

An Exploration of Specialist Nurses in Malta: A Qualitative Case Study

Corinne Ward

A thesis submitted in partial fulfilment of the requirements of
Bournemouth University for the degree Doctor of Philosophy

May 2016

Bournemouth University

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Abstract

The concept of specialist nursing and advanced nursing practice has been extensively debated in the literature internationally but to date no consensus exists on the preparation, titling and regulation of these nurses worldwide. The introduction of specialist nurses in Malta in 2003, now titled 'practice nurses', was seen as an evolution in nursing practice and launched in response to gaps in services and developments in health policy. This was perceived as a much needed career advancement option for nurses; an alternative to traditional administrative/educational roles; and a drive towards improving patient access and quality care. However there was still a paucity of information and evaluation of the nurses' role in Malta.

The aim of this study was to explore the perceptions of the roles, development and preparation of specialist nurses in Malta, an island with its own historical, political and social context. Using a qualitative case study design, a deep understanding of the complex issues surrounding specialist nurses was gained from multiple data sets using purposive sampling techniques. Data included a survey of the total specialist nurse population (N=27), in-depth interviews with a group of specialist nurses (N=9) and four focus groups with key professionals and policy stakeholders (total N=28). Data were collected between 2013 and 2015 and analysed using thematic analysis.

The main themes that emerged from the findings including concepts of advanced nursing practice, role boundaries, preparation, regulation and autonomy to practice. In spite of the very positive views on the roles and practice of these specialist nurses, a number of barriers to their future development were exposed. Barriers comprised the lack of understanding and support for their role and the paucity of evaluation research on their role. Additional areas affecting their advancement included the organisational and political systems that were seen to affect leadership, and power in nursing to achieve the ultimate aim of consistent provision of good quality nursing care. The study provides the first research-based insights into the role and development of specialist nurses in Malta, and concludes by highlighting the need for a legally accepted set of definitions, preparation and evaluation of the specialist nurse role from a national policy perspective.

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1. Introduction

The aim of this study is to explore the professional experiences of Maltese specialist nurses (SNs) with the intention to provide quality evidence about their role, preparation and development. This new insight aims at making a difference by providing a unique understanding of these specialists in context. In Malta specialist nurses are a relatively recent addition to the professionals engaged in the delivery of healthcare. They are of particular interest because they are at the forefront of new and advanced practice roles, contributing to the broadening of nursing practice and, as Abbott (2007) states, blurring intra-professional and inter-professional boundaries in healthcare.

The thinking behind this research is derived from different aspects of my professional experience. My initial interest in the area originates from my practice as a SN, working in the field of tissue viability, where I had first-hand experience of developing the role and services in Malta. During the past decade there has been an increase in the opportunities for SNs with changes in patterns of care delivery and the development of the knowledge and skills of these nurses to set up nurse-led clinics and specialist services. A second influence was my involvement in both national and international associations where I encountered many nurse leaders who inspired me to pursue my desire to explore the experiences and perceptions of SNs in Malta. Finally, my current position as a Senior Nurse Manager in the only acute hospital in Malta further encouraged me to follow my vision for this study. As a manager coming into contact with SNs in various fields I experienced a vacuum concerning the lack of direction, policy and understanding of these nurses. I wanted to investigate the work of these nurses to provide the much needed information about their role and development; but also believed that I needed to give them the voice and time for their experiences to be told. The constructivist paradigm used for this study provided a way of focusing on the understanding of these nurses, whilst the case study approach provided the opportunity to explore these experiences in depth, within their own context and from a variety of sources.

1.1. Definition of a Specialist Nurse

Since 2013 the actual title *specialist nurse* is no longer used in Malta, since both SNs and practice development nurses (PDNs) were re-titled under the one heading of practice nurses. This came about due to issues raised by the Medical Association of Malta (MAM), challenging the legality of titling a professional entity as ‘specialist’ when there was no

official body to register them as such, in this case the Council of Nurses and Midwives, Malta. However, for this thesis the words ‘specialist nurse’ (SN) or ‘clinical nurse specialist’ (CNS) will be used to refer to the type of nurses under study as this differentiates them from the PDNs and is more in keeping with internationally recognised terminology. The focus of this thesis is that of specialist nurses who have been employed as SNs in specific roles since the 1990s. These SNs are all employed by the health sector to perform advanced practice duties in a specialist area or for a particular group of healthcare professionals or clients/patients. These include SNs that were, for example, called infection control nurse, stoma nurse, pain nurse and informatics nurse (Sharples 2012, Director of Nursing, personal correspondence, 6 June 2012 see Appendix 1).

1.2. International Background

The development of Advanced Practice Nurses (APNs) including SNs is growing, and according to Begley et al. (2010) the skills and accessibility of these nurses is arguably regarded as an asset to the contemporary healthcare environment. As Pulcini et al. (2010) state, the shortages of doctors, an ageing population and providing accessible and affordable healthcare for long term disease management, are all global challenges that would benefit from the development of specialist and advanced practice nurses’ activities. Supporting this, Chang et al. (2012) state that key government international papers specify that health systems are required to deliver consistent and high quality care to patients and due to rapid expansions and development in medical knowledge SNs and APNs will be increasing.

Although SNs are considered to play a role in alleviating human resource shortages in healthcare, Pulcini et al. (2010) emphasise the need for evidence to support them and enable service providers to justify their development. Most importantly, as Holloway et al. (2009) explain, accurate data concerning both their demand and cost-effectiveness are important since this information underpins the progress of any effective workforce. In addition, SNs’ impact on patient outcomes has been recognised in studies outside Malta, and has been attributed to: increased satisfaction with care (Brooten et al. 2004); decreased length of stay (Dawes 2005), fewer hospital readmissions (Naylor et al. 1999) and decreased cost to the service (Burns and Earven 2002). Notwithstanding this, MeiLing (2009) explains that more studies are needed to evaluate the impact of these nurses, by using systematic and measurable approaches to establish their real therapeutic influence.

1.3. The nature of the problem and the research aims

Despite the creation of 29 SN posts in Malta over the last two decades (Sharples 2012, Director of Nursing, personal correspondence, 6 June 2012 see Appendix 1) there is no SN register, and the information about them for this study had to be obtained from the Directorate of Nursing at the Health Ministry. The study will be the first of its kind in Malta since there is no literature about either advanced practice or SNs in Malta, and there is no evidence to show their need. Internationally, Dawes (2005) states that the literature is increasing regarding SN training, need and impact. However, these are from larger countries such as Australia, Canada, United Kingdom (UK) and the United States of America (USA), which have different backgrounds to the Maltese system of nurse education, different laws and different cultures. This makes their results difficult to apply to a small Mediterranean country, since its circumstances are different from the backgrounds of the original studies. Furthermore, in Malta, requirements of SNs and their preparation are not standardised. In an attempt to redress this, in 2012 the Maltese Government issued a call for SNs stating that these nurses needed to be educated to Masters Level. The nursing union disagreed, threatening industrial action. Pace (2012), the former president of the Malta Union of Midwives and Nurses (MUMN), stated that there was no international consensus on the level of education for SNs, and thus the government of Malta was imposing unfair standards on its nurses. Although Lowe et al. (2012) agree with Pace (2012) and state that there is no international unanimity on standardised entry level qualifications for advanced nurses, Pulcini et al. (2010) found in an international study that more countries are opting for a Master's Degree level of entry. In Malta, since 2013, SNs (practice nurses) are expected to complete a Master's Degree in 4-6 years from taking their position, but to date there is no specialist educational or experiential preparation as a pre-requisite for them to enter into this advanced nursing role (Sectoral Agreement 2013; Call for applications, see Appendix 14).

Nursing career pathways in Malta mainly lead to education or management positions, so the notion of SN positions is attractive to those who seek a clinically focused occupation. Additionally, due to the pressure on the health department for more services, the National Health Systems Strategy (NHSS 2014) is proposing the expansion of specialist nurse-led clinics in the community. Therefore the demand will continue to grow. However, although these positions are being recommended (NHSS 2014), no data or verification of SNs' impact, successes and/or failures could be found, indicating that more evidence is required to inform this debate. Notwithstanding this, it is paramount that these nurses' roles are outlined and

examined before evaluating their impact and establishing if these perceptions are indeed correct.

1.4. The Research Study

The overall aim of this qualitative case study is to explore the experiences of specialist nurses in this small Mediterranean island with unique challenges and successes. The study aims to create evidence on specialist nurses that is needed as a foundation for further understanding of their roles and development, and thus the objective is to create a profile of these nurses in Malta, with their background and attributes as professionals. Their stakeholders' experience of working with these SNs is aimed at providing an understanding from their perspective, and to explore if their expectations and needs are being met by these professionals. This study seeks to identify features that may need to be developed in specialist nursing in Malta, in an attempt to secure a supply of specialist nurses that would adequately meet the demand from their stakeholders and organisations in the future. Underlying the research study is another objective: to explore the influences on the advancement of specialist nursing practice in Malta and provide an understanding of what factors support or hinder specialist nursing progress.

A constructivist philosophy using Merriam's (1998) approach to qualitative case study design will be the methodology in this research to explore the context of specialist nurses in Malta. Data will be collected through a survey for all specialist nurses (N=27), four focus groups with professional stakeholders and nine interviews with a sample of specialist nurses themselves. Data from the survey will be used to inform the interviews and stakeholder focus groups, and the discussion generated by the participants in interviews and focus groups will be linked to the scope of practice, preparation, qualities required of SNs and legal and sustainability issues of these positions. The following section provides the background of specialist nurses in Malta with a brief historical account leading to the present situation. It aims at aiding the reader to understand who the Maltese nurses are and where they come from, thus providing the setting and context.

1.5. The Maltese Context

The Maltese archipelago is made up of three main islands, Malta, Gozo and Comino, and is located in the centre of the Mediterranean Sea. The total population in Malta was estimated at 421,364 as at the end of 2012, an increase of 21.9 per cent when compared to the 1985 figure

(National Statistics Office of Malta (NSO) 2013). In a European Union context, Malta remains the smallest country placed behind Luxembourg and Cyprus, the only countries with less than a million inhabitants (NSO 2012). However, as opposed to population size, Malta by far ranks first among all EU Member States in terms of population density.

Malta has the oldest free-standing building in the world, dating back to 5,800 BC (Tate 2006), and has a rich history, have been ruled by the Romans, the Knights of St John, the French and the British, to mention a few. It obtained independence in 1964 and has since become a Republic and forms part of the European Union as well the British Commonwealth (Tate 2006). The Maltese have kept their own language and their religious Christian beliefs, and although they are generally a peaceful people they are divided along political party lines (Mitchell 1998). As Austin (1996) states, politics is strong and political loyalty is facilitated in this closely-knit society. In fact, Mitchell (1998) explains that the Maltese society is very close to the Maltese State and party membership can be a mechanism in advancing individual and family interests. Although the Maltese proclaim democracy, many people don't publicly or formally complain since this criticism is then often taken as a political or personal affront and, as Richards (1982) states, is emotionally charged, resulting in deep conflicts and personal rivalries.

1.5.1 The Maltese Healthcare System

The healthcare system in Malta is based on the National Health Services system in the United Kingdom (UK), being mainly 'free' at the point of delivery. However, as Scerri (2014) states, there are dual systems of private and public health services. The primary hospital in Malta is the Mater Dei Hospital, which opened in 2007 and is one of the largest medical buildings in Europe (NHSS 2014). Scerri (2014) further explains that the public healthcare in Malta is funded from taxation and covers almost any treatment, from hospitalization, prescriptions for chronic illness, childbirth, surgeries to rehabilitation. The Government delivers primary healthcare through Health Centres spread over the Maltese Islands, but some choose to use the private services of general practitioners (GPs) and consultant specialists on a 'pay as you go' scheme due to convenience and continuity of care (Azzopardi Muscat et al. 2014).

Despite the generally good healthcare provision in Malta there are challenges that include: increased demands on healthcare; an elderly population; non-communicable diseases and a shortage of nurses (NHSS 2014). Moreover, with regards to the elderly population, the demand for long-term institutional care has increased not only as a result of the ageing

population but also, according to Azzopardi Muscat et al. (2014), due to the reduction in size of extended families, which otherwise served as the primary support network. Abela (2012) adds that the increase of women in employment in Malta over the past decade, has affected the demand on care, since they would have otherwise provided care to family members. In a report by Johns Hopkins (2012) and later confirmed by another Maltese Public Document (Dalli 2014) (both reports commissioned by the Ministry of Health part of consultation exercises), access to care due to inpatient and outpatient waiting lists is the most significant challenge that the hospital faces today, which has a negative impact on care quality. In The National Health Systems Strategy (NHSS) document, Fearn, the Parliamentary Secretary for Health at the time (NHSS 2014), states that in essence the government's plans for healthcare in Malta include an overhauling of the primary care facilities. Although the expansion of specialist nurses' clinics was mentioned in the Strategic National Plan (NHSS 2014), there was no information on how this would evolve. What is also important to note is the paucity of such information to healthcare professionals and the public in general. This latest National Strategic Plan (NHSS 2014) is the first such plan to be published in over 20 years since the publication in 1995 of the first ever National Strategy for Health, the "Health Vision 2000".

In the Patient's Charter of Rights and Responsibilities (2001), the Health Minister at the time stated that government services were focusing on placing the service user at the centre of all initiatives and activities. This was once again reiterated in the recent NHSS (2014) document by the present Parliamentary Secretary for Health. Whilst commending these visions, Azzopardi Muscat et al. (2014), in the WHO document for Malta, state that there has been limited evaluation of the services provided and limited input from patients and clients in Malta. Thus, without these evaluations, planning, forecast and resource allocation will continue to be a challenge for future healthcare in Malta. Moreover, from the documents mentioned, including the NHSS (2014) and the WHO documents by Azzopardi Muscat et al. (2014), little is mentioned of how nurses could be involved in the processes for improvement.

1.5.2 Nursing in Malta – an overview

Although the history of nursing in Malta goes back to the Knight Hospitallers in the 16th Century, little is known of how nursing was, and is, organized since, as Sharples (2012a) points out, little has been written about the profession in the country. St Luke's School for nurses was founded in the late 1930s and the Sisters of Charity managed it until the late 1980s. The School for nurses continued to provide courses leading to registration and to

enrolment, but according to Fenech Adami (2001) published literature regarding how this was provided is virtually non-existent, although nurse education followed systems in the UK.

Post-independence jobs were scarce and nursing was perhaps the only readily available opportunity that attracted many youngsters seeking a stable career, although they may not have chosen nursing as their first career choice. In the 1980s the course of nursing was planned so that students joined the nursing compliment and worked a roster of day and night duties including Sundays and public holidays. Student nurses up until the 1990s were used as a pair of hands. Sharples (2012a) confirms this and explains that if there was a shortage of nurses, students were transferred from one ward to another irrespective of allocation, and they were usually assigned menial jobs including cleaning of furniture, pantry, sluice duties and errands.

However, nurse education is nowadays provided through the University of Malta, and although Fenech Adami (2001) points out that it is owned and funded by the state, it is autonomous and independent as an institution. In 1988, Fenech Adami (2001) explains that the first degree programme in nursing studies was started at the Institute of Healthcare, and entry into University gave more independence from the State, and in this way students were protected and were stopped from being used as a pair of hands. Notwithstanding this there are new challenges for nurse education today. The shortened course from four to three years has seen an increase in students on the wards, and as Avallone pointed out in 1999, this has ethical implications. According to Avallone (1999) clinical areas that are overloaded with students give rise to ethical concerns if students are not adequately supervised, and a paucity of learning opportunities for the students is the result. Also, as Fenech Adami (2001) points out, the resultant lack of individual support is probably contributing to the high degree of wastage among nursing students.

Fenech Adami (2001) also noted that a subtle attempt at a one-level graduate nurse structure has been initiated, however to date (2016) this has not materialised. As Griscti (1999), a university lecturer at the time stated, this one graduate level of education would help in uplifting the status of nursing to the level of other professions and would additionally help with the public's recognition of professional nursing. Despite this, Fenech Adami (2001) explains that this may be over-ambitious for Malta, since given the situation where a shortage of nurses exists one would need to assess if an adequate supply of nurses could be provided through one portal of entry. Higher education qualifications may also pose a problem in restricting individuals who are willing to enter nursing, a profession that essentially revolves

around care delivery. As Fenech Adami (2001) maintains, potential student nurses in Malta would be forbidden to follow their career because academic qualifications rather than interest in nursing care would be given more importance, and so it was likely they would be discouraged to follow such a profession.

In addition to educational challenges for nursing in Malta, there are other compounding aspects that need to be considered. As Miller (1994) stated more than two decades ago, although changes in education might help nurses understand things better, it would not solve any prevalent problems or help enhance care delivery unless changes in education were accompanied by changes at the clinical, managerial and political levels in Malta. However, Azzopardi Muscat (1999) stated that although in 1994 the structure of the nurse population was reformed and a new management structure was created, this reform did not bring about the expected improvements. She further asserted that management structures cannot be changed effectively unless they are part of an inclusive strategy in which managers are given the necessary authority and support. The European Observatory on Healthcare Systems (EOHCS) (Azzopardi Muscat 1999, p.24) in a report called *Healthcare Systems in Transitions, Malta*, further explains that “*the problems of excessive centralization and bureaucracy as well as inefficient management have not been overcome*”. The report continues to explain that the process of decentralization is proceeding at a slow pace partially due to highly centralized financial and administrative regulations and a centrally controlled recruitment process, but may also be explained by resistance to erosion of the central political power base. Although these statements might seem to be outdated, they are still valid arguments in Maltese nursing and healthcare today, as evidenced by the two reports commissioned by the Health Department (Johns Hopkins 2012; Dalli 2014) who both assert the need for change within the structure and delivery of care in Malta that is still centralized within the Health Ministry.

What is also significant to note is that the Government is the main employer of nurses and most of the leaders in Nursing are politically appointed. There is one overall director of nursing at Ministry level, one director in the main hospital and primary care, both of whom were appointed by the Minister in positions of trust. A position of trust is when a Minister chooses to employ someone in a position without any public competition, and as Galea (2016, personal correspondence, 9 July 2016 see Appendix 2), the General Secretary of the Malta Union of Midwives and Nurses (MUMN), states is adopted to eliminate the bureaucratic process of the civil service and engage someone of their trust. The Director of

Nursing at Ministry Level, Chief Nurses, Senior Nursing Managers, Charge Nurses and all other grades (Figure 1.) of the nurse population in Malta, are appointed following a formal call for applications and a successful interview. To provide further context, it is also worth mentioning that from 2013 to 2016, following the change in Government in 2013, nursing in the Acute General Hospital had three nurse directors appointed consecutively within a three-year span. This ensued due to a change in government in 2013 that saw the Director of Nursing at the present day move to another entity, and then a change in Health Minister in 2014. This situation challenges the nursing stability since the continuity and direction of nursing changes with new people bringing in new ideas, personalities and priorities within a short time frame. Another recent addition to the nursing structure, in a position of trust, is titled Head Nurse, positioned at the same level or grade of seniority (Galea 2016, personal correspondence, 9 July 2016, see Appendix 2) as the Chief Nursing Manager (Figure 1). Figure 1 illustrates the hierarchical structure of nursing in Malta by providing an overview of the complete structure using the Acute Hospital (Mater Dei) as an example.

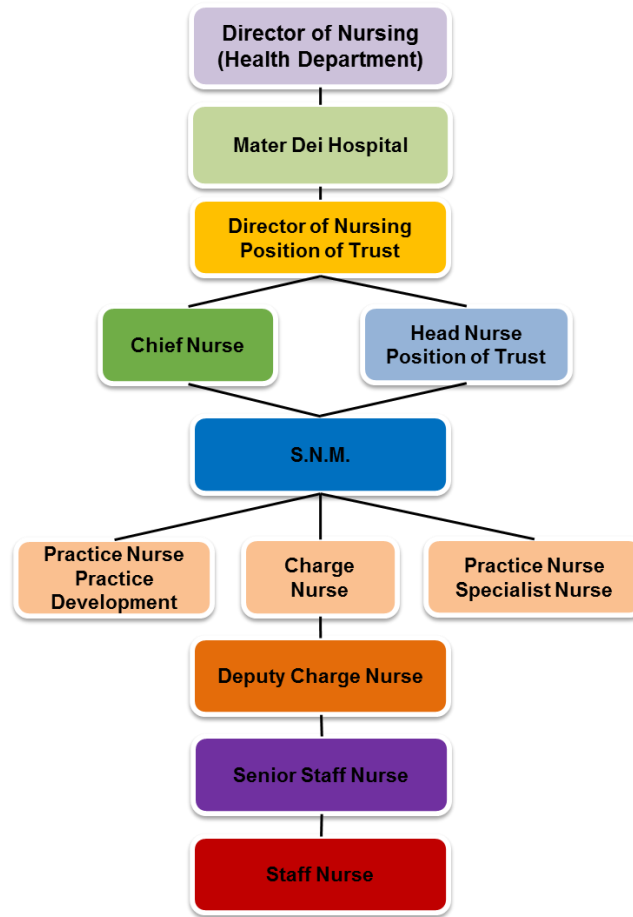


Figure 1. The present nursing structure in Mater Dei Hospital, Malta 2016

As evidenced by the amount of positions of trust held in senior positions in Nursing (Figure 1) and the bureaucratic and highly centralized and regulated system mentioned by the three reports (EOHCS 1999; Johns Hopkins 2012; Dalli 2014) it is fair to note the political influence that could leave little space for senior nurse leaders to be involved in change or service development. This observation is in agreement with Johns Hopkin's (2012) consultation report on the healthcare services in Malta, that portrays a situation where critical decisions lie outside Mater Dei Hospital. This report states that with management unable to hire or fire staff, decisions handled through lengthy and bureaucratic processes and final decisions made within the Office of the Prime Minister leave the hospital's leadership with no authority to make decisions of its own. Another important element is the cultural component of nurses in Malta. As explained in Figure 2, Fenech Adami (2001) outlines the cultural characteristics of nurses in Malta that are worthwhile considerations prior to introducing change. Although these are more than a decade old, they are still valid in today's reality. What is most evident is the value nurses place on job and financial security that could impact their future careers.

- Job mobility is not a common phenomenon in nursing, while job security is of major importance, and is permanent in the state sector, unlike the situation with the private sector.
- Financial security is very important particularly as a result of the heightening standard of living in Malta, and also the possibly more materialistic lifestyle being adopted by the younger generations. Such financial and job securities are prominent factors among the male population and increasingly becoming so among the female population.
- Excessive bureaucracy means that it takes a very long time for the process of staff recruitment to be completed, in any area of the government (Azzopardi Muscat 1999), even in the University of Malta, which is funded by the state.
- Healthcare employees within the Department of Health are considered to be civil servants and thus their roles and wage have to be organised within the fixed structure for civil servants with the state. As part of the civil sector, the health service has never operated a system of incentives and penalties. Employment with the state is permanent.
- The relatively low pay structure and the nature of healthcare work have engendered a situation where working overtime or carrying out an additional job in the private sector is increasingly becoming the norm for the majority of healthcare employees, including nurses (Azzopardi Muscat 1999).

Figure 2. Cultural characteristics that need to be addressed (Fenech Adami 2001, p.39)

1.5.3 Context to the development of Specialist Nursing in Malta

“A typical example here in Malta, or better at Mater Dei Hospital, is the nurses working in the pre- hospital care. Although such nurses possess specialized training yet they cannot (according to Maltese legislation) even administer a simple tablet such as a paracetamol to their patients since the Health Minister never took the MUMN’s initiative to update the law as to allow nurses to prescribe lifesaving drugs in an emergency setting. MUMN was proactive on this issue but the Health Minister did not honor the commitment to update the legislation. Till this very day, nurses working in an emergency setting find themselves in a situation where they need to save lives through giving treatment but are not allowed to do so with the result that patients’ lives are being jeopardized especially on the ambulances on their way to Mater Dei Hospital. ...Other European countries have also the posts of ‘Nurse Practitioner’ but the Health Division being run by doctors, with the Health Minister being also a doctor, would never allow nurses to give such a service to their patients. In fact nurses, who are embarking on a degree or masters level in nursing and some even reading a doctorate level, continuously voice their concerns that after successful completion of such courses, they are not given an opportunity to put their new knowledge into practice” (Pace 2012, Press Release).

The above extract, taken from a press release from the president of the Malta Union of Midwives and Nurses (MUMN) at the time, identifies two important issues. One is the need to change legislation for advanced practice nurses to be allowed to care for their patients

appropriately and safely; and the other is related to the medical dominance felt by nurses in Malta. Advanced nurses that have been trained and certified, as in the Emergency Department, need to be recognised and more importantly encouraged to utilize their skills both for the benefit of their patients and also to keep them motivated in their job. The importance of a legal framework for advanced practice is of paramount importance to facilitate the role of these specialist nurses. Internationally, Delamaire and Lafortune (2010) reported that where specialist nurses' roles were introduced successfully there was evidence that politicians were on board and legislative change was carried out.

The other point raised by Pace (2012) is that doctors will 'never' allow nurses to give such a service. These are strong words that clearly indicate the medical dominance and the medical and nursing divide. The resistance by the physicians could be related to many factors that will be discussed later in this thesis. Notwithstanding this, advanced roles such as tissue viability, infection control, continence and stoma care, seem to have been accepted within the healthcare system and have grown and flourished. Once again, no statistics and evidence is available, but at least these roles and services provided by nurses developed considerably in the last few years. When analysing why this is the case, the nursing roles that managed to develop are roles considered to be 'nursing' duties like wound care, infection control, chronic disease management and continence care, thus not 'intruding' into the medical domain of care like that of prescribing. This was also noted in Canada, and DiCenso and Bryant-Lukosius (2010) referred to this occurrence as 'double standard' since advanced practice nurses were supported to practise in areas where physicians did not want to (i.e., rural and remote communities), but otherwise, there was little perceived need for the role.

Another issue to consider is why advanced nursing positions in Malta developed in the first place. As Delamaire and Lafortune (2010) point out, internationally specialist nurses and advanced practice nurse positions developed across Europe mainly due to a shortage of doctors. However, this does not appear to be the case in Malta, since according to the WHO (2013) report there is minimal medical shortage in Malta, portraying more of a problem with the shortage of nurses. Thus, this is a valid point to investigate in future studies and to consider when developing more roles, since a lack of a shortage of doctors in Malta may be one reason, hampering any progress in the development of advanced nursing roles. Consequently there could be areas of specialist nursing that do not follow international trends and would not be viable in Malta if medical care is being adequately provided by physicians. Despite this, specialist nurses in Malta could focus on areas that involve the nursing element

of care including specialist services for chronically ill patients and not the replacement of medical skills.

From the issues raised, the nursing context is unique and needs attention when carrying out research and change in Malta. Although varied advancements in education and opportunities in nursing are noted, there still seems a lot more to be done. This is especially related to the political and bureaucratic systems and the medical dominance that could be rendering nurse leaders powerless to challenge and change direction. The cultural aspects and the value nurses place on job security are also important characteristics when analysing and interpreting the data and also when future recommendations are put forward. The present study focuses on exploring the roles and development of specialist nurses in Malta and aims at answering the research question: How do specialist nurses in Malta explain their roles, development and experience, and do these concur with those of their stakeholders?

1.6. Organisation of this Thesis

Chapter 1: This chapter introduces the background to the thesis and the study aims and objectives, and describes the organisation of the thesis chapters. It describes the Maltese health situation with a particular focus on issues related to nursing and specialist nurse development. It is important to give this topic specific attention to provide context for the case study.

Chapter 2: The Literature Review. This chapter will outline the systems used in reviewing the relevant literature and will discuss a number of international studies that have explored the concept of advanced nursing practice and SNs. A historical explanation of the development of the SNs' role both in Malta and internationally will be discussed with specific reference to regulation, deployment and preparation for practice. Definitions, titles, roles and theoretical frameworks of advanced nursing practice will also be discussed with a particular reference to SNs. Throughout this chapter gaps in the literature will be highlighted justifying the need for this study.

Chapter 3: Methods. This chapter will be presented in two main sections, namely the methodology behind the study and the method used to undertake it. The methodology discusses the constructivist philosophical underpinnings and explains the reasons why choices were made including the case study design (Merriam 2009). This section also discusses my position as nurse and researcher through reflexivity. The method will discuss the three phases of this case study that will be detailed as to how the research began, was

planned and undertaken from acquiring ethics approval to designing the study, tools utilised, sample selection, and thematic analysis.

Chapter 4: Findings. The findings chapter describes the results from all the data sets, illustrated by the results of the survey and direct quotes from the participants. The results will be themed and compared to each data set outcomes, focusing on commonalities and opposing opinions and perceptions. It will conclude with a table illustrating the results alongside the case study objectives.

Chapter 5: Discussion and Implications. The data will be discussed in relation to the existing literature referring back to answering the research question and establishing how the results related to the case study's objectives. This chapter concludes with implications for the Health Department, specialist nurses, nurse leaders, and future research.

Chapter 6: Conclusions and recommendations. This chapter concludes the research study by outlining the most salient results and putting forward recommendations that will be discussed under three headings: nurse empowerment in Malta, future nurse researchers, and the wider body of knowledge. This chapter also identifies the strengths and weaknesses of this case study and will conclude with a reflection of the journey during this Doctoral study.

2. Literature review

2.1. Introduction

The previous chapter was devoted to presenting a background to the Maltese system of health and nursing to provide an in-depth context for this study. This literature review examines the issues surrounding specialist nurses (SNs), specifically professional concerns, government and European policy and research that contribute to the work of this professional group. The first section will discuss issues related to concepts and definitions, related terminology, the need for, and preparation of, SNs, in order to provide a perspective for the review. The second section will consider SN development around the world, including Malta, and will discuss emerging trends within the literature such as the regulation of these practitioners. Contemporary issues such as the shortage of nurses and other less recognized matters that may be affecting the development of SNs will be discussed next. These will include the personality of individual nurses, the impact upon SNs of the feminization of the nursing profession in general and contextual issues, in particular the political and cultural background of a small country such as Malta. Finally, matters related to employing specialist nurses in post and providing a rationale for the current investigation will conclude the review.

2.2. Background to the study

In Europe, confusion surrounding the role, qualifications and even title given to SNs still exists (ESNO 2010). In countries such as Malta, nursing career pathways have until recently only led to education or management positions, thus the relatively recent introduction of SN positions would be attractive to those who seek clinically focused careers or roles. Malta traditionally looked toward the nursing systems of the United Kingdom (UK) for models of service development (Fenech Adami 2001). However, even in the UK, there is no single accepted system for standardised recruitment and selection of SNs, nor any established entry level qualifications (Begley et al. 2013). Moreover, in Malta there is no literature in relation to this group of nurses. The current study is the first to explore the roles and development of SNs and aims at filling this gap in the literature and also in creating a better understanding of their development and support mechanisms.

The concept of the clinical nurse specialist (CNS) is not new and the role, globally, has seen rapid growth in recent decades (Trevatt and Leary 2010). Notwithstanding this,

Trevatt and Leary (2010) state that the lack of clarity about the definition for these nurses is still evident even in places such as the UK. Ball (2005) supports this statement following a national study in the UK on advanced nursing practice and agrees that there is still confusion surrounding these practitioners. Despite this, evaluations of the specialist nurses' role have been positive, and as Fulton and Baldwin (2004) explain, improvements have been demonstrated in patient health status and satisfaction, quality of life and care, health system costs and a reduction in patient length of inpatient stay. SNs were introduced in Malta during the 1990s and received official recognition in 2003. However, to date, more than a decade later, there is still no formal strategy to either develop these roles or prepare nurses for this specialised activity. This has resulted in a trend that sees SNs creating their own roles to fill perceived gaps in service provision. Such self-directed roles may not be fully understood by either the authorities or other professional staff and could therefore lead them to being used inappropriately. As Rutherford et al. (2005, p. 97) state, when *“new nursing roles are created, they require an effective organisational infrastructure if they are to survive, let alone succeed”*. They further explain that with the development of the role, career progression and the identification of clear lines of authority may help alleviate problems associated with role ambiguity, lack of support and career progression. From a national perspective, during the First World War Malta was nicknamed ‘The nurse of the Mediterranean’ when sick and wounded soldiers from Gallipoli and the Dardanelles were received in great numbers for treatment and convalescence (Sharples 2012a). Ironically, nurses in Malta know little of how their profession developed, and as yet there are no published studies (Sharples 2012b).

2.3. Literature Search

As a consequence of the absence of Maltese sources, and perhaps to place this in context, this review will consider the wider international evidence on SNs, their roles, responsibilities and competency frameworks. Computerized databases searched were: the Cochrane library, Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Excerpta Medical Database (EMBASE). Concurrent searches were undertaken on several occasions over the six years of the study to identify any newly published material. However, this literature search was done up to the date of gathering my data in 2014 and was followed by a more updated review for my discussion chapter in 2015 and 2016.

The primary electronic search strategy used key words from the different elements of the literature under examination. As demonstrated in Table 1 these included key words such

as ‘specialist nurse’, ‘advanced nurse practitioner (ANP)’, advanced practice nurse (APN) and other related topics such as framework and roles. The initial search of APN generated over 40,000 articles in the text and over 2,000 in the title. When combining both words (‘specialist nurse’ and ‘advanced practice’) 550 articles were identified. This was further refined for duplicated articles and an advanced search was developed using the key words used in combination with each other as illustrated in Table 1 below.

Table 1. Search strategy (1960-2014): Words searched, Inclusion/Exclusion criteria, Computerized databases, Other Searches

Words searched	Inclusion/Exclusion criteria	Computerized databases	Other Searches
1. Clinical Nurse Specialist/s 2. Specialist Nurse/s 3. Nurse Practitioner/s 4. Advanced Nursing Practice/ or advanced nurse practitioner 5. Nurse Consultant/s 6. Consultant nurse/s 1 or 2 or 3 or 4 or 5 or 6 7. Conceptual Models / or Frameworks 8. Leadership/ or Leader 9. Barriers/ challenges 10. Role/s 11. Development 12. Regulatory/ regulation 12. Attributes 13. Skills 14. Competency/ies 15. Policy 17. Standards 18. Expert/s 7-18 and 1-6	Participants <ul style="list-style-type: none"> • Clinical nurse specialists • Nurse practitioners • Advanced nurse practitioners • Consultant nurses Setting <ul style="list-style-type: none"> • Any location: studies which included participants working in: Acute settings, primary care or other community locations • Any country • Language: English • Methodology: Any type of Studies Exclusion criteria <ul style="list-style-type: none"> • Studies which included participants only working in midwifery. • Studies which included staff groups other than the populations of interest. 	CINAHL (Ovid version) Embase Medline (Ovid version) HMIC – searched June 2002 British Nursing Index PsycINFO (Silver Platter version) Google Scholar RCN Journals Database Online Thesis	Manuel search – University Library Of Malta and Bournemouth Malta Union of Midwives and Nurses Journal Directorate of Nursing Malta - unpublished documents

During the initial search of the existing literature, based primarily on titles and abstracts, papers that were inappropriate to the study were immediately discarded. Abstracts from all other papers were examined and where the abstract was relevant, or when there was insufficient detail to ascertain its value, papers were obtained. Additional references found from within these papers were further obtained where the title indicated relevance to the study. Furthermore, when key papers were traced, the names of the authors were used to search and crosscheck with other related papers. The inclusion and exclusion criteria listed in Table 1 were applied and mainly included all papers in English that identified APNs or SNs from the 1960s up to the time of my data collection in 2014. The 1960s was chosen since SNs were introduced in the USA in the 1950 and later in Europe, thus relevant written documentation could be captured from this time onwards. However, most of the literature obtained was from the 1990s onwards.

During the process of literature searching, relevant articles were also obtained from the University libraries of Bournemouth and Malta or from Google Scholar. To locate 'grey literature' absent from the main databases, references from journal articles were scrutinized and the Dissertation Abstracts database was searched. The review of the literature revealed that there was limited research that focused on the development or evaluation of the introduction of policy to guide these specialist nurses or their stakeholders (Buchan and Calman 2004). Most of the studies focused on the roles of SNs in specific clinical areas such as diabetes (McDowell et al. 2008; Davis et al. 2008), dementia (Dewing and Traynor 2005), or older people (Reed et al. 2007), with little exploration of the value of specialist nurses in general. However, there was an increase in the published studies related to advanced nursing and the outcomes of these roles from around 2005 that may have been triggered by budgetary constraints associated with these roles. As Tarrant et al. (2008) explained, there is concern that the SNs' role is under threat in the UK due to financial pressures within the National Health Service (NHS), with more research needed to support their demand and role.

The final comprehensive review of the literature on the subject and related topics, in accordance with the specific criteria highlighted above, amounted to over 300 relevant articles. The literature was evaluated using a set of criteria that considered the data on the study aims, development, design, methods, and the populations involved in the study. To aid judgment on the extent of the methodological quality of the literature, I used the Methodology Checklist of Critical Appraisal Tools, designed by the Critical Appraisal Skills Programme (CASP), as adapted from Guyatt, Sackett, and Cook (1993). These tools helped

analyse the robustness of the studies by assessing their trustworthiness, relevance, and results so that a more holistic decision could be made as to their use within this study. Using critical appraisal skills and the tools enabled me to reach a more informed judgment on the strengths, limitations, and ethics of the chosen articles. On one occasion when I needed more specific information and detail of the study of Ball's (2005) study, I personally contacted her and obtained the full report and questionnaire.

