the discussions in the preceding sections, this also needs to be set within the broader cultural context of nursing as a profession in our society, which is explored in the following section initially in terms of the gendered implications of nursing at the macro level of society.

7.4.1 Implication of Nursing as a Gendered Profession

The social context of nursing is reflected in the general gender balance within the nursing profession, which is skewed primarily toward females (Buchan & Catton, 2020). Nursing has traditionally been a predominantly gendered profession and continues to be dominated by female participants, with the OECD (2019) citing 89% of female nurses globally. As discussed in Chapter 2, there is an assumption that caring is a natural feminine trait and 'ways of knowing' are associated with vocational nursing models, which are displayed in the beliefs and values that reinforce who we are as nursing professionals and nurse educators. This normative gendered landscape and assumptions about care and femininity were significant elements of this research's context. This is crucial when considering the changing role of specialist roles, which give nurses more power and autonomy over activities formerly within the remit of the masculine-dominated medical sectors. Chapter 2 highlighted the tensions within the profession between practice and theory, where the vocational practice is associated with nursing as a female-gendered caring service and theory is associated with professionalised knowledge and the academy, which were traditionally considered masculine in nature. This shift is significant when viewed in terms of power and authority. Power is crucial in determining what individuals include and exclude in perceptions and how people conceive agency, role, stance, or position negotiation.

Clayton-Hathway et al. (2020) and Ud Din, Cheng, and Nazneen (2018) view a lack of power in this female profession as a consequence of personal and family situations, not ability or educational levels because many nurses choose to work part-time, take career breaks and are primary family caretakers. This view positions the responsibility at the individual level rather than the systemic or cultural level, which orientates females towards these hegemonic feminised and caring roles and positions their profession in a subordinate status (Badgett, 1999). This gendered culture and approach to power, which many nurses express, lie in the backdrop of this research, especially as advanced respiratory specialists take on new roles and challenge existing relationships and patterns of authority in the healthcare field, both within nursing and across the sector. Lynch (2021) notes how care is perceived as highly gendered, describing how care is not considered work that requires recognition or reward because of the assumption that it is a natural female trait.

The progression of nursing professionalisation has been problematic because of these wider cultural and societal gendered assumptions about caring and nursing being viewed as female jobs with little value and recognition assigned to their specific knowledge base, which was discussed in section 3.6.4, through the term of socialisation (Lai & Lim, 2012). The experiences of these participants illuminated how the role relationship and organisational power of the respiratory CNS/ANP are evolving as their extended scope of practice embraces forms of knowledge and capacities which traditionally had been reserved for medical staff (Young, 2008), given its unique multidisciplinary basis, which draws on knowledge from many health disciplines into its own applied and patient-centric approach.

This applied nature of nursing's way of knowing through the lens of patient experience means its education bridges theoretical and practical knowledge forms. Chapter 2 outlined that applied forms of knowledge based on care, vocation and experience have been less recognised or valued than the theoretically based traditional "powerful knowledge" of the established disciplines such as medicine (Allais, 2014; Wheelahan, 2015; Young, 2008).

These shifts in practice and knowledge highlight the need to reconsider the gendered nature of the knowledge and capacities of nursing and its position in the broader healthcare professional field. It indicates the need to reassess what is “powerful knowledge” for nursing as a profession.

7.4.2 Autonomy and Advocacy

Participants acknowledged a core part of their professional capacity and knowledge base is through their ability to be agentic in their enhanced advocacy role, which they described in three distinct ways: by hearing and giving voice on behalf of/with the patient, by questioning multidisciplinary team members locally and at a national level in the development of disciplinary knowledge through their work on guidelines and policies, presentation of research and international publication of research and policies, and conference attendance. As outlined in section 5.1 on teaching, all these forms of agency are grounded in their clinical experiences and holistic ways of knowing. This gives them a sense of voice and the capacity to represent others, highlighting the role of experience-based ways of knowing. They recount how, in an embodied way, respiratory patients can find themselves caught up in a healthcare system where their voice is not heard due to breathlessness and their condition. This is allied with the general lack of recognition of patient autonomy and rights in healthcare as a sector. The respiratory CNSs and ANPs are very aware of this lack of voice and act as advocates for the holistic health and care of their respiratory patients.

Participants acknowledge that the capacity to be agentic is inextricably linked to the level of power enabled within the healthcare system and its influence at different policy levels. Matthews (2017) and Rafferty (2018) highlight how nurses have an essential contribution to make to healthcare policy, calling for more involvement of nurses earlier in the policy-making process to harness their evidence-based practice knowledge rather than expecting policy to be accepted and implemented by nurses. The findings demonstrate that respiratory nurse

specialists are taking on this responsibility. Respiratory CNS/ANPs participate in work-related committees and encounter other multi-disciplinary committee members who acknowledge their expertise, enhanced knowledge, and contribution to the organisation at a policy level.

The respiratory CNS/ANP listens, observes, analyses, and processes the information they receive from their patients. They use this knowledge from people's lived experiences to become autonomous professionals with a strong patient-centred orientation. Some participants were very mindful of the impact of this patient-centric and relational approach and the resultant orientation in their practice for the patient and other healthcare workers. This connection was evident in the findings about how participants used new ways to keep in contact with patients during the Covid-19 pandemic through virtual clinics, phone calls and by writing a postcard. This can be related to the commitment to patient care, which is rooted in the evolution of nursing as a profession and has been maintained in the Advanced Practitioner role of respiratory CNS/ANPs (Rowen, 2010).

As part of this patient-centric ethos, participants built a long-term invested relationship with patients where compassion and care develop over time, as described in section 6.2. The value of this was evident in the holistic nature and length of time over which respiratory CNSs and ANPs knew patients, with consultants and other staff valuing the sustained relationships and deep knowledge respiratory nurses had of patients and their life context. Participants also felt there was an awareness of the respiratory nurse specialist's role and autonomy with the patient and their family where *"we got feedback from people as well that they were happy really happy that service we provided (P12)*", expressed in section 6.1. As noted in section 3.3, the extended relationship with patients and their embeddedness in people's lives and communities is a notable feature of respiratory CNS/ANPs' work through their nursing care, educational role, and patient advocacy in a multidisciplinary team context. New ways of working are acknowledged as important in maintaining the highest standards of professional education and training (Sundararaman, Muraleedharan, & Ranjan, 2021).

Participants were aware of the scope and boundaries of their professional autonomy. Autonomy refers to a nurse's ability to make some decisions within their profession, recognising their right and responsibility to act according to the shared standards of that profession (Varjus, Leino-Kilpi, & Suominen, 2011). Weston (2008) acknowledges that nurses have increasing opportunities to shape professional and organisational rules, leading to autonomy over the context of practice (Manojlovich, 2007). Pratt and Corley (2007) describe professional role identity in two parts. Firstly, the individual skills and knowledge where individuals are doing what they can do, which results in their actions being seen as unique and specific in the eyes of colleagues and patients. Secondly, the feeling of individualism explores how people develop and retain a sense of uniqueness in their work identities (Pratt & Corley, 2007). This role identity helps respiratory nurse practitioners maintain their sense of professional autonomy.

Professional autonomy stems specifically from respiratory CNS/ANP's knowledge, skills, education, and clinical practice to offer safe, quality respiratory health care for the patient (Nursing and Midwifery Board of Ireland, 2015). Individual levels of autonomy might differ based on various legislative, organisational, and personal circumstances (Nursing and Midwifery Board of Ireland, 2015). Clinical autonomy is linked to independence, collaboration, and practising as a professional in their own right, which involves continuing to work as a clinician (Cotter, 2016). Understanding the multifaceted nature of professional autonomy is necessary to establish good work environments (Pursio et al., 2021). Nurses may act autonomously while requesting assistance from a professional group member and as a collective (Trapani, Scholes, & Cassar, 2016). Understanding the nature of professional autonomy is key, especially in the context of an emergent practitioner role like CNS/ANPs.

Participants described the increased professional and clinical autonomy they now hold as respiratory CNS/ANPs in treating patients. In the findings, participants described respiratory nurse specialists' high standard of education and the specialised experiences they had gained

as respiratory nurse specialists. Respiratory CNS/ANPs are in a unique space when providing patient care due to the holistic nature of their interaction and relationship with patients. As noted in section 5.1, the participants outlined their patient advocacy and education role, teaching inhaler techniques to encourage a patient self-care focus and health care promotion. Section 5.1 describes how the rise of new education methods during Covid-19 supported patients to self-manage their conditions and ensured better medication adherence. This holistic patient care view from respiratory CNS/ANPs can provide more critical focus than can be achieved by medics, which was acknowledged by consultants, as section 5.1 reveals. Respiratory nurse specialists have specific roles such as education, promoting self-management strategies, supporting early discharge, and long-term care and management of people living with respiratory conditions (Gibson et al., 2013). As nursing practice is continually evolving, nurses are expanding their scope of practice to include roles previously undertaken by professionals defining professional identity, as discussed in section 3.5.

7.5 Blurring of Professional Role Boundaries

As noted in section 1.4, it is a formal requirement for all respiratory ANPs to have level 9 qualifications (Nursing and Midwifery Board of Ireland, 2017) and all respiratory CNSs to have a level 8 qualification. However, post-specialist courses in HEIs are currently offered at a level 9 qualification standard; therefore, CNSs have level 9 qualifications and some additional educational requirements that can lead them onto the ANP pathway. As discussed earlier in section 7.3.2, participants in this study were mindful of what they described as their qualification deficiencies or needs. Some participants described a sense of being ‘inbetween’, which can be viewed as role confusion or blurring.

Some participants were working as respiratory CNSs with the same academic qualifications as respiratory ANPs. There were respiratory CNSs with fewer qualifications than other respiratory CNSs, all performing similar roles. Some respiratory CNSs would like to get onto

the ANP pathway, while others were content to remain on the CNS pathway and expressed that there was little difference in patient care. These findings reveal that the emergence of advanced nursing positions to produce an advanced contribution in practice, teaching, research, and administration has led to role overlap and misunderstanding of roles (Wall, 2006). Confusion surrounding the duties of the respiratory CNS function can hinder the respiratory ANP from successfully implementing the extended nursing role. Some multidisciplinary teams and patients could not distinguish between these different nurse duties and credentials. As discussed in Chapter 3, respiratory CNS/ANPs must clearly explain their role to patients and families and, most importantly, clarify their professional identity and learning identity to colleagues in their multidisciplinary teams on an ongoing basis to claim their professional identity and status.

During Covid-19, the redeployment of respiratory CNS/ANPs to work in areas like swab centres and multitasking, as noted in section 6.3, meant that their specialist role potential was not maximised fully. As discussed in section 3.7, Gilburt (2016) acknowledges professional identity within multidisciplinary teams as a complex process correlated with higher levels of perceived integration. Therefore, respiratory CNS/ANPs professional identities will continue to be shaped and reshaped as their professional landscape changes and core values will remain constant while other elements evolve. Along with the unknowable nature of the pandemic and the ensuing public response during this period, respiratory CNS/ANPs frequently performed dual responsibilities as ward nurses while fulfilling their expert respiratory roles concurrently. While these roles created opportunities and space for reshaping or creating new identities, their ‘past’ identities cast a long shadow (O'Brien & Furlong, 2015), especially where participants had previous nursing roles before entering their specialist roles. As discussed in section 3.7, teams must recognise that members possess multiple layered identities and histories, including their professional identity and their shared identities as part of a team, an organisation, and a professional group and in this environment, Edmondson (1999) asserts

that people need to be confident in their personal and professional identities and those of their colleagues. These participants may still be acknowledged or viewed within the domain of their previous nursing role rather than their current specialist role, and the impact of these biographies and history on advanced nursing practitioners needs to be considered by nurse education.

The legacy of the vocational ethos of care in nursing also casts a long shadow for many participants. Respiratory CNS/ANPs expressed stress and anxiety over being redeployed during the Covid-19 pandemic, conveying a feeling of guilt for leaving and abandoning their cohort of respiratory patients, as expressed in the findings sections 6.2 and 6.3. This represented a tension for these nurses between a sense of duty and wanting to return to the clinical workforce and their commitment and obligation to the development of the future nursing profession (Dewart et al., 2020).

