THE UNIQUE KNOWING OF DISTRICT NURSES IN PRACTICE

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Abstract

Several issues have impacted on district nursing practice and education within the UK, which can be conceptualised within four main areas: national policy; local organisational structures and practice; professional and disciplinary theory; and practice of individuals (Bergen and While 2005). However, there has been a lack of direction in district nursing in recent years within the UK, with a decline in the number of district nurses being educated (Queen's Nursing Institute 2014a) and the educational standards supporting district nurse education being over 20 years out of date (Nursing and Midwifery Council 2001). In addition to this, the standards of education for pre-registration nursing (Nursing and Midwifery Council 2010) have supported a graduate workforce with an increasing focus on nursing in the community. This was identified as a consideration for me as an educator when examining the future educational requirements of nurses beyond the point of registration in the community, and became the focus of this study.

Knowing in practice is a key concept within this thesis, that is, the particular awareness that underpins the being and doing of a district nurse in practice (Chinn and Kramer 2008). This study explores the unique knowing of district nursing in practice, and how this professional knowing is developed. Understanding the knowing of district nurses and how this is developed will contribute to future educational frameworks and ways of supporting professional development within community nursing practice. A question that is often asked is what makes district nurse knowing different from nursing in inpatient settings, and this emerges in this thesis.

A qualitative study using an interpretative approach within a case study design was adopted using three Health Boards within Scotland as the cases. Within each Health Board area, interviews were undertaken with key informants and also, group interviews with district nurses were undertaken using photo elicitation as a focussing exercise. The data were analysed using framework

analysis (Spencer et al. 2003). This approach illuminated a depth and breadth of knowing in district nurse practice and how this knowing is developed.

The study findings depict the complexity of knowing in district nursing, acknowledging the advancing role of district nursing practice, where the context of care is an essential consideration. The unique knowing can be described as a landscape that the district nurse must travel: crossing a variety of socio-economic areas; entering the private space of individuals, and the public space of communities; as well as acknowledging professional practice; navigating the policy agenda while maintaining clinical person-centred care; and leading others across the terrain of interprofessional working. The unique knowing in practice that characterises the expertise of district nurses is a matrix of elements that incorporates different aspects of knowing that contribute to leadership, as suggested by Jackson et al. (2009).

The participants in this study recognised that due to the complexity of the district nurse role, and its continuing advancements, that district nurse education needs to move to a Master's level preparation and it needs to continue to be supported by a suitably qualified practice teacher. Furthermore, the findings within this study demonstrate that the development of the unique knowing in district nurses does not happen in isolation and it is very complex. It consists of networks, conversations, engagement with policy, understanding of professional contexts, adhering to organisational boundaries, and interaction with complex and challenging situations. Theory and practice are mutually dependent on each other; change is inevitable and is unpredictable; and practices change by having experiences, therefore change is integral to practice. Consequently, it was concluded that the interdependent elements, which interact, develop the unique knowing of district nurses in practice.

Finally this thesis makes recommendations and discusses future implications for policy, practice and research.

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Chapter - 1 Introduction

1.1 Introduction

The purpose of this study was to explore an aspect of my professional practice that has been of significant interest to me in recent years: the unique knowing of district nurses and how this knowing is developed within education and practice. District nurses are qualified nurses who have undertaken a further graduate specialist programme to autonomously lead a team to deliver nursing care in the community (Department of Health (DH) 2013). In this context the term unique knowing can be summarised as the particular awareness that underpins the being and doing of a district nurse in practice whereas knowledge is knowing that can be expressed and articulated to others (Chinn and Kramer 2008). In using the word unique I do not mean to suggest the knowing is qualitative to the role of the district nurse, but instead, that it is specific to their practice. Since moving into education in 2002 from a previous role as a district nurse team leader, I have become increasingly aware of tensions between the concept of practice-based knowing and how it is developed within district nursing to meet the needs of the policy agenda, and the changing context of health and social care. Having an understanding of the unique knowing of district nurses and how it is developed will ensure that education is progressed accordingly.

As an educator I have had a wide experience in planning, delivering, assessing and evaluating nurse education. Initially, I worked in both pre- and post-registration nurse education, and then focussed on post-registration nurse education for nurses working in the community. More recently, I have led postgraduate education within the School of Nursing and Midwifery at Robert Gordon University, Aberdeen. Throughout these experiences I have emphasised the importance of moral and professional responsibility to ensure that nurse education enables practitioners to become competent, capable and 'fit to practise' to address healthcare needs of individuals, families and communities (Scottish Government (SG) 2013a; SG 2013b; NHS Education for Scotland (NES) 2011a, 2011b; Nursing and Midwifery Council (NMC) 2010;

Scottish Executive (SE) 2006b; NMC 2001; United Kingdom Central Council for Nursing and Midwifery (UKCC) 1999).

Recent public enquiries into healthcare services, such as those led by Maclean (2014), Francis (The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013), Keogh (2013) and Berwick (National Advisory Group on the Safety of Patients in England 2013), all reinforce the importance of quality, person-centred care and imply the importance of education. All these reports focussed on failings within the acute sector of the National Health Service (NHS) rather than in the community and within district nursing. Additionally, these reports must be reviewed with caution, as it is recognised that some of the recommendations about best practice within them are unsubstantiated from the body of evidential material from the enquiries, and appear to be influenced by assumptions that are not made explicit within the reports. Nevertheless, it is clear that many of the findings could equally be applicable to other areas of the NHS, and to community nursing practice and education. For example, Francis identifies that high quality education is a driver for improving the culture of the NHS.

In Scotland, the Chief Nurse, in her review of nurse and midwifery education in 2012, in relation to the aim of meeting the Scottish Government's strategic direction for health and social care, and supporting its quality ambitions (SG 2013a; SG 2013b; SG 2010), reported that:

> This can only be delivered by a workforce that is confident, competent and caring with access to the best education and development (SG 2014).

It is often asked what makes district nursing knowing different from nursing in inpatient settings that it would require additional education (Dickson et al. 2011b). One fundamental difference is that in hospitals there is twenty-four hour care and monitoring, provided by a team of practitioners working within a defined area, whereas district nursing is unable to provide twenty-four hour care and is often described as a 'ward without walls' (Haycock-Stuart et al. 2008) in

that capacity is never reached within a defined population. Care in the community is delivered frequently by lone workers to a population who, as well as being vulnerable for the same reasons as inpatients, have the added dimension of the diversities of the community within which they live. The interrelated components of poverty, social exclusion and health inequalities from each individual's home circumstances all need to be considered when assessing and managing care in the community (DH 2013). It is district nurses who are accountable for safeguarding these vulnerable patients on their caseload and they must delegate appropriately to staff that have the capability and capacity to address individuals' care needs (RCN 2013). Therefore, it is the district nurse who is the decision-maker and who is ultimately accountable for the quality of nursing care being delivered twenty-four hours a day, seven days a week, in the community setting.

The Department of Health (DH 2013) recently developed a vision and service model for district nursing and the Royal College of Nursing (RCN 2013) has published a position statement highlighting current challenges. However, educational standards for post-registration district nurse education (NMC 2001) remain out-dated. The UKCC first published these educational standards in 1994. When the UKCC was replaced in 2001 by the NMC, the standards were rebranded to the NMC but there were no changes made to their content. These standards are not thought to reflect the requirements of contemporary community nursing (Queen's Nursing Institute (QNI) 2014a, 2014b, 2013a; Dickson et al. 2011a).

The out-dated educational standards (NMC 2001) and the lack of research in relation to traditional post-registration nurse education have had a direct impact on the provision of education. Some employers have looked at alternative options for the educational preparation of community nurses, in particular, district nurses (QNI 2013a). The consideration of alternative options has been compounded by the challenge to release nursing staff to undertake professional development within current resources, which has resulted in a return to an apprenticeship model of continuing professional development within community nursing in some areas of the UK, including Scotland (Cook et al. 2011; Dickson

et al. 2011a). In Scotland, it is recognised that there is an absence of a national infrastructure to support post-registration and postgraduate nurse education (SG 2014). This lack of direction has resulted in the withdrawal of some district nursing programmes (SG 2014) and to inconsistencies across the UK in the education and development of registered nurses working in the community (QNI 2013a).

It is worth noting at this point that often the term ‘district nurse’ can be used interchangeably in the literature with the term ‘community nurse’. To ensure clarity throughout this thesis, the community nurse is defined as a registered nurse working in the community without a further post-registration qualification and the district nurse is a registered nurse with a graduate-level education and specialist practitioner qualification, recorded with the NMC (2001). The district nurse is therefore qualified to assume additional accountability such as leading teams of practitioners in the community.

This study aimed to explore the unique knowing of district nurses in practice, and how this professional knowing is developed. Understanding the knowing of district nurses and how this is developed will contribute to future educational frameworks and ways of supporting professional development within district nursing practice. Therefore there is the potential for this study to make contributions to practice, policy and research. This chapter will now provide the background to my study from both a policy and professional perspective, introduce the research questions, and then discuss my position in the study.

1.2 Policy Context: Trends Influencing District Nurse Education

Several issues have impacted on district nursing practice and education over recent years within the UK. Changing demography and disease patterns, the increasing number of people living with long-term conditions, and the increasingly complex needs of an aging population have resulted in a changing focus on the way health services are delivered (Public Bodies (Joint Working) (Scotland) Act 2014; SG 2013b; Welsh Assembly Government (WAG) 2013; Balanda et al. 2010; DH 2010a; SG 2009; WAG 2007; DH 2005b). Government

policy across the UK reinforces the requirement to prepare practitioners to work in the community in a variety of ways and settings, and to meet the changing needs of the population within financial restraints whilst acknowledging the aging workforce.

There are also a number of policies and strategies that have attempted to influence changes to be adopted in practice delivery, such as Scotland's *National Dementia Strategy* (SG 2013c), *Reshaping Care for Older People: A Programme for Change 2011-2021* (SG 2011b), *Equity and Excellence, Liberating the NHS* (DH 2010a), *Better Health, Better Care,* (SG 2007), *Supporting People with Long Term Conditions* (DH 2005a, 2005b, 2005c), *Visible, Accessible Integrated Care: A Report of the Review of Nursing in the Community* (SE 2006b), and *The National Health Service Knowledge and Skills Framework* (KSF)(DH 2004). These policies emphasise the message that people have the right to a choice of locally-based services from practitioners who are highly experienced and educated. There are some differences in approach among the policies of the four UK countries, partly due to population demographics, but also as a result of the differing political stances since devolution. However, all the policies have a shared philosophy; that keeping people out of hospital is preferable and the shift in the balance of care to the community setting is imperative (Bain and Adams 2011).

Considering the implications of the policy context for primary care throughout the UK, the implementation of change requires support and action from all partners within both health and social care. This has resulted in the four countries in the UK shifting towards the integration of health and social care rather than have them as independent organisations (Ham et al. 2013; Goodwin et al. 2012). In England, unlike Scotland and Northern Ireland, health and social services have not merged, but there is currently a range of contractual models being developed and implemented across England (Addicott 2014). The aim of the integration of health and social care in Scotland is to address the shift in the balance of care in combination with the quality agenda (Public Bodies (Joint Working) (Scotland) Act 2014). It is envisaged that the integration of services will promote improved outcomes by providing consistency in the quality of

services, ensuring people are not unnecessarily delayed in hospital and maintaining independence by creating services that allow people to stay safely at home. The integration of health and social care will result in a shift of roles and responsibilities of professionals and this will include some challenges such as the professional aspects of accountability, and the potential delegated authority that will be required for the implementation of this agenda (RCN 2014). However, community nursing, including district nurses, has a unique opportunity to contribute to this policy agenda by developing partnerships and case management approaches to care delivery in the community (DH 2013; RCN 2013; Dickson et al. 2011a).

1.3 Professional Context: the Current Role and Education of the District Nurse

1.3.1 Professional Regulation

In the UK the NMC exists to safeguard the health and well-being of the public through regulation of all nurses and midwives. As part of this role they promote standards of education and practice, maintain a register of those who meet these standards and take action when a registrant's fitness to practise is questioned (NMC 2014). The standards of education and practice are required to be met by all nursing and midwifery students on NMC-approved programmes at both pre- and post-registration levels prior to their entry into the relevant part of the register (NMC 2010; NMC 2008; NMC 2006; NMC 2004; NMC 2001).

1.3.2 District Nursing

Traditionally, in the United Kingdom, community nursing has consisted of three main roles: practice nursing; district nursing; and health visiting. Community staff nurses and health care support workers support these roles. Within Scotland the role of the health visitor was integrated with the role of the school nurse and they were known as specialist community public health nurses between 2001 and 2013 (SE 2001). More recently, the Scottish Government, in response to the *Children and Young People (Scotland) Bill* (2013), has returned to using the titles 'health visitor' and 'school nurse' rather than the title

‘specialist community public health nurse’ (Moore 2013). General medical practitioners mainly employ the practice nurses, whereas the NHS Boards directly employ district nurses, health visitors and school nurses. District nurses, as defined earlier, are registered nurses who have undergone additional post-registration education to achieve a recognised district nurse qualification (NMC 2001).

The Department of Health (2013), in a recent statement of vision, has confirmed that this classification for district nurse is still applicable. District nurses are normally employed as Band 6 of the NHS KSF, or Band 7 if they have the role of team leader (DH 2004). Appendix 1 provides an illustration of the career framework levels (Skills for Health 2010). Definitions of the district nurse role are varied and demonstrate the increasing complexity of nursing in the community; there are many inconsistencies. The definition given by the ADNE (2014, n.p.) reflects the holistic nature of the district nurse role:

> The district nurse is accountable for the care and care planning for individuals and carers with a range of needs, including the management of those with complex needs. In addition to holistic needs assessment and the skilled care of individuals, district nurses undertake service review and health needs assessment with the aim of co-ordinating or influencing the development of services.

The specialist nature of the district nurse role is explicit in this definition. Considering the standards of education where there is a requirement for 50% theory and 50% practice within a programme of education (NMC 2001), it is implied that clinical nursing expertise develops from both theoretical learning and practice exposure. District nurses build on the knowledge and skills from their pre-registration preparation (NMC 2010), followed by consolidation, before undertaking a recognised post-registration course (NMC 2001). The above definition also reflects the district nurse’s leadership role, both in terms of service redesign and leading teams. The district nurse is said to work autonomously and exercise higher levels of judgement and decision-making in clinical care (NMC 2001) beyond that expected of a nurse at initial registration.

Therefore, a further consideration is the NMC's educational standards that support both pre-registration and post-registration nursing referred to above. Since the publication of the *Standards of Specialist Education and Practice* in 1994, post-registration community disciplines, including community mental health nursing, community learning disability nursing, general practice nursing, community children's nursing, occupational nursing, health visiting and school nursing, all adhered to these standards (NMC 2001). These standards included generic and core elements depending on the area of community nursing practice. However, in 2004, the NMC created a third part to the professional register for specialist community public health nurses (SCPHN), which encompasses health visiting, school nursing, occupational health nursing and other public health nurse specialities, in the belief that public health work has distinct characteristics that require public protection, in that they work with both individuals and populations. This may involve making decisions on behalf of a population without having direct contact with every individual in that community. The development of the third part of the NMC register resulted in the publication of associated standards (NMC 2004). All existing health visitors, school nurses and occupational health nurses migrated onto this part of the register and all newly qualified specialist community public health nurses also register their qualification with the NMC on this third part. District nurses remain on the first part of the register for nurses, with a recordable, rather than registerable, qualification.

This anomaly remains, despite the considerable development of the district nurse role and the misplaced assumption that district nurses solely work with patients on an individual basis (DH 2013; RCN 2013; Toofany 2007). Family health nurses, a designation resulting from a pilot initiative in Scotland (Macduff and West 2003), have also been allocated to the third part of the register along with some other nursing roles. However, there does not appear to have been any consistency in such decisions (Dickson et al. 2011b). These decisions have created much debate amongst professionals, and have had an impact on education provision. This is because the educational standards for the third part of the register have different criteria from the previous ones and the ones to which the district nurses are still adhering (NMC 2004; NMC 2001).

In 2011, the NMC acknowledged that this is a ‘shambles’ and proposed to review it (Weir-Hughes 2011). However, in the last three years it is widely known that the NMC has had to reprioritise to deliver effective regulation in response to two major publications: the strategic review carried out by the Professional Standards Authority, and the publication of the Francis Inquiry (NMC 2013). In response to these reports, the NMC’s resulting corporate plan 2013-2016 aims to ensure that the NMC carries out its business effectively, so that it can better fulfil its primary role of protecting the public. Its six key priorities during this period are as follows:

- Continuing improvement to fitness to practise processes.
- Achieving financial stability.
- Ongoing review of registration policies and processes.
- Implementing a model for ensuring that nurses and midwives continue to be fit to practise.
- Delivering a robust engagement strategy.
- Continuing to improve and implement new NMC systems and processes.

As a result of this re-prioritisation, it is not envisaged that a review of post-registration educational standards will be undertaken in the near future by the NMC. This has implications for district nurse education, as, with recent policy changes, the NMC (2001) standards will become increasingly outmoded. Additionally, the NMC, as the one governing body for nurses and midwives in the UK, must take into account four different healthcare systems.

Higher Education Institutions (HEIs) have adapted their community nurse programmes to meet the changing needs of practice by taking cognisance of the required standards (NMC 2004; NMC 2001). Whilst many HEIs are utilising innovative and creative ways of meeting the standards for district nursing to reflect contemporary practice and the needs of the local National Health Service (NHS) Boards and Strategic Health Authorities (Cook et al. 2011; Dickson et al. 2011a, 2011b), this may potentially lead to an erosion in national professional standards, resulting in inconsistency – the very thing the standards

are intended to prevent. This situation poses challenges for practitioners, HEIs, Health Boards and Strategic Health Authorities alike, and out-dated standards (NMC 2001) do not send a positive message to practitioners, employers or the public. This lack of direction for the future education of district nurses by the NMC has resulted in divergence across the UK as employers have considered alternative roles and models of service delivery and supporting educational preparation such as community matrons to meet the policy agenda (DH 2005a). The decline in the number of practitioners accessing district nurse programmes in recent years reflects this trend (QNI 2013a). However, there is some indication, through the Association of District Nurse Educators (ADNE) and the QNI (2014b) report on district nurse education in the UK, that, following the publication of the DH (2013) vision, there has been an increase in the number of practitioners accessing district nurse programmes in the last year.

Whilst educational standards remain out-dated, the educative practices for district nurses will continue to diverge across the UK, as employers consider other alternatives. Given the current economic climate they may decide that a cheaper option to delivering clinical care at home is preferable or that other ways of educating nurses to undertake the role of the district nurse should be considered. Some areas have changed the skill mix of staff with an increase in the number of registered nurses and healthcare assistants, to support district nurses where there is a decline in the number of district nurses within geographical areas (QNI 2014a; QNI 2013a; QNI 2011; QNI 2009). Another consideration is the older age profile of current district nurses and planning the future workforce, when large numbers are due to retire in coming years (RCN 2013). The time to review future education for district nurses has arrived, especially when new pre-registration standards are now in place (NMC 2010).

The NMC Standards for pre-registration nursing (2010) contribute to a developing graduate workforce where all nursing graduates will join the register with a first degree as a minimum. This has implications for post-registration education where a greater proportion of the nursing workforce will require postgraduate education to practice at a higher level (SG 2014). However, the NMC (2001) standards do not reflect this change in academic levels and state

that programmes must be offered at a minimum of degree level. Therefore, educational programmes for district nurses can potentially be offered at the same academic level as a nurse at the point of registration. It is acknowledged that nursing is in a period of transition as it moves towards an all-graduate profession for its entire nursing workforce, but for post-registration standards to require the same academic level as pre-registration standards, the principles of lifelong learning and progression through the academic levels are not met (Scottish Credit Qualification Framework 2014).

Another aspect of the pre-registration standards is that they have been designed to ensure that nurses are better prepared to work in the community (NMC 2010), given findings that newly qualified nurses are often unprepared to work in the community (Cook 2010). These standards were designed to support the development of innovative community-focussed pre-registration programmes (Arnott 2010). However, whilst they may help develop nurses' understanding of the community context, it is unlikely that they will ensure that graduate nurses develop the complex skills and competencies needed to lead practice autonomously in the community. This is the reserve of nurses working beyond the level of initial registration. The Queen's Nursing Institute has acknowledged this and developed an online resource to support the transition of a qualified nurse moving to work in the community (QNI 2013b).

Another concern is that pre-registration educational standards are open to interpretation to allow for flexibility by both education providers and practice areas to develop programmes to suit local requirements. Goldsmith (2009), in the consultation phase of the pre-registration standards, took a different perspective and reported that there was no guarantee that there would be an equal number of community placements in comparison to the acute sector to prepare nurses adequately, resulting in an inequity of experience. Dickson et al. (2014), in their systematic literature review, found that the evidence to support the lack of community placements was anecdotal. However, they did acknowledge there were various innovative models of community placements throughout the country, but these tended to be on a small scale, at local level and dependent on individuals. It is evident that these differences will have

implications for future post-registration education, as there will be variations in community practice experience at the point of registration.

Both pre- and post-registration nursing programmes currently comprise 50% formal education (theory) and 50% learning in clinical settings (practice). Students are assessed in both theory and practice by suitably qualified individuals as identified by the NMC, including registered nurse teachers within HEIs; and mentors, sign-off mentors and practice teachers in practice (NMC 2010; NMC 2008; NMC 2001). This is quite a different path from that of community staff nurses, who follow the apprenticeship model. They are expected simply to learn the community nursing role from the district nurse team with which they are working. This model of work-based learning appears to be what some NHS Boards and Strategic Health Authorities have moved towards as they have chosen not to educate further district nurses (Dickson et al. 2011a). This apprenticeship model has no formally prescribed standards or competencies, and ways of working and delivering care are learned by following existing practices. This model poses a risk of the community nursing workforce becoming stale and stagnant, and of increasing divergence between the practices of local areas. However, to date there is limited evidence to either support or oppose such a model.

The QNI report published in 2011 highlighted the importance of the 'right nurse having the right skills' to meet patients' needs in the community and acknowledged the importance of education. Recent publications (QNI 2014a; DH 2013; QNI 2013a; RCN 2013; SG 2012a) all make reference to the district nurse qualification (NMC 2001) and these publications are discussed further in chapter 2. However, there is a need to consider three things: first, the evolving nature of the complex role of the district nurse within the current policy context; second, the unique knowing required to undertake this role; and finally, the processes of developing professional knowing following initial nurse registration. This study explored these three concepts and adopted a practice-based perspective examining district nurse knowing in its local context, acknowledging that knowledge is situated both in a practice and situated socially, whereas knowing is connected with doing in and through a practice

(Gherardi 2009; Orlikowski 2002). The concept of knowing will be explored further in chapter 2.

1.4 Research Questions

This research was developed following a review of the related literature and aimed to explore the unique knowing of district nurses in practice, and how this professional knowing is developed. Understanding the knowing required for professional practice and how this is developed is of great importance if district nurse education is to meet the needs of professional practice. Therefore, towards this aim, the following research questions were established:

- What is the unique knowing in practice that characterises the expertise of district nurses?
- How do different workplace elements help develop the unique knowing in practice of district nurses?
- What formal educational frameworks in curriculum and policy might best support the development of district nursing knowing?

1.5 Methodological approach

To address the identified research questions, this study was designed with an interpretative theoretical perspective and adopted a case study approach. Three National Health Service Boards in Scotland comprised the cases, and these were chosen to be studied to ensure that various perspectives were considered. The methodology and methods used will be discussed further in chapter 3.

1.6 Significance of the study

The outcomes of this study will be relevant to educators, district nurses, employers and policymakers. It offers fresh insights into the unique knowing in contemporary district nursing and how post-registration nurses working in the community develop this professional knowing. It is envisaged that the findings

will contribute to future educational frameworks and signpost new ways of supporting professional development within district nursing practice, as indicated earlier. It is outwith the scope of this study to consider the other community nurse disciplines, such as community mental health nurses, still adhering to the NMC (2001) educational standards, however, elements of this study may equally be applicable to other community nursing disciplines.

It is acknowledged that exploring the unique knowing of district nurses in practice, and how professional knowing is developed, is a complex concept within the continually shifting boundaries of the current political and professional context. It is recognised that there will be conflicting views of practice knowing and that district nurses at various stages of their professional journey may have different perspectives of knowing required for district nursing practices. Given the context of care within the National Health Service and the focus of government policy throughout the UK, the role of the district nurse has evolved and will continue to evolve to meet these challenges. This study will help make visible and explicit not only the dynamics of district nurses' knowing in practice in relation to other roles, but also the importance of recognising these as unique in health care service. Therefore, this study can contribute to policy and practice regardless of any system changes and substantial differences.

1.7 Understanding my Positionality

Being explicit about my position within this study is one of the most important factors that will influence the trustworthiness of the findings (Simons 2009). I did not come into this study uninformed, but rather, as a nurse, who has practised as a district nurse and team leader for several years before moving into education in 2002. Recently, I have been leading the education of district nursing at Robert Gordon University. My interest in how knowing is developed has grown in recent years, particularly since becoming chair of the ADNE, a UK organisation (www.adne.co.uk), and being a member of the Education Sub-Group for NHS Education for Scotland (NES), Modernising Nursing in the Community. In these roles I have become increasingly aware of the diversity of models of skill mix, within district nursing teams across the UK and of conflicting

opinions around the education of district nurses. I have become more aware of both the political and the NMC's influence on community nurse education, including both district nurses and specialist community public health nurses as suggested in the peer-reviewed articles I have written with colleagues from other institutions (Cook et al. 2011; Dickson et al. 2011a, 2011b); I am a realist and comfortable with change management, and recognise that the status quo is not an option.

While undertaking this study I have led the redevelopment of the post-registration courses for all routes of community nursing at the Robert Gordon University. These include district nursing, heath visiting, occupational health nursing and school nursing. It is outwith the scope of this thesis to explore this curriculum development process; however it is acknowledged that much of the development relating to district nursing occurred in tandem with the data collection phase of this study and heavily influenced the outcome of the new curriculum in my own institution. During this time I also contributed to reports produced by: the RCN (2013), the DH (2013), the QNI (2014b), QNI (2013a) and the SG (2012a). These reports focussed on clinical aspects of the district nurse role and acknowledged that district nurses' expertise is at the forefront of leading and providing acute, longer term and end-of-life care for patients, their families and carers, and maximising the use of technology. I believe that district nurse education needs to recognise the advanced cognitive, interpersonal and psychomotor skills required for contemporary district nursing practice to deliver safe, effective and person-centred care, with the skill to advance and lead new and innovative healthcare services.

As a result of this curriculum development, Robert Gordon University's Master's-level district nurse course was the first in the UK to be both approved by the NMC (meeting the NMC standards, 2001) and accredited by the RCN for advanced practice (2012). These approvals ensured that the practitioners would still be able to record their district nurse qualification with the NMC. Additionally, to reflect the Scottish context, the NES (2011a) *Career and Development Framework for District Nursing* was utilised to develop

competencies for the learning in practice element and these were mapped to the NMC standards to ensure the professional standards were adhered to.

I am aware that my professional experience and the context within which I work have influenced, and will continue to influence, me and to provide assumptions that need to be acknowledged when developing nurse education (Cohen et al. 2011; Crotty 2003; Usher 1996). I am also aware that tensions may develop between my roles as a nurse, researcher and educator, 'but if tensions are embraced rather than avoided, they can often provide access to useful energy and sensitivity, which in turn can be used to inform practice' (Mason 2002, p.219). Reflexivity refers to 'the way in which all accounts of social settings – descriptions, analyses, criticisms – and the social settings occasioning them are mutually interdependent' (Cohen et al. 2011, p.19). In other words, reflexivity is not a single event but an amalgamation of multiple elements. As indicated in the example above in relation to developing the district nurse curriculum in my own institution, I integrated all the required elements of being part of an institution: a professional body; having professional affiliations to some national groups; and having experience in practice as a district nurse to move district nurse education forward in challenging times. It can be difficult to adopt a critical stance when you are immersed in the phenomenon but these associations and infrastructures were used in a constructive manner to achieve an outcome that met the needs of all stakeholders. These associations and infrastructures surrounding me may continue to influence me and result in further assumptions that are acknowledged throughout this thesis.

1.8 Conclusion

This chapter has introduced the complex concept of professional knowing and how it is currently developed within district nursing. The policy landscape that influences district nursing was outlined, acknowledging that the district nurse has an opportunity to contribute and lead this policy agenda. The professional context was discussed, highlighting that the existing out-dated educational standards supporting district nurse education (NMC 2001) have presented challenges to both educators and practice. In addition, it was identified that the

implementation of new NMC standards for pre-registration nursing (2010) leading to the development of a graduate nursing workforce, will have implications for future post-registration nurse education. This was identified as an issue for me as an educator and previous district nurse when considering the future educational requirements in community nursing and how to support individuals to become district nurses. This discussion resulted in the research questions being introduced.

A case study approach was adopted to acknowledge the importance of the context of practice and its complexities in addressing the research questions. My position within the study has been acknowledged. It was recognised that during the period of this study there was increasing recognition nationally that district nursing educational standards needed to be reviewed (DH 2013; QNI 2013a; SG 2012a) and that I was involved in some of this work. Reflexivity will be explored at relevant points throughout this thesis to contribute to the trustworthiness of the study.

In the next chapter, relevant published literature that has informed my study over a period of time from starting out on my doctoral journey, to the completion of this study, will be examined. The relationship between research, policy and practice will put the study in context; then knowing in practice; district nursing unique knowing; and formal educative supports for professional development in district nursing, will be reviewed. Chapter 3 will justify the selection of a case study approach and the methods selected to address the research questions. Chapters 4 and 5 will focus on aspects of the findings prior to the final chapter, which will make conclusions and discuss the significance of these findings for future practice.

Chapter - 2 Reviewing the Literature

2.1 Introduction

The practice of conducting a literature search and review is a vital element of the research process. Polit and Beck (2010) suggest numerous reasons why a comprehensive literature review is essential prior to commencing a research study. First, it may help to inform the research question, aims or hypothesis. Second, it shares the results of other studies and avoids duplication. Finally, it allows for a framework to be formulated and presents the researcher with useful methodology, knowledge and reliable tools for conducting the study (Coughlan et al. 2013; Hart 1998).

This review involved an extensive search of the literature using both health-related databases, mainly CINAHL, MEDLINE and the British Nursing Index, and a variety of educational databases, such as ERIC, the British Education Index, and Educational Research online, along with the Web of Knowledge database. Relevant government policy was also accessed. Three broad areas informed the search strategy: practice knowing; district nursing unique knowing; and educative supports for developing professional knowing in community nursing. Key terms included in the search strategy included professionalism, professional knowing in practice, district nursing, community nursing, and education and continuing professional development in community nursing. The majority of the literature came from online articles. The search engine, Google Scholar, was also accessed and was particularly useful in obtaining full text copies of some of the literature not available through either my own institution or place of study's library. For the purpose of this review the following inclusion criteria were identified: written in English; empirical research; and peer-reviewed materials. Date parameters were considered, however, these were thought to be of little significance due to the out-dated professional standards supporting district nurse education (NMC 2001) and the limited published empirical research relating to district nursing.

First, this chapter will examine the relationship between research, policy and practice to put the study in context. The impact that these relationships have on district nurse practice will then be examined, taking cognisance of the four areas from Bergen and While's (2005) model. Finally, knowing, district nursing unique knowing, and formal educative supports for developing professional knowing in district nursing will be considered.

2.2 The Connections between Research, Policy and District Nurse Practice

Chapter 1 introduced the policy context relevant to community nurse education and practice; and clearly, policy has had implications for the developing role of the district nurse. Similarly, it recognised the contribution that research makes to inform policy and practice, and that would include the development of educational frameworks. It is therefore worth exploring the connections between research, policy and practice.

In considering the relationships between research, policy and practice, it is useful to consider them as three separate spheres, initially (El-Khawas 2000). It quickly becomes clear that, depending on individual circumstances, these elements have different relationships (Glasby 2011). Two may work closely together with the other situated on the outside, or the three elements may work together equally and many other configurations are possible. What is important is that despite being separate spheres of activity they are interrelated and impact on one another (see figure 1). First, research and policy will be discussed; however, it is clear that, even in this discussion, elements of practice are embedded within it.

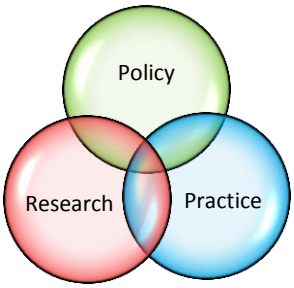

Figure 1: Conceptual model of policy, research and practice

The contribution that research makes to the development of policy is not as direct and as systematic as policymakers would have us believe (Glasby 2011; Blumer 1986). Research does influence policy but policy is often the outcome of conflicts between competing groups, each with their own agenda, and does not always follow a structured process (Clarke 2001). The way policies are developed, implemented, monitored and revised is influenced by the wider social and political contexts (Shaxson 2005). Clearly, the relationship between research and policy is complex and a number of different models have been developed to explain the use of research within policy-making. Clarke (2001) describes four main models, the knowledge-driven model, the decision-driven or engineering model, the political model, and the enlightenment model. A central feature of these models is that the researcher and policymakers are seen as two separate communities (Allen 2007).

Some of the initiatives relating to community nursing in Scotland in the last decade have been as a result of the linear 'decision-driven model' (Kennedy et al. 2009; SE 2006a; Macduff and West 2003), that is, the need to make a policy decision that has influenced the direction of the research being undertaken. This model is based on common understandings between the researcher and the policymaker but the policymaker commissions the research and prescribes the objectives of the research. This model can be regarded as a weakness of this type of research as it suggests that the research has a political agenda and does not allow the researcher the flexibility to establish the research questions (Cohen et al. 2011). Macduff (2007) supports this perspective and this approach is evident in several works on community nursing where the

commissioner has imposed the methodology (Elliott et al. 2012; Kennedy et al. 2009; SE 2006a, 2006b; Parfitt et al. 2006; Macduff and West 2003). There will be further exploration of these works later in this chapter.

Having briefly considered research and how it fits with policy, the impact this has on practice now needs to be considered. Practice is defined, for this purpose, as 'application', which is what actually happens in professional practice (Kaneko 2000: p.52). Models to demonstrate policy implementation are often represented as two opposing positions: 'top-down' or 'bottom-up' (Dickinson 2011: p.74). However, in reality, this does not represent the complexity of the process and the power and influence which individuals or organisations at either end of the scale can have. Van Meter and Van Horn (1975) developed a framework to aid the examination of policy implementation. They identified six independent variables which provide the link between policy and practice: policy statements and objectives elaborate overall goals; resources facilitate policy administration; effective communication and enforcement strategies reduce diversion; characteristics of implementing agencies influence the capacity to implement policy; economic, social and political conditions affect performance; and the disposition of implementers is affected by their interpretation of the policy, their personal opinions of the policy and the intensity of those opinions. Consideration of these variables would suggest that successful policy implementation in practice is dependent on a consensus of goals, when marginal changes are required.

Lipsky's (1980) concept of 'street-level bureaucracy' acknowledges Van Meter and Van Horn's framework. He studied public service workers to attempt to understand the routines they establish and the processes they develop to cope with the uncertainty and the pressure of their work. Similarly, he linked policy, organisational structure, resources and the individual to policy implementation, but he also highlighted the significance of education and ideologies. Bergen and While's model (2005) synthesises these two theories into four areas: national policy; professional and disciplinary theory; local organisational structure and practice; and practices of individuals. In order to evaluate the impact of policy and using my experience at Robert Gordon University

developing the recent district nursing curriculum to meet the needs of practice as an example, four areas from Bergen and While's (2005) model can be considered (see figure 2).