There were eight studies that were widely utilized in this literature review and also as contextual material for my study. These studies were found to be comprehensive in exploring the definitions, role and development and challenges of specialist nurses and advanced nurse practitioners that were used to inform this study. These included four UK-based studies (Manley 1997; Gibson and Bamford 2001; Read 2001; Ball 2005) an Irish Study (Begley et al. 2010) and three internationally conducted studies, Sheer and Wong (2008), Pulcini et al. (2010) and Delamaire and Lafortune (2010). These were also important studies since they provided me with evidence and an international perspective on the experience of the introduction of specialist nurses' roles in various countries. Local literature from Malta that informed this chapter included one unpublished internal discussion document from the Directorate of Nursing, given to me during this study, and theses that included a PhD transfer document (Sharples 2012a), a PhD Study addressing the Adequacy of Nurse Education in Malta (Fenech Adami 2001), and two Master's level thesis on the roles of Practice Development Nurses (Petrova 2011) and Leadership in Nursing (Aquilina 2010).

Following the critique of these studies, it was evident that a vital step was to understand the concepts related to SNs and the research evidence supporting their role. Thus, the next section of this literature review focuses on the explanation and discussion of the concepts surrounding advanced nursing practice and SNs.

2.4. Concepts

The wider concept of advanced nursing practice will be considered before discussing issues related to the role and development of SNs. As Hupcey et al. (1997) stipulate, the ultimate purpose of concept analysis is to enable the researcher to delineate the phenomenon and facilitate its operationalization. Analysis of the concept 'Advanced Nursing Practice' in relation to specialist nursing is complex and must therefore be clearly defined so that a strong understanding of what this term means is facilitated. Moreover, defining concepts is vital to strengthen the philosophical underpinnings that guide nursing as a profession (Hupcey et al.

1997) and thus it is important to discuss and truly understand these concepts to provide theoretical strength to, and practical guidance in, this study. In this section of the chapter the concepts related to specialist nursing will be discussed and will include: advanced nursing practice, leadership, being an expert, autonomy to practice and the clinical nurse specialist.

2.4.1 Advanced Nursing Practice

The definition of the International Council of Nurses (ICN 2001) states:

“A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master degree is recommended for entry level.”

[online] (<http://www.advancedpractice.scot.nhs.uk/definitions/defining-advanced-practice.aspx>)

As outlined by the ICN, the context and country within which an APN practises play an important part in determining individual features of an APN role. Although there have been some attempts over the years to compare roles between countries, advanced nursing practice is complex because there remains confusion about the terminology surrounding advanced nursing roles (Elsom et al. 2006; Gardner et al. 2007; Por 2008; Begley et al. 2010; ESNO 2010). The unique geography and demography of each country, in addition to existing variations in nursing education, professional standards and regulation, influence health service delivery and nursing roles. Nevertheless, Castledine (2007) states that advanced practice in nursing represents the general development of nursing towards a more autonomous profession, made possible by nurses undertaking the additional study required and applying this knowledge into new developments and expertise. In trying to understand this concept, related issues of autonomy, expertise and additional study must be understood and, these will be discussed in further detail later in the chapter. However at this stage it is important to highlight the ambiguity surrounding advanced practice titles in nursing roles and the variations that exist internationally in relation to SNs.

2.4.2 Titles

The title of ‘advanced practice nursing’ is usually an umbrella term used to embrace the roles of nurses who practise at a more advanced level than that of the regular nurse (Sheer and Wong 2008). The two most common advanced practice roles are those of the Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP), and even though the CNS role developed

before that of the NP, Begley et al. (2010) stated that even in the USA the CNS role is not as clearly defined. Additionally, the two roles are viewed as more different than alike, both philosophically and practically (Mick and Ackerman 2000). This was evident in a study carried out in the USA by Mick and Ackerman (2000). From among a group of CNSs and NPs (N=18), acute NPs placed higher importance on tasks related to assessment, including conducting histories and physicals, diagnosing and performing diagnostic procedures; whereas the CNS placed greater importance on case management, education, research and leadership. The CNS and NP roles are seen as similar by some authors, who refer to both under the heading of APN (Kuebler 2003) but despite debates about combining and blending the CNS and NP roles, this has not yet occurred (Begley et al. 2010). Additionally, advanced practice has been defined by some authors (Castledine 2007) in terms of the degree of autonomy enjoyed by the nurse in the form of extended and expanded practice roles, whereas others (Donato 2009) consider advanced nursing practice as a unique blending of nursing (caring) and medicine (curing). To add to this debate, Begley et al. (2010, p. 46) stated that in Ireland the posts of ANP and specialist nurses “*are on different levels on the same clinical career pathway*”.

The lack of uniformity and the many different titles used internationally to describe advanced practice roles were evident in Sheer and Wong’s (2008) analysis of data from 14 countries in five continents. They found that in the USA advanced practice nurses’ designations included nurse practitioner, clinical nurse specialist, certified nurse anaesthetist, and nurse midwife. They also established that the clinical nurse specialist and nurse practitioner roles were adopted across international settings, whilst the title of advance practice nurse was adopted only in some countries. In a later study Pulcini et al. (2010) surveyed 18 countries and identified 14 different terms for advanced practice nurses. Both these studies illustrated the complexity of the various titles, roles and contexts of the concept of advanced practice nursing internationally. They are worth serious consideration since they portray a relatively recent picture of the situation regarding advanced practice nurses across the world and indicate the challenge for nurses to get together and work on common standards and understandings for SNs. This is important to support professional practice in terms of reciprocal expectations by nurses themselves and by their employers.

Elsom et al. (2006) further concluded from a literature review that the titles used in one country could be used differently in another. For instance, the clinical nurse specialist role as envisaged in the USA is similar to other ‘clinical nurse consultant’ roles in Australia,

and the clinical nurse consultant role in Australia is similar to the role of the ‘advanced practitioner’ in the UK. Although Elsom et al.’s (2006) review points to interesting and important issues related to the nomenclature used in the concept of advanced nursing practice, one needs to be aware of the limitations of this paper. No detail was given to the number of articles retrieved, how they were analysed and by whom. Additionally, psychiatric/mental health nursing was the focus of this review, though Elsom et al. (2006) claimed that it was likely to have relevance for all nursing specialties. Despite this, Por (2008) stated that the literature supported the notion that criteria for advancing professional practice and its related concepts needed further critical analysis and debate. To date very little of this activity has been reported within the literature, probably due to countries having their own approach, policy and structure of nursing and regulation. However the literature did indicate that there would need to be a united way forward to define ANP and enable the development of universal standards (Pulcini et al. 2010). This would perhaps not only facilitate the mobility of these professionals around the world but would help in providing a strong foundation for advanced nursing practice generally. Another advantage would be that having the role standardised would assist SNs working and learning from one another, nationally and internationally. In an article Koskinen et al. (2011) presented the International Partnership for Advanced Practice Nursing Education and Research (international APN partnership), that was established in London in 2009 by four universities, across three continents, to enhance the development of a collaborative advanced practice nurse (APN) education model. The partner universities in Europe, Australia and the USA developed various cross-cultural competencies and student exchange programmes since 1994. Koskinen et al. (2011) have confidence that this approach would help by clarifying the scope of advanced practice within the context of respective countries and would describe the country specific educational needs. Although Koskinen et al. (2011) considered that the nature of nursing was dynamic and related to the sociocultural characteristics of each country, advanced practice nursing had recurring characteristics that reflected core values of the profession that included viewing health and illness holistically and providing evidenced based care with a focus on nursing and patient relationships.

In Malta, advanced nurse practitioners come under one ‘umbrella’ titled ‘practice nurses’ that includes two types of practitioners: practice development nurses and specialist nurses. This title does not follow international trends and thus adds somewhat to the conceptual muddle. An example is Pertova’s (2011) explanation of why Practice

Development Nurses (PDNs) were chosen as her sample population in her Master's degree dissertation. The aim of her study was to explore the perceived roles of nurses practising at an advanced level who influenced others to advance their profession. She explained that PDNs were the only nurses in Malta who practised at an advanced level with the sole aim of developing the profession, and excluded specialist nurses from her study because SNs developed knowledge in a specific area of practice and their roles excluded them from the strategic planning and development of the nursing profession as a whole. This perception was not in line with the literature on advanced nursing practice since various seminal researchers (Manley 1997 (UK), Hamric 2005 (USA)) stated that advanced practice nurses, including specialist nurses, had responsibility for advancing their profession both nationally and internationally.

It was evident in the literature that the concept of advanced nursing practice was active and had been the subject of numerous debates internationally (Manley 1997; Por 2008; Sheer and Wong 2008; Pulcini et al. 2010). According to Manley (1997) two schools of thought existed for the development of advanced nursing practice: 1) the changes in specialist medical training and the shortage of doctors, and 2) the advancing of nursing practice. Advancing nursing posts were seen as multidimensional, promoting nursing culture and policy and, as Manley (1997) stated, were enhanced by the transformational leadership skills of caring using innovative and critical approaches to the delivery of care. Following her seminal work on the development of a conceptual framework for advanced practice in the UK, Manley (1997) established that through a shared vision, inspiring, high-level communication, valuing others, and developing trust, opportunities would be created to take on challenges and develop advanced nursing practice. Despite Manley's work being nearly two decades old it has remained relevant in today's nursing world because no other conceptual material has taken its place and so much of the literature has been based on her work. Whilst there was lack of clarity between the roles and concepts used in nursing that needed further consideration there was also continuous reported change associated with the development of advanced practice. The literature suggested the foundation and drive for ANPs remained based on improving patient care underpinned by nursing principles.

2.4.3 Clinical Nurse Specialist / Specialist Nurse

Following on from the debate above concerning the complex issues and definitions of advanced nursing practice, as the focus of this study is specialist nurses, it is important to

discuss what the literature says concerning their definitions and roles in an attempt to provide further context. As the Royal College of Nurses (RCN) (2012, p.5-6) stated:

“For a considerable amount of time, a major concern of the NMC, the public and many NMC registrants is the existence of the plethora of job titles that do not help the public to understand the level of care that they can expect. There are nurses who hold job titles that imply an advanced level of knowledge and competence, but who do not possess such knowledge and competence. In addition, their practice may not be subject to the scrutiny of another professional as they often act as independent practitioners”.

Whilst a number of SN posts have become available around the world the International Council of Nursing (ICN) reported the growth of specialties themselves had continued unabated (ICN Document 2009). This made it difficult to ascribe any global uniformity to the evolution of nursing specialties with respect to titling, scope of practice, education, practice standards and portals of entry into advanced practice (ICN 2009). In their discussion paper, the ICN recommended that specialty preparation takes place around the major fields of nursing and proposed standards that included formal education through a recognized programme of study with preparation and authorization in accordance with a scope of practice plus the regulatory policies and practices for post-basic specialists in other professions (ICN 2009). Although this document was not based on scientific research, it was derived from an analysis of definitions, functions, competencies and job descriptions from different specialty groups and thus had relevance to this study.

Earlier related terms in the literature included ‘expert practitioner’ and ‘specialist practitioner’ (Begley et al. 2010). The term Clinical Nurse Specialist (CNS) was usually used interchangeably with that of SN and as Ball (2005) concluded from her survey on SNs in the UK, there was an overlap and no real differentiation as to what either of these terms meant. According to Sparacino (2005), a CNS was an advanced nurse practitioner whose care focused on a specific patient population. The Director of Nursing in Malta defined a nurse specialist as:

“a registered nurse who is academically and practically trained beyond the level of a generalist nurse and authorised to practice as such in a focused area of nursing care, which is beyond the general scope of practice” (Sharples 2005, p.6).

Sharples (2005) further described the nurse specialist as working at an advanced practice level of nursing which required the proficient use of this knowledge in implementing independent nursing interventions. This is similar to how Castledine (2003) described a

specialist nurse; i.e. a nurse who narrows her focus of knowledge and skill down to the specific medical and nursing needs of a particular group of patients.

2.4.4 The Role of Specialist Nurses

In the international literature it is argued that the title *specialist nurse* falls under the heading of ‘advanced practice’ (Pulcini et al. 2010) but because advanced practice “*is not defined by the title but by the level of skill to which it is performed*” (Bird and Kirshbaum 2005, p.161), more exploration is required. The role of the specialist nurse is an ongoing debate around the world especially in the UK and USA. Many authors, researchers and position papers (Hamric 1989; Raja-Jones 2002; Ball 2005; Farrell et al. 2011; Begley et al. 2010; ESNO 2010) describe the complex role of the SN and try to identify and define its components and characteristics involved in the role (Bamford and Gibson 2000; Ball 2005; Pearce and Marshman, 2008; Farrell et al. 2011). Hamric’s (1989) American model of advanced practice identified four sub-roles: expert practitioner, educator, researcher and consultant. These were further endorsed later in the UK by Manley (1997) who added transformational leadership as an important characteristic for these nurses. Additionally, Bruce (2006) explained SNs maintained a clinical focus and worked within a multidisciplinary team, developing policies and procedures, participating in clinical research, education and enhancing patient care. They would usually assume the role of case manager, one who organizes and coordinates services and resources cost-effectively.

The roles identified previously by Hamric (1989), Manley (1997) and Bruce (2006) correspond with what Bamford and Gibson (2000) found in their study in the UK while exploring the role and development needs of clinical nurse specialists (CNSs) in two Healthcare Trusts. The data were collected using focus groups and analysed thematically. The sample consisted of all the 76 nurses listed in the trusts working in specialist roles and areas, out of which 50 responded and from which only 39 identified themselves as SNs, leaving the final sample of 25. These SNs came from a variety of specialties including intensive care, acute pain, stoma, diabetes and infection control. All 25 were female, based in hospital settings but with some undertaking outreach work into the community and with other hospitals. From their five 90-minute focus groups, six categories emerged. These were a clinical focus, involvement in education and training, acting as a consultant and participating in or undertaking research, along with administration. Although this study was relatively small, dated and only using focus groups as a single source of data, it was and still is a

worthwhile study. Despite its limitation of not being generalizable, the method and findings used in the study remain relevant to the roles of SNs today. Moreover, other studies that followed both in the UK (Pearse and Marshman 2007; Ball 2005; Read 2001) and in Europe (Begley et al. 2010; Delamaire and Lafortune 2010) came to the same conclusions, substantiating the valuable role of the SN. Another contentious issue in the literature was that not all practitioners that had the title of Specialist Nurse automatically practised at an advanced level. As Delamaire and Lafortune (2010) stated, some nurses working in a highly specialist area did not diagnose or treat autonomously, nor exercise the higher levels of decision-making and judgment associated with advanced practice. This further challenged the SNs' position to be able to provide evidence that they were practising at an advanced level and beyond the scope of practice of a generalist nurse. As Begley et al. (2010) found in their national Irish study, specialist nurses needed to be supported in becoming more advanced practitioners, as this was not evident in their study. In fact, in Ireland, the term advanced practice nurse was not used as an umbrella term, but there was a clear distinction between the core concepts of advanced practice and clinical nurse specialist (Furlong and Smith 2005). The National Council for the clinical nurse or midwife specialist in Ireland (NCNM 2008a) distinguished their core concepts of clinical practice: patient advocacy, education and training, research/audit, and consultation, from the four core concepts of advanced nurse practitioners, which were autonomy in clinical practice, expert practice, professional and clinical leadership and research (NCNM 2008b).

This classification was underpinned by Begley et al. (2010), who performed one of the first large-scale national case study evaluations of clinical nurse and midwife specialists in Ireland called the SCAPE study (Specialist Clinical and Advanced Practitioner Evaluation). This study evaluated the role of the clinical nurse and midwife specialists and advanced nurse and midwife practitioners in a three-phase sequential exploratory design case study. It focused on the clinical, professional and economic impact of the roles in the publically funded health service in Southern Ireland. Begley et al.'s (2010) study was robust, and utilized various methods of data collection including the Delphi method; observations of practitioners to collect data within a real-life context using multiple sources of evidence that included audits, diaries and work-programmes; plus interviews with policy makers to set the findings in context and a service-user survey. The Logic model developed by Bryant-Lukosius et al. (2009) was used to evaluate the practitioners' practice. This model begins with identifying the main goal of the post and evaluates practice under four main core categories:

clinical practice, clinical leadership, professional leadership and research. This study substantiated the sentiment that specialist nurses were not all practising at an advanced level of practice and raised concerns about consistency of practice across clinical specialist areas, and a lack of governance that led to individualist developments. In contrast, advanced practice was unanimously endorsed and there was agreement that these nurses provided a number of strategic advantages such as improved service delivery, faster patient throughput, reduced costs and a clear governance and accreditation structure. Begley et al. (2010) concluded that SNs' roles needed clarifying and the nurses needed encouragement for continued development as it was evident that their posts were at different levels on the same clinical career pathway. This study was not only robust and well-designed but added another dimension to the term of advanced practice. According to Begley et al. (2010) these roles are hierarchical in nature and a clear difference exists between the two posts of specialist nurses and nurses in advanced practice roles.

A similar conclusion was arrived at in an earlier study carried out by Ball (2005). Ball's study was commissioned by the Health Department and the Royal College of Nurses (RCN) in the UK, entitled "Maxi nurses". 758 nurses in advanced-specialist roles in the UK were invited to take part in a survey asking them about the activities undertaken by nurses in these posts in order to develop an activity based role typology. 544 (of the original 758 sent) were returned and 480 were useable responses. Further analysis looked at how the activities undertaken aligned with five commonly used role titles: nurse practitioner (NP), clinical nurse specialist (CNS), nurse consultant (NC), specialist nurse (SN), and advanced nurse practitioner (ANP). Additionally it was found that nurses in these roles spent the majority of their time (60% on average) in clinical activity, 17% of time in education, 14% in management activity and 4% in research. Certain 'core' activities such as patient assessment/referrals, autonomous decision making and offering specialist advice, were undertaken by 90% of the sample (Ball 2005). Whilst the roles had much in common with one another the level at which nurses practised and the prevalence of key activities such as making professionally autonomous decisions, making referrals and offering specialist advice to other staff, was not common. These findings were similar to those found later in the SCAPE study (Begley et al. 2010). Ball (2005) concluded that the main job titles referred to differences in the activities undertaken by nurses with different roles. For example, according to Ball overall CNS and SN undertook a similar range of activities (primarily case management related) and could be regarded as one group. Nurse consultants undertook a

wide range of activities but it was the ‘diagnostic’ and ‘organisational’ elements of their job that distinguished them from others. Nurse practitioners saw both the ‘diagnostic’ activity types and ‘case management’ activities as being what made them different from other nurses, whilst advanced nurse practitioners did more of the diagnostic activities and saw these as central to their role. Ball’s (2005) study was another strong and important UK study. The 70% response rate to the survey was good and the detail and rationale given for the questions asked were exhaustive. The analysis of the study was simple and easy to follow, thus providing results and arguments clearly.

It was often quoted that SN roles aimed at providing patient-centred care depending on the patient’s level of need (RCN 2014). The term ‘person-centeredness’ was used freely yet some authors argued that it was used without any real sense of what the term actually meant (McCance et al. 2011). Person-centeredness was defined as “... *a standing or status that is bestowed upon one human being by others, in the context of relationship and social being. It implies recognition, respect and trust*” (Kitwood, 1997, p.8). At a fundamental level, McCance et al. (2011) explained that the word ‘person’ captured those attributes that represented humanness and the way in which people constructed their lives. Furthermore, McCormack (2004) argued that there were four core concepts at the heart of person-centred nursing: being in relation – that emphasized the importance of relationships and interpersonal processes; being in a social world – that considered a person’s meaning through their being in the world; being in place – recognizing the impact of the ‘milieu of care’ on the care experience, and being with self which emphasized the importance of persons ‘knowing self’ and the values they held about their life. Respecting individuals as persons and acknowledging their place in the care partnership appeared to be the most consistently applied idea across definitions, as did the focus on building relationships (Begley et al. 2010). In addition, Nolan et al. (2004) argued for a move away from meeting individual needs, to a focus on interactions among all parties involved in care whose needs would be taken account of if good care were to result. This would also be consistent with the views of McCormack and McCance (2010, p.4) who stated that ‘person’ in their work encompassed all those individuals who care including “*patients, clients, families/carers, nursing colleagues, and other members of the multidisciplinary team*”.

2.4.5 Qualities and preparation of a Specialist Nurse

The success of particular nurse specialists was not fully reported within the literature. There was no 'special' course which would prepare SNs for their role or a stipulated amount of experience to have before becoming an expert autonomous practitioner. As already discussed, it was much more complex than this. Although an educational and experiential background to the specialty was considered a must (Hill 2010; Por 2008; ANA 2004) these alone were not seen to guarantee success in the role. According to Por (2008) an area that was seldom considered was that of the personality of the individual SN. The deeper one looked into the role of the SN the more challenging circumstances these nurses worked in became apparent when compared with other nursing colleagues. Working alone and taking responsibility for their actions in sometimes unknown territories would require determination and an ability to bring together their knowledge and experience for practice. Por (2008) insisted these were special attributes recommending consideration for the notion that SNs were successful because of their whole 'package' that included their personal characteristics like perseverance, risk taking and the ability to work alone and lead a nurse-led initiative. Ramis et al. (2013), in an Australian review, also identified personal attributes such as trust, empathy, courage and stamina as being important pre-requisites for the APN role, along with the ability to carry out the more defined clinical roles within the position. This finding was related to a theory called 'person-environment fit' (Holland 1959) that suggested certain elements of personality were linked to an ability to cope better in specific work environments. This was referred to by Clancy et al. (2006) in a UK qualitative study that explored factors influencing recruitment and retention in addiction nursing. Using focus groups with specialist addiction nurses, Clancy et al. (2006) found that personal qualities were important to that role. Specifically, they found that addiction nurses perceived that 'robust and hardy' personalities are needed if they were to carry out their role successfully. The nature of the clients and the associated drug culture suggested that those 'faint of heart' and who struggled to assert themselves would be particularly vulnerable. Whilst Clancy et al. (2006) stated that personality testing for these SNs would not have been appropriate, emphasis on supporting addiction nurses in developing good interpersonal and counselling skills was seen as part of their continuing professional education. This study was important since it provided an in-depth understanding of why personality was regarded as important for addiction nurses and supported other studies (Por 2008; Ramis et al. 2013) in what was otherwise a relatively unsubstantiated consideration within the SN debate.

Apart from identifying the role of SNs, Bamford and Gibson (2000) investigated SNs' needs for the development of their role. The value of experience, having a role model to act as a guide, peer support, an orientation programme, being knowledgeable about the service and opportunities for education were all identified as factors that they felt helped in their role development. Both clinical experience and education were identified as important ingredients in the making of a SN, but it was emphasised that qualifications alone would not result in an independent practitioner who accepted accountability and responsibility. The ability to make decisions with confidence and to follow them through would need clinical expertise and role models who could train and mentor them through the initial phases of their role development. Even though this might be plausible in the UK and America, it might be more difficult in places like Malta since there is only one general hospital and as SNs are still in their infancy education and training would need to be carried out abroad. Although this happens quite regularly since close links exist between the UK and Malta, the challenge arises when nurses return home to a different culture with varying expectations from those experienced abroad. Based on the literature it could be argued that this would take a 'special' kind of nurse to be able to implement 'new' and sometimes controversial ideas in a medically dominated environment (Pace 2012).

Delamaire and Lafortune (2010) examined the developments in APN roles in 12 developed countries: Australia, Belgium, Canada, Cyprus, the Czech Republic, Finland, France, Ireland, Japan, Poland, the UK and USA, where it was once again shown that there was a difference across countries and sometimes within countries. The countries in this study were selected mainly on the basis of their interest and willingness to provide the necessary information to contribute to the study and thus could not be considered representative of all countries. Furthermore, the study's information came largely from a policy and data questionnaire which was drawn by designated national experts in the participating countries in the autumn of 2009. The report, therefore, could be regarded as somewhat dated given that change within SN provision has happened rapidly since it was undertaken. Despite this, it still provided a good understanding of what the problems were/are and illustrated the experiences of both countries that had a long experience in implementing APN roles, and others that were just beginning.

It became apparent from the literature that in most countries, a post-graduate degree in nursing (e.g., a Master's degree) was recommended or required to qualify as an advanced practice nurse. This was the educational requirement that had been established, for instance,

in Australia, as new university-based programmes were being set up to produce advanced practice nurses. In the USA and Canada, there had been a gradual increase in the educational requirement of NPs and CNS, with a Master's degree becoming the norm, although in some Canadian provinces, a post-baccalaureate certificate was still sufficient to become an NP. (Delamaire and Lafortune 2010). However, it was noted that the UK's position was that any nurse who had been educationally prepared, whether at BSc or MSc level, against the RCN competences, was entitled to be referred to as an ANP, though in Wales and Northern Ireland an MSc was required (Begley et al. 2010). The RCN (2012) justified the UK position by stating that nurses who undertook a Bachelor degree in ANP programmes were prepared educationally to achieve the same advanced nursing practice competences as those undertaking a Master's degree, thus Master's level thinking was incorporated into these courses. Although, this was seen as commendable, Manley (1997) disagreed with this statement, illustrating that ANPs should at least be in possession a Master's degree so that they had the ability to understand and be able to participate in research. Moreover, Delamaire and Lafortune (2010) referred to the maturation of the nursing profession from the diploma programmes of the early 1990s to undergraduate education, and subsequently to Master's level, as one that further confirmed the maturation of advanced nursing practice, and in a way confirmed the need to have advanced nursing practice nurses prepared to the level of a Master's degree or higher. Whilst this was seen as possibly reducing the number of nurses eligible to lay claim to the title, such a situation would clarify the advanced nurse practitioners' position within the healthcare team, and allow others to have more uniform expectations of the roles involved. It could also be argued that raising the required entry level of education might also promote further reflection on the nature of advanced practice, and the relationship between SNs and the wider profession of nursing itself.

The discussion surrounding the SN illustrates that a single definition of the term SN is difficult, but studies usually look at defining SNs in terms of their skills, their area of expertise or their preparation for the role (Ball 2005; Sparacino 2005; Castledine 2007; Begley et al. 2010; ESNO 2010). The results of the studies discussed in this review and the arguments they raised may be utilized to develop posts, services, policy or standards when new specialist nurses are recruited. However, while one could draw upon the work carried out in these studies, caution is still indicated when transferring recommendations or implications to Malta. As Fenech Adami (2001) explained, findings of any one study may never be seen as

universally unquestionable prescriptions and should always be evaluated within the context where they are going to be used.

The next section will discuss three important concepts that arise from the literature on specialist nurses, namely being an expert, leadership and autonomy to practise.

2.4.6 Being an expert

There was agreement in the literature that an essential ingredient of a SN as an advanced practitioner is that of being an expert. The concept of clinical expertise is difficult to discuss and many debates arise due to its disguised notions, which assimilate different kinds of knowledge such as experiential, scientific and tacit (Conway 1998). As Hill (2010, p.1) explained:

“Experiential knowledge is characterized by skillful execution of nursing procedures as well as the ability to perform complex, multidisciplinary assessments and to recognize early signs of deterioration in the condition of a patient. Nurses who are both well-educated and experienced are in the position to give the highest quality of care”.

Evans and Donnelley (2006) explained that tacit (skill) knowledge was better known as ‘the how to’ knowledge, in contrast to theoretical knowledge, and was acquired primarily through experience, including observational experiences, preceptorship and working with mentors. Castledine (2009) explained that it was impossible to be an expert in all aspects of healthcare, and specialist nurses would provide for the specific needs of specific types of patients. Moreover, according to Begley et al. (2012), SNs were able to provide more expertise than even expert level staff nurses, who typically had their responsibilities spread over many different sub-areas. Some researchers focused on so-called internal forces and explored characteristics that they felt shaped expert practitioners (Por 2008). According to Verger et al. (2002) excellent decision-making, expert/specialist practice, problem solving and critical thinking all contributed to their role.

Additionally, Benner (1984) introduced the concept that expert nurses develop skills and understanding of patient care over time through a sound educational base as well as extensive experiences. She further explained that the development of knowledge in applied disciplines such as nursing was composed of the extension of practical knowledge through research and the characterization and understanding of the “know how” of clinical experience. Over two decades ago Benner (1984) identified various stages of clinical competency and explained them in stages from novice to expert. The first stage involved nurses as novices being taught rules to help them perform; and according to Benner they

tended to apply these rules universally. The next stage was described as being advanced beginners who used principles based on experience to guide their actions. Nurses in the third stage concentrate on outcomes rather than specific tasks. The next stage of proficient nurses reported learning from multiple past episodes and began developing a feeling of “intuition.” The final stage was that of the expert nurse, who according to Benner (1984) had an intuitive grasp of a situation and was more accurate and less wasteful when considering alternative diagnoses or solutions. Clancy et al. (2006) found similar nursing stages to Benner (1984) that were termed encounter, engagement, stabilization, competency and mastery. The five-role development stages indicated that by anchoring the competencies to specific stages, consideration could be given to monitoring progress, thus offering individual nurses and those supporting their development a framework on which to base their introduction to the specialty and their future training needs (Clancy et al. 2006). Although this study was limited to the speciality of addiction nurses in the UK, which tends to limit its generalizability, it did serve to support Benner’s (1984) previous work on role attainment.

Billay et al. (2007) also agreed that the proficiency of clinical nursing skills developed along a trajectory and the intuitive knowledge, ergo intuition, of nurses was critical for the practice of nursing. Traditionally, according to Billay et al. (2007), nurses were conditioned to value empirical knowledge above all other forms of knowledge. However, there were other important dimensions to take into consideration, such as intuition, that needed to be considered as a rich source of knowledge to the practice of nursing that required intentional nurturing. Unlike Billay et al. (2007), Manley and Garbett (2000) argued that education was the key feature of a person with the title of expert because it instilled the practitioner with more confidence, creativity and the ability (or courage) to take risks. Manley and Garbett (2000) extended the debate by stating that years of experience on its own did not make the nurse an expert because clinical expertise needed to be dedicated to life-long learning. This was similar to the stance taken by Daley (1999, p.5) who did not use “years” as the differentiator for expertise but rather referred to “*events that occur in clinical practice and the professional person’s response to those events*”. Hill (2010) agreed with both sides of the argument, explaining that expertise in nursing was influenced by applicable experience as well as related factors, such as learning styles and educational opportunities, all over a period of time.

The above arguments provided an insight into the complexity of defining what constituted an expert nurse. However there was a strong indication that experience over time

and a life-long educational foundation was what should constitute an expert nurse in practice. This blend of knowledge and experiences in turn would affect the intuitive capabilities of SNs to act professionally and economically. As Manley (1997) stated, the combined expertise of the 'know-how' and 'know-that' of nursing practice would accord credibility to the post and would make it easier to initiate and manage change. Finally, the concept of expert practitioners was compounded in advanced nursing practice by issues related to leadership skills and autonomy to practice. These need to be explored further.

2.4.7 Leadership

The concept of effective leadership was an issue in healthcare literature in recent years due to the complex and the ever-increasing challenges in this sector (Contino 2004). As Meliniotis (2011) stated, a good nurse leader was someone who would inspire others to work together in pursuit of a common goal, such as enhanced patient care. According to the American Nurses Association (ANA 2010) leaders did more than delegate, dictate and direct but helped others achieve their highest potential by empowering them to be professional, competent leaders in healthcare. Aquilina (2010) explained that the new paradigms of leadership theories that had received a concerted focus of attention over the past years include transformational, charismatic and authentic leadership. This reality delineates the need for nursing leaders to shift from maintaining the status quo to inspiring commitment towards the organization's mission so as to constantly grow and meet new organizational challenges (Saporito 1996). In contrast to rational or transactional approaches to leadership, Avolio and Gardner (2005) further stated that transformational and charismatic theories had been developed to acknowledge the affective and emotional needs and responses of followers.

Within the CNSs' practice, Lewandowski and Adamle (2009, p. 79) explained that they led in three areas: "*direct patient care, nursing practice and systems*". In Ireland Begley et al. (2010) established that advanced practice nurses were found to mentor a wide range of healthcare staff within their own area of clinical practice, and were highly valued for their leadership in developing and benchmarking policy and guidelines against national and international standards. Additionally, specialist nurses were developing and strengthening their clinical leadership roles and demonstrated a number of the activities identified as part of the role of the advanced nurse practitioner (NCNM 2005) such as teaching, consultancy and practice development. Additionally, participants of an earlier study by Gardner et al. (2007), who explored advanced nurse practitioners' leadership functions in Australia, mentioned that

being involved in presenting a research paper in a conference, sharing their knowledge and expertise in the clinical area with others and being part of the team, were all part of being leaders in their profession and clinical field.

Higgins et al. (2013) further explained that one of the core functions of clinical specialist/advanced practitioners (CS/APs) was to lead change in response to patient need, service demand and to develop health reform through their profession. Higgins et al. (2013) reported on findings from the SCAPE study (Begley et al. 2010) in Ireland that used a case study design involving 23 CS/AP and multidisciplinary team members working with them. Data were collected using interview, observation and documentary analysis and the findings showed that there were factors that influenced these practitioners' ability to perform leadership roles. These included the presence of a framework for professional development, opportunities to act as leaders, mechanisms to sustain leadership and personal attributes of practitioners. In summary, Higgins et al. (2013) highlighted that support for leadership in CS/AP positions needed strategic, organisational and personal investment to develop skills and maximise their potential. This was in agreement with other findings from the leadership literature that indicated that skills could be learnt and that leaders who adopted and learnt such skills would see an improvement in the performance, quality and well-being of their followers (Eigel and Kuhnert 2005; Aquilina 2010). Although the SCAPE study (Begley et al. 2010) had its limitations since the sample was small, as was the observation period, thus limiting the generalizability of the findings to other contexts, it did illustrate important factors that enabled leadership activities for CS/APs in practice. Additionally, the strength of using a case study and gathering different sources of data, together with representativeness of the sample, decreased some of the limitations. Another advantage of this study was the clarity of the method used to undertake the research thus making it potentially easier to replicate in other locations.

In the absence of any literature found in Malta about advanced nurse practitioners and SNs, this study looked for papers and materials that investigated leadership in nursing to provide context to the subject. Aquilina (2010) pointed out that Maltese studies looking into the leadership styles, effect of leadership on staff motivation and emotional intelligence, all identified a gap in the leadership skills in nurse managers that was negatively affecting the culture of the local healthcare organizations (Caruana 2005; Sharples 2003; Xuereb 2001). This could have had both a direct and indirect effect on the development of advanced nursing practice and the profession at large since as Manley (1997, p187)) explained, for the role of

advanced nurse practitioners to be conducive to the organizational culture, there needed to be “shared values and a non-hierarchical, open management style”. Furthermore, as Van der Kleij (2011) stated, globally nurse managers comprised the largest group of first-line managers in a hospital setting, and they were responsible for implementing the hospital’s vision, mission, core values and objectives where it matters most – in the clinical setting. The Maltese Department of Health embarked on providing formal leadership training programmes for Nurse Managers; however there was concern that the application of knowledge and skills was still lacking (Aquilina 2010). In a study carried out by Aquilina (2010) called ‘an executive coaching programme’ for Nurse Managers, using action research, it was found that there was a perceived lack of support felt by Ward Managers in their leadership role and indicated a need for a formal and continuous programme of personal and professional development. Since this study was undertaken using action research the findings were only applicable to nursing leadership within the only state-funded Maltese acute hospital. Additionally, the sample of 12 ward managers was small even though they were chosen randomly from the total of 60 Ward Managers within the hospital. Thus, although not providing generalizable findings, it did give an indication of the perceived situation within this group of nurses. In theory this study could be replicated on advanced nurse practitioners in Malta and might reveal the situation experienced by them to provide a better understanding of the leadership challenges being faced by these practitioners.

2.4.8 Autonomy to Practice

The success and satisfaction of the specialist nurse experience was often linked to the level of autonomy granted to them in practice (Begley et al. 2010). According to the RCN (2012) autonomy normally described a practitioner, nurse or otherwise, who had the ability to make independent decisions about their actions. Weston (2008) further explained that autonomy referred to the ability to act according to one’s knowledge and judgment, providing nursing care independently within the full scope of practice as defined by current professional, regulatory and administrative rules. Notwithstanding this, the RCN (2012) recommended that ANPs did not use independence as an elitist or a separatist concept, or to describe their work situation. As the RCN (2012) stipulated, the concept of autonomy was not simple and did not relate solely to the ‘independence’ of the specialist nurses’ practice. In fact in Ball’s (2005) study, whilst 72% of her participants reported that they worked primarily on their own and 97% reported that a high level of autonomy was required in their role, they functioned as part

of a wider team or teams, and their roles were characterized by interfaces with a wide variety of other staff.

The caveat to any commentary about autonomy has to involve the issue of role expansion or development and the fear of litigation and who ultimately has responsibility for clinical care. In essence, for nurses, Read (2001) explained that the Scope of Professional Practice sought to make clear that any new duties of a technical nature which had been or are still also being performed by doctors were viewed as 'extended roles' needing training, examining and certifying in the local area. Examples of the tasks viewed as extensions were suturing, applying plaster of Paris, infiltration of local anaesthesia and the giving of intravenous drugs through a cannula or lines (Read 2001). In addition, some authors (Mercer 2007; Delamaire and Lafortune 2010) suggested that professional power for nurses was derived when they were supported by statutory licenses. Others argued that the development of nursing autonomy ought not to be solely dependent on extended roles that encompassed tasks (Bryant-Lukosius et al. 2004).

As Koskinen et al. (2011) explained, APNs globally had not only taken responsibility for routine patient care previously carried out by physicians, but had taken responsibility for new services not previously provided. Chronic disease management was one such new service area. In addition, Ball's (2005) study clustered the main activities identified by APN's autonomy in practice in three primary categories: 'Case Management' involving care planning in collaboration with others and admitting/discharging patients; 'Diagnosis' involving physical examination, diagnosing, screening patients and ordering investigations; and 'Organisational activity' which included leadership, educating staff and initiating research. However, 38% of the respondents felt that the service was not getting the most out of their role for the benefit of patients, since 23% of those who made referrals had had them refused because they were a nurse rather than a physician. Equally a third (33%) who requested investigations had been refused on the same grounds. Due to the study being carried out more than a decade ago and in one country (UK), the findings are not generalizable for other countries due to situations being contextual to the place where ANPs practise. However, this study was still seen as significant to this present one since it illustrated some of the difficulties and issues that these nurses encountered. Additionally, the survey tool developed was clear and validated and thus might potentially be replicated and used in other countries if modified to take into consideration contextual issues.