Professional commitment has been threatened by this ‘blurring’ of elements of their role, and it is important to note the implications of ‘professional’ rather than ‘occupational’ allegiances (Stronach et al., 2002). This could explain why there could be a blurring of boundaries, discussed in section 5.3, both at the same level of qualification and in interprofessional relationships and empowerment between respiratory CNS and ANP, which can be problematic (Langley et al., 2019). Such ‘blurring’ of roles can lead to tension, evident in section 6.4, where differences in experience, knowledge and expertise within roles may seem similar. As discussed in section 3.7, avoiding blurring the lines between distinct professional groups encourages a shared team professional identity that recognises and honours the unique talents of all multidisciplinary team members. Section 1.4 describes when the role of CNS started; it was not fully delineated, and there was a limited number of respiratory CNS specialist roles in the country at the time. So, in a way, these pioneer respiratory CNSs were instrumental in demonstrating that these roles, both CNS and, crucially, ANP roles, worked

and had a lot of benefits. A lot of gratitude had to be shown to these pioneering CNSs, but unfortunately, that did not translate into equivalent levels of professional recognition for CNSs.

Instead, greater professional recognition has been attributed to the ANP role. For example, the ANP roles undergo a registration process to accredit practitioners, whereas the CNSs undergo an 'approval process' (Begley et al., 2014). The differing process of accreditation (which is automatic if you fulfil the criteria) and approval (with connotations of judgement about whether you will be permitted entry) indicate the differing types of professional recognition given to the two roles. The requirements for educational qualifications are crucial points of distinction. As evident in section 6.4, respiratory CNSs and ANPs need to be aware of potential tensions and professional jealousy at the start and throughout their careers (Cleary et al., 2016). Evans, Traynor, and Glass (2014) highlight how nursing rivalry can materialise when nurses see others receiving what they perceive they deserve, provoking emotions like anxiety, envy, and jealousy.

The findings reveal that the professional identity of the respiratory CNS's role appears to be unclear and is an area where confusion and conflicting opinions are visible, as discussed in Chapter 3. This, along with the expansion of respiratory ANPs' role in recent years, means that respiratory CNSs have had to accept the development of the respiratory ANP role in a way that has led to a blurring of the boundaries between the role of respiratory CNSs and ANPs and the professional identity of respiratory CNSs. Participant 3 notes that many people *'doesn't understand the education component. There's a lot of line blurring. People don't understand what an ANP does and what CNS does'* as was discussed in section 5.3.

7.6 Significance of Relationships and Change in Nursing

Respiratory CNS/ANPs described how they were not always noticeable in their profession, and their position was not fully recognised amongst their nursing and healthcare colleagues. However, when the Covid-19 pandemic arrived, we entered a new set of rapidly changing

shifts in coping with the respiratory implications of Covid-19 in healthcare settings, and the position changed for the respiratory CNS/ANPs rather quickly. As discussed in Chapter 3, professional identity and career development are inextricably linked with theoretical frameworks investigating how change affects professional identity in deep and ongoing ways (Chulach & Gagnon, 2016; Currie, Finn, & Martin, 2010; Monrouxe, 2010).

Kotter's model describes and predicts the impact of change, such as what was experienced by healthcare and the professional role of participants during the Covid-19 pandemic. However, the literature suggests identity can be damaged when positions change, and skills and capacities may be lost (Borthwick et al., 2009). Kotter's theory focuses on how leadership, management and motivation must be adaptable and changeable in the workplace, which is very relevant during emergencies and disasters such as Covid-19. Respiratory CNS/ANPs described how they could accommodate new working methods and education across multidisciplinary contexts, which, in the unprecedented service demands during the Covid-19 pandemic, revealed their leadership, motivation, value, and importance in multidisciplinary collaboration. The Covid-19 pandemic demonstrated the importance of respiratory CNS/ANPs' role, who were recognised for their substantial contributions to frontline care, leadership, education, and continuity of care for vulnerable patients with acute and chronic lung disorders in very responsive and relational ways.

However, participants acknowledged that this did come with a cost in terms of the emotional stress and anxiety placed on respiratory nurse specialists during that period, as identified in section 6.2. In addition to the intense and stressful working conditions, participants also identified the stress of coping with an unbounded sense of constantly changing conditions as new information emerged about the impact and response to Covid-19. This points to the importance of change management theories (Kotter, 1996) considering the specific context and pressures of working in emergency contexts such as Covid-19.

7.7 Professional Relationships, Teams, and Power Sharing

What emerged from the participants' experiences is the significance of the development of the role and relationships of the respiratory CNS/ANPs for patient respiratory care in the healthcare system. Core to this is the relationship between respiratory CNS/ANPs and others in their multidisciplinary teams. As discussed in section 3.4.1, respiratory CNS/ANPs hold multiple identities, personal and professional, and are likely to identify as part of a greater whole, whether as employees of an organisation or a professional body. Brown et al. (2020) note how there is movement between identities, reconciling and integrating them to create a blended or hybrid identity, but others may struggle to combine these identities in relation to the participants' interactions and relationships with other healthcare professionals and patients. This research reveals how instrumental collaboration and consultation were in successfully implementing the role of respiratory CNS/ANP. As discussed in Chapter 2, complex power flows between structure and agency are evident in the interprofessional relationships which exist in the multidisciplinary team-working context of respiratory care.

The extent to which respiratory CNS/ANPs feel empowered was attributed to the relationships and relations they established. In section 6.2, participants spoke about the strong bonds they develop with patients with chronic respiratory conditions, which build over a long time through the continuous patient education they provide and the attendance at nurse-led clinics. In section 6.3, participants highlighted their extended role and capacity to work with other healthcare professionals and multidisciplinary teams such as physiotherapists and respiratory consultants. Today's emphasis on patient care has shifted to a holistic team approach with different disciplines working together towards the betterment of patients and their care. This more democratic structure leads to collaboration and trust between professions and acceptance of each member's role and responsibility (Maxwell et al., 2013). As discussed in section 3.8, it is necessary to create a solid professional identity for recognition of other people’s professional identities and to negotiate one’s professional identity while establishing

those of other professions. Best and Williams (2019) note how critical trust is when dealing with professional identity in nursing, especially during times of change, such as during the Covid-19 pandemic.

The context of Covid-19 revealed how professional relationships changed and healthcare staff supported and covered each other's roles. In the findings, several participants described receiving good support from the respiratory consultants' during the Covid-19 pandemic when rapid changes in work practices occurred. This was evident in section 6.3, where participants had to be redeployed during Covid-19, and the teamwork blossomed during this pandemic. Participants described how some respiratory consultants took some of their workloads when they were on the frontline during the Covid-19 pandemic. Teamwork and respect for each other's role within interprofessional team members become stronger and tighter through these emergency times (Goldman & Xyrichis, 2020). Goldman and Xyrichis (2020, p. 580) highlight phrases like 'we're all in this together' and 'camaraderie is everything' as a call to recognise all healthcare workers who are essential members of the 'team' including respiratory therapists, cleaners, doctors, and nurses becoming stronger and more robust through the Covid-19 pandemic emergency times. A similar theme emerged from this study, where teamwork was evident in the findings in section 6.3. As discussed in section 3.9, professional identities are shaped through an individual's participation or engagement with different teams; learning through interactions with different groups and recognition of these roles is key. However, it is important not to be overly rigid in terms of professional identity, and it may fail to equip the respiratory CNS/ANP as changes in working patterns, practices, environments, and new ways of working should not be perceived as a threat to pre-existing professional identities (Monrouxe & Rees, 2017).

When respiratory CNS/ANPs were redeployed during Covid-19, medics took on the role that respiratory CNS/ANPs previously performed by helping with their patient load to free up their nursing skills in other areas of Covid-19 care as needed. The relationship and interaction between respiratory nurse specialists, whether CNSs or ANPs reveal elements of power. Power is extra personal, which means that an increase in power must be compensated by someone else surrendering part of their power. This is evident in section 6.4, where doctors and consultants were willing to relinquish some responsibilities to respiratory CNS/ANPs and take some of their tasks as additional aspects of their workload. Providing opportunity, effective information, and support at all levels of the organisation are critical tools for generating power (Kuokkanen & Leino-Kilpi, 2000).

Multidisciplinary team members, including physiotherapists and respiratory consultants, were noted as important sources of support and particularly important in terms of discussions and shared decision-making (Fallon, Cassidy, & Doody, 2018). There were some multidisciplinary teams where respiratory CNS/ANPs shared equal input in respiratory patient education programmes and promoting living with respiratory conditions. Participants in this study, for the most part, expressed a great sense of collegiality with physiotherapy colleagues where the physical therapies played a vital role in the respiratory care of Covid-19 patients.

This resonates with Goldman and Xyrichis (2020), who suggested that teamwork improves working relationships with other healthcare professionals even more so during pandemic times. The study findings showed that strong professional relationships were significantly enhanced during the first wave of the Covid-19 pandemic, with the professions of medicine and physiotherapy, whereby in the past, Fletcher (2006) found that power arose out of and between those relationships.

As autonomous professionals, most participants in this study established and ran their nurse-led clinics, discussed in findings section 5.1. They classified their position as respiratory nurse

specialists who were empowered in their practice and focused on the care of the respiratory patient. There was a shared power with their roles in nurse-led clinics, which was grounded in a keen sense of the diverse roles and relationships involved in patient care. Relationship-based care identifies three critical relationships for providing compassionate healthcare: the nurse's relationship with self, team members, and patients and families (Koloroutis, 2004).

Some participants expressed that by running their nurse-led clinics, they were reducing the consultant's workload and taking on junior doctor tasks, for example, blood results and x-rays. Delamaire and Lafortune (2010) concluded that respiratory specialist nurses improve access to services and patient-centred care and reduce waiting times, providing effective use of healthcare resources. This points to the need for clarity about role responsibilities and careful consideration of their impact on the boundaries between different roles and disciplines. When respiratory CNS and ANP roles are being formed, the focus should be placed on the clinical and professional leadership aspects of the positions to maximise their capacity to influence and grow others' practice and contribute to service development (National Council for the Professional Development of Nursing and Midwifery, 2010).

7.7.1 Acceptance and Recognition by Multidisciplinary Teams

Out of fifteen participants, ten participants articulated that they were considered part of the team by their medical colleagues and viewed as having positive input. Consultants who work with respiratory CNS/ANPs recognise the contribution of their role, with the findings describing how consultants see them in a positive light. Part of the reason for this recognition of their contribution is the in-depth knowledge and familiarity consultants have with respiratory nurses. Many consultants have worked with respiratory nurses for years; some could have even mentored them at different stages during their career development.

The medical team working with consultants rotates every six to twelve months. In contrast, the respiratory CNS/ANPs are a continual presence within the team, leading to stability and

knowledge consolidation. Respiratory consultants know and appreciate the knowledge and expertise that emerge from the long-term familiarity and relationship CNS/ANPs have formed with patients. The findings emphasise the significance of the respiratory CNS/ANPs' ability to provide enhanced care through this holistic continuity of care. Continuity of care allows a trusting relationship between patients and the respiratory CNS/ANP and a depth of knowledge about patients and their conditions, which are vital elements in holistic care. The findings highlight the encouragement and support that some respiratory consultants gave to the participants in this study, identifying the progression of respiratory CNS/ANPs in advanced practice and motivated joint practice. The findings show that consultants are committed to improving patient care and have a genuine desire to see respiratory specialist nursing develop professionally. They know the significance of interprofessional and interpersonal interactions for the future benefit of education and collaboration techniques.

Another factor relates to the growing expertise of respiratory CNS/ANPs who have taken over roles and routine tasks that were once viewed as solely the doctor's role. This allows the medical profession to concentrate more on acute respiratory care. From a professional viewpoint, this could be considered as the respiratory CNS/ANPs expanding and enhancing their respiratory specialist nursing role (Nursing and Midwifery Board of Ireland, 2015, 2017). However, doctors acknowledge that collaborating with nurses is essential for patient outcomes, especially given the longer-term relationship and in-depth knowledge that nurses have of patients (Delamaire & Lafortune, 2010). This acknowledges the specific origins and type of knowledge which nurses have based on the holistic care of patients and deep listening to and knowledge of the experience of patients living with respiratory conditions.