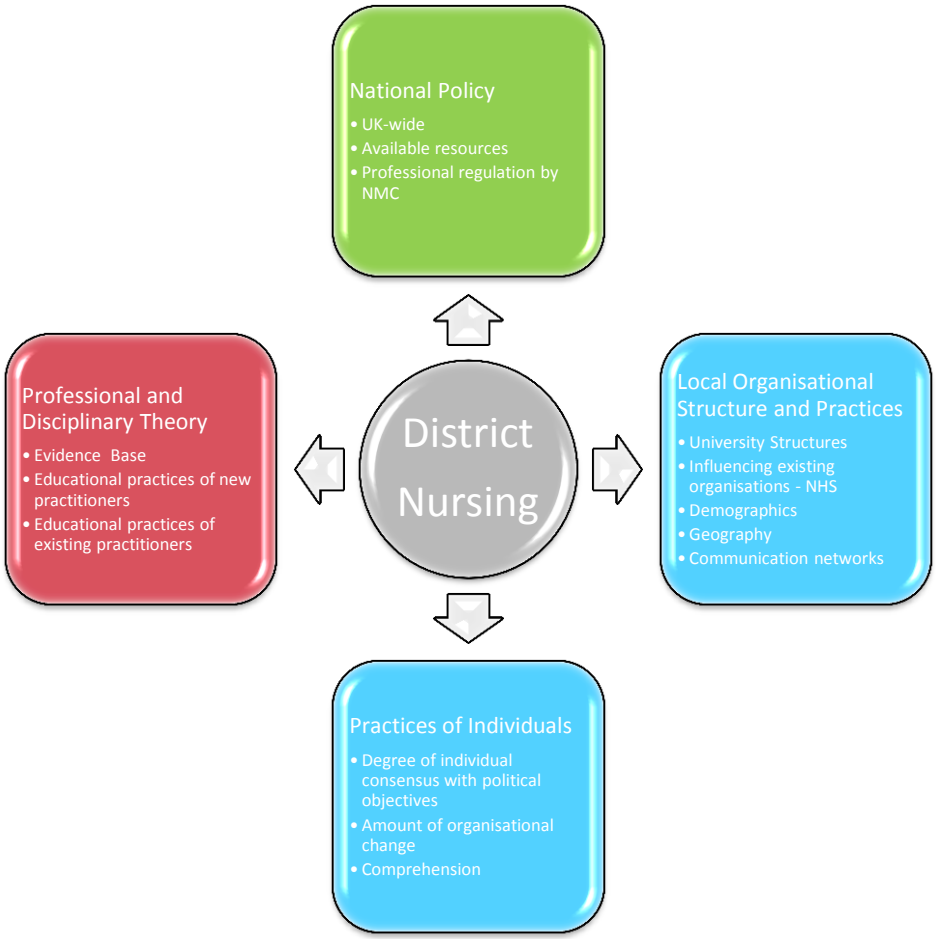

Figure 2: Implementation theory and street-level bureaucracy (Bergen and While 2005)

First, Scottish policy needs to be considered in conjunction with UK-wide policy. It is clear that Scottish policy will have the most influence, but our potential student population is UK-wide and therefore there is a requirement to focus on policy from across the UK. The policy context will obviously influence the knowing required in contemporary district nursing (NES 2011a). From a nursing perspective, another important policy consideration would be that of our professional body, the NMC, which is a UK-wide organisation and sets the standards of practice and education for the four home countries. These standards allow practitioners to work in any of the UK countries without

additional education, however, to meet the needs of all, the content can be argued to be broad and allows local areas much flexibility in their interpretation (NMC 2010; NMC 2004; NMC 2001). In Scotland, NHS Education Scotland (NES) often poses additional requirements in educational programmes and HEIs will then undertake mappings to ensure the requirements of all stakeholders are met. This is one way in which out-dated standards can still be seen to meet contemporary practice. *The NES Career and Development Framework for District Nursing* (2011a), discussed later in this chapter, was considered in the developments at my own institution to ensure that the knowing required for district nursing practice identified within this document was embedded within the curriculum.

Second, local organisational structure and practice must be considered as well as the impact that these have on district nursing knowing. This involves both the University structures and the NHS Boards as they support our students' development in practice and provide the context to developing district nursing knowing (NMC 2004; NMC 2001). While University regulations must be adhered to, the University must also respond to the needs of the potential market by developing appropriate, flexible and cost-effective courses (Cook et al. 2004; Hewitt-Taylor 2003; Chapman 2000). Working in collaboration with key stakeholders facilitates this development and helps with the process of change (Fullan 1991). Collaborative working was identified as being an important element in the Review of Community Nursing (SE 2006b) when some NHS Boards were involved in the development sites and others were not. Similarly, not all Board areas contributed to the career and development framework for district nursing in Scotland (NES 2011a). It is due to these variances that a case study approach has been selected for this study to capture some of these differences and to explore whether different NHS Board areas have different perceptions of district nurse knowing.

The next area to consider is the impact that professional and disciplinary theory has on district nursing knowing, that is, the evidence base supporting the unique knowing required by district nurses (NMC 2001). This topic will be discussed further in section 2.5 of this chapter. Finally the practice of individuals

is explored, again, within the University context, including its rules and regulations, and also those from clinical practice. The practice of existing district nurses is variable; in some areas there is evidence of innovation and advanced leadership and in other areas there is evidence of apathy and a failure to develop practice (Smith and Jack 2012; Kennedy et al. 2009; Stanwick and David 2005). This dichotomy requires further consideration. New practitioners who are being prepared to embrace innovation can quickly become demoralised as their skills are not being fully utilised. This was identified in the evaluation of the Family Health Nurse project (SE 2006a; Macduff and West 2003) and in the subsequent community nurse pilot in Scotland, when nurses returned to their original teams after receiving education to support the changing role but experienced conflict (Elliott et al. 2012).

In order to take cognisance of the impact of policy on practice, and the consideration of how research is utilised in the process, it is necessary to move away from seeing research, policy and practice as separate spheres and on to a broader view of how these elements can come together. Local priorities and shared understandings need to be addressed as highlighted by Bergen and While (2005). Researchers, policymakers and practitioners need to work in collaboration to address key issues. These interrelationships will be considered further in this study, when analysing the findings.

2.3 Professionalism and District Nursing

Within this study aiming to explore the unique knowing of district nurses in practice, and how this professional knowing is developed, the concept of professionalism is an important consideration. First, it is useful to consider the term ‘profession’. Styles (2005) lists the following characteristics of a true profession: it is derived from a higher education; it provides a distinct service or practice; promotes evidence-based knowledge; has autonomy; follows a code of ethics; and is guided by a regulatory body. Nursing, like many other occupations, has been engaged in the process of profession-building as its education has moved into Higher Education Institutes aiming for an all-graduate profession (Allen 2007; NMC 2010). In 2000, the United Kingdom Standard

Occupational Classification (Office for National Statistics 2000) classified nurses in the third major occupational group entitled ‘associate, professional and technical occupations’, which may have accounted for the common use of the term ‘nursing profession’. However, in the revision of this classification in 2010, a decision was made to reallocate nursing occupations from major group 3 to major group 2, classed as professional occupations (Office for National Statistics 2010), due to the growth in the number of nurses holding a university degree or equivalent and that entry to nursing is now only via a degree route (NMC 2010). District nursing since 1994 has required a degree level qualification to be recorded as a district nurse on the NMC professional register (NMC 2001). This classification of professions appears to be part of the UK culture and is very hierarchical (Watson 2000); however to me what is more important, is the term ‘professionalism’.

The term ‘professionalism’ is widely discussed in the literature; and there are many perspectives available. The RCN (2003) distinguishes between professional nursing and nursing undertaken by other people to clarify professionalism; the difference lies in: clinical judgement processes; underpinning knowledge; personal accountability and professional regulation, all of which are essential elements of district nursing. The RCN (2003) perspective also supports Eraut’s (1994) influential work where he identified the core concepts of professionalism as: specialist knowledge base, autonomy and service. Interrelationships between Eraut’s work and the RCN’s (2003) are clearly evident; and while Bergen and While’s model (2005), explored in the previous section, did not aim to define professionalism, there are clearly similarities. Table 1 illustrates these interrelationships.

Eraut (1994)	RCN (2003)	Bergen and While (2005)
Specialist knowledge base	Underpinning knowledge	Professional and disciplinary theory
Autonomy	Clinical judgement Personal accountability	Practice of individuals
Service	Professional regulation	National policy Local organisational structure and practices

Table 1: Relationship between concepts in Eraut (1994), RCN (2003) and Bergen and While (2005)

The concept that a profession has a specialist knowledge base is the key to the ideology of professionalism. In district nursing it is this unique knowing that underpins higher levels of judgement and decisions in practice (NMC 2001). Considering the second concept of professionalism, district nurses have high levels of professional autonomy that are linked to professional judgement and personal accountability which will be discussed further in section 2.5 (DH 2013; QNI 2014b; QNI 2009). However, it must be recognised that autonomy is dependent on networks of practice and this will potentially heighten or lesson as the integration agenda progresses within Health and Social Care. Eraut's (1994) final concept is service, which, in simplistic terms, is the relationship service users have with the district nurse. In reality, practices are much more complex and the political context, professional regulation, and local organisational structure and practices can influence how an individual practises. This suggests that professionalism is a contextual concept.

Evetts (2009) addresses this contextual concept in her exploration of professionalism, and suggests that two new and different types of professionalism are developing: organisational professionalism and occupational professionalism. Organisational professionalism involves bureaucracy, hierarchy, output and performance measures, and also relies on external forms of regulation. In contrast, occupational professionalism involves relationships and is based on practitioner autonomy, discretionary judgment and assessment, and is dependent on education and training, guided by codes

of professional ethics. In reality, professionalism is not simply one of these types but will comprise elements of both types.

Within the public sector in particular, Evetts (2009) acknowledges the growing dominance of organisational professionalism as the result of high profile cases of medical negligence. Jasper and Rolfe (2011) support this view with evidence that there is an increasing emphasis on public protection and risk reduction within the regulatory bodies concerned with healthcare professionals and recent public enquiries confirm this further (Maclean 2014; Francis 2013; Keogh 2013; Berwick 2013). These perspectives substantiate the linking of trust, competence and professionalism (Calnan and Sanford 2004), however, these links are now being challenged (Evetts 2009). It is difficult to identify the causal links between these three elements and how they contribute to professionalism and the growth of organisational professionalism, and little research is available on these aspects of professionalism. It has been implied that organisations' complex systems of accountability and audit can actually damage trust and reduce the length of time that practitioners spend with clients (Evetts 2009). Within district nursing in Scotland this aspect has been recognised and addressed with the 'releasing time to care' initiative outlined within the Quality Strategy (SG 2010). This initiative provides practical modules to support staff to improve processes to allow more time on direct patient care. Alternatively, one could argue that this initiative is about meeting the increased demand for healthcare within finite resources. However, the SG (2012b) suggests that professionalism needs to reflect person-centred care and should put the service user before the professional's self-interest, or any professional or organisational regulation and this is reflected in their policy (SG 2010). A pragmatic description of professionalism can therefore conclude that contemporary professionalism is fluid and considers external and internal drivers of organisations and occupations. This concept is evident in Bergen and While's model (2005).

It is evident that, in considering the characteristics of professionalism, professionals have a role in implementing relevant areas of policy within their practice. Professionals need to consider their attitude to new legislation, the manner in which they will approach it and the degree to which it will be

implemented (Bottery 1998). They need to show an awareness of the salient issues, be flexible and behave ethically. These qualities are vital in the development of practice and, as supported by Fullan (1991), if change is to work it has to be altered by and tailored to practitioners' values and needs. What is absent from the debate on policy, research and practice (Haycock-Stuart and Keane 2013; McAskill 2009) is an indication of its impact on the education to support district nurse knowing. Lack of recognition of this connection reflects how many of my colleagues and I in education are caught between the two discourses of politics and practice.

2.4 Nursing Knowledge and Practice

A wealth of literature has been published on professional knowledge and expertise, both within nursing and other professions, and there is now a new body of literature that talks about practice-based knowing. Different professions are built on different foundations and are concerned with different perspectives on knowledge, resulting in some confusion and conflict with the terminology (Makitalo 2012; Bonis 2009). Similarly, there are conflicting perspectives within the literature around the concept of practice and what is meant by knowing in practice (Gherardi 2009). There is clearly a complexity of these concepts and the nature of practice knowing. Orlikowski (2002) acknowledges that the distinction between knowledge and knowing may seem subtle and inconsequential, however she believes it has significant conceptual implications. Orlikowski cites Schön's work (1983) and suggests that our knowing is in our action rather than the application of a priori knowledge to a particular action or decision. Gherardi (2012, 2009) agrees, and suggests the term 'knowing in practice'. Knowing is intimately embedded in and emerges through everyday practice, and practice is always the enactment of different forms of knowing. Knowing and practice cannot be separated: knowing cannot exist outside practice, and practice is always immersed in knowing (Feldman and Orlikowski 2011).

Knorr Cetina (2001), in her analysis of knowledge-based practice, argues that practices which focus on human skills and habits, and which consider practice

as routine, are incomplete. She proposes that 'practices' instead is a relational dynamic that links subjects and objects governing the advance of practice. Knorr Cetina (p.177) suggests that the transition to knowledge societies:

> … involves more than the presence of more experts, more technological gadgets, more specialized rather than participant interpretations. It involves the presence of knowledge processes themselves … it involves the presence of epistemic practice.

Epistemic practice is therefore a complex phenomenon, related to knowledge and its development thorough interactions with individuals and organisations.

Much of the discussion surrounding knowing in practice is based on the assumption that learning is something which individuals do and it is assumed that learning has a beginning and an end (Wenger 1998). Considering the patterns of knowing and the increasing attention that experience in practice has on learning led to the rethinking of learning theory in the early 1990s. There has been an increasing interest in knowing in practice within organisations, which has challenged some theorists. Lave and Wenger (1991) perceived learning as a process that takes place within a framework of social participation rather than within the mind in a variety of social contexts. The key concepts introduced in their work include communities of practice, situated learning and legitimate peripheral participation. Lindkvist (2005, p.1193) summarises communities of practice in that a 'community involves both affect-laden social relationships and a substantial degree of shared ideational or cognitive communality'. In knowledge communities individuals learn unintentionally while participating in practice. There are still many who focus on reflection and reflective notions of learning (Rolfe et al. 2011; Kolb 1984; Schön 1983). These concepts tend to focus too much on the individual, whereas in this study, I am focussing on practice-based learning. Learning in these settings is situated learning where the individuals can see and feel how the practices of the community should be performed. In the nursing context, where there are extended periods of working together, sociocultural learning, along with supervision, has the potential to

foster professional and educational development (Spouse 2001) with the development of a shared repertoire and shared ways of attributing meaning.

Ranmuthugala et al. (2011) conducted a systematic review of the literature to examine communities of practice in healthcare. They suggested that communities of practice involve collaboration among professionals, building trust, sharing values and focussing on patient care. However, they also acknowledged that communities of practice can facilitate evidence-based practice. Thyrsoe et al. (2012), in a small study of nine newly qualified nurses, found that interaction within communities of practice aided professional development, but that engagement is influenced by the extent to which the nurses are included in both professional and social interactions. The opportunity to contribute knowledge from their previous nursing studies also enhanced engagement within communities of practice. This was a very small-scale study; however, it does highlight the key aspects of interaction to participate positively within a community of practice.

As stated earlier, Orlikowski (2002) in her paper sees knowledge and practice as inseparably intertwined. The knowledge and reflexivity of humans is emphasised and learning occurs as they go about their work, monitor the consequent action and construct new knowledge or update existing knowledge based on experience. Following an exploratory study of the work practices of a successful software company, she argues that competences or capabilities should not be taken for granted. Instead they should be considered actively in the everyday practices of actors. This idea supports the principles that knowledge is continuously being created and recreated, and that practice learning is the process whereby knowledge is created through the transformation of experience, as originally suggested by Kolb (1984).

In recent years contributions have been made towards the development and classification of knowing in nursing. The seminal work of Carper (1978) identified four fundamental ways of knowing in nursing: empirics, aesthetics, personal knowledge and ethics. Carper's work illustrates the complex phenomenon of knowing and suggests that nurses depend on additional

knowledge to that provided by empirical science. This work continues to be reflected in the nursing literature, although its limitations have been identified (Porter 2010). Porter accepts the importance that Carper's work has contributed to nursing knowledge, but the culture of evidence-based practice requires empirics to be involved in all patterns of knowing. Others have recognised Carper's patterns of knowing and developed the concept further. White (1995) added sociopolitical knowing in an effort to include the context of care. Munhall (1993) recognised the need to be open to new knowledge and ideas, and identified the sixth form of knowing, 'unknowing', a concept that means putting aside all that is known and being open to different meanings, interpretations and perspectives. Chinn and Kramer (2008) more recently added emancipatory knowing to engage in the issues of equity, justice and transformation, including nursing leadership. Jackson et al. (2009) propose that these seven forms of knowing have the potential to contribute to nursing leadership knowing. Sociopolitical issues and emancipatory knowing provide rich contexts with what occurs in nursing management and leadership, and the unknowing illustrates the flexibility of responsiveness to new ways of knowing.

Bonis (2009) builds on Carper's work and undertook an analysis of knowing in nursing, through a systematic review of the literature, with the ontological assumption that there are two types of knowledge. One is objective knowledge that is logically constructed, the other is subjective that is inductively constructed through reason. She, like Carper (1978), identified the complexities of nursing knowledge:

> … the concept of knowing in nursing involves a uniquely personal type of knowledge, constructed of objective knowledge interfaced with the individual's awareness and subjective perspective on personal experience, it is a dynamic process and result of personal reflection and transformation (p.1330).

She identified six attributes to knowing: knowing is a type of knowledge; lies in personal experience; is personal knowledge; is shaped through personal perspective; is a dynamic and changing process; and evolves as a person lives

and interacts in the world. Carper's (1978) model and its subsequent developments (White 1995; Munhall 1993; Chinn and Kramer 2008) offer little on how this can be applied in practice, whereas Bonis (2009) highlights that knowing occurs through experience and is enhanced through awareness and reflection; and the consequences of knowing include understanding, finding meaning and transformation. Bonis mirrors Eraut (1994), who highlights that knowledge is not only applied in practice, but is also transformed into situationally appropriate forms. This dynamic process of knowing enhancing theory, research, practice and education is acknowledged within Bonis' concept analysis.

2.4.1 Expertise and Knowing in Practice

Within the discussions on knowing in nursing practice the exploration of the concepts of expert practice are implicit. The definition of 'expert practice' within professional practice is open to debate. For some it is an objective concept, while others regard it as an intuition underpinned by deep understanding and experience (Benner 1984; Dreyfus 1982). The Dreyfus model (Dreyfus 1982, Dreyfus and Dreyfus 1986) consists of five stages of progress: novice, advanced beginner, competent, proficient and expert. The focus of this model is that individuals can proceed from being novices where they are governed by rules to help them carry out tasks to experts who rely on a deep tacit knowledge to act intuitively in a given situation.

Benner (1984), in her seminal work, often cited in nursing literature, applied this model to explore the notion of intuition in expert practice within nursing practice and challenged the fact that skill is the mere application of knowledge. In Benner's description of each stage there is a major difference between competent and expert. The competent practitioner consistently uses an analytical framework for conscious and deliberate planning. An expert is defined as someone who no longer practises by formally analysing every decision, but practises intuitively, based on the experience of having met the situation before. While this is a useful analogy and implies that an individual's development can be categorised in stages and at expert level knowledge is

implicit, in reality this underestimates the analytical and conscious problem-solving required in some practices at expert level (Gobet and Chassy 2008).

Manley and McCormack (1997) critically analysed the literature relating to practice expertise and identified five attributes characterising nursing practice: holistic practice knowledge; knowing the patient; saliency; moral agency; and skilled know-how. Acknowledging these attributes helps to define expertise within nursing practice. Turner (1994) suggested the term 'practice' as transferable, teachable, transmittable or reproducible. However, Gherardi (2009) suggests practices are difficult to access, observe, measure or represent because they are often hidden, tacit and inexpressible. Practice is clearly a complex concept that must be explored while considering its different dimensions. The other challenge of defining practices is the consideration of the epistemic positioning of different researchers that is either objectivism or subjectivism.

If people are learners who start from different points and acquire their knowledge through a different set of experiences, it may be that it is inappropriate to have a tacit rule book. It is evident that knowing in practice is multifaceted. The patterns of knowing first developed by Carper (1978) and subsequently developed in the latest work by Jackson et al. (2009) are useful theories to conceptualise 'knowing in practice'.

2.5 District Nursing Knowing

While theoretical concepts about knowledge and knowing in practice are valuable in classifying knowledge, it is difficult to decide which model is most pertinent to district nursing. The standards for specialist practice in post-registration nursing are centred on four outcomes: clinical practice; clinical practice leadership; care and programme management; and clinical practice development (NMC 2001). These four broad outcomes still reflect today's practice and reflect the practice of nurses working at a level beyond initial registration, whatever the context (Dickson et al. 2011b). However, the specific outcomes within these areas do not reflect the changes in the integration of

health and social care, and the role of the modern district nurse. Therefore, it could be suggested that they do not encompass the unique knowing required by district nurses today.

Carper's model (1978) and its subsequent developments are informative but offer little as to how this knowing can be developed in the practice setting. Similarly, Benner's concept of novice to expert provides a useful concept which can be mapped against the KSF to suggest levels of practice at bands 6 and 7 (DH 2004). However, Benner's theory does not specify the knowing required at the various stages of one's professional journey, nor does it consider some aspects of expertise and, in particular, the importance of abstract theoretical knowledge that is required at expert level in some situations (Gobet and Chassy 2008). There is little empirical evidence that examines the unique knowing required by district nurses. One of the most frequently cited is Kennedy's work (2004, 2002a, 2002b) which examined one aspect of the district nurse's role. Other publications that refer to the required knowing are educational standards; while implicitly, some national frameworks also do this (NES 2011a; 2008, 2007; NMC 2001), as does some recent work exploring leadership in community nursing (Cameron et al. 2010; Haycock-Stuart et al. 2010).

Kennedy (2004, 2002a, 2002b) undertook a qualitative ethnographic study to explore the knowledge required by district nurses undertaking first assessment visits. This small study with a sample size of 11 developed a typology of knowledge for district nursing practice. Kennedy identified six aspects: getting to know the patients in their own setting; getting to know carers; knowing what needs to be done now; knowing what might happen in the future; knowing knowledge deficits; and knowing community resources and services. Kennedy also acknowledged that district nursing knowledge comprises a combination of theoretical knowledge or 'knowing that' and practice knowledge or 'knowing how'. However, she challenged Carper's (1978) theoretical framework and focussed on uncovering and illuminating knowledge in use as these are integral to the 'knowing how' rather than knowledge classified into distinct categories.

Kennedy's findings suggest that a broad-based education that includes life and social sciences is essential for district nursing practice, because learning about how to undertake an assessment has an experiential component. She suggests that the form of practice placements and work-based learning offered in specialist practice programmes of education are suitable for this purpose (NMC 2001). There is a limitation in this study that Kennedy acknowledges; that, as it was an observational study that took a snapshot of district nurses' knowledge, there is therefore the potential that there is an under-estimation of the district nurses' knowledge, as subsequent visits might require different skills. In addition to these limitations it must be noted that the study was undertaken in the late '90s and, as stated previously, the role of the district nurse has evolved considerably since then (RCN 2013; Dickson et al. 2011a; Cook et al. 2011; QNI 2014b; QNI 2009).

More recently, a number of reviews of district and community nursing services have been undertaken across the UK (Elliott et al. 2012; SG 2012c; Department of Health Social Services and Public Safety (DHSSPS) 2011; NHS Camden 2010; Kennedy et al. 2009; WAG 2009; NHS Darlington 2007; NHS Northumberland 2007; Kennedy et al. 2006; SE 2006a, 2006b) identifying what community nurses do with the aim of remodelling services. Perhaps one of the most controversial was *Visible, Accessible and Integrated Care: Report of the Review of Nursing in the Community* (SE 2006b), which identified a new community nurse model including a generic community health nurse to work across all age groups in Scotland (Elliott et al. 2012). This was to replace the role of specialist community public health nurse (health visitor and school nurse), district nurse, and the family health nurse model which had been piloted in early 2001 (Macduff and West 2003). Seven core elements of community nursing were highlighted to support this model and some structure was offered for career progression for registered nurses working in the community.

The core elements identified in the review of nursing in the community included: public health approaches to protecting the public; multidisciplinary team working; coordinating services; meeting the health needs of communities; supporting anticipatory care; supporting self-care; and working directly with

people (SE 2006b). It can be argued that these core elements were not new concepts within community nursing but were new terms for previous language. For example, supporting anticipatory care and self-care to avoid hospital admission (Baker et al. 2012) could be seen as approaches to health promotion (Naidoo and Wills 2009). Health promotion is referred to in the *Standards for Specialist Practice* as core content for all community disciplines (NMC 2001).

The core elements identified by the SE (2006b) were subsequently developed into capability frameworks to support this development for a level beyond the point of registration and at an advanced level (NES 2008, NES 2007), and the RCN (2009) published a vision for community nursing in Scotland. The RCN (2009) built on the work of the SE (2006b) and implicitly identified unique knowing required by all nurses working in the community, particularly around leadership and information technology. However, in 2009, the implementation of the new generic community nurse role was withdrawn, following discussions between the relevant trade unions and the Scottish Government (Elliott et al. 2012).

The Scottish Government commissioned three studies related to this review of community nursing (SE 2006b). First, a literature review was undertaken (Kennedy et al. 2006), which is no longer available online, but was subsequently reported elsewhere (Kennedy et al. 2008). This review aimed to identify the contribution of all nurses, including district nurses, working in the community to meet the policy agenda and inform the new model, but found little evidence to support the different models of community nursing. However, elements such as the importance of developing trusting relationships, having knowledge of the local population, and that nurses in the community are ideally situated to perform health assessment of both the healthy and unhealthy population, were identified. A baseline study was subsequently carried out involving the development sites across the four Health Board areas in Scotland who had volunteered to be involved in the pilot (Kennedy et al. 2009). This baseline study was designed to support a subsequent evaluation of the model of community nursing (Elliott et al. 2012). However, the extent of the implementation of this model was never clear and the change of government

during the period added to the complexity (McAskill 2009). While there was commitment from the Health Boards involved, the level of support for the new model was not consistent across Scotland to allow full implementation. One of the biggest criticisms was the erosion of existing professional boundaries, in particular between the roles of the district nurse and health visitor, and it was also found that the knowledge and skills required to carry out the new generic model were unrealistic (Elliott et al. 2012).

Scotland has since championed Modernising Nursing in the Community (SG 2012c) which supports the development of the community nursing disciplines such as the district nurse, and more recently, in response to the *Children and Young People (Scotland) Bill* (2013), health visiting. The generalist role remains for some community staff nurses, however, post-registration qualifications require specialism, which is what the professional standards support (NMC 2004; NMC 2001).

During the work of implementing Modernising Nursing in the Community, NES provided some of the tools to facilitate this transformation. NES developed a *Career and Development Framework for District Nursing* (NES 2011a), which maps progress through levels five to eight of the *NHS KSF* (DH 2004) with a slight adaptation to reflect the terminology used in Scotland. The framework is organised using the four pillars of practice described within the toolkit: leadership; facilitation of learning; research and development; and clinical practice (Sabin 2008). This terminology is in contrast to what the Department of Health (2010b) identify as advanced level nursing themes: clinical practice; leadership and collaborative practice; improving quality and developing practice; and finally, developing self and others, and which are not far removed from the four outcomes identified in *Standards for Specialist Education and Practice* (NMC 2001). NES (2011a) states that the material that is presented in the first three pillars are standard to any professional group, whereas it is the clinical practice pillar which defines the specific nature of the district nurse. This district nurse framework does identify some elements of district nurse knowing and practice, but it fails to identify the complexity and specific capabilities required for the leadership role of the district nurse. The process of how the

unique knowledge, skills and behaviour for the district nurse were identified is not included within the document and it is noted that the professional and education requirements are recommended, not required. This is perhaps because at the time it was unclear how the publication would affect any future review of educational standards from the NMC, and perhaps can be linked to the decision-driven model of policy-making discussed in section 2.2 (Clarke 2001).

Interestingly, following the NES (2011a) publication, the Modernising Nursing in the Community Board undertook a scoping exercise of district nursing within Scotland in partnership with the Scottish Government and NES in order to gain a better understanding of the national picture (SG 2012a). Its aims were:

- to gain an overview from NHS Board stakeholders of the current models of district nursing service provision and educational preparation for this;
- to discuss Boards' vision for the development of district nursing services and the future skill requirements;
- to discuss current provision of education for community nursing and district nursing with HEIs and their vision for future provision;
- to identify Boards' preferences for education that would meet their needs for future district nurse skills development;
- consultation with education providers from each of the HEIs in Scotland to gain an overview of current provision and potential for future options; and
- identification of various current and possible educational options to meet the identified skill requirements.

All 14 NHS Boards in Scotland and all the 10 HEIs contributed to this report; the individual contributors were not identified. The report summarised the findings from this work and organised the findings into three themes: models of care delivery; skills; and education. There was no specific detail from the various stakeholders provided within the report but it did acknowledge that there was variation in the skills of the district nurse beyond the level of specialist practice

(NMC 2001), not only between NHS Boards, but also within Boards. However, there was general consensus in the report that the skills required for the future district nurse were more characteristic of advanced practice. There was reference to the four pillars of practice (Sabin 2008) within the scoping exercise and the identified skills were mapped to these pillars. Overall, this scoping exercise provided no new areas that NES (2011a) had not identified and therefore it can be assumed that its content is substantiated. The educational aspects will be discussed below.

Another point of note is the dissemination of the district nurse scoping exercise (SG 2012a). It went to all those involved in the scoping exercise and the Board of Modernising Nursing in the Community, but has not been posted on the supporting website. Considering the timing of these documents, the SG (2012a) and NES (2011a), both of which are national organisations working in collaboration, it is suggested that perhaps there are conflicting interests and political agendas. One would normally expect a scoping exercise to be undertaken before a career and development framework is produced, and this would be followed by wide dissemination. However, on the face of it there is nothing controversial within any of the documents.

In England, the DH (2013) has taken a different approach to community nursing and its development, setting out a model for district nursing, set within a framework of *Compassion in Practice: A Vision for Nurses and Midwives and Care Staff* (DH 2012). The purpose of the district nursing service model was to focus on leadership and to raise the profile of the district nurse role. The model was developed with the strategic partner, the Queen's Nursing Institute and other partners, including the ADNE (DH 2013). It identifies three core elements for district nurses to lead and co-ordinate teams to provide a service:

- Population and caseload management
- Support and care for patients who are unwell, recovering at home and at the end of life
- Support and care for independence.

The RCN (2013) also published a position statement on district nursing, considering policy across the four countries of the UK. The RCN identified three

district nursing care domains: end-of-life care, complex care, and acute care at home with an infrastructure to support it. The three most recent publications (DH 2013; RCN 2013; SG 2012a) have all adopted different language and focus, however, the underpinning knowing required is similar and all implicitly or explicitly focus on leadership and reflect the ADNE (2014) definition of the DN role.

2.5.1 Leadership and District Nursing

It is outwith the scope of this thesis to explore the theories of leadership but leadership practices unique to the district nurse will be considered. As indicated above, the *NES Career and Development Framework for District Nursing* (NES 2011a) included nothing specific to leadership relating to district nursing. While the national career framework applies (Skills for Health 2010), this is disappointing as leadership is one of the key factors identified in policy documents such as *Leading Better Care* (SG 2008). Cameron et al. (2010) examined how leadership is perceived within community nursing teams and explored how these perceptions are translated into the working practice of band 6 and 7 nurses. An exploratory descriptive qualitative study adopting a case study approach was undertaken using four cases within two Health Board areas. Although clinical knowledge was cited within the findings it was not a dominant attribute. What was noted was the influence of grade banding on perceptions and practices, which was not surprising as grade banding reflects job descriptions (NES 2011a; DH 2004). One unexpected finding in this study was in relation to behaviour, which was categorised in terms of family dynamics and labelled 'the team as quasi-family'. This was not as evident in band 7s, who placed less importance on relationships, whereas band 6 nurses expressed clear needs to be acknowledged, respected and valued and placed less emphasis on clinical knowledge and competence. This finding suggests that band 6 nurses wish to retain patient-focussed autonomy, and band 7 nurses are comfortable with developing leadership responsibilities. Cameron et al. (2010) concluded that nurses working in the community have different perceptions of leadership and practices. This assertion must be viewed with caution as this was a small study and relied on self-reporting. However, overall

it suggested that band 7s were well prepared for leadership roles and had had specific leadership preparation and considered themselves as 'expert' practitioners. No details were provided in the study as to what this preparation was.

Another study on leadership in Scotland relating to community nursing (Haycock-Stuart et al. 2010) aimed to identify how leadership is perceived and experienced by community nurses and the interaction between recent policy and leadership. Interestingly, the research questions were similar to those of Cameron et al. (2010), but the study focussed across all bandings and had participants from across disciplines, although more district nurses participated than other disciplines of community nurses. Both studies were funded by the Queen's Nursing Institute Scotland. There is no reference to how the data were analysed in the report and the findings are reported under the same headings as the research questions. Therefore, it is difficult to conclude the level of abstraction of this study. Leadership was evident in nurses across all bandings and the hierarchical structure of the NHS was acknowledged. However, in the discussion on skill mix and the decrease in numbers of band 6 and 7 nurses in practice, it was suggested that there was a correlation between clinical leadership and specialist community knowledge, and that good leadership is influenced by role-specific knowledge.

This finding corresponds to a larger but similar Australian study, which reported that two qualities possessed by quality clinical leaders mentioned by all participants, were clinical competence and expert knowledge (Van Loon 2006). Nurses at lower levels want skills-based programmes to develop clinical leadership. Those in middle levels request input regarding managerial functions, such as project management and policy and guideline development, whereas district nurses at higher levels are interested in visioning, networking, mentoring and reflection on clinical practice. Van Loon's report suggests that clinical leadership has moved away from the apprentice model of nurse education, and supporting education around clinical leadership should be integrated with other postgraduate programmes in order to build a career pathway in district nursing. How the authors arrived at this conclusion is not

made clear. It was also suggested that roles and responsibilities should be articulated across the Australian career structure or via the clinical proficiency levels of beginner, competent, advanced, specialist, and nurse practitioner. These conclusions are in line with Benner's continuum (1984), the KSF (DH 2004) and the recent work of NES (2011a). Unlike NES (2011a), Van Loon (2006) acknowledges that the community is a different practice context from that of acute nurses and there are specific aspects, such as support systems, variation between acute and community care, local demographics, and population profile information, that need to be considered when thinking of knowledge and competencies for clinical leadership in district nursing.

Much of the above literature has reported, from a professional perspective, aspects of knowing that district nurses require in practice. The QNI (2011) has completed a report that collates stories from the public following a campaign about the 'right nurse with the right skills'. Although not a research report, the findings are based on various data collection methods, such as: an open access survey with 265 responses; face-to-face interviews with eight participants, 650 online comments; individual service reviews from five district nursing service reviews; and stakeholder roundtables involving 13 patient organisations. A working group of experienced district nurses was developed to analyse the data. This publication is not acknowledged as empirical research but the report includes enough detail for the reader to make conclusions about its validity. The findings support many of the peer-reviewed articles recently published (Cook et al. 2011; Dickson et al. 2011a, 2011b). This report highlights the importance of nurses working in the home to have key skills that are focussed around competence, confidence in the home environment, and caring. Specifically, it suggests three key traits: knowledge of a patient's illness, treatments and support systems; that interventions, treatments and procedures are performed properly; and the ability to co-ordinate care services and manage on-going care. This report does not suggest that the nurse working in the community has to be a qualified district nurse, but it does acknowledge the importance of education, but like others, this report is not explicit in how that education should occur (Cameron et al. 2010; NES 2011a). Of note is that only the Australian study suggests that the education should be considered within

postgraduate programmes (Van Loon 2006) rather than at ordinary degree level.

From the literature reviewed above it is apparent that there is unique knowing required by the district nurse working at band 6 and progressing to band 7 (DH 2013; RCN 2013; SG 2012a; Cameron et al, 2010; NES 2011a; QNI 2011; Haycock-Stuart et al. 2010; RCN 2009; Kennedy 2004; NMC 2001). The knowledge identified varies in form and detail and it is noted that much of this evidence has come from reports from national organisations and professional bodies rather than having been informed by research. The need for education to support the development of the knowing of district nurses is acknowledged within the literature, however, there is no consensus based on evidence as to how this professional knowing is developed.