In Ireland, Begley et al. (2010) also found similar results to Ball (2005), mainly that both APs and CSs were both seen as having the autonomy to manage their caseloads, which ensured smoother transition of patients/clients through the healthcare system. However, the quantitative results in Begley et al.'s (2010) study showed APs working at a higher level than CSs. APs appeared to be engaging in autonomous decision making to a much greater degree than were CSs. A key distinction was that APs appeared to be able to both refer and accept referrals, in contrast to CSs, whose ability to make referrals was not evidenced in the field note observations. In particular, there was field note evidence that some healthcare professionals (e.g. physiotherapist, occupational therapist) would not accept referrals from them. The APs also performed assessment, screening and diagnosing, which helped to reduce total patient visit times and ensured a faster throughput of patients or clients. Therefore, the autonomous role of the APs was linked to their success in reducing waiting time as the service user could be seen by one person rather than waiting to be referred to other members of the team, facilitating the reported swifter throughput.

Read (2001) in a UK study entitled 'Exploring New Roles in Practice' (ENRiP) examined the meaning of the new roles from the perspective of post-holders, patients and stakeholders. Although this study did not only focus on nurses, it is an important study to discuss here since it provided insight into how changes in practice and developments in care had been achieved as a result of innovative roles. Furthermore, it was a strong case study using various methods of data collection. Representation was considered by using a number of sites, professionals and stakeholders, and the study showed rigor and trustworthiness in its undertaking, providing a detailed description of the research process. Read (2001) also highlighted important issues related to autonomy. One of their findings was that although the post-holders had a high degree of autonomy, ultimate responsibility rested with the medical team who, on the basis of trust and confidence in individuals, informally permitted expanded practice (e.g. admitting and discharging patients). This was also supported by Mercer (2007) who studied the meaning of professional autonomy for ANPs, namely nurse practitioners in the UK. Mercer (2007) established that a number of barriers to the development of their professional autonomy related to professional relationships, found not only to be central to the experience of autonomy but also to the future development of the nurse practitioner role. Similarly, in Read's (2001) study, although most of the post-holders had substantial autonomy within their professional boundaries, stakeholders were clear that there were also limits to professional autonomy. Additionally, Read (2001) found that role boundaries and lines of

accountability were seldom reflected accurately within the job descriptions that had been endorsed by management. This was again comparable to the findings in Ball's (2005) survey which showed that many roles grew beyond the post's job description. Although this was positive and showed further role development, it also raised concern due to a lack of an up-to-date job description, when the legal implications of specialist practice in this context were obviously profound.

From the issues discussed in the first part of this chapter, there was evidence from a number of studies that SNs were central players in the growth of managed care, and they served to manage the complexities of different parts of healthcare practice. The educational role was also seen as important, covering patient education for nursing staff as well as non-nursing members of the team. The SN's role remains perceived as a good career choice for the clinically excellent nurse who wants to both positively influence one-on-one patient-care situations and improve the processes that comprise healthcare systems. Likewise, SNs would practise independently, or be based in hospitals and long-term care facilities, or for various healthcare agencies, and might choose an area of specialization ranging from neonates to elderly care. Notwithstanding this, it was evident that the autonomy of APNs depended on several factors including the relationships built with the medical team, the type of service specialty or role and an acceptance by others of the practitioner to practise at an advanced level. The findings of the main studies outlined here (Read 2001; Ball 2005; Begley et al. 2010) inferred that the boundaries of the roles were not clearly defined and accepted, and reinforced the need for clearer definitions and reflection on the nature of advanced practice. Moreover, the developments in the knowledge base of the nursing profession and a growing sense of autonomy called for a new approach to professional accountability for 'extended roles' for advanced nursing positions.

Following the discussion on the related concepts, definitions and roles of advanced nursing practice with a focus on SNs, the next section discusses the development of these nurses in practice. I will briefly discuss the historical origins and appraise the development of specialist nurses in Malta to provide a better understanding of their evolution in Nursing and Healthcare.

2.5. The International Development of Advanced Nursing Practice

“The introduction and development of advanced nursing (APN) is one of the most important developments in nursing during the twentieth century” (Oddsdottir and Sveinsdottir 2011).

Castledine (2003) described advanced nurse positions such as SNs as an evolution and not a revolution. Historically the role originated in the USA and as Fulton et al. (2010) state, spread around the world with several countries being at different stages of their implementation and/or evaluation of these roles. In North America, the CNSs' role developed within the acute care (hospital) setting (Sparacino 2005) and evolved globally to meet gaps and emerging needs in the healthcare system. From an international evaluation, Delamaire and Lafortune (2010) combined the most common reasons for ANP development into four groups: the shortage of doctors; the changing demands for services; growing healthcare costs and the development of professional careers in nursing. Notwithstanding this, what was evident in the literature was that despite the initial impetus for the advancement of nursing practice the main reason it was maintained was to increase the quality of care either through access to services, keeping experienced nurses at the bedside, or the progress made within education and technology. In fact, nearly half a century ago, Reiter (1966) stated that "the CNS movement grew out of a perceived need to improve patient care".

According to Bryant-Lukosius et al. (2010) international literature highlighted a number of influential factors in the development of advanced practice nursing roles that had both facilitated and hindered their progress. Delamaire and Lafortune (2010) explained that a detriment to advanced nursing practice was the lack of a formal coherent career structure that led to a disorganized approach to career progression. In Canada, Bryant-Lukosius et al. (2010) state that the challenges to the development of the CNSs' role, due to this unsystematic system, was apparent during its initial implementation in the 1970s and continued to plague its implementation in some states till the present day. This was consistent with the UK and the US (Fulton and Baldwin 2004). This diversity and lack of consensus created problems with standards of education and the scope of practice that interfered with operationalizing these roles in nursing. Moreover as Schober and Affara (2006) stated, this ambiguity in turn made it difficult for their further development due to the difficulty of stakeholders understanding their roles. Recommendations were put forward to address some of these issues, such as standardizing the CNS role by developing clear role definitions and promoting the use of similar job descriptions and position titles (Canadian Association of Nurses (CAN) 2006), and implementing basic structures and resources to support the development of CNS roles and promote their sustainability within the healthcare system, including the development of standardized education, credentialing, regulation and outcome reviews (Bryant-Lukosius et al. 2010). This literature review aimed at providing an

understanding of the broader conceptual and empirical elements of the subject area, namely specialist nurses, and will now continue with a discussion on experiential achievements in the past in Malta as well as abroad, highlighting societal and policy change needed for the future.

2.6. Nurses' Position within the Healthcare Team

Internationally the changing role of nurses to take on tasks that were formerly performed by medical staff has raised professional and legal concerns (Delamaire and Lafortune 2010), thus reinforcing the need for clearer definitions of the SNs backed by statutory control. However, in addition to regulatory issues related to this evolution, nursing would need to acknowledge key implications that would affect the further development of SNs. Mercer (2007) and Sheer and Wong (2008) pointed out the need for an understanding of these nurses' position within the healthcare team that in turn was affected by the status of nursing within the hierarchy of healthcare professions.

With nursing being predominantly female and the medical profession, who directed and led clinical decision making, being predominantly male (Mercer 2007), Witz and Annandale (2006) stated that nursing would be at a disadvantage in terms of potential clinical leadership activities. Additionally, the continued invisibility of women in some cultures ensured that at times nursing remained invisible and often inconsequential. Davies and Eng's (1995) work explained that with the arrival of more formalized nursing care, the medical profession began to offload some tasks to nursing, under the auspices of expanding nursing practice and giving nurses increased levels of responsibility (Daly and Carnwell 2003), but in a way this had contributed to the maintenance of the medical profession's prestige and the subservient position of nursing (Zelek and Phillips 2003). These factors could also have affected, and may continue to affect, the advancement of nursing and would be issues that needed consideration and further study in Malta. Such an enquiry might help to illustrate the possible underlying socially constructed ambivalence of nursing and nurse leadership within the country (Mercer 2007).

Medical opposition could be another significant factor to consider in Malta and could be due to several factors evidenced in the existing literature. Perhaps not surprisingly Delamaire and Lafortune (2010) showed that APN roles tended to be more developed in those countries where there was a relatively low number of doctors, a relatively high number of nurses, and thus a high nurse-to-doctor ratio. This was the case in Finland, the USA, Canada and the UK and according to Delamaire and Lafortune (2010) in these countries the much

greater number of nurses compared to doctors could have been both a cause for developing advanced roles for nurses as well as a consequence of such a development. On the other hand, Japan provided the example of a country that combined a low number of doctors, a high number of nurses and a high nurse-to-doctor ratio, but this supply “imbalance” had not yet been accompanied by a strong development of APN roles. Additionally, research indicated that individual-based fee-for-service payments for doctors, as is the case in Malta in primary healthcare where GPs and private physicians use a direct system of payment, could act as a barrier to the development of APN roles, specifically in primary care (Bourgeault et al. 2008). Any transfer of tasks to nurses would potentially result in a loss of income for doctors, unless they are able to offset the reduction by providing other and possibly more lucrative services. Any research designed to explore the development of APN roles in Malta would need to consider not only the current composition of the workforce and their respective position towards each other, but also future trends based upon changing roles and responsibilities.

2.7. Specialist Nurse Development in Malta

The demographic changes and increase in the elderly population of Malta is increasing the demand on state healthcare services (Azzopardi Muscat et al. 2014). As the only General Acute Hospital on the island, Mater Dei Hospital bears the pressure since it provides acute care for all Maltese citizens. This demand is leading to an increased economic and human resource burden that requires the effective management of scarce resources (Aquilina 2010). The only official but unpublished document on SNs was obtained for this review from the Director, Nursing Services. This was an internal document dating from 2005 called “Specialisation Career Framework for the Nursing and Midwifery Professions” (Sharples 2005). This nine-page document outlined the reasons why nursing specialisation developed locally and suggested three major forces namely new knowledge, technological advances and public needs and demands. New knowledge and technological advances were related to the development of medical education and technology in healthcare and its delivery, while public needs related to increased knowledge by the general public, resulting in more needs and demands. Although this reasoning was supported by Ormond-Walsh and Newham (2001), it was quite different to other countries that mainly introduced advanced nurse practice because of the shortage of doctors and/or reducing junior doctor’s working hours (Gardner et al. 2007; Delamaire and Lafortune 2010; Begley et al. 2010).

A decade ago, Sharples (2005) stated that nursing specialisation was still in its infancy compared to other countries and further asserted that developing nurse specialisations was linked to contextual factors including the number of nurses working on the Maltese Islands, the health needs and demographic changes. The international literature suggested that when there was a nursing shortage SN positions were adapted to organisational needs, with SNs asked to fill in for less experienced or qualified nurses (RCN 2012; Delamaire and Lafortune 2010). Whilst this did not necessarily mean that nursing shortages would affect the development of SNs, it did indicate that health administrators viewed SNs as something of a luxury (RCN 2012). Their priority would not be to increase quality but to cover or fill in vacant shifts on the wards. Advancing careers would inevitably be jeopardized by such a view and this may have been the case over the years in Malta, as indicated by Sharples (2005), though no scientific evidence exists to support such a conclusion. The RCN (2014) stated that nurses required a stable work environment to function properly that included career advancement if they were not to leave the profession for higher salaries or to seek greater job satisfaction. In an attempt to support SNs the RCN called for governments and entities to commit to the following: all patients with long term conditions would have access to a SN; SNs would be allowed time to accomplish the vital aspects of their role; increased funding for SN roles; other providers and commissioners would need information to better understand the wider cost implications; and health improvements to be gained in continued investments in SNs for both medium to long term (RCN 2014).

Sharples (2005) further explained that specific health policies might also affect the development of specialisations as was seen with the introduction of a Breast Care Service implemented to tackle the high incidence of breast cancer in Malta. However, according to the former Union President for Nurses and Midwives (MUMN) Pace (2012), there did not seem to be a plan to expand SNs' roles to address population, hospital or community needs in Malta. Although the role of Maltese SNs evolved from the early 2000s, at face value they had not progressed as much as in other countries such as the Netherlands or Finland (Delamaire and Lafortune 2010), who developed SNs at around the same time as Malta, but who had managed to change the law, create a structure for training and education and even achieved rights to prescribe medicines for APNs (Delamaire and Lafortune 2010; Pulcini et al. 2010). This could have been due to many reasons as Sheer and Wong (2008, p.210) explained and included *“the perceived status of nursing and women, the need for healthcare services, existing*

health policy and resources, and the ratio of physicians to nurses. Although the evolution of APN differs in each nation, similarities exist.”

2.8. Political Commitment

The international study by Delamaire and Lafortune (2010) concluded that it was evident one overarching factor needed to be present to develop new roles in healthcare; that of political commitment. Nearly all countries participating in their study that succeeded in the development of advanced nursing practice roles had political support. Sharples (2012a) also pointed to the importance of politics in Malta and explained that a new government or a change in key personnel such as ministers or civil servants had the potential to change direction and re-prioritization of problems, and re-shape the wider political context. According to Delamaire and Lafortune (2010), in relation to health and nursing, political influence would include professional bodies, senior nurses, unions, regulators, policy experts and academics. Brown (2013) also recommended that ANPs became more involved in developing policies and being political. She stated that it was paramount for nurses to become politically astute since they could be called upon by politicians to critique services, refine and shape potential policy options or used as a policy’s advocate. Moreover, Brown (2013) explained that ANPs needed to be aware of ‘windows of opportunity’ such as a reform in healthcare or the annual national budget. Although the predictability of these opportunities was difficult to determine, Brown (2013) explained that there were various ways of taking advantage of these chances, for example through conferences, speeches and draft policies.

One such Maltese policy document was related to the Health Strategy issued by the Health Minister through the Superintendence of Public Health, Malta (SPH). Cassar (2012) the Health Minister at the time, stated that the public had the right to safe, quality healthcare delivered by professionals with the appropriate education, training and experience. (The SPH is responsible for the regulation of healthcare services and healthcare delivery by professionals mainly through legislation and standards). The said document referred to standards that were updated and regularized, and stipulated that “*national standards support healthcare professionals to understand their responsibilities and enable them to make decisions and guide their thinking*” (SPH 2012, p.4). However, this document, although commendable in its intention, lacked further guidance on where to acquire these standards, how they (SPH) would inform both healthcare professionals and the general public of these standards and how they had evaluated healthcare services and professionals under their

auspices. Despite this, the document quoted the Maltese Healthcare Professions Act (CAP 464 of 2003), which demanded registration by the governing body of individual professions, both generalists and also enabled a practitioner to use the title of 'Specialist'. The act stipulated that professionals would be managed and registered following appropriate criteria for training and accreditation by their professional governing body. However, more than a decade since officially introducing these ANPs in Malta, SNs are still not able to register as 'specialists' at the time of the present study. Moreover, the last and only issue of the Scope of Practice in Nursing in Malta was issued in 2002, again more than a decade ago. Such a policy document (SPH 2012) and the Scope of Practice could have been 'windows of opportunity' to regularize Maltese SNs, but all the evidence indicates that this did not happen.

2.9. Regulation

The European Specialist Nurses Organisation (ESNO) affirmed that policy and law needed to be amended to bring forward the changes required for nursing professionals to function and flourish (ESNO 2010). Malta was not alone in the quest for credentialing and regularizing SNs. For example, in the UK successive professional regulatory bodies failed to define the roles of advanced practice nurses (Mercer 2007). Although the Royal College of Nursing (RCN) and the Nursing and Midwifery Council (NMC) in the UK did address the professionalization agenda, nearly two decades after the publication of their 'Scope of Professional Practice' document and the initial consultation on the regulation and registration of advanced nurse practitioners, no final decisions had been made (RCN 2012).

When new roles are established and the practitioner works outside the boundaries of practice normally associated with that profession, considerable concern is raised over lines of accountability, responsibility, liability and regulation (Begley et al. 2010; Delamaire and Lafortune 2010). In the study carried out by Read (2001) it was found that new roles created difficulty for some post holders to maintain their registration when little of their original professional repertoire was required to fulfil the delegated tasks. The study recommended that clear and logical lines of accountability and responsibility needed to be agreed locally and written into the job descriptions of the post holders that would require regular review as the posts evolved. Additionally, the literature (Mercer 2007; Delamaire and Lafortune 2010) suggested that in most countries, the development of more advanced roles for nurses required a series of legislative and regulatory changes to facilitate the implementation of these new roles. The rights of a nurse to autonomously prescribe pharmaceutical drugs or to perform

extended roles in either primary care or hospitals demanded regulation to ensure that patient safety would be protected through necessitating proper training and monitoring of competencies. Delamaire and Lafortune (2010) found that in countries where responsibilities for healthcare delivery and the regulation of health professionals was more decentralized, legislative changes were enabled for a broader scope of practice of nurses. In England, the scope of practice of APNs was not defined in a specific legislation, which ironically reduced the barriers to modify their scope of practice. In Canada, the scope of practice for the CNS was the same as that of the registered nurse (RN) and additional legislation and regulations were not required since DiCenso and Bryant-Lukosius (2010) found few reports of Canadian CNS involvement in diagnostic or prescribing activities. Conversely, in France, the responsibility for defining the scope of practice of different health professions was very much centralized and defined specifically what each could (or could not) do. Any modification to the scope of practice of nurses would therefore require legislative changes, which often raise sensitive issues. Delamaire and Lafortune (2010) suggested that the scope of practice should be defined in terms of general “missions” rather than specific tasks/acts since it would create a greater flexibility to adapt the roles of nurses to evolving needs at both a local and national level.

Currently, the issue of quality of care and its relationship to regulation would appear to be at the centre of both government and professional concerns, and this is likely to continue (SPH 2012). Innovations in the organisation and delivery of care would be likely to have a particular impact. As the pattern of service delivery became transformed, modes of accreditation and regulation would also need to be altered to prevent harm to both workers and patients (Mercer 2007). Ongoing uncertainty regarding statutory regulation of specialist nurses, and continuing variation in their role definition, was felt to have implications for maximizing the potential of their roles (Ball 2005). As the literature suggested, professional autonomy could not be achieved merely through the establishment of statutory roles, but regulatory clarity would help to define the parameters of SN clinical practice, which in turn might help them to achieve the professional recognition that was essential if they were to enhance their opportunities for autonomous practice. Moreover, Magdic et al. (2005) explained that one way to ensure patient safety was via the process of credentialing and delineation of clinical privileges for health professionals, such as SNs. Thus, through their healthcare organizations, unions and other stakeholders including the University of Malta and

the general public, SNs would be able to work together to develop policies and standards and campaign for political commitment to improve their employment status.

2.10. Resources and the Value of Specialist Nurses

Another interrelated factor affecting the development of specialist nurses was the availability of funding for these positions (Sheer and Wong 2008). Di Censo et al. (2009) observed that when there were budget cutbacks in hospitals, the necessary funding to support the introduction or maintenance of advanced practice nurse posts was compromised. Although Delamaire and Lafortune (2010) stated that the extension of primary healthcare, an increase in the elderly population, an increase in the costs and demands of healthcare and professional development had all contributed to the need to create new roles for nurses in advanced practice, more scientific evidence was still required to be able to effectively evaluate their outcomes and benefits. The evidence needed to be focused, as Manley et al. (2011, p.36) asserted, on the political context that *“emphasises quality improvement, with a specific emphasis on health outcomes, effective use of resources and improving productivity through prevention and innovation.”*

There were many studies that showed the value of using SNs in the clinical setting (Prichard and Kendrick 2001; Read 2001; Price 2012; Kleinpell 2007; Begley et al. 2010; Vidall et al. 2011). These were associated with diverse populations and related to effective SN practice in improving the outcomes, such as patient satisfaction, health status, readmissions and the reduction of complications (Cunningham 2004). Delamaire and Lafortune (2010) also added that there was evidence to show improved client access to services and reduced waiting times. Vidall et al. (2011) stated that SNs in the UK, who ran nurse-led clinics, potentially saved consultant time. Although there was no evidence from Malta as to whether there was an actual shortage of doctors, the cost benefits as shown above would go much further than just financial savings with potential for a positive effect on the quality of the services provided. As Leary (2012) explained, the patient-centred and timely interventions provided by a SN not only helped to reduce patient morbidity, they also potentially prevented costly unplanned hospital admissions. The direct reduction in readmission rates (Petkar et al. 2011) had clear financial implications for the UK National Health Service. Similarly, in oncology or chronic illnesses, patients receiving certain medication regimens would potentially develop side effects, making significant demands on primary care or emergency services. Vidall et al. (2011) explained that evidence suggested

that the utilization of specialist nurses' skills might alleviate some of this demand and minimize both the human and financial burden imposed by these side effects.

Nevertheless, in a global value-driven health service the literature showed that it became imperative to provide evidence of the financial benefits, as well as the quality-of-care justifications for investment in SNs. However, the evidence base underpinning the cost-effectiveness of SN was limited (Delamaire and Lafortune 2010; Begley et al. 2010; Vidall et al. 2011; RCN 2013). Moreover, in the UK most evidence was derived primarily from studies of charitable bodies that had commissioned and funded them, such as Epilepsy Action (2010). Although demonstrating cost savings to the NHS, one of their limitations was that they were undertaken by the same charities that had a vested interest in their outcomes. The question of bias needed to be taken into consideration as it may inevitably have created scepticism amongst policy makers. Additionally, the strength of the studies, attesting economic value, was questionable and nowadays more robust evaluative studies would not be seen as a luxury but essential to substantiate the impact of SNs and whether or not they really did make a difference (Kleinpell 2007).

Begley et al.'s (2010) insightful and well-designed study evaluated the outcomes of specialist and advanced practice nurses as part of their objectives in the Irish SACPE case study. They evaluated AP/CS outcomes in three ways: 1) in-depth interviews from 41 service users/family members/carers; 41 healthcare professionals; 23 Directors of Nursing or Midwifery who oversaw care and a survey of 279 service users; 2) a systematic review of 20 international systematic reviews on nurse-led clinics that were analysed using the Assessment of multiple systematic reviews (AMSTAR) tool (Shea et al. 2007); and 3) an economic evaluation that included 10 matched pairs of post-holding and non-post-holding sites, comparing salary costs across the sites. The results of the economic analysis did not show a difference in costs between CS/AP's care when compared with the usual care given when only salaries were used in the comparison. This suggested that the higher wages payable to CSs/APs were offset by an increase in activity levels. Moreover, qualitative data and quantitative service user surveys showed that service users' satisfaction with physical care, emotional support and practical advice was higher for all specialist and advanced practice nurses. Being treated with respect was the most important factor for service users. In addition, the areas that were identified as having more of a positive impact related to "developing therapeutic communication, health promotion, education of service user and family, the use of physical and psychosocial interventions, and increased patient/client

satisfaction” (Begley et al., 2010, p.15). Strategically, there was a difference between the specialist and advanced practice nurses’ outcome with APNs being more involved than SNs. APNs were also found to provide greater clinical and professional leadership with more research and improved service delivery. The findings of Begley et al. (2010) further highlighted a growing body of evidence about the value of SNs and ANPs. From this systematic review, Begley et al. (2010) noted that some studies were methodologically weak and there were complications in comparing nursing roles internationally due to the context that existed within nursing in different countries. Although there was little uniformity between studies in the outcome measures evaluated and relatively few robust economic evaluations, the main findings were significant and noteworthy because all of them indicated, in one way or another, that there were benefits from employing SNs. Essentially, the care provided by CSs and APs was deemed cost neutral but improved patient/client outcomes and service delivery, thus making a case for introducing more CSs/APs in practice areas. These findings further supported the premise that the numbers of SNs needed to be adequately maintained across clinical areas and populations (Fletcher 2011). Moreover, the study helped SNs defend their positions and services, supporting the production of robust business plans and policies by demonstrating the evidence-based benefits of their role in terms of health service outcomes.

2.11. Career Structure/Framework

With the increase in evidence supporting the benefits of SNs practice, the literature also pointed to the necessity to appreciate the value of SNs. Pearce and Marshman (2008) stated that as the SN became more valued by patients then so too must their role be supported through a career pathway in which their skills and knowledge were acknowledged and developed. A number of conceptual frameworks to evaluate and support specialist and advanced nursing roles were present in the literature (Hamric,1989 (US); Manley 1997 (UK); Elliott and Walden 2014 (US)). Many were based on Hamric’s (1989) sub-roles of ANPs; expert practitioner, educator, researcher and consultant and on Donabedian’s (1966) structure-process-outcome (SPO) framework. As interrelated categories of quality assessment (Donabedian 1966) when applied to specialist and advanced nursing, ‘structure’ included the components necessary to facilitate care provision, and referred to characteristics of the specialist (e.g. education, experience) and the practice setting (e.g. adequacy of resources, medical staff support). ‘Process’ referred to the care provided by the specialist and the

appropriateness of that care (e.g. client education, physical and psychosocial needs met), which aimed to deliver person-centred care. ‘Outcomes’ related to specialist sensitive outcomes which were complex and involved interventions undertaken as a result of the academic, practical and scientific knowledge of the nurse (Begley et al. 2010).

According to Rutherford et al. (2005) a framework for ANPs would enhance a clear vision, organisational thinking and working practices that were needed for standards and the consistent quality associated with advanced practice (Elliott and Walden 2014). Moreover, as MeiLing (2009) explained, no matter how experienced nurses were as generalists, they were still novices when they became APNs, thus using a model would guide the preparation needed for the professional to achieve organisational effectiveness, safe practice, professional growth and career advancement (Elliott and Walden 2014). The use of a model, such as the recently endorsed US Consensus Model for Advanced Practice Registered Nurses (APRN) Regulation includes the essential elements: Licensure, Accreditation, Certification and Education, that provides a comprehensive foundation for nurses who want to pursue advanced practice (American Nurses Credentialing Center (ANCC) 2008) The American Nurses’ Association (ANA) (2004) explains that problems with existing regulation that included lack of common definitions related to advanced practice roles, lack of standardization in programmes leading to their preparation, proliferation of specialties and lack of common legal recognition across authorities and States, are thought to be alleviated by such a conceptual model. Stanely (2012) further stated that such a conceptual model would allow advanced nurses to practise to the full extent of their competences and would enable them to assume a leadership role within the healthcare system and participate as an equal partner in redesigning healthcare.

Another recommendation found to enhance the development of SNs was to network globally. Koskinen et al. (2011) described the work of the international APN partnership, the Enduring Health Needs Management Course and the application of the progressive inquiry framework as the pedagogical approach in the developmental process. Six countries – Finland, Wales, Ireland, Bulgaria, Australia and the USA – were part of this partnership and although their findings could not be generalised to the rest of the world because of the nature of the national structures, it was a study worth noting since it involved a team with different histories and experiences in developing APN and education. The partnership believed that through the development of a collaborative APN education model, delivered online, an APN would gain intercultural competence by being prepared in global perspectives on care

provision, leadership, research and improved skills for international networking. As the project was in its early stages no systematic data were available about the detail of APN roles or scope of practice within the different health systems of the partnership. However, using the feedback from such a course might provide developing countries, such as Malta, with intelligence about the obstacles the six countries involved faced, enabling them to be better prepared and equipped for their own journey in the development for advanced nursing roles.

2.12. Conclusion

This chapter reviewed the literature on advanced nursing practice, focusing on the role and development of SN globally and specifically in Malta. The scientific studies about SNs were all internationally based since no research on their development, roles and impact was found in Malta. Through this research study, I intend to fill this gap in the literature by providing the evidence of specialist nurses' role and development in Malta.

This review showed SNs to be at the centre of modernizing and expanding roles within healthcare systems in the interest of patients whilst providing a combination of vital services, education and quality care. The evidence at the present time showed that operationalizing the SN's role could be challenging and nurses all over the world were at different stages in developing advanced practice. The lack of role clarity was a common factor affecting recognition to further professional development and identity. Authors, studies and research activities throughout the international literature all pointed towards the need for a more robust definition of the SNs' role, enshrined in statutory regulation as a way forward to increase safer quality practice. This was deemed important for both patients, who had the right to know who was looking after them, and for specialists to protect them from litigation. There was therefore a general call for a comprehensive evaluation of SN roles to inform health policy decisions about their future funding and development. Although it was found that there was global impetus in advanced nursing practice to create frameworks for standardised roles and preparation, this review highlighted the difficulties of extrapolating any generalised or "international" statement about evidence for nurses in these positions. There was a difficulty drawing conclusion from these studies because of the variances in contextual factors, such as the differing health service delivery systems, educational systems, organisational and legislative issues and the culture of the country in which these studies were carried out. Despite this shortcoming, the findings indicated core roles and common developmental factors that were evident internationally and could be used to inform

practitioners, policy makers, researchers and managers to develop similar services and new roles in countries, such as Malta, whose SN development was still in its infancy. The broader contextual factors that were found to influence the growth of specialist nurses included political commitment, shortages of nurses, preparation and regulation, multi-disciplinary team relationships and the acceptance of the medical profession. Additionally, the review identified less-studied components of the qualities required of an SN such as the personal attributes of courage, perseverance and strong personalities (Clancy et al.,) that are required for the APN role.

The following chapter will discuss the methodology of this study to reach its goal. The overall aim of this qualitative case study is to explore the experiences of specialist nurses in Malta and the objectives are to:

Explore the scope of services offered by specialist nursing throughout Malta

- Identify roles and services provided by specialist nurses;
- Explore the attributes of a specialist nurse;

Explore the specialist nurses' and their stakeholders' experience of their development

- Provide a profile of specialist nurses;
- Provide a historical background of their development;

Explore the influences on the advancement of specialist nursing practice in Malta

- Explore what factors supported or hindered specialist nurses' progress.

3. Methodology

3.1. Introduction

This chapter will be presented in two main sections, namely the methodology behind the study and the method used to undertake it. The terms *methodology* and *methods of data collection* are often used interchangeably. However, according to Denzin and Lincoln (2005) methodology assists the reader to understand the viewpoint of any assumptions that justify techniques used for gathering data in a particular research project, whilst research methods are the actions used for collecting data. The first section of this chapter will outline the focus of the study followed by a critique of the methodology that underpins the principles of the research.

3.2. Focus of the Study

This research intends to provide robust in-depth evidence of the specialist nurses' experience. It is not intended to be representative of a European perspective but to explore the specific situation in Malta and provide a better understanding of these specialist nurses in context. Although international literature on the various issues related to specialist nurses is increasing, it is difficult to use in the Maltese context since studies were usually carried out in larger countries such as the UK (Read 2001; Ball 2005), Ireland (Begley et al. 2010), Australia (Gardner et al. 2007) and Canada (DiCenso and Bryant-Lukosius 2010), that are very different to Malta. As demonstrated in the two previous chapters, the diversity made it hard to translate into the Maltese situation and further supported the need for this current case study to explore specialist nurses in their setting. In Malta, the concept of specialist nurses started around the 1990s and was officially recognised in 2003. There was considerable time between the implementation of the specialist nurses' role and the start of this research; therefore specialist nurses and their stakeholders would have been sufficiently cognizant of the role to have the ability to reflect on the impact and challenges that specialist nurses faced whilst trying to improve the quality of nursing care. Till February 2017, there was no professional register, no audit of their work and no research surrounding this small group of nurses who were providing services either to vulnerable groups of patients or healthcare professionals.

This research aims at a better understanding of specialist nursing in Malta and thus relates to the human world: the social sciences (Appleton 2002). The issues surrounding the experiences of these professionals are not straightforward and the depth of information, not only of the specialist nurses but also of the stakeholders, is needed to ensure the phenomenon is revealed. In an attempt to uncover the understanding of the complex nature of specialist nurses in Malta, a constructivist approach to inquiry is needed to respond to the research question - *How do specialist nurses in Malta explain their roles, development and experience and do these concur with those of their stakeholders?*

3.3 Philosophical Underpinnings

All research is based on philosophical beliefs about the world, also called worldviews or paradigms (LoBiondo Wood and Haber 2006), that have assumptions concerning the nature of reality, the position of human knowledge, and the methods that can be used to answer research questions (Guba and Lincoln 1994). This section presents the constructivist epistemology and ontology underpinning the choice of methodology for this research. LoBiondo-Wood and Haber (2006) explain that epistemology is what we know, and is concerned with why and how we know certain things, whilst ontology relates to the study of existence or being, and deals with what is real versus what is fiction or appearance. There are at least three competing paradigms: positivism, constructivism, and critical theory (Guba and Lincoln 1994) that have three distinct epistemologies (Myers 1997; 2016). Additionally, there is the pragmatist position that does not choose one-sided paradigm allegiance but advocates methodological appropriateness and uses theory and related methods to make rational decisions (Ulin et al. 2005). These understandings are neither right nor wrong but represent different ways of viewing the world.

3.3.1 Constructivist paradigm

According to Guba and Lincoln (1994) the fundamental principles that underpin the constructivist paradigm are based on philosophical assumptions with five principles: (i) reality, (ii) causality, (iii) unique contexts, (iv) relationships, and (v) values. Reality is viewed as pluralistic, since there will always be many different interpretations in a study that can be made. In practical terms, Ponterotto (2005) explains that reality, according to this qualitative position, is subjective and influenced by the context of the situation, namely the individual's experience and perceptions, the social environment, and the interaction between

the individual and the researcher. Therefore, ontologically, constructivists believe in multiple, constructed realities rather than a single true reality. Causality refers to the nature of constructions that depend on the meanings that people attribute to them. In other words, construction which emerges from a qualitative inquiry may be seen as unique, for a particular set of circumstances that may never occur again in exactly the same way (Appleton and King 2002). Unique contexts, relate to the settings being studied that are particularly valued. Generalizations are not meaningful nor sought in constructivist research. Moreover, as Appleton and King (2002) explain, when studying human behaviour, the interrelationships that influence people's interpretations and which give the data meaning are required. Finally, with regards to values in this philosophy, objectivity has no place in research where the belief is that reality consists of multiple mental constructions through a process of interaction between the researcher and study participants (Ponterotto 2005).

Constructivism is concerned with the participant, and in explaining the participant's point of view (Myers 1997; 2016) it believes that people give meaning to reality, events and phenomena through sustained and 'complex processes of social interaction' (Schwandt 1994, p. 222). This contrasts to positivist values of objectivism. As Guba and Lincoln (2005) state, positivism views the world as real, a world of science and testing hypotheses. In the positivist world, researchers are objective and strive to minimize sources of bias wherever they can. Ontologically, the nature of reality from a positivist's perspective is that there is but one true reality that is identifiable and measurable (Guba and Lincoln 1994). Norton (1999) further explains that positivist epistemology is based on the belief that the social world can be studied in the same way as the natural world where science is independent of the researcher. On the other hand, constructivism regards all knowledge as "constructed" in that it is dependent on human perception and experience. Similarly, critical theory, as Ponterotto (2005) explains, relates to multiple realities with a focus on power relations and patterns of dominance and acknowledges a reality shaped by ethnic, cultural, gender, social, and political values (Ponterotto 2005).

In this study, ontologically I seek the different realities of individuals to demonstrate the various meanings and understandings of specialist nursing (Creswell 2013) constructed from the range of stakeholders who understand the world of the specialist nurse in Malta. I also acknowledge my position as a researcher that has subjective views and that is an intricate part of this research.

3.3.2 Methodological Rationale

Luck et al. (2006 p. 107) states that it is “*beholden upon the inquirer to logically justify their philosophical position, research design and include a coherent argument for inclusion of varying research methods*”. Much time was spent considering which qualitative methodology would be the most appropriate to respond to the emergent research question (Salmon 2012) to ensure that there was congruence between philosophy, methodology, and method (Geanellos 1998). In other words, I needed to translate the philosophical principles that provide the basis of the methodology into a coherent and workable research method.

Other constructivist methodologies such as ethnography or phenomenology may also have been appropriate methodologies. Fetterman (2010) explains that ethnographical research is holistic and has the ability to capture cultural dimensions of the social world that are covert and tacit. Subsequently, this qualitative approach could have expanded the knowledge base surrounding the interactions of specialist nurses and the culture in which they operate; however, this may not have entirely responded to the research question. The central value of ethnography is observation (Fetterman 2010). A conscious decision was made to veer away from the observation of specialist nurses. Having worked previously as a specialist nurse, there was personal concern that as an observer, I might have looked but I may not have seen what the specialist nurse was engaged with because the nature of their work would have been familiar to me. Aside from these concerns, an ethnographic study (Fetterman 2010) may be more appropriate once this research has provided further knowledge in relation to the development of the specialist nurses’ roles.

The research could also have adopted a phenomenological approach (Creswell 2007) by gathering and analysing the essence and meaning of what it is to be a specialist nurse, their experiences and behaviours (Salmon 2012). However, the research question and the study objectives are more grounded in the establishment of the specialist nurse’s role and development. The gap in current knowledge that I have identified was not concerned with drawing on the lived experience of specialist nurses but in providing a more holistic understanding of the experience of specialist nursing. Learning more about the lived experience would be a valuable piece of research, but again possibly after more is known about the roles and contributions that they have made to date.