Although the benefits of the expanded role of respiratory nurses are acknowledged, some medics can struggle with differing power relationships and organisational constraints (Tang et al., 2018). While the importance of power in medical encounters is becoming more well-recognised, research in this field is still in development (Bleakley, Bligh, & Browne, 2011).

When power is displayed in the physician-patient relationship, it is often portrayed as something physicians own and use to their benefit with minimal awareness (Nimmon & Stenfors-Hayes, 2016). Individuals who were conscious of this power strategically share, assert, moderate, and release power in response to situational contexts (Nimmon & Stenfors-Hayes, 2016). Physicians traditionally hold more power in this relationship because of their cultural and symbolic capital, which is legitimised through the structures of the medical establishment and gendered norms about care. As discussed in section 3.4.1, the efficacy of advanced practice positions is jeopardised if the impact of these broader societal norms and hierarchies is not considered. There is a link between changing professional identity, positioning and cross-border cooperation with colleagues (Currie, Finn, & Martin, 2010; Powell & Davies, 2012).

Nursing and medicine are two professions that work closely together. Health and Care Professions Council (2014) discusses the importance of other professions' acknowledgement for recognition processes. This recognition and appreciation are important to build on as literature shows that these two professions are frequently pitted against one another and portrayed as hostile regarding differing status, cultural values and institutional position (Price, Doucet, & Hall, 2014). Interprofessional relationships between and within professions substantially impacted job acceptance (Maxwell et al., 2013). The principles of social identity theory emphasise how belonging to a group is very significant, and emotionally valuing group membership is acknowledged as necessary.

7.7.2 Professional Hierarchy

Earlier chapters describe how the medical profession dominated the healthcare field, which had the power and expected respect from other professions, including nurses (Friedson, 1994). In the past, the medical profession had the knowledge and level of education to legitimate this agency over nurses (Royal Australasian College of Surgeons, 1987). Bourdieu

(1990) refers to knowledge as cultural capital in which those in power decide which knowledge is important and create pathways and professions to legitimate who can use and access this knowledge in society. Knowledge is a source of power that allows people opportunities, but 'privileged knowledge' can also leave others with less freedom and choice (Noddings, 2006, p. 238).

With the establishment of specialist nursing roles, new grades of healthcare professions and the practice expansion of non-doctor healthcare professionals, medics and doctors no longer held the dominance or status over the medical professions that they enjoyed in the past. Through the introduction of legislation, clinical guidelines, policies and an educated public, the medical monopoly over healthcare delivery has been decreasing (Freidson, 2017; Willis, 2020). Respiratory CNS/ANPs have been part of this story and the challenge to the traditional dominance of the medical profession in healthcare.

The findings chapter reveals how the increased knowledge and educational levels for the respiratory CNS/ANP can be disruptive as they can have more knowledge of respiratory conditions than non-respiratory medics or doctors. Fourteen out of fifteen participants in this study had nurse prescribing qualifications, giving them a formally recognised power, which disrupted the doctor's traditional power and professional monopoly. As discussed in section 3.4, the respiratory CNS/ANPs are practising skills and knowledge that doctors only practised in the past, indicating a significant shift in the development of the nursing profession, which reflects the continual development of knowledge and capabilities that shift positions and power dynamics between these professions. Lundgren et al. (2017) highlight the expanded role of respiratory CNS/ANPs that provides them with a greater capacity to make choices and decisions in their practice.

7.8 Professional Recognition

The changing responsibilities and status of the respiratory CNS/ANP role do not always bring professional recognition. Instilling confidence and respect for the profession, as discussed in section 3.5, allows for the presentation of proper actions and demeanour of the professional identity to society. There are a variety of formal and informal techniques for recognising and rewarding professional accomplishments. Informal recognition and reward focuses on expressing direct, sincere, and individualised gratitude for workers' contributions (The University of Queensland, 2022). Formal recognition and reward are resourced and funded by the faculty, institute or organisation and could be in the form of financial reward or promotion (The University of Queensland, 2022).

Symbolic recognition of respiratory nursing and general healthcare workers was evident through the lens of the Irish Government when, in 2021, the Irish Labour Leader requested the Irish Government gift healthcare workers a once-off €1,000 as a pandemic bonus payment to recognise their work on the frontline during the Covid-19 pandemic. While it was an act of recognition, the participants in the findings questioned if this addressed the problems underpinning professional recognition in nursing and called for formal recognition in terms of wages, funding, and educational support. Another example of symbolic recognition was the public clapping of healthcare workers during the height of the pandemic. Clapping with our healthcare professionals was appreciated, but it was noted that this is not enough unless it is not accompanied by financial and organisational recognition of the healthcare professional's roles.

The participants revealed how they were conflicted about whether respiratory CNS/ANPs roles should carry additional financial recognition rewards given the typically cost-saving nature of their work, as was also discussed in section 3.4.1, where respiratory CNS/ANPs role providers improved service delivery, faster throughput and transparent governance and accreditation

structure. They were cognisant of how healthcare professions and patients had utilised their expertise during the recent Covid-19 pandemic, above and beyond any previous work commitments. A recognition and reward framework method would improve the ability to engage, retain, recruit, motivate, and retain employees to help individuals and organisations achieve their goals (The University of Queensland, 2022). Section 3.4.1 discusses how nurses struggle to assert their professional power and autonomy relative to other professions, evident in recognition of their professionalisation that has yet to be fully translated financially as Ross, Barr, and Stevens (2013) identified in Australia and reflective of a worldwide challenge. This recognition would respond to some extent to the guilt nurses spoke about in terms of feelings that we are not *'doing enough'* for patients, '*I suppose it was difficult being redeployed. I felt like I was abandoning my patients' (P7),* as was noted in section 6.3. They also spoke about the impact of the broader media, where they are bombarded by a media portrayal of being overworked and under pressure, which can leave nurses feeling distressed and disempowered (Garfin, Silver, & Holman, 2020). In section 3.10, it was acknowledged that the media recognised nurses' professionalisation during the Covid-19 pandemic as everyday heroes, unwavering in their commitment to patients and their profession. However, Cox (2020) noted the difficulties when the media focuses on 'healthcare heroes' and acknowledges the degree of personal risk exceeding the duty of care.

The INMO pay scale (announced in 2021) shows the current wages for nurses and specialist nurses. Notably, ANPs were paid approximately 15% more than CNSs and senior staff nurses, which is interesting considering the blurring of professional role boundaries mentioned in section 7.5. However, payment for nurses and specialist nurses like respiratory CNS/ANPs is a continuous battle for the nursing profession. Participant 15 discussed their lack of recognition, describing how their wages do not equally reflect respiratory CNS/ANPs' impact on healthcare. They feel this inequity sharply in terms of its lack of recognition of CNS/ANP as a prestigious role with similarly qualified healthcare professionals. At the start of my

doctorate programme in 2018, nurses took industrial action to get pay parity with other degree-qualified healthcare professionals (Wall & Clarke, 2019).

The quandary remains: how does one put a price on care? To achieve effective equality, people must recognise that they require love and care not merely to survive but also to grow and develop (Lynch, 2007), and this must be recognised and recompensed at a societal level (Lynch, 2021).

Participants of this study who work in respiratory specialist areas are paid an additional allowance in recognition of their specialist qualifications. Nurses with respiratory qualifications working in non-specialist areas are not paid anything extra despite their added education and knowledge in the field of respiratory nursing. Pay and recognition are linked to their position and role in healthcare rather than based on their specialised knowledge and achievement level.

Many participants felt that additional financial recognition for their role was warranted, as Participant 2 noted that their roles are more professional, not vocational, as seemed in the past. All the participants recognised that their role was to produce cost savings for the organisation in which they were employed (Delamaire & Lafortune, 2010). However, they were unsure how to achieve reward and felt conflicted and 'felt bad' about wanting additional payment for care. This can be linked to the 'moral imperative' to care that O'Brien (2007) spoke about, with the care roles women feel compelled to take in society being given less recognition and value. There was an unspoken emotion being expressed by participants in thinking, "am I less caring if I demand more financial reward?". Benjamin (2017) and Honneth (1996) psychologically oriented recognition theories consider care relationships as crucial since emotionally rewarding interactions reflect the earliest form of recognition that humans experience. This led me to reflect on the equilibrium between professional and vocational elements and how respiratory nurse specialists view themselves as we emerge from a fourth

wave of Covid-19, at end of 2022, with no sign of extra financial or official recognition of the ongoing efforts made by nurses since the onset of the pandemic.

Money is used as a metric for success and an indicator of ability and worth in our society, a common denominator by which everything is compared and judged. Lack of financial reward has previously been reported, with the nursing profession feeling underpaid, leading to dissatisfaction amongst our nurses and as a deterrent to nurses being encouraged to expand their practice (Goodare, 2017). Nursing, in general, remains a profession where staff express a sense of being financially challenged, with constant worry due to a lack of financial compensation for their role. This is evident through the manifestation of a series of industrial actions and strikes that have occurred in Ireland (Mulgrew, 2022). The time has come to frame a new politics of care and emotive justice that challenges the narrative of solely self-serving politics (Lynch, 2021).

7.9 Conclusion

In reflection on the findings of this study, there is an overall positive development for respiratory CNS/ANP nurses in the contemporary healthcare sector. Respiratory CNS/ANPs support and educate patients to communicate knowledge about respiratory care, but, more importantly, they guide, facilitate, and provide space for their colleagues to learn through reflecting on their knowledge and experiences in a profoundly patient-centric holistic manner.

Respiratory CNS/ANPs working as autonomous professionals, developing nurse-led clinics and were at the forefront of respiratory education for the healthcare profession during the first wave of Covid-19. However, some aspects are challenging, such as recognising how respiratory specialist nurses are agents of change, their role in multidisciplinary team contexts, and the role confusion arising from the shifts in the extended scope of practice in their work.

The findings reveal that professionalisation's increased status in the respiratory CNS/ANP role does not always bring professional recognition. A formal recognition and reward framework method would improve the ability to engage, retain, recruit, motivate, and retain respiratory nurse specialists to benefit individuals and organisations in achieving their goals. The participants discussed their lack of recognition, highlighting how their wages do not equally reflect respiratory CNS/ANPs' impact on healthcare.

The specialist respiratory nurse CNS and ANP can contribute to enhanced agentic capacity and showcase their professional identity and professionalisation in nursing. The aspects that influence each can be achieved and have been identified and discussed. Some aspects or factors require more work to be done in recognising the contribution the respiratory nurse specialist makes, whether it is the respiratory CNS or respiratory ANP’s role to the Irish health service.

In Chapter 8, I will reflect on my journey to date and how this journey has impacted my professional development as an educator and researcher. I will outline the recommendations and implications of my findings for respiratory nurse education and the development of policy to enhance and expand practice for respiratory CNS/ANP and make some recommendations. Finally, I will reflect on my journey over the previous four years.

Chapter 8: Learning from Practice: Reflections from Research and Education in the Sector

8.0 Introduction

This qualitative research study explored the experiences of respiratory nurse specialists (CNSs and ANPs) working in respiratory care settings to generate practitioner-based knowledge that can inform education, research, policy, and practice in the area. The following questions guided the research:

- *How has the role of respiratory CNS/ANP developed in the Irish healthcare field as a profession?*
- *How do the experiences of respiratory nurse specialists (CNS/ANP) enhance practice development, generate knowledge-based practice, and contribute to learning and education?*

The research is based on the insights of fifteen respiratory nurses CNS/ANPs from all over Ireland, working across various clinical settings, who participated in one-to-one semi-structured interviews in 2020 after the first lockdown of the Covid-19 pandemic. All participants worked in respiratory care, from acute to outreach service, at the time of the interviews.