2.6 Education for Professional Learning in District Nursing

Literature specific to post-registration education for community nursing, including district nursing, is sparse, and, as suggested in the previous section, it is more frequently referred to within national reports from organisations such as the DH (2013), NES (2011a, 2008, 2007), QNI (2014a, 2013a, 2011, 2009), RCN (2013, 2009) and SG (2013a, 2012a, 2012c) as well as our professional body, the NMC. While the DH (2013), RCN (2013) and NES (2011a) all make reference to the district nurse having the specialist practice qualification (NMC 2001), it was the SG (2012a) in their scoping exercise who asked whether current educational practices would meet the needs of future service delivery. The SG (2012a) found that, overall, the specialist practice qualification (NMC 2001) was regarded favourably but what it did not address was a structured development framework for community nurses followed by a move to advanced practice for district nurses. It acknowledged that undertaking individual continuing professional development modules in the absence of a core framework of knowledge and skills for community nursing does not necessarily give nurses the comprehensive and holistic approach required of the district nurse (SG 2012a).

The systematic review evaluating the impact of all post-registration nursing and midwifery education on practice provides a useful overview (Gijbels et al. 2010). It identified 61 studies that were mainly of a retrospective and descriptive nature, often with small cohorts and set in one educational setting. The findings indicate that there are benefits for the students who undertake post-registration education, and there is some evidence that the students apply their newly acquired attitudes, skills and knowledge. However, there is limited evidence of the impact of post-registration education on service delivery. Similarly, McCormack et al. (2006), in a literature review surrounding practice development, found no evidence that formal education had any effect on the development of practice. Although there is consensus in the literature that continuing professional education is essential (Nolan et al. 2000), it is evident that the impact of post-registration education on practice requires further exploration, and perhaps alternatives need to be considered.

From a community perspective, perhaps the most useful study is that of Macduff and West (2003), which evaluated family health nursing through both education and practice. Scotland had piloted a new discipline, family health nurse, a generalist role focussing on families, with public health a high priority. The aim of this pilot was primarily to address remote and rural areas but it was later piloted in an urban area as well. This evaluative study had its objectives prescribed by the Scottish Executive which could be perceived as a weakness of the study as it suggests that there is a political agenda, and it is an evaluation of a given initiative rather than allowing researchers the flexibility to establish the research questions (Cohen et al. 2011). However, the researchers adopted two approaches to this evaluative research with several data collection methods to achieve both a breadth and depth of perspective. This strategy allowed triangulation of some of the data, increasing the validity of the conclusions (Polit and Beck 2010).

Macduff and West (2003) illustrated the strengths and weaknesses of the curriculum developed to prepare the family health nurse, and in particular identified that many students felt challenged during practice due to the barriers and misconceptions of their role despite feeling that the education provided

them with the required professional knowledge. Important variables such as previous post-registration education are described but are not considered within the analysis. Support required in practice is often dependent on experience and educational background as found in other studies (Stanley 2003; Hardwick and Jordan 2001; Wildman et al. 1999). Due to the small sample size, it would have been difficult to demonstrate any statistical significance, yet considering various variables would have perhaps indicated key themes that may benefit future researchers. Lauder et al. (2004), in a related study about the associated transfer of learning on the family health nursing course, focussed on situated learning theory (Lave and Wenger 1991) and the establishment of a virtual community of practice to support learning in practice, but communities of practice were not referred to by Macduff and West (2003).

Within the review of community nursing in Scotland (SE 2006b), education was developed to support the transition of existing practitioners to the new generic community health nurse role (Elliott et al. 2012). This education involved a work-based learning module using the NES-developed capability frameworks to identify the learning required (NES 2008, 2007). Four HEIs in Scotland supported this education, each taking a slightly different approach in relation to delivery methods. The participants valued the transition education (Elliott et al. 2012). It developed their awareness in the wider aspects of health and social care and encouraged reflection upon their role to support change in practice. However, Elliott et al. (2012), in their evaluation, identified that the education did not provide the depth required or address the breadth of knowledge required to prepare practitioners to take on the generic role of the community health nurse. This was despite the fact that the participants already had an initial post-registration qualification of a district nurse, health visitor or specialist community public health nurse. It was recognised that the transitional education was delivered over weeks rather than a complete programme of education as in the family health nurse pilot (Macduff and West 2003) and both projects were challenged to implement the new roles into practice (Elliott et al. 2012). Reference was also made in the evaluation of the community health nurse that the participants' initial nurse education may have been a factor as to their knowledge base (Elliott et al. 2012), but it is unclear as to whether this was

referring to their pre-registration nurse education or to their post-registration education. Considering both the pilots of the family health nurse and the community health nurse (Macduff and West 2003; Elliott et al. 2012), it is evident that the knowing required in practice needs to be reflected in education for the development of new roles, but in addition to this, there needs to be a strategic vision to implement change.

Another relevant study is Ewens et al.'s (2001) action research that explored the experience of newly qualified district nurses to establish if they were fit to practice. The study used a spiral of critical reflections consisting of five cycles. The researchers found that students felt unprepared for practice on completion of their post-registration course, but again felt they had the required theory. The researchers acknowledged this gap and explained it by the way in which practice placements were sequenced. It is unclear how the authors reached this conclusion and if, in fact, this is the case. Scott (1998, p.6) describes this phenomenon through the concept of *metis* – 'the knowledge that can only come from practical experience'. It is evident that there is disparity between theory and practice and the understanding of knowledge required for professional practice and this warrants further exploration. What may be of particular significance in this study would be the amount of community experience that the participants had in their pre-registration training as this may have affected the findings. This study was undertaken over ten years ago when, unlike the new NMC standards (2010), there was less focus on community placements. It is envisaged that nurse education within the UK will be in a period of transition for many years with the variation of pre-registration nurse education that practitioners have undertaken. More recently-trained nurses will have a first degree and experience in the community; others may have a diploma with only an observation placement in the community.

Presently there is no empirical evidence in the literature as to what effect the NMC standards (2010) will have on post-registration district nurse education. However, it is noted that at the point of initial registration, nurses should be capable of working in the community as staff nurses. As in any profession, the community nurse role is evolving and community nurses must be prepared to

develop and change to meet a society that becomes more complex and demanding (DH 2013; RCN 2013). Similarly, the SG (2014, p.6) has proposed, as one of its six strategic aims, to 'develop a sustainable approach to post-registration and postgraduate education and continuing professional development.'

The RCN (2009) promotes more flexible approaches to postgraduate education being developed to allow nurses to continuously develop their career through modular, accredited, postgraduate courses in protected time using work-based learning opportunities. The RCN also supports that all community nurses working at 'specialist practitioner' level or above should have completed the appropriate mandatory post-registration training. It could therefore be argued that district nursing is a continual process of development involving the refinement of knowledge and skills gained at the point of registration (NMC 2010). However, as Christensen (2010) suggests in his debate, advancing practice is more than simply acquiring experiential knowledge or academic qualifications for organisational or professional need. It is a process of continuing professional development using research, further education, leadership and clinical practice (Sabin 2008).

Despite the awareness of the attributes of expertise within nursing practice, curriculum development that meets the needs of professional practice remains a challenge and it is unclear why this is so. Nurse education appears to be dominated by professional regulation and government policies.

2.7 Conclusion

This chapter put my study in context by examining the relationship between research, policy, and practice. The subsequent impact this has on district nurse education and practice, using Bergen and While's (2005) model was explored. The changing face of professionalism (Evetts 2009) was then briefly discussed and it was concluded that professionalism is a contextual concept where policy, professional regulation, and local organisational structures and practices are fundamentally linked.

This then led on to examining knowing in practice and identifying that knowing and practice are intrinsically linked (Gherardi 2012, 2009). It was acknowledged that much of the nursing literature focusses on reflection, but this tends to focus on the individual rather than the situated learning which is clearly part of professionalism and practice-based knowing, which is my focus. The literature relating to knowing in practice focussed on the relevant nursing literature, and Jackson et al.'s (2009) framework developed from the work of Carper (1978) and the subsequent work of White (1995), Munhall (1993) and Chinn and Kramer (2008) was reviewed. Jackson et al.'s (2009) approach has the potential to encompass the multifaceted dimensions of nursing, and nursing leadership to frame unique knowing within district nursing.

Considering the literature reviewed in this section there is clearly a gap in the literature about the unique knowing required by district nurses to meet the needs of today's population and the lack of empirical evidence specific to the educational effectiveness of current educational programmes. Education and training are vital for promoting quality care for patients (SG 2014; SG 2013a; 2010; Francis 2013; QNI 2014a; 2013a, 2011, 2009; RCN 2013, 2009), and the professional development of district nurses has the potential to overcome some of the challenges that exist with nursing in the community. However, the education needs to be tailored to meet the needs of the district nurse, both in terms of their knowledge and skill-based learning (knowing that), and in developing their competence and confidence in practice (knowing how), as well as considering local organisational structures, professional regulation and national policy (Bergen and While 2005). District nurse education also needs to be responsive the changes in demography, epidemiology and the changing health and social care agendas outlined in chapter 1. There are no indications in the literature to suggest any one approach to the future education of district nurses, and, in fact, some documents have not been explicit in their recommendations in this area (NES 2011a; QNI 2011) and suggest that employers should have the flexibility to decide the education of their staff. However, more recent documents (DH 2013; RCN 2013; SG 2012c) highlight the definition of the district nurse as being a registered nurse with a specialist practitioner qualification (NMC 2001). Therefore, it would appear that there is a

need to focus on articulating and making explicit the unique knowing in district nursing and to explore how this knowing in practice develops.

In all areas of the literature reviewed there was an emerging emphasis on contextual factors; hence the selection of a case study approach for this study. Chapter 3 explores the methodology and methods of data collection, and the subsequent process of data analysis used in this study.

Chapter - 3 Methodology and Methods

3.1 Introduction

This chapter will describe and evaluate the methodology and methods developed to address the research aim of this study. The aim of this research was to explore the unique knowing of district nurses in practice, and how this professional knowing is developed. The research questions were:

- What is the unique knowing in practice that characterises the expertise of district nurses?
- How do different workplace elements help develop the unique knowing -in-practice of district nurses?
- What formal educational frameworks in curriculum and policy might best support the development of district nursing knowing?

A qualitative study using an interpretative approach within a case study design was adopted. In the following sections, I first discuss the theoretical perspective that underpins the study, then the chosen methodology along with my reasons for choosing it. Second, I explain in more detail the specific methods selected to address the aims and objectives of the research. These include the participant recruitment and selection processes, data collection, the analysis process, and the procedures used to address ethical considerations and to ensure trustworthiness. Finally, I discuss the study limitations and issues related to my positioning in this research.

3.2 Theoretical Perspective

In the nursing research literature, Porter (2000) describes research as being founded on a number of assumptions, which can be categorised on four levels of understanding. The first is ontology, which asks: what is reality? The second level is epistemological, which asks: what is considered to be knowledge? Methodology is the third level, which examines how we can understand reality, and the fourth is the methods that enable the researcher to collect evidence

about reality. Porter (2000) integrates any theoretical perspective within the methodology level. This model can be considered as one version of the assumptions underpinning qualitative research.

Crotty (2003) has similarly developed a four-staged column framework to illustrate the research process. He starts with the proposed methods, and then presents the methodologies supporting these methods. Third, he refers to the theoretical perspective that informs the methodologies, and his final element is epistemology, the theory of knowledge that informs the theoretical perspective. Ontology is excluded from the framework but he believes that it would sit alongside epistemology informing the theoretical perspective. The process may go in either direction, across the columns and within the columns the direction of the research may go up and down, confirming the complexity of the process. Both frameworks have several common elements and tend to focus on qualitative research.

At this stage of designing my study I struggled with many of the abstract concepts of epistemology and theoretical perspectives, while recognising that there were no definitive answers to the varying perspectives given in the literature. The development of this study did not take place in the conventional linear way as suggested by Crotty (2003) and Porter (2000), but started with acknowledging that a qualitative, interpretative approach was the most appropriate to answer the research questions. Central to the interpretative approach is the search for meaning and understanding, acknowledging the significance of both the participants' and the researcher's interpretations in the social context of the people being studied (Ormston et al. 2014; Willis 2007).

This then led to the identification of suitable methods and an understanding of the epistemological stance. Figure 3 illustrates the elements of this study, which will be discussed further throughout this chapter.

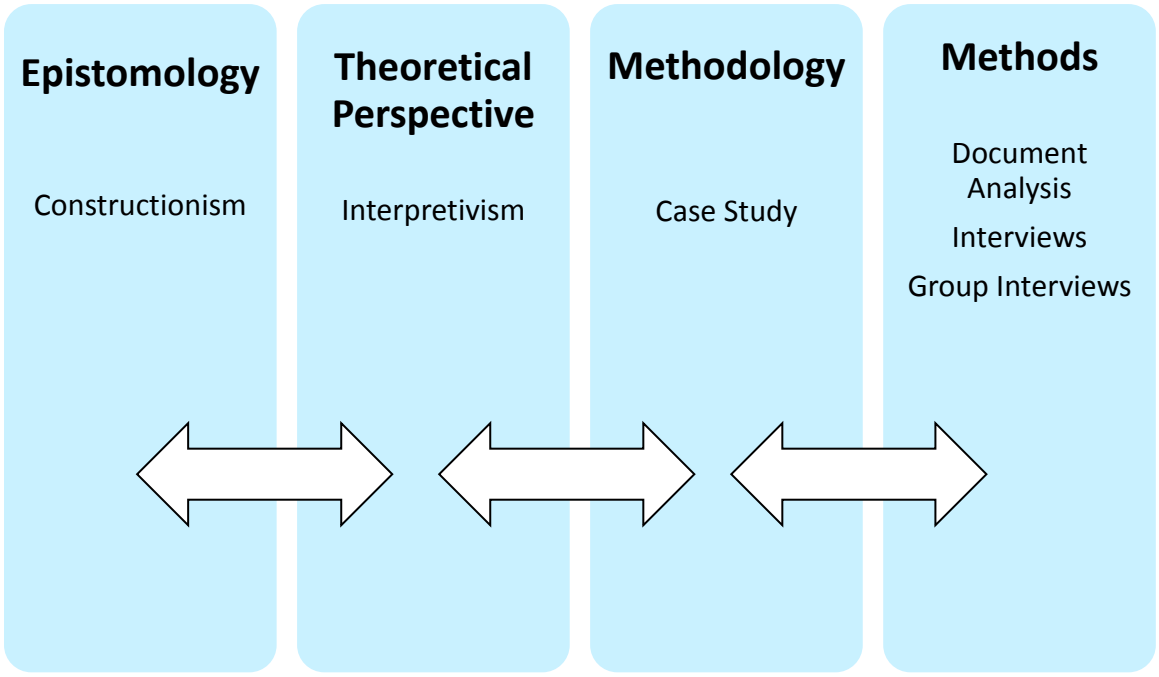

Figure 3: Elements of the study

Within many research studies the epistemological stance is implicit, as knowledge claims are made, however, it can be argued that research should be explicit in how claims are deduced (Usher 1996) to increase the validity of the findings. There are many ways in which the world can be viewed. Crotty (2003) outlines three epistemological stances: objectivism, where meaning exists independently of consciousness; constructionism, where meaning is constructed through engagement in the world; and subjectivism, where meaning is imposed on the object by the subject. However, these are not to be seen as watertight concepts, and can overlap and influence one another.

Constructionism developed from a view that no enquiry can be value-free (Guba 1990) and rarely is an indisputable explanation possible. Even the selection of the research topic is influenced by the researcher's values and belief system, and any enquiry demands interaction between the researcher and the participants, a process which questions the notion of objectivity. This perspective also assumes that it is essential for the researcher to understand the context within which the phenomenon is being examined. Crotty (2003, p.42) states that constructionism is the view that:

> ... all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.

This view is consistent with the approach required for this study; recognition that multiple realities exist, and that knowing is produced through practices, interactions and experiences within the context in which it occurs, and that knowing is a complex phenomenon. Throughout this study I have been very aware of my own experiences and the assumptions I bring with me. I acknowledge that interpretation is grounded in data, but I also recognise that new knowledge is actively 'constructed' by human beings, rather than passively being received by them and will have different perspectives (Ormston et al. 2014).

Constructionism informs an interpretive research approach, which aims to understand and explore human and social reality (Crotty 2003). This was the underpinning theoretical perspective of this study and supports my belief in multiple realities with my role as a researcher being important within the interpretive process. Within district nursing, how one individual interprets the unique knowing and how that is developed may not be the same as another. In order to understand the social world, human action needs to be interpreted (Usher 1996). Interpretive research uses data drawn from naturalistic settings and conversations to generate understandings about human experience, rather than imposing particular abstract constructs to make human experience fit pre-determined theories (Glaser and Strauss 1967). These understandings are often diverse and multifaceted (Cohen et al. 2011).

Within the interpretative paradigm various approaches can be adopted (Crotty 2003), which can involve a variety of data collection methods. Any type of interpretative approach would have been appropriate for this study, as each examines meaning and describes the complexity of human experience within its context and in each case the unit of analysis is words (Burns and Grove 2006). Selecting the most appropriate method depends on what one wants to know,

what the expected outcomes of the research are and the resources available. The concepts of phenomenology and symbolic interaction were both carefully considered for this study, partly because both are becoming increasingly common in nursing research as well as in studies of professional experience. Phenomenological research is the investigation of everyday experience from the perspective of those living the experiences (Cohen et al. 2011; Burns and Grove 2006). This approach would have provided a framework to examine the participants' perception of the unique knowing in district nursing practice. However, it would not have explained any differences between these experiences and therefore would not have defined how these might influence future education and practice. Symbolic interactionism, initially developed by Mead in the 1920s, was another theoretical perspective that was considered. Mead claimed that individuals act towards things according to the meaning that those things have for them; and these meanings result from social interaction and are modified through interpretation (Cohen et al. 2011; Holloway and Todres 2006; Blumer 1969). This concept is the basis of grounded theory (Glaser and Strauss 1967). The principle of grounded theory is that theory is derived from data collected; the process of analysis begins from the first time data is collected and analysis continues until the study is complete; there is no hypothesis; and the researcher must acknowledge and overcome assumptions, be flexible and keep an open mind (Holloway and Todres 2006). Grounded theory is a relevant method to address complex questions. However, the development of a general theory involves taking the research into a variety of contexts, ensuring full theoretical sampling and, in reality may take years, a process which would not have been feasible for my study (Creswell 2007). But more importantly, an open-minded approach would be very difficult to sustain, particularly when I have examined the literature and have been immersed in the subject area through my professional role. Therefore, in this instance grounded theory was not a feasible approach.

It was at this stage that I acknowledged the multiplicity of perspectives which are often context-dependent. I thought at this point that the different Health Boards in Scotland may have different perspectives on district nursing knowing depending on the demography of their populations. Therefore, the development

of this study began with the idea that a case study approach was the most appropriate to explore the research questions, acknowledge the context of practice, and collect rich data which were potentially complex (Stake 1995; Yin 2014). Studies drawn from the literature reviewed, that had utilised a case study approach, highlighted the importance of context and complexity (Kennedy 2004; Macduff and West 2003; Bergen and While 2000). They all illustrated that case study research had the potential to build up an in-depth understanding that is contextualised.

3.3 Case Study Methodology

Case study research has been described widely in the literature (Yin 2014; Stake 2000; Merriam 1988) and is receiving growing attention in general research textbooks (Ritchie et al. 2014; Cohen et al. 2011; Polit and Beck 2010; Gerrish and Lacey 2010; Creswell 2007; Burns and Grove 2006). Case study research is mainly carried out within an interpretative paradigm (Cohen et al. 2011; Stake 1995; Merriam 1988).

Yin (2014, p.16) acknowledges the evolving definitions of case studies. First, he defines the scope of the case study as an approach to empirical enquiry that:

- 'investigates a contemporary phenomenon within its real life context, when
- the boundaries between phenomenon and context are not clearly evident'.

Second, he identifies features of a case study that are appropriate because the phenomenon and context are not always clearly identifiable, and therefore suggests that a case study:

- 'Copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result
- Relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result

- Benefits from the prior development of theoretical propositions to guide data collection and analysis'.

This definition, first published in 1984, clearly highlights the significance of the context within the phenomenon; to research one without the other would provide an incomplete account. There is a complexity in real life situations that require multiple data sources to explore the phenomenon. In this study the decision to select a case study method was based upon the research questions and the literature reviewed; and this method also guided data collection and analysis. I chose to view case study research as a framework, which is determined by the focus of the study and is a suitable approach when a holistic, in-depth investigation is required (Yin 2014; Cohen et al. 2011; Denscombe 2010; Feagin et al. 1991).

Clarke and Reed (2010) suggest five key points of this approach:

- A phenomenon is explored in its context and assumes that this context is of significance to the phenomenon
- It is a flexible and holistic approach in which the boundaries of data collection are created by the case
- Ensure the case illustrates the area of investigation
- Insider knowledge of the context is important in the sampling and data collection methods
- The ability to transfer the findings beyond the case is important.

These five key points from Clarke and Reid encompass both the scope and features of a case study identified by Yin (2014), but in addition, they highlight the value of insider knowledge in the sampling and data collection stages, and the ability to transfer the findings beyond the case. Within this study, having knowledge of the various Health Boards in Scotland was valuable to gain rich data and varying perspectives, as discussed further in section 3.5, and my experience of district nursing was invaluable in the analysis of the data, as illustrated in subsequent chapters. In summary, case study methods allowed a

meaningful exploration of the unique knowing of district nurses in practice and how this professional knowing is developed from different perspectives.

3.4 Types of case study research

Yin (2014) identifies that case studies can be categorised into three groups. These categories are: descriptive, where the purpose is to examine the case within a particular context; explanatory, in order to identify aspects of causal arguments; and exploratory, to examine a hypothesis. Although each strategy has distinct characteristics, there are overlaps between them. Merriam (1988) similarly identifies three types in her work, which are: descriptive, interpretative and evaluative, that is, ways of describing, explaining and judging. It is evident that there are similarities in the terminologies developed by Yin and Merriam. The present research was both descriptive and explanatory/interpretive in nature as it sought to examine the unique knowing and how professional knowing in district nursing is developed from different perspectives, using a combination of different methods such as one-to-one interviews and group interviews.

Creswell (2007) categorises case studies by the size of the case and the intent of the case analysis. Stake (1995) identifies three variations relating to intent. In a single case study, one case with distinguishable boundaries is used to illustrate the issue identified. A collective case study is where multiple case studies are selected to illustrate the identified issue, and the final type of case is an intrinsic case study in which the focus is placed on the case itself and there is no expectation that the findings will be useful other than understanding that particular case. This study involved the examination of multiple cases to examine and provide a fuller picture of the issue, allowing the findings to be interpreted for use in different contexts.

The need for clear procedural steps to maintain the methodological integrity of the case study is important (Yin 2014; Luck et al. 2006; Bergen and While 2000; Stake 1995). Rosenburg and Yates (2007) suggest the use of a schematic structure to illustrate the research design and to develop a visual

map of the interrelated elements of the key concepts, underpinning theories, and procedural steps. The use of a diagram also helps to give structure to the audit trail of any study. Figure 4 demonstrates the elements of this study, at the planning stage.

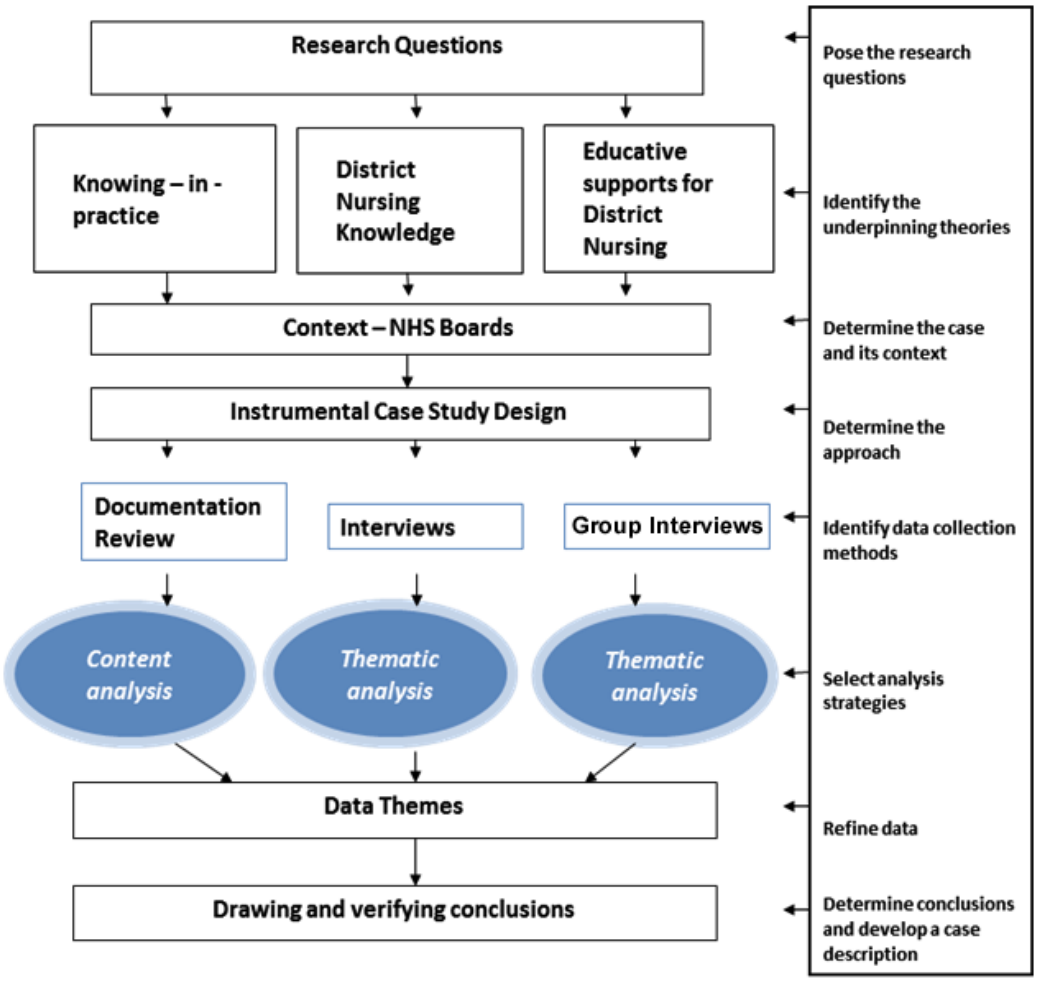

Figure 4: Schematic diagram of research process adapted from Rosenburg and Yates (2007)

However, as the study progressed, the process was not as sequential as the figure suggests. The study was informed by the related literature and this was continually reviewed during both the data collection and analysis stages. As the study advanced, it became clear that the proposed documentation review within each Board could not be an explicit part of the data collection and analysis, as this would allow identification of some of the participants. While some participants were happy to be identified there was no consensus on this issue

from all participants. Therefore, the document review was utilised to support the drawing of conclusions but could not be included in the reporting of the findings.

3.5 Selecting the Cases and Potential Participants

Qualitative studies are associated with a limited number of cases (Creswell 2014; Ritchie et al. 2003) and it is recognised that the selection of a sample has a profound effect on the ultimate quality of the research (Creswell 2014; Coyne 1997). One of the potential challenges in considering selection is that it can be difficult to maintain confidentiality and anonymity. These and other ethical issues will be discussed later in this chapter.

Strategies for case selection can be either random or information-oriented (Flyvbjerg 2006). The aim in this study was to gain the richest information while acknowledging the significance of variation due to circumstances, such as the size of an organisation and its location. Therefore, a purposive sampling strategy was employed (Denscombe 2010; Ritchie et al. 2003). Three different Health Boards across Scotland were selected as the cases, using my experience and knowledge to ensure that varying perspectives were considered, such as the different geographical areas of Scotland. Additionally, the extent of the engagement of each Health Board with the shifting role of the district nurse was considered: one Health Board area had had previous involvement within the Review of Community Nursing in Scotland as a pilot site; another had not actively engaged with this review; and the third had undertaken some recent service redesign within community nursing. Previous researchers have identified when undertaking intensive in-depth case studies (Flyvbjerg 2006) that any preconceived views, assumptions, concepts and hypotheses may be challenged. I had envisaged that there would be significant variances between the selected Health Boards, however, this assumption turned out to be incorrect.

An important consideration at this point is the ‘case’. Cohen et al. (2011) suggest case studies are set in geographical, organisational or other contexts that allow boundaries to be drawn around the case. It can be defined with

reference to the shared characteristics of individuals and groups involved or can be defined by participants' roles in the case. Yin (2014) considers the case as a 'unit of analysis'; the case can be an individual, an event or an entity. While this may sound straightforward, the identification of what constitutes the case can be challenging (Stake 1995). In this study, NHS Health Boards across Scotland were chosen as the cases to provide the context within an organisational boundary, and within each case, numerous research participants were identified. In all cases, to maintain anonymity, I have used codes to represent the board areas and the individuals.

3.5.1 The Cases: NHS Boards

3.5.1.1 Board A

Board A consists of a large geographical area containing vast areas of rural regions as well as urban spaces, with one large city and several smaller towns and villages. There are three community health partnerships within the area, which, like the rest of Scotland share local authority boundaries to promote partnership working and to ensure that health and social care is integrated (Community Health Partnerships 2014).

The city community health partnership, situated in the most densely populated area, which has areas of affluence and contrasting areas of deprivation, has over 30 general practices, which have no geographical boundaries. The general practices are arranged in clusters to manage the overlap of geographical boundaries. The district nurse service in this area has adopted a geographical approach in the last few years with the development of direct delivery teams led by a district nurse within each of the clusters. All practices have a named district nurse, who is classed as practice-attached and who supports the direct delivery team in the management of complex patients. It is the practice-attached district nurse who is responsible for the assessment, review and evaluation of care, but it is the delivery team who delivers the prescribed care.

In the other two community health partnerships in Board A the district nursing teams are all aligned with general practice, some to one specific general

practice, others to clusters. Both of these community health partnerships contain several small towns and villages of moderate population density and some rural areas with very low population density.

All three community health partnerships in this board area have a mix of skills within their district nursing teams. This skill mix includes band 3, health care support workers from the Knowledge and Skills and Framework up to some band 7 nurses who are district nurses and who lead either a cluster or group of practice attached district nurses at band 6. The practice teachers of the district nurse students in this area are also awarded a salary grade of band 7.

3.5.1.2 Board B

Board B is of a slightly smaller size than board A. It, too, has three community health partnerships. One community health partnership is based within a city that is densely populated which has substantial areas of deprivation, one is a moderately populated area and the other is a sparsely populated area, which has few areas of deprivation.

The district nursing services in board B are all aligned to general practices. The skill mix in the district nursing teams in this board area is mainly drawn from band 3 health care support workers to 6 nurses. There have been considerable recruitment issues in some of the community health partnerships in this board, which has resulted in there being vacancies within band 6 posts. This board area has limited practice teachers of district nurse students, and there is only one currently awarded a band 7 for this role, thus the service has to rely mostly on band 6 district nurses who are sign-off mentors to support district nurse students. This board has recently recognised that there are variances between district nursing services across this board area and is currently undertaking a baseline study with the aim to standardise the district nursing service across the board area.

3.5.1.3 Board C

Board C is a varied geographical area with several towns and villages and is within easy access to a major Scottish city in a neighbouring board area. There are three community health partnerships, each of similar density of population but with varying socio-economic demographics and one having a higher level of deprivation. There are over 50 GP practices and associated primary care multi-disciplinary teams. This board explicitly identifies the practice team being the core model of delivery for district nursing services.

This board area has made several developments in district nursing services in recent years. There is an established clinical leader in district nursing at a senior level and the district nurse teams consist of a range of personnel from bands 3 to 7 working across home, clinic and community settings. Unlike other board areas there are some band 7 nurses in this area who are awarded this grade due to the advanced level of clinical work the district nurse is performing rather than them being in a leadership or teaching role. Other band 7s manage a cluster of district nurse teams and continue to have a clinical role, too.

3.5.2 The Participants

Key informants, normally a lead nurse and/or an individual who is responsible for continuing professional development, were selected as participants within each board area. These key informants provided one perspective for this study. In addition group interviews were then conducted with district nurses working at bands 6 or 7 in each Health Board area. The nurses who participated in the group interviews provided a practice-perspective on professional knowing in district nurse practice.

The key informants from the three Health Board areas were selected from my personal experience of their lead role within their organisation. They all had a district nurse qualification themselves and were working beyond the level of a band 7. They were initially contacted by email with supporting information about the study and this was followed up by a further email or telephone call if they preferred to ask questions. The key informants were my main contact

throughout the study to facilitate access to the group interview participants: band 6 or 7 district nurses in each Health Board.

In total there were 24 participants; five key informants and 19 participants in the group interviews. All of the participants who took part were white European women with no ethnic minorities represented. Table 2 illustrates the number of participants.

Health Board	Key Informants	Group Interviews	Total Number of Participants
A	n = 1	GA1 (n = 2) GA2 (n = 6)	n = 9
B	n = 2	GB (n = 6)	n = 8
C	n = 2	GC (n = 5)	n = 7
Total	n = 5	n = 19	n = 24

Table 2: Number of Participants

3.5.2.1 Key Informants

Originally, I planned to interview two key informants from each Health Board and have one group interview in each Health Board with the band 6 or 7 district nurses depending on the availability of participants. I predicted that this would provide saturation and provide a manageable amount of data. Due to staff sickness, only one key informant was able to participate in one of the Health Board areas. As the key informant interviews progressed, however, I found less new information being revealed: previous discussions were being substantiated and therefore the loss of one participant was not seen to have an impact on the findings.

The profiles of the key informants are illustrated in table 3. I chose not to consider the participants' age range but focus instead on their length of experience as a district nurse. The participants each have over 20 years'

experience in district nursing and hold the district nursing specialist practice qualification (NMC 2001). Four of them are in management roles with this experience varying from three years to over 20 years, and one has a senior clinical leadership role. They are all educated to a minimum of degree level with two having completed a Master's degree and one who has evidence of Master's level study.

Individual	Role	Years involved in District Nursing	Details
A1	Senior Services Manager	32	Management role for about 15 years; DN qualification; first degree
B1	Manager of DN service in a community health partnership	30	Management role for last 20 years; DN qualification; completed an MSc
B2	Clinical Service Manager for adults and older people	21	Management role for 14 years; DN qualification; educated to Master's level
C1	Clinical Leader	20	DN for 12 years; numerous practice development and management roles; completed MSc in Advanced Practice
C2	Clinical Nurse Manager	20 +	Management of DN services for last three years; first degree

Table 3: Key Informant's Profiles

3.5.2.2 Group Interview Participants

The size of the group interviews was determined locally. However, I aimed for no more than twelve so as to encourage debate and allow all the opportunity to participate (Goodman and Evans 2010). At the first group interview in Board A, only two participants were able to attend on the scheduled date due to unplanned clinical demands. Eight had originally responded and had indicated an interest. I therefore arranged a subsequent group interview for these remaining six participants to ensure that I captured their perspectives. The

interviews were all arranged through the key informants, who were all extremely supportive and encouraging, to afford their staff the opportunity to participate in this study. The group interviews were all arranged to take place within an existing structure, that is, a regular meeting that was extended in time to allow for the group interview to occur. Refreshments were provided and, if the meeting took place over lunchtime, lunch was supplied. Whilst one may consider ethically that 'there is no such thing as a free lunch', it is well recognised that recruiting to research studies can be challenging to busy professionals and this is certainly a strategy I would recommend to other researchers to maximise participation.

Table 4 provides the profiles of the 19 participants of the group interviews. There is a range of experiences; from one having completed her district nurse qualification one year ago, to some having over 20 years' experience as a qualified district nurse. Only one has no degree level study, undertaking her district nurse qualification before the NMC (2001) standards required degree level and has undertaken no formal study within a Higher Education Institute. Another one has a district nurse diploma and has undertaken a postgraduate certificate but does not have a first degree. Eleven have undertaken further study from their initial district nurse qualification, whether it is a certificate or a diploma to gain a first degree. The six who have undertaken their district nurse qualification in the last 10 years all have a first degree. One has progressed to undertaking a Master's degree; two have completed education at postgraduate diploma stage; another at postgraduate certificate stage; and some have completed stand-alone Master's-level modules. From my experience this variation in academic profiles is mainly representative of district nurses.