In line with the constructivist worldview an emancipatory approach was also considered. Ontologically, emancipatory research also believes in multiple constructed realities rather than a single true reality (Ponterotto 2005). However, as Holloway and

Wheeler (2010) point out, the emancipatory or advocacy/participatory view as a research inquiry needs to be intertwined with politics and a political agenda. Creswell (2009) further explains that emancipatory research contains an agenda for reform that may change the lives of the participants. This approach was seen as limiting since I recognized that it assumed that the system needed changing and failed to address my research question which, as the first study of specialist nurses in Malta, sought to explore the nature of their role and development. This was also the reason why a non-traditional design called evaluation research (Clifford and Clark 2004) was not chosen. Although Cormack (1997) states that well-designed and conducted evaluations have the potential to provide insights into how services or projects operate and meet intended goals or needs of recipients, the prime intention, as Clifford and Clark (2004) assert, is to contribute to policy making – be it at unit level or, at the other end of the spectrum, the government. Consequently this research design could not have answered the research question in this study. Although it could have gathered the information on specialist nurses' perceived needs, the aim of the study was not to make changes (Clifford and Clark 2004). The overall intention of this case study was to carry out an initial exploration of the phenomenon of specialist nurse in Malta.

The methodology that was repeatedly considered was the qualitative case study. The case study acknowledged the contribution that could be made to the research by a variety of sources (Merriam 2009). The fact that this study was being carried out in Malta, a small island state, with its own historical and socio-political situation, further supported this choice because the case study design enabled me to research the case, utilizing contextual data to interpret my findings about the phenomenon, that is, specialist nurses. As Stake (1995) explains, in case study research, the researcher is to study the one special complex case, typical or unique. The aim, as Stake (1995) and Merriam (2009) explain, is not to strive to achieve generalisation but particularisation and the privilege of being able to thoroughly understand one case in order to capture the multiple realities and interpretations. The importance of focusing on the particular and having the time to go into depth enables the detail of the single case to emerge (Stake 1995). In addition, case study methodology allows the bridging of qualitative and quantitative methods while keeping the experience and perceptions central to the constructivist investigation (Ulin et al. 2005). Finally it allows the interpretation of the findings that will lead to a more complete understanding of specialist nursing in Malta, providing current information that could not be collected otherwise.

3.3.3 Merriam's Orientation to Case Study Research

Case studies are thought to be derived from social constructivism, which acknowledges that there are a range of perspectives (Yin 2009) and that there is no one truth or viewpoint. Thus, this approach was also thought to enhance and contribute to the constructivist ontology of multiple realities needed in this research to understand the complexity of specialist nurses in Malta by employing a range of research methods. One characteristic of a case study is to be able to utilise a range of methods: interviews, focus groups, observation and historical data and although they are not used simultaneously, it is perceived to be valuable to use more than one (Yin 2009). As a developing researcher Merriam's (1998) approach provided me with an accessible methodology to case study research that is organized and embedded in the constructivist philosophy. For description purposes, it is important to explain the differences in the philosophical beliefs between the three main authors of case study research – Yin (1999), Stake (1995) and Merriam (2009) – and where they may theoretically position themselves on the constructivist-positivist continuum.

Yin (1999) originates from a positivist viewpoint, although Appleton (2002) affirms that he does not explicitly state this. Notwithstanding this, Yin emphasizes the use of a systematic approach to data collection and analysis and thus bases his approach within a scientific framework recommending the use of hypotheses and collecting empirical data. Consequently, he could be positioned on the far right on the continuum since he allows positivist generated data, and rather than a reflective approach to data collection prefers procedural steps that are made explicit. Alternatively, Stake (1995) is rooted in the qualitative paradigm and could be considered to be at the far left of the continuum. Stake's (1995) approach to case study is the most 'constructivist' epistemologically in case study research, since according to Appleton (2002), it is essentially philosophical and focuses purely on qualitative aspects. His belief is that case study research should enrich the understanding of the case and proposes that knowledge is constructed rather than discovered. Merriam (1998) on the other hand, is located in the middle of the continuum, since although firmly grounded in a qualitative paradigm, she offers a pragmatic approach to case study research and recommends the researcher to use theoretical frameworks to define the problem and also to analyse the data. Merriam (1998) covers the mechanics of conducting a qualitative case study in a straightforward manner.

As a researcher I find Merriam's (2009) perspective to case study research comprehensive, especially in her application of qualitative research to gain an understanding of the situation. Although one could argue that Stake (1995) is the most 'constructivist' and appropriate for this case study, he is also the one who provides the least description and guidance (Appleton 2002). In contrast, Merriam's methodology afforded significant direction from case identification, sampling, data collection and also analysis. Additionally, Merriam (2009) subscribes to a qualitative ontological and epistemological research philosophy, as described previously in section 3.3, that was subsequently followed in this research.

In summary, this exploratory research is underpinned by a constructivist philosophy and the case study design is the approach used to collect data. Thus this brought forth world views that celebrate participants' ontologies and constructivists' epistemologies, where I, as the sole researcher, and the participants co-create understandings (Denzin and Lincoln 2008). Reflecting on my previously stated research question – *How do specialist nurses in Malta explain their roles, development and experience and do these concur with those of their stakeholders?* – a case study approach was most suited to answer the question, and fits well within this study's constructivist philosophy (Merriam 2009). The case study approach allows for qualitative research to take place in a natural setting, where I, as the researcher, is the means of data collection, and that data collection is flexible and sensitive to the social context of nursing in Malta. It is also congruent with the constructivist world views that encourage data analysis to be rich, contextual and detailed, with the aim of elucidating meanings people bring to the data, and through interpretation to understand the phenomenon under investigation (Denzin and Lincoln 2008; Creswell 2009). Finally, as the only researcher in this study, it acknowledges my own personal interpretations of the world but rather than remove such 'experiences' (Denzin and Lincoln 2008) it recommends consideration and monitoring of these understandings throughout (Merriam 2009). A discussion will follow on the frame of reference and the process of reflexivity used in this case study.

3.4 Frame of Reference

This section provides rationales for the choices and conclusions made in this study in a transparent way that is in line with the constructivist paradigm (Denzin and Lincoln 2008). It will outline my epistemological understandings as a researcher that were influenced by my observations, experience, political commitments, interest in nursing practice, and growing academic deliberation. Moreover, together with my knowledge of the case study approach,

my thinking was enhanced by ‘other’ knowledge that included the literature on the subject area of specialist nursing and the related concepts of leadership, expert practice, and advanced nursing practice as discussed in Chapter 2 of the literature review. I also knew most of the participants being studied, and thus I had subjective material based on my individual experience and views (Creswell 2013). I had first-hand knowledge of specialist nurses since I was a practising tissue viability nurse until five years previous to the study beginning, and as a senior nursing manager in the main hospital I had regular contact with these nurses where most of them were based. Ultimately this frame of reference is an illustration depicting what I bring to the research that shaped my thought processes and influenced the direction and findings of this study. This was not a planned process prior to the study, but an evolution that developed throughout the years of this research. I think this explanation is important because I believe it will reduce ambiguity by putting the phenomenon into focus and the process of the development of the case study under investigation (Ulin et al. 2005). Furthermore, it could provide the reader with an outline of key important steps for the prospect of transferability. As Yin (2009) suggests ‘thick description’ should be included within the study to increase the possibility of transferability of the findings being applied to other similar settings. Within this study, a full description of the methodology and methods used is evident in this chapter. Moreover, the context of the phenomenon was described in detail in Chapter 1.

Figure 3 shows that the frame of reference is not linear but ongoing and interrelated with the focus on the circular dynamics shaping the growth of this study. Outlining this background, accompanied by the process of reflectivity used throughout, follows the methodological integrity required in qualitative case study design, to ensure what Morse (2011) describes as study credibility.

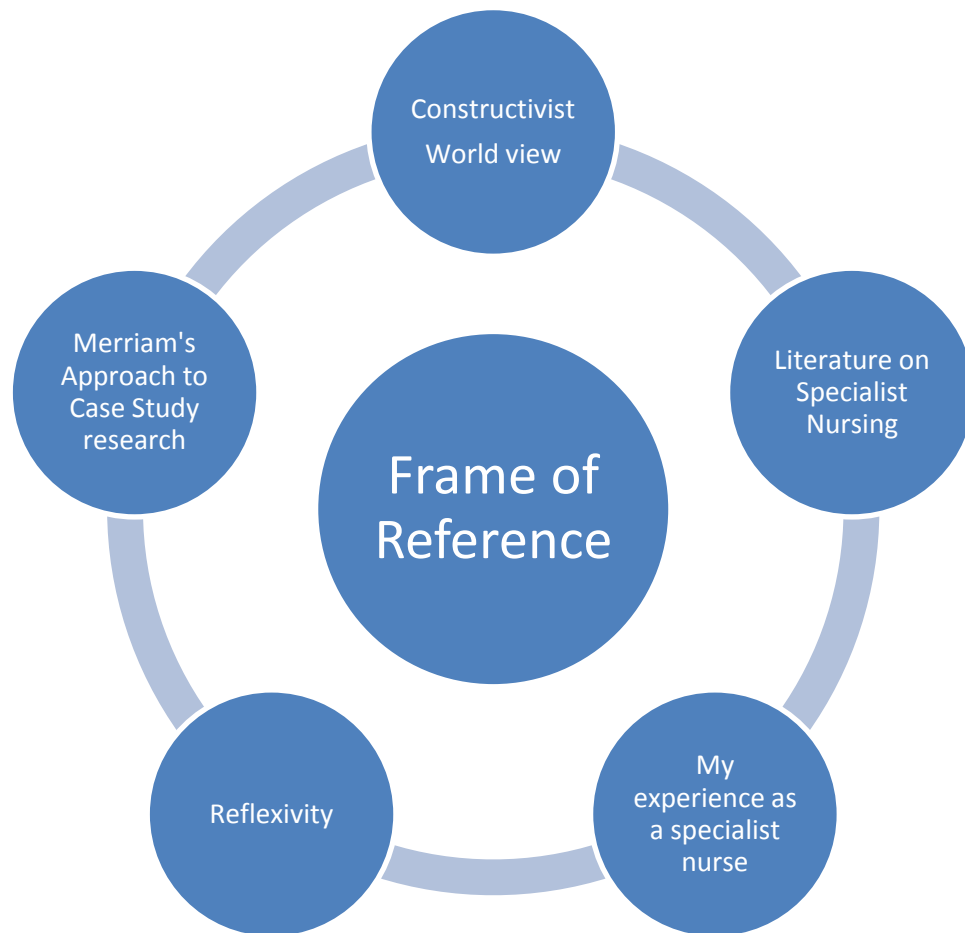


Figure 3. Frame of Reference

3.4.1 Case study literature

Originally the study was based on a subjective view that was later enriched by literature on the international issues surrounding specialist nurses and advanced nursing practice that prepared me for the study ahead. Initially, studies on specialist nurses were critiqued and encompassed robust studies like Read (2001), Ball (2005), Delamaire and Lafortune (2010) and Begley et al. (2010). Likewise to help in my understanding of the concepts and conceptual frameworks of advanced nursing practice the seminal works of Hamric (1989) and Manley (1997) were evaluated. Moreover, following my conviction that the case study was the most appropriate approach for this exploration, specific studies involving the topic (specialist nurses/advanced nurse practitioners) and methodology (case studies) were examined to give more information and confidence of how to operationalize this case study. These studies that outlined commonly used parameters for describing specialist nurses or

advanced nursing practice were adopted in structuring the descriptive elements of the survey and interview schedule. In addition, recurring issues from the literature were used to trigger discussion where respondent perceptions on role value and appropriateness were required.

Hyett et al. (2014) explain that case study research is a popular approach among qualitative researchers which provides methodological flexibility in paradigmatic positions, study designs and methods. However this flexibility, without the necessary description, could become haphazard. The next section will discuss how the literature formed part of the frame of reference for this study. Primarily, a debated issue in qualitative research revolves around when researchers should complete a review of existing literature (Holliday 2007). I was aware that one of the reasons for this debate is that qualitative researchers must be cautious not to use existing research findings as a substitute for their own thoughts. Rather than attempting to fit their findings with the conclusions of previous research, qualitative researchers must be vigilant to formulate their own concepts (Silverman 2000). Thus, Holliday (2007) states that in some qualitative research it is best to wait until researchers have entered the field before they begin exploring research in their topic of interest. On the other hand, Creswell (2009) explains that qualitative research inquirers use and present the literature in a manner consistent with the study methodology and also the available literature on the subject.

In this case study, since the survey was conducted in the first phase and in a sequential method, a substantial literature review was conducted to help establish a rationale for the research question and also to help with the formulation of the questionnaire. Moreover, although internationally the subject of specialist nurses and advanced nursing practice were extensively researched, their definitions and concepts were diverse. Therefore the literature review was traditionally placed in the beginning of this thesis to provide definitions and discussion on the main concepts and issues surrounding specialist nurses' roles and development. Notwithstanding this, I was aware that this may limit the inductive approach when exploring a phenomenon (Stake 1995) but to safeguard against becoming deductive, I wrote my thoughts and decisions and discussed them with colleagues and supervisors to determine if my thinking became too driven by the literature and frame of reference (Merriam 2009). Moreover, the search for literature continued after the data collection since there were issues that needed further exploration from the constructed themes in the findings.

Following the initial literature evaluation, the hard part was finding a research question that would yield worthwhile and unique results. What was immediately noticeable

was the lack of literature, public information and policy on nursing in Malta. This made it difficult to compare with the rest of Europe and the world. In contrast, over the past decade there was increased literature globally on the introduction and evaluation of services or roles by specialist nurses. As a developing researcher, narrowing the idea was a difficult process. Familiarizing and understanding the multiple definitions of case study was also a challenge. A simple definition of a case study that was easy to understand was a '*systematic inquiry into an event or a set of related events which aims to describe and explain the phenomenon of interest*' (Bromley 1990, p.302). According to Zucker (2001), the unit of analysis can vary from a person to an establishment or corporation. Thus, it was important to see how other researchers investigated the notion of specialist nurses and see how they undertook it practically.

The initial challenge was to define a specialist nurse since it became apparent that titles used in different countries had different meanings and functions. Moreover, in every country, due to their scope of practice and their legal structure, these nurses practised various roles that were once again unique for their country or even hospital. Thus, I started off with an understanding of the concept of advanced nursing practice as an umbrella to all the other titles that fall under it. The focus on specialist nurses, as a title that was relevant to Malta but also abroad, these nurses could be called advanced nurse practitioner, clinical nurse specialist, nurse practitioner and consultant nurse. They all seemed to have common roles that they undertook, including clinical practice, education and research, but their difference was in the amount of autonomy, extended roles and leadership that they practised. I identified 11 studies (see Table 1A, Appendix 1) that used a case study approach and that explored the roles and effectiveness of specialist nurses, advanced practice nurses and/or consultant nurses. From these studies it was evident that there were various types and methods that could be employed when carrying out case studies. The points in Table 2 that were extrapolated from the literature gave me a broader understanding of case studies and how specialist nurses could be explored in Malta. For example, all the studies outlined in Table 1A (Appendix 1) used interviews as the main method to gather data, accompanied by observational and/or documentary methods, and the majority of these studies involved service users. However, I realized that not all methods were appropriate or could be used in Malta either due to the culture, situation in nursing or to the position that I held in the hospital.

Table 2. Features in Case Study design when exploring Advanced Practice Nurses/Specialist Nurses' literature

Features in Case Study design when exploring Advanced Practice Nurses / Specialist Nurses' literature
1. Used multiple data collection methods and the choice of interviews was common to all the studies either to retrieve data from the nurses and/or stakeholders.
2. Developed semi-structured interviews from a model such as the Logic Model (Bryant-Lukosius et al. 2009) for advanced practice.
3. Structured the interview from an expert panel (Elliott et al. 2012).
4. Used propositions. McCarthy's (2006).
5. Utilised the help of a framework to analyse the data including the Ritchie and Lewis's (2003) thematic coding framework.
6. Managed their data by using a computerized system, namely NVivo.
7. Used various terms like qualitative, intrinsic, mixed-methods, single.

After much deliberation, involving patients or clients was an issue that was thought premature at this stage. A reason for this was that culturally, although Maltese tend to criticize the service, they seem anxious to voice their opinion officially since it may be construed as being political (Sharples 2012a). Another reason why patients were not involved was because there are limited services or only one specialist nurse per unit, thus potentially making patients feel uncomfortable. I also feared that the results would not yield the reality since patients would be apprehensive to talk about the service that they may need in the future due to fear of retribution. These considerations led to the decision of not using the service users but it is believed that this study could be the stepping stone for further research on the subject involving service users (Holloway and Wheeler 2010).

Hyett et al.'s (2014) study critically reviewed 34 case studies from health sciences, social sciences and anthropology, and methods research was used to further support my design especially on the importance of explaining rationales for choices made during the process of this case study research. It also encouraged my decision to provide the necessary detail on the context of the study, the frame of reference used and where I am positioned as a researcher, since these elements show methodological integrity and honesty that are both valued in the constructivist research tradition and case study design (Wager and Kleinert 2010).

Table 3. Hyett et al.'s (2014) Summary of Case Study Findings and Recommendations

Findings	Recommendations
<ul style="list-style-type: none"> • Did not provide a clear methodological description or justification relevant to case study. • Did not provide sufficient information for the reader to understand case selection, and why this case was chosen above others. • The context of the cases were not described in adequate detail to understand all relevant elements of the case context, which indicated that cases may have not been contextually bounded. • There were inconsistencies between reported methodology, study design, and paradigmatic approach in case studies reviewed, which made it difficult to understand the study methodology and theoretical foundations. 	<ul style="list-style-type: none"> • Although case study research can be situated within different paradigms with an array of methods, clear descriptions of the paradigm and theoretical position and methods should be provided so that study findings are not undervalued or discredited. • Providing methodological descriptions that demonstrate a strong theoretical foundation and coherent study design will add credibility to the study, while ensuring the intrinsic meaning of case study is maintained. • If case studies are not methodologically and theoretically situated, then they might appear to be a case report.

As Hyett et al. (2014) state, poorly described methodological descriptions may lead the reader to misunderstand study findings, which limits the impact of the study. Hyett et al. (2014) further noted that a considerable number of case studies reviewed were missing key elements that define qualitative case study methodology and the tradition cited. A summary of Hyett et al.'s (2014) findings is listed above in Table 3. **From further analysis of these studies, it was evident that there were variations in the use of issues such as propositions. Whether it was due to limited editorial space or a lack of appreciation of the components of case study methodology, the proposition phase had a tendency to be overlooked in most published case study research. As Merriam (2009) explained propositions are like hypotheses and their use in the methodology of case studies provides clearer formalized direction towards the finalization of the research study. Although the use of propositions could provide direction to carry out the research (Sangster-Gomley 2013) researchers, like me, could have found this particular element of case study research confusing since it does not follow a constructivist philosophy. Although I valued the importance of identifying essential issues to be explored in the case study I found the term 'propositions' misleading when conducting a constructivist study.**

Propositions are related to a positivist approach and thus could give the impression that the study is reductionist. Thus I did not use the terminology of propositions since it was not in keeping with the constructivist philosophy but was transparent about what I brought to the research as discussed below.

3.4.2 Reflexivity

Part of the frame of reference in this case study included 'me' as the sole researcher in this study. As a researcher I locate my work within a constructivist paradigm and I will make my beliefs and values explicit (Creswell 2013) by acknowledging my personal contributions and impact as a researcher upon the study (Jasper 2005). I understand that there are multiple realities through which one can see and understand the world, and I know that the construct of my reality is influenced by my beliefs, values, culture, and experiences. As a person and a nurse, I find the constructivist paradigm a natural direction to research since its nature and concepts are closely related to the basic principles of care in nursing practice. These principles take the patient or client to be the most important person in any interaction (Serrant-Green 2006). Consequently, I feel that this approach enables me to be the voice of participants in this research study. This is supported by Serrant-Green (2006) who states that the methods of qualitative research allow nurses the opportunity to reveal and understand a range of issues from the perspective of the participant.

Dahlberg et al. (2002) explain that it is necessary for the researcher to practise reflection on the whole inquiry work since the experience of the researcher conditions the research. As a nurse I was used to being reflective in my work as this technique is a useful source of professional development. However, reflexivity goes deeper and as Mortari (2015) states, supports critical introspection. It involves a deep inward gaze into every interaction, whether it is in research or any other interaction in life. Throughout this study my thoughts, feelings and behaviour were considered within the context of this study and delve in my ideologies, social and political realms. I also used reflection; however, this occurred after my action and not during. I describe my reflection of this study in section 6.3. Mortari (2015) states that the tension of reflection and being reflexive could be conceptually confusing and that being reflexive is not a straightforward matter since there are various disciplines (such as, anthropology, psychology, and sociology) and types of reflexivity. However, a clear definition is explained by Sandelowski and Barroso (2002, p.222)

“Reflexivity is a hallmark of excellent qualitative research and it entails the ability and willingness of researchers to acknowledge and take account of the many ways they themselves influence research findings and thus what comes to be accepted as knowledge. Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share”.

3.4.2.1 Situating myself

I used reflectivity throughout this research study and I will present a critical view of myself (Finlay and Gough 2003) to offer clarity of thought and self-discovery (Jasper 2005). I also share my views and choices throughout the study, since I believe that this sense of transparency to the work enhances trustworthiness (Crookes and Davies 2004). Ulin et al. (2005) state that whether consciously or not, every researcher works from some theoretical orientation or paradigm that would affect the perspectives of how they see the world from a cultural, philosophical or professional lens. Peshkin (1988) points out that an individual's subjectivity is not something that can be removed, and does not view subjectivity as necessarily negative; he does feel it is something that researchers need to realize and acknowledge. Accordingly, it was important to examine my own subjectivities throughout the research process so that I was aware of how these subjectivities could influence my interpretations and portrayal of events (Koole 2012). To begin with, my personal interest in this work originated from experience in a previous role working as a nurse specialist in Tissue Viability. As I was one of the first nurses to initiate, develop and run a nurse-led service in Malta in 2003, the topic of specialist nursing was a subject of interest. Since these posts were rather new, there was no mentorship or support for training or a role model to be guided by. Notwithstanding this, the situation was advantageous too, since there were no expectations and no one could compare our work with others. As pioneers we were treading new ground and the journey was not easy but exciting and challenging. After a few years in post, the roles of advanced practice in nursing issues, including the preparation, motivation, career structure, personality and governance, were all subjects of interest. I embarked on this work in order to increase awareness of specialist nurses in Malta and the potential contribution of these nurses to patient care. As previously mentioned, the absence of literature in Malta created a curiosity to explore who these individuals were and what they were doing in practice to impact on direct or indirect patient care and service provision. The experiences of stakeholders that influenced these nurses' development were also part of the complexity of this case study. This work was meaningful to me, thus I tried to maintain the

awareness that the research that I wished to pursue was not necessarily the research that the participants wished to follow.

As a researcher, it was also important to attend to my own subjectivities that I brought to the study based on gender, age, ethnicity and socioeconomic status (Ulin et al. 2005). Initially I felt that at times I lacked self-awareness of how these orientations impacted on the way that I viewed the world. However I tried to be conscious of these factors while doing my research to minimize these subjectivities that may have influenced the research. An example of this related to my status (Mortari 2015). My status in relation to my age (40) and my position as a graduate nurse – and also being a senior nursing manager in Malta – could have influenced my participants. This could have been in a positive way in that they were more compliant in taking on the invitation to participate; or could have been an influencing factor when responding to some questions, thinking that they might need to please me. My socioeconomic background was also taken into consideration, since this could have impacted the level of confidence that I felt when undertaking this study. Although a manager today, I come from a working class background and until a few years ago I was a specialist nurse, so nurse participants could have been more comfortable in my presence since I used to be one of them. In contrast, the multidisciplinary and the medical consultant participants in the focus groups, who came from backgrounds of higher status both in relation to levels of education and socioeconomic status, created more anxiety. At times, I did feel out of place and I was aware that I felt most comfortable when interacting with nurses and nurse managers. (A specific discussion on minimizing the power and participant research gap is discussed in more detail in the ethics section 3.8.3).

I was also mindful of newly emerging subjectivities that may not have been considered and that would potentially influence my research (Peshkin 1988). One such example was when I was confronted about my world views. I initially identified myself as a constructivist with a pragmatist lens, when one of my supervisors challenged me on my paradigm, indicating that there was an element of feminism in my work. On first thoughts I discounted this observation but on searching for the meaning of feminism I started relating myself with what previous feminists fought for. As a person I always felt I had to defend the weak, fight for the oppressed or the person being discriminated against, fight for my rights as well as those of others; but never under the umbrella of feminism or equal gender rights. I mainly try to reform nursing by breaking new grounds both for male and female nurses – it was never about gender issues but about ‘human rights’, democracy, transparency, and

meritocracy. However, on supplementary reading on the subject and reflecting upon myself, I could further identify with the feminist perspective. I realized that the fact that I wanted to narrow the gap between theory and practice, and bringing professional equity between professions with equal opportunities and rights as other healthcare professionals, were all inclinations towards a feminist philosophy (Whipps 2013). As Ulin et al. (2005) explain feminist research has grown from a commitment to gender equity to addressing power relationships of many kinds, including the acknowledgment that long-standing differences in access to power have a profound effect on social phenomena that shape people's lives. This recognition is of particular importance in this research because of the history and culture of nursing in Malta that has influenced me as a person, nurse, and researcher.

As mentioned previously specialist nurses have no written history to date in Malta (Sharples 2012b) and this study could give them a voice in the healthcare system and nursing profession that is both hierarchical and patriarchal in nature (Buttigieg 2012). Moreover, a history of subordination to males is also the case locally (Darmanin 2006), where gender inequality has persisted to date with Malta ranking amongst the lowest (99 out of 142 countries) in the Global Gender Equality Index (Hausmann et al. 2014). I feel that the very concept of a specialist nurse can be seen as challenging to a culture that is biomedicine rooted in patriarchy. As outlined in Chapter 1, my view of the political and medical influence in the health structure adds to my socio-political angle to this study that needs to be made explicit. Notwithstanding this, throughout the data collection I was particularly aware of keeping my questions open and general. For example I would ask '*what do you think influenced the development of specialist nurses?*' Also of significance, I became aware of my inclination towards feminism during data analysis when constructing meaning and discussing my findings with one of the supervisors. This then made me particularly judicious and reflexive during the data analysis and reporting of the case since my aim was to portray my participants' views and not my own.

In addition to my feminist views and subjectivities, there is also another important belief that I need to be explicit about. This is important because as Miles and Huberman (1994) explain, constructivism is built upon the premise of a social construction of reality and one must not undermine the close relationship between the researcher and the participant. My belief that specialist nursing could make a difference to patient/client care by delivering quality patient-centred services to the public other than a traditional medical-oriented approach, is important to make clear. Consequently, when analysing the data and throughout

the research process, I was sensitive of my outlook and thus attentive to its implications of introducing subjectivities. In order to minimize the impact of my inclinations, I closely scrutinized my feelings as I carried out my research. I looked for situations where I felt uncomfortable or that I wanted to avoid, as well as situations where I felt comfortable and that I wanted to continue. When these feelings arose, I realized that I was usually being influenced by subjectivity (Glesne 1999). An example would be feeling, during an interview, that the specialist nurse was 'submissive' and her approach – that the doctor knows best – was not in line with my views. After analysing my feelings, I considered how they related to my subjectivities, and realized how important it was for me not to show my emotions during the interview. I employed my counselling and listening skills through non-judgmental behaviour and allowed the participant to communicate and recount her story from her perspective. Additionally, following the interviews, I asked the participants to check the transcripts, and in the focus groups I asked a moderator to take part in the group discussion and also review the transcripts and themes that evolved from the data (Greenbaum 2000). This was important since I was the sole researcher, and being aware of my influence I wanted to remain true to the participants' views and meaning throughout the research process.

Together with my beliefs, experience, and the literature it became apparent that there were subjects that needed to be explored in this research. These included the roles and attributes of specialist nurses and the influences and support needed for their development. These issues were used to address both the research question and objectives of this research that were influenced by my subjectivities, as outlined above. As Strand (2000) states, "the researcher's values, experiences, and personal points of view are as much a part of the research process as those of the people studied, and they should be discussed and acknowledged" (p. 91). The next chapter will discuss the preparation, methods and ethical considerations in the undertaking of this case study.

3.5 The Method

3.5.1 Introduction

This section of the chapter will focus on the Method used in this qualitative case study. The exploration in this study was related to the development and preparation of specialist nurses in Malta, and all possible approaches to gain the best information to answer the research question were searched and adopted. It will initially outline the aims and objectives and discuss the method of the study undertaken in the three phases of the study. This will be followed by an in-depth evaluation of the data collection and analysis methods and concludes with important ethical considerations. Figure 4 presents an overview of the case study plan that will be described in more detail in the following sections.

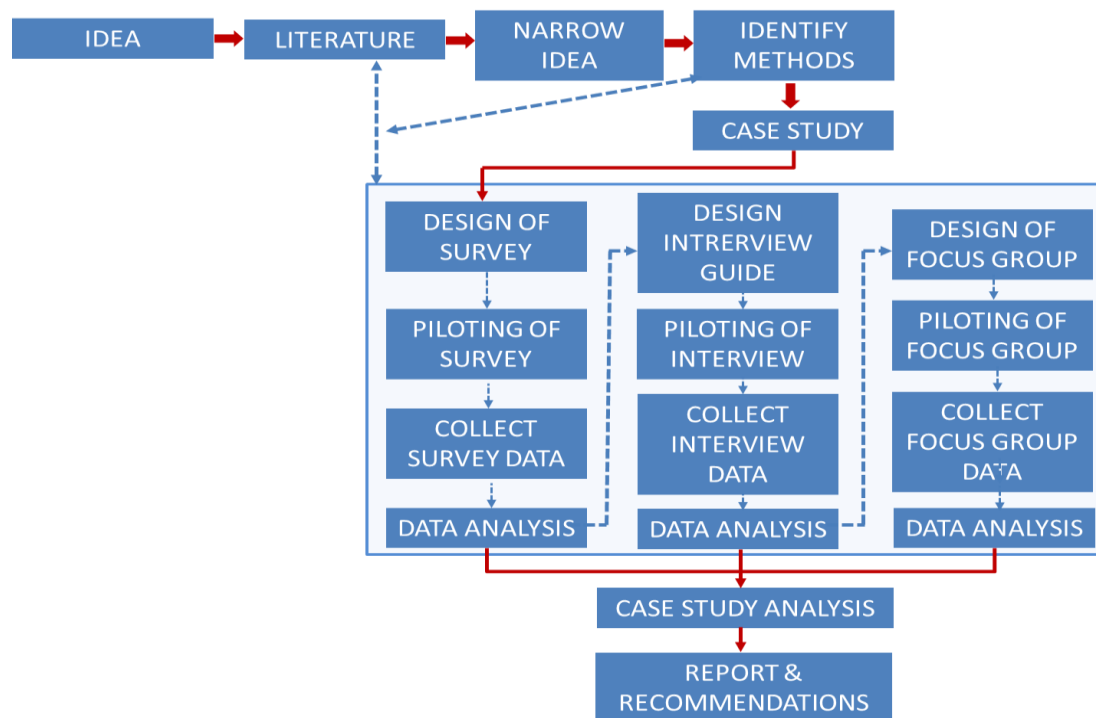


Figure 4. The Case Study Plan

Figure 4 outlines the whole process from the idea of studying specialist nurses, to the literature, the case study method, collecting data and analysing them, to producing the results and report of the study. Although Appleton (2002) states that the constructivist paradigm does not advocate a detailed design or plan since it must emerge and develop, Lincoln and Guba (1985) in contrast agree that a plan is needed for broad contingencies, without however indicating exactly what will be done. I was aware of this and although having a plan, I was

open to the necessary changes needed, as was evident when another focus group with staff nurses was deemed important when considering their experience as stakeholders of specialist nurses.

3.5.2 Aim of the Case Study

The overall aim of this qualitative case study was to explore the experiences of specialist nurses in Malta both from their own and their stakeholders' perspective. The objectives are outlined in Table 4 below. As one may note, the only objective that did not require the qualitative element in the study was that of number 3(a) which aimed at providing a profile of all specialist nurses in Malta through the survey.

Table 4. Objectives of this Case Study: Phases and Data Collection Methods Used

Objectives and Phases of the Case Study			
Objectives	Phase 1 Survey	Phase 2 Interviews	Phase 3 Focus Groups Survey
Explore the scope of services offered by specialist nursing throughout Malta	√	√	√
1a) Identify roles and services provided by all specialist nurses	√	√	√
2) Explore the attributes of a specialist nurse	√	√	√
3) Explore the specialist nurses' and their stakeholders' experience of their development	√	√	√
3a) Provide a profile of specialist nurses	√		
3b) Explore the specialist nurses' and their stakeholders' experience of their development	√	√	√
3c) Provide a historical background of their development	√	√	√
4) Explore the influences on the advancement of specialist nursing practice in Malta – factors supporting or hindering specialist nurses' progress	√	√	√

3.5.3 Type of Case Study

This qualitative case study is exploratory in nature and according to Merriam (2009) it is called a heuristic case study design. Merriam (1998) acknowledged that the use of a case study is often misunderstood but maintains that the “single most defining characteristic of a case study lies in delimiting the object of the study, ‘the case’.” Merriam’s (1998) ideology is to fully understand and articulate the case under study that could be the limit on the number of people to be interviewed or a finite time frame for observations or issues to explore. According to Merriam (1998) the case study does not have specific data collection methods but “focuses on holistic description and explanation” (p.29). Within her view, a case study could be described as particularistic, heuristic or descriptive. Particularistic relates to the

specific focus of the case and suggests to the reader what to do in a similar situation. Conversely, a descriptive case study is complete and literal in its reporting of the research and it is referenced as the 'thick description'. This case study explored specialist nurses both from their point of view as well as those of the stakeholders, and could be categorised as a heuristic case study (Merriam 2009). This was because a heuristic case study sheds light on the phenomenon – in this case specialist nurses – extending the experience, discovering new meaning or confirming what is already known. It gives reasons for what and why things happen with a background of the situation. This case study followed a three-phase sequential design and focused on the role and development of specialist nurses in Malta as outlined in Table 5 below.

3.5.4 Bounding the case study by time, place and context

To avoid the tendency to answer a question that was too broad or choose too many objectives for this study, boundaries were established (Creswell 2013; Merriam 2009). The case in this study was the experience of specialist nurses in Malta, and the nature of the research question required participants (both specialist nurses and their stakeholders) who had the adequate knowledge and understanding (Polit and Beck 2009) of specialist nursing in Malta. Using a qualitative case study within a sequential exploratory design was thought to ensure the best way to capture and handle data. Planning the study started around 2010/11, but the actual case study and data collection began in 2013-2015 and was based in Malta focusing on a group of nurses called practice nurses working as specialist nurses. Table 5 provides an outline of the case study depicting the time frame used for data collection and pilot studies. As a part-time student, gaining the necessary permissions and ethical approval was a lengthy process. Informal interviews both with University and also with the health department could not be underestimated. The value of me setting the scene for this study was vital. This is recognised as an important element in a case study inquiry that fits well with constructivism (Lincoln and Guba 1985). As explained in Chapters 1 and 2, due to the political context in Malta I had to ensure that I had the authorities and professionals on board. Most authors (Yin 2009; Stake 1995; Merriam 2009) acknowledge the time needed for the exhaustive and detailed study of the case. Notwithstanding this, I found this time valuable to 'immerse' myself in the subject and explain the case prior to collecting the evidence. Moreover the planning phase of the study and the time needed for meetings, liaising with ethical committees, communicating at many levels, spending time gaining access to study

sites, writing letters and making telephone calls, were all worth the effort since the response from the participants and authorities was very positive. As Appleton (2002, p. 94) stresses, *“At the end of the day, the process of gaining access and the progress of the study will rely on the participants’ goodwill”*.

3.5.5 Purposive Sample

Bounding the research further involved exclusively studying professionals. In line with a constructivist philosophy, purposive sampling techniques were used in this case study (Appleton and King 2002). The aim of this technique is to obtain information-rich data through a transparent system of selecting participants (Patton 1990). I focused on a combination of pre-selected criteria for all participant groups and the sample selection was conceptually driven to underpin the research question (Appleton 2002). I selected participants that I thought reflected specific particularities to explore the common and unique experiences of specialist nurses (Sandelowski 2000). In this process, I was aware of the potential bias that exists in selecting participants in qualitative research (Patton 2002) but as Patton (2002) explains, this subjective component is a major disadvantage when such judgments are poorly conceived with no clear criteria. Thus, in every stage of sample selection I was reflexive and explicit about my selection criteria. As Stake (1994, p. 243) suggests, if qualitative research requires cases to be chosen, then “...nothing is more important than making a proper selection of cases”.

Table 5. Outline of the Case Study's Sample

Case study outline							
Phase	Data source	Population	Number	Sample	Tools	Data Collection	Pilot
Phase 1	Survey	Specialist nurses	N=27	Purposive	Questionnaire adapted from Ball/Reed Appendix 3	June-July 2013	January 2013
Phase 2	Interviews	Specialist nurses	N=9	Purposive	Interview guide Appendix 4	June-July 2014	March-April 2014
Phase 3	Focus groups	Stakeholders: Multi-disciplinary	N=7	Purposive	Focus group Guide Appendix 5	February-March 2015	January 2015
		Nurse directors and Senior managers	N=8				
		Consultants	N=6				
		Staff nurses	N=7				

A total population sample was used for the survey, where the entire population of specialist nurses was chosen. This was deemed important since the population of specialist nurses was small (N=27) and if they were not all included in the sample a significant piece of the phenomenon might be missing (Patton 2002). The specialist nurses eligible to participate in this case study (both for the survey and the interviews) needed to be employed by the health sector, in post as a 'practice nurse', and performing advanced practice duties with patients or for a particular group of healthcare professionals in a specialist area. These included specialist nurses that were, for example, called infection control nurse, stoma nurse, and informatics nurse.