Findings focused on how the professional identity of nursing practitioners is enhanced when respiratory CNS/ANPs can practice with the scope and lead out on advanced practice and educational roles. These roles contribute to greater professionalisation of nursing, strengthening the recognition and status it affords advanced practitioner roles and their knowledge base. Participant experiences also highlight that their specialist respiratory role in the time of Covid-19 offers the capacity to act more agentically, which was developed in different ways, including extended advocacy and educational roles, multidisciplinary teamwork, and enhanced holistic care. However, numerous challenges were also described,

including workload, interruptions, emotional, and psychological and physical barriers that are discussed in this chapter in terms of the implications for the professional identity and education of staff in the sector and for research about healthcare education.

While the research findings mirror some of those previously published within nursing settings, this research is the first known to address the experiences of specialist respiratory nurses working in respiratory care in the middle of a Covid-19 pandemic. This chapter discusses the implications of the findings of this thesis before identifying key recommendations of the study for research, education, practice, and policy. I am acutely aware of how my practice as a nurse educator of respiratory nurse practitioners has altered and transformed over the course of this research, and I explore this through personal journal reflections on my doctoral journey in the middle of this global pandemic, including the implications for me as a healthcare educator and researcher.

8.1 Overview

The findings reveal how the practices of respiratory nurse specialists (CNS/ANP) enhance greater professionalisation of nursing in terms of their advanced practice role, their contribution to nursing in a multidisciplinary team context and, most notably, their holistic sense of patient care. This level and type of professionalism is a significant shift for nursing, which has traditionally operated within a more supportive role in the hierarchical model dominated by medical expertise, which was described in section 2.4. It is clear from the accounts of practice articulated by the participants in the study that they are practising in a collaborative, autonomous way with other healthcare professionals in multidisciplinary contexts. Rather than these relationships being based on hierarchical dynamics, with one profession dominating over another as had traditionally occurred in healthcare settings, these relationships are based on collaborative teamwork and allow for the greater autonomy of individual respiratory CNS/ANP professions. Greater autonomy and empowerment are also evident in their

educational preparation and ongoing CPD, which enhances respiratory specialist nurses' ability to have a clear, professional nursing identity within this interprofessional environment. The findings clearly identify how the specific body of expertise of advanced nurse practitioners is informed by their content knowledge of respiratory care and is based on a deep, holistic knowledge of patients built up over long-term relationships and their capacity to share and educate their fellow healthcare colleagues, patients, and families. This gives advanced nurse practitioners a unique knowledge base and web of relations within multidisciplinary teams, which often hold a deeper and longer knowledge of the holistic conditions and care requirements of patients than many of their professional colleagues on multidisciplinary teams who had shorter-term and more occasional interactions with patients.

However, this unique knowledge and role is not always fully recognised within the profession or by colleagues and others. Key tensions and challenges are evident in the ongoing evolution of the profession across the multidisciplinary team, between ANPs and CNSs and with other colleagues in the context of Covid-19. These are discussed in this chapter in terms of the themes and sub-themes for implications for Education and Professionalism, Teaching and Learning, Professionalism and Professional Identity.

8.2 Implications for Education and Professionalism of Advanced Respiratory Nursing Roles

The Covid-19 pandemic has profoundly impacted nursing and nurse education in higher education and clinical healthcare environments because of nursing’s central role in the health and care of patients impacted by Covid-19 and other illnesses during this time. The findings of this research document the experiences of respiratory nurse specialists (CNS/ANP) roles concerning education and professionalism and have significant implications for education, practice, research, and policy for respiratory care roles as well as across the healthcare system, as documented in figure 8.1 below.

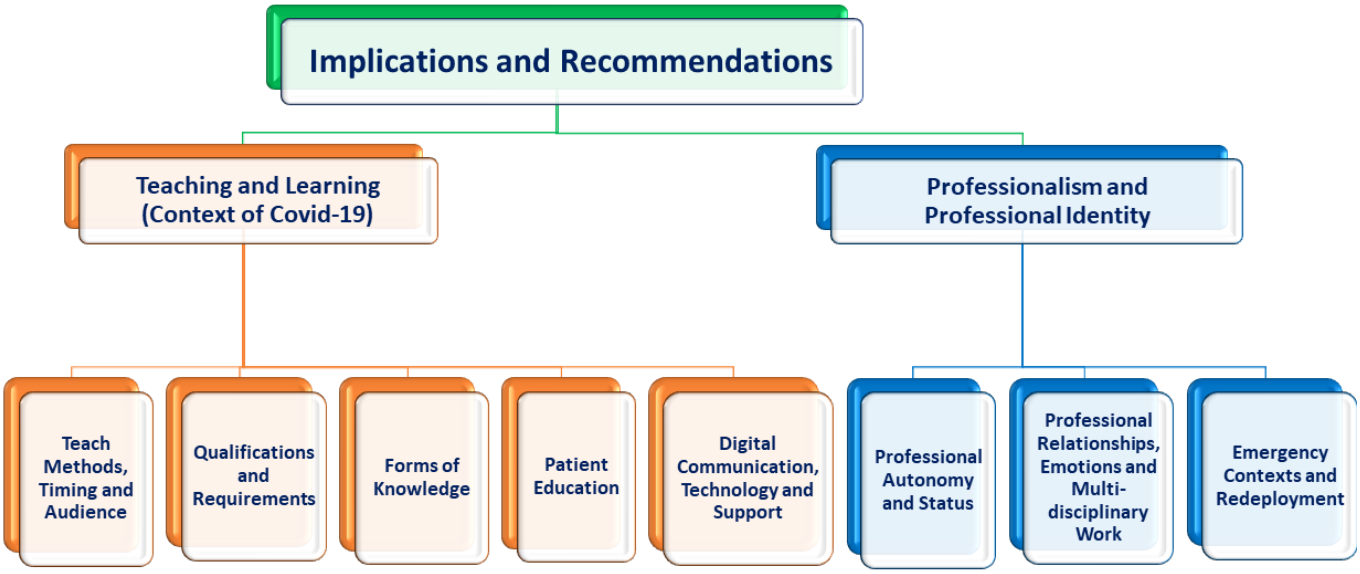

Figure 8.1 Implications for Education and Professionalism of Advanced Respiratory Nursing Roles

The research also has implications for education, which are discussed in this chapter. It is intended that this will assist educators, managers, and policymakers in nursing and healthcare educators like me in designing and producing education to support the adoption and functioning of these roles within healthcare settings.

As discussed in section 1.4.1.1, the role of the respiratory CNS/ANP from an international aspect differs between countries or regions; therefore, it is important to form a comprehensive understanding of the roles of respiratory CNSs and ANPs in other jurisdictions. Ongoing research is required to prepare respiratory nurses for active collaboration with other healthcare professionals in order to address patient care for both chronic and acute diseases. There is a global need for recognition of the role of respiratory nurses across different healthcare providers, each with its own speciality and standardised levels of education. World Health Organization (WHO) provides international guidance and support as the implementation of such recommendations may vary across countries due to differences in healthcare systems, regulations, and resources. Local and regional healthcare authorities and professional

organisations also contribute to shaping the practice of respiratory CNS/ANPs based on their specific context. The implications and recommendations of the research are positioned in the specificity of the Irish healthcare context but have relevance for respiratory nurses working in other healthcare systems worldwide.

As Covid-19 starkly demonstrates, healthcare challenges are not confined by geographical borders when it comes to respiratory diseases, health disparities and health trends. The general findings of this research have global relevance in terms of implications for practices amongst respiratory care professions, education of healthcare professionals and research. The identification of common experiences and themes about the impact of the changing professional roles of advanced practitioners is key to the ongoing transformation of healthcare. Sharing of experiences across healthcare systems is also very pertinent, given the mobility of healthcare workers globally.

8.2.1 Teaching and Learning (in the Context of Covid-19)

The research demonstrates how respiratory care teaching methods became vitally important during the Covid-19 pandemic, where respiratory problems became common side effects of Covid-19 infections, and all medical staff needed to have the skills to combat the virus. Participants noted an obvious lack of key respiratory skills amongst various levels of healthcare staff who previously were not exposed to or using these techniques in their daily tasks. A recommendation of this research is to ensure that basic respiratory skills are continuously included in the healthcare curriculum as a practical skill set that must be used and updated in continual learning situations. This research reveals that it is vital to learn from practitioner experiences of working during the Covid-19 pandemic when working roles and contexts in nursing, especially respiratory roles of CNS/ANPs, were stretched beyond their normal range. This involves the two aspects of respiratory care of patients in an emergency

context and supporting the education of healthcare staff in response to respiratory care of Covid-19 conditions.

8.2.1.1 Teaching Methods, Timing and Audience

Participants spoke of the intense and immediate scale of new learning required during Covid-19 regarding knowing the basics of looking after a patient with this new respiratory disease. This new learning occurred in active clinical settings/environments as staff were being redeployed as nurses in wards to help in respiratory areas. Learning from practitioner experiences was identified as crucial through, for example, teaching methods such as a 'train the trainer' approach to upskill existing staff and a 'teach back' way to show patients how to use an inhaler and respiratory treatments. Advanced respiratory staff became key in educating healthcare staff across the sector, teaching respiratory therapies in multidisciplinary contexts to a wide range of staff who had not previously needed this knowledge in their roles. Advanced respiratory staff were responsible for bringing this learning to their colleagues with the immediacy of a global pandemic using digital communication, which had implications on their role as these were new skill development opportunities for them. The immediate need for this type of specialist respiratory knowledge and skills amongst medical staff during Covid-19 meant that education and learning interventions had to be focused and timely and could change at a moment's notice.

Participants described how this teaching role had improved their practice through the need for increased and continual knowledge and the impact of practice-based knowledge for nurses on wards where they could see the longer-term implication of this for their practice. Much of their teaching occurred in clinical settings as they taught and learnt in practice together in response to specific and purposeful practice, with participants conscious of how this new knowledge and capacities gave power, agency, and co-learning to staff and patients. Respondents described this as having a highly responsive and carefully tuned balance

between clinical judgement and learning from education, which enabled them to develop a 'store of knowledge' that became the respiratory nurses' professional knowledge. Acknowledging and rewarding respiratory CNS/ANPs who actively contribute to the learning and development of their colleagues is crucial. This includes supporting the development of communities of practice, where respiratory nurses of all levels, regardless of experience, are encouraged to share their insights and learn from each other. This allows knowledge-sharing simulation of complex respiratory scenarios and enables respiratory CNS/ANPs to practice decision-making and critical thinking in a controlled learning environment.

All participants described how they used clinical judgement to care appropriately for patients and spoke of how these clinical judgement skills are supported by experience and education, the unique intuitive capacity of each respiratory nurse specialist in nursing practice. Intuitive capacity is about being able to synthesise numerous and varied sources of information from respiratory knowledge, skill, and continuous learning to act in a time-sensitive manner rapidly and accurately. The intuitive capacity allows respiratory CNS/ANPs to take a course of action that is not explicitly spelt out in their protocol or policies but is guided by accumulated knowledge and keen observation skills, which was the case during the first wave of the Covid-19 pandemic.

8.2.1.2 Forms of Knowledge

The research participants identified the need to balance the level, interaction, and sequencing of work-based practical and theoretical-based learning in postgraduate studies to ensure relevant and incremental development of the practical application of their skills. This points to the balance needed between practitioner experience, expertise on the job, and academic accredited knowledge. This has an implication for educational theory in professional areas like nurse education, where learning occurs in and between tacit or intuitive knowledge in practice settings, clinical learning on the job and theoretical knowledge about respiratory conditions

and care. Respiratory CNS/ANPs offer expert guidance and are skilled in respiratory nursing, including non-invasive ventilation, pulmonary rehabilitation, and management of chronic respiratory diseases (Rafferty & Elborn, 2004), which spans these different types of knowledge. Facilitating learning of different knowledge requires high levels of the key elements of respiratory nursing work, which are i) experience-based learning on the job, ii) practice-based learning, and iii) relational learning from social interaction with colleagues and multidisciplinary teams.