Individual	Role	Years involved in District Nursing	Further details including educational background
GA11	Team Leader	28	DN certificate, in-house training
GA12	District Nurse	4	DN degree
GA21	Team Leader	20+	DN certificate, Open University degree, practice teacher
GA22	District Nurse	5 (2-year break)	DN degree
GA23	District Nurse	7	DN degree, Non Medical Prescriber
GA24	District Nurse	5	DN degree
GA25	District Nurse	6	DN degree
GA26	District Nurse	15	DN diploma, first degree, Non Medical Prescriber, PG Diploma, Experience in other Health Boards and another UK country
GB1	Clinical Team Manager	17	DN certificate, first degree, Practice Teacher, Management role 8 years
GB2	Team Leader	14	DN certificate, first degree
GB3	Team Leader	30	DN certificate, MSC, Non Medical Prescriber, Practice Teacher
GB4	District Nurse	1	DN degree, Non Medical Prescriber, currently undertaking MSc
GB5	Team Leader	25	DN diploma, PG Cert Leadership
GB6	Team Leader	20	DN certificate, first degree, PG Dip, Practice Teacher
GC1	Team Leader	20	DN certificate, first degree, TL role 2 years
GC2	Team Leader	15+	DN certificate, first degree, TL role 1 year
GC3	Team Leader	15	DN certificate, first degree, Non Medical Prescriber, COPD diploma, TL role 1 year
GC4	Team Leader	10	DN degree, PG cert
GC5	Team Leader	25	DN certificate, first degree, MSc modules, TL role for 2 years

Table 4: Group Interview Participants' Profiles

3.6 Data Collection

Data collection must reflect the epistemological and theoretical perspective of the study and be suited to the research aims and questions (Crotty 2003). This research planned to use three main methods of data collection within each NHS Board area to provide multiple perspectives: document analysis from the local health and social policy; semi-structured interviews of key informants; and group interviews with band 6 or 7 district nurses from that area. I facilitated both

the interviews and the group interviews. While it is acknowledged that this strategy has the potential to introduce bias (Cohen et al. 2011), I believe that it enriched the data, as I was able to use open, non-leading questions so that meaning was clear and my experience allowed for probing when relevant.

3.6.1 Semi-structured Interviews

To address the research questions of this study and determine the key informants' perceptions of knowing in district nursing and how professional knowing is developed, a semi-structured interview was used. This is a type of interview where certain major questions are asked of each participant but the researcher is free to alter the sequence and probe for more information (Tod 2010). This method allowed me to focus on issues of particular importance to the research questions, while at the same time, the respondents were given the freedom to address particular issues, relate their experiences and focus on what they perceived to be important (Polit and Beck 2010). The participants were invited to share a significant event within the interview to illustrate the practices they perceived to be of significance.

The interviews were recorded using a digital audio recorder with the respondents' consent in order to have a record of the entire interview. Additionally, brief notes were taken to record any non-verbal communication, which were valuable in the analysis stage of the study. Both the recordings and the notes will be destroyed when the study is complete. I stated the aim of the study, and outlined the research questions at the start of all of the interviews and explained what the data would be used for. Anonymity was assured and a signed consent form was obtained from each participant prior to starting the interview (see appendix 2). It was at this point in the first interview of a key informant that I realised that complete confidentiality would be difficult to achieve if local documentation was used to support the analysis.

The interview schedule used to structure the interview can be seen in appendix 3. The schedule was designed by considering the literature and, in particular, the document from NES (2011a). It was during the data collection phase of this

study that the DH (2013) and the SG (2012c) published further work on district nursing, however, these contained no additional content that I felt needed to be considered in subsequent interviews.

First, basic demographic information was obtained from each participant in order to analyse if any difference found was a result of these dimensions. This was particularly useful in the data analysis phase of the study, which will be discussed further in a subsequent chapter. The questions that followed were purposively designed; some to be specific to the research aim, for example:

- Can you tell me about the knowing in practice required as a district nurse at band 6 and how this is obtained in your area?

To make it clear to the participants, I did define what I meant by knowing, and I explained that knowing is connected with doing in, and through, a practice (Gherardi 2009; Orlikowski 2002). Other questions were broad, and I asked for practice examples from the key informants' experience to allow for the exploration of issues of interest and importance. This approach also aimed to provide further richness to the data from the specific questions and was useful in the analysis of the data, for example:

- Can you provide an example of a district nurse who recently demonstrated good practice? What was it that made it you select this example?

In order for the interview to provide rich quality data, advanced communication skills were required. As an experienced nurse and educator, interviewing was something I felt comfortable with, albeit not for research purposes, and I knew I had the skills to utilise questioning techniques to deal with any communication problems if they arose. A common problem occurs when respondents give answers to anticipate what the interviewer wants to hear. I was also aware that I had had previous professional relationships with some of the key informants which potentially could have influenced their responses. A primary task of the interviewer is to put the respondent at ease so they will feel comfortable expressing their views. The sensitivity of the researcher is an essential

component of interpretative research (Denscombe 2010), therefore care was taken over the initial explanation of the interview, and I was explicit that this was for the purposes of my doctoral studies rather than my employment as an educator at Robert Gordon University. All interviews were organised to take place at a mutually convenient time and I strived to create a permissive atmosphere to encourage openness. I tried to use active listening skills, and to avoid influencing the participant in any way. This was a challenge at times, as some of the responses would have led themselves to some professional debate between the participants and myself. I was very conscious that I could probe, but challenging any of the responses was not my role in these interviews. For example, one of the key informants made reference to the perceived 'top-down' 'empire-building' contribution of a national organisation during the interview, which, on balance, was a very personal opinion.

The interviews each lasted about one hour, apart from the interview with the final key informant which was cut short due to her clinical demands. However, being the last interview, I had gained experience in the mode of questioning and was able to quickly focus on the salient points. Field and Morse (1996) advise that interviews should not be continued beyond one hour, whereas Polit and Beck (2010) suggest that a respondent's construction of their experience only begins to evolve after lengthy dialogues, and they forget that the interview is being recorded after a period of time. Obviously, this will depend on the individual participant and the interviewer.

3.6.2 Group Interviews

Group interviews are a widely used method for collecting qualitative data. The terminology of 'group interview' is often used interchangeably with the term 'focus group'. The latter is the more recognised term and suggests a group that works together, but the former describes the concept of the group who may or may not be focussed (Ritchie 2003). The main advantage of group interviews is the purposeful use of the interaction between group participants (Bloor et al. 2001; Kruegar and Casey 2000). It is this interaction that distinguishes group interviews from other data collection methods and provides a richness of data

(Goodman and Evans 2010; McLafferty 2004). One of the advantages of groups is that the group dynamics encourage people to express and clarify their opinions and even revise their original ideas and understandings; this is less likely to occur in a one-to-one interview (Goodman and Evans 2010; Kruegar and Casey 2000). This was clearly evident in one of the group interviews where one of the participants totally revised her original thoughts on postgraduate nurse education for district nurses. Within this study, the data that were produced as a result of such an interaction were considered within the analysis.

Again, I was aware there was a potential that some of the participants may have felt inhibited from speaking their mind as they may have knowledge and experience of me in an educational role. To some, this may have appeared as if I was in a position of power, which potentially could have had an impact on group dynamics. The relationships they had with each other outside of the group interview could also have influenced the participants' contribution. However, a group interview gives a sense of 'safety in numbers' and it can be argued that I was an appropriate person to moderate the group as I have the required background to probe and encourage an in-depth discussion of any emergent themes (Kruegar and Casey 2000). In an attempt to minimize any bias and to encourage interactive discussion, questions were structured in an open manner. I found that my moderation skills gained from my experience as both a nurse and an educator were very helpful, particularly in relation to knowing when to probe and when to pause to encourage the group discussion. At times I felt I was 'listening in' and the interactive nature of some of the discussions allowed the questions to be developed naturally from participants rather than from the interview guide.

Like the interviews with the key informants, the group interviews were recorded with the groups' consent, after outlining the aim and research questions of the study. Although it was planned that I would take short notes to record any non-verbal communication, these were limited due to the intensity of the discussions. However, there were several key points in some of the interviews where note was made of 'rolled eyes' which adds further depth to the study.

Both the audio recording and the notes will be destroyed on completion of the study.

The group interview schedule had similar themes to that employed for the key informant interviews (see appendix 4), however, this was more of a guide than a schedule and was informed by the research questions. It was intended that the group interview would commence with a less structured approach allowing free discussion and then move to a more structured discussion to encourage consistencies across the study. Morgan (1997) describes this as a funnel-based approach and it is a compromise between a structured or less structured approach.

An activity was used within the group interview at the start to encourage participants to focus on each other and the relevant topic of unique knowing in district nursing rather than me as the moderator. Bloor et al. (2001) refer to this as a focussing exercise and it can be seen as an ice breaker. I had had personal experience using a variety of pictures within group work previously and decided to mirror this activity as from my experience the activity would potentially facilitate dialogue. This can be regarded as a form of photo elicitation.

3.6.2.1 Photo Elicitation

Much of the literature refers to the use of photos in research as photo elicitation (Tinkler 2013). Banks (2001) and Hansen-Ketchum and Myrick (2008) support the use of photos in the development of knowledge, and photos can encourage greater response than words alone (Harper 2002). Dewar (2012) concurs with this and found in her research that photo elicitation prompted participants to articulate the concept of compassion which can often be an intangible subject area to verbalise. Similarly, it is acknowledged that the concept of knowing about one's practice can be difficult to articulate and therefore I felt that the use of photos in a focussing activity could address this challenge.

It could also be suggested that the use of photos encouraged the use of metaphors that had the potential to represent the unique knowing of district nurses in practice. Metaphors are a method of communication that describes a specific aspect of life by relating it to a conceptually similar example (Beaty and Silvia 2012). This is an innovative method within nursing research and, in comparison to other research methods, little has been written about how pictures can be used within interviewing.

I did consider in this study asking the participants to generate their own photos to bring to the interviews. However, the potential ethical challenges in adopting this as part of the data collection would have been considerable. While I could have developed guidelines to address these ethical issues, taking into account the ethical frameworks within healthcare, the participants would have been limited as to what they could have photographed that represented the unique knowing of district nursing due to maintaining the confidentiality of their practice. Therefore, participants generating their own photos in preparation for an ice-breaker to provide focus, or as sole method of data collection, would have been counterproductive to contribute to the research questions. Consequently, it was decided to access photos from a commercial company that sold them as packs of picture postcards (Stokes 2012). Examples of pictures within the cards can be seen at: http://www.evokecards.com. Using postcards avoided the ethical issues of using photo elicitation but still promoted deeper levels of thinking (Hurworth 2003). The group were able to select from a choice of 52 ‘evoke cards’ that contained a variety of photos from panoramic views; objects; signs and mottos; all to stimulate debate and express their views on what they felt represented district nursing. It was interesting to note how different individuals could view the same picture differently. For example:

- A picture of two meerkats, sitting on a wall looking in opposite directions was said to illustrate the district nurse scanning the horizon for new opportunities and another felt it was about practitioners moving in opposite directions
- A picture of a telegraph pole was chosen in three different group interviews and was seen to represent, by one participant,

accessibility and technology; by another, complexity of care; and finally, the hub of practice and the variety of assessment skills required in district nursing practice.

This activity allowed the participants to drive the interview, to have a sense of ownership around the interview and to set the agenda. A reflexive approach where the data were generated through the triad of the researcher-image-participant was adopted. That is, the data were not contained within the pictures, but the pictures were used to encourage participants to be more reflexive in their thoughts about professional knowing in district nursing practice. In using this method I hoped that any perceived authority of the researcher would be reduced (Tinkler 2013). This was a valuable activity and will be referred to briefly within the analysis chapters. A detailed analysis of the selected photos was not intended for this study, however, having now used this method I would certainly advocate its potential use to provide rich data. Following on from this icebreaker activity using photographs, open-ended questions using what, where, why or how were used to facilitate discussion, for example:

- Tell me about some of the practices that are everyday, but unique to the district nurse. What are the capabilities involved in that practice? What key relationships are involved in that practice – official/unofficial?

Again, as per the interviews with the key informants, asking them to provide examples of significant events encouraged practice examples, and I aimed to avoid theorised questions to promote the generation of rich data.

Time-keeping was important to show respect to the participants, and it was important to allow time for further comments and to reflect on the experience of the group interview (Bloor et al. 2001). However, one must also take cognisance of the demands on the participants' time, too. Unfortunately, due to bad weather conditions and flash flooding on one of the days of a planned group interview, the respondents were late in arriving. This meant I had to cut this interview short.

3.6.3 Validator Interviews

Following initial analysis of the data, I returned to the key informants and the participants of the group interviews with the key themes to confirm if they were a true reflection of the interviews. This was done by email with an invitation for a follow-up telephone conversation if they wished. No one took up this offer of a telephone conversation. Two of the five key informants acknowledged that they were in agreement with the key themes. It is known that one of the other key informants has now retired from her role and it is unknown why the others did not acknowledge the email. Within the group interviews only one of the 19 participants chose to reply to my email invitation and this person agreed with my interpretations.

3.7 Ethical Considerations

Naturally, any research of this kind must follow the required ethical approval process, and I followed the processes outlined within the University of Stirling's *Code of Good Research Practice* (University of Stirling 2009). I adhered to the British Educational Research Association's Revised Ethical Guidelines for Educational Research (BERA 2011) and the Scottish Educational Research Association's Ethical Guidelines (SERA 2005) as well as my own code of professional conduct (NMC 2015). In addition to educational research standards, I was required to take cognisance of the National Research Ethics Service (NRES), an established framework for ethical review of research within the National Health Service. This involved an online application through the Integrated Research Application System (IRAS 2008). This is a single system for applying for approvals of health and social care research in the UK, which, in my naivety, I believed would avoid going through each Health Board independently to seek ethical approval. However, in reality, what it meant was that I was only required to input the required data from my study once into a national database, instead of completing separate application forms for each Health Board. A site-specific form was still required to go to each of the three selected Health Boards. This misunderstanding resulted in much wasted time. Fortunately, as I was only involving NHS staff in this qualitative study, I did not

require full ethical approval but what is known as ‘research and development approval’ from each Health Board, which is a slightly quicker process.

What was also misleading was the different approach that each Health Board took to receiving the same details from the IRAS form. One accepted it after receiving confirmation from the University of Stirling that they would provide sponsorship and professional indemnity cover; another requested completion of the recognised research application form with a copy of my own criminal record disclosure; and the third asked for copies of all of my professional qualifications and a letter from my employer confirming that the required pre-employment checks had been taken on my appointment and that I remained of good health and character. These inconsistencies certainly do not make for a national approach to NHS Permissions. I did raise this issue with an experienced researcher in my own Institution and suggested that my experience could be written into a guidance sheet; however, I was told that we needed to be sensitive to these differences. This is something I will explore further in the future.

Full approval was finally granted after an extended period. However, ethical approval does not guarantee that all ethical issues have been addressed or considered; ethical issues must be carefully considered at all times. The main ethical issues to be addressed in this research were in relation to participants’ informed consent, anonymity, confidentiality and the perceived ‘power’ role of the researcher.

3.7.1 Informed Consent

Informed consent was the principal ethical concern of this study. This means that participants received adequate information, were capable of understanding the information and had the opportunity to either decline or participate (NRES 2011; BERA 2011; SERA 2005). Consent was obtained in this study on two levels. First, from the key informants who undertook the one-to-one interviews, and second, from the band 6/7 district nurses who the key informants helped to identify. The participants were sent an email inviting them to take part. I had the

email addresses of the key informants and the key informants subsequently emailed possible participants of the group interviews on my behalf. All emails included the supporting participant information leaflet outlining the aims, objectives and research questions (appendix 5). This leaflet was developed under the direction of the National Research Ethics Service Guidance (2011). Participants were given an opportunity to volunteer or decline and the decision took place away from the researcher so there was no pressure to consent. Written consent was obtained from the participants prior to commencing the study (see appendix 2) and participants were advised that they had the right to withdraw from the study at any time.

3.7.2 Anonymity and Confidentiality

Another ethical principle to consider was that of anonymity and confidentiality, which was explicitly addressed. As well as being my responsibility, the group participants were reminded that they too had a role in protecting one another's anonymity and confidentiality. This study involved the recording of interviews therefore ethics were considered in relation to the recorded interviews. Participants were assured that the recordings were only available to the researcher and transcriber, that recording could be stopped at any time during the interview, and that recordings and transcripts would be destroyed on completion of the study. All data were number coded to maintain anonymity and the code numbers were kept separate from the data collected. Electronic files were held on secure electronic networks at my place of employment and were password-protected.

However, case study research is context-dependent and full confidentiality cannot be guaranteed (Clarke and Reed 2010). The in-depth information that was obtained made it difficult to protect the identities of the participants when reporting the findings, despite changing minor details but leaving the content unchanged. In order to address this issue, participants were invited to view transcripts if they wished, but not one took up this offer. From the responses provided it was clear that the participants were happy to see their professional

knowing profiled appropriately and to share the findings in the wider academic and practice population.

3.7.3 Power Relationships

My role as an educator and researcher had the potential to raise issues of power relationships, particularly in relation to the practitioners who have previously been supported by me during their academic studies (Cohen et al. 2011). It was made clear to all participants that this study was not part of my role as a lecturer but was for the purpose of undertaking doctoral studies. However, I was aware that this, too, could allow the participants to make assumptions about me as a professional. Throughout the process I was clear about the purpose of the study.

Throughout this study I have acknowledged my potential influence. As discussed in chapter 1, I have been immersed in this area of nursing from both a practice and education perspective for several years, and adopting a reflexive stance has helped me to distinguish between my 'district nurse', 'educator' and 'researcher' roles and to identify any perceived power relationships. In particular, I found my research supervision where I was questioned and challenged, was very useful to help me to consider and acknowledge any personal perspectives. The different roles I had during the period of the study potentially could have been competing. In addition to being researcher, I was a course leader, chair of the ADNE, and a member of national working groups, however, I believe these affiliations all contributed positively and allowed me to focus my study in a way that I feel has allowed district nursing practice and education to develop during the period of this study.

One of the most useful strategies I found in facilitating the group interviews to address any perceived power relationships was the use of 'evoke' postcards (Stokes 2012) where the participants directed the interview as discussed earlier in this chapter. In the interviews with the key informants, who were senior members of staff, there appeared to be a collaborative approach within the research interviews and they were all keen to share their experiences to

contribute to the study. However, I do acknowledge that as researcher I developed the research questions, led the interviews, subsequently analysed the data and discussed my findings; therefore, there can never be completely equal relationships in the research process.

3.8 Data Management and Analysis

The aim of data analysis, regardless of the type of data, is to impose some order on large amounts of information so that conclusions can be made and then disseminated (Polit and Beck 2010). However, analysis should avoid merely describing the data. The analysis in this study was embedded within a number of sources from within and across the participating NHS Boards and this resulted in a wealth of rich but highly complex data that helped to answer the research questions. All this data needed to be organised so that they were easily retrievable and, as Yin (2014) suggested, this was achieved by placing each set in a case study database categorised by each NHS Board. This database organised the data into a manageable resource for the intensive analysis part of the case study research (Merriam 1988). It is worth noting at this stage that the data collection and the analysis became a simultaneous process (Merriam 1988). Analysis began with the first interview taken and therefore emerging insights led to some refinement of questions in the latter interviews. This is why it was so important to acknowledge the interaction in all directions between the researcher, the participants and the data to allow the interpretation of rich and thick description. The intensive analysis stage followed on from this and was not completed until the thesis was completely written up.

The documentary data from the NHS Boards were originally planned to be analysed by a thematic content analysis approach using Ritchie and Spencer's (1994) framework. However, as referred to earlier, this would have resulted in a loss of anonymity. Therefore, there is no explicit reference to any documents that would identify the Health Boards, but broad general information is provided to outline the context. The documents accessed did add to my understanding of some of the issues that the participants discussed and certainly helped in the analysis phase to understand the different perspectives.

3.8.1 Transcribing the Interviews and Making Meaning

The approach taken to analyse both the one-to-one interviews and the group interviews were similar. The names of the recordings were all coded to differentiate and anonymise the roles of the participants. The recordings were transcribed word-for-word, using guidelines from Field and Morse (1996): pauses were denoted with dashes, a series of dots indicated prolonged pauses and all exclamations were included. Due to time constraints I utilised clerical support (an individual who was bound by confidentiality) for this stage. Whilst it is acknowledged that using transcribers can remove the researcher from the data, I utilised strategies to avoid this (Cohen et al. 2011). To ensure consistency, I developed a template and guidance for the transcriber. The transcripts were typed with a generous margin on both sides of the page; the left was used for the critiquing of the interview and coding, and the right for comments regarding the content.

Following the initial transcribing of the interviews, I replayed the media files to check the transcripts for accuracy and to add further notes, such as changes in tone of voice. At this point in the group interview transcripts I listened again to each recording, identifying the voices and colour-coding each participant in the transcripts. I also inserted a copy of their selected postcards from the focussing activity at the relevant point in the transcript. An excerpt of these transcripts can be seen in appendix 6. Despite using clerical support for the initial transcribing, this process was still time-consuming. However, it was such a vital stage of the study where I felt I was becoming familiar with the data and was continually thinking of potential findings and had to continually go back to the research questions to remain focussed. I was also aware at this point that the metaphors from the postcards provided rich data and had the potential at this stage to signify themes in the data (Simons 2009). However, I was also conscious that I needed to be cautious as the interpretation of metaphors is rarely straightforward and there can be hidden meaning within them (Inns 2002). After transcribing, two copies were saved on encrypted pen drives and the original on my personal secure server of my computer, which was password-protected. A

hard copy of each transcript with a front cover was stored in a lever arch file kept in a locked filing cabinet (Data Protection Act 1998).

The transcripts were then read numerous times allowing me to become immersed in the content. It is important in the analysis stage that the analysis is holistic. There is a danger that data can be fragmented within the coding stage, thereby losing the synergy of the interview as a whole (Cohen et al. 2011). Within the group interviews, I was interested in understanding the content of the discussions. Therefore, I had less interest in the interactions within the group. However there were times when this was important to acknowledge, for example, when there was a high level of conflict or consensus within the discussions, this was important to consider in the analysis (Morgan 2010); to ignore this would have resulted in inadequate research. There are times when reporting the group interviews quotations from individuals were used, and others when sequences of interaction were required to establish meaning. The aim was to learn from the data a new way of seeing things, not to reconstruct the subjective experience of the participants. It is a process of interpretation that begins with the tacit understanding the researcher gains from the transcript, and how the participants invite us to share their view of the world (Packer 2011). Language is a subjective phenomenon, and my knowledge of language played an important role in the analysis of the interview. This was particularly true when participants used terms that were unique to district nursing practice.

Yin (2009) identifies three main strategies to make meaning from the data: relying on theoretical propositions; thinking about rival explanations; and developing a case description. More recently, he has added a fourth strategy ‘working your data from the ground up, (Yin 2014, p.136), and has redefined ‘thinking about rival explanations’ to ‘examining plausible rival explanations’, which generally combines all of the three other strategies. I believe this research has adopted two of the aforementioned strategies as, in undertaking the initial literature review, it could be suggested that there would be a reliance on the theories examined in particular ‘knowing in practice’; in reality, during the initial analysis other concepts were considered and there was an element of

reviewing and developing the previous concepts explored. In addition, there was an element of case description within this study as a descriptive approach for its complexity aided explanation.

In order to support these analytical strategies, Yin (2014) describes five main analytical techniques within case study research: pattern matching, explanation building, time-series analysis, programme logic models, and cross-case synthesis. In this explanatory case study, both explanation building and cross-case synthesis were utilised. Here the aim was to analyse each case on a case-by-case basis and build an explanation about the case, then consider whether different cases shared meaning. Therefore, the cases were examined in isolation and also as a whole to draw conclusions.

3.8.2 Explanation Building

Yin (2014) acknowledges that the detail of explanation building has not been well documented in case study research, therefore, in order to have a systematic approach to the data analysis, thematic analysis was considered. Thematic analysis is a process of identifying, analysing and reporting themes from the data (Braun and Clarke 2006). Thematic analysis is a term widely used but is often misleading in the literature (Saldana 2013; Braun and Clarke 2006) and different authors represent different perspectives on the process (Creswell 2007; Braun and Clarke 2006; Ritchie et al. 2003; Miles and Huberman 1994). A semantic approach can be adopted, where the themes are explicit in the data and presented descriptively, or alternatively, as in this study, a latent approach was adopted where the underlying ideas, assumptions are identified and interpreted, supporting constructionism (Braun and Clarke 2006).

The process of undertaking thematic analysis is not distinctive and the stages are interrelated. Creswell (2007) illustrates it as a spiral in that the researcher moves in analytical circles starting from the data collection phase. Spencer et al. (2003, p.212) present it as an ‘analytic hierarchy’ sometimes referred as the ‘framework approach’ which has three stages: data management; descriptive accounts; and explanatory accounts. The analytic hierarchy is represented as a

ladder to demonstrate the linear process throughout the analysis. Each stage has different analytical tasks to move towards abstraction (Miles and Huberman 1994). Braun and Clarke's (2006) six phases of thematic analysis have similar stages. Theirs does not explicitly promote the higher stages of analysis required for a latent approach as Spencer et al. (2003) do, but includes a 'generating initial code' phase which Spencer et al. (2003) refer to as indexing. Braun and Clarke's (2006) process is also flexible, where the researcher moves back and forth as required, and it includes a 15-point checklist for good thematic analysis.

Whilst all the above processes informed the analysis of this study (Cresswell 2007; Braun and Clark 2006; Spencer et al. 2003), it was mainly Spencer et al.'s (2003) framework analysis that was utilised to guide this study as it is logical and acknowledges the importance of developing an explanatory account required to meet the aim of this study. However, the 'coding phase' was considered in light of Saldana's (2013) work and integrated into the generating themes and concepts process. For a novice researcher like me, the 15-point checklist was also a useful addition (Creswell 2007; Braun and Clarke 2006). This process is conceptualised in Figure 5 below.[1]

[1] Subsequent to the thesis analysis being complete, Ritchie et al. (2014) published a 2nd edition of their book where they, too, considered the work of Saldana (2009) and Braun and Clark (2006).

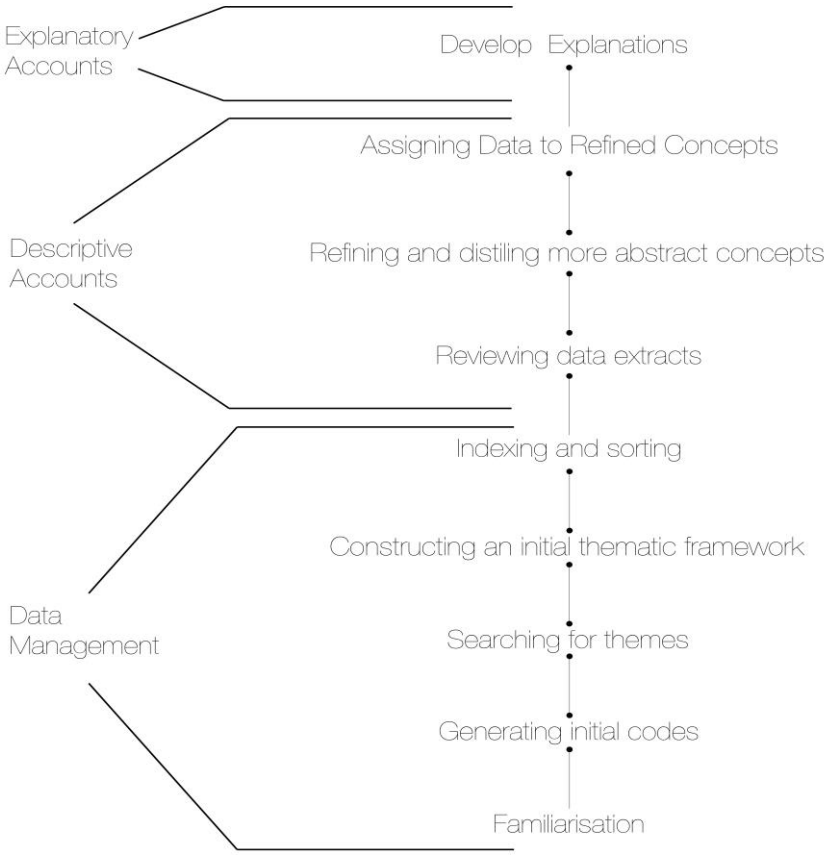

Figure 5: Data Analysis Process adapted from Spencer et al. (2003)

3.8.3 Identifying Initial Themes

Developing categories, typologies and themes involves looking for regularities in the data (Merriam 1988) and in this process both convergent and divergent thinking is required. Convergence is where pieces of data fit together, whereas divergence is fleshing out the categories and identifying the emerging themes (Lincoln and Guba 1985). Saldana (2013) suggests that a theme is an outcome of coding, categorisation or analytic reflection, and coding is the labelling of a category to a piece of data (Cohen et al. 2011). Spencer et al. (2003) avoid the term ‘coding’, as they believe the term ‘indexing’ represents the status of the categories and the way it fits the data rather than coding which is precisely defining the content. However, I would argue that coding is a stage before indexing and that it contributes to an index whether it is alphabetical, hierarchical, chronological or developed around categories. In this study, an

eclectic combination of attribute, structural, descriptive, narrative and causation coding was applied to the data using the margins of the transcripts (Saldana 2013) to inform initial themes and concepts. Individuals in the group interviews were colour-coded, to enhance the analysis both when analysing their selection of postcards and their meaning, and in the narrative of the interview.

This stage was done manually, was very time consuming, and it was very difficult to see across interviews as large volumes of data were generated in this study. A computer package such as NVivo 9 was considered to support this process, but I had previously used this in another study and recognised the potential for language to lose its meaning within a computer programme, so did not want to rely on this solely. Computer technology does not replace the thinking and decision-making required by a researcher to intelligently analyse and interpret data. Computers only remove the tedium of repetitive calculation and organisation to allow more time for data interpretation (Denscombe 2010). Therefore, in order to attempt to obtain a feel of the data, I developed mind maps for each transcript using the codes to inform themes. Appendix 7 provides an example of this process.

It was from the process of developing mind maps that the themes and subthemes began to emerge. Upon working through the analysis it became evident that the same set of codes and themes could be used for both the interviews with the key informants and the group interviews. Themes and subthemes were reviewed and refined several times to find frequently shared experiences and meanings; and tensions and outliers were examined before I was able to develop a manageable index which was then used to create thematic charts. Table 5 illustrates the initial framework developed.

A separate chart was used for each theme and all participants were provided with a separate line. Using this approach I was able to identify the individual key informants and the participants of the group interviews, and to which Health Board they belonged, and it also allowed me to analyse within cases or cross-case and consider the context of the individual Health Boards. To populate the charts I returned to the transcripts and my earlier coding, and paraphrased the

identified text into the chart providing page numbers. I used bold in the framework to highlight elements that could support more than one theme. This approach allowed me to easily move between the themed data and the original transcripts to ensure context was maintained. An example of a themed chart is contained in appendix 8. It was important at this stage not to deviate too much from the language used by the participants (Spencer et al. 2003), however, this stage did move beyond description and began to consider meaning (Bazeley 2009). The charts were then used to build explanatory accounts of the data, which are found in the subsequent chapters that present the findings. Themes 2 to 6 contribute to the research question, 'what is the unique knowing in practice that characterises the expertise of district nurses?' Theme 7 provides an insight into how this professional knowing is developed.

Background 1.1 Professional role 1.2 Length of time involved in community nursing 1.3 Professional and academic qualifications 1.4 Other	Clinical ways of working 2.1 Practices of registered nurses 2.2 Autonomous practice 2.3 Professional judgement and decision-making 2.4 Advanced assessment of individuals, families, carers and communities 2.5 Complexity of care and case management approaches 2.6 Interprofessional working 2.7 Public Health 2.8 Context of Practice
Organisational ways of working 3.1 Skill mix 3.2 Service redesign 3.3 Political influences and the integration agenda 3.4 Caseload Management	Developing technology 4.1 Technology to support change 4.2 Challenges of limited technology 4.3 Support to develop the use of technology
Building relationships 5.1 Engagement within and across professionals 5.2 Patient-centred relationships	Leadership 6.1 Levels of leadership 6.2 Characteristics of leaders 6.3 Developing staff
Perspectives on continuing development 7.1 Supporting frameworks 7.2 Individual support 7.3 Organisational support 7.4 Impact of individual's profile to development 7.5 Experiential learning 7.6 Formal learning 7.7 Implications of undergraduate nurse education	

Table 5: Framework

Another consideration in the analysis was the group-focussing activity in the interviews, which was never intended to be part of a detailed analysis. However, the value of this activity as discussed earlier was clearly evident. Therefore, the selected photos were mapped to the themes and are discussed within the subsequent chapters to further illustrate the concepts raised in the

data. Similarly, the significant events provided in the interviews of the key informants and the group interviews were all mapped to the themes, as illustrated in table 6. These significant events varied in detail and are used to explain particular points within some of the themes.

Significant Event	**Themes**
Team leader who supported service redesign	3; 5; 6
Challenging patient	2; 3, 5; 6
Person at end of life	2; 5; 6
Palliative care meetings	3; 5; 6
Named nurse in wound care	3; 5
Palliative care of an individual	2; 5
Palliative care within teams	3; 5
Just-in-case box for end-of-life care; revision of policy	3; 6
Advanced practice	2; 3
Team leader who supported service redesign (2)	3; 5; 6
People with complex needs staying at home	2; 4

Table 6: Mapping of significant events to themes

3.8.4 Cross-Case Synthesis

Once this initial analysis of all the transcripts was complete, analysis across the cases was undertaken, starting with the factors identified as being most influential in order to build abstractions across cases (Merrium 1988). Miles and Huberman (1994) describe how cross-case analysis develops case-specific explanations to findings that reinforce constructs. The processes related to this are similar to those within single-case analysis. During this stage, causal links were identified and compared across cases. Some similarities and differences were identified, but to my own surprise, comparative differences between Boards were minimal and differences were mainly between individuals than Boards. This finding will be illustrated in the subsequent chapters.

The process of analysing the interview data described in this chapter provides a summary of the steps taken within this study. Whilst the overall framework

approach adopted was based on Spencer et al.'s (2003) work, I found the spiral that Creswell (2007) describes as the analytical circle a more accurate reflection of my own experience with the data rather than seeing it as an analytical hierarchy. Seven themes were developed during the analysis process and the findings are presented in chapters 4 and 5 of this thesis. They include a description, interpretation and explanatory account of the unique knowing in district nursing practice, how different workplace elements help develop this knowing, and what formal educational frameworks and policy best support the development of district nurse knowing.

3.9 Trustworthiness

Understanding is the main aim in case study research, therefore the criteria for ensuring the research is rigorous are different from those in experimental research. Different criteria exist in the literature which allow for judgement of trustworthiness (Yin 2014; Cohen et al. 2011; Shenton 2004; Merriam 1988). Yin (2014) outlines four areas for establishing the quality of qualitative research designs: construct validity, internal validity, external validity, and reliability. Within case studies it is important that these concepts should be considered throughout the case study and not just at the beginning.

3.9.1 Construct validity

Construct validity involves establishing acceptable operational measures for the concepts being studied (Yin 2014). To establish construct validity I needed to be assured that my construction of a particular issue agrees with other constructions of the same issue, for example, professional knowing. This was achieved with consideration of the literature and by using multiple sources of data during the data collection. In this study, the context of the cases was acknowledged whilst maintaining anonymity, and data were obtained from both semi-structured interviews and group interviews.

An audit trail of the data collection was maintained to provide a chain of evidence and to allow thought processes and actions to be followed (Yin 2014;

Lincoln and Guba 1985). In addition to this record, memos of all analytical processes have been kept which includes the handwritten draft mind maps, notes of the developing and refining of themes, member checks with participants, and all decisions made. This chapter has outlined all the steps taken, justified the decisions made and demonstrates the process as to how the conclusions were made (Shenton 2004). Finally, the participants had the opportunity to review their transcripts, comment on the analytical framework and a brief summary of the findings to elicit their views and check for accuracy. It has been suggested that the best way of demonstrating validity is to ask the participants (Yin 2014; Merriam 1988).

3.9.2 Internal Validity

Internal validity is a strength of case study research. Cases are examined in sufficient depth for the results to be taken as true reports using different methods and sources. Using both individual and group interviews and by sampling across three Health Boards to set up a range of views to read against one another contributed to the internal validity of this study. Internal validity also considers how one's findings match reality (Merriam 1988). Because the researcher is instrumental in data collection, the internal validity was influenced by my skills, competence and rigour. Although I am a novice researcher, as a nurse and educator I have many transferable skills such as advanced communication skills and I have experience with conducting interviews.