Homogeneous sampling was the purposive sampling technique used for the interviews with a sample (N=9) of specialist nurses and for the focus groups (N=4) of stakeholders that were grouped according to their profession (Table 5). This aimed to achieve a sample that shared the same (or very similar) characteristics and backgrounds. As Patton (2002) explains, homogeneous sampling is used when the research question that is being addressed is specific to the characteristics of the particular group of interest, which is subsequently examined in detail through criteria. Notwithstanding this, a maximum variation sampling technique was then used to identify the specialist nurses and also the focus group participants. According to

Lincoln and Guba (1985) this method of sampling concentrates on the many specifics and not on the similarities to generalise but to provide context and uniqueness to the study. In the last focus group with staff nurses I used a nominated sampling approach that used an informant that invites another participant (Morse 2011) in the study (explanation in 3.5.5.2). Although I did not have a priori theories of the selected participants (Appleton 2002) for the second and third phase of this study, insights emerged following the preliminary work both from the literature and also from the analysis of the survey results. This according to Appleton (2002) is in line with the constructivist view that assumptions of the sample should be influenced by the multiple realities that are encountered as the study unfolds.

3.5.5.1 Selecting Participants - Interviews

Knowing most of the specialist nurses I grouped them according to their educational background, years of experience, personality (outgoing or more reserved), and gender. These criteria seemed important to provide a varied group and also to keep me focused and transparent of my choices. I then went down the list to try and be as descriptive as possible to provide me with an understanding of the potential sample. The criteria outlined below formed the framework to include the varying composition and characteristics of specialist nurses that were interviewed. These contextual factors were intended to increase my understanding about specialist nurses by selecting participants that seemed to offer ‘an opportunity to learn’ (Stake 1994, p.243). The criteria included:

- Being willing to participate freely
- With and without a Master’s degree
- Had their own case loads and those that did not have direct patient care like infection control or occupational health nurses
- Developing over the years and growing from one to more specialist nurses and those that did not grow in number
- Managed by different professionals, medical, nursing and other.
- Very active and less active in professional activities including research, publishing, and conference participation and organisation.
- Outgoing or more reserved
- Although more females were in post, I deliberately chose males (3 out of 9) to have a balance of opinions.
- The number of years they were in position, with at least two years’ in post to allow for them to share their experience.

3.5.5.2 Selecting Participants - Focus Groups

The focus groups involved professional stakeholders that either worked directly or indirectly with specialist nurses, or who could influence their role and development. Choosing

participants for the focus groups was complex because I aimed at grouping professionals with similar backgrounds in each session and I depended on their availabilities. Thus, I had to have a list of participants and if one was not able to make it, I would invite another professional with similar criteria aiming at providing group representation. The first three focus groups included multidisciplinary team members, the nursing managers/directors and the medical consultants. In these groups the homogeneous sample technique (Patton 1990) together with a maximum variation strategy was designed to identify good exemplars of the phenomenon under study. Within the first three focus groups, I chose differing types and tried to create a balance of males and females. Selecting the sample of the second focus group that involved nurse directors/managers was in a way more straightforward since there was a small amount of senior managers in nursing and also because they were all exposed to specialist nurses in their hospital or in their role as director/manager. Most of these managers/directors participated with a predominately male presence indicating that the top positions are in fact held by males (Chief Nurses at the time were all Males). Two females participated in this group, one was a director and another was a senior manager. This gender divide was also apparent in the medical consultant group since there were not many female consultants in post when compared to the male consultants. Only one female consultant participated out of the three identified. Moreover, since I was a specialist nurse myself I knew individuals who were supportive/unsupportive of the specialist nurse role thus I tried to select a mix of individuals. This was important since as Appleton (2002) explains, researchers could determine practitioners who could offer a variety of constructions to assist them in understanding the phenomenon under study. Once again, all potential participants were chosen to give a blend of opinions and enhance balanced discussions. The criteria for these first three focus groups included:

- Be willing to participate freely
- Have experience working with specialist nurses
- Be leaders in their own profession or department
- In the multidisciplinary group a blend of backgrounds were selected including: managerial, clinically based, involved in unions or educational posts
- Supporters of specialist nurse roles and those that were not so in favour

In the final focus group I did not choose the participants myself. It targeted nurses working on the wards and I used a nominated sampling approach. Morse (2011) explains that the nominated sampling approach is when an informant invites another participant and the researcher uses this referral to solicit the second person to be part of the study. In this

research, I used the nurse in charge of the ward as the ‘informant’. This was purposefully done due to ward exigencies and also because of the charge nurses’ knowledge of her/his staff. Moreover, since I was a senior manager at the time, I could have influenced the participants’ decision to participate since they might have felt obliged or afraid not to join. The areas from where the nurses were chosen included wards and specialized units that I knew were in regular contact with specialist nurses. I explained to the nurse in charge the purpose of this research and why I had to do this on an ad hoc basis. I then left it up to the charge nurse to speak with the nurses and I didn’t ask for any names. The only criteria I set was that nurses were working on the ward for at least five years and that they were willing to discuss their experience of specialist nurses in a group environment amongst other nurses. Prior to the focus group discussion, I gave the nurses time to read the information leaflet and ask any questions. I further explained the study and the reason why they were chosen and how. I also reiterated the fact that during this study and focus group, I was a student and not a manager and that they could stop participating at any time without penalty.

The criteria explained to the Charge Nurse included:

- Willingness to participate in the study – staff nurses would be free to refuse or continue to participate in the focus group at any time
- 5 years’ experience on the ward
- Knowledge and experience of Specialist nurses
- Prepared to discuss their opinions within a group environment
- In case the charge nurse did not find a nurse fitting the criteria, they themselves could join the focus group if they so wished

3.6 Data Collection

A range of methods of data collection were considered prior to undertaking this case study. As Merriam (1998) explains, the in-depth exploration of the person, programme or process in a case study requires intensive data from various sources including: a questionnaire, observations, focus groups, interviews and documents. As Patton (1990, p.196) points out;

“What is certain is that different methods produce quite different information. The challenge is to find which information is most needed and most useful in a given situation, and then employ those methods best suited to producing the needed information”.

Although a survey is associated with a positivist approach to enquiry, in case study research its use is recommended to provide a holistic understanding of the phenomenon under study (Merriam 2009). The methodology and the use of multiple methods in qualitative case studies not only provided a more in-depth data set but also allowed me to synthesise the data

and increase the rigor of the findings (Appleton 2002). In line with these recommendations, and my constructivist beliefs, my primary sources of data collection were face-to-face interviews and focus groups, and the survey was undertaken primarily to provide a descriptive profile of specialist nurses in Malta and thus produce a more complete picture. Capturing the essence of the role and development of specialist nurses in Malta was essential since there was no archival or policy data to gain this information from. The survey was also important to provide the context needed for this sequential case study for the next step of designing the interviews with specialist nurses. Yin (2009) further explains that statistics could help to understand the world of the topic in question by bringing to life what goes on in the setting and thus creates a broader understanding of the 'real-life' situation. This case study filled this need since both the descriptive richness and analytic insight into people, events and passions of specialist nurses' real-life environments were needed to answer the research questions.

This case study could have encompassed the collection of data in other documentary material (Yin 2009), including calls for applications, job descriptions and annual reports; however the focus of this case study was on the experience and perceptions of the specialist nurses and their stakeholders, and thus was not used formally but only as background information when available. However, despite me not using documents in my formal analysis, I created a reflective journal of meetings, calls for application, phone calls and emails that provided me with supplementary information. Keeping this journal aided my reflection and thinking in relation to my experiences and perceptions throughout the study in a way that kept me grounded in what I wanted to achieve. Merriam (2009) expresses some concern about using personal documents such as journals as data but acknowledges their use when conducting a qualitative research as a means to reflect the participants' perspective.

3.6.1 The Survey - Phase 1

The first phase of the study was a scoping exercise of all (N=27) of the specialist nurses working in Malta. Table 6 outlines the total sample population of the specialist nurses (N=27) who were eligible to participate in this case study. All the 27 replied to the survey giving a 100% response rate. Table 6 further outlines where they were based and how many specialists were working in the same specialty.

Table 6. Description of participants in Phase 1 – Specialist Nurses in Malta-August 2013

Type of Specialist Nurse	Location	Total
Infection Control SN	General Hospital	3
Infection Control SN	Primary Health Care	1
Diabetes Specialist SN	General Hospital	2
Pain Specialist SN	General Hospital	1
Breast Specialist SN	General Hospital	3
Haematology SN	General Hospital	1
Rheumatology SN	General Hospital	1
ENT SN	General Hospital	1
Clinical Nutrition SN	Malta and Gozo	1
Clinical Nutrition SN	Elderly residence	1
Stoma SN	Malta and Gozo	2
Psychology SN	General Hospital	1
Theatre SN in Urology	General Hospital	1
Theatre SN in Orthopaedic	General Hospital	1
Ophthalmology SN	General Hospital	1
Occupational Health SN	General Hospital	1
Breast Screening SN	Primary Health Care	2
Cardiology SN	General Hospital	1
Radiology/Gamma SN	General Hospital	1
IT SN	General Hospital	1
	Total SN in Malta	27

The aim of this survey was to establish a comprehensive understanding of how many specialist nurses were employed, their base to provide the service, how they were recruited, what their roles entailed, including any managerial, leadership and organisational engagements, and their future aspirations. It also provided a map of their roles, responsibilities, competences and educational preparation and any support before and during their employment. A survey was thought to be the most suitable since it was the most economical in gaining the information needed. In this part of the study, the aim was to reach the majority, if not all specialist nurses and due to time constraints in-depth interviews for all the participants was not thought feasible. In addition, as Oppenheim (2005) states, this method is anonymous, less threatening and hence less prone to bias than is possible through the interviewer's interpretation. However, Clifford and Clarke (2004) assert that one problem with a survey is that it treats participant feelings as a categorical variable, thus ignoring the fact that people are capable of making finer judgments. With this in mind, for the case study a

group of these specialist nurses were interviewed so that their experiences could be captured in an open and in-depth manner.

The questionnaire (Appendix 3) was an adapted tool which was already validated by Ball (2005). However, I also considered a couple of questions from the Department of Health's (UK) study tool, 'Exploring new roles in practice; implications of developments within the clinical team' (Read 2001). Notwithstanding this, the majority of the questions and format were adapted from Ball's tool to suit the type of questions relevant to the Maltese situation and to address the specific research objectives. Moreover, nomenclature was adapted to suite the Maltese context. This mainly pertained to the description of the grading system of their role and their place of employment. Malta's services differ from those in the UK and thus questions had to be changed to be in line with what is available in Malta. Moreover, there were questions in Ball's questionnaire that were removed since they focused on describing the type of post. In Malta, there is no other type of specialist nurse, such as nurse practitioner, clinical nurse specialist or nurse consultant, thus these questions were not required. The questionnaire only had closed questions since the open and in-depth questions were left for the interviews. A detailed account of all the changes made to Ball (2005)'s questionnaire is described in Appendix 6.

3.6.1.1 The Survey's Pilot Study

Following the changes made to the original tool by Ball (2005), the questionnaire was tested for reliability and validity. Oppenheim (2005) explains that reliability of the measuring instrument means consistency and relates to identifying 'genuine' differences in the readings, while validity is the degree to which an instrument measures what it is intended to measure.

Initially, statistical advice was sought from a statistician mainly on the issues related to the tools to be used for this type of investigation, suitable sample size of the group of participants and appropriate methods and software to analyse the data gathered. Since the sample of the population was estimated to be around 30 participants, according to the statistician, a sample size of two to three participants was considered to be adequate for this pilot. Lancaster et al. (2004) also explain that there is no explicit justification of the sample size of a pilot study since it depends a lot on the complexity and type of study. Additionally, since I had a select group of professionals I did not want to contaminate the sample. Thus, instead of piloting specialist nurses in post, I piloted nurses that were working as specialist nurses but with no title. These nurses still gave the indications necessary since they had the

experience and worked in the same role; the only difference was their official title. Participants were recruited by using a purposive sampling technique and were asked formally to participate in this pilot study.

In this study, internal reliability was tried by the test and retest scores (Oppenheim 2005) by two nurses who were given the same questionnaire twice and I left a four-week period between the first and second test to ensure enough time between the tests, so that the responses were not remembered. I looked for the respondents to answer in the same way in the majority of the items. If they answered positively or negatively in the pre-test they should have answered the same way in the post-test. The analysis was carried out in the same way in both pre-post tests and I performed the analysis myself to reduce variability and demonstrate the stability of the instrument (Suhonen et al. 2000) and reliability of the tool (Holloway and Wheeler 2009). The results showed that the questions were reliable since they were answered in nearly an identical fashion. Validity was considered by content that was provided by the conceptual definitions based on a systematic literature review. Additionally, the content was analysed by the nurses who participated in the pilot test and who also reviewed the questionnaire to ensure relevance and clarity of the instrument and support the its face validity. All nurses gave their feedback either in written format or verbally (I made notes of these comments). The content of the tool was thoroughly considered and it was confirmed that the areas were pertinent. A couple of international professors who worked with specialist nurses also commented on the questionnaire to establish face validity. Combined with the content validity of the providers and the face validity of the international professionals, I felt confident that all the variants of the diverse roles of specialist nurses were addressed by the tool. Consequently, the pilot study of this phase took approximately six weeks to complete.

3.6.1.2 Conducting the Survey

Following approval from the authorities (Appendix 12) and the ethics boards of both Bournemouth University and the University of Malta (Appendix 13), and when I was confident that the questionnaire was valid and reliable, I requested all the names of the specialist nurses from the Directorate of Nursing. The list was then double-checked with the results of an official public document that was issued on a notice board in March 2013 with all the names of practice nurses. As explained previously, following the sectoral agreement of 2013, practice development nurses and specialist nurses were under one umbrella title called

practice nurses. In 2013 all practice nurses had to be officially recognised and this publication was an indirect census of practice nurses in Malta. The next step was to confirm who was working as a specialist nurse or a practice development nurse, and this was done by an individual email to the nurses whom I was not familiar with. When the list was compiled I sent an email with the letter of invitation/information (Appendix 7) and the questionnaire (Appendix 3), using a link to SurveyMonkey™ and consent was assumed upon submission of the survey (Albaugh 2012). A reminder was sent after two weeks and within three weeks all participants responded to the survey. This was done in the month of July 2013.

3.6.2 Interviews – Phase 2

Phase two consisted of semi-structured, person-to-person interviews that explored the experiences of a smaller group of nine Maltese specialist nurses who participated in phase one. Merriam (2009) describes interviews as conversations that are used to gather information that cannot be observed and could include participants' feelings, interpretations of certain events and/or descriptions of past events. She further explains that interviews can occur in a variety of formats, with some interviews occurring person-to-person and others occurring within a group context. Additionally, there were three different types of interviews that were considered: structured, unstructured and semi-structured (Srivastava and Thomson 2009). Structured interviews are built on questions that are asked to all participants with no variation. Unstructured interviews have no prearranged set of questions (Patton 2002) where the interviewer usually starts the conversation with a broad question and semi-structured interviews strike a balance between the structured and unstructured interview.

3.6.2.1 The Interview Pilot Study

After reading about the styles and types of interviews (Merriam 2009; Ulin et al. 2005; Creswell 2009) I initially thought it best to leave the interviews open and free from any guide. As Merriam (2009) suggests, the unstructured interview is considered exploratory as it is often used when a researcher needs to gather more information on a phenomenon prior to additional interviews. However, most studies employ a combination of interview types in order to collect data (Merriam 2009). During my first pilot study I was quick to realize that if there was a quiet and timid nurse the depth of the interview information could be limited. I also thought that people might go on different tangents and I would not be able to conclude or gather enough data to discuss. Thus an interview guide was developed to follow with each participant, providing a steer but curtailing my views on them (Jacob and Furgerson 2012).

This is supported by Rubin and Rubin (2005), who suggest that a guided approach to the interviews allows the participant to add and extend upon points that were relevant to them. Moreover, as supported by Gubrium and Holstein (2002), I used open-ended questions to encourage discussion by not limiting the respondent's answers, but being channelled by the interview guide.

Information from phase one (Survey with specialist nurses), and an adaptation of the tool developed by Read (2001) in a similar UK-based study, provided the basis for the interview guide. Notwithstanding this, the experience gained through reflection from the pilot interview together with the literature was also vital in further shaping the interview itself and also reinforced the importance of asking good questions during interviews. In fact, Merriam (2009) suggests that researchers conduct pilot interviews in order to refine interview questions as well as interviewing skills. Following the first pilot, another pilot was carried out using the developed guide (Appendix 4). I felt comfortable in carrying out the interview with the developed guide because it gave structure to the interview. Also, when the interviewee finished her/his story, the questions or statements from the guide were used as probes during silences. Silence was a situation I needed to get used to and stop getting anxious about. In the first couple of interviews I became worried when there were a few seconds of silence. However, by the third interview and after reflection, these silences were thought necessary for the participant because they were either thinking or recollecting their thoughts. Additionally, I used these times of silence to think on what was said and to further reflect on the conversation (Jacob and Furgerson 2012).

3.6.2.2 The interview process

Semi-structured interviews were chosen after the pilot study was carried out as direction was thought important to provide some focus to the interview while still allowing the participants space to tell their story (Rubin and Rubin 2005). In this phase, a purposive sampling strategy as explained in section 3.5.5 and 3.5.5.1 enabled me to draw the best information from these participants who had the necessary experience and attributes to be able to answer the research question (Appleton 2002). They were invited through an email attached with the letter of invite, the information and consent form and the interview guide. The interview guides were given to interviewees in advance so that they could feel prepared and less threatened. It is also recommended by Polit and Beck (2010) so that participants feel more at ease with the interview and do not consider it a sort of assessment. Written consent was obtained from all

participants (Appendix 8), following a detailed explanation prior to the initiation of the interview that lasted between 60 and 80 minutes. Although time was not restricted from the ethics and governance board or from the hospital authorities, I kept the interviews to around one hour ensuring that clinical participants were not removed from their duties for excessive periods (Brown 2013). I was keen to ensure that the interviews were as natural and relaxed for my participants as possible (Rubin and Rubin 2005). A more detailed discussion will follow in section 3.11.3, on minimizing the power relationship between the participants and me. Only two persons preferred to have the interview in their office, but the others all came to a room that was chosen by me. This room was away from the clinical area and situated in quiet surroundings close to a pantry. This was important since I could offer refreshments and it served as an ice-breaker. It was a small room with a couple of chairs and a small table, and I purposefully did not stay at the head of the table but chose to stay close to the interviewee, not to show any signs of superiority. This was also important so that the Dictaphone was placed in a place that could pick up both voices. As Polit and Beck (2010) suggest, the circumstances under which data are gathered are critical not only to create a comfortable place but also to provide a non-judgmental atmosphere in which participants feel free to behave naturally. Having felt prepared also ensured that I could be fully engaged with the participant (Rubin and Rubin 2005).

The purpose of these interviews was to access the specialist nurses' world and to capture their views, opinion and feelings on their role and development, thus providing me with a better understanding of the specialist nurses' realization of this concept (Brown 2013). Through these interviews, the expectations and experiences of these nurses were explored, aiming at providing information about factors affecting the development of their advanced nursing roles. Thus, I was cautious to ask the correct type of questions as outlined below. An effort was made to avoid jargon, leading questions, multiple questions at a time, and questions that can be answered with a simple yes-no response (Merriam 2009). Finally, the analysis was carried out concurrently with the data collection (Rabiee 2004) and was completed after nine interviews, since no new themes emerged from the data and theoretical saturation was achieved. Lincoln and Guba (1985) call this 'informational redundancy' which denotes that no new concepts or dimensions for themes can be identified. The full method of data analysis will be explained in Section 3.10 in this chapter.

3.6.2.3 Asking the ‘right’ questions

In addition to the guide that I had tested, I also used the recommendations for asking questions by Strauss et al. (1981), as cited in Merriam (2009). They proposed four kinds of interview questions that I used throughout the interviews as well as the Focus groups. These included:

- Hypothetical – hypothetical questions call for interviewees to speculate about a certain situation or topic. One such hypothetical question was *“What if you were to employ a specialist nurse, what attributes would you look for?”*
- Devil’s advocate – devil’s advocate questions are often used when researchers are interested in interviewees’ opinions regarding a controversial topic. *“Some people say that specialist nurses need a Master’s degree level of education.”*
- Ideal position – ideal position questions are used to garner opinions or information from interviewees about a certain topic or experience. Ideal position questions can begin with *“Describe an ideal nurse-led service?”*
- Interpretive – interpretive questions are used to ensure that the meanings derived by researchers from certain responses are accurate. They can also be used to encourage interviewees to share more information. *“Just to clarify, you said that you believe doctors hinder progress of advanced nursing practice, could you explain this further please?”*

Another important consideration was my position as an ex-colleague and, at the time of the study, a senior nursing manager within the hospital. These positions could have impacted the trust and sharing that is needed for dialogue to occur (Stake 2006). Most of the participants knew me as a colleague; and that could have put me on equal footing and created an information sharing opportunity (Rubin and Rubin 2005). Conversely, being in a managerial position at the time of the interview could have restricted their ‘real’ expression of feelings and perspectives. Thus, before each interview I emphasised the fact that I was a student there and that I wanted to learn from them and that their viewpoint was very important. I also reiterated that although we had the same job role, everyone’s perspective is different; therefore it was important to be open and not to assume that I knew all. On the whole, because of the professional connection, relaxed informal discussions occurred prior to the interviews commencing (Garton and Copland 2010). Moreover, I felt that most of the participants felt comfortable and at ease during the interview and I felt a sense of them ‘telling their story’. This was important since as Oppenheim (2005) explains, the quality of

the interview will depend on the rapport built between the interviewer and the participant who keeps the conversation going and the participant motivated in answering the questions truthfully.

3.6.2.4 Interview Participants (Specialist Nurses)

The profiles of the nine specialist nurses taking part in the interview are described in Table 7 below. The average time that specialist nurses held their post was eight years with one nurse in post for just over two years. All specialist nurses were employed on permanent contracts, eight full-time and one on reduced hours. There were three men and six women. All had extensive professional experience ranging from a minimum of 10 years to a maximum of 40 years. All but one had a Master's degree; two were not related to their area of specialisation. All specialist nurses who participated in the interview stated that they trained abroad, mainly in the UK.

Table 7. Description of participants in Phase 2 – Interviews with Specialist Nurses

Profile of Specialist Nurses for Interviews	Number
Male	N=3
Female	N=6
Age	35-60 Years
Experience in Nursing	10-40 Years
Experience as a specialist nurse	2-11 Years
Full time Posts	N=8
Reduced Hours	N=1
Master's Degree	N=8
No Degree	N=1

3.6.3 Focus Groups – Phase 3

The third and final phase of this case study included focus groups. Four focus groups considered the perceptions of specialist nurses' work and development by key stakeholders. Krueger (1994, p.6) defines a focus group as 'a carefully planned discussion, designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment'. Focus groups could be classified as exploratory, clinical or phenomenological (Barbour 2007). It can be considered as one form of group interview, with the distinguishing feature of group interaction (Kitzinger 1994). In this case study, the focus groups were exploratory and information from group interactions was used as research data (Freeman 2006).

3.6.3.1 Planning for the Focus Groups

Focus groups were chosen to collect data since they were thought to be the most valuable and economical method (Stewart et al. 2007) when exploring the issue of specialist nurses from a group of professional stakeholders. The groups were planned to take between one and a half to two hours. This phase of the research project was particularly challenging since some participants were people in authority that I felt could become defensive. However, it was an opportunity to review and discuss their values and beliefs on the role and development of specialist nurses and the overall aim was achieved beyond expectations. In preparation for the focus groups, there was careful planning of the groups' participation list and back-up list just in case there were withdrawals. A moderator, who had the experience of running and facilitating focus groups, was identified and booked ahead (Greenbaum 2000). The room was also booked well in advance and a couple of days before the focus groups, the moderator and myself went to check what was needed, such as paper and pens, coffee facilities and snacks, and a Dictaphone.

The groups were thought to be best divided according to the participants' background, thus consultants were in one group, the directors/managers of nursing in another and the multidisciplinary group in another. This method is called Homogeneous sampling technique (Patton 2002) and a full explanation is found in section 3.5.5. and 3.5.5.2. The aim was to create meaningful discussions and ensure that the participants invited to the group were able to contribute and generate rich data (Patton 2002). Additionally, being amongst peers was thought to make the group feel more secure by reducing possible feelings of vulnerability (Patton 2002). Another key component of the focus group was the topic guide that was developed (Appendix 5) for these groups (Parahoo 2006). The questions for the focus groups were drawn from the survey and interviews, and I formulated short phrases as prompts that were found to be helpful in directing group discussion. I employed the same skills as I explained and used in the interviews in section 3.6.2.3, to ask the right questions and keep the discussion flowing (Strauss et al. (1981), as cited in Merriam (2009)).

With regards to the stakeholders' focus groups in Phase 3, identified potential participants were invited by email and were given the option to refuse to be included in the study. Emails were collated and sent as a blinded group email with a calendar invite through the Health Service intranet. This was thought to help the process with keeping a list of who accepted or declined, and facilitated a structured response for me to follow. Over a period of one month I added on and invited potential participants with the aim of attaining the numbers

in the groups close to eight. This was successful and all three groups were well attended. The third group, consisting of medical consultants, was found to be the most difficult because most of them work only in the mornings in the General Governmental Hospital and in the afternoon most have private practice. Thus, 13.30 hrs. was the chosen time. All invitees were reminded the day before the focus group, again by a group email, and a text message was also sent in the morning on the day. After each session, a thank you email was sent out to all the participants in the focus groups. Most wrote back with positive feedback and stated that it was a well-organized focus group and that they enjoyed the experience and thanked me for inviting them. Some of the emails I received were truly encouraging and continued to motivate me.

After the second group and on reflection I noticed a gap in the people chosen, especially when it transpired that the groups were looking at specialist nurses from different angles. This was later confirmed when the third group involving the consultants took the conversation and discussion to new heights. Although all the focus groups' discussions yielded very rich data, it showed that the stakeholders' perceptions were taken from different viewpoints. Thus, it was felt that the involvement of nurses from the wards was needed to explore their perceptions of specialist nurses. The addition of this focus group is in line with case study design that allows the flexibility with a rationale for one's activities (Merriam 2009). This is also consistent with the constructivist philosophy that advocates for the study design to be allowed to emerge as the researcher interacts with the participants and begins to understand important issues (Appleton 2002). As Appleton (2002) explains, the researcher is unlikely to be clear about all aspects of the case at the beginning of an inquiry and process is likely to unfold as the study progresses. Thus, the fourth group was planned. No further ethical permission was needed since I had originally asked to have four focus groups, and this group of professionals was integrated in it. Staff nurses and charge nurses were considered closer to the patient and were asked to participate. What was different about this group was that due to the shortages on the wards, it was decided that the invitation would be given on the day that the group was set. After identifying the wards that could have nurses that fit the criteria, I invited the nurses through their charge nurse. This method is called a nominated purposive sampling technique (Patton 2002) and a full explanation of the participant selection is outlined in section 3.5.5 and 3.5.5.2.

3.6.3.2 Focus Group Participants

There were four focus groups with six to eight members each providing a total of 28 participants. A description of the groups is given in Table 8. Focus group one included members of the multidisciplinary team and was made up of a charge nurse, a pharmacist, a midwife, a medical doctor, a practice nurse working in practice development, a senior physiotherapist and a senior occupational therapist. The session lasted one hour twenty two minutes in total and all participants stayed for the duration. Focus group two was made up of most of the directors in nursing and senior nurse managers leading nursing in Malta. There were a total of eight and they came from a variety of backgrounds including the general hospital, strategy, elderly and oncology hospitals. Most of these directors/managers were involved in policy and were directly or indirectly involved with the Nursing and Midwifery Council. Focus group three involved six medical consultants that worked directly or indirectly with specialist nurses and included areas of dermatology, anaesthesia, surgery (N=2), pathology and infection control. They were purposefully chosen because of their experience and knowledge of specialist nurses. This session lasted for one hour. Focus group four was made up of nurses including three charge nurses and four staff nurses coming from various areas that utilise the services of specialist nurses. They included a nurse from the discharge liaison unit, medical ward, orthopaedic ward, paediatric ward and the neurosurgical unit.

Table 8. Description of participants in Phase 3 – Focus Groups with stakeholders

N	Focus Group One	Focus Group Two	Focus Group Three	Focus Group Four
	Multidisciplinary	Nursing Directors/ Managers	Consultants	Nurses/Charge Nurses
1	Physiotherapist	Director Nursing Policy	Dermatology	Surgery
2	Occupational Therapist	Director Nursing General Hospital	Pathology	Neurosurgery
3	Pharmacist	Chief Nursing Manager Policy	General Surgery	Orthopaedic
4	Doctor Policy	Chief Nursing Manager Elderly	Breast Surgery	Medicine
5	Charge Nurse	Chief Nursing Manager Oncology	Anaesthesia	Paediatrics
6	Practice Nurse	Senior Nursing Manager, Oncology	Infection Control	Discharge liaison
7	Midwife	A/Chief Nursing Manager, General Hospital		Day Care
8		A/Senior Nursing Manager, Outpatients		

During the actual focus groups, careful thought was given as to when I intervened or not, either in directing the group or when giving explanations (Patton 2002). For example it was pertinent to explain what my focus on specialist nurses was, but when it came to the role of specialist nurses I had to literally control my instinct to intervene and explain the roles of specialist nurses. One poignant example was when one of the participants stated that specialist nurses should not be expected to do the actual work but should be used on a consultation basis only. Another instance was the explanation of the different types of specialist nurses that existed in Malta at the time, especially when a particular participant veered away from the study topic of specialist nurses and discussed issues that were not related to this study. At this point I thought it important to redirect the focus of the group by explaining that not all specialist nurses have a hands-on role with the patient, like the infection control nurses and the IT nurse. So careful consideration was given to what I said during these groups so as to direct the group but not influence their thoughts.

3.7 Case Study Analysis

Following the constructivist philosophy I used an inductive approach and coded the text openly from the data (Creswell 2009). Additionally, in keeping with the constructivist orientation, I was committed to giving a ‘voice’ to the participants’ with their multiple experiences and meanings as reported by them (Braun and Clark 2012). However, as Braun and Clarke (2012) explain, in reality it is impossible to be purely inductive since researchers always bring something to the data when they analyse it, and they rarely ignore the semantic content of the data. Therefore, I outlined these elements in my frame of reference and reflexivity section in chapter 3 (Section 3.4) and was aware of what influences I could bring to bear on the study. I also established that the process of data analysis involved thinking and theorizing about the data that provided the rich informative story at the heart of the case. The following section will discuss the process used in data analysis and will include the transcription phase and the thematic approach employed by Braun and Clarke (2006).

3.7.1 The process used in this Case Study Analysis

Data analysis in this study was done in a sequential manner and then put together as one database for further holistic and in-depth analysis (Creswell 2007). As suggested by Merriam (2009), data analysis started during data collection rather than after collecting all data. During this research, all data, notes, and documents were stored using a Microsoft Word

document and I organized them in such a way that they were understandable and retrievable (Saldana 2009). After transcribing the interviews and coding and sorting out the themes manually, initially using paper and colours and then cutting and pasting into the Word document, I felt it unnecessary to use the NVivo programme that I had anticipated using at the outset. I was also aware that as the National Institute for Health Research (NIHR) (2009) emphasised, there are no short cuts to the demanding process of reading and re-reading the data, sorting, categorizing and analysing the data. Thus, seeing that the data were manageable and the software is a tool that cannot replace me as the researcher to think, reflect and analyse (NIHR 2009), I felt comfortable and confident to still be able to produce a good thematic analysis without the use of the computerized programme.

The first phase analysed the quantitative data that included the facts of the group, and included their background, experience, role and demographic data. The data were then inputted into Microsoft Excel and analysed descriptively. Initially, the raw data included percentages; however, since the sample only consisted of 27 participants, the percentages were removed as it was not thought to add any value to the description of the data (Polit and Beck 2010). After the quantitative analysis of the survey, the interviews and focus groups followed and this was done on an ongoing basis since I needed the information to continue formulating, adapting and improving the format of the interviews and focus groups to yield the most information and also to know when to stop collecting data. As mentioned previously, I stopped collecting data when I reached data saturation and felt sure the data collected were sufficient to answer the research question. Merriam (2009) supports this method since ongoing data analysis ensures that the data collected are not unfocused and repetitious. For both stages two and three, I converted the audio-recordings into type-written word-for-word transcripts and in both phases, this was followed by a thematic analysis intended to produce major issues of interest.

3.7.2 Transcription

Accurate transcription is essential to the validity and reliability of qualitative research (Easton et al. 2000). The interviews and focus groups were audio recorded and then transcribed orthographically, reproducing all spoken words and sounds, including hesitations, (indicated by mm.hm, ah. Ha), laughter, long pauses (indicated by pause) and strong emphasis (indicated by under-score). Inverted commas were used to indicate reported speech, and three full-stops in a row (...) signalled editing removing any words or clauses. To keep anonymity

some minor changes were made to the text after transcription. This mainly happened when they mentioned their areas, their consultants or their specialities. For instance, rather than naming their specialist area as *educating the patient in stoma care management*, I altered it to *education management* in the area. If they mentioned infection control or health and safety policies or guidelines, I removed the title of the guideline, unless generic, and stated developed guidelines on related subjects. I also removed names of directors and if only one director existed I changed it to *higher authorities* or *senior management*. This process was done with great attention since I did not want to lose the significance of what was being said or in any way change the meaning of the conversation (Polit and Beck 2010).

3.7.3 Thematic analysis – Braun and Clark (2012)

Thematic analysis as described by Braun and Clarke (2012) was chosen as the method of qualitative data analysis for this case study. Their six-step approach was perceived as being clear and offered direction on the mechanics of coding and the process of qualitative analysis (Braun and Clarke 2012). In turn it allowed me to make sense of collective or shared implications and experiences, identifying unique and distinctive meanings (Braun and Clarke 2012). Using such a method follows Merriam's (1998) recommendation of using a structure during analysis because as she states, "*historically, data analysis in qualitative research has been something like a mysterious metamorphosis. The investigator retreated with the data, applied his or her analytic powers, and emerged butterfly-like with 'findings'*" (p. 156). In this statement, Merriam (1998) implies a lack of transparent processes and commends the analysis to be systematic, sequential and verifiable. This is paramount because as Attride-Sterling (2001) points out, it not only serves to enhance the value of the findings' interpretations, but also aids other researchers wishing to carry out similar projects.

Common to all forms of qualitative analysis the first step involved immersing myself in the data and reading and re-reading textual data (Braun and Clarke 2012), whilst listening to the interviews and focus groups at least twice and sometimes more, depending on the clarity or the points being made (A sample of an interview and focus group can be found in Appendix 10 and 11 respectively). The reading of the text was *active reading* in that I started thinking about what the data meant critically (Braun and Clarke 2012) thus enabling me to start the coding exercise. Coding is defined by Gibbs (2007, p.38) as "a way of indexing or categorizing the text in order to establish a framework of thematic ideas about it".

Specifically, coding provided the opportunity to retrieve all the passages coded with the same label and combine them together to create an overall picture of the same phenomenon.

As the extracts of data were coded the codes were written down and the text marked. Some texts were used more than once. For example, when talking about prescribing: this was included in the section of Role Development, Prescribing as a Role, and Medico-Legal Matters. Once all the data were coded a Word file was created and the coded material was cut and pasted into it. In the interviews a colour-coded system was used for each participant so I would easily identify where this information originated. With regards to the Focus Groups, all participants had a code and the groups that the excerpts were taken from were colour-coded for ease of reference. An example of this process for the interviews and the focus groups is provided in Appendix 10a and 11a respectively. There is no right or wrong way to manage the physical process of coding, but this system worked for me since I collated the coded text as I went along coding and recoding. What I kept in mind was what Braun and Clarke (2012) stipulated; what is important is that coding is inclusive, thorough and systematic.

3.7.4 Data synthesis

A fundamental component of a case study approach is the requirement to ensure effective data synthesis (Merriam 2009), or as it is termed by Yin ‘*convergence*’ (Yin 2009). After the initial inductive system of analysing each data set individually, the data sets were pooled to form one data set (Yin 2009). In this way, all data were treated with equal importance to enable the richness to be drawn out. After all data were combined as one text, the next step involved the methodical coding into emergent categories. This phase involved reviewing the coded data to identify areas of similarity and overlap amongst the codes and to identify broad topics or issues across the three data sets. Many codes clustered around the development and ‘journey’ of the specialist nurses in Malta with a specific emphasis on the support and preparation of these professionals. The developing categories were then reviewed in relation to the coded data and the entire data set. This was essentially about quality checking and involved checking the codes and categories against the collated extracts of data. An example of this process of categorisation is illustrated in Table 2 (A) (Appendix 9).

I then started the process of constructing themes and this is when the analysis started taking shape. According to Braun and Clarke (2006, p.82) a theme: “captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set”. The other aspect of this phase was

working out what to call each theme. The themes chosen aimed at being informative and focused on answering the research question and the objectives of the study. Analysis on three important themes emerged: roles and attributes, the trajectory of their development and the influences affecting the advancement of specialist nurses. The end version of the process of identifying a theme is illustrated in Table 3 (A) (Appendix 9a). This table aims at outlining the way I constructed the third theme from my interpretation of the pooled categories from all three data sets. The participants' 'voice' is in the first column followed by my interpretations in the second leading to the last column describing the theme on the wider influences affecting the advancement of specialist nurses in Malta. Following the construction of the three main themes, the data were then further analysed and compared to ensure that all data from all methods were utilised. An example of this process is found in Table 4 (A) (Appendix 9 b) and illustrates how I brought together related categories from all data sets that connected to the theme identified as the Roles and Attributes of specialist nurses. Finally to provide order to the data, I designed data analysis tables. The tables were simple but provided a central position for text that had been identified to a specific theme. As Braun and Clarke (2012) emphasize, data do not speak for themselves thus simply paraphrasing the content of the data would not be enough. Relevant data were grouped together using in-vivo coding to ensure that the data analysis stayed as close as possible to the participants' contributions. An example of the data analysis table is provided in Table 9.