Greater recognition and appreciation of these distinctive forms of disciplinary knowledge and ways of knowing respiratory nursing is required in nursing research and healthcare education. The research showed that the unique knowledge basis and capacity of respiratory nurses were formed using theoretical knowledge from different disciplines involved in healthcare, such as medicine, pharmaceuticals, physiotherapy, etc., which is distilled through the patient-centric, experience-based, and caring practice focus of nursing. Professional recognition of the distinctiveness of this type of practitioner-based knowledge is vital for nurse education as a field, with Wheelahan (2015, p. 752) highlighting the importance of developing 'the specialised knowledge that underpins practice in their occupational field' to understand and address the challenges about the 'nature of the practice, ethical issues and dilemmas, and different perspectives in their discipline'.

Respiratory CNS/ANPs need to articulate their distinctive forms of disciplinary knowledge and ways of knowing. Cultivating specialist knowledge is pivotal in tackling the multifaceted challenges that arise within respiratory nursing practice. Through articulating their respiratory knowledge as specialist respiratory nurses, they can enrich their contribution to healthcare, ensuring informed decision-making elevates the quality of care for their patients. With the development and recognition of disciplinary knowledge, respiratory CNS/ANPs can actively engage in multidisciplinary discussions and offer distinct perspectives informed by their unique area of expertise.

8.2.1.3 Qualifications and Requirements

The findings outlined how formal qualifications required for CNS and ANP posts are at postgraduate QQI levels 8 and 9 and determine the career pathways of respiratory CNSs and ANPs. These qualification routes were slow to develop but are now seen as more transparent for ANPs in their accreditation pathway. However, findings reveal that confusion remains about career pathways and qualifications required for CNSs with its approval process and subsequent career progression options. As documented in this research, it can cause confusion and professional jealousy between colleagues, which is explored in the later section, 8.2.2.2 below.

A related implication of this research is the extent of clinical experience required for respiratory CNS and ANP positions, especially given the changing profile of applicants. A recommendation is for healthcare institutions and regulatory bodies to collaborate to establish clear and standardised qualification criteria for clinical nurse specialists (CNS), recognising that the changing landscape of applicants may bring diverse but valuable perspectives to respiratory nursing. While clinical experience is important, considering a balance between practical experience and the potential for innovation, fresh insights, and adaptability is key in a review of the pathway to a CNS position.

8.2.1.4 Patient Education

Patient education is at the centre of respiratory care in the form of communicating health promotion, supporting patient adherence to their treatment, self-assessment of risk factors, and ongoing training for staff and patients. This has the intention of self-empowerment for patients to manage their condition and improve their quality of life. Patient education occurs at the care receiver and the caregiver level as an active process of understanding and is about checking people's level of knowledge, arming them with the tools to manage their condition and, most importantly, listening to and responding to the patient. This holistic and relational

care role is a significant element of the professional capacity and the teaching role of advanced respiratory practitioners, which needs to be recognised as a crucial aspect of the professional identity of respiratory nurse specialists. A curriculum recommendation would be to develop more updated, effective patient education strategies incorporating digital communication technology, health literacy and cultural sensitivity and being aware of patient preference. Embedding this in a theory of relational and holistic-based theory of care to support practitioners to be critically aware and reflective about their professional care role is essential.

Changes in patient self-care and medication adherence were evident in this research, with participants describing how Covid-19 had mixed impacts on respiratory patients. Due to the fear of Covid-19, many patients with underlying respiratory conditions were adhering to their medication instructions and cocooning for the first time, in conjunction with rising public knowledge of respiratory conditions and care. Learning from these different patient responses to Covid-19 and cocooning was significant for the patient, especially where it led to deconditioning anxiety and stress (Health Service Executive, 2020c). Generally, because of Covid-19, participants in this research felt that patients' overall well-being deteriorated due to the widespread impact of cocooning, isolation, and anxiety. Respiratory CNS/ANPs play a crucial role in influencing healthcare policies, promoting preventive measures, and advocating for resources to improve respiratory care at both individual and population levels. It is key for the respiratory care field to critically reflect with patients, learning from these types of changes in patient behaviour and ensuring that it is included in future research and healthcare education. Given the advocacy and communications role of respiratory nurses for their patients, a curriculum that empowers nurses to participate in policy development and advocacy related to respiratory public health is vital.

8.2.1.5 Digital Communication, Technology and Supports

Digital communication emerged as a significant mode of communication in healthcare settings during the Covid-19 pandemic, enabling different team members of multidisciplinary teams to manage patient care, especially during periods of lockdowns and respiratory CNS/ANPs redeployment. Virtual Clinics and webinars where respiratory CNS/ANPs communicated with patients were vital in reducing infection risk, providing ongoing care and communications and reassuring patients. Both virtual clinics and telephone support enable ANPs and CNSs to provide vital advice channels for patients who were cocooning or isolating, particularly about managing their conditions and life during a lockdown context and managing the ongoing risk of infection in general contexts.

While the benefits of digital technology communications for healthcare are documented in the emergent literature on Covid-19 (Health Service Executive, 2020a), specific implications emerge from this research for respiratory care diagnosis. The impact of the loss of the direct in-person context for patient diagnosis and care in virtual communications needs to be considered from a healthcare and diagnosis perspective, especially in terms of the ability to read facial and bodily cues and social engagement cues from patients. This also includes tactile contact cues and the capacity to conduct some respiratory tests and procedures which require body contact. Participants in the research stated that it took them longer to diagnose patients using digital communications effectively. A recommendation of this research is that the use of virtual communication needs to be carefully considered and tailored to specific healthcare contexts. This will enable digital technology use to be customised to health conditions and patient profiles (such as the tactile cues and the focus on breathing needed for respiratory diagnosis).

Communicative preferences are also key to consider, with many older patients preferring telephone communications over computer-based communications. Participants

acknowledged the ongoing psychological impact of video-calling patients and their families during Covid-19 restrictions. While it provided an essential means of communication during periods of lockdown and cocooning, participants spoke of the quality of their connection with patients, finding that the medium and momentum of virtual clinics meant that they focused on the technical and numerical aspects of patient information rather than the person and their holistic wellbeing. An implication of the rapid adoption of digital communication is the technical challenges that arise for respiratory CNS/ANPs, including the rapid IT learning curve for healthcare staff with very little training prior to the pandemic and the time spent sourcing IT equipment.

Technological advancement in education as a consequence of the Covid-19 pandemic has transformed the way respiratory CNS/ANPs approach learning and teaching in respiratory nurse education. Respiratory CNSs/ANPs are required to adapt to emergent contexts and new technologies. As a nurse educator, there is now a requirement to integrate technology focusing on the development of digital literacy skills, telehealth training and the use of simulation-based learning, thus enhancing the respiratory CNS/ANPs technological skills. The development of the All-Ireland Nursing and Midwifery Digital Health Capability Framework (Health Service Executive, 2020a) and the Digital Health Competency Standards and Requirements for Undergraduate Nursing and Midwifery Education Programmes (Nursing and Midwifery Board of Ireland, 2023) as frameworks to support technology advancement of nurses and update the respiratory nurse education curriculum, digital health competences now being integrated and recognised in the pathway and structured programmes for the respiratory CNS/ANP.

Exploring these implications of using digital communications for respiratory nursing education and in respiratory nursing to manage respiratory conditions from prevention and early detection to treatment using the latest evidence-based approaches is key. The benefits of digital communications for respiratory care are clearly evident from this research. Incorporating virtual digital media during multidisciplinary respiratory rounds when discussing

patient cases forms a valuable basis for respiratory multidisciplinary telemedicine communication in the future. The development of virtual online respiratory simulation labs for various scenarios related to respiratory care enhances training, education, and knowledge transfer. Digital respiratory patient education, where respiratory CNS/ANPs would guide patients via video demonstrations, enables staff to reach patients who are cocooning or in isolated and distant areas. Creating online support communities allows respiratory CNS/ANPs to create reliable platforms where patients can share experiences, look for support and seek validated information. Incorporating new digital tools and platform developments into the specificity of respiratory healthcare and into the respiratory nurse curriculum will enable future cohorts of respiratory nurses to keep abreast of ongoing technological advancements and evidence-based practice.

8.2.2 Professionalism and Professional Identity

8.2.2.1 Professional Autonomy and Status

Core to the professionalism and professional identity expressed by respiratory CNS/ANPs in this research is their competency in their field of practice and their professional autonomy to take charge and self-manage in circumstances where they are in authority. What was also expressed in this research was the relative newness of the advanced practitioner role and their autonomy in the nursing field in Ireland. In light of this, there is a need for greater consideration in research and practice of how the organisational structure of the healthcare system supports or hinders the professional identity and autonomy of respiratory CNS/ANPs. This is very pertinent for career progression for advanced practitioners, where career posts are unavailable or not yet facilitated for respiratory nurse specialists with specialist qualifications.

The research revealed a certain amount of confusion and lack of clarity between respiratory CNS and ANP career pathways and roles. Research also revealed a lack of knowledge or

awareness from other nurses and healthcare professionals regarding the difference between the role of respiratory CNSs and ANPs. A clearer agreement and awareness about each role, the regulations, and the development of policies governing their work is required.

Positive learning from the pandemic for respiratory nurses was the appreciation of the collective sense of teamwork and effort that emerged amongst the healthcare staff, with healthcare staff at all levels and disciplines supporting patients and each other. While they appreciated public displays of appreciation for their work, participants expressed concern that this appreciation for their work and these extraordinary conditions might disappear when things returned to normal. Participants felt that additional financial recognition for their role was warranted, but they were unsure how to achieve reward and felt conflicted and guilty about wanting additional payment for care. This is linked to the gendered 'moral imperative' to care that O'Brien (2007) speaks about, with women feeling compelled to take on the care roles in society and the long-standing pay gap between nurses and other medical staff that must be addressed at a policy level.

This is set within a context where the prestige and financial recognition of the respiratory CNSs and ANPs profession have not kept up with its growth or contribution to the healthcare field. There is a need for improved recognition of the profession with better remuneration, funding, and paid education required, as well as support from management across the healthcare sector. The research identifies the need for recognition equivalent to colleagues on multidisciplinary teams with similar roles and postgraduate qualifications at levels 8 and 9. This also highlights the need for a greater emphasis in the educational curriculum on the development of policy knowledge and advocacy capacities to empower respiratory CNS/ANPs in the shaping of policies and decision-making by regulatory bodies and government authorities relevant to their professional field of practice.

The lack of recognition of respiratory nurses' contribution echoes the broader issue of caring, and interdependency is not recognised at a societal level and reflects the denigration of the role of caring in society and in our healthcare education system (Lynch, 2021). This must be considered in light of the gender imbalance within nursing professions, which is skewed primarily to females and the lack of recognition in pay and conditions for women generally. Changes in the power dynamics and autonomy within this female-dominated profession are essential and must occur within a context that explicitly acknowledges and tackles this hegemonic dominance. Collaborating with nursing education institutions, educational bodies, and policymakers is required to achieve change, including facilitating respiratory CNS/ANPs on such collaborating committees, which will ensure meaningful action is achieved. Greater awareness and discussion on gender bias and the importance of care within society is needed in the respiratory healthcare educational curriculum and across the profession. Shifting the power dynamics within the respiratory nursing profession is essential, empowering respiratory CNS/ANPs to have stronger input in the decision-making process and policy development, which is cognisant of these gendered dynamics. By addressing the complex interplay between gender, caregiving, and societal norms, it is possible to begin creating a more inclusive and equitable system.

8.2.2.2 Professional Relationships, Emotions and Multidisciplinary Work

Compassionate relationships with patients are a vital characteristic of the role and work of respiratory CNSs and ANPs. Participants in the research demonstrated how their professional value and commitment to patient care and well-being guide their work. They spoke of the necessity of showing compassion to their patients, families, colleagues, and themselves as a professional, and this can be traced to the caring nature of nursing and specifically to the long-term relationship they develop with their patients through their lifespan. This is part of the unique knowledge that they bring into multidisciplinary working contexts, which needs to be acknowledged and recognised.