Causal relationships may be identified in data, whereby certain aspects are shown to lead to other aspects as distinguished from false relationships (Yin 2014). Within this study some causal links between knowing and how this professional knowing were developed and identified, which are discussed in subsequent chapters. Potentially, some other extraneous factor could have led to this conclusion, which was not acknowledged. However, as indicated above, offering the participants the opportunity to review the reports helped address this issue and reduced any potential threat to maintaining internal validity (Creswell 2014; Lincoln and Guba 1985).

3.9.3 External Validity

External validity, or generalisability, can be defined as the degree to which the research methods justify the inference that the findings are true for a broader group than the study participants and can be applied to the larger population (Polit and Beck 2010). Within a positivist perspective, findings are presented as objective truths, claiming validity and often generalisability (Crotty 2003). However, within the interpretative paradigm, the complexities of multiple realities are acknowledged. The research does not intend to yield generalisable data but rather rich description that can inform local practice.

Issues regarding the generalisation of the findings within case study research are widely discussed in the literature (Yin 2014; Cohen et al. 2011; Denscombe 2010; Merriam 1988). Flyvbjerg (2006), in his discussion paper on the five misunderstandings about case study research, suggests that generalisability can be increased by the strategic selection of cases. In this study, selecting cases across three contrasting NHS Boards may make the findings more transferable, however, this has to be viewed with caution as the study was largely context-specific and therefore cannot be applied broadly without careful consideration.

Some of the responsibility for making generalisations falls to the reader, however, they must be provided with the necessary detail to make an informed judgment about the relevance of findings to other contexts (Denscombe 2010). A criticism of some of the literature reviewed was that it was difficult to identify the influence of some of the variables identified if there was a lack of contextual information (SG 2012c; Cameron et al. 2010). Therefore, noteworthy features of the cases, whilst maintaining anonymity, are included throughout the thesis in order to show how the findings compare with others in terms of these features.

3.9.4 Reliability

Reliability and validity are interlinked (Merriam 1988); it is impossible to have internal validity without reliability. The reliability of such research is weakened

by the fact that the process is under-standardised and relies on the ability of the researcher. My summary curriculum vitae outlines my experience and was an essential part of the Integrated Research Application System (IRAS 2008). Denscombe (2010, p.300) suggests that the question, 'if someone else performed the research would the results be the same?', should be asked. Therefore, Denscombe suggests three ways of dealing with the issues. The researcher should provide an account of:

- the aim and objectives of the research;
- how the research was undertaken, and
- the reasoning behind the key decisions in relation to sampling.

Therefore, there should be complete openness in the presentation of the research process. What is being studied is complex, multifaceted and contextualised and therefore it is difficult to achieve reliability in the traditional sense (Merriam 1988). Lincoln and Guba (1985) suggest the alternative phrases, dependability and consistency of the data results, rather than stating that an alternative researcher would obtain the same results. In order to ensure that the results are dependable I have discussed my position throughout, described in full the selection of the cases and their context, ensured that the data collection methods and the analysis process is explicit, and that the audit trail discussed earlier demonstrates transparency of the process taken.

3.10 Limitations

There are many advantages and limitations of case study research discussed in the literature (Yin 2014; Cohen et al. 2011; Merriam 1988). Case study research allows the exploration of complex cases in real-life situations and offers insight and meanings within an interpretative paradigm. The complexity of case study research often highlights differences, while recognising similarities, and allows readers to judge the implications of a study in relation to their own context. In this study the flexibility to address complex variables was a major benefit.

However, there are several challenges in case study research and the approach has been criticised mainly in relation to the credibility of generalisations made from the findings (Denscombe 2010). Identification of the cases to be studied was an important stage of the process and it was important to demonstrate the extent to which the cases selected for this study were similar to or different from others of its type. Within this case study the cases were NHS Boards. The bounded system within each case is therefore wider than the participants of the study but all include the context of district nursing. As stated previously, multiple cases were selected. Utilising one NHS Board would have enabled a different perspective to the study using ethnographic data collection methods. However, this would have resulted in in-depth data about one area (Creswell 2007) and would have provided little external validity. Selecting multiple cases helped me to explore if there was a variation of perspectives in the knowing of district nurses in practice and how this is developed, and therefore improve external validity.

3.11 Conclusion

This chapter has outlined the methodological approach and methods adopted within this study. It has referred to some of the challenges such as gaining ethical approval within the NHS to undertake research in this study. Some of the practical issues, such as the arrangement of group interviews to maximise participation, were highlighted. Aspects of case study research were discussed and some of the limitations were identified. The data management and analysis phase was introduced and the findings will be presented in the next two chapters.

In the subsequent chapters, the results of the data analysis are presented in a variety of ways. The next chapter will examine the interview data from both the key informants and the group interviews to explore the unique professional knowing in district nursing, and chapter 5 will consider how this professional knowing is developed.

Chapter - 4 Complexities of Practice

4.1 Introduction

This chapter presents the findings of the research study that contribute to the unique knowing in practice that characterises the expertise of district nurses. The framework analysis, as described in the previous chapter, contained seven themes which were constructed from the data rather than being defined beforehand, keeping an open mind. When analysing the data it became apparent that five of those themes explicitly relate to this chapter. While there are interrelationships between these five themes, this chapter will use these five themes and their subthemes as headings to provide clarity:

- clinical ways of working,
- organisational ways of working,
- developing technology,
- building relationships,
- leadership.

Quotes from the data are included within each theme to illuminate the findings, and to show similarities and differences from the participant's perspective. Photographs from the focussing exercise are used on occasion to illustrate the participant's perspective of district nurses' practices and selected significant events from the data are used to provide further perspectives in some of the discussions.

4.2 Clinical Ways of Working

This theme focusses on the clinical aspects of district nurse practice. Within the accounts, the participants indicated the advancing role of the district nurse to meet the changing context of care, but interestingly, the accounts also acknowledged elements of the registered nurse (band 5) practices. The practices related to each band can be reviewed in appendix 1. It is important to understand the different knowledge and skills associated with each band in order to identify the unique knowing of the district nurse, which is built on these

foundations. Therefore, the practices of registered nurses will be presented first.

4.2.1 Practices of Registered Nurses

In all of the interviews there was mention of the variations in practice within bands 5s, 6s and 7s. It is evident within all the data that the unique knowing of the district nurse in practice is built on the knowing of a nurse at the point of registration and is focussed on the higher levels of practice. However, it is also evident that in some instances the scope of practice of band 5s is increasing, albeit that it remains at an individual level rather than on a population as a whole.

Participants within the group interview mainly selected photographs in the group-focussing activity reflecting the complexities rather than the foundations of nursing care. However, two participants, in their selection of photograph, acknowledged the fundamental principle of caring within nursing. One participant selected a picture of a teddy bear in the icebreaker exercise and stated:

> I picked the teddy bear just because it looked, it represented caring for me and always remembering that that's what it's all about at the end of the day it's going out and looking after people and caring and nursing for them. (GA24)

Another picked a field of poppies, acknowledging the importance of the home environment but building on the caring and public health aspects of nursing care before moving onto the complexities of nursing in the home.

> I picked a field of poppy flowers 'cause it looks very nice and that is how I feel we try to keep people healthy, help them to grow, be happy, a nice environment as far as possible, it's District Nursing, it's all about caring and nurturing and making things better if you can. And District Nursing I think is all the complex care we have with patients coming out of hospital earlier, with more complex needs and all the different directions, all

> different people we have to talk to try and get a package all together to promote care at home and, busy, busy, busy, busy. (GA23)

The above quotes relating to the two selected pictures suggest that practices of registered nurses are subsumed within existing practices of district nurses in that the continuing importance of principles, such as caring, is a foundation for their current practice. The majority of participants did not feel the need to be explicit in this aspect. As expected, participants within the group interviews viewed themselves as working at a level that reflected their grade from the KSF (DH 2004) but made reference to their colleagues working at different levels within bands. Overall, band 5s are being encouraged to develop. However, all participants reported variances of practices across teams and within NHS Boards. There are some areas where it appears band 5s are being restricted in their practices.

> I think there's a lot of practices where district nurses just wouldn't let the staff nurses, band 5s do that. They don't trust band 5s to go and do a syringe pump. It's insane. (GA24)

In contrast, another key informant shared how the shifting of the balance of care into the community has resulted in major changes in practices of community nursing that all nurses have adapted to. District nurses and band 5s are now managing practices that were previously only seen in the hospital setting. The following quote illustrates the developing practices of nursing in the community that includes the administration of chemotherapy and using technology for symptom control in end-of-life care.

> If you look at the hick and the picc lines (peripheral inserted central catheters), I mean, but then it is all the nurses in the community, so it is not just the district nurse. It would be the staff nurses … And you look at the palliative care stuff, the recent chest drains they're starting to change … there is a big difference with the clinical part of it … (C2)

One key informant, when referring to the band 5s who had been working in the community for many years, gave one perspective of practices. She identified that band 5s work with individual patients, but do not always make links to wider concepts such as communities and the policy agenda.

> Some of the band 5s … can become quite task-orientated in the care they deliver. I think with the band 6 it's much more holistic around what they do. The staff nurses don't have a grasp of the national kinda strategies, policies and the NHS B policies, you know they were just doing the job, I don't think they had linked all of that together. (B2)

It could be suggested the band 5s can adhere to local policies and guidelines to practice, but do not always see how they are derived from national policy and empirical evidence. This lack of awareness of the bigger picture could be related to unknowing in that these individuals are unaware of new perspectives of practices. Other key informants recognised a certain knowing in the 'new' registered nurse that reflects the move to a degree profession in nursing.

> Our Band 6 workforce are quite a mature workforce and … our Band 5s who are very skilled and knowledgeable and sometimes are the more proactive. They bring with them a wholly different energy and understanding of all the potential. (B1)

> I would say I've been very very, eh, not so much surprised, inspired by the motivation and practices of band 5s. (C1)

> We are trying our best to utilise the band 5s to the level of what they are coming out with … You know they are very bright, technical. We are in a bit of a transition because we have also got band 5s that have been in the community for 20 years. (A1)

These quotes illustrate that practice is in a time of transition as nursing has moved to a graduate workforce and this has had an impact on practices with a shift in competence for some individuals. There is a dichotomy in the practices

of registered nurses in relation to their understanding of wider issues, such as policy agendas and organisational structures, which appears to be linked, not to experience in the community, but rather to the level of education of the nurse and their level of engagement with keeping up to date. These findings are explored further in chapter 5 when I draw on these interpretations and examine how the unique knowing in practice of district nurses is developed. From the analysis of the data there is an assumption that all registered nurses' practices are based on the principles of caring and delivering person-centred evidence-based care, but it tends to be at an individual level rather than across the whole population. It is the higher bands that move beyond the individual and adopt a broader perspective to practice.

4.2.2 Autonomous Practice

This theme considers the level of autonomy of the district nurse. All nurses working in the community demonstrate a level of autonomy, and being often a lone worker heightens this level of autonomy as the practitioner is working with little direct supervision. The difference between nursing in the home compared to nursing in other settings was articulated by district nurses in this study. Additionally, the level of autonomy of the district nurses who have responsibility for their team, while managing the care of the individual, carers and families within their caseload, is reflected in the following quotes.

> … in district nursing you need to know a bit of everything, you need to be able to deal with absolutely everything ... you're a generalist … and I suppose if you're in charge of a team as well, you're in charge of a bunch of nurses, are out and about, outwith your control, whereas if you're in the Hospital, everybody's there, you can see what they're all doing. I suppose you're out and about on your own really wi' not nearly the same support as you have in the hospital. You've got your doctors there, you can just go and grab somebody or when you're out on you own, you really are on your own. (GA12)

> … and that's why district nursing is different because you are a lone practitioner. You are out there taking and making decisions on your feet. You know, independently … And if anything happens it is up to you to take responsibility. (GA26)

> I think district nurses are resilient to people, they know that they are out there in the main working autonomously and very often alone. (B1)

> I know we have said it time and time again, but I think it is, it certainly is quite a specialised area of nursing … you are working with people in their homes. I think it's quite an autonomous role, but you're working with people in their environment and you're a visitor in their house. (C1)

All of the above quotes highlight that the district nurse has a higher level of autonomy due to the level of responsibility, managing a team where practitioners are often working as lone workers in isolation, and the district nurse is accountable for delegated work. The last quote illustrates sensitivity to practicing differently when in a home instead of an institution. Additionally, the use of the word 'resilient' by one key informant could suggest that the district nurses require a certain level of resilience to work with the complexity of people in the community as a lone worker. In contrast, district nurse practice depends on its networks and relationships as described in the theme 'organisational ways of working'. However, autonomy is not just about practicing alone but is about professional judgement and decision-making within interprofessional working.

4.2.3 Professional Judgement and Decision-Making

This subtheme explores the professional judgement and clinical decision practices of the district nurse. Professional judgement and the level of clinical decision-making can be linked to educational level and the KSF (SCQF 2014; DH 2004), and this theme illustrates this in the context of the community. However, this theme also suggests that as the practices of district nurses have developed, so has the level of decision-making. The complexities of decision-

making by district nurses are suggested in the group interview icebreaker by some of the participants in their selection of photographs.

> Right, well, the spade, I think that's because we have to dig deep … we have to problem-solve … and decide what should be done. (GB3)

> I think with the peeling apple it kinda says things are never what they appear to be, you know you kinda go under the skin an' if you think it's going to be simple it'll be harder than you imagined. (GC2)

> I've picked a home because that's what it's all about, you know district nursing is about going into people's homes and doing a holistic assessment and gauging what the needs are, it's not just the building it is everything that goes with it … we have these additional advanced skills to sort of practice autonomously. (GA26)

The metaphors contained within the photographs can be seen to represent situated practice and the analytical and conscious problem-solving required in the decision-making practices of district nurses to support the individuals within families within the larger communities. The community staff nurse can apply and analyse knowledge, but the metaphors above of digging deep and apple peeling suggests that the district nurse thinks through issues at a deeper level, synthesising, evaluating and considering the wider context of population need. Another participant contrasted decision-making in the hospital setting to that in the community. She suggested that in making decisions in the hospital setting there are opportunities for continual re-assessments, but in the community setting there is only the period of time allocated to that visit to make an evidence-based decision that will inform the plan of care until the next visit.

> What you do and say in that visit may have an effect. So your clinical judgement at that minute and time and that information that you've got is more important or more, you know, balanced than in the hospital, because they come and say, "Oh all right, you all right?" and then five minutes later, "Oh, she's not looking so great." And then in the

> community you have to do your whole consultation in that time that you've got … 'Cause you've got another however many patients so you have to try and get the precise information at that time to let you make an idea of your care plan and be safe and then move on. (GB4)

The above quote demonstrates that a key element of district nursing decision-making is within the assessment and management of risk. In the analysis of the data it was identified that decision-making is also linked to the role of the district nurse in evaluating a variety of complex interventions, including planning and managing care, which involves engagement with other professionals. One participant articulates it in the following excerpt:

> Main focus, where Band 6s, when they have those complex clinical decisions to make, they're very good at co-ordinating and bringing in the available resources to manage patients at home, and that happens time and time again. (B1)

This level of decision-making also appears to be reflected in the context of the ways of working. In the Board area that has district nurses attached to a GP practice and a group that works geographically, there is a different pattern to the level of decision-making. One participant describes the practices of the district nurses working geographically who then refers back to the practice-attached district nurse for further assessment.

> They can, you know, if, if the patient complains about something or if they've, if, if they're not happy about something, they'll get that information, they'll feed it back, but I don't think they're doing the notes the same as what we'd maybe do at assessment level. They're really, I think they're just in to do the job and back out. So they may not see the big picture whereas, I think, we're still doing that. (GA11)

Rather than the practitioners not being able to make decisions, this practice perhaps indicates that the higher levels of decision-making are not being

utilised in this way of working, as another participant who worked geographically reported:

> I don't think they are using us properly. I think it's very poor. I think they are allowing very specialised people to lose their skills. (GA26)

This excerpt could suggest that organisational structures, as well as occupational boundaries, contribute to the level of decision-making that individuals make. Decision-making also appears to be linked to the practices of registered nurses and their supporting education.

> So the more intelligent Nurses you're getting coming out today, the better you would hope decision-making skills they would have, and looking to the future and managing change better and all this. (GA12)

It is evident from the data analysis that professional judgement and advanced levels of decision-making are integrated within the unique knowing of the district nurse practices. However, it is also apparent that professional judgement and the level of clinical decision-making appear to vary between staff nurses and district nurses. It appears that the reasons for this are multifaceted. It could be linked to formal education and the increase in nurses who are graduates at the point of registration and within post-registration. There is also the significance of the advancement in district nurse practices where people with complex needs are managed in the community, which some district nurses have embraced. Considering the clinical aspect of district nurse practices, it is surmised that professional judgement and decision-making is linked to assessment and the management of complex interventions. However, factors such as organisational structures can, at times, be seen to be a barrier to the level of decision-making and level of autonomy of district nurse practice. In conclusion, it is suggested that professional judgement and decision-making are developed through practice and increased knowledge, and that this integrates all elements of knowing (Jackson et al. 2009) with the support of professional and disciplinary theory, and the organisational structures in which these skills are developed (Bergen and While 2005).

4.2.4 Advanced Assessment of Individuals, Families, Carers and Communities

In the discussion of the previous subtheme it is apparent that the practices of district nurses have developed in recent years and that advanced assessment skills are becoming embedded in the practice of some district nurses. The district nurses in one group interview, where two participants had the non-medical prescribing qualification, discussed this. All participated in the conversation and agreed, demonstrating a consensus of opinion. One of the non-medical prescribers stated:

> If they need a prescription, I don't have to go and look for a GP if I know that patient … and the reasons behind it, and I'm happy to prescribe it, then I can just go and do that. The list goes on and on and on. I'm really glad I did it. I think it should be part of the DN course. And the physical health assessment … it's a complete eye-opener to everything. (GA23)

This account suggests that all district nurses should have the required knowledge and skills to be able to undertake an advanced physical assessment and be able to prescribe under the same conditions as general practitioners. One participant concluded:

> … district nurses should be on a par with your advanced nurse practitioners. (GA25)

Considering this statement on its own, it could be argued that this would be the case for all nursing practices at an advanced level and it is not unique to district nursing practices. However, GA25 then developed the discussion further and applied it to the community context, considering not only the environment, but also again the individual in the family in the community.

> …. in the acute sector you're looking after the symptom and the cause whereas within the community you're looking at the whole picture, you're nae just looking at that patient, you're looking at the environment they live in, you're looking at the, you know, the, the family dynamics that

> they've got, any kinda support network that they've got, and I think it differs fae that point of view as well. (GA25)

A participant in another group interview mirrored this view and her quote illustrates the complexities within district nursing that need to be considered within assessment practices:

> It's an uncontrolled environment that you work in, every patient is completely different, and I know this, the hospital says that they treat them as individuals, people disrobe when they go into a hospital, if you ask them to do something, they will do that. It's completely different when you go into their house, you're a guest in their house, and they will assert themselves, so I, I think that the environment and the people, that even the knowledge base of the people that we go into, whether they're, you know, deprived or affluent, it's completely different now, their expectations are completely different, it's more about negotiating care, you know, so you have to have an awful lot of skills that, not everybody can. (GC5)

As in hospital settings, care in the community is person-centred. However, this quote suggests that people are less likely to lose their own identity in their own home. The individual and family have control in the initiation of the relationship by allowing the nurse to be a guest in their home, and the concepts of self-care and empowerment can be chosen to be embraced or not by the individual. Therefore, for the district nurse, having the knowing of being able to undertake an assessment of not only an individual but also of their family and informal carers is crucial. Socio-political and environmental factors must be considered at individual, family and community levels to ensure that health and social care needs are met, whether it be to facilitate self-care, develop anticipatory care plans or to adopt case management approaches, as discussed further in the next subtheme. This level of advanced assessment appears to be unique to the practices of a district nurse.

One key informant spoke about the challenges of working in an advanced way in the community as the structures are not in place to facilitate it. This was mainly due to the lack of technology to support electronic recordkeeping between professionals in her area. In order for nurses to undertake advanced clinical assessment, the best practice guidance is to have access to the person's medical records. Developing technology will be discussed further in 4.3.3, however, B1 did acknowledge that the vision she had was for all district nurses to practice in this way in the future. Another key informant, who worked in the Board area that had integrated advanced nurse practitioners into the district nurse team, was asked to give an example of a district nurse who had demonstrated good practice. She chose to focus on the group of advanced nurse practitioners who were also district nurses working in the area and acknowledged:

> Their passion for community nursing, their clinical skills around assessment, their assessment process, their holistic process, their ability to work with the multidisciplinary team and what their role as a district nurse was about and the knowledge and skills required to do that role. … Still wanting to keep district nursing skills but to advance level of knowledge and become an advanced nurse practitioner within community nursing. (C1)

In this subtheme, all accounts made reference to advanced assessment within district nurse practice. Interestingly, there was no explicit reference made to the benefits for individuals, families and carers in this development of district nursing practice. However, this could perhaps be an assumption by all participants that they didn't mention it because of my understanding of nursing, and that person-centred care that is safe and effective goes without saying. It was also evident that discussions about the advanced assessment practices were referring not only to long-term care but also to acute care in the community. The context of the care was identified as being vital in that assessment process. An individual had to be assessed with consideration of all elements of their lives, and this concept is interlinked with complexity of care and case management approaches. However, what also emerged was a

difference of opinion as to whether all district nurses were required to practice in this advanced way. This will be considered further in the section 4.3, ‘organisational ways of working’.

4.2.5 Complexity of Care and Case Management Approaches

This subtheme explores case management, a term used to describe a range of strategies to address the needs of people with complex needs, and the importance of the context of care will be reinforced in this subtheme. Case management includes six core elements: case-finding or screening; assessment; care planning; coordination and referral; monitoring; review; and care co-ordination, which includes: medication management; self-care support; advocacy and negotiation; psychological support; and monitoring and review; followed by a final element, case closure, for time-limited interventions (Ross et al. 2011; Hutt et al. 2004).

All of the participants acknowledged, that, while the essence of nursing in the home has not changed, the care needs of people requiring care in the community has risen and the practice of district nurses has developed to address this complexity. The participants in the group interviews did not explicitly refer to the term ‘case management’ as defined in the literature, however, much of their discussion made reference to key elements within these approaches. All the key informants made reference to the term ‘case management’ and that it is a large part of district nurse practice. B1 discussed the principles of case management, linking them to the development of integrated care. She suggested that the district nurses must be comfortable with the blurring of the boundaries between roles, but there is also a need to be clear about each individual practitioner’s role in addressing complex healthcare needs. She suggested that collaboration for assessment and decision-making, and delegation and reviewing, would be the key skills needed by district nurses to support them working in this way. C1, in her account, spoke much about the principles of case management within district nurse practice and highlighted the ongoing assessment aspect of it, which contributed to quality care. She also linked it to the building of relationships, a theme that will be discussed further in 4.3.4.

> Being a good case manager, to me, is a very important part of a district nurse, but also being aware that it doesn't stand still … I sometimes think there's far too many people going into the patient's house but I've got to be honest there's some very, very, very good nurses that have had a relationship (with the patient at the end of life) from the beginning and others they meet the patient at the end which is, it's a recipe for disaster. If you can get it right with the district nurse working closely with services I think it can work really well but I think it's got to be managed carefully. (C1)

C1's account acknowledged variances within practices, not just between district nurses, but also across services, in particular, social work. Normally she would advocate that the district nurse should be the case manager for people with long-term conditions and requiring end-of-life care in the community. However, she recognised that what is more important is that the district nurse has the required knowledge and skills of case management but can equally recognise there are times where the district nurse may not be able to take on the case manager role and another professional may be better suited to be the care manager. This is a key requirement within interprofessional working, as discussed in the next subtheme.

Key informant C2 gave an example where the district nurse, when managing a young adult's care, had practiced the principles of case management. It illustrates that the district nurse has appointed herself as the case manager. The district nurse describes how she practices assessment, care planning and care co-ordination with her nursing team for the management of the person's health needs, but also that there was a need to refer on to other services for her housing needs.

> … complex diabetic, loads, loads of stuff really. It was a health problem, although a social problem as well and she went in there and she managed that that care … with the home situation, linked to home carers, with the staff and staff nurses to look after the diabetes and report back, so she is a case manager. (C2)

This subtheme integrates many of the concepts addressed in the previous subthemes relating to decision-making and advanced assessment. These are linked to the context of care that contributes to a unique knowing of district nurses in practice in managing the healthcare of people with complex needs. It is also suggested that it is mainly the district nurse who assumes the role of case manager, but it is acknowledged that at other times an alternative professional may be the more appropriate to adopt this role. This highlights the requirement for the district nurse to have the knowing to practice interprofessionally as discussed in the next subtheme.

4.2.6 Interprofessional Working

In the previous subthemes the participants made reference to the requirement of the district nurse to work interprofessionally and across professional boundaries, but they also made reference to multidisciplinary working. It would appear that some participants are using these terms interchangeably rather than recognising the difference between them. It is outwith the scope of this thesis to analyse these terms in depth, but for clarity, multidisciplinary working refers to two or more disciplines working with an individual or family. Multidisciplinary team working normally involves independent assessment with each professional setting their own aims and planning care in isolation (Batorowicz and Shepherd 2008). Interprofessional working is regarded as working collaboratively, having a shared aim and being informed by a common understanding of each other's professional roles and organisational boundaries (Warmington et al. 2004). Therefore, to work interprofessionally you require an understanding of professional roles and team working ability, and there is more likely to be a blurring of boundaries. This theme explores the practices of district nurses in working interprofessionally. One group interview illustrated the variety of elements of interprofessional working, as one participant commented:

> 'Cause you're not only dealing with the patient, you're dealing with the carers, the family … all the problems that go with it. You know, the housing situation, I mean you're really a social worker, you know DN, doctor, the whole lot rolled into one. (GA26)

Taking this excerpt in isolation it may appear that the district nurse is taking on the role of all professionals and the boundaries are becoming increasingly blurred. Or, alternatively, the district nurse is working beyond the scope of her practice and agreed policies within her area. However, if you consider the data analysis as a whole, what is becoming apparent is that district nurses, like other professions, have expertise that is specific to them, but they also share commonalities of practice that other professionals could perform.

C1, throughout her interview, highlighted interprofessional working and how it has a strong correlation with the role of the district nurse in case management. In her account below, when referring to end-of-life care, she uses the term 'team working' and also refers to a multidisciplinary team meeting. However, there is a strong suggestion that decisions are person-centred with a common goal, and there is an assumption that the district nurse knows what is appropriate and understands professional roles.

> I think it's about team working including the patient, if for example it was a patient that was going home to die, it's about making sure that there's a multi-disciplinary team meeting with the patient or carers, whatever is deemed appropriate at that time, so that decisions are made and people know who, what roles is what. (C1)

It can therefore be concluded in this subtheme that district nurse practice has moved towards interprofessional working rather than multidisciplinary working, particularly to embrace the concepts of case management that address complex healthcare needs as referred to in the previous subtheme. Therefore, the district nurse requires unique knowing to practice clinically in this way and to meet the developing political agenda and the implementation of integrated care (Public Bodies (Joint Working) (Scotland) Act 2014). It is worth noting that these data were collected prior to the implementation of the integration agenda in Scotland, but current practice at that time supported this way of working across the UK. Elements of this subtheme will be discussed further in sections, 'organisational ways of working' and 'building relationships'.

4.2.7 Public Health

This subtheme demonstrates how public health is embedded within the practices of all district nurses and is built upon from pre-registration nursing onwards as depicted in the picture of a field of poppies selected by one participant, as discussed previously. Another photograph that has particular applicability to this subtheme is the picture of an overflowing rubbish bin selected by participant GC5.

> It represents a bin, with lots of waste products round about it, but I think it's a real picture 'cause it captures social diversity, not just in the (region) of Scotland, all over the UK really, and that that's the kinda spectrum we deal with patients who are more enabled, who live in nicer lifestyles but across the spectrum we deal with poverty even in 2013. So yeah, it wouldn't be unusual for us to pass a bin like that. (GC5)

The selection of this photograph might be seen to portray a negative image of the environment and district nurse practice but when the supporting statement is analysed, it instead depicts aspects of social diversity within various populations that the district nurse practices in. The earlier comment referring to the resilience of the district nurse is also represented in this photograph. This participant also suggests that this is not just about one area of Scotland but also similar locations across the UK, and it can be concluded that an awareness of socio-political factors are central to district nurse practice. Other participants in the various group interviews confirmed this population focus in district nurse practice:

> It's about integration with our social work colleagues, promoting health and well-being, taking things back to communities, you know supporting communities needn't be complex but it is about time and investment. (GC2)

From previous subthemes and analysis of the data it is apparent that the district nurse considers public health within aspects of decision-making at both an individual and a population level. The district nurse also encompasses aspects

of both biomedical and socio-political public health practice. However, while district nurses are clear in their role in public health practices, it is not always evident to those who are outwith the discipline. This is compounded by the fact that the district nurse was not given status on the third part of the NMC specialist community public health register (NMC 2004).

One key informant illustrated the unrecognised public health practice of the district nurses and suggested that because the district nurse did not always contribute to quality indicators within general practice this element of the role was hidden.

> … the public health component I think is something that district nurses do, but it's not particularly recognised, so you know we have lots of public health targets etc. and I think district nurses contribute to that hugely … they enable, empower clients and patients to self-care, that's their key function but I don't think we're particularly being recognised as doing that because we are not doing it in the way that meets the government targets. (A1)

However, another perspective of this quote could address the outcome-focussed approaches outlined within Modernising Nursing in the Community (SG 2012b). That is, the outcomes should refer to what is important to people who use the service and that district nurses are required to work in partnership with individuals, families and carers adopting an assets-based approach to uncover priorities, strengths and capacities. No matter which perspective is preferred it is the district nurse who requires having this knowing of quality indicators and how they relate to public health.

Another key informant (C2) described how the public health practice of the district nurse has responded to the shifting balance of care to the community, and the changing political landscape (SG 2012b, SG 2008). She provided an example of how the district nurse had engaged with case management approaches which involved case-finding within populations and the subsequent development of anticipatory care planning for individuals. However, she did

recognise that not all staff have embraced all aspects of this population approach.

> I'm not sure, to be honest, if all frontline staff are getting it. I think this is a massive challenge getting nurses to believe that this not just another change for change sake, we need to consider the demographics of the country and not to focus on specific diseases. (C2)

The analysis of the data supports the changed practice of district nurses moving from a reactive service to a proactive approach, enabling, empowering and advocating individuals, families and communities to manage their health and well-being. However, as seen in other subthemes, there are some variances between perspectives. It is apparent that the level of socio-political awareness differs between district nurses and there remains the potential to develop this awareness further in the knowing of district nurses to address the policy agenda. What is clear is that the context of care in district nurse practice does influence public health practice. Opportunities are available for the district nurses in their practice to consider such factors as the biological, social, political, economic and environmental to improve health and well-being with individuals, families and communities.

4.2.8 Context of Practice

Throughout the substantial theme, clinical ways of working, the environment of the district nurse in practice is seen to contribute to the uniqueness of the knowing. I have chosen to organise this theme as a subtheme in order to make it explicit, but in reality, it brings together all the subthemes of this theme and its contribution seems to be significant with all the participants referring to the context of practice. The two main aspects that are apparent in the data are the intensity and unpredictability of nursing in the home, and the environment providing uniqueness in every nursing encounter. The following quotes illustrate the significance of the context of practice:

> You just don't know, you think you are going for one thing and it's completely the opposite … you uncover a massive complex situation and you thought you were going in to do an eye drop. (GB1)

> It is a unique environment, and each environment is different … truly in respect to people's uniqueness, eh, the ground rules are a bit different. (B1)

> We're so much aware of their social environment, and the social baggage, if I am allowed to use that, that goes with it, because within the context of the hospital, it's very speciality focussed. It's on that particular condition at that time within their four walls. (GC5)

> I think it is much more difficult in an inpatient service to get the whole picture of somebody. We're seeing them in their environment, this is where they live and you know, I think we get a much better picture and we should be picking up on that. (GB5)

These quotes demonstrate that participants were keen to convey their experiences relating to the context of care that they work in. The element of being a guest in someone's home and the person being at the centre of care within an environment that is unique and belongs to that individual is acknowledged. This type of care is perceived to be quite different from nursing in the hospital environment where it is often condition-focussed rather than seeing an individual in their entirety. The above quotes are clearly linked to assessment practices as discussed previously in section 4.2.4 where the context of practice provides additional considerations such as social networks to support care at home.

4.2.9 Summary

The importance of the context of practice is illustrated when the practices of registered nurses were explored and it was identified that it is mainly the district nurse who is able to see beyond the individual, take a population approach and demonstrate clinical expertise at a higher level. This context of practice

provides nuances where the district nurse is both a solitary visitor in a person's home and also a professional.

When considering autonomous practice, again, the environment was highlighted as a factor in the level of autonomy demonstrated by all nurses working in the community due to their mainly being lone workers. However, in this subtheme it was not the environment that differentiated the level of autonomy between the bands of nurses but the level of professional judgement and decision-making practiced.

When considering professional judgement and decision-making, consideration of the environment, both from an individual perspective and the community, appears to be unique to the practice of a district nurse. It is the advanced assessment practice of the district nurse that goes beyond the individual to consider the family and the community, whether it is acute or long-term care. Additionally, the approaches to managing healthcare needs by the district nurse, whether it is at an individual, family or population level, requires the context of care to be taken into account. The context of care of district nurse practice also supports interprofessional working, and allows district nurses to move towards a socio-political approach in public health working. It is acknowledged that there are variances between practitioners and across Health Boards, however, there is an association between the context of care and the unique knowing of the clinical practices of the district nurse.

In conclusion, this theme has provided insights into the clinical ways of working in district nurse practice. The practices of registered nurses are variable, but many of the participants highlighted that those who have undertaken a graduate form of education have a knowing that is unique to those band 5s, which is different from those who have had many years of experience but who have chosen not to undertake any formal further education. Similarly, there are variances of practice within district nurses. What is emerging is that as the practices of some band 5s develop so does that of higher bands, and the practices of a district nurse are moving to an advanced level. Elements of this finding are further reflected in the next theme.

4.3 Organisational Ways of Working

This substantial theme focusses on how district nurses organise their practice to deliver their clinical care and what unique knowing they require to practice, whether it is at a caseload level to deliver care, organisational level or national level, to deliver the political agenda. Elements of this theme need to be considered alongside the previous theme to identify what is unique to the knowing of district nurses in practice. The context of practice and how it contributes to the practices of district nurses is illustrated as in the previous theme. Again there are similarities and variances between participants and across Board areas.

4.3.1 Skill Mix

This subtheme illustrates the elements of skill mix that the participants identified as being unique to their practices and highlights local variances of practice. In recent years the skill mix within community teams has changed and there is a reduced number of band 6s (QNI 2014a, 2014b) and the band 7 roles, while conforming to *Leading Better Care* (SG 2008), demonstrate a level of practice within a variety of roles across Board areas. Some band 7s are the team leader, others the practice teacher of student district nurses, in other areas they are the advanced nurse practitioner in the community, and elsewhere they are a combination of these elements of advanced district nurse practice. This reflects three of the pillars of advanced practice: leadership; facilitation of learning; and clinical practice (Sabin 2008). It is evident in all Board areas that the change in skill mix has resulted from the development of the band 5 role and changes in competence.

> What used to constitute a staff nurse and their education and what now constitutes a staff nurse and their education is quite different. They are much more seen as a senior member of staff. ‘Old school’ band 6s are not happy, but band 5s are more than able and that debate’s actually across Scotland. (A1)

Group interview GA2 spent some time discussing skill mix from their experience. The participants acknowledged that previous practices in district nursing where there were a higher number of higher grades than other areas of nursing practice were not sustainable. However, there were different perspectives in relation to whether the district nurse should just manage the clinical elements of care or manage staff and teams. The key informants were all clear in what they expected of band 6s for today, however, in practice, it was not always the case as the following quote suggests.

> A band 6, I think now the expectation of that role is immense, the fact that they will be leaders, they will influence more, even more than their caseload that whole big picture. Some are working in traditional ways but that's not the future vision. (B1)

The participants in the group interview in Board B identified the challenges of skill mix from a district nurse perspective and all appeared to indicate they were working in a 'modern' way.

> Cause we're working with such large skill mix teams, unlike a ward where you've got direct care observation, we don't have that so we have to make sure our staff are competent out there … we don't know the patients on our caseload as well as we ever did, we've got the skill mix team delivering the care now, but there's a whole lot of work to be done outwith the patient setting as well. (GB6)

Participant GB4, a recently qualified district nurse built on this point and highlighted the importance of the district nurse's responsibility within a team. Within these excerpts it is suggested that the responsibility of the district nurse within the flattened skill mix has increased, particularly in relation to delegation and supporting staff in practice.