The final phase of the analysis was producing the report that intended to provide a compelling story about the specialist nurses in Malta. The report writing of the findings of this study followed suggestions made by Braun and Clarke (2012) who advised avoiding repetitions and unnecessary complexity. Careful selections of the themes were paramount to connect logically and meaningfully and provide the participants' story. Throughout the report data extracts were used with interpretations that were relevant in indicating how they answered the research question. Examples were used to provide the reader with a pattern and confirmation that what was being written was really evident. In addition, the overall analysis was revised and scrutinized and as Yin (2009) recommends the data were compared iteratively to the study's objectives and research question. This was demonstrated in Table 11 in the findings Chapter (4) that presented the findings and conclusions in a complete picture of the case.

The data collection and analysis proceeded concurrently, resulting in an attempt to examine and understand key issues surrounding specialist nurses in Malta. This level of

analysis assisted in bringing together meaning of specialist nursing in Malta. True to the constructivist paradigm I regarded the data as emergent (Appleton 2002) and accepted that I, as the researcher, would unavoidably have views on what I might expect the results to be, based on my knowledge and experiences. However, throughout the analysis I was reflexive and made a concerted effort to let the text speak for itself and to listen and construct what was being said by the participants (Appleton 2002). As the research involved multiple data collection sources, the synthesis process had to ensure that the data gathered from all the methods were compared to ensure that I could code them into emergent categories and then themes (Hewitt-Taylor 2001). Due to my subjectivity, I consciously included a detailed description of the events and process of 'how' the analysis was carried out (Krueger and Casey 2000). I also specifically used Braun and Clark's (2012) approach to thematic analysis to reduce the potential for bias, and to demonstrate the systematic and sequential method undertaken. In this way I also aimed at demonstrating thoroughness and credibility of the analytical process (Merriam 2009). The next section will discuss further considerations taken to increase rigor and trustworthiness and ultimately improve the integrity of the outcomes of this research.

3.7.5 Rigor and Trustworthiness as applied to this study

Lincoln and Guba (1985) conceptualize trustworthiness as the mechanism of persuading readers of the research that the process and subsequent findings of enquiry are worthy of attention. To enhance the credibility of this case study several actions were taken, as evident from the previous discussion, to ensure the robustness of the process and subsequent findings (Rolfe 2006).

Primarily, multiple sources (Merriam 2009) of evidence were used together including a survey, semi-structured interviews and focus groups. The survey data from the first phase permitted triangulation of the data with the information from the second phase of the case study, since the responses from the survey and the interviews from the same participants could be compared and analysed. Thus, this could promote data credibility or 'truth value' (Lincoln and Guba 1985). As Baxter and Jack (2008) explain, triangulation of these data can provide comparison, convergence and also confirmation of findings that could improve data quality. The inclusion of another dimension of the case by studying the stakeholders' experience further provided understanding of the case under study. This, not only facilitated a holistic understanding of the specialist nurses (Yin 2003; Baxter and Jack 2008), but also

intended to increase data credibility by providing convergence of the data that adds strength to the findings and is associated with rigor (Creswell 2009).

A decision was made prior to commencing the research that member checking (Lincoln and Guba 1985) would be used. Therefore all the interview transcripts were sent to participants for verification to reduce the risk of me inadvertently biasing the data (Lincoln and Guba 1985). Member checking is thus recommended because it ensures that the data remain 'true' or trustworthy. However, I was aware that allowing the interview participants to read the transcripts could have led participants to change their responses once they had had time to consider them in more detail. In particular, they might have been concerned about their frank responses to questions about their managers or the system, particularly when they were less than complimentary. (Sandelowski 1993; McDonnell et al. 2000). Notwithstanding this, I wanted to gain the participants' confidence and trust prior, during and after interviews, and this I believed was an important part of the process. In fact, all the participants did not change any responses. With regards to the focus groups, the decision taken was not to send the transcripts to the group for practical reasons since there were multiple participants and this could have complicated and stalled the process of analysis. The decision was made mainly due to time constraints. Nevertheless, for reasons of rigor and to maintain the real and true 'experience and narrative' of the participant (Merriam, 2009) I chose a process of asking the moderator who was present for the focus groups to double check the transcripts and also the themes and interpretation from the data. This was thought to be important since I was the sole researcher and was not presenting the focus group participants the transcripts (Easton et al. 2000).

Rigour and trustworthiness in this study was also assured by the transparency of decision making during the research process and the final study findings (Lincoln and Guba 1985). The description and detail provided in this study is thought to provide the necessary clarity of my thoughts and actions. This was also supported by maintaining a case study database where all the written and electronic information was attentively stored in a recognised, chronological order. Yin (2009) refers to this as the 'chain of evidence'. I stored all data securely and will continue to do so for five years after the end of this Doctoral thesis. I keep all versions of the chapters that could be retained to indicate how the final work developed. The documents can show how the research started, progressed and finalized in a detectable and clear process.

Additionally I used reflexivity throughout this case study to ensure rigor and trustworthiness of my research. A daily diary is sometimes suggested to capture reflective thoughts and to challenge ideas and create new perspectives (Koch 1994), but this may not be practical. Moreover, as Finlay and Gough (2003) explain, reflection can occur within oneself without committing those thoughts to paper. Although I did not use a personal diary, I did keep a journal and took note of issues and activities that needed particular attention, discussion and reflection. I further discussed any concerns with my supervisors or colleagues.

I acknowledged my personal contributions as the researcher and the impact that it might have upon the final findings. I specifically devoted a section of this chapter to ‘the self’ and explained the importance and process which was instrumental in enabling me to identify my location as a nurse, a person and a researcher. This reflexive process (challenged my thoughts on how I could have influenced the development and findings of this research. I also consciously gave a rationale for my choices and thoughts and made these explicit throughout the study, once again for transparency, understanding and ultimately credibility.

Table 9. Data Analysis Table

Theme: Roles and Attributes of Specialist Nurses What was said and by whom?	Category	Interpretation	How does this relate to the Research Question?
<p><i>All specialist nurses (N=27) in the survey identified inter-personal skills as being the most recognised skill that was essential to the role.</i></p> <p><i>“the unit can easily isolate a practice nurse but the practice nurse has all the ability to integrate very easily...better communications, not only with the nursing staff but during Multidisciplinary meetings ...(FG 2.D,5)</i></p> <p><i>“Apart from the knowledge, it is all about the way they deliver... the approach, if the specialist nurse is here (gesticulates to show a difference) and the ward nurse is down there, I see it from my staff, they will see you as someone to avoid.”(FG4.N, 3)</i></p> <p><i>“You really have to be a people person so that people will end up coming round your way without even realising. So if you are going to improve an area you need to get everyone on board.”(FG1. MDP, 6)</i></p> <p><i>“A specialist nurse, ...you need to manage other people, you need to have communication skills, and you need to be diplomatic, I must say, at times you need to be, sometimes assertive, but there are times when you need to dictate, you know, so you need those skills. Communication as I told you, and a theoretical background.” (SN 6)</i></p>	Good communicator	Specialist nurses' communication was deemed essential both with patients and staff.	Agreement between specialist nurses and stakeholders that they need to be strong communicators with the right approach –related to their role and attributes
<p><i>“Personality, because I believe that to carry this role you have got to be assertive, you have got to be a fighter, a good communicator, you have got to be committed, to what you are doing and believe and then you have the three Ps, persistence, perseverance and patience because without those you will go nowhere.” (FG 2.D,6)</i></p> <p><i>“So yes, ensuring quality and sharing of information, dissemination and ensuring that a whole section of people have learnt new techniques but being passionate about the job they do and having the personality does come into it.” (FG1. MDP, 4)</i></p> <p><i>“What I mean by perseverance is that she has to be strong willed and not easily disheartened (FG1. MDP, 6)</i></p> <p><i>“You have to be passionate that is true about the role that you love it and that you get excited about it,” (FG 2.D,2)</i></p> <p><i>“I think that they really need to love the job they do, they need the passion to do it.” (FG4.N, 5)</i></p> <p><i>“It is a package and one of them is that you are nice with everybody. Nice means this unconditional support even phoning from home ...Friendliness is another important factor.” (FG4.N, 1)</i></p>	Personality, being pleasant but passionate and perseverant. Motivated and dedicated.	Specialist nurses need to have a people personality with a passion for their job and resilience. They need to be strong but open and patient.	Directly linked with the attributes needed by specialist nurses on the personality of the specialist nurse. There is also agreement between the stakeholders and the specialist nurses themselves on the need to have the right personality that is strong, perseverant, motivated and enthusiastic.

3.8 Ethical Considerations

My first duty as a researcher is to ensure that the research shall not harm any participant. As the National Research Ethics Service (NRES) (2011) states, the researcher should:

“protect the rights, safety, dignity and well-being of research participants; and facilitate and promote ethical research that is of potential benefit to participants, science and society”. (<http://www.nres.npsa.nhs.uk> 2011).

Ethical considerations and implications were deliberated throughout this research, from the planning of the case study, the selection of participants, right through to the report and future publishing of the findings. In addition to considering the risk of harm to any of my participants during and after the study ended, I also felt a moral and ethical obligation to provide a quality piece of work that will yield the benefits to the participants, the profession of nursing, the authorities and most of all to the patients. Polit and Beck (2010) state that consideration must also be given to the subjects' time and energy to make sure they are as free from constraints as possible. In this study, the participants were given an indication of the possible duration of the time required from them for the particular data collection activity so that they could plan their day in advance and not cause undue stress on themselves or their patients. It was also thought to be courteous and show appreciation for their time. Since the study centred specifically on specialist nurses in Malta, and without their active participation it would not have been successful, they might have felt coerced into taking part. Moreover, since the focus was both on individual and group participation the participants might have felt exposed and vulnerable. Therefore I had to ensure that measures were taken to avoid these feelings or recognize them if they happened. I discussed with colleagues and mentors methodological arguments and techniques, including sampling varieties, triangulation and monitoring bias and their ethical implications (Zucker 2001). In any correspondence or at any encounter with the participants I emphasized their freedom not to participate or to withdraw at any time. I further explained that the project was monitored and reviewed by the service manager who was approached to gain their approval to undertake the study. Their approval was important since the study involved the nurses talking about their everyday practice as specialist nurses.

3.8.1 Gaining Participants' Access

Permission to conduct this study was given from both the director of nursing of the general hospital and the director of nursing for Malta (Appendix 12). Approval was also gained from both the ethics committee under the auspices of the University of Malta and the Research Ethics Committee at Bournemouth University (Appendix 13). I identified the directors of nursing as the key gatekeeper to the research site and in relation to nursing since the Maltese Health Authorities did not have their own governing board to review research proposals. However, I followed the usual process of gaining approval from the ethics and research board of the University of Malta and then gaining permission from the hospital authorities. There was no written guideline in place at the time of seeking approval, but the process of gaining approval enabled me to ensure that I had fully considered every aspect of the research study and the anticipated impact on individuals.

Following a successful one-to-one meeting with the director of nursing, approval and support was obtained. Prior to conducting the study, arrangements with the Chief Nurse (at the time) took place regarding any 'difficult' issues which may be brought up by participants during the study. In case this happened, the participants would be directed to their respective manager for support and if it could not be dealt with then the Director of Nursing Services of the hospital would intervene. An information sheet with the details of the study together with the consent form (Appendix 8) was sent to all potential participants via email prior to the data activity, thus ensuring enough time for them to read or ask questions before consenting. Notwithstanding this, prior to the interview or focus group, participants were once again verbally informed about the aim of the study and their right not to participate or to withdraw at any time without giving a reason and without prejudice. They were also reassured that they would be free not to answer questions that they feel uncomfortable about. None of the participants stated any concerns about the research and no problems were encountered that needed intervention from the nursing manager.

3.8.2 Anonymity and confidentiality

Confidentiality and anonymity are terms that are sometimes used interchangeably and as Brown (2013) explains are two concepts that are inextricably linked and equally distinct. The definition of confidentiality is "intended to be kept secret" and anonymity is "not identified by name" (Soanes 2002). Anonymity was safeguarded during and after the study in the following ways. The name and personal details were not recorded on any of the data and a

unique code was allocated to the participants for the questionnaire, interview and/or focus group. The contact details were only kept by myself and stored in a file on my personal computer which was password protected. During the focus group sessions, which were digitally recorded, individuals chose a fictitious name and during transcription a unique identifying code was allocated so that they would be identified as a person participating in a particular group but not identified with their real name. The recordings and transcriptions are and will be stored securely for five years after the end of this Doctoral thesis and then destroyed.

Confidentiality could not be guaranteed for the focus group participants in this study since any of the participants might have breached that confidence outside of my control (Brown 2013). However, assurance of anonymity – that nothing will be attributable and therefore identifiable to a named person – was given and explained prior to the focus groups and also the interviews. Notwithstanding this, according to Oppenheim (2005) anonymity could only be guaranteed in certain circumstances when the researchers cannot identify their respondents. This was again not possible due to the nature of one-to-one interviews and also for the focus groups. Notwithstanding this, I assured them that the data provided by them would only be used for the purpose of this research study and respondents will not be identified under any circumstance in the material produced and published. All attempts to protect their anonymity were made with regard to their specialism, place of work and role. During transcription I deleted any reference from the text that mentioned any identifiable characteristic as explained in section 3.10.3.

3.8.3 Power relationships

Qualitative research approaches propose a relationship between me as a researcher and participants, characterized by dialogue, mutual respect, as well as the co-involvement of both participants' subjectivity throughout the research process (Wiesenfeld 2000). However, striving for a level of egalitarianism between me and my participants may not be possible because as Anyan (2013, p.3) explains "*regardless the interviewer's deliberate attempt to shed off power to appear less powerful, the interviewee may perceive the interviewer as possessing a greater power*". Notwithstanding this, I believe that the first and most important step is to recognize this power difference that creates an imbalance in the relationship when conducting research, and then working towards reducing it. Additionally, ensuring that the research participants were appropriately supported and valued during the research process,

and remaining true to my epistemological thoughts were paramount to me. Thus, throughout this study I was keen to minimize the power relationship gap by consciously expressing the fact that I am a student eager to listen and learn from the participants, and through reflexivity (see section 3.5.1) recognizing the particular bias of my own history and its influence on my approach to the object of study and interpretation of the participants' accounts (Ritchie and Lewis 2003).

In this study, I knew most participants in broad professional contexts and although this shared community was useful for recruitment since engagement was not a problem, I was aware that studying members of a group to which I belong has both advantages and threats. As Chew-Graham et al. (2002) noted, perception of the researcher as a peer with a shared understanding can make participants less cautious, resulting in more genuine data or, in contrast, cause them to compete or seek to impress the researcher. Moreover, I considered this power imbalance from two perspectives; a) that I was the person who chose the topic and context with which I was more knowledgeable and b) that I had access to the participants' information and intimacy but not the reverse. Wiesenfeld, (2000) explains that in qualitative research a symmetrical relationship does not exist and as Anyan (2013) explains this is related to power relations that are not equal. Both the interviewer's scientific competence and the interviewee's behaviour to affect the information given are instances of power manifestations in qualitative research. Hutchinson and Wilson (1994) point out some examples of participant power, for instance, during data collection participants can use various manners such as social desirability to please the researcher and can also shift the focus of the interview by not responding to the questions being asked. Ultimately participants also have the power to decide to terminate the interview. Conversely, during data analysis, the researcher maintains the power since they have to report what the participant said. As the only researcher in this study, I had to consciously interpret and report the experience of the participants into a new historical and socio-cultural context (Karnieli-Miller et al. 2009) but maintain the essence of what they really meant. Accordingly, as Wiesenfeld (2000) asserts, qualitative research calls for a researcher-participant relationship in which the participants' life experience and the meanings they attribute to it are reported in a climate of equality and mutual respect.

I was particularly attentive during the interviews and focus groups by positioning myself next to the participant and not at the head of the table, and emphasising the fact that participants had the choice to stop the interview or to stop taking part in the focus group at

any time. This was important since according to Anyan (2013) it gives 'power' back to the participant. On the other hand, to be able to achieve my agenda I needed to sustain the interview situation by influencing the interviewee to stay and respond to my lines of question. However, as required of interviewers, I had built a healthy rapport with the interviewees and so after explaining why I needed the recording and their consent it was important not to pressurize or coerce them during the interview or focus groups for disclosure of sensitive information. As much as possible I endeavoured to establish the rapport by discussing my academic background before each interview and focus group. As Karnieli-Miller et al. (2009) assert, to gain the experiences of the participants the researcher must enhance the sense of rapport between them and build a sympathetic relationship and a sense of mutual trust in the research interview. To instil a sense of trust I invited the interviewees to read the transcription of their interviews but due to time constraints and practical reasons I was not able to offer this to the focus group participants. However, I involved a moderator during the focus groups and emphasised that my interpretations of these focus groups will be discussed with the moderator to further assure that I would be interpreting their experiences as truthfully and representative as possible. I also assured them that they would be given the results and or thesis if they so wished a copy.

To further compensate for power imbalances, during the analysis I looked at the data from several perspectives to reflect on my own drives within the interpretations. As Hammarstrom and Alex (2007) state, these practices help to minimize experiences of power problems because they unveil the researcher's awareness of how knowledge is/was created, which is referred to as practising reflexivity. I considered reflexivity an important aspect throughout this study because it helped me become more self-aware of my beliefs and biases that could affect the research and the participants. Additionally reflectivity helped me identify unexpected critical situations and deal with these in an appropriate ethical way (Guillemin and Gillam 2004), as explained in section 3.5.1.

The discrepancies I express above and the suggested paths of being aware, respectful and appreciative to the participants were followed to overcome some of the power issues within this qualitative research. Moreover, I acknowledged the fact that there are different versions of power relations and experiences, and understanding this power asymmetry between the participants and myself and its countermeasures has provided a greater understanding of minimizing the power dynamics during data collection and analysis, which has contributed to making the study more trustworthy.

3.9 Conclusion

This chapter discussed the constructivist philosophy and critically appraised both the chosen methodology and tools used within this qualitative case study. I clarified my ontology and epistemology to afford a better understanding of the foundation for this research and provided thick description of the whole research process. I made explicit justifications for choosing Merriam's (2009) case study approach, ethical considerations, data collection methods, sampling and analysis techniques/procedures. A holistic understanding of the undertaking of this case study intended to provide transparency and help with the transferability of the results. Finally, the chapter concluded with a critical review of how I considered trustworthiness to produce credible and worthy findings. The next chapter will describe the study findings.

4 Findings

4.1 Introduction

This chapter presents the main findings of this case study and brings together the data from the survey with all the 27 specialist nurses, the interviews with nine specialist nurses, and the four focus groups with the stakeholders' perceptions of these nurses in Malta. In presenting the findings, all exemplars from the interview transcripts and focus groups are anonymized as necessary. All references to the gender of the specialist nurses were changed to 'she' or 'her' to preserve the anonymity of the fewer male participants and all reference to their area was removed and replaced with generic terms like *clinic*, *specialist area* or *specialist*. Thus, quotations used within this chapter are not attributed to site, title, specialist unit or specialisation to preserve anonymity. For that purpose, the nine specialist nurses were called SN1, SN2, SN3, SN4, SN5, SN6, SN7, SN8, SN9. For the focus groups they were also coded according to their group and given a number. To facilitate the description of the findings and still provide context of a group opinion, the groups and participants each had a code that would be used. Therefore, focus group participants were allocated a code that included the focus group and a code in front depicting the professional background so; FG1. MDP,5 meant this person was in focus group one and came from the multidisciplinary group and was the 5th person in this group. (FG2.D,8) D was for the Directors group, (FG3.Cons,4) Cons was for the Consultants and (FG4.N,2) N was for the nurses.

The findings of these data sets will be combined and structured in response to the study objectives and in answering the research question *How do SNs in Malta explain their roles, development and experience and do these concur with those of their stakeholders?* Thematic sections will be structured into three main parts:

- Part I The roles, attributes and preparation of specialist nurses
- Part II The development of specialist nurses within the Maltese health services
- Part III The influences on the advancement of specialist nursing practice in Malta

Part I will focus on the roles and attributes of specialist nurses in Malta as identified by the participants, and will include related topics such as professional leadership and research. It will also discuss the findings related to extended and expanded roles. Part II will focus on the experiences expressed by the specialist nurses and their stakeholders on the development and support for these posts. Part III identifies key aspects that influenced the

advancement of specialist nursing practice in Malta. The findings will begin with a short summary of the survey results outlining the profile of specialist nurses in Malta.

4.2 Profile of Specialist Nurses in Malta (2013)

The survey provided a profile of the characteristics of specialist nurses in Malta and shed light on the roles and work situations. The objective was not to engage in deep thought but to give an overview of their roles and background. The Survey was carried out in 2013 and addressed the whole population of 27 specialist nurses in Malta. Table 10 presents an illustration of these nurses' profiles. The survey aimed at identifying a series of descriptive data including biographical information, their working environment, qualifications, training and support for their continued professional development. The participants were then asked to provide details as to how they allocated time to the different aspects of their working day in an attempt to explore and conceptualize their roles and included a range of activities and referral systems they assumed. The next section dealt with managerial and developmental issues relating to their job description, career pathways and future intentions. Finally, the survey explored these specialist nurses' views on the evolution of their roles, the support they received, working autonomy and their understanding of the way they were perceived both by their patients and other professional groups. Except for the descriptive data, all the other information will be integrated into the case study findings and will be included within the thematic headings.

The results concluded that the breast care clinics had the most specialist nurses N=5, with three specialist nurses working in the general hospital and another two working in the breast screening unit in Primary Healthcare. The infection control department was another area with three specialist nurses in the Acute Hospital and one in Primary Healthcare. There were also another two areas that had two specialist nurses in the unit, namely the Diabetes unit and the Stoma Care unit. All other specialist nurses (N=15) worked by themselves. It was also of paramount importance to note the paucity of specialist nurses in primary healthcare, that only amounted to three specialist nurses in total (two breast screening nurses and one infection control nurse). The majority (N=23) were located in the acute general hospital and one was located in an elderly institution with most (N=21) having a patient case load. The results showed that the average amount of years in post was 6.4 years with most (N=19) being pioneers who started the service themselves.

There were more females N=17 than males N=10 amongst this group of specialist nurses and the age profile ranged from 30 to 60, with most participants being in the age bracket of 40-49 years of age. The results found that out of these 27 nurses no one held a PhD, 12 had a Master's Degree, four had a first degree, seven had a Post Graduate Diploma and eight had a Diploma. Since respondents could have chosen more than one answer it could not be established if specialist nurses had a degree level of education plus a Master's degree or a post graduate diploma and a Master's.

Table 10. Survey Findings – Profile of Specialist Nurses Malta (2013)

Survey Findings		
<i>Variable</i>		<i>n</i>
Specialist Nurses Total Sample in Malta (Table 6)		27
Type of Specialist Nurse	Location	Total
Specialist nurses	General Hospital	23
Specialist nurses	Primary Healthcare	3
Specialist nurse	Elderly Residence	1
Age and gender of specialist nurses in Malta 2013		
Age	30 - 39	4
	40 - 49	17
	50 - 60	6
Gender	Male	10
	Female	17
Established posts in Malta by specialist nurse as of 2013		
Average years in post:		6.4 years (excl. 2 respondents)
Post established before taking up post	Yes	8
	No	19
Specialist nurses in Malta (2013) base and where they see patients		
Based in:	Acute Hospital	23
	Health Centre/Primary Health Care	3
	Elderly Institution	1
Visit Patients	Yes	21
	No	6
Qualifications		
Qualifications	Diploma	8
	Postgraduate	
	Diploma	7
	First Degree	4
	Master's Degree	12

Part I: Roles, Attributes and Preparation of Specialist nurses

This section will focus on the roles and attributes of specialist nurses. It will outline the findings relating to their role in clinical practice, education, research and leadership. Autonomy to practise will also be covered in this section, outlining issues pertaining to their level to practise independently, extended and expanded roles and the training and preparation needed to accompany these roles.

4.3 Roles of Specialist Nurses in Malta: expert practitioner, educator, researcher and leader

Part of the mapping exercise of the survey looked into the roles of specialist nurses and found that less than 50% of their time was dedicated to clinical work, 18% was dedicated to education and training and 14% to management. Notwithstanding this, in the interviews there were other tasks mentioned by the specialist nurses that were not mentioned in the survey. These included procurement of equipment, clerical duties and the organising of clinics for consultants. An area of concern was the very small amount of time dedicated to research (7%). It was evident that specialist nurses received and referred patients from a variety of sources. The majority of referrals came from consultants followed by other healthcare professionals, but a large amount were self-referred. Most specialist nurses referred their patients to consultants, while nearly half of them referred to other specialist nurses and allied health professionals. The role they seemed to participate most in was supporting people to enable them to manage/live with their illness. Health promotion/education and providing counselling also featured as important roles for these specialists. It was significant that of the top five activities, two related to clinical activity (assessment) and the other three related to communication and education to patients and staff. These findings were similar to those found during the interviews with specialist nurses, where information was explicated through description of their roles.

“I did this helpline and I get calls from patients who are...having pains, maybe they are having side effects with their drugs may be they did not understand well how to take their drugs, a lot of these things which take up a lot of your time.” SN 8

“...I realised that patients were treated physically but nobody seemed to give attention to the psychological aspect of the patients, so I decided to study “ SN 9

4.3.1 Experts providing continuity of care

There was unanimous agreement in all data sets that the specialist nurses' accessibility and availability was a service that doctors were not in a position to offer since they did not have the time. Moreover, this availability provided continuity of care.

"... they do a fantastic job, the patients know that they can always talk to them because they are always there, because the consultants are not there every day. So the specialist nurse would be much more accessible. And the nurses are actually doing things for them and showing them how to do and they have much more time than clinicians would have." (FG 3. Cons, 3)

"And what they are offering is continuity. You go there and you find the same nurse, and that is how it should be." (FG 3. Cons, 6)

Most of the specialist nurses who worked clinically and with patients mentioned that they run their own nurse-led clinics mainly where they assess and monitor their patients. They also explained that they see urgent referrals and provide constant support to patients and their relatives. This supporting role was according to the expectations of the stakeholders. In the Directors' group it was described as being that of a case manager that helped their patients through co-ordinating their care.

"Case manager, navigator, case coordinator and we have these nurses who are the patients' advocates and literally, they know how to navigate patients through the system." (FG 2.D,1)

In the Consultants' group, their role was described as supporting what was said during the patient's visit, especially when bad news was given and when offering the patients practical and important information about procedures and medication. This was perceived by most participants as improving adherence to treatment compliance because, as was clarified, some patients needed more time for explanations. Another concept was that patients needed time to accept and adjust to their lifelong condition and that as specialist nurses this was part of the management process.

"So I see her role, as the patients gained since there is someone specialised in that area, and they can talk to her, relate to her, she knows how I work, she knows about the subject and she does research and she reads and she can pass on the information since she knows about the drugs they use, the tablets and the injections. So she is knowledgeable." (FG 3. Cons, 1)

"Or sometimes you get a patient that you notice is not being compliant and it could be because he did not understand anything about the treatment regimen. You notice because he is not applying or using the treatment correctly and it is also an issue of accessibility and safety of the patient because he would go on mixing up the treatments if he would not have come to the clinic or ask on the helpline." SN 8

4.3.1.1 Accessible to Patients and Staff

Nurses in the focus group spoke about the accessibility from their point of view as nurses and expressed the importance of the specialist nurses' willingness to help them. The importance of keeping generalist nurses updated with the latest care, treatment and technology was raised in nearly all groups. It was emphasised that their knowledge should be shared with all staff.

"A specialist nurse in my opinion, has not only to know the knowledge herself but she should be able to share and disseminate." (FG1. MDP, 3)

From the Directors' standpoint, accessibility was seen as being reachable so that the patient load on the general hospital was reduced. One Director of Nursing stated that specialist nurses were picking up problems and navigating the patient through the system since the process could be daunting. These nurses were proving to be invaluable to the patients with whom they come in contact.

"...accessibility so like that we reduce the load on the general acute hospital, and care of the elderly, and there should be such a pathway, or a network where everybody is reachable. ..." (FG 2.D,4)

4.3.2 Educator

The specialist nurse also had a role in educating patients, nursing colleagues and other staff. A couple of specialist nurses spoke about selling their product, being knowledgeable and believing in what they do in this important process. Getting professionals to change their behaviour and practice needed expertise and time to educate. The role of change agent and the ability to introduce innovations and raise standards through education was seen as vital and integral in their role. Additionally, they considered themselves as points of reference for difficult situations. Education, for the patients was perceived as improving adherence to treatment, compliance, as was described by the specialist nurses.

"Another thing which I did was the nurse led clinics which I did myself where the consultants used to refer either for patient education or to follow up or may be when they need to taper their drugs and I help them to do that." SN 8

"My role also involved education and professional development of other nursing staff or other members of the team. How much do I manage to do that? Because we were talking about deskilling staff but if we don't want them to be deskilled we need to make sure that they know about what needs to be done. And how much can we do that?" SN 1

"... finally you can see that you have convinced him, that he is seeing results that he is managing well, and that he has accepted his condition. That is the most important and all this gives a lot of satisfaction. We are constantly there for them." SN 4

“The involvement of the areas, the identification of the problems, the education, the data collection, the feedback to the staff, is a whole process of the actual education, the whole cycle, which we have been doing.” SN 3

4.3.3 Researcher

Research was identified by all specialist nurses both in the interview and in the survey as an essential and important part of their role. However, during the interviews it was noted that they rarely undertook research themselves and stated that they needed more time and training. In the survey it was also noted that only three participants stated that they always initiated research, and it was evident that these specialist nurses did not work directly with patients but were those who had a practice development element in their role. Also, a couple of nurses that did undertake audits did so to appraise the equipment being used as a measure of quality control. Nevertheless, the majority of specialist nurses stated that they wished to audit their work because it could demonstrate their value but they did not have the time or resources to do so.

“We audit for the equipment and monitoring for the quality control - we are auditing as a point of care. I am in the point of care, and last year we went around the wards to see if the quality control, using the control solution, was being done.” SN 4

“...research. I mean personally it is one of the roles of the specialist nurse but unfortunately that is the role that I do least because the role is so time consuming that it does not leave you to do any research.” SN 6

“If we were to be able to audit, we would be able to demonstrate the value of what we are doing. I would like to carry out a study to see what the problems are according to patients and not according to me.” SN 1

Specialist nurses further explained that there were various ways of utilizing and interpreting research and most importantly disseminating this to other colleagues, such as journal clubs and presenting papers at conferences. This was in accordance with the expectations of the stakeholders who spoke about disseminating knowledge and empowering staff.

“We do also journal clubs, somebody finds and presents a paper, we also present topics from the programme of a conference that we would have attended, it is impossible to present all but we choose topics.” SN 2

“It is the ability to share the knowledge because if I have a specialist skill the aim is not for me to hang on to it but to empower colleagues. I am always going to have more skills than others if I am the specialist.” (FG1. MDP, 2)

There was general consensus that specialist nurses should be trained in research and it was perceived that they had more time than ward nurses to keep updated in their specialty. Most of the specialist nurses valued the need for research and knowledge although they admitted that it was not always easy.

“...here it is difficult. You have to do your own research, most of the time, even for educational activities, it is after your time.” SN 6

Stakeholders appreciated specialist nurses as a resource to fill the theory-practice gap. It was recognised that they facilitated evidence-based practice and were part of the evolution of the nursing profession not only in Malta but also abroad.

“I see specialist nurses ...that can keep up to date with the latest research and knowledge because when you are a nurse or a midwife on the ward you cannot specialize in everything...” (FG1. MDP, 3)

Another participant in the focus group explained;

“My idea is not to be bound by the walls of this organisation ...It is learning but also contributing to learning and research is the contribution. Another part of this and I am going to full circle is that the specialist nurse needs to see what is happening abroad and seeing if it applies to Malta.” (FG1. MDP, 7)

4.3.4 Leader

Most of the participants agreed that specialist nurses needed to be leaders in their area to bring people on board with their ideas. In addition to moving the profession forward, stakeholders felt that they were experts in their practice and an asset to both the patients and other professionals.

“You need them to be a leader because you need them to be charismatic, they need to attract people to their ideas, and there are ways and ways. It does not mean that you have to be a loud mouth, but you can be assertive, and you make your point in very different ways.” (FG2. D,2)

“Specialists, they need to be leaders, every specialist nurse must be a leader and the poor consultants that I come across are poor leaders.” (FG3. Cons,2)

There was evidence that specialist nurses were actively engaged in leadership processes by being a role model for ongoing professional development. They created a positive environment towards ongoing development through behaviour, such as changing practice on the wards, keeping up-to-date with new practice and equipment, and research evidence by attending courses, conferences, other education fora, networking with other colleagues both nationally and internationally to keep abreast of new developments and also in benchmarking

their practice. The statements below further described the leadership experiences of specialist nurses and their impact on the nursing profession.

“My personal opinion is that we made a huge leap in the nursing profession; we started implementing more clinical, diagnostic aspects rather than being submissive to recommendations given by other professionals and I think by time now we have been through this for a long time and the posts are more respected and other professions are literally seeking advice from these professionals.” (FG2.D, 3)

“...they are the fountain of information, they are the experts, they are the resource...and our interaction with specialist nurses has always been on an individual patient but it then goes beyond that because that is the beauty of it.” (FG1. MDP, 2)

Specialist nurses and stakeholders further held the same view that these specialists were leaders for quality. The sharing of knowledge and its impact was seen as elevating the quality and standards of the system and of the care provided. They were seen as important liaisons between patients and professionals and offering a more patient centred approach that could increase the quality of life and reduce readmissions to hospital. Being a patient advocate was also mentioned as one of the greatest benefits both from the perspective of being the voice of the patient with the doctors but also as a re-enforcement and support network for them. Moreover, it was acknowledged that they had a significant role in formally developing guidelines and standard operating procedures.

“I know that through these nurses, patients will be getting better care, will be followed up more, get less readmissions... that will eventually improve the quality of life of the patient and also of the health service.” SN3

“When they are trained they are ideal drivers of clinical qualities because they serve as an important liaison and they can provide guidance and they know both the basics as well as the specialist part.” (FG3. Cons, 2)

“It is my role to set up a standard operating procedure for the same investigations, we investigate those and we try to seek the root cause, of such incidents and that would in turn help us to design policy with the aim of reducing accidents as much as possible.” SN 7

“I am working in an area where I need to go to the clinical area and change practice, because at the end of the day that is why you have specialization so you would have people doing things in a better way.” SN 1

The specialist nurses' role of change agent and developing policy was appreciated by most stakeholders too. One participant described specialist nurses as being the 'fuel' for managers or leaders to aid decision making.

“I see them as the fuel for these managers, because the provision of this knowledge and expertise provides the management or whatever leadership there is with the appropriate evidence and decisions for the clinical area.” (FG1. MDP,6)

4.3.4.1 Reflective Practitioner

Being a reflective practitioner was another way of developing and learning that was mentioned by a couple of specialist nurses. They spoke about how they learnt from each other and how they discussed what went wrong or how they could improve their practice and events in their department. This characteristic was seen as essential for a specialist nurse because it could help motivate and develop oneself.

“In our department we also do a lot of post-mortem so to say. If for example we introduced a policy and it is not being abided to or the change has not turned out as planned, we usually meet and discuss what happened. Even if we organise a conference, we do a post-mortem and see what was good, what could have been better and improved. Reflective practice.” SN 2

4.4 Essential attributes of Specialist Nurses’ ‘A Package’

Most participants acknowledged that a specialist nurse should have ‘a package’ of attributes coupled with the right personality. One consultant interestingly identified that the specialist nurse should have the drive to develop the service and should not be seen as the assistant to the medical consultant. A nurse, on the other hand, stressed that they needed to be friendly and supportive with everyone.

“...So from the nursing point of view, they have to have the background knowledge, they have to have the background skills and they also have to have an interest in research and they have to have an interest, in a way, to move and bring the whole system forward, not just being the assistant in that particular field, as we tend to interpret them now.” (FG3. Cons,5)

“It is a package and one of them is that you are nice with everybody. Nice means this unconditional support even phoning from home ...Friendliness is another important factor.” (FG4. N,1)

4.4.1 Personality and approachability

Personality was deemed important since a specialist nurse needed to be a people’s person and empathise with the staff but also needed to be assertive at times. However, most of all they needed to have persuasive and empowering traits with the ability to get people on board and drive change.

“Personality, because I believe that to carry this role you have got to be assertive, you have got to be a fighter, a good communicator, you have got to be committed, to what you are doing and believe and then you have the three Ps, persistence, perseverance and patience because without those you will go nowhere.” (FG2. D,6)

“You really have to be a people person so that people will end up coming round your way without even realising. So if you are going to improve an area you need to get everyone on board.”(FG1. MDP, 6)

“Diplomacy and tact. Being able to take a step back sometimes keeping your mouth shut and knowing when you have to stop.” (FG1. MDP, 2)

In addition to the personality of the specialist nurse, being passionate about what they do was thought to be very important. According to the majority of the participants, specialist nursing had to be something that they loved doing. The role of a specialist nurse was not only about being very good at research or having the knowledge, but about really wanting that clinical area to be the best it could. They associated these attributes with being committed and approachable.