Consideration of the long-term impact and learning from the rapid deployment of respiratory staff across different roles in healthcare services is crucial. The research recommends that we must find new ways of working to ensure we adapt during emergencies like Covid-19, with the pandemic demonstrating the importance of multi-professional working amid unprecedented service pressures, working together as part of a new single team.

The findings demonstrate how good professional relationships are vital for the multidisciplinary team context, where respiratory CNS/ANPs work with everyone on the team, and all are aware of their specific skill set and capacities, complementing each other and trusting each other. Effective communication, information sharing, and dialogue are critical to these positive working relationships. The research highlights the need to take time to build trust and team relationships; however, the process can be slow or diluted, especially during times of crisis and continual change, such as the Covid-19 pandemic. It is timely to reflect on and develop this as we emerge from the immediacy of Covid-19. Trust emerges from the respect created during continued interaction between CNSs and ANPs with other healthcare staff and teams. Administrative and management personnel organising teams must understand and identify these challenges, especially in more fluid or transitory teams, or if professional boundaries are compromised, as such clarity can be challenging to achieve and impact professional identity. As outlined previously, both from literature and the research participants, there is limited research focusing on the professional identities of respiratory CNS/ANPs in multidisciplinary healthcare teams concerning their practice, and it is a research area that emerged in this study which should be explored further.

The emerging nature of respiratory CNS and ANP as advanced practitioner roles in recent years has resulted in changing relationships with doctors and consultants. Consultants recognise the reduced consultant workload over time due to the professional capacity and continuity of patient care provided by respiratory CNS/ANPs. This recognition has resulted in consultants taking on formal and informal mentoring roles to support respiratory CNS/ANP

staff development. These issues of professional development, autonomy, the recognition of different roles in these areas, and support from other colleagues are areas which warrant further investigation.

Participants highlight the importance of an understanding and awareness of professional emotions and respect for the CNS and ANP role within and across this type of multidisciplinary teamwork. This is vital to developing a shared practice identity and working practices within multidisciplinary teams to respond to the need for a holistic and patient-orientated approach with different disciplines working together in patient care and treatment. Understanding how professional emotions such as jealousy and envy can be engineered by the demands for high productivity and intense competition for limited resources and jobs in the area is vital, as well as exploring implications on the working environment, workplace relationships and individual/team performance.

This research reveals the importance of professional emotions and tension, discussed in section 7.6, being addressed through nursing education. Developing safe spaces for reflective practice to discuss and acknowledge those professional emotions in training contexts and through ongoing communities of practice is vital. Developing an educational module incorporating an understanding of group dynamics and teamwork, the importance of building team relationships, and consideration of their own role and the role of others with awareness of the emotional and personal relationship on a professional level within the context of nursing are key elements which emerge from this research. As a researcher and nursing educator, I am currently exploring undertaking a leadership mentoring and coaching programme to educate myself and explore how to incorporate this into my own professional work and the field of respiratory nurse education as a result of this research.

8.2.2.3 Emergency Contexts and Redeployment

The Covid-19 pandemic provides positive lessons about how staff supported each other to provide patient care and highlights the significant challenges experienced by participants of this research. Challenges documented in this research include the pressure of learning to work in new contexts and roles, maintaining existing coverage of their roles, transitioning rapidly from one service area and task to another, and training with many different groups of healthcare staff across the systems. As information and guidance on Covid-19 were continually emerging, decisions were often made quickly, and often circumvented the usual channels and cycle of communication. Agu et al. (2021) highlight the need for nurse education systems to adapt to withstand unexpected events and future crises and recover rapidly from them. While Sundararaman, Muraleedharan, and Ranjan (2021) note that education programmes must respond to changing service needs; however, disaster planning is a new element which is vital for future planning in all healthcare environments.

The findings of this research reveal how multi-tasking and changing roles during Covid-19 brought physical and psychological pressures regarding the risk of infection, insufficient rest time, continued work with intensity and continual change under challenging circumstances. The emotional distress of dealing with ill patients and colleagues, worry about their own and their family's health and well-being, and the psychological pressures of this unknown, emergency, and ever-changing context were deeply felt. Covid-19 highlighted the importance of paying attention at an individual and systemic level to the wellbeing and self-care of staff who carry this emotional load. Developing a model of coaching and mentorship across healthcare settings for staff during these types of emergency contexts of continual change is essential. One such model would involve respiratory CNS/ANPs connecting with other multidisciplinary teams and mentors in roles across different healthcare settings, where knowledge sharing, collaboration and a broader perspective on handling emergency situations would be nurtured. Building resilience and adaptability into the respiratory CNS/ANPs role is

important as their role often involves making critical decisions under pressure. Providing mentorship strategies to manage stress and enhancing coping mechanisms that include discussions around the ethical dilemmas the respiratory CNS/ANPs encounter during emergency scenarios is key. Integrating coaching on utilising technology effectively in these contexts, especially during emergencies when telehealth, digital media and virtual communication became vital tools. A coaching and mentorship model could incorporate a comprehensive support system that enhances the ability to excel in their respiratory CNS and ANPs roles, make informed decisions, and contribute effectively to emergency healthcare delivery.

Participants expressed a sense of wellness that breeds professional confidence to know their role and have confidence to take on new jobs, roles and tasks and connect with multiple levels and networks of staff and patients as they had done throughout Covid-19. However, participants also acknowledged the challenges of multiple pressures, stress, and anxiety they experienced during the first Covid-19 lockdown period. Participants spoke of how they felt pulled in multiple directions, worked long hours, lacked work structures and schedules, working on wards with persistent acute illness and deaths, felt the isolation and abandonment of their patients, a sense of powerlessness, the intense tiredness, the burden of future occurrence, and worry about the potential of themselves or colleagues or family getting ill. The ongoing emotional and psychological impacts of these cumulative pressures need to be considered and addressed by healthcare management. Formal counselling and support are essential in supporting staff during these periods. Informal supports such as talking to colleagues, connecting with someone to chat, self-care and exercise are also acknowledged as vital, with participants speaking of how they missed the usual routines of expressing appreciation for each other in social events and daily encounters during the lockdowns. Preparing respiratory CNS/ANPs for working in high-pressure environments to effectively navigate professional tension using conflict resolution skills and to collaborate with fellow

healthcare professionals would enhance respiratory CNS/ANP's capacity for well-being and promote a collaborative approach to patient care.

To conclude, the key implications and recommendations have been addressed as illustrated by the themes in Figure 8.1 (p. 243-244). The following section will discuss the broader contribution of this research to scholarship and education in the healthcare field.

8.3 Contribution of the Research (Scholarship and Education)

As a nurse educator, I am significantly involved in research and evidence-based practice and found it challenging to transition into and between a nurse researcher role and a nurse educator role. These difficulties can affect one's sense of professional identity and clarity of the educator and researcher. This required me to develop a capacity to navigate the dual identities during the transition into a researcher and to critically reflect and examine both aspects of my professional roles. It facilitates my examination of thoughts and feelings at the time of this research, living through the first wave of Covid-19 and continuing to work in nurse education while conducting this research, as explored through the critical reflection journalling below. This brings us back to the immediacy of healthcare provision during the initial period of Covid-19 in 2020.

Easter Reflection Living in Lockdown (April 2020)

Usually, Easter marks the beginning of a new epoch: a time for healing and restoring dignity for all. Easter Sunday morning has no celebrations this year; there were 14 deaths, 727 positive cases, a total of 334 deaths and 9,655 confirmed cases on this island.

There is this overwhelming grief for those who are ill, those who are dying, and those who are mourning. The stories I am hearing and listening to from my colleagues and students of patients dying alone and families not allowed access to visit them for fear of spreading the virus. I wish and hope next year will be different for all those.

Reflecting on the consequences of this pandemic, I have to remind myself that we are still in our initial stages. There are many questions and uncertainties about the future. If I were to think about this deeply, it would be disconcerting.

We are only beginning to understand that this pandemic was born from viruses found in all living organisms with which we share creation. I am only beginning to understand the fundamental importance of building a new life that respects the balance on which all life rests,

Scientists, research doctors, nurse caregivers, and political decision-makers who serve the common good and the poor are carrying the burden of the future.

As a nurse educator, I hold onto my professional identity, viewing the researcher's identity as complementary to my initial nurse professional identity. Both dual-professional identities connect healthcare and research, but they also create challenges for me, which I now recognise need more attentive critical reflectivity. At the time, I was overwhelmed by the scale of death and grief, and unclear why I was reflecting:

Dark Day (2020)

We cannot protect our front-line workers; I am thinking of the respiratory nurse from past and current educational programmes and all my friends working in healthcare. We cannot protect patients who seek care. The lack of access to testing cannot be what kills people. What can be done if people do not have access to testing? It is so difficult when you hear research data from just one single day in this country. Today, the most significant number of people lost their lives to Covid-19. 30 of those 41 people who died had underlying conditions.

My research journey reveals the importance of more research and critical reflectivity being developed to examine the path from nurse educator to researcher and how this impacts their professional nurse educator identity. The depth of emotion and commitment to nurses and patients evident in the Dark Day reflection illustrate the commitment and insight I can bring as a practitioner-researcher who has a deep experience of practice. As nurse researchers are becoming commonplace in healthcare, research education programmes need to include strategies to help nurse researchers navigate their nurse educator and researcher identities.

This is vital for developing a stronger research basis for the unique knowledge basis of advanced nursing practitioners that this research demonstrates.

8.4 Reflection on this Research

My Thoughts on Dark Day

This research had a profound experience on me as a person, nurse, researcher, and educator. There were a lot of tears while listening over audio and reading my participant's transcripts, and there were moments of laughter and solitude where you had to step away and reflect on yourself. At times, my supervisor was my counsellor. It's true to say that in undertaking this research, I was forced out of my comfort zone, e.g., using digital platforms to conduct my interviews online and having research discussions with my classmates and supervisors as Covid-19 prevented us from in-person interactions. Covid-19 surrounded me as an educator, and I was delivering a respiratory nursing programme. As a nurse, I was swabbing individuals for Covid-19 before vaccinations when there were huge unknowns; what would happen next? I was researching experiences of respiratory CNS/ANPs where Covid-19 was part of every interview. Not to mention family life and the fear of bringing Covid-19 home. Although my research journey is coming to an end, I will likely revisit elements as time goes by, as parts of the findings will require revisiting to seek additional experiences and understandings. I expect to use the knowledge and experiences gained to embark on other research paths, as I hope to use my experiences for future research.

In addition to providing direction for further research and education, practice and policy, this research contributes significantly to what is known about the role of respiratory CNS/ANPs and the experiences of working in respiratory care during the first wave of the Covid-19 pandemic. No previously published work has specifically focused on respiratory CNS/ANPs, and the findings emerging are significant, as discussed in section 8.2. The findings provide a rich account of how respiratory CNS/ANPs can empower practitioners and enhance their professional identity and their capacity for agency. Their contribution to continued nursing professionalisation also emerges clearly. What is particularly illuminating, though, are the factors that can influence the extent to which professional identity, power and agency can be achieved. Sharing these accounts of learning with their fellow practitioners and contributing to

and becoming researchers is a vital part of practitioner research and the communities of practice suggested in section 8.2.1.1.

8.4.1 The Significance of Relationships and Process for Practitioner Research

Participants of this study knew about my involvement in the respiratory nursing education programme. As an educator, I would have shared aspects of my professional nursing life with students in classroom settings, offering realism to our exchanges and reducing the power difference (Dickson-Swift et al., 2006). Therefore, I was not a total stranger to some of the participants in the study. There may be a probability that the experiences participants shared may have been subjective as a result of their past collaboration and perceptions of me as a nurse and nurse educator (Richards & Emslie, 2000). On the other hand, past collaboration, perception and relationships could have inspired them to participate in the study and simplified the sharing of their lived experiences (McConnell-Henry et al., 2010). This sharing of experiences may not have occurred had they not known me and knew there would be a high level of trust. This capacity for shared connection and understanding was vital as this was the first time these participants shared their stories at a time when the world was dealing with an unprecedented pandemic.