Both the key informants in Board C shared the same views in practices of band 6 and 7 district nurses. The participants of group GC made no reference to skill mix within their accounts or any associated challenges. It is suggested that this

may be because they have undertaken service redesign recently and a clear indication of everyone's roles and capabilities has been communicated in this Board area with facilitated support to manage change. In conclusion, it would appear that there is a need for local variation in skill mix due to local population needs within the parameters of the KSF (DH 2004). Therefore the knowing that is required in relation to managing teams of varying skill mix has developed for today's district nurse out of the knowing from previous years.

4.3.2 Service Redesign

Service redesign is a subtheme that illustrates some of the practice developments that the participants have experienced. Everyone involved in this study was aware of the demographics of the UK and the move of care into the community in all four countries, and that practices could not continue as they have previously. However, what was also recognised was the impact of this redesign on resources. One participant summarised this in the following quote:

> They're shifting the balance of care but they're not shifting the finance and they're no shifting people. (GC5)

With this in mind, all Board areas in this study have looked at delivering services in different ways. All key informants made reference to some level of service redesign in their Board areas that had occurred recently within the district nurse service. Some of this redesign has been developed from the Scottish review of nursing in the community (SE 2006b) and some as a result of more recent work, *Modernising Nursing in the Community* (SG 2012b). One of the community heath partnerships within Board A had undertaken recent service redesign with some district nurses working in geographic teams and others remaining attached to GP practices, as indicated in a previous subtheme. While the key informant in this Board highlighted a commitment to it, many of the participants within group interviews GA1 and GA2 were in opposition to this new way of working. It could be that these differing perspectives are related to managing change rather than the service redesign. The key informant in Health Board A was fully aware that many of the band 6s

in her area were finding it difficult to support this change. Interestingly, this key informant selected as an example of good practice a district nurse who was 'instrumental in grabbing the community nursing redesign' (A1). The key informant selecting this as an example demonstrates her commitment to change and that she has recognised those who will support the service redesign.

She reports that this was an individual, who did not really want to change her way of working, but who adopted a professional approach as a change manager, was always solution-focussed and used her team leader and motivating skills to support her staff with the change. While it may be argued from the data that this service redesign adopted a top-down approach and provided additional layers of service, which, as suggested by GA26, caused conflict, the attributes this individual displayed are key for all district nurses who are required to manage change.

Board B were in the infancy of redesigning their service at the time of data collection and did not offer anything of significance to this theme, although key informant B2 also gave an example of good practice; a district nurse who put together a proposal to manage an aspect of care differently, keeping quality improvement at the heart of it. Again, within this example the key informant identified what she expected to see within a district nurse's practice.

Board C has undertaken recent work in relation to service redesign and clarifying roles within the district nursing service, moving towards a proactive service developing anticipatory care and case management approaches. Key informant C2 summarised it:

> It's been a challenge trying to get some kind of standardisation, consistency across the district nursing communities and I'm not underestimating what (Board C) has done in the past few years, absolutely not, but I think we are now at the journey where people are beginning to recognise change and that it happens. (C2)

The fact that the group interview in this Health Board did not focus on challenges but were able to demonstrate a clear understanding of the service confirms that this change has been embedded in local practice. In addition to this they adopted a team approach to the redesign and involved all practitioners in the process. A part of this work, which both the key informants and group participants were keen to share, was the concept of 'virtual wards' or 'community wards' as termed in some areas, which have been integrated into their practice. This is where the 'ward' mirrors a hospital ward but the person remains in their own home, with the relevant services and professionals networking 'electronically' to manage the care (Ross et al. 2011). This way of working is formalised with the identification of clear processes and roles.

> An example of that is the community ward, there's a GP and an advanced nurse practitioner (band 7 district nurse), the community ward administrator. They would go out together and do the first visit and then from that assessment, which can take up to two hours, they would then go back and decide on whether or not it was a multi-disciplinary approach required, and then identify who they at that particular time would be best to take on the case management and care would then be co-ordinated through community ward meetings face-to-face and virtual. (C1)

The knowing that the district nurse needs to practice in this way is explicit and supports the move towards advanced assessment skills, case management approaches and interprofessional working as described in the theme 'clinical ways of working', but it also brings in additional organisational aspects of working within teams and managing change. This practice has been influenced by policy and, in particular, the integration agenda.

4.3.3 Political Influences and the Integration Agenda

Political influences, whether at a local or national level, are threaded throughout all of the themes and subthemes but were identified as a subtheme in within 'organisational ways of working' to illustrate some variances between practices. As expected, the key informants were all able to illustrate the impact of policy

on district nursing practice. Key informant A1 illustrates this in the following quote:

> We're a bit further ahead in terms of the integration agenda, I personally feel that's our get-out-of-jail. The bit that I thought was good that England is doing is defining and supporting the role of the district nurse and valuing it. I think we need to do a bit more aware of that in Scotland in terms of looking at the workforce workload, information gathering. (A1)

She linked her knowing to a UK-wide level in what England was doing in developing a vision for district nursing (DH 2013), however, was aware that currently England are not integrating services. Another key informant, B2, identified the elements of *Leading Better Care* (SG 2008), which the district nurses in her Board area were currently engaging with.

The political awareness of the group participants varied considerably. Group A1 found difficulty in responding to the question, 'What impact has policy had on district nursing practice?', participant GA12 was able to refer to the integration agenda and shifting the balance of care but then asked, 'Are policies and initiatives the same?' Participant GA11, who offered nothing to this conversation, with probing then replied:

> I think we are very policy-orientated, you know, we are very scared for our jobs you know a wee bit scared. I'm thinking of the attendance one that came out recently, there's been an awful lot of focus on attendance management. (GA11)

Both of these participants in this group interview demonstrated a lack of political awareness at a national level. First, GA12 was unclear of definitions related to policy and second, while GA11 referred to attendance management, it was in the context of her managing sickness absence in her team rather than at a national level managing levels of absence in the nursing workforce. GA11 is a district nurse who has done little formal study since obtaining her district nurse certificate 28 years ago but I would have expected GA12, because of her recent

academic study, to have been able to have provided a more in-depth response to this question and to have also made reference to *Modernising Nursing in the Community* (SG 2012b). This provides an example of the complexities as to how district nurse knowing is developed, which are discussed further later in this thesis. There was a similar picture in group A2, where they too focussed on local policy and initiatives such as 'releasing time to care' as a result of policy, but did not articulate their origin nor did they make links to the quality indicators that these initiatives are contributing to (SG 2008). However, one participant, GA26, who is educated to Master's level and had practice experience in various Health Board areas across the UK, did make reference to national health and social policy in Scotland and the rest of the UK.

The group from Board B appeared much more politically aware at a national level although at times they appeared cynical. It could be suggested that this may be due to their previous involvement at a national level in the pilot of review of nursing in the community (SE 2006b). They also do not want to lose their identity as a district nurse with the integration of health and social services in Scotland.

> There was visible, accessible and obviously that was … there was a lot of anxiety … then there was an evaluation … and there was nothing. (GB2)

> And now staff are, are apprehensive about integration … we've come through this and now there is a new agenda, will it be abandoned as well? (GB6)

> Again, if we have a unique role, which I think most of us, think we do, we don't want lost with integration I think we want to keep our identity. (GB5)

Board C mirrored Board B in their national awareness but did not appear as cynical about the integration agenda and regarded it as a way of working that was required in district nurse practice. However, they did make reference to some of the small projects initiated nationally, to be implemented locally, with

pockets of money often from the ‘change fund’. They saw those projects as a means to meeting government targets because of the deprivations scales in the local area but they did not believe them to be sustainable projects once the money runs out. Board A had identified similar issues with this source of funding.

> We have managed to get funding through the change fund for the out-of-hours service. There have been some great developments here. But the generic workforce still can’t tap into that resource. (GC2)

The accounts from all the participants demonstrate the need for the district nurse and the service to have a full understanding of national policies to ensure services are developed to meet priority areas but are also sustainable and are not raising public expectation for them then not to be continued. While there is some cynicism in relation to the integration agenda, it is here indefinitely in Scotland. Again, the level of knowing related to political awareness is variable among the group participants, but there is some evidence that some district nurses are becoming increasingly aware of the political landscape and the implications it has on practice.

4.3.4 Caseload Management

As indicated previously, the district nurse’s accountability for care extends beyond the person’s immediate need and therefore, managing caseloads to meet the healthcare needs of the population is complex. This theme explores this element of district nurse practice. A caseload is defined as the designated population within a practice or geographical area that the community nurse is responsible for (Bain and Baguley 2012). Within this role the district nurse is responsible for ensuring that the actual and potential needs of individuals and families are identified and met. There is also a responsibility to ensure that the health needs of individuals and families within caseloads are balanced and equal with those of the wider community in order to provide an equitable service (Kane 2014; Jones and Russell 2007). Caseload management is a complex process that encompasses many elements, including caseload profiling; referral

processes; documentation and tracking processes; skill mix; delegation; corporate and single caseloads; and geographical or GP-attached working (Kane 2014; Bain and Baguley 2012). Within all of the participants' accounts, all of these elements were discussed, but due to the inter-relationships between many of the concepts some have been reported within other subthemes to avoid repetition. This was a subtheme that the key informants did not explicitly contribute to, and while all of the group interviews did, each Board group focussed on different aspects of it.

Group A2 very much related their discussion on caseload management to the service redesign and the different ways of working which required different approaches. First, they identified the 'named nurse concept'.

> It has great benefits for patient care and things and having like a specific named nurse going into the same patient and just that continuity of care an' because you're communicating closely with them, it does make a big difference in a patient care. (GA25)

In both the practice-attached team and the delivery team working geographically in this Health Board, they strived to maintain a named nurse for all individuals. The participants did not identify this fact when discussing the service redesign and instead focussed on negative factors. While one could argue that having a named nurse is common practice in most areas of nursing, what this group is illustrating is that within district nursing, where there is no constant observation by a health professional, there are further complexities related to maintaining effective and efficient nursing care in the home. For example, the district nurse may only see a person once or twice a week for wound care. If there is no documentation detailing all aspects of the assessment and resulting care, and if different nurses are visiting the person without this information, any improvement or deterioration may not be obvious.

This group also had a fairly heated discussion on the principles of referral criteria to support the district nurse in practice. There became a particular focus on what was meant by 'housebound' and whether only the district nurse should

visit the housebound. It is outwith the scope of this thesis to explore the definition of the term 'housebound', however, what is important to consider is the various perspectives provided within this discussion and what this means to the unique knowing of district nurses.

> I mean some folk do take advantage of it. There's people that go away on holiday but have their bloods taken every fortnight at home. (GA22)

> I dinna think they fully understand that it's housebound that we should be dealing wi' an' you know, there are some patients oot there who, and family members, who feel it's their right to expect a visit, to expect district nursing input in some shape or form. I mean there are variations to that but I think the district nursing service canna cope with anything other than housebound, really. (GA25)

> But I mean there's people who say you're not housebound if your relative can take you out once a week … I mean that is housebound. (GA24)

To makes sense of this debate in relation to the unique knowing of the district nurse, consideration must be given to the advanced assessment of the individual, in a family in a community where environmental factors are intrinsically linked to professional judgement and decision-making, as described in the section 4.2, 'clinical ways of working'. It would appear that there is complexity in this particular decision required of the district nurse within their organisational ways of working to decide whether or not care should be delivered in the home.

Another element of caseload management that Board B introduced was the district nurse having to balance both a clinical role and a management role.

> When you're leading a team of thirteen, you've got all the management and the development and all of that around that bigger teams you need to keep a balance that team leaders are embedded in the caseload,

> particularly around the more complex ones. You can't manage your caseload if you don't see your patients. (GB5)

While the group appreciated that band 5s were able to undertake much of the direct care, it was acknowledged that the district nurse has the advanced assessment skills that often uncovered new healthcare needs that others had not identified. This does not mean that the district nurse has to undertake every visit of a person with complex needs, but there must be an identified plan for re-assessments of all needs, which must be considered within the management of the caseload. Managing the caseload therefore requires the district nurse to analyse not only the workload but also the dependency of individuals, carers and families within the context of care in the community to ensure that the team has the required skill mix and contributes to continuous quality improvement. This can be linked again to the accountability role of the district nurse within the duties of delegation and being aware of the capabilities of those in the team.

Participants of the group interview in Board C, in their accounts, focussed on the importance of the district nurse in co-ordinating and drawing in resources to contribute to caseload management. They highlighted the facilitation role of the district nurse in multi-disciplinary and multi-agency working. This is demonstrated in their example discussed earlier of the community ward.

Within this subtheme, some elements of caseload management are raised which contribute to the unique knowing of the district nurse. There are overlaps with other aspects, such as interprofessional working, as reported previously, and developing technology, as reported in section 4.3.3. What is evident is that the district nurse requires the skills and knowledge to organise care and manage a caseload, which involves care organisation, prioritisation, co-ordination and delegation, whether that be within a practice or an otherwise defined population.

4.3.5 Summary

This theme has demonstrated that in order for district nurses to practice they must have a good understanding of organisational ways of working in the

community. This theme has explored, at a micro level, caseload management; at a meso level, service redesign; and at a macro level, the impact of national policy on organisational ways of working. Again, the level of knowing in this theme demonstrated by the various participants was variable. However, it is evident that for the district nurse service to ensure the needs of the population are identified and addressed within the policy agenda, the district nurse must possess a knowing beyond that of a registered nurse and one that is specific to the context of where they are working. This knowing in practice involves the analysis of data at both a caseload and population level to ensure efficient and effective healthcare is delivered in the community.

4.4 Developing Technology

While developing technology is integrated throughout many of the themes, and particularly in 'organisational ways of working', as indicated earlier, I have selected it to be a theme in its own right in order to highlight the development of new practices of a district nurse. All Board areas made some reference to technology. Board A and B focussed on the use of information technology (IT) to support their ways of working, whereas Board C focussed on technology to support the management of individuals' healthcare needs in the community using telehealthcare. There have been parallel developments between telecare and telehealth, as technology has developed, but as care has become integrated, there has been a convergence of telecare and telehealth, resulting in the term, 'telehealthcare' (Bain 2012).

4.4.1 Technology to Support Change

The use of technology to support change of practice is currently developing from both a person-centred care and professional perspective. However, the different board areas are at different stages of integrating technology into everyday practices. Its availability and the ability of practitioners to use it vary considerably. One of the recurring discussions in this theme was the potential for caseload management software that could cross professional boundaries and enhance ways of working between health and social care staff. The participants of Board A reported that they were in the infancy of introducing

systems and they had raised this at a national level as an area that needed more resources and support to develop.

> Our IT being very linked into our practices, we don't want a separate system that's a do-it-yourself for community nursing that doesn't speak to anybody else. It might give us the information and what we need but it doesn't join up for the patient and most of our patients are not going to be ours in the future … the kind of patients we're now looking after will be seen by multiple people, I would say. (A1)

Overall, there was a perception that it would improve working practices, however, others thought it would take time away from the persons receiving care and the potential increase in the use of IT could reduce contact time, as GA26 implies:

> You think that will help, you're going to take so much time doing your IT, you'll not be able to see your patients. (GA26)

It is difficult to make a conclusion from this quote currently, as the development of IT is in its infancy and not embedded within current practice. Another consideration is they are in the transition phase with staff learning new systems. This issue is illustrated in the Board B group discussions where there are several processes being used as they move towards electronic health records and caseload management systems while they are also still using some paper-based systems. They acknowledge that it is time-consuming but identify its future value:

> You've got your record in the home done, you've got your Midas done, you've done the workforce tool, you've updated the Excel spreadsheet, all time-consuming … we just have to keep abreast of what's going on, things are changing all the time. (GB4)

Interestingly, Board C did not use the same language when referring to technology in the organisation of care but instead focussed on their local

development of ‘community wards’, as discussed previously. This Board also appears to be more accepting of its use of technology as everyday practices and did not focus on the challenges as the participants in Board A and B did.

Surprisingly, there was little reference to the use of technology to manage individuals’ healthcare needs in any of the data, particularly support for self-care, as promoted in Scottish policy (SG 2013b, SG 2010). The group interview in Board C was the only group to highlight the use of telehealthcare.

> Aye, I’ve done about two years work on it now, so it’s been great, we’re really having a lot of success in keeping patients out of hospital and treating their exacerbations at home … it’s not just the telehealth on its own, it’s working with social work and enablement services, bringing in all the services at the right time for them to support them at home. It’s been really successful, it’s not just the telehealthcare on its own, an’ I think people get kinda bogged down with the actual equipment, it’s not just about the patient, it’s the bigger picture. (GC1)

These group participants had a good understanding of telehealthcare using the terminology accurately and identifying its links to the policy agenda. It is apparent that this group identified telehealthcare as being part of managing healthcare needs at an individual level, supporting self-care or case management, but also within the larger context, whether that be at the community level or as a way of delivering a service in a new way. They demonstrated the underpinning knowledge, skills and capabilities needed to practice in the evolving eHealth world (SG 2011a). For example, they described a person with chronic obstructive pulmonary disease using an ‘app’ to monitor his vital signs, and if the signs were outwith normal limits, he would then contact the district nurse for intervention and support. This approach promotes self-care and provides a new way of working for the district nursing service. Another example was provided in relation to the sensors used within a local sheltered housing complex that allows high-risk people such as those with dementia to live in their own homes. Interestingly, this group focussed on the benefits of technology rather than the challenges.

4.4.2 Challenges of Technology

Board A and B gave accounts that reflected the challenges of technology. This is not to say that there are no challenges within Board C, but they provided a different perspective. One participant, when asked to describe a challenging situation that she was able to resolve or not, decided to discuss the caseload management tool. She regarded herself as an expert in its use: 'I am a super user and it's still challenging' (GA24).

What she identified as a major challenge was that the technical competence of staff was not standard. One participant identified her lack of IT ability and relied on other staff members if she needed to access material electronically.

> I mean, I'm not really, really good at getting my way around the computer. I mean, I know what I need to do at work, but sometimes going into the internet and finding some of the policies is a bit daunting. Sometimes I, I like to have the younger members of my staff, you know, giving me a hand 'cause they're a bit more orientated to the computer. You mean we download and we copy them and you think well, it just sits in a folder. (GA11)

She made reference to IT usage being linked to age, however, when considering the data across the participants in table 2, there does not appear to be any correlation to age, as other participants with similar age ranges were IT literate (participants' age was not asked, but from their experience in district nursing and my knowledge of the participants, a range could be estimated). Rather than to age IT literacy could perhaps be linked to other factors, such as recent study and personal motivation. Another point in the excerpt above is that GA11 identified a need to download and have a hard copy of the policy rather than always accessing it electronically. Another participant focussed on another challenge; the lack of IT infrastructure to advance practice. She used non-medical prescribing as an example.

> I was very keen on non-medical prescribing, when it came out, but the reality is the processes are so difficult. You almost feel that they are investing a lot of time in running back and forward with bits of paper. (B1)

This comment relates to the earlier reference to the lack of electronic health records and shared record-keeping systems. Reliability of systems was also another factor that was raised in this group. Many were apprehensive in case the system crashed and there was no back-up. One participant reported that:

> We've had a few significant events with GPs when patients have been missed because it (IT systems) fails. (GA22)

The participants in this group appeared to have a lack of confidence in developing technology and were focussing on its negative aspects. They did suggest that administrative staff should be inputting into IT systems and there should be further availability of technology to support practice.

4.4.3 Support to Develop the Use of Technology

Group A2 had a robust discussion as to whether staff were being used to their full capability and linked this to the use of IT and the lack of administrative support.

> And the amount of IT, that you're doing the faxing, they seriously need to get some really good admin people. (GA26)

It was recognised that administrative staff could be a solution to some of the challenges. However, in reality, technology will not address healthcare agendas unless practitioners develop beyond computer literacy, obtain information literacy and are able to integrate all of the elements of eHealth into their practice (SG 2011a). The key informant from Health Board A recognised this in their service redesign and regarded technology as one solution to support leadership and the development of practices:

> So actually, delivery of care will be done much more by band 5s, and ultimately band 4 and band 3, and then supported much more by the admin processes, because there is gonna be much more technology. (A1)

This quote demonstrates that all practitioners will have to adopt the concepts of eHealth and its technology within everyday practice. It is apparent that many will require support for this to happen, but it will be the district nurse as the leader of the team who would have the responsibility to support staff in their professional development in this area. Some participants made reference to the lack of training in IT for all district nurses:

> We're not computer trained are we, no. (GA22)

> Is it because we are not IT trained? (GA23)

It appears here that the participants are focussing on computer literacy when they refer to training. The dichotomy demonstrated in the above excerpts could be related to the workforce within district nursing who have undertaken no formal education in recent years and it would appear that there has been limited availability of in-house training. In contrast, there are those who have independently sought available opportunities to develop skills in the practice of using technology to support their work. Nurse education providers have now embedded computer and information literacy within their programmes and the NMC (2010) recognises that it is a requirement for all registered nurses to become competent in the use of technology. For those who undertook nurse education prior to the 2010 NMC standards, they have a professional responsibility to practise effectively according to the revised code (NMC 2015). Not being competent in technology to address today's healthcare needs could therefore be seen to be a breach of the professional code.

4.4.4 Summary

This theme illustrates that technology is a major and dynamic element in the practice of healthcare. This theme has illustrated the diversity in practices of

district nurses in the use of technology, whether it is to manage caseloads or to address healthcare needs. While it has been identified that applying the principles in district nurse practice can be a challenge, these challenges need to be overcome. eHealth is integral to government policy and all registrants have a responsibility to be competent in the use of available technology. What is not explicit in the analysis of the data is whether the district nurse will require further unique knowing to that of any practitioner to support their practice in the use of technology. However, it can be assumed that this would mirror some of the discussions in the section 4.2, 'clinical ways of working' and 'organisational ways of working', in that the influence of structures and systems within the context of care in the community will require the district nurse to have some specific knowing in the use of technology, in particular, telehealthcare.

4.5 Building Relationships

In all of the themes explored in this chapter so far, the significance of building relationships at all levels within district nurse practice is evident. This is particularly apparent in the 'interprofessional working' subtheme. In order to best illuminate this theme, some of the significant events shared within the interviews will be used to illustrate the importance of building relationships.

4.5.1 Engagement Within and Across Professionals

The practice of the district nurse working within and across professional boundaries, again, is highlighted within all of the accounts and it continues to evolve as the integration agenda becomes embedded within practice. The following quote from a key informant illustrates this point:

> In the future we cannot work in isolation because we haven't, any of us, got the capacity to do that anymore, we are going to have to fine-tune what all our bands do, so getting the best of our resources so that we're optimising it and being the most efficient that we can be. And that's working jointly with our council colleagues, and to do that you need to build up trusting relationships and that's not just within health and our social work colleagues, it's our private agencies. (A1)

However, while this is an example of the ideal, a significant event shared by GA21 demonstrates the reality of what can happen in practice within these relationships.

> I was phoned by the GP at quarter past four, one Thursday afternoon, and I wanted to know about the patient before I could do anything, he wanted me to go and set up a syringe driver, when I didn't know nothing about the patient, blah, blah. So eventually after about ten minutes, I got the gist of what he was wanting, so I went in, the person had been in agony since two o'clock, I was there about twenty to five. She was promised a nurse to come at two, apparently he'd left a message on the practice-attached nurse's mobile phone, who was on holiday. Private mobile phone, she was on holiday, so anyway, so that, that was fine so we've got the lady settled, that was fine, I got her, he came rushing in after me and, she wasn't written up for a syringe driver, but she was written up for just the breakthrough, which I'd given her. So he, I got him, I said, 'Right, write her up for a syringe driver,' I got the evening nurses in, so everything was sorted. The family were very unhappy with him, the Doctor, so he bounces it back to me, and blames me. So then there was a significant event with the GPs. And he was trying to accuse me that I held him up and he was a young Doctor and however, that was basically sorted … The outcome was the patient settled within ten minutes after we got there, and she did die, you know, after a couple of days, and she was settled after that, but it was the initial, that he'd promised a Nurse would be in from two o'clock which I knew nothing about 'til when I got there, and that was the gist of it. That was quite harrowing for the family. (GA21)

First, this event demonstrates that there were tensions between the practice-attached service and the direct delivery service. The practice-attached district nurse had been caring for this person independently and information about the care was not shared at this person's advanced stage of illness. While maintaining this level of personalised care can enhance the relationship between individuals and the nurse, when out-of-hours care is required, or if a

person's needs suddenly alter, as in this case, the rest of the service is not fully aware of the situation. From other excerpts in the accounts from this Health Board it would appear that there are some differing opinions in the ways of working between the practice-attached and delivery service for the provision of end-of-life care that could have contributed to this situation.

The second issue to explore within this scenario is the relationship between the GP and all district nurses involved. Of note is that a personal mobile number was used between the GP and the practice-attached district nurse. While most would agree that this is not best practice and erodes personal boundaries, as stated in section 4.3.3.1, the availability of technology is limited in some areas so it can be normal custom and practice for professionals to use personal mobiles between each other. This would also indicate that the relationship between the GP and his attached district nurse was well established. In contrast, the conflict between the delivery service district nurse and the GP demonstrated a lack of teamwork and a poor relationship. Both, on the face of it, were blaming the other, rather than taking a step back to examine the relevant issues and build professional working relationships. The professional relationships also have an impact on the relationships that the individuals have with the person and the quality of care provided. While this is an example that demonstrated some conflict in relationships within and between professionals, there are many accounts in the data of positive outcomes.

Another participant in Board A described the development of multidisciplinary palliative care meetings which changed from fortnightly to weekly due to their value in managing care. Board B shared an example of where they developed a relationship with paramedics and a minor injury nurse to address a gap in out-of-hours services. While the participants acknowledged some teething problems and some found it difficult to accept other professionals being involved in this service, overall they were positive about the new relationships established and the service provided to their local population. Board C's example of the virtual wards, as described earlier, is also an example of how district nurses build relationships.

Human factors will always challenge relationships between individuals, and the district nurse, like any other professional, will, on occasion require the skills for conflict resolution between and across professions. Building working relationships involving trust, mutual respect and acceptance of diversity are common to all professionals, but what is unique to the district nurse is the advanced level of her practice and the greater responsibility of district nurses to build effective working relationships to lead and manage professional networks within and across professions. These highly developed interpersonal skills, involving influencing and negotiation skills, support partnership working and result in the development of services.

4.5.2 Person-Centred Relationships

The importance of person-centred relationships was apparent throughout the analysis of the data. One of the main differences from the inpatient setting within the relationship is the fact that the nurse in the community is a 'guest in people's homes' and this can have an impact on the relationship. GB4 summarises this:

> We're guests in people's homes you know, the intensity is different, we have long-term relationships with patients over years often and are intimately involved in their lives. Also you may be the only person this person sees in the next two weeks. (GB4)

Considering all these elements it is apparent that the relationship that a nurse in the community has with the people she is providing care for can have different perspectives to the professional relationships within a hospital setting. One of the group participants shared a significant event that demonstrates the importance of building relationships to provide non-judgemental, value-based care, which can be considered as emancipatory knowing.

> I was new to the caseload and I had a patient who thought that she hadn't been well treated because of her age, because she didna fit certain age criteria for getting home visits, and there had been lots of in-fighting with Nurses wi' attitudes towards her, and her attitudes towards

> Nurses and when I came along they wanted a huge case conference for me to set up and to go and deal with this, but I just remember thinking, I don't like the way that anybody's treated this lady, and I just thought it would be a good idea having to, I didn't hardly know anything about her, I had no opinion about her, whatsoever, but I mean she was on the point of, suing. Because her treatment had been so bad, so I did go in and speak to her and ask her what it was that she wanted, what kind of care that she wanted and removed everybody from her care for quite a while and just did it myself, 'cause she had been on the books for about two years, and things definitely calmed down way much after that to the point that she's just about healed, and off the books and a very happy customer. (GA12)

This example demonstrates the ability of the district nurse to develop a relationship with the person avoiding previous assumptions that were perhaps influenced by her colleagues. It is not always in the person's best interest for one nurse to have a relationship with the person to the exclusion of others as demonstrated in the first significant event, however, in this case the district nurse utilised professional judgement and decision-making skills for a positive outcome. First, the district nurse made a professional judgement that the relationships that this person had with the existing nurses involved in her care were not conducive to addressing her healthcare needs. A decision was then made to remove those individuals from her care so a new relationship could be established to facilitate her care. This action demonstrates the expertise of the district nurse in using professional judgement and decision-making skills in establishing relationships and resolving conflict, and also taking account of the context of care and being a guest in an individual's home.

4.5.3 Summary

The significant events shared in this theme illustrate practices of the district nurse in relation to building relationships within and between professionals, and of having the person at the centre of the relationship. What is unique in district nurse practice is that the nurse is a 'guest' in a person's home, which can add a

different dimension to the relationship. The ability of the district nurse in establishing relationships can be linked back to the themes, 'clinical ways of working' and 'organisational ways of working', in that the context of practice is unique and that some advanced interpersonal skills are required.

4.6 Leadership

The final theme that contributes to the unique knowing in practice that characterises the expertise of district nurse is leadership. Leadership was recognised by all participants as a key component of practice in all levels of staff. However, there were some different perceptions of what leadership is. There was a tendency for some of the participants within the group interviews to see some leadership activities of the district nurses in the practice congruent with managing teams and caseloads. When one participant was asked, 'What do you mean by leadership?' she replied, 'Just, well running the team, you know' (GA12). The majority of participants distinguished leadership and management in the practice of district nurses as individual concepts and were able to articulate them across the bands of the KSF (DH 2004) and some explicitly linked leadership to *Leading Better Care* (SG 2008). Others within their discussions focussed implicitly on clinical leadership, as identified in *Leading Better Care*, that is, leadership that takes place in the clinical setting, in this case, the community, which aims to enhance care and results in positive patient outcomes (Taylor and Martindale 2013).

4.6.1 Levels of Leadership

The participants discussed the levels of leadership across the bands of staff and identified staff at all levels who demonstrated leadership. However, it was mainly a hierarchical image that was portrayed, in that band 5s lead healthcare support workers and band 6s lead band 5s. It could be suggested that this is linked to clinical decision-making, as the following quote illustrates:

> Well, I know in my team, the, the girls (band 5s) will come back from their visits and say, 'Oh, I'm not sure about this wound, will you go and see it?' So now I'm trying to keep up with and review every so … (GA24)

In this case it would appear that higher bands display greater autonomy in their decision-making. While all levels of staff assess and manage evidence-based clinical care, the above quote suggests that if the registered nurses at band 5 assess any change they would refer this on to the district nurse for re-assessment. This district nurse has built these occurrences into her practice and plans regular reviews with the people she is managing to avoid unplanned visits. It could be argued that this practice is stifling the development of practice within the band 5s or, alternatively, it represents a level of practice that requires the district nurse input.

Board C identified clinical leadership in both band 6s and 7s and indicated that the knowing that district nurses practice is dependent on leadership at a higher level.

> The band 6s for me lead their team, they're responsible operationally, for managing the team but they're also responsible clinically. Some band 7s are more of an isolated role at the minute with the band 7 advanced nursing practice, the key's about the decision-making … you know I think there's certainly very good areas of clinical leadership out there, and I think, there's other areas where it's maybe not so good and people are stilted and I think that's the same in any role. I think sometimes, there is a lack of direction … Boards, I think, do go to the government and say, 'Tell us what to do,' but then, there's the other bit where Boards say, 'No, we don't want you to tell us what to do.' We have a leader in community nursing in our Board at consultant level. I think the leadership at this level has to be a good thing if the organisation uses the post effectively. (C1)

> There's the operational part of the team leader's role, but there's also another part around integrating with other services, working at a higher level and we would expect our band 7s to be leading that. (C2)

The practices of the band 6s and 7s in the community in Health Board C are not common to all areas as indicated previously. In particular, some of their band

7s have developed in relation to advanced practice. The use of the phrase ‘at the minute’ by C1 suggests that it is the band 7s who are contributing to leading this change in district nurse practice presently, but in the longer term the roles of lower bands will be developed to work in new ways. C2 confirms that it is the band 7s who are working at an advanced level, leading change across professionals. It would appear in this Health Board that having an identified clinical leader at a strategic level has had an impact on the district nurse practices in that her clinical experience has been used to drive service improvements and develop a vision for the service.

In Health Board B, a key informant discussed the difference between a band 6 and 7:

> I think the 7s have an operational management and leadership role of the teams, over more than one team. (B2)

The above quote suggests that the leadership at band 6 level is related to managing a caseload and that band 7s have further responsibility across teams. This view was shared with the key informant from Board A. Unlike C2, key informants from Boards A and B made no reference to leading across professional groups when speaking about leadership. However, when referring to the integration agenda and the need to work interprofessionally, all key informants implied that the district nurse will be required to influence and deliver on this agenda.

It is apparent in this subtheme that the Board areas are in a period of change as roles are being developed and some areas are further ahead in this agenda. Overall, it can be concluded that the band 6 district nurse is accountable for the management of a defined caseload, whereas the band 7 district nurse is accountable for leading teams. It would appear that having a clinical leader at a strategic level facilitates change amongst leaders at all levels; and that as the practices of district nurses develop in new ways leadership attributes are also developed.

4.6.2 Characteristics of Leaders

As identified within *Leading Better Care* (SG 2008), leaders are required to ensure person-centred, safe and effective practice. One of the key aspects of leadership identified in the analysis of the data is that of being a positive role model. The following quotes illustrate this:

> Her own personality and her own enthusiasm and her own professionalism have taken her. We've recognised that through eh, the way that we work and developed her. (A1)

> You can still make a difference by contributing to whatever you are discussing, and to make the most of time that your all together … rather than just go, 'That meeting was a nightmare,' when you come out … there's a lot of that. We have dignity at work and we're all very good at listening an' letting people say how they feel and having the discussion and openly talking about what their concerns are without falling out with anyone. (GB4)

Both these quotes identify elements of being a role model that contribute to leadership and adhere to professional codes (NMC 2015). The second quote focusses on the leadership role individuals have within meetings where everyone has a responsibility to the team success, and professional respect and the ability to have constructive professional debate are illustrated. The following quotes recognise other attributes of leadership, such as self-awareness, and suggest that for effective practice, change management skills are also required.

> It's pivotal but at the end of the day, it's your nature as to whether you're going to challenge yourself if you're not open. You know, if you're resistant to change all the time and you're not self-aware, it doesn't matter about the KSF, that's not gonna change, but if you have enough self-awareness to say you know I'm really good at this I need to push myself in that direction and here I've got somebody in the team that's

> good at it so we'll work together to do that, but you have to as a team leader know that. (GB5)

> If you don't have a team leader who's keen on change, and you don't have anybody in the team who will push for change, then you're stagnant. (GB1)

The attributes of leadership have been documented widely and many are evident in the quotes above. However, many are not unique to the district nurses and could equally be applied to any area of nursing. What is unique to the district nurse is the context of practice and their requirement to work with policy and, in particular, the integration agenda (Public Bodies (Joint Working) (Scotland) Act 2014; Addiccott 2014) to lead safe, effective and person-centred care, not just within their own team but across professional groups.

4.6.3 Developing Staff

Another aspect of leadership that is apparent in the data is that of developing and motivating staff. Staff development will be explored further in the next chapter when the perspectives of continuing professional development are explored, however, as many of the participants linked the supporting role in developing staff to leadership, this subtheme will be briefly discussed here. The following two quotes illustrate this relationship:

> You know we're getting much better at identifying if staff have got the knowledge and skills and looking at leadership and using our policy frameworks. (GA12)

> Leadership, making sure that all the team members are as knowledgeable as they need to be for the caseloads that they are currently managing. Leadership is in that wider sense of working alongside other agencies when you're trying to plan and negotiate different approaches. (B1)

Knowing the individuals' level of competence and being able to support them using available frameworks links back to the district nurse being responsible for her team as indicated previously. It could be concluded that the assessment of staff's competence will be increasingly important as the integration agenda is fully embedded in practice (Public Bodies (Joint Working) (Scotland) Act 2014) and the district nurse will need to consider individuals' practices beyond the nursing team. To deliver the political agenda, the district nurse is required to adopt strategies that create a suitable environment in which to support the development of staff. Furthermore, they are required to anticipate the practices and capabilities that will be required and plan proactively for future care delivery based on current directions of travel in policy.