“You have to be passionate that is true about the role that you love it and that you get excited about it!” (FG2. D,2)

“I want to see a Practice nurse as being passionate... really loving what they are doing and showing it. Because then you will want to approach them and you will feel that they really want to teach you. Because there are some that you will go to them but you cannot drag out any information out of them.” (FG4. N,5)

Being open to feedback, not stubborn or self-centred were other traits that were deemed important by specialist nurses. These characteristics were stated when asked what attributes would one look for in a specialist nurse:

“As a person I would look for a person who is open, open minded. I don't wish her to join our team and then be stubborn or very self-centred like she decided to do something and that is what she is going to do.” SN 2

All specialist nurses (N=27) in the survey identified inter-personal skills as being the most recognised skill that was essential to the role. This was in parallel to what the stakeholders perceived. Specialist nurses' communication was deemed essential both with patients and staff. Although they all agreed that knowledge and experience were essential they mentioned other necessary features that a specialist nurse should have to succeed in her role. Most mentioned the need to be assertive and a team player because they were attributes believed to build relationships that were strongly cited by specialist nurses and by the consultants group. As stated below a specialist nurse was expected to work in different areas and needed to work with the consultant and the team.

“The person has to be a person that works in a team. “ (FG3. Cons,1)

“If they have done all the training and practice and they are not team players with the medical consultant then for sure that specialist nurse will be a flop. “ (FG3. Cons,4)

Moreover, a member of the multidisciplinary team stated that she saw specialist nurses as communicating the needs of the patients to other members of the team focusing on meeting their requirements. The level of communication with these specialist nurses was noted as being at a higher level than that with other nurses on the ward.

“It is using that focus and their skills to meet patient needs which we could all identify with and that is what brings that true communication with professionals ‘cause I think our communication, at least I feel that our communication with specialist nurses is sometimes at a higher level than with other nursing colleagues and I think it is because we are focusing on something together.” (FG1. MDP,2)

4.5 Autonomy to practise

Extended roles were linked with autonomy to practise. In the survey, specialist nurses were practically unanimous with the statement that a high level of autonomy was required in their role. Notwithstanding this, the extent to which the specialist nurse could work autonomously was questionable. In fact, as an indicator of the degree to which the autonomy of these roles was recognised, two questions in the survey were asked: whether respondents had ever had a referral refused because of being a nurse and not a doctor; and the pattern of requesting investigations such as bloods, X-Rays and wound swabs. Although only two specialist nurses had their referral refused, less than half, ten out of 25 respondents, requested investigations. Specialist Nurse 8 in fact explained that some professionals still do not accept her referral whilst others did not seem to have this problem anymore.

“... sending a note to a professional saying can you please assess this patient because she is for treatment and we need an assessment? The professional would be upset because I would write the note. We are still there.” SN 8

4.5.1 Extended Roles

Specialist nurses also confirmed that they were undertaking extended roles including requesting of blood tests, their interpretation, explanation to their patients, and the adjustment of treatment. It was obvious that hospital policy was not that clear.

“I was checking blood tests since I could do that, and then I got the ordering rights after I don't know how long...” SN 8

A few specialist nurses still sought approval from medical doctors because they still needed their go ahead but in actual fact they were the ones directing and suggesting medication changes –this created a sense of frustration as noted in the statement below.

“Most of the time I have to direct the doctors but need their go ahead but what could we do? I would also have to ask them to write a note on the medical notes, the records of the patients so I would be covered and safe. It is stupid!! ... as a specialist nurse we have no legal backup so with the nurse practitioner we might get it. So that we can take more initiatives because we are stuck. There is a limit and if you go over that limit you are in trouble. SN 5

Others were given conflicting advice from hospital administration and legal advisors on what they can or cannot do in relation to their extended role. Some specialist nurses felt competent but did not feel autonomous to practise. However, what was of interest is that none of them brought this up as an important aspect to help in their development or facilitation of their roles and future positions, but just mentioned it while pointing out problems related to their roles and responsibilities.

“But here you cannot reduce or increase the drugs as you know. I have to liaise with the doctors. Sort of I always have to put on the file discussed with and... not long ago I met the lawyer, who told me don't give results 'cause of hospital policy and if you are giving results you are breaking the hospital policy, but how can you tell me not to give the results?” SN 8

This was conflicting with a couple of directors' vision. They foresaw that specialist nurses could move to controlled prescribing because this would be cost-effective. It was seen as being cheaper than having only medical doctors in this role and also because it would possibly reduce admissions to hospital.

“...and nurse specialists I think could move to a controlled prescribing such as wound care products and other medicines would help because it is much cheaper than having consultants and full time medical officers outside in the community to do certain work and again help reduce admissions and readmissions to hospitals.” (FG2. D,4)

4.5.2 Expanding Roles

Most agreed that a decade after the introduction of specialist nurses into the system, more needed to be done to extend and expand their roles into other fields. One participant echoes this feeling in the comment below:

“... now I believe it is about 13 years or 10-13 years since their introduction I think that now we should start expanding the specialties...so it is time to expand.....but I think that due to this lack of legislation this will stop the Practice nurse from evolving into a nurse practitioner. This will stop this so called evolution.” (FG2. D,5)

In the directors' focus group the importance of expanding the roles to the community, providing 'outreach' services, was supported by all and as one director pointed out this direction should be emphasised in the future because it could improve the services in general and reduce bed occupancy. They added that exporting this service into the community and to other institutions would not only benefit patients but would also be efficient for nursing, since there would be less duplication of work. The direction should be on national consensus of protocols and sharing of resources.

"I think that there should be more sharing within all the healthcare systems and that way together with the educational, consultancy roles certain ideas can also be transferred to other areas of care like within the community, primary healthcare... Being a small country...it should be easier for us to have consensus and working groups across Malta on how we should deliver care throughout. (FG2. D,4)

Although this was supported by the consultants and nursing group they pointed out that the correct structure and support should be in place to see this happen.

"...so I hope that the nursing structure will actually support these people and I also see another role for them as they get better and more involved in actually liaising with the public, for example not just with the patients who come to the hospital, so their role could expand more." (FG3. Cons,3)

Another interesting issue emerged from the Nurses' group and the specialist nurses themselves. They actually thought that the authorities themselves were not open-minded to the benefits of allowing the specialist services to expand into the community. As one nurse stated, it was not management's priority and specialist nurses literally had to fight to outreach their patients in the community. This proved conflicting expectations and realities.

"If it wasn't for some specialist nurses, ...outreaching especially in the community was never in the lines of thought of our administration. One started fighting to start outreaching, that should have been one of the priorities. Are we investing enough? So that even more people in the community ... because we would be better in this hospital, we will get less patients because they are catered for in the community. (FG4. N,1)

This notation was supported by a specialist nurse who gave a real example of how her manager could not see the need for creating an awareness of her specialty, and was stopped from going out to provide these sessions into the community.

"I had problems to be released from work to go and give talks on awareness outside hospital. I had problems when I was actually stopped from going so I used to go on my off day!! So and then they wonder why there is burnout in nursing!" SN 1

Another fact that supports these two nurses' arguments is the number of specialist nurses actually deployed out of the general hospital. The survey noted that 23 of all the 27

specialist nurses in Malta were based at the acute general hospital. The survey further revealed that a total of only six specialist nurses gave a service in the community but one specifically added that she had to stop visiting patients in their home due to lack of human resources.

The element of autonomy to practise was related to the amount of risk and responsibility taken by the individual specialist nurses. The situation in Malta was criticized since the consultant was ultimately responsible for the patients' care and although they felt that specialist nurses were afraid of the accountability associated with extended practices, specialist nurses felt that they were not in a position to take on this responsibility since they felt they were not in a legal position to do so. However, there was a feeling that some specialist nurses were more cautious than others and that in this type of post there was an element of risk. As a specialist nurse emphasised, one should not be afraid to take decisions within their boundaries:

"...if you are going to base everything on fear then you can't move on, you can't develop 'cause there is always an element of risk even in developing the role of the specialist nurses there is a risk and you can't expect, as nurses we cannot always expect a doctor to endorse every decision.... Specialist nurses need to have this quality to be able to take decisions obviously within their boundaries but without expecting the rubber stamping of a senior or of a doctor every single time." SN 3

Although Consultants seemed content with the specialist nurses' current practice they spoke about their 'fear' to progress. An interesting point that emerged from this group concerned the level of responsibility of these nurses and that it should be further developed because they attributed this responsibility with being more professional. One consultant emphasised:

"'No Taxation without Representation.' They want to be professionals but they don't want the responsibility... So I think that is very important and so if you want to develop it further you have to start thinking about taking on some more responsibility." (FG3. Cons, 6)

As one director stated there was a need to revamp the scope of practice and amend it in such a way to allow specialist nurses to practise in line with clear guidelines and peace of mind.

“When one sees the scope of practice, which I think it is about time that it is revamped totally, there are certain things which in itself, since it is issued by the council for nurse midwifery in Malta, it is a legal document. It defines nursing practice and everything....if the scope of practice states that nurses cannot enter body cavities etcetera and they cannot do certain things how can nurses practise in certain specialities, like endoscopic practice etcetera. Is that in line with the scope of practice?” (FG2. D,4)

4.6 Roles that should be deployed

Support is needed to carry out their role to their full potential and to the needs of their patients. However, there needs to be a better support system in place not to waste valuable human expertise and resources.

“I am spending half my time doing work which does not require my skills. If we were to be able to audit, we would be able to demonstrate the value of what we are doing. I would like to carry out a study to see what the problems are according to patients and not according to me. But one of the things that I am sure will come up would be lack of privacy.” SN 1

4.6.1 Procurement

Introducing new equipment and products both to the patients and to the staff was also described as an integral, lengthy and tedious part of these nurses’ roles. Moreover, SN 5 explained that sometimes, the time waiting for this equipment would result in their needs changing and the process will have to be initiated once again to keep up with the demand, once again consuming valuable time.

“This is a big part of our job to introduce new products and the process takes months if not years to get the item after the request done for new items. ... so in the time of this wait our needs increased especially with the ageing population and so we lack equipment, so we need more....” SN 5

“We make a case for that and it comes back and it goes back and forth and back and forth, until it is approved. The time I spent doing all that, surely cost three times more than the equipment would have cost.” SN 7

Specialist nurses explained that the time devoted to procurement and the running around that goes with it as ‘wasting a lot of time’. A couple of nurses stated that nearly every day they were following up on items that are waiting to arrive or out of stock and by some this was considered to be one of the biggest challenges that was hidden in their role.

“We do a lot of procurement in this department because if we don’t order items no one seems to do...Then we have the problem with people phoning us saying that this is out of stock, or that is out of stock, these are chores that we have sort of carried with us from the old hospital to here.” SN 2

Notwithstanding this, the knowledge of specialist nurses concerning medical equipment was appreciated both by the nurses and the consultants:

“Now it is all done automatically by these specialist nurses. They have now taken this over completely and they used to go to a public supplier; but they are now doing it all themselves. So I think that is a role.” (FG3. Cons, 6)

“... we get specialist nurses for expert advice and for some extra information and sometimes when we find difficulties with equipment by the way, because they help us a lot.” (FG4. N, 1)

4.7 Role Preparation

Almost all specialist nurses in the survey and during the interviews indicated that they thought specialist clinical skills were essential to their role and that although nearly all stated that they had received training, the majority still required more. Negotiating skills was also deemed as an essential skill in their role by the majority of specialist nurses; however this was not discussed by any stakeholder. Another finding was related to financial management. Less than half the participants in the survey thought that it was an important skill to be trained in as a specialist nurse. This did not correlate with what consultants and directors envisaged. According to a consultant they were in a better position to take on the financial matters because she believed they had more time. Moreover, a director stated that she was not happy with specialist nurses because they were not structured. She was the only one that directly mentioned the need for business orientation from all the groups and participants in all data sets.

“I am not happy because they are not structural, they are not business oriented they are not focused, in my opinion, they do their own bit so it shouldn't be like that.” (FG2. D,1)

“I would also see them into things like cost, because most of the doctors don't have the time to go into... going into cost-effective issues.” (FG3. Cons, 3)

4.7.1 Training Opportunities

There was consensus by most stakeholders and specialist nurses that academic certification was not the only preparation that specialist nurses needed. Training was needed in a wide range of activities because they would need skills to initiate, run and develop services. The survey confirmed that there existed training needs, in particular to research, audit, IT/computer skills and finance. Respondents also noted barriers with education and training particularly due to the distance of attending courses abroad. When discussing the roles and

qualities of a specialist nurse, assertiveness and leadership skills were also mentioned, thus training in these areas was essential to bring people on board and manage their service.

“I think they need more managerial skills installed in them because I don’t think or rather I think they find it difficult. ...(Specialist nurses) they need training in education and also in time management... they need all the staff and skills that a manager would have; time management, assertiveness, educating and leadership skills, and all the rest that come with managerial skills.” (FG4.N, 4)

Job shadowing or experience abroad featured high amongst the specialist nurses. Nearly all of them had experience in the UK and others ventured further. In the interview, all but one stated the importance of going abroad and working alongside specialist nurses in their area of specialisation. Most stakeholders and specialist nurses agreed that mentoring or coaching was essential alongside the technical skill, experience and certification. Coaching, as one stakeholder in the multidisciplinary group explained, was about refining attributes, such as people skills, that were essential components of being a specialist nurse. The situation of ‘learning on the job’ was also heavily criticised as being unprofessional and unsafe.

“I was glad that I went for that experience because it gave me new ideas and I could see what the role is, and because there was no role, so what I wanted to do are the correct things and no one tells you what to do.” SN 8

“They also need to be coached on site...It is where they could pick up on gaps in their skills, like people skills. This is not only about their technical skills or academic skills but if you are watching someone whilst they are working with their patient and their nursing colleague, you start picking up certain things like ‘we are not getting here’ or was there a superior attitude here?”(FG1. MDP,2)

A debate centred on the issue of who should be responsible to accredit specialist nurses or check their competence levels, especially in areas where there was only one specialist nurse. A couple of suggestions included bringing in professionals from abroad or specialist nurses themselves choosing a person of trust as an expert to mentor and assess them. There was also controversy and divide in the stakeholders’ group where some participants placed more emphasis on the experience and others on qualifications.

“I think that apart from gaining a Master’s degree they should be obtaining a doctorate because that is how we are moving, but I also understand that these things evolve and it is a process and you can’t ignore persons who have given a service and have a lot of experience and you sell them out.” (FG2. D,2)

“Yes you need academic qualifications but experience is most important.”“(FG1. MDP,5)

“Another possibility lies with the responsibility of the nursing leadership, but they can delegate the responsibility outside of the unit, some external expert from abroad and they would come here.” (FG1. MDP, 1)

The following section will outline related issues that were found to affect the development of these specialist nurses in more detail.

Part II: Development of Specialist Nurses within the Maltese Health Services

This section of the chapter will look into the development of specialist nursing in Malta that was discussed in all data sets. Most of the participants seemed positive of this concept and growth in nursing, and stakeholders seemed to recognise the benefits of these roles. They were seen by clinicians as an asset to the patient and organisation but most of all to their profession. Also of note was the confidence and trust in these nurses. Moreover, most stakeholders spoke favourably about specialist nurses describing them as:

“subject matter experts” (FG1. MDP,1), “emanating knowledge and evolving knowledge” (FG1. MDP,6), “very much needed and helpful” (FG4. N,5), and “what they are offering is Continuity” (FG3. Cons,6).

“I am really confident that every speciality is up to scratch and up to date. I am sure of it, I have never seen anybody where I can complain that they don't know what they are doing. They do know what they are doing, they are specialist and they are knowledgeable ... moreover I can TRUST them, all of them.” (FG4. N,5)

There were only a couple of participants that voiced their concern with a minority of specialist nurses, who in their opinion, were not up to standard and might be in the role for the wrong reasons, such as for better working conditions.

“I am afraid that some of our specialist nurses are there just for maybe the convenient conditions. Not necessarily because they really love what they are doing, I am not pointing any fingers but sometimes ... or may be a better pay.” (FG4. N,2)

Although the consultant's group was mostly complimentary of specialist nurses they did comment that nurses needed to work around the patients and not the other way around. This referred to the system of rosters that these nurses work and that renders them unavailable during weekday ward rounds because they work on Sunday. While the consultants understood that specialist nurses should be paid well, they also expected them to be on duty when the team and consultant were present.

“...even the working hours should correlate with the working hours of the clinic, how can you justify an out-patient nurse coming to work in every Sunday when the out-patients is closed.” (FG3. Cons,6)

It was also noted that certain specialist nurse positions were more developed and supported than others and some stakeholders asked why this could have happened. One nurse explained that it was because one particular specialist unit was run by a medical consultant and another

stated it was due partly to the introduction of Malta within the European Union (EU) and the standards and policies that went with this process.

“...from all the specialist nurses one unit seems to be the ‘elite’, and I think we all know why, because it is run by a medical officer; by a consultant ...the best department, which was well prepared not only in physical resources but also manpower.” (FG4. N,1)

“I think that because we entered the EU they had to act, that is why they had improved, that is why there were more resources, because it was their priority at that time...It is all about priority, it is not who is in charge, or who is leading, I don't think I agree, it is what the administration wants at the end of the day. It was the priority of the hospital and a health and safety issue...Why? Because it was a policy and a political agenda and issue.” (FG4. N,4)

Notwithstanding this progress, the majority were not happy with how specialist nurses developed over the past few years, mainly because there seemed to be a paucity of planning and strategy to support and develop these professionals. It was also evident that most nurses persevered in the development process of their role that usually started from nothing. Most of them started working as specialist nurses without being given the official title, training and facilities; some of them years before they were actually contracted into their positions and scales. Most agreed that the specialist nurses were just ‘thrown in the deep end’ and the experiences of specialist nurses as the one described below should be avoided:

“So you graduate as a nurse, or become a specialist nurse or a practice nurse and then you are sent to do the job, you are thrown in the deep end... what I am saying is that nurses usually have to learn on the job. There should be mentorship.” (FG3. Cons,1)

Most of the nurses interviewed were ‘pioneers’ in the role, having established their practice in areas where specialist nurses had not previously been deployed. It was thus evident that the story that they told was of a journey, and most seemed proud of their achievements. The majority started from nothing and had to build their knowledge, practice and clinics. They also spoke about acceptance and increasing independence that was necessary for professional autonomy, and although this was achieved in various degrees they all referred to the challenges they faced both on a personal and a professional level.

“When I started there was nothing, sort of practically I created the post, there was no SN in my area, there were these two consultants and I was the clinic nurse and what I did apart from being a clinic nurse was run the injection clinic as well...” SN 8

The general impression of the nursing group was that the nursing administration did not support these specialists and did not bring them together to work as one driving force. A Nurse described her thoughts as:

“...everything came by accident, that means that up till now we are still fragmented with regards to services, there was never a base where you can knock and find this specialist and this other specialist together working in harmony, meeting regularly to set up policies themselves, not of their own speciality but of the concept, so we are still fragmented in this way. (FG4. N,1)

This was supported by a couple of directors who explained and stressed:

“We have been proliferating a lot of specialities in all sections but do we have a real objective where we would like to go and decide this is where we want to reach. Do we have a target where we are going to reach, because ...” (FG2. D,4)

“Locally, we have a lot of nurses that are very good and very experienced but due to the infrastructure, because it was not there before, some people did not keep up ... but I also understand that these things evolve and it is a process and you can't ignore persons who have given a service and have a lot of experience and you sell them out.” (FG 2.D,2)

On a positive note, it was assured by one of the directors that a structure is being devised to enhance the career pathway of specialist nurses. The statement below explains two more levels that a specialist nurse can achieve, that of a senior practice nurse and advanced nurse practitioner, the latter one being equivalent to a consultant nurse in the UK. As explained below, the senior practice nurse would have a group of practice nurses who she/he would be in charge of, and the advanced nurse practitioner would be the advisor to the department of Health and Nursing Services on a national level. The director's own words were:

“It was very expedient and it shouldn't be like that but it should be structured –Now that we have a career pathway, we are at the process of defining the role of a senior practice nurse... has a number of practice nurses under his or her charge... Whereby there is a component of clinical expertise coupled with the management of a unit... The advance practice nurse as I see it in my opinion, is a nurse consultant who is to advise the Department of Health or the Department of Nursing Services...” (FG2. D,1)

Despite all the challenges, specialist nurses seemed happy with their job. In the survey it was clear that specialist nurses intended to stay in their position; nearly half of them stated that they would like to become more specialised and most wished to remain in the same or similar role. The majority explained that the highlight in their day-to-day life was the patient. Another area that gave these nurses satisfaction was seeing patients comply with treatment after understanding their condition. Knowing that they were part of this journey motivated them to continue improving on their role and the service for their patients. As one specialist nurse stated:

“The satisfying part of the job is the patients, I mean that the fact that most of the patients do appreciate the care that you give them and they show it in small ways like by saying thank you, phoning sometimes even after they are well, because they see you as a point of reference. That is the satisfaction.”SN5

The following section will outline the findings that were discussed mainly concentrating on issues relating to how and why these nurses developed, were chosen and introduced into the system. The final section will focus on influencing factors that affected the development of these specialist nurses.

4.8 Motivation for Specialist Nursing

Specialist nurses’ motivation to move into their new role was derived from different experiences. For most of the specialist nurses the drive was to increase the quality of care, but there was also a sense that it was a means to improving their career prospects without leaving the patient for administrative or educational posts that were the only other two options available in a nurse’s career. Most of the specialist nurses interviewed stated that they became interested in their speciality through their previous job, except for one who had to look for a job in nursing that did not involve manual handling due to medical reasons. It was evident that the role was either created due to a gap in the patients’ care or a new service or policy developed that needed the co-ordination or specialist care from nurses. As a specialist nurse explained, no one regarded the psychological impact of caring, and so she felt the need to do this. With her experience as a nurse she furthered her studies to be better informed to help her patients and provide a holistic approach to care. She explained that at the beginning she was borrowed from her ward to help a group of patients and was finally released to her present role today, but was officially recognised years later. As she explained patients were left to deal with their condition on their own and she felt the need to do something for these patients:

“...like the consultant would come in the morning, he or she will tell us that this patient can go home, and at that time we do a session to teach them how to manage. So you can imagine what teaching it was. And they will just go home, maybe, with a community nurse referral, and they face this tragedy alone. NO? And that used to bother me. But I didn’t stop there, I said what can I do?” SN 6

There were a couple of posts that were developed or instigated by doctors that saw the need for specialist nurses to help their patients.

“Like a lot of things in Malta, this developed from the fact that there was one of the surgeons who used to see patients in out-patients... So he had the foresight to see that you know this should be a specialization – that there should be someone to look after these patients in particular.” SN 1

4.9 Confusion in the Expectations of Specialist Nurses

There was controversy in the MDT focus group when one member of the group stated that the leader does not have to be the specialist because the leader should be the person who saw everybody’s merits from the broader picture. She explained that specialist nurses should be leaders in their area but still needed to be orchestrated by the organisation.

“Churchill said ‘Experts are to be put on tap and not on top’. Because experts are lopsided. They are blinkered because if you get an expert in a field, most of the time if they exercise their expertise they would not be able to see the whole picture... They would be subject matter experts but not necessarily leaders...They need to be led by the nursing leadership.” (FG 1. MDP, 1)

Another area of controversy arose in the Directors’ Focus Group when it emerged that there were conflicting beliefs. Some wanted them to work in the clinical areas at the patients’ bedside and others thought that they should act like consultants, so they would be called in for advice, without actually performing the skill or the management that they recommended. This was an interesting debate because indirectly it shows the difference in perceptions of the people that are actually directing change or influencing the development of specialist nurses in Malta.

“The clinical nurse specialist is the person who knows a lot about quite less and is not expected in my opinion to do ‘hands-on’ but I expect that he would teach the nurses on a general ward to deal with similar situations and the clinical nurse specialist is the resource to look upon and say what to do in this sort of situation. And I do not expect the specialist nurse to come and do it himself, and that is wrong, and if people reason it out like that it is mistaken.” (FG 2.D,1)

“Yes hands-on because keeping just the education and consultation as a point of view I think that, that is not what I believe I have in mind as a specialist nurse. Let us put it into another profession let us say a doctor, if I may, an obstetrician is a specialist in his field but it does not mean that he does not operate in obstetrics.” (FG2 .D,4)

The following appraisal was further described by a specialist nurse:

“A specialist nurse, in my opinion, needs to be a clinical practitioner, needs to know managerial roles..., you need to have communication skills, and you need to be diplomatic, I must say, at times you need to be, sometimes assertive, but there are times when you need to dictate, you know, so you need those skills.” SN 6

One Nurse emphasised that the approach of specialist nurses might make the difference to making a change on the wards and ultimately to the patient. Another participant in the directors' group voiced her concern over the relationship between the two groups of nurses and spoke about the need for specialist nurses to integrate with staff on the wards, and one way of doing this was during multidisciplinary meetings.

“the unit can easily isolate a practice nurse but the practice nurse has all the ability to integrate very easily...better communications, not only with the nursing staff but during multidisciplinary meetings, she should be present because this will help her integrate more with the clinic with a better result and better care for our patients.” (FG2. D,5)

“Apart from the knowledge, it is all about the way they deliver... the approach, if the specialist nurse is here (gesticulates to show a difference) and the ward nurse is down there, I see it from my staff, they will see you as someone to avoid.” (FG4. N,3)

In the multidisciplinary focus group, diplomacy was argued as being a preferred attribute by most of the participants. However, there was one particular participant who stated that she would opt for someone who was not diplomatic because she attributed diplomacy with being less honest. She explained that a necessary unique attribute was that of being reasonable but she agreed with most of the group that specialist nurses should know what battles to fight.

“I would go for someone who is not diplomatic. Let me tell you why. Most of the problems we are in, in Malta, are because of abuse of diplomacy. We lack honest people, we want people who know when to act ...people who would know what battles to tackle but then I would prefer to work with people who are honest but I want them to be reasonable too...You have to speak softly but then carry a big stick...If I had to choose between honesty and diplomacy, I would choose honesty.”(FG1. MDP,1)

4.9.1 Acceptance by professionals: “You do not become a specialist nurse to become a Prima Donna”

“... so it is not a one-man-job or a prima donna, ok it is a unit that works” (FG2. D,1)

The above quote implies a sense that some specialist nurses went into this position ‘to become a prima donna’. The majority of specialist nurses expressed such attitudes towards them during the transitional period and stated that being accepted was also influenced by professional boundaries as emotionally expressed below by a couple of specialist nurses:

“That we would and will be accepted by other similar professionals like psychologists and other professions ... I do feel that this is very existent – actually I do not feel it, I know it.” SN 9

“Although some accept my referrals they would still want the doctor to sign it and with regards to others I don’t feel so confident in sending a referral although I wrote a couple and they did not come back. There is a problem with this issue since other professionals have not accepted us.” SN 8

The survey further provided evidence that specialist nurses thought their role was recognised by nurses and patients but were less acknowledged by the medical staff. This was confirmed during the focus groups that felt that there had been improvements with regards to acceptance by nurses.

“I think that nurses in general are appreciating their services nowadays. Not like twenty years ago or even fifteen years ago. They struggled so much.” (FG4. N,4)

This idea was supported by a couple of specialist nurses who felt that there was better acceptance of their roles at the time of the interview but explained that it took time and recounted issues arising from their relationships with their fellow registered nurses, who had perhaps felt undervalued or saw specialist nurses as an ‘elite’ and as a professional group to compete with. One participant further stated that this acceptance was all due to their perseverance and personal achievement.

“So my perception is that there is a positive acceptance of specialist nurses today and we have worked hard for this and no one did it for us but ourselves. It is surely a personal thing that we did with our perseverance and I think also by us and being ourselves that we managed this success. It was we who made it.” SN 5

Another specialist nurse, SN 7, interestingly explained that although she was not sure if her role was accepted or not, since she worked in a place that was required by law the authorities and management could not really ignore her requests and position. This she believes, made her journey and transition easier than that of her counterparts:

“...the area we are functioning in is part of the legal requirements and thus so it is not like one could just ignore them!! And the way it works is that in order for someone to be in a justifiable legal position they have to either provide the resources or else be able to justify in court why the necessary resources were not available.” SN 7

This view was echoed by a specialist nurse who experienced the lack of recognition from the nursing directorate. She summed up her frustration as feeling a sense of reluctance from her ‘kind’ and, as she says, a lack of giving them recognition and priority.

“The other disadvantage is that we do encounter difficulties within the nursing stream that unless we get a doctor involved, to push things, they would not go forward. It is really frustrating for me, because I believe that as specialists, a nurse specialist, why should we in the nursing directorate wait for the push from the medical doctor to approve things?” SN 3

Most seemed to be prepared to take on this advanced position in nursing at the time of the interview. However, some admitted that when they started this was very different and it could have affected the acceptance of other professions and nurses. They attributed this to their lack of credibility.

“At that time, I had no idea what it was all about, I remember the first day I met the consultant they had a particular case and he gave me a leaflet and told me to go and read it and then go and speak to the patient. You can imagine (laughs).” SN 2

“Without the academic qualifications we cannot get this credibility. So it is not a question of people saying that I have been in this role for so many years. It does not make you a specialist.” SN 3

4.9.2 Credibility

Another reason that could have affected the development of specialist nurses was the lack of training (as mentioned above) that led to decreased credibility from professionals and authority/administration. One of the Medical Consultants that was exposed to specialist nurses from the very beginning expressed her thoughts on why the training did not go hand in hand with the posts. Mainly this was due to lack of investment and funding:

“...we have mouth or lip service by the administration who wants specialists by name but not necessarily by competence because if there was really a feeling that we need these nurses and these are important and they will improve the service then like anything else in life, people would put their hands in their pocket and would find the necessary funding to train these people and come up with a training programme.” (FG3. Cons,2)

This was supported by a Nurse Director who stated:

“I think that we should try and push for the education and training to be registered. I think that having the specialist register for nurses will give us credibility with other professionals, but mainly the medical profession which is highly legislated.” (FG2. D,4)

Education was an important aspect for all interviewed specialist nurses. All but one had a Master's degree and all agreed that this was essential for various reasons. Notwithstanding this, the one that did not have a Master's degree still believed that a Master's degree is essential for the role that specialist nurses were undertaking. Another argument was that without academic qualifications there would not be much difference between a specialist nurse and a generalist nurse with experience.

“...what defines a specialist nurse? And what defines a staff nurse? I mean education is the main thing, the additional expertise, the additional knowledge and skills which are crucial and things are always developing so unless we are up to date, I mean, you can drop the specialist and we will just be nurses, general nurses working in the hospital.” SN 3

Notwithstanding this, there were a couple of nurses that acknowledged that before doing the Master’s degree they could not see the value of this level of education, but only thought that experience was the necessary component for a specialist nurse. They spoke about a sense of confidence instilled in them that reflected in their practice. The educational process provided them with a further understanding of evidence-based practice that made them more independent and placed them in a better position to argue their cases, write reports and relate to other professionals. A specialist nurse explained how the Master’s degree enabled her practice:

“Since I did the Master’s degree, I changed a lot. Even the knowledge and things I do. I would not have expected myself to go to the Laboratories and perform some tests. Even talking about evidence-based practice. At the beginning we did not know the meaning of it; we were not really into research. Before I used to find something from abroad and then just photocopy it and use it. I used to say this was already done I do not need to question it or reinvent it.” SN 2

The variance in quality of specialist nurses was mentioned by the consultant group and multidisciplinary group as another factor affecting specialist nurses’ development and credibility.

“What irks me is the difference in attitudes. So, over here we have one level of specialist nurses who are expected to do policies, who are expected to drive change, whereas in other hospitals, although they have quality standards, although these were driven by us, but we have two weights and two measures...” (FG3. Cons,2)

Specialist nurses agreed that the system created a difference in standards and quality and was very much dependent on the individual or speciality area. Most expressed concern that the profession did not recognise and reward personal initiatives and that nurses progressed irrespective of their effort to improve and evolve.

“If I take initiative and engage in a lot of different things to further my education and my colleague doesn’t care about it, we tend to progress together irrespective of whatever we do.” SN 7

This was also noted in the Nurses’ Focus group and appraisals were discussed as a means of monitoring the work and evolution of the specialist nurses’ role that could also help in the development of these posts. This was particularly important since none of the specialist

nurses interviewed had a review done by the nursing management. There were two specialist nurses that had a regular performance review once a year by their lead consultant.

“Appraisals. Because then you will have facts on people’s performance... and that they are proving that they are continuing to improve and ...” (FG4.N, 6)

4.10 “Building castles that look lovely but we are not giving them any foundation” SN1

“... And they are going to topple... unless we are going to have the foundation for these services and unless we are going to make sure that these services are built properly, with all the support they need, we are wasting time and money. And we are frustrating the people that are working. I would very much like to be in a situation where we would have resources, physical and human resources; to be able to see patients...” SN1

The quote above was the feeling of the majority of specialist nurses. This impression was supported by survey findings when specialist nurses stated that they were under-resourced in terms of accommodation, equipment and support staff. The findings revealed that, on taking up post, many respondents had not been equipped with what they felt they needed to do the job. In most cases these deficiencies had subsequently been remedied but some were still outstanding. Till 2013, a few needed a desk, a filing cabinet, an office, specialist and educational equipment, appropriate IT hardware and software and a pager. A substantial number also needed adequate secretarial support. The paucity of support was emphasised in all data sets. The support particularly, from administration/nurse managers, was discussed and was found, as one nurse expressed, ‘unacceptable’. This Nurse stated that when a specialist nurse was expected to start a service it was not only about performing skills in her speciality but it was about developing a facility that needed support especially from the administration.

“For those people who have become a specialist nurse, there has never been a sound structure of training people to be a specialist nurse. Because you may be excellent in performing the skill of your speciality, but starting something like this altogether without any structured system and some extra help especially from administration is just unacceptable.”(FG4 .N, 1)

4.10.1 Support for Specialist Nurses

The lack of support from nurse administration/directorate level was a subject that was discussed in detail mainly by the specialist nurses, the Nursing focus group and to a lesser degree the Consultants’ group. It was agreed that this had affected the progress of specialist nurses. SN1 further explained that the constant struggle that she felt could lead to being

‘burnt out’ as exclaimed below. This quote is supported by SN8 who also connected her outlook of ‘getting tired’ with the system.

“I don’t think that we are burnt out that we don’t care, but we are gradually, sort of, eroding all the commitment of people. Because how long can somebody work and battle against the flow?” SN1

“I have my role and it is disappointing to see that management do not understand our role.” SN 8

4.10.2 Strategic involvement and appreciation

The support required ranged from physical to educational and even related to feeling appreciated and involved in the system. This was even felt by general nurses in the Focus group who stated the nursing administration did not really accept specialist nurses. The Quote from SN3 also demonstrates this feeling.

“Also specialist nurses should be included in the structure of the hospital. Why are some memos not sent to them? And sent to separate groups? ...specialist nurses are always out of the picture, and nobody knows what is going on, on the other side.” (FG4. N,4)

“And also we as a specialist nurse/practice nurse whatever, I don’t think that we ever had a meeting together with the director of nursing or assistant director as a group, so actually we are a number of individuals working in isolation” SN3

In addition to the hospital management and organisation, specialist nurses expressed that the Ministry did not seem to understand their specialist role. The reasons for this situation included the lack of acknowledgment of their role.

“No, No, they do not know what we do, and it is not only management but the Ministry, nobody knows what our roles are.” SN 4

“The health division has not respected these nurses.” SN3

What was noticeable was the fact that the support needed for the development of these roles and the sustenance of the services offered by these specialist nurses was only mentioned once briefly by one participant in the Directors’ Focus group.

“They have to be supported with an office, if they go on outreach with a driver, with a car, with insurance, with these things.” (FG2 .D,6)

4.10.3 Funding for training

Funding these specialist nurses’ education and training especially when they needed to travel was discussed in all data sets except the Directors’ Focus group. This was particularly emphasised in the Consultants’ Focus group.

...the necessary funding to train these people and come up with a training programme that initially would have to involve being abroad and shadowing, especially in areas that we still don't have specialist nurses, but these are bona fide specialist nurses. " (FG3. Cons,2)

Support for continuing professional development (CPD) was another support mechanism that was needed. Some specialist nurses spoke about the funds needing to be available and others spoke about the time and opportunities to facilitate this activity. Most of the nurses interviewed expressed the need for more support for educational opportunities and explained that the continuing professional development fund of 700 Euros a year is not even enough to cover one international conference. This view was in line with the Consultants' and Nurses' group feelings.

"The other important thing is that they also support our educational initiatives. There are funds locally, for training, it is very difficult to understand who manages these funds and even when we personally made contacts for job shadowing." SN 3

4.11 Legislation

It was further noted that due to a lack of legislation the development of specialist nurses in Malta was affected negatively and its future evolution would be impeded. On a positive note, the Directors stated that they wanted to see this legislative framework in place and were in the process of planning and setting up an institute to cater for the training of specialisations.

" I need to see the legislative framework, so that there is legal cover for all professional decisions...I am working for this, to see the setting up of an institute that will take care of the development of specialisations and the training thereof...hopefully in my lifetime. (FG2. D,1)

The Council for Nurses and Midwives in Malta is the regulatory body that should be establishing the rules and regulations including the Scope of Practice and the Code of Ethics. However, there was criticism by the stakeholders that this body did not seem to be functioning to its full capacity. Apart from not keeping the Scope of Practice updated there appeared to be overreliance on the nursing union and a lack of general awareness of its role within the Nursing Profession.