My own curiosity initially guided the research. The qualitative interview approach allowed the participants' interests and issues of concern to be explored and analysed. I feel this successfully established the participants' voices and experiences to the fore of the research. Thus, power was rebalanced to some extent, resulting from the co-constructing of shared knowledge with nurse practitioners using a social constructivism paradigm. Though the research was initially guided by my own interest in the field, the semi-structured interview approach allowed the participants' experiences and issues of concern to be made known. This shared positionality, and common understanding is core for research such as this, which seeks to explore practitioner knowledge.

Dissemination of work undertaken as part of this Doctorate has already begun. Several presentations were made at various nursing and educational conferences, including the 6th Sigma Biennial European Conference hosted by Omega Epsilon at-Large Chapter of Sigma in Ireland in partnership with RCSI University of Medicine and Health Sciences held in June 2022 and the European Respiratory Society (ERS) International Congress held in September 2022, Barcelona, Spain. Findings from the thesis were presented at the Irish Respiratory Nursing Association Conference in the spring of 2023. A paper focusing on digital platforms while conducting research during a pandemic with respiratory nurse specialists was published in the Nursing Times in 2022. Further publications are currently being planned over the coming year, including an article focusing on professional identity and education preparation for specialist respiratory nurses, as well as other healthcare and educational journals and conferences. These intend to share experiences and learn from this research.

8.5 Conclusion

This study explored the experiences of respiratory CNS/ANPs working in Irish healthcare environments at a unique time when the Covid-19 pandemic profoundly impacted nursing and nurse education in higher education and clinical healthcare environments. Completing this study has developed my research competencies and my own teaching and nurse education practice. I believe this was achieved through critical reflective practice, examination of the literature and research of participants' experiences, and reflection on my practice. As a hesitant academic who arrived at higher education in 2014 due to professional, personal, and family circumstances, I developed a deeper appreciation for education and teaching. I recognised the importance of higher education in empowering our nurses to make their way through professional life. Critical reflection on my own education practice enhanced my teaching and learner engagement. As a social constructivist educator, I endeavour for an inclusive classroom where each student's skill, learning and knowledge are valued and used as a teaching and learning tool in all learning environments.

I believe that curriculum development should align with the respiratory nursing needs within contemporary healthcare demands, with the integration of competencies, evidence-based practice, and specialised training in the following areas:

- Integration of Competencies: through a forward-looking respiratory nursing curriculum that intricately weaves core competencies such as patient assessment, critical thinking, and interdisciplinary collaboration.
- Evidence-Based Practice and Specialised Training in Technological Advancements: the curriculum equips respiratory nurses with the ability to synthesise the latest research and clinical evidence, fostering a culture of evidence-based decision-making.
- Respiratory Healthcare Disparities and Community Care: respiratory nursing education includes an emphasis on understanding and mitigating healthcare disparities among diverse populations. Integrating community-focused care models into the curriculum enables nurses to provide culturally sensitive, patient-centred interventions, thereby promoting equitable respiratory healthcare access and outcomes for all.
- Professional Tensions and Policy Development: acknowledging and addressing professional tensions within the healthcare system, such as professional emotions, role conflicts and interprofessional dynamics in teamwork, is vital. The curriculum should also delve into healthcare policies and regulations, empowering respiratory nurses to advocate for patient-centred policies, contribute to policy development, and navigate the regulatory landscape to improve respiratory care standards.

As I continue and enter the next stage of my professional career as an educator and researcher, I seek to create an inclusive classroom for respiratory CNS and ANP students that makes them feel valued and provides them with opportunities to critically collaborate and learn in preparation to meet the contemporary healthcare demands in providing high-quality care in a rapidly evolving respiratory healthcare environment.

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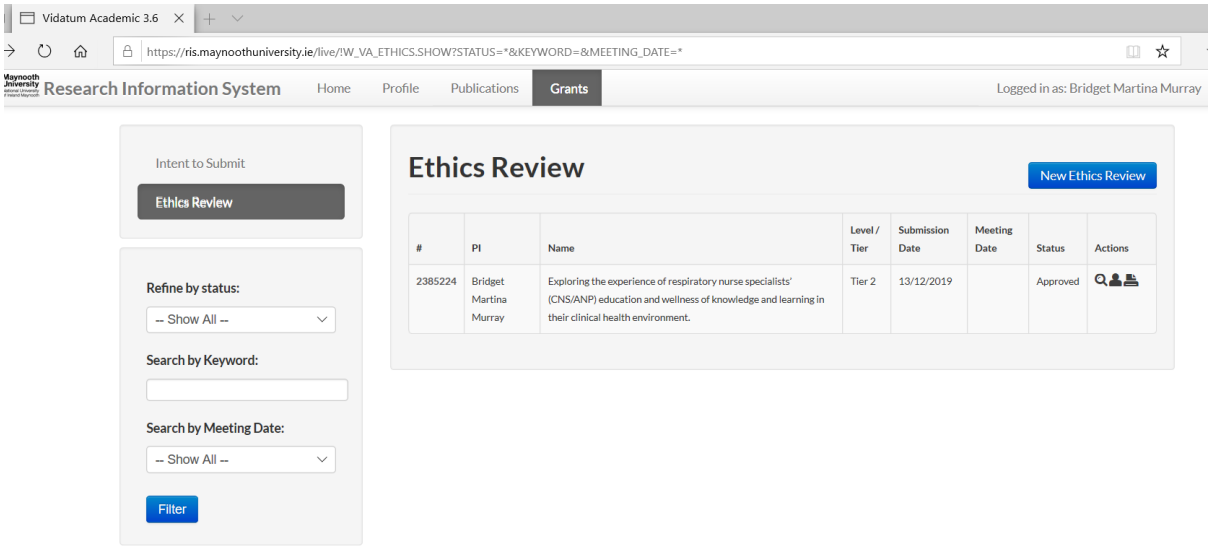
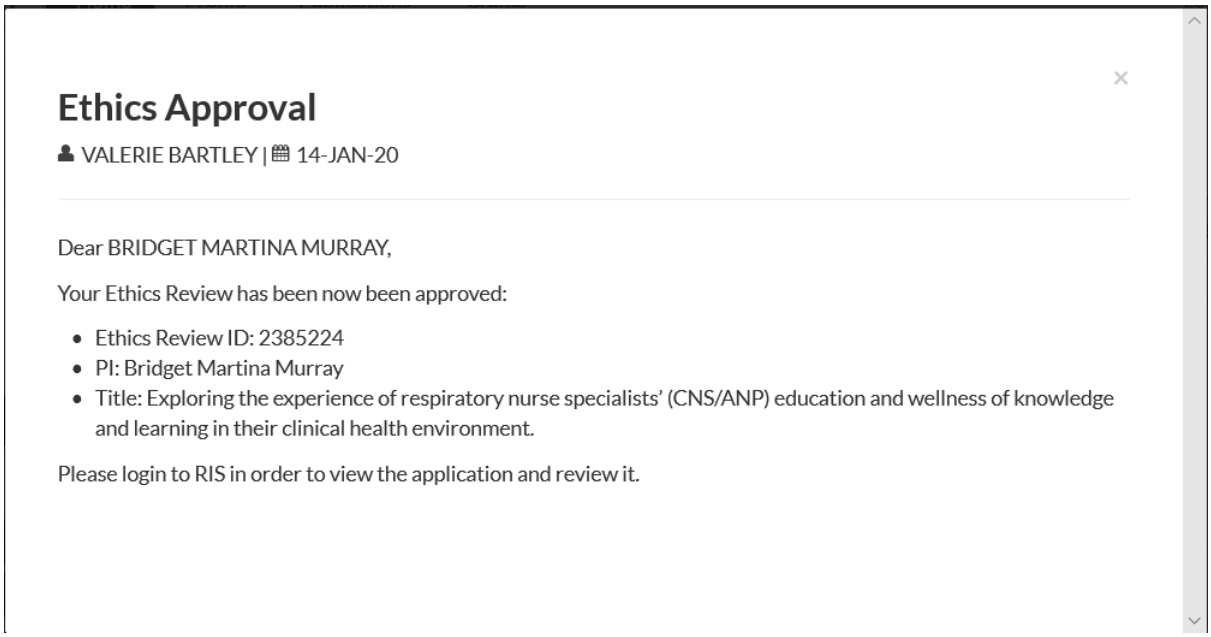
Appendices

Appendix A: Ethical Approval Maynooth University



Appendix B: Ethical Approval RCSI University of Medical and Health Sciences



Ethics Approval

VALERIE BARTLEY | 14-JAN-20

Dear BRIDGET MARTINA MURRAY,

Your Ethics Review has been now been approved:

- Ethics Review ID: 2385224
- PI: Bridget Martina Murray
- Title: Exploring the experience of respiratory nurse specialists' (CNS/ANP) education and wellness of knowledge and learning in their clinical health environment.

Please login to RIS in order to view the application and review it.

Appendix C: Information Sheet

INFORMATION FOR RESEARCH PARTICIPANTS

- *The aim of this form is to facilitate informed consent by communicating with participants in language that they can understand.*
- *Please adapt depending on whether participants are children or adults and for the type of interaction you are proposing, e.g., survey, interview, focus groups etc.*
- *If participants are not native English speakers translate this information sheet appropriately*

The material below is a sample –Adapt it to fit the circumstances of your own study. Some of the sample text below assumes a study involving qualitative interview data. If that's not your methodology, adapt the text to the approach you are using.

Information Sheet

Purpose of the Study. I am Bridget Murray, a doctoral student, in the Department of Adult Education, Maynooth University. As part of the requirements for doctorate, I am undertaking a research study` under the supervision of Dr Bernie Grummell.

This study looks to understand how the educational remit of respiratory nurse specialists (CNS/ANP) enhances practice development, adds to knowledge-based practice, and contributes to learning and education in the sector while fostering their own and others' wellness.

What will the study involve? The study will involve you agreeing to participate in one-to-one interview which is semi-structured and conversational in nature about your experiences as a respiratory nurse specialist. Interviews will last no longer than 1 hour. Interviews will be audio recorded and transcribed. Transcripts will be provided to participants to review and verify the accuracy of their interview.

Who has approved this study? This study has been reviewed and received ethical approval from Maynooth University Research Ethics committee. You may have a copy of this approval if you request it.

Why have you been asked to take part? You have responded to information about the research which was distributed by ANÁIL. The research is being conducted amongst respiratory nurse specialists (CNS/ANP) from many health care clinical settings, from all over Ireland. All participants are currently working in respiratory care.

Do you have to take part?

No, you are under no obligation whatsoever to take part in this research. However, I hope that you will agree to take part and give us some of your time to participate one to one semi structured interview with me as the researcher. It is entirely up to you to decide whether or not you would like to take part. If you decide to do so, you will be asked to sign a consent form and given a copy and the information sheet for your own records. If you decide to take part, you are still free to withdraw at any time without giving a reason and/or to withdraw your information up until such time as the research findings are anonymised. A decision to withdraw at any time, or a decision not to take part, will not affect your relationships with Maynooth University or the Royal College of Surgeons Ireland.

What information will be collected? Interviews will be audio recorded and transcribed. Transcripts will be provided to participants to review and verify the accuracy of their interview.

Prior to the study commencing, a pilot interview will be undertaken to ensure that questions posed are appropriate and allow for deep exploration. Content analysis of transcripts will be undertaken, and a series of categories will be identified. These categories will be scrutinised for emergent themes.

Will your participation in the study be kept confidential? Yes, all information that is collected about you during the course of the research will be kept confidential. No names or identifying markers will be identified at any time. All hard copy information will be held in a locked cabinet at the researchers' place of work, electronic information will be encrypted and held securely on MU PC or servers and will be accessed only by Bridget Murray.

No information will be distributed to any other unauthorised individual or third party. If you so wish, the data that you provide can also be made available to you at your own discretion.

'It must be recognised that, in some circumstances, confidentiality of research data and records may be overridden by courts in the event of litigation or in the course of investigation by lawful authority. In such circumstances the University will take all reasonable steps within law to ensure that confidentiality is maintained to the greatest possible extent.'