Developing staff to cope with change management has also been linked to leadership. The following quote illustrates how, through enabling staff development, change can be facilitated:

> It's about bringing in their leadership of how they get their teams on board an' also to support staff to see there are other ways to do things. If you get left and you've always worked in a certain way, do you continue to work in that way? If you've got a leader who's motivated and encouraging people and, you know, taking the time to understand. There are maybe some of these people who you can coach to move on in a different way. (B2)

In order for the district nurse to support staff in this way, an advanced level of knowing is required in relation to the context of practice to support the application of leadership. In conclusion, this subtheme has suggested that the district nurse's ability to lead has an impact on the development of staff. The next chapter will explore this finding further.

4.6.4 Summary

In this theme, participants' perceptions of leadership were consistent, overall, with the literature and they were able to recognise it across bands of practice with the hierarchical structure of the NHS evident. In particular, clinical

leadership as identified in *Leading Better Care* (SG 2008) is practiced. While leadership is common to practices of all professionals, it is apparent that leadership is contextualised within the practice of district nurses, and this contributes to the uniqueness of their knowing in practice.

4.7 Conclusion

This chapter, through the selected five themes, illustrates the unique knowing in practice that characterises the expertise of district nurses. There are varying perspectives provided from participants and Board Areas, with gaps between the accounts of district nurses and the key informants, and between district nurses and individuals, and across Health Boards. It is apparent that district nursing practice is in a period of transition with the shifting policy agenda, and with the changing context of health and social care having an impact on future district nurse practices.

The starting point to identify the unique knowing of district nurses in practice is the consideration of the knowing of the registered nurse. Caring and person-centred evidence-based practice was identified as a fundamental part of nursing practices in all settings. However, the data in this study highlighted that registered nurses normally adopt an individual perspective on care, but it is the district nurse who works at a higher level and considers individuals, carers, families, and communities; and adopts a population focus that reflects the policy agenda. This requires an advanced level of practice where the context of care is an essential consideration and characterises the unique knowing of the district nurse in practice.

The themes were all developed from the data and interrelationships between the five themes and subthemes were identified at all stages of the analysis, but I chose to present them as they stood to ensure that I did not make assumptions. Now, having explored it fully, a matrix of district nurse knowing has emerged with two major themes: clinical ways of working and organisational ways of working; and crossing these are those of: developing technology; and building relationships. Leadership cuts across all themes and

the subtheme ‘context of practice’ within the substantive theme ‘clinical ways of working’ is also seen to cut across all the themes. In the exploration of the themes in this chapter it has also emerged that the unique knowing of district nurses in practice is an amalgamation of all the different aspects of knowing that contribute to leadership as suggested by Jackson et al. (2009); and professional and disciplinary theory (Bergen and While 2005), which will be discussed in chapter 6.

Chapter - 5 The Development of Knowing

5.1 Introduction

The previous chapter presented the findings from the data analysis that represented the unique knowing in practice that characterises the expertise of the district nurse. It was acknowledged that there are some variations in the practices of registered nurses and district nurses. This chapter discusses the findings in relation to how the knowing of district nurses in practice is developed, and contributes to the second and third research questions: considering the workplace elements that help to develop the unique knowing in practice of district nurses; and the formal educational frameworks that support the development of district nurse knowing. The theme identified in the analysis of the data: perspectives on continuing professional development, contributes to this chapter.

5.2 Perspectives on Continuing Professional Development in District Nursing

Chapter 2 identified that literature specific to the development of knowing of district nurses in practice is sparse and there is no consensus based on evidence, as to how the professional knowing identified in chapter 4 is developed. This substantial theme, 'perspectives on continuing professional development in district nursing', which emerged from the data will illuminate some aspects of this. As in the previous chapter, the subthemes will be used to structure the chapter and quotes will be selected to illustrate points.

5.2.1 The Appraisal Process in Practice

This subtheme brings together the discussions related to the appraisal process for individuals within the NHS, which is currently linked to the KSF (DH 2004). This Framework is recognised as a broad generic framework but does not provide the specifics of individual roles. All participants were asked directly, 'To what extent does the KSF support district nursing?', and all participants contributed to this discussion to varying degrees. The group participants

focussed on the framework from an individual perspective. Overall, they acknowledged that it was time-consuming but were positive in its use as confirmed by one participant:

> I think, it's quite challenging, the KSF, but it's good. (FGA11)

However, GA2 provided a different perspective on it, claiming that it was a tick-box exercise, while another group interview, in Board B, acknowledged that it had the potential to be a tick-box exercise, but argued that it has the ability to support individual development with critical feedback. The framework was also recognised as being a useful tool for supporting a community staff nurse to progress to a district nurse.

> Well, they should progress on naturally to do their district nurse degree, I mean this is what happens here the staff nurses are nurtured, they get experience, they get a lot, you know, support from their district nurse and then they just go on. (GA26)

This supports the framework's value in providing a platform to plan staff development. The key informants all focussed on how this framework feeds into the organisation and supports personal development plans and local training plans. Key informant A1 outlined how it identified individuals' development needs over a period of time and the links to the organisation and key informants B1 and B2 highlighted its flexibility and mutual benefits.

> I think we're getting much better at using the KSF and proving then the worth and value of what a district nurse's skills is required to do the job and also the band 5s. Team leader role has the responsibility of identifying what is required in their teams in terms of knowledge, skill … we've got training plans out there and they've got their appraisals, so there's ways of identifying, you know, short, mid and medium to longer term. (A1)

> I think it's a good framework, it allows staff to see how they are being measured, gives guidance and mutually agree developments, I would say not in a prescriptive way. (B1)
>
> We look at individual needs through personal development plans and we have improvement plans for the service and as part of that we have a training development plan. (B2)

While both key informants in Health Board C were supportive of the KSF, both highlighted how in Health Board C a newly developed competence framework specific to district nurses had been integrated into the framework. This could imply that the KSF as it stands is not robust and does not support the continuing professional development of district nurses, which could perhaps explain the variances in practice between individuals. However, another perspective is that the context of practice is different across Scotland and this allows some local flexibility to build on top of the KSF.

It can therefore be concluded that the KSF is a useful tool to measure performance through a formal review process and provide a tool for planning continual development needs. However, it does not suggest how development can be acquired or maintained, and is broad in the sense that it does not identify the unique knowing required of a district nurse.

5.2.2 Organisational Support

This subtheme explores various aspects within organisations that the participants identified as developing the unique knowing of district nurses in practice. There was a strong view in all of the interviews that leadership within organisations potentially develops knowing. In addition, some of the practices around the infrastructures and organisational processes were identified as either supporting or restraining development.

The group interview within Board B had an in-depth conversation about leadership within district nursing and suggested that this is the reason why there are so many variances across Scotland in the district nurse service. This

group were very clear that there needed to be a leader of district nursing at national level, and at Board level above a band 7, to provide strategic leadership to support change and develop district nurses. The following quotes illustrate some of their views.

> My perception, I mean I'm not sitting on the Board so I don't know, but my perception is there is nobody taking a lead, so where other Boards may have looked at their population and decided what direction we are going in. I am certainly not aware that been the case within (Board B) ... we need a lead, we need a vision. (GB4)

> If we had in (Board B) a strong leader of community nursing, who could speak for us all, I know I keep repeating myself but I do think this is the crux of the problem. We have no lead, and we have no vision, we have to try and manage that, you know set up a framework for ourselves that make it safe, you know. (GB5)

> Thinking about the variances … we still need someone above that (the band 7s) that is gonna actually support us, you know. (GB6)

The group participants in Health Board A mirrored the views of Health Board B, identifying too the lack of professional leadership and a vision to support staff curtailed the development of district nurses in practice, as stated in the following quote:

> It's difficult to get support from the organisation if we don't know where we are going. (GB5)

This is quite a different view from Board C, where practices have developed as discussed in the previous chapter, and where in section 4.6.1, it was suggested that the knowing in district nurses' practice is dependent on professional leadership at a strategic level, and on the support provided to staff in managing change. Therefore, it can be concluded that professional leadership influences

the development of practices and provides part of the infrastructure for this to occur.

The previous subtheme explored the value of the KSF; this subtheme now considers how the framework fits in with organisational processes and resources to support the development of staff. First, key informant A identified that the practices of district nurses are related to resources:

> We're quite good I think at recognising our district nurses aren't going to be doing that … because we don't have the capacity. (A1)

She then went on to discuss how the planning of resources for the continuing professional development of community nurses is bottom-up:

> We've got a very good system of allocation and criteria (for post-registration funding) … again it's priorities, and it's done from bottom-up cause we know what's required from the service level. The other CHPs may have a different perspective but we have the same standards but we have to deliver it in different ways. (A1)

The above quote is interesting in that it states that there is a bottom-up approach. However, it can be concluded that what she is referring to is that the decisions on how the budget is spent are made at her level throughout the three CHPs in Board A, and this is not what many would regard as a bottom-up approach as the key informant is at middle management level. The participants in both groups in Board A confirmed that they were not involved in how the resource was allocated and identified limited support from some managers for formal education, such as undertaking the non-medical prescribing module.

> They actually said to me yesterday if it's of benefit to the service you'll get it. (GA22)

It would appear that there is a challenge between an individual's goals and service priorities in some instances. Participants in Board B shared the

perspectives of Board A. Board C made no reference to the challenge of meeting both individual and organisational priorities. Perhaps this finding could be related to the professional leadership discussed earlier, in that Board C are explicit in their direction of travel and all staff have had a recent opportunity to develop.

The infrastructures in the three Boards to support in-house training and some of the packages available nationally, which will be referred to in section 5.2.8, were all referred to in a positive manner. However, it was acknowledged that resources, both within the organisational structures, to provide protected time for training was an issue, and some aspects of staff development, had to be devolved down to the teams. Additionally, it could be perceived that there is a reliance on individuals who are professionally accountable to ensure they develop (NMC 2015).

> It is excellent what the practice development unit provides, but they're over capacity and can't deliver on everything they are expected to do so well. So we try to do things locally. (A1)

> You know I guess it's responsibility, and accountability how much you want to extend your practice … it is obligatory to keep up to date though. (GA26)

It would appear from the data that organisations are aiming to provide a culture and infrastructures to support staff to develop within financial restraints. However, it is these financial restraints that seem to have an impact on some of the individual's perspectives to support their continuing professional development. In addition to financial restraints, the process of managing change within organisations, as services are redesigned, can have an impact on the development of individuals positively or negatively as indicated in section 4.3.2. With the implementation of the integration agenda it is expected that there will be further complexities in the support that organisations provide to develop staff. The interrelationships of varying organisational supports to

develop knowing are summarised in the following quote from a key informant from Board C:

> You can educate people to death, if you don't have the clinical support and supervision and the organisational backup, and the infrastructure to support it, then … nothing. (C1)

What this quote does not reflect explicitly is that professional leadership within an organisation potentially has an impact on the development of knowing of district nurses in practice; and yet it comes from the Board who has professional leadership in district nursing. Perhaps in this Board there is an assumption that professional leadership is part of the infrastructure.

In summary, there are elements within the infrastructure of organisations that support the development of knowing of district nurses in practice, such as professional leadership at a strategic level, the organisational processes and practices, financial resources and sociocultural aspects. Additionally, organisations have to consider the organisation as a whole, and there can be competing priorities, which may impact on an individual's goal development. In addition to this there are further variables that contribute to the development of the unique knowing of district nurses that other subthemes will consider.

5.2.3 Individual Support

This brief subtheme illustrates the support from individuals that practitioners identified that aided their development of district nurse knowing. There is a connection between this subtheme and the subtheme, 'experiential learning', and the role of the practice teacher, which is discussed in the 'formal learning' subtheme. The accounts all reflect that individuals have an impact on the development of knowing. The following excerpts illustrate this.

> It's pivotal of the role core of a team leader, but if you've got someone in the team that is a change agent and is you know pushing things along, then people will develop, I'm not saying it will happen overnight. (GB5)

> I mean you're continually learning from everybody that's senior to you as much as from the people that are junior to you. (GC5)

> I think the support of your peer group 'cause that can differ quite significantly and you can have somebody like X that's just through (her district nursing course) and very enthusiastic and keen to move forward but others don't have the same vision. (GB6)

These quotes illustrate that support to develop knowing in district nursing is not necessarily only about an individual's level of practice. A junior colleague can support the development of knowing as much as a senior practitioner, and this was illustrated further in the previous chapter where it was recognised that many of the practices of band 5s were inspiring and motivating to senior district nurses. It is evident that some individuals develop from enacting behaviours they have observed in the practices of others. Another consideration is that the development of district nurse knowing can be curtailed or developed depending on the practices within the teams they are working within. These divergences in practice of district nurses identified in the previous chapter and how they contribute to the development of knowing are illustrated in the following two quotes:

> You really need to make sure there's clear professional role models and mentorship. (GC4)

> It depends on the team you work in, I see one or two staff nurses and think they could have been different had they been in a different team. (B1)

In conclusion, support from individuals can be given at all levels and there is a diversity of practices that some people will respond to, and others not. This individual support, which is often described as role modelling, first introduced in section 4.6.2, is often an implicit and unrecognised activity that facilitates development for some individuals where other individuals develop from other factors and change over time.

5.2.4 Impact of an Individual's Profile to Development

The previous subtheme briefly illustrated that some individuals can be supported to develop by others informally. This subtheme explores individual characteristics that can contribute to the development of the unique knowing of district nurses in practice. Historically, there has been the perception that prior to working in the community there is a need for hospital-based experience to develop the required experience before moving to community nursing and then developing further to a district nurse. This culture is changing for many, but there are still variances in opinions. The following quote illustrates a historical perspective:

> Could you have gone out as a lone worker to a patient in their own home as a newly qualified nurse? (GA26)

This individual is suggesting that she would not have been prepared to be a lone worker at the point of registration. However, what is an important consideration is that previously, student nurses had minimal placement in the community, whereas in today's undergraduate programme (NMC 2010), nurses should be prepared to work in a hospital or community setting. Therefore, comparing one's experience to current practice may not be relevant in debating if undergraduate programmes prepare nurses to work in the community at the point of registration.

Group participants of Board A had an in-depth discussion around what supports an individual to be able to work in the community and to deal with all the complexities of the required knowing, as suggested in the previous chapter. Excerpts from their discussion are included below:

> I dinna think it's actually the community experience, I think it's the life experience, the working experience and the experience of different conditions … It's the individuals as well … so it's individual personalities. (GA25)

> It works for one person and not another. (GA22)

> I'm looking at one in particular who's late twenties, I don't think she would have been ready when she finished her training, I think she's a very young person, younger than others the same age. (GA21)

> So you're saying a degree nurse cannot get a job straight into the community. You do get some excellent third-year students that could easily work in the community. (GA24)

This discussion suggests there are different opinions as to whether a nurse at the point of registration is prepared to work in the community and can subsequently develop to become a district nurse. It becomes apparent that this is not only about the formal educational preparation that the individuals have, but other factors such as perceived maturity, responsibility and relational skills are involved. The key informants from Board B illustrate these factors in the following excerpts:

> Some are mature, some have got that capability of being autonomous, and some sadly won't get it because it is in a wholly different environment. (B1)

> You know people go and do the same course, get the same education and come out in practice and will work in different ways, so there is definitely something about personalities, ways of learning, enquiring mind, all of them have an impact on how they practice and how they go through their career … and is it affected by leadership in practice. (B2)

The individuality of practitioners, and how they develop differently in the context of nursing in the community depending on personalities and maturity, is evident from these quotes. Maturity is not related to age but to the knowing one has. Key informant C1 recognised individual characteristics in her example of a practitioner who demonstrated good practice and who initiated her own learning. Similarly, A1 acknowledges personality as a concept that has an impact on the development of knowing.

> I suppose her as a person, and her motivation, and very enthusiastic and willingness to learn, you are working yourself a lot of the time identifying your own learning needs and doing something about it. (C1)

> But personality, like everything in life, probably has a bit to do with it, I would say, and the personality that understands community care and enjoys working out there autonomously … all the things we do automatically, without recognising their value, is something that not everyone would want to do. (A1)

In this subtheme some of the factors that are contained within an individual that contributes to their development of knowing are considered. It is some of these factors such as personality and maturity, which can be seen to explain some of the variances within practices and that support how knowing is developed.

5.2.5 Experiential Learning

This subtheme explores how experiential learning develops district nurse knowing in its broadest sense. The previous chapter explored the unique knowing in practice that characterises the expertise of district nurses and identified its complexity. In some of the elements such as decision-making, it was implicitly suggested that the unique knowing was developed from both experience and knowledge acquisition, and that other concepts such as the development of leadership were much more complex. The following quote refers to learning form past experience:

> When it comes to professional because you've dealt with it and seen a lot of things over the years … you learn from past experiences … I mean reflecting is just one of the ways to progress. (GA25)

This quote focusses on the individual and past experiences; it does not encompass the multiplicity of knowing identified in the previous chapter to support the shifting context of care and the knowing required for future practice. Interestingly, staff rotation, which does not commonly occur in the community setting, was another experiential learning opportunity that some of the

participants referred to and there was an implicit link to reflective practice within it:

> Staff rotation supported the development of staff at all levels. (GA26)

> I think there could be opportunities for rotating staff around. I do accept that people need theory to back up their practice and I think they need a bit of both. (B1)

> Going to different areas and seeing how different leaders work … I remember also viewing the bad things as well, and remembering how you felt in that situation, or how someone else felt, and just mentoring other people. (GB4)

The above quotes all suggest that experiential learning in different contexts support the development of knowing. Staff rotation can be considered as a way in which social interaction increases and new networks are developed, facilitating the development of knowing. However, like GA25, the quotes suggest that knowing required for district nurse practice cannot be achieved by experience alone. Formal learning, mentoring and networks of social interaction within the experiences, related to the context of practice are all required to help district nurses learn from experiential opportunities.

Another group member spoke about experiential learning in relation to transferable knowledge form different experiences:

> It's transferable because I was sort of a nurse practitioner on an island … and I've just brought it with me. (GA26)

This individual, who has a vast amount of experience and has been educated to Master's level, was able to discuss how her previous experience was transferable to a new role, although suggests it is different working on a remote island. The quote does not explicitly suggest that any knowing was developed from previous experience. However, other assertions from this participant

demonstrate that she is aware of the complexities and advancing practices of the district nurse, is politically aware, and has many established professional networks. It could perhaps be suggested the development of her knowing is an accumulation of various factors, and that her experience in different contexts has facilitated this.

Another consideration when contemplating experiential learning is that chapter 4 identified variances in practices between practitioners and across Boards. Therefore, there is a potential for increasing divergences in district nursing practices from experiential learning alone. While all the participants valued experiential learning and valued it to support career progression across the bands, all were clear that to become a district nurse at band 6, the formal district nurse qualification is required. This view is perhaps not surprising as this mirrors their own experience of becoming district nurses. However, perhaps it is this formal educational framework that supports the development of knowing in practice of district nurses and provides employers with some consistency of experience of practices. Formal learning will be explored further in section 5.2.7. However, first the implication of undergraduate nurse education to post-registration education will be briefly considered.

5.2.6 Implications of Undergraduate Nurse Education

The practices of registered nurses were explored in the previous chapter in section 4.2.1 and it was concluded that all registered nurses' practices are based on the principles of caring and delivering person-centred evidence-based care that focusses on an individual level. Additionally, it was recognised that there is a dichotomy in practices that appears to be linked to the level of education of the nurse rather than to their clinical experience. Today's registered nurses display the attributes of graduateness and continue to develop their knowledge and skills gained at the point of registration through the KSF and plan their own personal development plan. In order to explore how the knowing of district nurses develops, the implications of undergraduate nurse education must be considered briefly within this theme.

It is acknowledged that practice is in a period of transition as nursing becomes a graduate profession and there is an increasing focus on nursing in the community. The participants were all experienced at having worked with undergraduate students and all the Health Board areas had had the students in the community for at least two placements in their three-year programme. This was expressed by one key informant:

> Today's pre-registration curriculum is bound to have an implication on future district nurse education because they have that exposure early on and are more prepared to work in the community, however, that is not at the level that we need our district nurses to be working at. (B1)

This view was supported in the group interviews in all Board areas where the participants acknowledged that the district nurse needs to be at a higher level and needs further development to reach this point. There was also recognition that district nurse practice was advancing as discussed previously. Therefore, it can be concluded that district nurse practice has evolved and will continue to do so in response to policy, technological advances and the development of new evidence, each of which impacts on the development of the required knowing to practice at all levels, and therefore requires a higher level of education than ordinary degree level.

5.2.7 Formal Learning

This subtheme considers the formal accredited learning that is supported by Higher Education Institutions, both within courses and modules. Traditionally, to become a district nurse a recognised NMC-approved course, as discussed in chapter 1, must be undertaken (NMC 2001). Potentially, there was the possibility that the district nurse course, which was developed on out-dated standards, would not meet the needs of practice, but this was found not to be the case as suggested by all key informants in the following quotes:

> I have to be honest and say I don't know exactly what's contained in a district nurse's degree. But they do need all the theory behind the

> evidence of working out in the community and our new band 6s certainly have that. (A1)
>
> I'm very reassured that these district nurse students will meet the learning needs within the course. (B1)

Another key informant, B2, recognised that the course content has moved over the years and while there are variations in practices, 'they are working differently once they have done the course'. It can therefore be assumed that the courses that the Boards are accessing are contemporary, despite the out-dated standards. While this potentially could contribute to the variances in practices, none of the participants supported this view.

All key informants and participants within this study stated that to develop as a district nurse, the current formal education was still required, and that further experience, in-house training and frameworks can be utilised to further develop to a band 7 district nurse, which is what one Board area has done with the development of its competency framework described earlier. As indicated previously, the participants' perspectives appear to represent their own experiences, and present a positive view that includes continuing formal learning as illustrated in the following quotes:

> The district nurse course has definitely helped me, I've a lot more knowledge, and am lot more competent and patient-centred than I was before … I'm a new person … I go on every course I possibly can as things are evolving all the time. (GA12)
>
> As I say, our leadership that we learnt in our DN training has been essential. (GA22)

However, one participant in a group interview in Board A instigated a heated discussion on the development of a staff nurse to becoming a district nurse, which did not represent her own experience, initially advocating a modular approach and made a comparison to the acute sector in that band 6s there do

not have a further qualification. The following are some excerpts from this discussion:

> She's going to do a wound care course … she should be able to get a band 6 in a couple of years. (GA22)

> No 'cause you still have to apply your theory in practice. (GA25)

> I still think the DN course is the way forward, you need to be assessed in practice … it couldn't be with one module definitely not … you need to know … you can't do that in a couple of modules (GA26)

> But are you gonna get the interest if they've done their first degree and then you have to do another degree to be a district nurse. (GA22)

> Not another degree at the same level, a postgraduate diploma. (GA26)

> I think what GA26 is saying is a good idea, but I don't agree with two degrees to be a DN, but the two different levels I think sounds better. (GA22)

This interchange illustrates how GA22 changes her viewpoint and recognises that to become a district nurse a postgraduate qualification is required. Group B were unanimous in their view that to become a district nurse required a qualification because of the 'uniqueness of the role' (GB1). They also had a vision for the future that the district nurse required being educated at Master's level to support the complexity of care, although a postgraduate diploma may be a suitable exit point.

> They should be working at that higher level, more critical thinking, and why would you want to go and do two first level degrees … it needs to be a postgraduate diploma or something. (GB3)

This is in congruence with Board A's opinion. However, what they stated that muddied the waters is the banding within the KSF, as having a Master's level of education reflects band 7 and district nurses start off at band 6.

Participants identified the role of the practice teacher, as the key relationship to develop the knowing required of a district nurse within the district nurse course. It was recognised by some that this role needs to be at a higher level than a sign-off mentor, which is the level required in pre-registration nurse education. A sign-off mentor is what the NMC (2008) standards advocate as a minimum for district nurse students.

> Because a lot of them (sign-off mentors) don't challenge what they write or practice because they're a bit in awe. (GB3)

> Our practice teachers are key to it (the development of the district nurse). (A1)

> Assessment in practice, that's quite important in any module … you don't know how much people have really developed their knowledge and skills unless they are assessed in practice. (B2)

It is not a surprise that some sign-off mentors do not challenge district nurse students, as while they will have had local preparation to undertake the role, they have not had an NMC-approved course at an academic level beyond that of the student they are supporting. This is a situation that is not consistent across the Board areas as A1 indicates above where the practice teacher is pivotal in the development of the student district nurse. This therefore supports the value of a course that is both theory- and practice-based, as B2 suggests in her example of someone demonstrating good practice, and when asked what made her practice in this way, B2 responded:

> She's recently studied, has got the picture of the policy agenda, why we are making change, she's got that understanding, she's motivated and she's aware that because you've done it one way it doesn't mean it

> always has to be that way. I think people need some of the education from the University and then they need practice, it's a combination. Looking at myself it was the combination of what I got in theory and then going out working in practice. (B2)

Although all participants stated that the district nurse qualification was required, one participant in Board C shared that, following an advertisement for two qualified district nurses where no one applied, two individuals were put into band 6 district nurse posts without the qualification and it was reported that:

> The development is there, they're doing a good job so we're full of contradictions, and it's about getting the right people I think. (GC4)

However, in another Board area, two band 6s from the hospital setting were put into band 6 district nurse posts, and they left the posts within three months as they did not have the expertise to fulfil the role. This therefore suggests that there are other variables that potentially develop the knowing required of the district nurse rather than just formal learning.

Key informant C1 spoke about some of these variables but was clear that formal learning was still required:

> I don't think you should take away formal learning, I definitely don't, that kinda worries me when I listen to people across Scotland and again very much a personal opinion, it's so crucial to have the theory to underpin the practice. But we need the infrastructure in practice to support their learning and their consolidation and the sustainability of that. (C1)

In conclusion, every participant recognised the importance of formal learning and indicated that it was needed to develop the knowing required in district nursing. However, this concept must be reviewed cautiously as every participant has developed their own knowing in this manner and there is a potential that no new ways will be therefore be considered. The assessment of

formal learning in practice and the theoretical are important elements. How they can best be designed to complement each other is not revealed within the data.

5.2.8 Supporting Frameworks

This final subtheme discusses the supporting frameworks referred to in the data that contribute to the development of the unique knowing of district nurses. Key informant C1 provides detail in her interview about some of the supporting frameworks that have supported developments in Health Board C. In particular, the NES (2011a) Career Framework for District Nursing and the Advanced Practice Toolkit (NHS Scotland 2015) were utilised and then a context-specific competency framework was developed on top of this for the advanced practitioners working at band 7. The importance of national consistency using a co-ordinated approach is evident within the following quote:

> I do think there needs to be national guidelines with the HEIs involved, they don't mean anything to anybody if there is no buy-in from Universities and no buy-in from frontline staff and then they sit on a shelf. (C1)

While Board C found NES frameworks and resources useful to support their service, Board A was not as positive about implementing them in practice:

> I think it's good what NES produce. How we then transfer that into actual day-to-day working is what we are not good at. How many times the district nurse actually goes and looks at some of these frameworks, has the capacity and the time to do that, I would argue. What would be good is if we could get the expertise from NES locally, instead of it sitting at the side and developing things that we don't have time to put in place. (A1)

She then develops this conversation and implies that there are some national organisations that are empire-building with the documents they produce. This perhaps reflects the perceived lack of professional leadership within this Board rather than being a true reflection of a national organisation. Another key

informant, B1, had not accessed the NES framework, but found other tools such as the national workload tool useful to determine what individuals and the service require to support their practices.

Within the data, as suggested in the previous chapter, national policies support the development of district nurses. One that is referred to several times in the data that supports the development of district nurses is the resources developed as a result of *Leading Better Care* (SG 2008):

> I'm doing this Leading Better Care, in fact I think it is a module, but it's all there as part of your development in trying to develop district nursing. (GA11)

> Leading Better Care, it's actually been quite helpful. I think that will raise the bar once the band 6s are exposed, we've only just done it with the band 7s. (B1)

At the time of data collection, these supporting resources had not been disseminated to all district nurses, but for those who had engaged with them they reported the value in developing leadership. Other formal frameworks were also reported to be of value. Key informant B2 describes how elements from *Modernising Nursing in the Community* have been utilised to develop leadership. The group in Board C shared their experience of 'LearnPro', an online resource, and its value in supporting continuing professional development.

In summary, within this subtheme there are several national tools that are perceived to be of value in supporting district nurses in practice and to support consistency across Scotland. However, there are variances in how they are utilised within the different Boards and it would appear that there is a relationship to leadership in their implementation.

5.3 Conclusion

This chapter through the theme, ‘perspectives on continuing professional development’, discusses the findings in relation to how the knowing of district nursing practice is developed. Within the subthemes, elements within the workplace and the formal educational frameworks that support the development of the unique knowing of district nurses in practice are considered. The previous chapter identified that there is a unique knowing that is considered central to district nurse practice, and the continuous advances, emerging technology and the changing political landscape necessitate an advanced level of practice.

First, the KSF is acknowledged as a useful framework within which to support the continuing professional development of individuals. However, this framework is unspecific in relation to the development of knowing that is specific to district nursing practice. Additionally, how the framework is used within organisations is variable and depends on elements within the infrastructure, including professional leadership. It is acknowledged that there can be competing priorities given to staff development within organisations, as organisations tend to look at the service as a whole when considering how developments are supported. Second, the support from individuals to develop the knowing of district nurses connects across all the subthemes, but it is recognised that all levels of practitioners have the potential to facilitate the development of knowing of district nurses. This can be seen to contribute to the diversity of practice. Third, the individuality of practitioners is recognised as a factor in developing knowing, but there is no consistency about the reasons why one individual develops and others do not. Finally, experiential learning is valued, and experience in different contexts with the establishment of networks potentially develops knowing in district nurses, but not in isolation of other supports.

In relation to the formal educational frameworks that support the development of district nursing knowing, this study acknowledges the changes in the undergraduate curriculum which advocate further community experience within

placements and has shifted to meet the demand that all registered nurses depart with a degree. This has a potential impact on how the knowing of district nurses is developed which also requires a minimum of a first degree qualification, as discussed in chapter 1. While there is a continual process of development that involves the refinement of knowledge and skills gained at the point of registration, not surprisingly, there was consensus among the participants that to develop the unique knowing of the district nurse a further degree specific to district nursing was required. However, it was acknowledged that all the participants had themselves developed in this way, and their views represented their own experience, and therefore, there is a potential lack of objectivity in this view. Nevertheless the participants recognised that, due to the complexity of the district nurse role and its continuing advancements, district nurse education needs to move to a Master's level of preparation.

The importance of assessment in practice with a suitably qualified practice teacher was seen as essential to develop the unique knowing of district nurses within educational programmes. However, formal education also interacts with other elements that develop knowing, such as the changing political landscape. The supporting frameworks available within national policy to support the development of district nurses were all seen to contribute to the development of knowing. It was recognised that there are variances in how these frameworks are used across the Board areas and this appeared to be linked to professional leadership.

Within nursing, the development of knowing has always been seen as an individual and mostly a cognitive process. The findings within this chapter have demonstrated that the development of knowing of district nurses does not happen in isolation. It consists of networks, conversations, engagement with policy, understanding of professional contexts, adhering to organisational boundaries, and interaction with complex and challenging situations. Theory and practice is mutually dependent on each other; change is inevitable and is unpredictable; and practices change by having experiences, therefore change is integral to practice. Consequently, it can be concluded that the

interdependent elements, which interact, develop the unique knowing of district nurses in practice.

Chapter - 6 Discussion, Conclusions and Recommendations

6.1 Introduction

I started this thesis aiming to explore the unique knowing of district nurses in practice and how this knowing is developed within education and practice. At the outset I wanted this study to inform future education and was open to what that would potentially involve. During the literature review phase and early in the data collection I did begin to question whether I arrived at this research with the assumption that the knowing of district nurses in practice is unique; and I was aware of the potential complexities of knowing in practice having been introduced to some of the practice-based theories such as Gherardi (2012, 2009). Now having completed the study and analysed the data in depth I would argue that there is evidence of the unique knowing of district nurses; however, the data do not 'fit' neatly with existing theoretical frameworks; and the complexities of how this unique knowing develops allows for alternative approaches to develop knowing. This chapter presents a discussion of the findings of the research study.

Chapter 1 introduced my position in this study, and stated how I had become aware of the tensions within the development of knowing in district nurses to meet the changing context of health and social care. It identified that the existing educational standards supporting district nurse education are out-dated (NMC 2001), and there is a lack of empirical research in relation to post-registration nurse education to inform future direction. In addition to these issues, the education of pre-registration nursing has developed with a stronger focus on nursing in the community (NMC 2010), which could potentially have an impact on the requirements for post-registration education. Additionally, the pre-registration standards are open to interpretation, which can result in an inequity of placement experiences in the community during pre-registration education (Dickson et al. 2014; Cook 2010; Goldsmith 2009). This differing placement experience could potentially have an impact on the practices of nurses at the point of registration. Therefore, it became apparent that in order to ensure that

district nurse education meets the needs of professional practice, an understanding of the knowing of district nurses in today's practice and how this is developed is required. I also wanted to be explicit in discovering what is 'unique' in the knowing of district nurses that requires additional post-registration education, unlike nurses in the inpatient settings, who do not have this requirement to have a recordable post-registration qualification on the NMC register.

This study did not aim to generalise the findings but to provide an in-depth understanding that was contextualised. However, one may argue that the strategic selection of the cases allows for some generalisation. First, the chapter will consider the appropriateness of the research approach used and then discusses how the study has addressed the research questions that were first introduced in chapter 1 with reference to some of the literature explored in chapter 2. The chapter concludes by reviewing the contribution that this study will make to policy, practice and research and suggests areas of future research.

6.2 Appropriateness of the Research Approach

The research approach used in this study was selected and developed to best address the research questions. Constructionism is a social theory in which meaning is understood to be constructed through one's engagement in the world and acknowledges that multiple realities exist; and the interpretative approach searches for meaning and understanding and acknowledges the interpretations of both the participants and the researcher (Crotty 2003). Recognising the multiplicity of perspectives, which are always context-dependent, supported my choice of case study methodology to address the research questions appropriately. The research questions were:

- What is the unique knowing in practice that characterises the expertise of district nurses?
- How do different workplace elements help develop the unique knowing in practice of district nurses?

- What formal educational frameworks in curriculum and policy might best support the development of district nursing knowing?

The study methodology included: using the case study to consider the perspectives of district nurse practices; photo elicitation as a focussing exercise, engaging group participants to drive the interview and facilitate discussion; interviewing both key informants and practicing district nurses to consider different perspectives across bands of the KSF (Skills for Health, 2010; DH 2004); and analysing the data in a detailed and systematic way as described in chapter 3. This resulted in the key themes presented in chapters 4 and 5, to address the research questions.

Three different NHS Health Boards in Scotland were purposively selected for this study, as I had thought that the organisational boundary within each case might have led to different perspectives being illustrated. This purposive sampling may have influenced my interpretations and findings. However, I believe that the decision to include such a sample is a strength of this study and actually challenged my assumptions, in that I was expecting to find differences between the selected Health Boards. While there were elements of difference within the infrastructures of the organisations that supported the development of knowing in district nurses, as illustrated in chapters 4 and 5, there were not enough variances between Boards to present the cases in isolation; in fact, there were more differences found between individuals.

The selected data collection methods generated rich data responding to the research questions. It could be argued that an observational study would have been more appropriate as the data collected describe knowing in practice rather than enacted knowing. However, considering Gherardi's (2009) view that practices are difficult to assess because they are often hidden, tacit and inexpressible, and that an observational study can be a snapshot of practices and therefore be an under-estimation (Kennedy 2004, 2002a, 2002b), semi-structured interviews were utilised instead. In addition, I was cognisant of the potential for further bias in using observation as a method due to my familiarity with district nurse practice which may have resulted in dismissing everyday practice that was familiar to me or that was implicitly embedded in practice.

The use of photo elicitation in the group interviews was of particular value as a focussing exercise and relaxed the participants before I began to open up the discussion with questions. I was very aware that the actual photograph was not important, but that it was instead the participants' ability to associate a particular meaning with that photograph. This activity allowed me to identify the participants' initial perceptions of what represented the unique knowing of district nursing and encouraged me to be open to any unexpected insights while ensuring the discussions remained focussed. Of note was the focussing exercise, which illuminated the practices of registered nurses that are subsumed within the practices of district nurses, such as caring and public health practices. The interviews of both the key informants and the group participants appeared to be open and honest. I believe that my professional background as a nurse, educator and researcher afforded me the opportunity to establish a rapport with the participants that facilitated free discussion.