What will happen to the information which you give? All the information you provide will be kept at Maynooth University in such a way that it will not be possible to identify you. On completion of the research, the data will be retained on the MU server. After ten years, all data will be destroyed (by the PI). Manual data will be shredded confidentially, and electronic data will be reformatted or overwritten by the PI in Maynooth University.

What will happen to the results? The research will be written up and presented as a report at a national conference and may be published. A copy of the research findings will be made available to you upon request and will be offered as a presentation through ANÁIL.

What are the possible disadvantages of taking part? I don't envisage any negative consequences for you in taking part or It is possible that talking about your experience may cause some distress.

What if there is a problem? At the end of the interview, I will discuss with you how you found the experience and how you are feeling. If you experience any distress following the interview you may contact the HSE Employee Assistance and Counselling Service (https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/employee-assistance-and-counselling-service/). You may contact my supervisor Dr Bernie Grummell at bernie.grummell@nuim.ie if you feel the research has not been carried out as described above.

Any further queries? If you need any further information, you can contact me:

Name: Bridget Murray
Phone No: 01 402 5195 (office hours)
Email: bridget.murray.2019@mumail.ie

If you agree to take part in the study, please complete and sign the consent form overleaf.

Thank you for taking the time to read this

Appendix D: Consent Form

CONSENT FORM FOR RESEARCH PARTICIPANTS

I……agree to participate in Bridget Murray's research study titled Exploring the experience of respiratory nurse specialist's (CNS/ANP) education and wellbeing on knowledge and learning in their clinical health environment.

Please tick each statement below:

The purpose and nature of the study has been explained to me verbally & in writing. I've been able to ask questions, which were answered satisfactorily. ☐

I am participating voluntarily. ☐

I give permission for my interview with Bridget Murray to be audio recorded and that I have the right to review and edit any transcripts to which I have contributed. ☐

I understand that I can withdraw from the study, without repercussions, at any time, whether that is before it starts or while I am participating. ☐

I understand that I can withdraw permission to use the data right up to the point of submission of doctoral thesis April 2021. ☐

It has been explained to me how my data will be managed and that I may access it on request.

☐

I understand the limits of confidentiality as described in the information sheet ☐

I understand that my data, in an anonymous format, may be used in further research projects and any subsequent publications if I give permission below: ☐

[Select as appropriate]

I agree to quotation/publication of extracts from my interview ☐

I do not agree to quotation/publication of extracts from my interview ☐

I agree for my data to be used for further research projects ☐

I do not agree for my data to be used for further research projects ☐

I agree for my data, once anonymised, to be retained indefinitely in the IQDA archive ☐

Signed……. Date…….

Participant Name in block capitals ……...

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.

Signed……. Date…….

Researcher Name in block capitals ……...

If during your participation in this study you feel the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the Maynooth University Ethics Committee at research.ethics@mu.ie or +353 (0)1 708 6019. Please be assured that your concerns will be dealt with in a sensitive manner.

For your information the Data Controller for this research project is Maynooth University, Maynooth, Co. Kildare. Maynooth University Data Protection officer is Ann McKeon in Humanity house, room 17, who can be contacted at ann.mckeon@mu.ie. Maynooth University Data Privacy policies can be found at *https://www.maynoothuniversity.ie/data-protection*.

Two copies to be made: 1 for participant, 1 for PI

Appendix E: Invitation to Participate Flyer

Invitation to Participate

An invitation for Respiratory Nurse Specialist (CNS/ANP) to participate in a study as part of a Doctorate Programme in Maynooth University.

Title:

Exploring the experience of respiratory nurse specialist's (CNS/ANP) education and wellbeing on knowledge and learning in their clinical health environment

Purpose:

Respiratory nurse specialists undertake specific educational respiratory related programs and this study looks to understand how the educational remit enhances practice development, adds to knowledge-based practice, contributes to learning and education in the sector while fostering their own and others' wellness.

Participation will involve a 1-hour long interview on your experiences with the researcher which will contribute to the body of knowledge in relation to the education and wellbeing of respiratory nurse specialists.

All information will be securely stored and guided by Maynooth University research ethics processes.

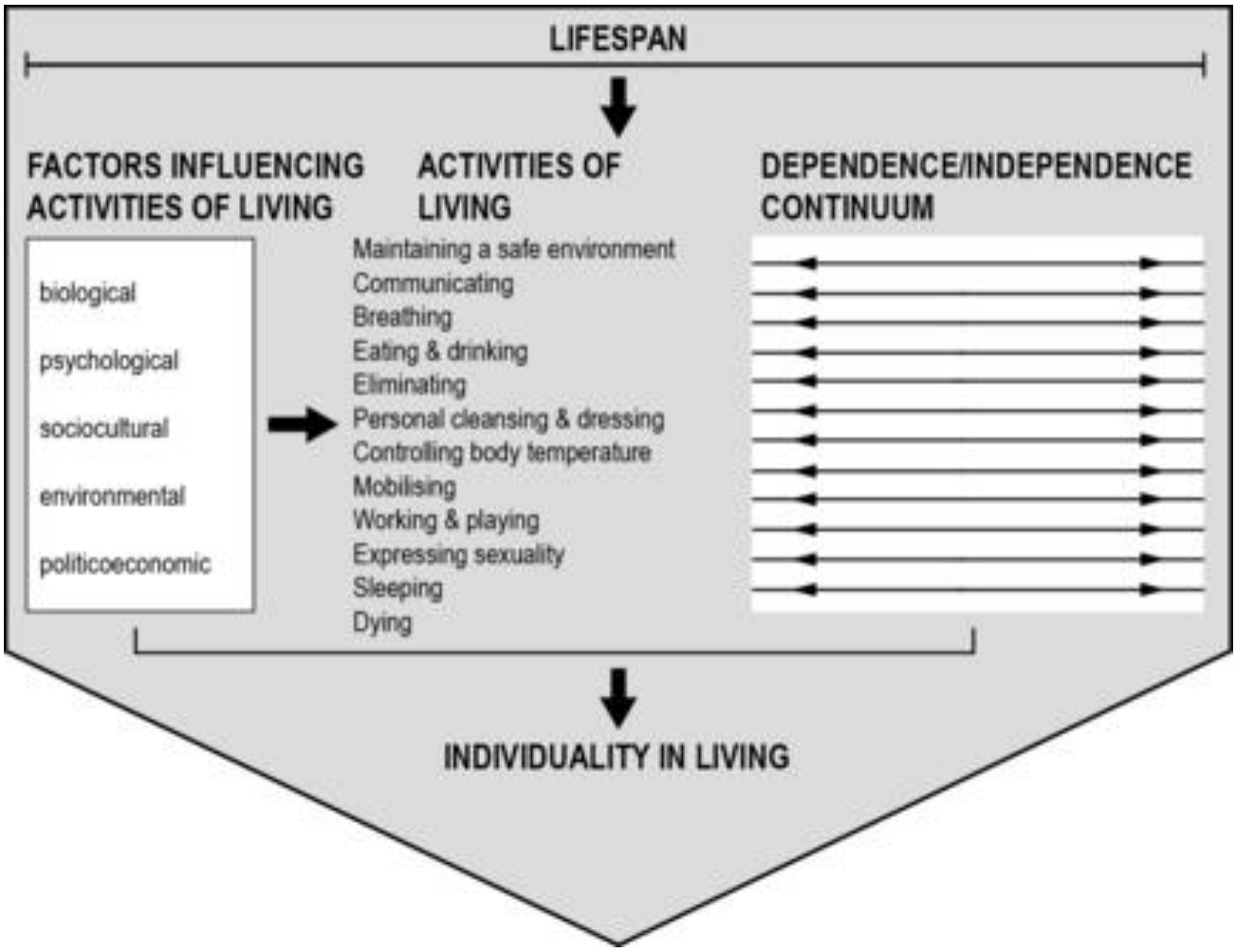
Commencement Date: Summer 2020

If there is anyone who would be interested, please contact details below.

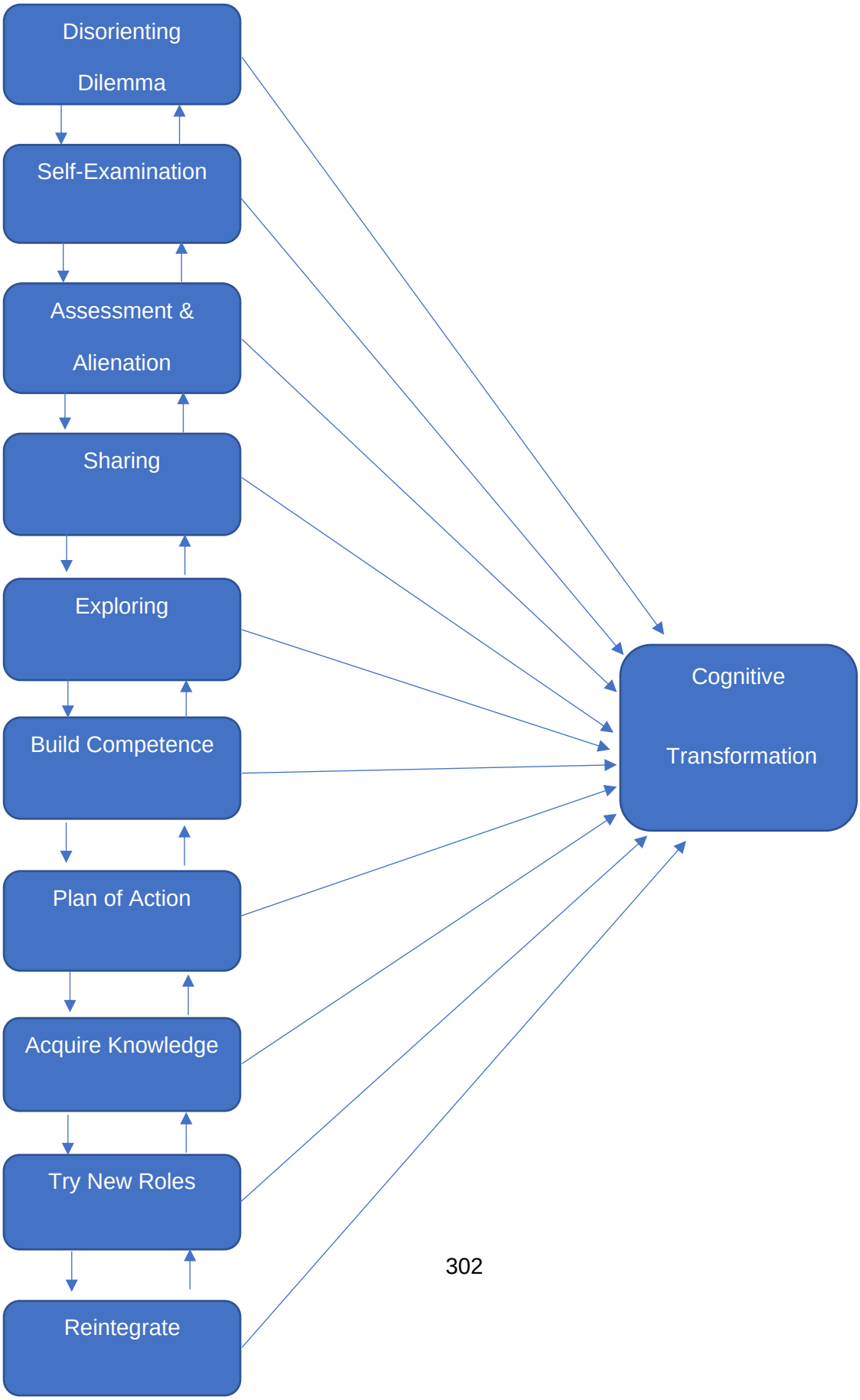
Maynooth University
National University of Ireland Maynooth

Bridget Murray
Doctorate in Higher and Adult Education Programme
Maynooth University
[redacted]@mumail.ie

Appendix F: Roper-Logan-Tierney Model of Nursing Based on Activities of Living (Roper, Logan, & Tierney, 2000)



Appendix G: Original 10 Phases of Mezirow's (1978) Model of Transformative Learning



Appendix H: ANÁIL Members Profile 2021 (ANÁIL, 2021)