It was unfortunate that document analysis could not be an explicit part of this thesis due to ethical issues as outlined in chapter 3. However, I have attempted to provide as much detail as possible while maintaining anonymity and confidentiality. The process I adopted of managing, transcribing and analysing the data, adapted from Spencer et al. (2003) as described in chapter 3, was rigorous. There is a potential limitation when data are analysed independently. However, the examples selected from the analytical process in chapters 3 and the appendices, and the inclusion of numerous quotes in chapters 4 and 5, invite the reader to construct their own interpretations as well as to validate the meanings and conclusions presented.

6.2.1 Limitations of the Study

This research has provided an insight into the unique knowing of district nurses in practice and how this knowing is developed using an interpretative approach within a case study design. However, like all studies there are limitations, as introduced in section 3.10.

The choice of theoretical perspectives on which to base my study initially challenged me. I struggled with the terminology and the more I read the more

contradictions there appeared to be between different authors. It was not until I acknowledged that an interpretative approach was the most appropriate to answer the research questions and that the different perspectives of district nurses in practice appeared to be context-dependent, which would suit a case study design that I was able to move forward and develop the study. This would not be seen to be the conventional approach to research design (Crotty 2003, Porter 2000).

Attempts were made to minimise the limitations of this study by using three Boards as the cases that had been purposively sampled in order to provide varying perspectives. Using one case would not have illustrated the importance of context and the consideration of any shared meaning, even though the study found minimal comparative differences between the Boards.

A combined limitation and strength is my background as an educator in district nursing, which has provided me with additional interpersonal and analytical skills. I knew many of the participants: some who support current district nurse students from my own institution; some had been on working groups with me; and others for whom I had been part of their journey to becoming district nurses, so, potentially, I may have influenced the development of their knowing. However, by using three cases across Scotland; inclusion of a detailed account of the analysis process in chapter 3; inclusion of a substantial amount of the participants' voices in chapters 4 and 5; and the efforts made to ensure trustworthiness outlined in section 3.9, all add to the credibility of the findings.

It is also recognised that this study is set in Scotland and that the increasing divergence of NHS policy in the four UK countries may have an impact on the unique knowing required of district nurses around the UK. However, all these countries work within the governance of the same professional body, the NMC. The data collection took place from 2012 – 2014. The changing policy context that occurred during the study and now the move to the integration of health and social care, with the merging of health and social care services in Scotland, could be seen as a limitation. Interestingly, this changing political landscape was found to support the development of knowing in district nurses in this

study. Nevertheless, the implications for district nurse education of the full implementation of the integration agenda in April 2015 in Scotland must be considered in future works.

A final limitation to acknowledge is that this study focussed on the practices of district nurses and did not consider the contribution of other fields of nurses working in the community at an advanced level. Being a district nurse is built on the foundations of previous education and experience and currently the NMC (2001) standards require an adult nurse qualification as an entry requirement for a district nurse programme and therefore, to consider other fields of practice would have demanded a different approach to the study and would not have addressed the research questions.

6.3 Summary of Study Findings

This section presents a summary of the study's findings in response to the research questions. It is structured around the three research questions.

6.3.1 Unique Knowing in Practice that Characterises the Expertise of District Nurses

In chapter 4, my interpretations of the five substantive themes from the data that contribute to the unique knowing in practice that characterise the expertise of district nurses were presented: clinical ways of working; organisational ways of working; developing technology; building relationships; and leadership. As indicated previously, the range of issues raised within all the interviews was similar with only a slight change of emphasis and there were minimal regional differences. In this section I provide a brief synthesis of these interpretations while referring to the relevant literature.

Prior to analysing the data, I had made an assumption that the unique knowing that characterises the expertise of district nurses may fit neatly into an existing framework such as the four outcomes identified in the standards for specialist practice (NMC 2001), or the more recent four pillars of practice (NES 2011a; DH 2010b; Sabin 2008) referred to in chapter 2. However, none of these

models were representative of all of the findings, and it became evident that the unique knowing of district nurses in practice is much more complex than this and that some data would be lost if they were organised into this representation. This finding supports Gherardi's (2009) view on the hidden, tacit and inexpressible elements of practices that can be difficult to identify; and the complexity of epistemic practice resulting from interactions with objects, individuals and organisations (Knorr Cetina 1977).

Alternatively, I had thought Jackson et al.'s (2009) proposal of the seven forms of knowing that contribute to nursing leadership would support the findings: empirics; aesthetics; personal; ethics; socio-political; unknowing; and emancipatory. However, while all these seven forms of knowing are evident in the findings, they alone do not represent the unique knowing in practice that characterises the expertise of district nurses, and could equally be applied to other nurses or indeed other health and social care professionals working in the community. It is the interrelationships of these seven forms of knowing within all the identified themes with the support of professional and disciplinary theory, and organisational structures (Bergen and While 2005, RCN 2003, Eraut 1994) that contribute to the unique knowing of the district nurse in practice. Therefore, in chapter 4, I concluded that a matrix of district nurse knowing had emerged from my themes.

One of the major themes within this study was *clinical ways of working*, which was first considered in the context of the practices of registered nurses. The fundamentals of caring and delivering person-centred evidence-based care, which are all subsumed within the practices of all registered nurses (NMC 2015, NMC 2010), were acknowledged in the findings, while recognising that there are also some different levels of practices within bands of nurses (DH 2004). In particular it was noted that band 5s demonstrated a lack of awareness of the bigger picture that was attributed to 'unknowing' (Munhall 1993).

The following subthemes were then explored: the level of autonomy; advanced assessment of individuals, families, carers and communities; complexity of care and case management approaches; interprofessional working; public health;

and the context of practice. All of these elements alone could be applied to the clinical pillar of practice (NES 2011a; DH 2010b; Sabin 2008), however, these would still not represent the complexity of the unique knowing of district nurses.

Therefore, it was identified that the context of practice cuts through this theme as an element that contributes to the unique knowing of the district nurse. The relationship between being a guest in someone's home to nurse is perceived to be quite different than the relationship between a nurse and a patient in the hospital setting (QNI 2014b). This notion of 'getting to know the patient' was acknowledged in the work of Kennedy (2004), where she identified that getting to know the patients and families in their own setting is central to the skills of assessment and clinical judgement of district nurses. The findings in this study illustrated in chapter 4, suggest that in today's practices, over 10 years later, one would expect a nurse band 5 nurse to take into account the context of care at an individual level (NES 2011a; NMC 2010). It is the district nurse, however, who goes beyond the individual to the population, acknowledging sociocultural and political factors that impact on practice, and, as such, is demonstrating clinical expertise at a higher level that, in many instances, can be associated with advanced practice (NHS Scotland 2015; DH 2010b).

Scott (2013), in her literature review, identified a lack of research regarding advanced practice in district nursing. What has emerged from this study is that there is some advancement in district nursing clinical practices and it is expected that this will continue to advance to support the health and social care agenda across the UK. Parallels can therefore be made with advanced practice (NHS Scotland 2015; DH 2010b). This is particularly true in the assessment practices, the decision-making, and the management of complexities, and how some district nurses have embraced the move to interprofessional working while navigating the policy, all factors that acknowledge the context of practice. In light of the current directions of policy, the district nurse has to be able to anticipate future directions of travel in policy and to practice accordingly, which in itself is a complex skill and requires an advanced level of practice, supported by Master's level education (RCN 2012, NES 2011a, DH 2004).

Similarly, the themes *organisational ways of working*; *building relationships* and *developing technology,* when viewed independently, could be seen to provide little to support the unique knowing of the district nurse. However, when considered within a matrix and the impact each element has on one another, the unique knowing in practice that characterises the expertise of district nurses becomes apparent. The theme *leadership* can be seen as the anchor within the matrix. Like Van Loon's (2006) Australian study, the practice context within community nursing was recognised as an added dimension when considering the knowing of leadership. However, while Jackson et al. (2009) apply the seven elements of knowing to leadership, this study suggests that they can also be considered to interlink with all elements of the matrix. It is this complexity of relationships between elements that represents the unique knowing of district nurses in practice.

In conclusion, the unique knowing in practice that characterises the expertise of the district nurse is multifaceted where the context of care is an essential consideration but it is the relationships among and between the elements, not the elements themselves that contribute to the unique knowing. The unique knowing can be described as a landscape that the district nurse must travel; crossing a variety of socio-economic areas; entering the private space of individuals, the public space of communities, as well as acknowledging professional practice; navigating the policy agenda while maintaining clinical person-centred care; and leading others across the terrain of interprofessional working.

6.3.2 Workplace Elements to Develop the Unique Knowing in Practice of District Nurses

The previous section discussed the unique knowing in practice that characterises the expertise of district nurses. It was described as a matrix where all the elements are interwoven. It is identified in the literature, as discussed in chapter 2, that knowing is embedded in practice and is a dynamic and changing process that evolves as individuals interact in the world (Gherardi 2012, 2009; Feldman and Orlikowski 2011; Bonis 2009; Schön 1983). Therefore, it can be concluded that the development of knowing emerges in

practice. This section briefly considers the findings from chapter 5 and explores the workplace elements that support the development of the unique knowing in practice of district nurses.

As explained in chapter 5, the participants identified infrastructure and organisational processes as either supporting or restraining their continuing professional development within district nursing. One of the most noteworthy findings was that all three Health Boards in this study identified that organisations that had a vision relating to the district nursing service, and had appointed a professional leader at a strategic level, were seen to support the development of practices more than Boards that did not. This finding is in congruence with Rome et al.'s study (2013), which evaluated the impact of the community nurse consultant in an NHS Health Board in Scotland.

Organisational processes and available resources to support the development of knowing were identified in the findings. The participants all made reference to the KSF (DH 2004) as a tool that is used to measure performance and support the development of personal development plans. It has broad competencies and the participants are aware of its role in supporting continuing professional development as identified in the literature (Stewart and Rae, 2012; Gould et al. 2007; DH 2004). There were some tensions identified in the findings as to whether the KSF supported the development of individuals or the organisation. Gould et al. (2007) and Spence and Wood (2007) have previously identified these tensions. However, more recently there has been an acceptance that as a generic tool the KSF can support development of both organisations and individuals if used appropriately, but that additional competency frameworks need to be integrated within it to support the development of individuals within specific areas of practice (Stewart and Rae 2012; Bentley and Dandy-Hughes 2010). These studies support the findings in this study and the integration by Health Board C of a competency framework specific to district nursing in addition to the KSF. Therefore, it can be concluded that the KSF supports generic development but not the unique knowing of specific areas of practice and that the integration of further tools into this process is perceived as beneficial with supporting resources, be it financial or in providing time.

The culture of the organisation in relation to supporting the leadership practices of individuals and teams within the organisations appears to influence the development of knowing within district nurses (Dickson and Coulter Smith 2013; Cameron et al. 2010; Haycock-Stuart et al. 2010). This support operates across all bands of staff but this study suggests this contribution is often an implicit and unrecognised activity that facilitates development for some individuals where others develop from other factors and over a longer period of time. It would appear that there are further variables outwith the workplace that contribute to the development of knowing. These can be linked to the characteristics of individuals, such as their personalities and level of maturity.

Experiential learning within organisations was also recognised as having the potential to support staff to develop knowing. Some participants identified the impact of staff rotation to support the development of knowing. Orlikowski (2002), in her paper, advocates the value of work-based learning whereby knowledge is created through the transformation of experience. However, it was also recognised that experiential learning has the potential to increase divergences in district nursing practice if it is not managed in a structured way or assessed effectively. Additionally, it was acknowledged that experience alone cannot develop knowing and that interactions, formal learning and mentoring were all contributing factors. This finding supports Knorr Cetina's (2001) view that epistemic practice is a complex phenomenon and needs to be considered alongside formal learning.

6.3.3 Formal Educational Frameworks in Curriculum and Policy to Support the Development of District Nursing Knowing

The third research question was also addressed in chapter 5. Importantly, the relevance of pre-registration nurse education (NMC 2010) and its implications for the future post-registration education of district nurses was explored. In this context, formal learning can be considered as an accredited quality assured module or as an academic course.

Within this study formal learning was discussed by the participants and it was identified that stand-alone modules do not develop the knowing of district

nurses in practice. The participants valued the role of the practice teacher and were clear that the practice teacher was the key individual to facilitate learning which was both theory- and practice-based. It was recognised that the practice teacher needs to be educated to Master's level to be able to support students who undertake Master's level study. This academic level of support in practice is not presently a requirement for practice teachers of district nurse students (NMC 2008) and alternative models using sign-off mentors can be utilised.

As discussed throughout this thesis, the current NMC (2001) standards to support the education of district nurses are out-dated and, because of this, I was expecting alternative models to be presented for the future education of district nurses. All the participants in this study stated that even though nursing is now a graduate profession, further formal education beyond the ordinary degree is still required to become a district nurse. This opinion is supported in recent literature (QNI 2014a; DH 2013; RCN 2013; SG 2012c) and, while the NMC (2001) standards are out-dated, the district nurse qualification is still valued by the participants. As stated in the previous chapter, this perhaps comes as no surprise as all the participants were prepared in this way.

However, section 6.2.4, which illuminates the complexity of the unique knowing of the district nurse in practice, and also suggests that it demands the requirements of advanced practice education (NHS Scotland 2015, DH 2010b) and needs to move towards a Master's level of preparation. Therefore, it can be concluded that a tailored postgraduate course is required.

It can also be concluded that the development of the unique knowing of district nurses in practice does not happen in isolation and is very complex, as identified in section 5.3. Chapter 5 highlighted that the development of knowing does not happen in isolation. In order to illustrate how this knowing is developed, both Bergen and While's (2005) model, which considers national policy, local organisational structure and practices, professional and disciplinary theory, and practices of individuals, and Evett's (2009) exploration of organisational and occupational professionalism, discussed in chapter 2, can be considered. These theoretical concepts have the potential to be considered

in the design of future education programmes for district nurses and other professionals.

6.4 Recommendations for Policy and Practice

This section outlines the implications of the findings for policy and practice. In terms of the wider implications of this research in district nursing beyond my own institution, I have been an integral part of working groups relating to district nursing both locally, within Scotland, and throughout the UK. I have influenced and am in a position to inform these groups using the findings of this research. One of the challenges is that district nursing is in a period of transition, and some of the workforces are not ready for a move to postgraduate study for post-registration nurses in the community. The findings in this study confirm to me that the complexity of district nursing, its unique knowing within the context, the emerging technology and shifting policy, all contribute to continual change and development. This practice requires a higher level of practice developed within practice-based curricula. This finding has been emerging in recent documents with no empirical evidence to support it (SG 2012a; NES 2011a). All participants in this study recognised the importance of formal education to develop the knowing of district nurses in practice and were unanimous in that it needs to move to Master's level to reflect the complexity of the district nurse role and its continuing advancements.

Recommendation one:

> *District nurse educators must consider the complexity in the unique knowing in practice that characterises the expertise of district nurses within their curricula and ensure that the indicative content is developed accordingly. The curricula must be built on the foundations laid down in pre-registration nurse education (NMC 2010), recognising nurse education as a continuum, and that district nurse practice has evolved and now displays an advanced level of practice. To achieve this aim educators must advocate for Master's level awards for the education of*

district nurses and ensure that the principles of advanced practice are embedded within (NHS Scotland 2015; DH 2010b).

This study illustrates that the development of knowing does not happen in isolation and that it is mutually dependent on theory and practice. The value of the role of the practice teacher was acknowledged to facilitate learning in practice. It was also recognised that the role of the practice teacher involved the assessment of the application of formal learning in practice.

Recommendation Two:

District Nurse students need to be based in practice and supported in practice by a suitably qualified practice teacher who is educated to Master's level to support their learning at an advanced level. To meet this requirement educators must work in collaboration with Health Boards to plan the timing of the learning in practice within curricula so that it best suits the service delivery of Health Boards; and also demands that educators ensure that the practitioners who will be supporting future district nurse students and taking on the role of practice teacher have the opportunity to develop to Master's level.

As well as formal education it was recognised that the unique knowing of district nurses in practice does not occur in isolation but that it is developed from networks, conversations, engagement with policy, understanding of professional contexts, adhering to organisational boundaries and the interaction with challenging experiences.

Recommendation Three

District Nurse Educators need to consider innovative and alternative approaches to developing professional knowing within curricula, recognising practice-based theory of learning. This in particular needs to involve emerging technology, the development of networks, and interaction with the political landscape which can be achieved by

educators embracing the digital age in activities such as: embedding social media within theory and practice to develop networks across organisations and globally; and developing teaching and assessment practices that ensure district nurses recognise eHealth as integral to all their practices. In being constructively aligned this will involve the use of technology at all stages of curriculum design.

In addition to educators acknowledging the complexity of knowing-in-practice, organisations that employ district nurses must do likewise, and consider their structures and processes, and shape them in ways that support and develop their district nursing workforce at both an individual and organisational level.

Recommendation Four:

Organisations such as Health Boards must review their existing structures and processes that support the development of knowing in district nurses in practice. There needs to be a vision within the organisation relating to district nursing that explicitly recognises the importance of strategic professional leadership; and specific frameworks must be integrated into generic systems such as the KSF appraisal process to reflect the requirements of knowing in district nurse practice. Staff induction processes must recognise the importance of establishing relationships both internally and externally and recognise the importance of emerging technology in practice. This can be achieved by encouraging the use of social media within professional practice, as this can be integral to developing networks and engaging with technology. Staff rotation needs to be considered by organisations as common practice to increase social interaction and develop new networks. Integrating staff rotation as common practice may involve the review of job descriptions to allow for flexibility. Additionally there needs to be formal supervision processes in place for all staff that recognises that knowing-in-practice is also developed as a result of challenging experiences. This supervision needs to use challenging experiences as a focus to develop future practice.

It is recognised that practice is still in a period of transition with some nurses at all levels still not having a first degree. This study has recognised the development of practices in 'new' band 5 nurses, and that emerging technology, and the shifting policy, all contribute to change and development within district nursing practice. However, there continue to be variances in practices between and across bands. The out-dated NMC (2001) standards do little to support consistency and do not reflect the advanced level of practice of today's district nurse. While educators, as suggested in recommendation one, can advocate for Master's level study and integrate the principles of advanced practice within educational programmes, it is the NMC who can ensure that there is consistency across the UK through educational standards.

Recommendation Five:

> *The Nursing and Midwifery Council, in collaboration with practice and education, must consider the implications of the pre-registration standards (NMC 2010) on post-registration education and its standards, to ensure they represent contemporary practice. This should involve a review and updating of post-registration standards.*

The five recommendations above embrace the complexity of knowing in district nursing, acknowledging the advancing roles in district nursing practice are all interlinked and suggest what education, practice and policy can offer to contribute to this complexity. During the course of this study, some positive steps have been taken towards achieving some of these recommendations. Recommendation five is the one that is the most challenging to implement in its entirety as it requires strategic direction from the NMC. The NMC at this time has chosen not to review post-registration education, but they are currently reviewing the pre-registration standards following their implementation in 2010, which will then inform their future stance in relation to post-registration nurse education. However, in the interim the NMC have supported the national work of the Queen's Nursing Institute and the Queen's Nursing Institute Scotland with input from the Association of District Nurse Educators, to develop voluntary standards for district nurse education and practice which will sit on top of the

current NMC (2001) standards. I have been a member of the advisory group in this work and have been able to use the findings from this study to influence the voluntary standards that will be published later this year. It was a challenge to gain consensus among all the stakeholders involved across the four countries of the UK, however the advanced level of practice of the district nurse is explicit and a staged approach to moving to Master's level education is suggested with the aim that, by 2020, it will totally implemented.

The other four recommendations that are aimed at both educators and practice are mainly achievable within existing resources and infrastructures. However, the cost of employing a strategic leader in district nursing in organisations may be a deterrent in many areas. Nevertheless, having a vision within organisations explicit to district nurse practice will provide future direction and contribute to the development of knowing-in-practice. It is acknowledged that embracing innovative and alternative approaches to education will be a challenge for some district nurse educators and organisations, who, for example, may not be familiar with social media as an educational tool. This change in culture will take time. However one can already see inroads by some individuals in this area such as the growth of @WeDistrictNurse on Twitter of which I am one of the chat co-ordinators. I believe the findings in this study will be accepted by my district nurse colleagues in both education and practice.

6.5 Areas for Future Research

This section identifies some suggestions for future research; some related to the methods used, some to the findings and theoretical concepts that have emerged, and some to the recommendations identified above:

- Photo elicitation could be considered as a sole method of data collection in group interview research. In this study it proved successful in stimulating unexpected insights as well as facilitating group dialogue.
- An exploration of community nurse placements within pre-registration nurse education and its impact on the nurse at the point

of registration being prepared to work in the community. The differing practices of band 5 nurses working in the community emerged in this study and it may have an impact on future post-registration nurse education.

- Further exploration of the role of a professional strategic leader supporting the development of knowing in practice could be undertaken. This study suggested that strategic professional leadership and a clear organisational vision supports the development of knowing.
- Evaluation of the role of the practice teacher in district nurse practice could be carried out. This study suggests this role is essential but the NMC standards (2008) state that a sign-off mentor is the minimum required within district nurse education.
- A similar study could be undertaken to explore the unique knowing of other fields of nursing in the community to examine differences and similarities. This study was explicit to district nursing and to practitioners who are on first part of the NMC register with an adult qualification (NMC 2001).

6.6 Final Thoughts

This chapter has argued that the methods used in this study were appropriate and has summarised the study's responses to the research questions. Study limitations were identified, and suggestions for practice and future research have been given.

In concluding this thesis I acknowledge both the professional and personal journey I have undertaken, and my learning as a result of undertaking this study. In particular, I recognise how I have been challenged in my position as a nurse and educator to move beyond the nursing literature and to consider literature from other social sciences. It was difficult at first to embrace the education research approaches adopted by other disciplines but I believe this is true of many nurse academics and, at times, I did return to the comfort of familiar literature. However, while in the analysis and writing-up stage I finally

recognised that the complexities of district nursing knowing and how that knowing is developed does not fit into ‘neat’ boxes.

My personal curiosity and professional responsibility to strive to provide education that meets the needs of professional practice has provided me with the motivation to progress with this study. When my thesis is read in its entirety I believe that the complexity of knowing in district nurse practice and the ‘messiness’ of how this knowing is developed is apparent. While individual readers will take from it what they wish and add their own perspective, I have gained insight into practice-based theory and its potential as a way of influencing professional practice and learning.

I have a responsibility to publish my findings in the relevant peer-reviewed journals. While submitting papers to journals related to community nursing will be a fairly straightforward process, I wish to challenge myself and consider publishing in an educational journal. I am still aware that participants, and in particular the key informants, may recognise themselves within my study. I will remain congnisant of this and will endeavor to protect them when presenting the findings in written form or at conferences.

In conclusion, the impact of this study and its findings, in many ways, has confirmed my initial thoughts that district nursing does have unique knowing that requires an advanced level of education to support it. My own institution’s re-approval of its district nurse programme, in 2013 by the NMC, enabled many of the emerging themes within this work to be considered within the design; in particular the need to move to a postgraduate education for district nurse education and to embrace the elements of advanced practice. We are proud of this development, being the first institution in the UK to have a district nurse course accredited by the RCN.

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Appendices

Appendix 1: Key Elements of Career Framework (Skills for Health 2010)

Appendix 2: Participant Consent Form

CONSENT FORM

The Unique Knowing of District Nurses in Practice.

I have been provided with a full explanation of this research study and voluntarily consent to participate.

I understand that the information gained from this interview will be audio-taped and transcribed. It could be used to inform future District Nurse education, further research and may also be published. I understand that data obtained from the interview will be stored securely then destroyed following completion of the study. I understand that my right to privacy and confidentiality will be maintained throughout. My personal details will not be revealed and I will not be identifiable within any of these materials. I understand that I am free to withdraw from the study at any time without prejudice.

I have read the participant information sheet and am aware of what is expected of me.

I hereby give my consent to participate in this.

Participant signature _____

Date _____

Interviewer signature _____

Date _____

Appendix 3: Key Informant Interview Schedule

Key Informant Interview Schedule

Aims of the research

The aim of this research is to explore the unique knowing of district nurses in practice, and how this professional knowing is developed.

Research Questions

- What is the unique knowing in practice that characterises the expertise of district nurses?
- How do different workplace elements help develop the unique knowing – in – practice of district nurses?
- What formal educational frameworks in curriculum and policy might best support the development of district nursing knowing?

Introductions:

- purpose of study,
- why they were chosen as an interviewee
- how long the interview will last.
- their rights as participants in the research
- check that they consent
- allow participant to introduce themselves

Interview Questions:

Demographic Information

- Role
- Outline of you professional education, level of educational learning
- Years of working in district nursing

Specific Questions

Can you tell me about the knowing in practice required as a district nurse at band 6 and how this is obtained in your area?

Can you tell me about the knowing in practice required as a district nurse at band 7 and how this is obtained in your area?

How are recent policy developments affecting knowing in practice?

What continuing professional education is available for district nurses in your area?

What kinds of support currently exist to develop knowing in district nursing?

What kinds of support do you think would be the most effective in the future?

Can you provide an example of a district nurse who recently demonstrated good practice? What was it that made it you select this example?

What is unique about this area of nursing practice?

What will be the implications of the implementation of the new pre-registration standards to district nursing?

To what extent does the knowledge and skills framework support district nursing? Are there any other frameworks that you find useful in your area?

Is there anything else you wish to add?

Prompts:

- That's interesting can you tell me more about that
- Can you give me an example of
- Why do you say that
- What do you mean
- How does that happen

Appendix 4: Group Interview Schedule

Group Interview Schedule

Aims of the research

The aim of this research is to explore the unique knowing of district nurses in practice, and how this professional knowing is developed.

Research Questions

The specific research questions which this study will explore are:

- What is the unique knowing in practice that characterises the expertise of district nurses?
- How do different workplace elements help develop the unique knowing – in – practice of district nurses?
- What formal educational frameworks in curriculum and policy might best support the development of district nursing knowing?

Introductions:

- purpose of study,
- why they were chosen as an interviewee
- how long the group interview will last.
- their rights as participants in the research
- check that they consent
- allow participant to introduce themselves

Interview Questions:

Demographic Information

- Role
- Outline of you professional education, level of educational learning
- Years of working in district nursing

Focusing Exercise

Using the postcards please select two that you feel represents the unique knowing of district nurses and be able to discuss their meaning with the other participants.

Specific Questions

What are the effects of policy on the knowing in practice of district nurses? Has this changed recently? If so, how and why?

Tell me about some of the practices that are everyday, but unique to the district nurse. What are the capabilities involved in that practice? What key relationships are involved in that practice – official/unofficial?

Can you tell me of a significant event that was a positive experience? - probe – what was it that made it a positive experience

Can you tell me of a difficult situation – one that you were able to resolve or not - probe – what was it that made it a difficult – how did you handle it?

Reflect on your role as a district nurse? What do you do differently now as to what you did 3 years ago? How did you develop?

How do we each develop to the way we are today? If the term leadership used – explain what meant

What will be the implications of the implementation of the new pre-registration standards to district nursing?

What kinds of support currently exist to develop knowing in district nursing?

What kinds of support do you think would be the most effective in the future?

To what extent does the knowledge and skills framework support district nursing? Are there any other frameworks that you find useful in your area?

Is there anything else you wish to add?

Prompts:

- That's interesting can you tell me more about that
- Can you give me an example of
- Why do you say that
- What do you mean
- How does that happen

Appendix 5: Participant Information Sheet

Participant Information Sheet

Study Title

An exploration of the unique knowing of district nurses in practice.

Invitation

You are being invited to take part in this study which is being carried out as part of the Doctorate of Education that I am undertaking at the University of Stirling. Before you decide if you want to take part in the study, it is important you understand the purpose of the study and what your participation will involve. Please take time to read the following information and to discuss with others if you wish. I would be pleased to explain anything that is not clear and/or if you require further information.

What is the purpose of the study?

District Nursing is currently in a period of uncertainty and is guided by professional standards that are out of date. The literature to date does not currently provide an evidence base identifying the unique forms of knowing required by district nurse to support the continuation of present systems of continuing professional development for district nurses.

The aim of this research is to explore the unique knowing of district nurses in practice, and how this professional knowing is developed. Understanding the knowing required for professional practice and how this is gained is of great importance if the district nurse education is to meet the needs of professional practice. Therefore from this aim the following research questions have been developed:

- What is the unique knowing in practice that characterises the expertise of district nurses?
- How do different workplace elements help develop the unique knowing – in – practice of district nurses?
- What formal educational frameworks in curriculum and policy might best support the development of district nursing knowing?

Why have I been chosen?

You have been chosen to participate in the study because you are one of the key stakeholders involved in district nursing and/or are currently practicing as a district nurse at band 6 or 7.

Do I have to take part?

There are a number of aspects to this study including document analysis, interviews and focus groups. If you complete the attached consent form you will be invited to be contacted to participate in an interview or a focus group. Once you have consented to participate I will contact you to ensure that you fully understand the purpose of the study and to provide you with the opportunity to ask any questions. I will then arrange a time to interview you either individually or as a focus group at a time and place that is mutually convenient. The purpose of the interview or focus group will depend on who you are and will relate to your views. The interview will take approximately 45 – 60 minutes of your time, and if you agree will be audio-recorded to all me to have verbatim transcription to enhance the data analysis.

What are the possible disadvantages and risks of taking part?

The study does not foresee any disadvantages or risks to taking apart. However if for any reason you feel concerned about any aspect you can relay this information to myself.

What are the possible benefits to taking part in the study?

I envisage that his study will enable me to contribute to the evidence base.

Will my taking part in the study be kept confidential?

All information that is collected about you will be kept strictly confidential as to your identity. All documents will be issued with a study number, and the data will be stored in secure conditions in accordance with the data protection act (1998) and analysed anonymously. The presentation of the findings using a case study approach will lead to collation of data specific to particular Health Boards. However the Health Boards will not be named. With the focus groups, participants will be interviewed along with people from the same Health Board. All audio recordings will be stored in secure units and destroyed after transcription.

What will happen to the results of the study?

On completion of the study, the data will be analysed by myself and the findings will presented as part of my doctorate work, The results may also be published and presented in journals or conferences for the benefit of others.

Who has reviewed the study?

The study has been granted full ethical approval from University of Stirling. If you at any time have concerns of the research process please discuss in the first instance with the researcher Heather Bain.

07738364630 or email heather.bain@rgu.ac.uk

If at any time you wish to make a formal complaint about the research process contact Head of the School of Education at the University of Stirling.

Thank you very much for considering taking part in this study.

Appendix 6: Excerpt of Transcript

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GC2: "Ehm, I think the, the apple with the peeling probably just because it kinda says things are never what they appear to be, you know, you, you go kinda under the skin an', if you think something's gonna be simple, it'll be harder than you image. If you think it's gonna be hard, it might be simpler than you imagined. So it's at, kinda probably education for District Nursing, I suppose will it ever meet what we, what we want it to meet."

Interviewer: "Mmh mh."

GC2: "This one I don't know, it just drew, drew my eye right from the word go, the fact I'm sitting here was quite handy."

Interviewer: "Is that a light bulb?"

GC2: "It's a bit like a crystal ball, so I suppose looking into that what you won't is utopia, you won't ever seem to be able to, ehm, I don't know, it just caught my eye."

Interviewer: "Okay, thank you. Last but not least."

GC1: "Ehm, I looked at this one, it reminded me of the secret garden an … whatever door you open and go in, there's always gonna be a new experience, ehm, and it's not always known to us, it's, but we'll take it on and we'll explore it, like you would a garden, and we'll, ehm, make it flourish like flowers, you know. Eh, most, mostly the fact that you, however experienced you are and however much education you've got, you'll always come up through a new experience and learn from it."

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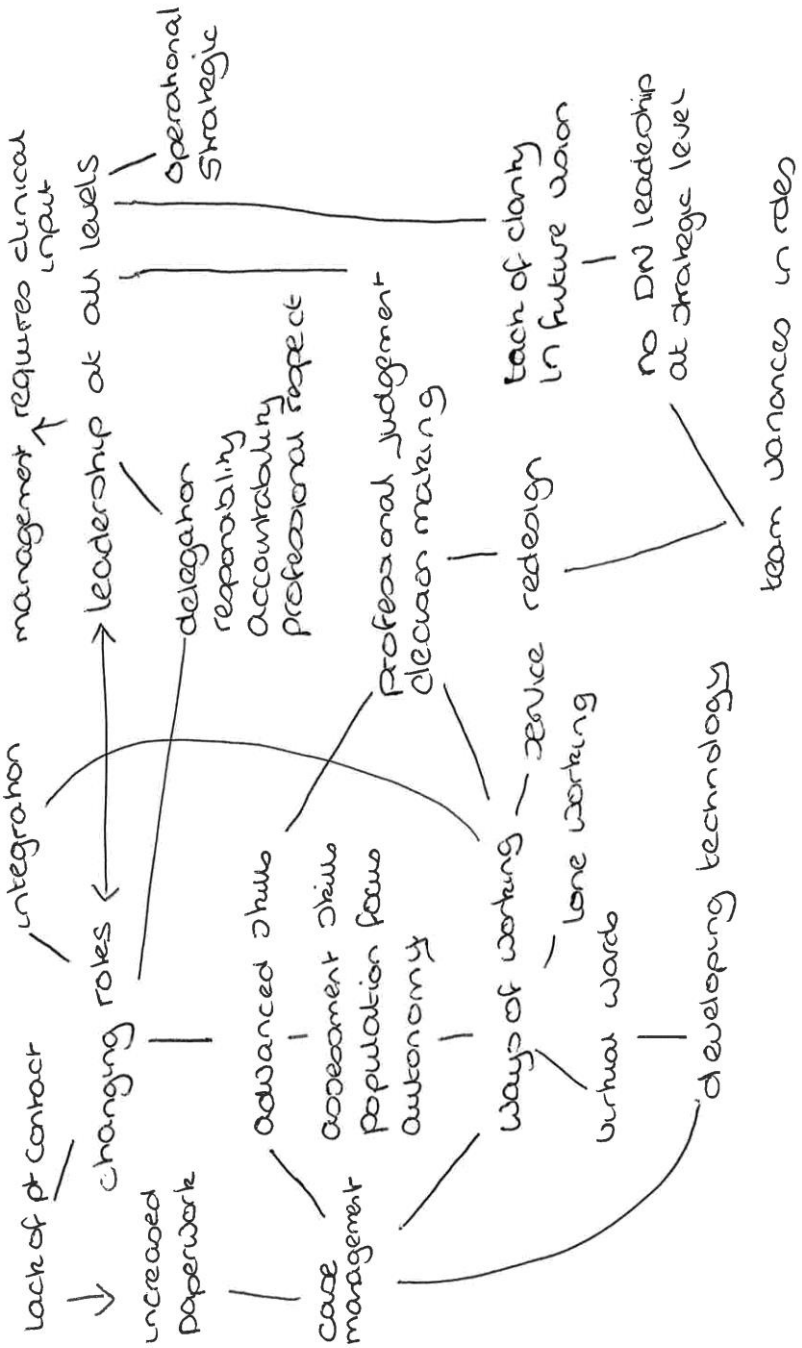
Appendix 7: Concept Map



Appendix 8: Example of Themed Chart

Case Name	3.1	3.2	3.3	3.4
A1	P5 – emerging roles within bands; P7 – developing consistency across band	P13 – commitment to service redesign **P15 – Significant Event example change manage**	**P9 – integration agenda to support case management**	P10 – equity of resourc
GA11		P13 – conflict of ways of delivery to approach taken	P11 – policy awareness	P22 – managing skill mix in sickness
GA12			P10 – changing practice guided by policy	**P21 – supporting care homes to deliver care**
GA21		P37 – conflict to new ways of working	P11 – policy affects ways of working	**P36 – caseload management to support communication**
GA22				P19 – referral criteria **P24 – Significant Event - development of palliative care meetings;** P41 **-** need to prioritise;
GA23			P11 – focus on local ways of working	P12 – knowing required to manage care varies depending on style of caseload management
GA24	P30 – skill mix of managing care	P44 – role of DN in ways of working; P46 coping with change and integration of clinical leadership;	P11- focus on local policy	P19 – referral criteria **P25 – Significant Event - named nurse concept**
GA25				P19 – referral criteria **P36 – caseload management to support communication**