The exemple below explained that there was no clear direction from the council:

"I will criticise it...If there is no clear direction from the council; and so if someone isn't a member of the union, and does not obey it, and the council does not issue any clear direction, so what is going to happen then? Is he or she legally covered? It is the council that has the jurisdiction of all the nurses and midwives in Malta and it is nobody else and it is they that should direct and give direction." (FG2. D,4)

What was of interest was that only on one occasion did a specialist nurse (or a nurse) mention the Council of Nursing and Midwifery.

“My speciality is not a place where the Nursing council has a register for, so the Council for Nursing and Midwifery does not have a specialist register for specialist nurses.” SN 7

4.11.1 Title Change to Practice Nurse

The change in titles right across the nursing sphere was noted but with little interest from nurses. However, most of the specialist nurses and consultants disagreed with this new title of Practice Nurse because it does not describe their role and creates more confusion. As one specialist nurse stated:

“...when I reflect on it I preferred it to have stayed as a specialist nurse because everyone is a practice nurse. If you are not a practice nurse –you are not a nurse at all...” SN 6

Another specialist nurse emphasised:

“Practice nurse is a nurse who practises and all nurses are practising. So I think it needs to be at least suggestive of the role they have, like the title specialist nurse would be suggestive of what the person does or practice development nurse.” SN7

The consultants also agreed that the title was confusing and that this change did not help facilitate the understanding of these nurses' roles. They agreed that the title should give an understanding of what these nurses were supposed to be doing and that it was unfortunate that the two roles of practice development and specialist nurses were grouped under one title.

“Even in this small group, we have different terms. This is a bit unfortunate, because even the word practice nurse, what my colleague was referring to is as someone practising daily, but the current understanding of what a practice nurse is someone who develops the practice and even a specialist nurse.” (FG3. Cons,1)

Additionally, and of utmost interest, was that no nurse or specialist nurse knew why there was a title change. However, this came to light in the Directors' and Consultants' groups. Consultant 6 explained that although it was the medical council to object to the title of specialist nurse it was not because they did not appreciate these nurses but it was a matter of principle, and also a means to safeguard the public because all specialists should have a training programme before earning the title and being registered. Thus, for there to be a change in 'title' for specialist nurses, a register should be in place to certify and licence these nurses to practise with the legal backing required. This was confirmed below by a Director.

“Personally I don’t like the title practice nurse but ...the public service commission did not want to refer to the specialist name if you were not registered under this title. The law states that you cannot make use of a title if you are not on that specialist register, there was an objection from the medical profession...”(FG2. D,1)

“The word specialist implies that they have specialist education, training and a specialist register. So we cannot use that word and I think even now it is accepted that the word practice nurse is used.” (FG3. Cons,6)

This was supported by a Director who explained that in the Scope of practice for nurses ‘reserved acts’ (that would allow for extended practice) could only be carried out when the nurse is trained in performing them:

“The scope of practice speaks about the basic core competencies of what makes a specialist nurse, and it speaks also about reserved acts: and it says about reserved acts that they are only, they can only be initiated and performed only if the person who performs it is trained to do so...” (FG2. D,1)

It was agreed that this promotional system would allow specialist nurses to advance in their career without leaving their expertise and also in that way for the hospital to keep their experts where they matter. As a member of the MDT said:

“In Malta this [creation of posts for specialist nurses] would be and would offer some very good opportunities because currently as things are for example for someone to move forward in their career most of the time they would end up as people doing administration work without necessarily having the good skills. You have some very good subject matter experts doing an odd job of administration.” (FG1. MDP,1)

Part III: Influences on the Advancement of Specialist Nursing Practice in Malta

The journey of development was evident; one nurse stated that when she started practice in her area it was primitive. From the previous sections, one could also see the development without the necessary support.

“...our area developed when I started; one could say it was primitive. When I started nine years ago the practices were primitive.....” SN 5

This section will outline further influences that could have affected the development of specialist nurses in Malta. This pertains to the professional, organisational and cultural aspects that were highlighted as important factors. There was agreement that nursing was still fragmented and that the services of the specialist nurses were not unified and working in harmony. This was supported by a director who was there from the beginning of the specialist nurse evolution and who explained that the focus ten years ago and up until recently was on increasing academic proficiency since half of the nurses in Malta were second level nurses.

“Ten years ago we had 2000 nurses with 50% of them that were enrolled nurses... you cannot achieve academic proficiency by having second level nursing ...” (FG2. D,1)

Additional concerns centred on the fact that there was no learning centre in the hospital and that there was division even within the nursing administrative system since they had different people in charge of these specialist nurses. Moreover the ‘manager’ was not looked upon as a leader but, as a specialist nurses puts it:

“I am accountable to a manager but only for my leave, my sick leave and maybe just to tell them I am going out with Time off, in lieu, that is all...” SN6

4.12 Nursing Culture in Malta

During all the focus groups and even during individual interviews it was often stated ‘well, that is Malta’. It was felt that certain things were accepted just because things have been ‘like that’ for so many years and that there were ‘hidden’ rules that occurred that were just known and not challenged. This cultural element was thought to further provide context to the findings described in this section of the chapter.

“Undisciplined ... We accept everything.” (FG4 .N,4) or

“This is another thing about culture. You learn through your experience, through your own experience.” (FG4 .N,4).

4.12.1 Promotional Systems in Malta

Only one group of stakeholders mentioned the grading of nursing and that of specialist nurses. The Multidisciplinary Group recognised that in nursing there was an anomaly with the grades (salary scales) and that specialist nurses needed to be upgraded. They stated that they should be paid in the same salary band as Senior Nursing Managers, although they had completely different roles. This was supported by the specialist nurses who stated that they deserved a salary scale increase that would not demand them to leave their specialist role and go into administration.

“in the previous structure you had a Departmental Nursing manager, responsible for a number of wards and areas within a speciality. They are on par, there; they are part of that directorate. (FG1. MDP,2)

“I wish that our grades were improved because I find it unfair that for me to get a promotion and an increase in grade and wage I would have to leave this unit and my specialisation...” SN 2

Specialist nurses and most stakeholders also felt that there needed to be a change in the way nurses are promoted, or chosen for positions within the health service. It was noticeable that the Directorate of Nursing group did not discuss issues that were discussed by all other participants, such as the promotional system of nursing in Malta, the paucity of career structure to progress and the loss of expertise due to these factors. It emerged that in this system, a nurse who worked in an area all her career could be sent as a nurse manager in a completely alien working environment to that which s/he was expert in, and was expected to lead a group of nurses. Consultants were once again very critical of this situation in the nursing profession and emphasised that this needed to be changed and that calls for application should be issued for the specific area to attract the right people for the job and keep experts in their area. An example was given of one Theatre Nurse who was promoted to Charge Nurse and sent to the Mental Health Hospital. There was also agreement that a nurse might be brilliant in practice but not in management and thus you will be losing very valuable expertise.

“Well I think there is a big problem with nursing grading in that to get a promotion, and to get paid more money, you have to become a manager. So you might have a very experienced theatre nurse, who enjoys her work, and her only way of getting seniority is to become a manager, and she might be a very bad manager, but a very good theatre nurse...” (FG3. Cons,6)

Most stressed that the whole system of Nursing needed to be changed to aid the national development of these nurses. The career structure should start from the first day of

employment and nurses should be encouraged to work in an area of their choice and not just sent anywhere in the hospital. This was particularly emphasised by the consultants:

“So the first step is that when nurses come into work, when they are employed, they go to the area where they are best suited for and where they are most likely to give their best output. (FG3. Cons,5)

4.12.2 Politics in Malta with the big ‘P’

It was also evident that the system of promotions or ‘choosing’ professionals was not always transparent and in fact one nurse stated that these posts should not be for ‘blue eyed’ boys. Another consultant stated that there should be a system that cannot be bent to ‘fit’ individuals and yet another explained that sometimes calls for application are not even issued and people are handpicked. In these instances they seemed to be inferring that the system was nepotistic. There was an element, both during the groups and individual interviews, that this lack of meritocracy could be another effect on the professional recognition of nursing posts, both past and present, which could stall progress.

“Well. Criteria should be well defined and written and agreed upon by all stakeholders... Yes, and not some blue eyed boy or whatever; he should be academically well trained, experience is extremely important...” (FG4. N,1)

“There should not be a system that fits individuals, so we can bend it. There should be one system for all, like we have a specialist register for specialists in medicine and to become a specialist you have to follow the full training.” (FG3. Cons,1)

“Or else even worst is if there will be no interview and somebody is put in that role.”
SN 3

In the Nurses’ Focus group the strong political situation in Malta was also referenced as a situation that did not help nursing in general to develop. According to the participants there were too many changes in such a short period of time to build relationships and make the necessary changes. As one nurse expressed, this system destroys everything:

....and there is not enough time to rebuild relationships, when it happens that fast. When you have three directors in one year, for me it destroys everything. (FG4. N,4)

Due to these factors and especially due to the recent changes in Directors at the general hospital, one participant in the MDT focus group stated that the strategy should encompass a vision shared by all stakeholders, and not be attached to a particular person or individual group because if those individuals moved on there would be a problem to sustain it.

“So, I ask is that vision embedded in our values, because if it were it would be no problem to continue with that strategy and we could move on in the person’s absence. But if we had to restart every time then we have to question the strategy.” (FG1. MDP,6)

Finally, it was emphasised that when introducing new systems or innovative roles Malta needed to be intelligent, cautious and ready to learn from other countries. A participant emphasised the need to take the Maltese local situation into consideration when adopting foreign models of healthcare. It was imperative, as she stressed, that whatever was imported would fit into the culture and also ascertain that the resources are available to sustain the changes implemented. The lack of planning was once again discussed in the MDT focus group.

“...we have to be intelligent enough that we adopt what models are in keeping with our culture, and I am talking about culture in the bio-medical culture, that we are part of because sometimes unfortunately we tend to follow and we don’t learn from their mistakes.” (FG2. D,2)

“I think we need a strategy because we suffer a lot in this country because we tend to get this and this and this without a plan. It is sometimes who shouts the loudest who gets it. There is no plan...But without a strategy we will suffer.” (FG1. MDP,7)

4.12.3 Recruitment and engagement of Specialist nurses

The engagement of specialist nurses was another topic discussed by both the specialist nurses and their stakeholders. According to most participants a ‘simple’ interview giving the right to work as a practice (specialist) nurse should be improved by developing these nurses before they actually start their new career. It was suggested that further work was needed to choose the right people during the recruitment phase and that one of the criteria to become a specialist nurse should be a passion for the area they work in and the willingness to further their studies both in the field and also on a continuous level of professional development. Experience in general and in the specialist area was also mentioned as a pre-requisite. A director strongly stated:

“My opinion after ten years is that it is not an experiment anymore, and I think that one needs to consider how for example, these practice nurses are being engaged. It is a simple interview, and from this the next day you will be appointed a practice nurse, and an interview makes you a practice nurse?...I think we need to try and find a way how these practice nurses need to develop themselves before they start their new professional job.” (FG2. D,7)

Another Director went a step further and stated that prior to engagement, the job descriptions should also be changed to allow for the expansion of their role since in her

experience they were restricting the development of these specialist nurses. Some specialist nurses, were not embracing the notion of their role evolving other than what was stated in their original contract that could be anything up to a decade old.

“...also within these job descriptions or structures, one has also to add that people who take them, have also to be open and able to change...we need an evolving job description but I don't know how one could go about it. So we won't get stopped if all of a sudden, a specialist nurse needs to carry out some clinical skills that have now become assigned to us; that we are not stopped by a rigid job description. (FG2. D,2)

Having a system similar to that of the medical profession that will allow professionals to specialise after the call for applications was also mentioned by the specialist nurses themselves. This was thought important since Malta is a small country with limited opportunities and the investment by the professional will be useless if they were not chosen for the post or if the vacancy never materialised.

“You cannot really expect people to invest their time and energy in a Masters in a speciality and then the call never comes out. ...I mean this is the same as the doctors; nobody specialises in, Jien Naf [trans. I don't know] surgery, unless they have a post as an HST or BST in surgery. It is not worth investing in that field since the call may not be issued or in the interview you are not chosen and somebody else is chosen.” SN3

A couple of specialist nurses distinctively stated that when they recruit a nurse they would wish to know her before joining the team:

“I think I would want to know that person beforehand, before having her on my team, not somebody who is just given to me.” SN 4

This was an unexpected request, however they explained that one might be working with this person for life in the current situation in Malta. It was also considered necessary to know how capable she is to work alone, with patients and within a team. Thus they felt it necessary that they would be part of the selection group and not be just given ‘a nurse’ to join because this could affect the whole team and service if chosen incorrectly. This was also considered important by the Consultants who further explained that as experts in their field and running their clinics they should be involved in who, and how many specialist nurses were recruited. They referred to another criticized system in Malta that ‘no one is ever fired’ thus if you get an unlucky draw of a nurse you are stuck with her/him for the rest of your career.

“Here you cannot do it even from the legal point of view ... God knows I had proof and I had everything and I had to pass through a lot of hell and this one wasn't even fired, he was placed somewhere else.” (FG4 .N,5)

The 'silo' situation of the hospital was referred to and most insisted that this did not bode well for the specialist nurse right from the very beginning of her engagement.

“Over here there are these silo effects...So if we have a unit, we have no say at all on how these nurses apply, are selected, chosen, how many they are, there is none of that...” (FG3. Cons,6)

4.13 Lack of empowerment

It was felt that there was a sense of powerlessness. It often came across as ‘What can we do? That is how things are done in Malta.’ This sense of helplessness seemed embedded in all the participants except the Consultants who seemed more assertive and more in control. One specialist nurse pointed out that they are not treated equally not even within the group of specialist nurses, since they are doing voluntary on-call hours. Her emotion was evident when explaining the situation and one could sense hurt and frustration:

“We also have a voluntary on-call system No we do not get paid for it, I asked to be compensated, I asked a year and a half ago, before the elections, so (laughing) and till now we had no compensation given. I raised the issue again two weeks ago but I find closed doors.” SN 5

Information was obtained not only from what was said but also from the silences and lack of discussion on certain issues that could affect the development of specialist nurses, namely their scope of practice. As mentioned above, only one specialist nurse mentioned the Council of Nursing and this was not brought up in the nursing focus group. This lack of awareness or ‘interest’ was further evident in that the nurses, although aware of the ‘new’ agreement signed by the government and union on behalf of all nurses, were unaware of what it entailed. As they stated they were aware that certain titles were changed and that they increased a salary scale.

“I think we need to really know what it consists of, nobody really gave it importance, like with any other documentation... it is frustrating not knowing anything.” (FG4. N,4)

“We were more concerned about changing names, the nomenclature.” (FG4.N, 5)

4.13.1 Power Distance Culture

This topic was discussed heavily in the Consultant’s group, related to the responsibility of these professionals and how they thought that specialist nurses were not all taking this on with respect to their daily and future roles. This was also explained in terms of the effect of the Maltese culture that had adopted a Mediterranean and North African system of having a pyramidal organisation. This, according to one consultant, created the ‘power distance

culture' that discourages people from taking responsibility. Moreover, the consultant further clarified that specialist nurses that are well trained and do not shed responsibility might actually be seen as being arrogant or 'pushy'.

"... so power distance cultures, where people are envisaged to be towards the apex of the pyramid, those in the base, will defer any responsibility that is characteristic across all these cultures. ...over here Mediterranean and North African, it is very pyramidal. ... I see that those who are actually and formally trained, those who go to meetings, those who perhaps do some research, or write papers. Those are people who do not shed responsibility absolutely. On the contrary, some people see them as being too pushy, because they are exactly what their UK counterpart is doing." (FG3. Cons,2)

It was also acknowledged that 'this fear' might be coming from other sources, including the union and administrators:

"I think the fear does not come from the specialist nurse him/herself. They are usually very enthusiastic to continue training and pursuing their service in their area of speciality. It is more the people at the top in the union and so on who show this fear..." (FG3. Cons,4)

This sentiment was confirmed in the Director's group and also by a few specialist nurses. It was stated that Nursing was cautious of developing these roles further just in case they were challenged and asked what these nurses were doing.

"Till today we have been very much cautious of the development because this is the dilemma, we don't want to be over zealous and create a lot of posts, whereby someone would challenge us and tell us what are these practice nurses doing? So till now we have threaded a very cautious pathway." (FG2. D,1)

When one considers what was being discussed – fear, lack of direction, clarity and legal backing – it again points to a lack power in nursing.

4.13.2 One Coordinator/Manager for specialist nurses

The clarity of lines of accountability varied considerably between specialist nurses interviewed. Most were accountable clinically and managerially to the senior nursing manager for their area but felt that the nurse manager did not have the expertise to advice other than on general administrative matters. One coordinator for all of specialist nurses was considered to be another important future support mechanism by most participants. The manager would be the coordinator and the voice of each and every specialist nurse and specialty. A nurse further explained:

“It is important because everyone will be on the same wavelength. So we are talking in the same language, the same direction... Also if they are together, they can look at each other and say look I can do that and help you with that, everybody can learn from each other.” (FG4. N,5)

This finding correlated with what the specialist nurses wished. They were in agreement that having one manager was the way forward. Although they had different roles, they seemed to have common elements in their role and also common challenges. Having the support of one manager was further needed to facilitate meetings with all specialist nurses as a group since they thought that meeting together would not only increase their collaboration but would also be a learning exercise.

“It would be nice to buddy, because it is like you identify with a group of people so when I come to work that I feel I am one of a group and not on my own. So that would be good but then as well it is for the patient as well. Some specialist nurses I don't even know and we are working in one hospital – you know?” SN 9

The concept of having these specialist nurses brought together as one group was also discussed and supported in the Multidisciplinary Focus Group. One participant suggested that specialist nurses would benefit from being part of a group because they would feel that they ‘belonged’:

“Even though they have different specialities they can still have a standard way of getting the knowledge and a standard way of developing an SOP, a standard way of developing a care path way ... they need to have a forum.” (FG1. MDP,4)

4.13.3 Career Advancement of Specialist Nurses

As mentioned previously the plan was that there would be a structure for specialist nurses (Practice Nurses) to advance in their career or rather be promoted. The directors of nursing pointed out that there would be two other scales within this structure. However, it was stated that the title of consultant nurse would not be used. Instead the title Advanced Practice Nurse was mentioned as the title chosen, denoting the consultant nurse's role in the UK. This, as was explained, was due to the perception that ‘Consultant’ was owned by doctors, and nurses could not use it.

“... Because even the word consultant, is a bit dirty because the doctors wanted to take ownership of the word consultant also. So the Euphemism of the word consultant is the word Advanced Practice nurse...” (FG2. D,1)

However, during the Medical Consultants' Group, without prompting, they suggested that specialist nurses should continue going up to consultant level. It was emphasised that although they would encourage this post, the title should be accompanied by a system that

would allow the practitioner to be independent and responsible for their work, plus that they would have followed a transparent and systematic criteria of training and competency testing to fit with the job.

“...as long as there is a structure and once he is consultant he takes all the responsibilities of a consultant nurse, but I would not have any problems because he/she has been trained.” (FG3. Cons,4)

4.13.4 The Nursing Union in Malta

In the findings stakeholders, mainly the directors and consultants and a few specialist nurses, felt that the Nurses’ union was a detriment to the specialist nurses’ development. As one Director actually stated:

“We are trapped by the schizophrenia of a union, or a body, which is in favour of the development of the profession of its members and then giving out directives that go against that spirit. And I am talking very responsibly here.” (FG2. D,1)

There was a general feeling that the union was directing the nursing agenda, and hospital policies were not run by management or the Ministry, but by the union. It was further emphasised that the much needed training programme would not happen until the union accepted it.

“And the issue is that policies in this hospital are run not by the management or the Ministry, but by the union... Until the union accepts that for specialist nurses to be called a specialist nurse, you need to have training, examinations and competence, we are going to skirt around the issue and fudge around the definitions, mix everything up together.” (FG 3. Cons, 2)

A specialist nurse agreed and further explained that the union worked and influenced people by creating ‘fear’ to get nurses to do what they are instructed with minimal challenges.

“And as you know the union has a lot of influence on a lot of people. Very few are able to challenge what the union says because again they are scared and the union knows that if they base their information on fear they get people where they want. If you analyse their communications the basis is fear.” SN 3

4.14 Nursing Care Decline – Handing over Nursing to carers

In relation to the misuse of specialist nurses’ services, an off-shot unexpected discussion evolved around the possible reason why this could be happening. Although there was general consensus that nursing developed, there was also a feeling that nurses were forsaking their bedside nursing duties and that care was being neglected and handed on to untrained carers, which they felt was not correct. There was general consensus that the quality of care

decreased because a lot of the work with patients was handed over to ‘untrained’ care workers. As one specialist nurse commented:

“That scares me because a lot of paperwork, a lot of desk work and then what is happening to the patient in that bed, it is scary that the care workers stay with the patient more than the nurses that seem not to have enough time for the patients, and the nurses are the ones that know more than care workers.” SN 8

Another specialist nurse actually felt that nursing regressed since it seemed that roles were being held back or not seen as a nursing role anymore:

“We are deskilling nursing. So we can’t insert a cannula, this we cannot do, this we cannot do, that we should not do – so I ask what are nurses supposed to do? Paperwork? Give a bed pan? No, not even giving a bed pan is considered our role anymore!” SN2.

With every development come its challenges. An area that did not have such dispute was the issue of deskilling colleagues. Most of the participants were aware of the situation on the wards and that the services of the specialist nurse were being misused. As one nurse explained:

“they (specialist nurses) are supposed to be just an extension of the service and not to replace that actual care and service”.(FG4. N,4)

A few specialist nurses actually remarked that they could have influenced this development. This was associated with role ambiguity and was described as a big challenge since staff had got used to them doing certain activities and that changing this practice was not easy:

“I go back to the role ambiguity and this I blame on the specialist nurses themselves, on us sometimes. Sometimes I question, we have developed these roles, they improved patients’ outcomes definitely, but sometimes I question if they are improving our nurses’ education? Are we leaving nurses to rely a lot on specialist nurses?” SN6

The word ‘abuse’ was used strongly and the nurses expressed their concern for not having a system to oversee what was going on. Examples of how these nurses were being used incorrectly included being called not because the ward or patient had a problem but because the staff were too busy to perform the task, so the Tissue Viability nurse would be called to change the dressing of a wound, or the clinical nutrition nurse to insert a nasogastric tube. One nurse called it a ‘take away’ system that should be stopped immediately and action taken to change this abusive situation. Remarkably, another nurse explained that without these ‘things’, referring to specific tasks the specialist nurses undertake, nursing would not be interesting, and thus should be in the interest of all to oversee what was happening on the wards since this could be a demotivating factor for nurses.

“So from areas I see development but from other areas there is the element of deskilling these nurses. And again, however, it shouldn't be and it should be the responsibility of the specialist nurse to make sure that nurses are not deskilled.” SN6

“Most of all the abuse of the system which is sometimes rampant, and I agree 100% that this should be changed.... So but you will get, especially novice nurses working who think that this is like a ‘Take away’ thing. Which is not on... (FG4. N,1)

To compound the situation, it was pointed out that there were no protocols or guidelines to enforce the follow-up of the advice given by these nurses, and it often happened that nurses on the ward would not comply with what was advised, creating lack of continuity and confusion of care.

“So for two days you might have a particular care plan and that would change because somebody else thinks that they prefer this dressing ... there are no protocols there to enforce them to continue.” (FG4. N,6)

Standardisation was one way of overseeing the system especially to try and reduce the chances of deskilling the nurses on the ground. There was full agreement that there needed to be a uniform system to use the services of a specialist nurse obliging both the professionals calling them and the specialist nurses to follow guidelines or protocols to curb the tendency that nurses or doctors called specialist nurses routinely without judicious care. Even more of concern was that as the nurse below stated; some nurses felt disempowered to care out of a fear of getting in trouble because the specialist nurse was not consulted.

“Consultants quite often refer to them routinely, so if there is for example any wound, they would call Tissue Viability, they are brought in no matter what. Which makes the nurse kind of feel that she is not able to do it, and maybe would actually get into trouble for attempting to do something that she may have the knowledge to actually manage.” (FG4. N,6)

A suggestion by one director was that all concerned had to stop and think about what was happening to the clinical nurses on the floors. It was evident from the findings that there was misuse of their services and thus better coordination and integration into the system should be a direction to take for the future.

“...we are getting rid of what I tend to believe is an integral part of our job, just for the simple reason that there is a specialist nurse. So there should be co-ordination, something that will do the opposite of what I feel we are moving away from each other. The specialist nurse is going in one direction and the clinical nurse is going in another direction so basically we need to integrate all this.” (FG2. D,8)

4.15 Medical dominance and equality amongst professionals

The influence of the medical profession on nursing in general and also on specialist nurses was mentioned by most specialist nurses interviewed as a factor that could be hindering their development. Most felt that doctors felt threatened by their position and that further advancement such as the issue of prescribing is being stalled because of doctors not accepting this as part of their role.

“We all know the problem here in Malta. The doctors are very dominant and they are refusing to give us this status as a nurse practitioner. I see it that in a way the doctors have a part to play in the lack of development in nursing – that is it!” SN5

One nurse even explained the fact that the uniforms were a means to create inequality and the following quote from this specialist nurse showed the power difference between the professions. The indirect emphasis in this quote could also indicate the dominance of the male-female culture in Malta.

“In Malta, the uniforms alone will let you know that we are not equal. I am a consultant, you are a doctor and ... There is big power difference here in Malta between doctors and nurses. You are not going to tell me what to do, you do as I tell you.” SN2

Private medical practice was also revealed as a deterrent for specialist nurses because if specialist nurses were to offer a better service in the national hospital service their private practice might be affected.

“...this is a really good role for a specialist nurse but there are a lot of interests when it comes to private practice so yes they will push back.” SN3

One specialist nurse also pointed out that funding is needed to be treated on equal terms as other professionals, especially when it comes to remuneration of work and funds for education. It was felt that there was discrimination between doctors and nurses since doctors have much more resources. Furthermore, link nurses; unlike link doctors did not have a sum of money to act as lead practitioners in an area although they worked in the same department.

“There is also a big difference between a nurse and a doctor. Why should a doctor have more funds than a nurse to travel? What has a nurse got less or different than a doctor?” SN 2

The hospital does not see investment in these roles as a priority. Contrary to these outlooks, the consultants felt that the union was holding back on the progress and expansion of these nurses. The consultants spoke about first-hand experience of how the union stopped

the nurses from developing, as in the following example of not wanting specialist nurses to take the lead in the coagulation unit.

“They would have been trained into the care of patients with warfarin, or any other coagulation, and they could dose the patient themselves and could give the warfarin to the patients themselves. This was unfortunately not agreed by the union of the nurses, to get a specialist nurse in this area. (FG3. Cons,4)

4.16 The future

Most of the 28 participants in all four Focus Groups spoke positively about the specialist nurses in Malta and envisaged that their role should develop further with the right support and structure in place. They praised them for their skills in caring for their patients and moving the nursing profession forward by keeping updated through evidence-based practice and sharing this information.

“... the experts in that field and anything else it entails with patients, with training, with research, even training other nurses.” (FG1. MDP,4)

Finally, the quote below captures most of the sentiments felt about the development and value of specialist nurses in Malta:

“The way forward is that specialist nurses should stay, get nourished and progress. The way forward is that we make them better. Everybody, especially the patient, will benefit a lot out of them.” (FG4. N,1)

“So being a specialist nurse is a ‘big deal’, not anybody can be one.” (FG3. Cons,5)

4.17 Summary of Case Study Findings

The aim of this qualitative case study was to explore the experiences of specialist nurses in Malta both from their perspective and that of their stakeholders. Table 11 demonstrates an outline of the findings and illustrates how the research question and objectives have been met from the findings that evolved in three main themes. As evidenced all the study objectives were reached and the research question answered. In relation to the theme *The roles and attributes of specialist nurses in Malta*, the strongest evidence from all data sets was related to the roles of a specialist nurse. Although the roles of these specialist nurses varied they still incorporated a range of activities that were similar. These included being an expert resource in practice, education (patients and staff), training of professionals, procurement of equipment and items for their specialty. The specialist nurses that were involved in patient care were also seen as case managers and navigators of their journey, who were accessible and who provided person-centred and evidence-based nursing care. In relation to the research

question, although the stakeholders mostly concurred with the experiences of the specialist nurses on their roles, there were important differences in expectations. Noticeable differences included the consultants' expectations that specialist nurses could take on more responsibility and reach consultant nurse level and that they should be more involved in financial matters related to their service. This was also echoed by the directors'/managers' groups who pointed out that specialist nurses needed to become more 'business minded'. When discussing the attributes expected of specialist nurses, diverse and numerous suggestions were put forward. However, both the specialist nurses themselves and their stakeholders discussed the need to have the 'right' personality that supported the last proposition of this case study. The need for good interpersonal skills and related aspects, including assertiveness, were voiced strongly. Being a leader, both clinically and organizationally in producing policies and change, was acknowledged by most participants. Having a positive attitude and being approachable were recognized as being essential attributes for the success of a specialist nurse. However, there was debate in the multidisciplinary group of whether diplomacy was needed or not. Although most stakeholders and specialist nurses perceived this attribute as being essential, there was concern that diplomacy could lead to someone being dishonest.

Theme 2, the development of specialist nurses, highlighted the support of their role from management and the need for the preparation of specialist nurses. Within this theme two other research objectives were constructed and related to the experience of the development of specialist nurse and a historical account of their development. This theme also included part of another objective in identifying what hindered specialist nurses' development. From the specialist nurses' accounts it was unmistakable that they persevered and most started a service or a unit with minimal training and resources. Notwithstanding this, as pioneers, they also felt proud and satisfied in their jobs. Specialist nurses and stakeholders pointed to organisational challenges and explained how they did not have the necessary requirements to develop their role. This was evident also in all stakeholder groups who agreed that when a new role is developed support was needed with the necessary planning and funds for it to be sustained and developed. All participants agreed that the minimum requirement for a specialist nurse was a Master's degree with a number of years of experience. The findings revealed collectively that participants believed that the legislation in Malta needed to be changed. There was also agreement among the stakeholders, especially the consultants, that the Scope of Practice needed to be updated coupled with the introduction of a specialist register to allow specialist nurses to practise autonomously and within the parameters of the

law. The need for a structure and a framework at national level was seen as an important step by all participants in ensuring the development of these advanced roles that would also make them more credible. Most perceived that the paucity of having a framework was affecting the autonomy to practise as a specialist nurses especially in performing activities such as interpreting results and altering treatment, and was still not clear if this was organizationally and legally accepted.

In Theme 3, the influences on the advancement of specialist nursing practice in Malta, two other objectives of the study were captured. There were differing views between the nurses and the medical consultants on the influences that affected specialist nurses. Nurses from all backgrounds, thought that the main influence related to the medical dominance and power of the doctors in Malta and thus hindering their progress. This indirectly related to gender issues within the profession of nursing since most felt that as nurses they are discriminated against in the conditions of work and in the opportunities provided. In the directors/managers groups they also had similar thoughts and even suggested that they could not use the title of consultant nurse because it was ‘owned’ by doctors. However, most of the medical consultants agreed that specialist nurses could develop further in their clinical roles and expand their skills even to consultant level. Thus, there was incongruence in their perceptions since the medics did not seem to perceive their influence on the development of specialist nurses, but attributed this to the lack of responsibility and framework that existed within the nursing structure. All data sets supported the notion that a framework is needed not only in the preparation but also in the procedures of how they are chosen, monitored and standardised. It seemed that there was recognition that the development of these positions should be more transparent and standardised. There was also consensus that the procedure of choosing a specialist nurse needed improvement since “a twenty- minute interview’ was not adequate to identify potential recruits for this position. The Maltese medical model of choosing and training specialists was mentioned as a possible framework to use for nursing specialists. Finally there were other important findings that answered the research question. A significant finding was related to the nursing care decline at the bedside and the cultural situation of nursing in Malta, especially related to the lack of empowerment in nursing. The bureaucratic and hierarchical system with political interference was felt by most participants, and this could have been related to feelings of helplessness into changing practice and conditions of work. These issues will be discussed and expanded in more detail in the next chapter.

Table 11. Case Study Findings: Themes, research question, and objectives

Case Study Findings		
Research question: <i>How do SNs in Malta explain their roles, development and experience and do these concur with those of their stakeholders?</i>		
Theme 1: The roles and attributes of specialist nurses in Malta		
Specialist Nurses and Stakeholders Agreement	Stakeholders' different perspective	Case study Objectives
<p>Common roles exist amongst specialist nurses although coming from different backgrounds.</p> <p>These include: patient and staff education, research, management and administration.</p> <p>They are considered -Expert Practitioners, Case-manager, professional leader, transformational leader</p> <p>Extended and expanded roles Administrative and procurement roles should be deployed to other workers</p> <p>Providing quality, evidenced-based and person-centred care Whole package: education (Master's Degree) and training, experience and personality. Interpersonal skills, assertive, approachable, passionate team player, motivated, love their job and positive</p>	<p>Consultants: SNs can take on more financial responsibility.</p> <p>Consultants: Some SNs are afraid to take on more responsibility to increase autonomy.</p> <p>Consultants: with the right education and training to become consultant nurses.</p> <p>Directors/managers: SNs need to be more business minded.</p> <p>Multidisciplinary: SNs should not be diplomatic – diplomacy felt as being dishonest</p>	<p>Explore the scope of services offered by specialist nursing throughout Malta</p> <ul style="list-style-type: none"> Identify roles and services provided by specialist nurses Explore the attributes of a specialist nurse
Theme 2: Theme: The development of specialist nurses		
<p>Support from immediate managers is a prerequisite for success</p> <p>The need of a legal, regulatory, educational and training framework; Clear definitions and title change; Happy with progress but more needed, especially in the community; Scope of Practice and Job descriptions need updating.</p>	<p>Directors and Consultants did not mention: having one manager to direct SNs. Unlike SNs, burnout was not mentioned</p>	<p>Explore the specialist nurses' and their stakeholders' experience of their development</p> <p>Provide a profile of specialist nurses; Provide a historical background of their development (Findings in Table 10).</p>
Theme 3. The influences on the advancement of specialist nursing practice in Malta.		
<p>Paucity of support from: Union; Organization re: promotional and recruitment systems; Cultural issues including political influence; paucity in leadership and empowerment. A decline in nursing Care at the bedside; Gender issues</p>	<p>Consultants do not see medical dominance as an influencing factor on the advancement of the SN but see a lack of training and structure in nursing. Consultants, Managers and the multidisciplinary group did not mention bedside care as an influencing factor to SN development</p>	<p>Explore the influences on the advancement of specialist nursing practice in Malta</p> <p>Explore what factors supported or hindered specialist nurses' progress (some aspects discussed in the previous theme)</p>

4.18 Conclusion

This chapter described and interpreted the findings of this case study and analysed the development and preparation of specialist nurses and their services in Malta. The findings also outlined the experiences of both specialist nurses and their stakeholders, of their role and their potential for future development. It was notable that there were two types of specialist nurses; one more clinically orientated with patients, clinics and caseloads and the other with a more practice development element with minimal contact with patients. Notwithstanding this, they had common elements and challenges in their roles. The case study showed that stakeholders held positive opinions on the impact of specialist nurses. The results mainly related to the encouraging impact on the profession, the patient and the quality of the service. All groups agreed that specialist nurses were part of the evolution of the nursing profession and that they seemed to be more accepted today than before. On the whole, specialists were perceived as being passionate about their role and were described as dedicated and motivated. There was a positive feeling that the development of specialist nurses was needed and that certain measures were under way including a structure that would allow them to grow in their advanced position without the need to leave their specialty to be promoted. Moreover, despite all the challenges that they faced, most specialist nurses saw their position as a positive move in their career that gave them job satisfaction. They also seemed motivated to continue to develop and expand their role for the benefit of the patients.

The following chapter will critically discuss the described findings that were constructed from the data within the context of the current literature reviewed.

5 Discussion

5.1 Introduction

The overall aim of this case study was to explore the experiences of specialist nurses in Malta. A survey with all specialist nurses (N=27) identified their roles, services and attributes and provided a profile and background information to these nurses. Interviews with nine specialist nurses and four focus groups with their stakeholders gave additional understanding on the influences on the development of specialist nursing in Malta. As demonstrated in the previous chapter (section 4.17) the findings answered the research question and met its objectives (see Table 11). The three themes that were presented in Chapter 4 will be discussed consecutively in this chapter, namely: the roles and attributes of specialist nurses in Malta, the development of specialist nurses, and the influences on the advancement of specialist nursing practice in Malta. The analysis of the data, particularly the participants' comments and recommendations for specialist nursing in Malta, revealed findings that had not been predicted from the study. These included the shortage of nurses and the organisational culture that was perceived by the specialist nurses as causing a decline in 'nursing care' on the wards. Another issue arising from the findings that was worth exploring further was that of the potential for nurses' burnout including specialists who had not been reviewed previously. The inductive nature of qualitative research indeed encourages me to include any additional relevant literature in the discussion of the findings (Merriam 1998). This included a recent study published in the European Union (EU) called *Consortium for the Study of Effective Health Workforce Recruitment and Retention Strategies*, (CSEHWRRS 2014) that was used to further support the unexpected issues arising from the findings. At the end of the chapter a summary of the findings and recommendations from the study will be outlined, closing with a personal reflection and concluding remark.

5.2 The Roles of Specialist Nurses

The findings from the study showed that the main roles that were described both by the specialist nurses themselves and their stakeholders revealed significant consensus around clinical practice. While there were varied roles across settings, agreement for several items was achieved especially in areas of providing quality evidence-based practice, delivering education to patients, families and staff and acting as the patient's advocate. In fact, the role

they participated most in was supporting people to enable them to manage / live with their condition and to optimize health. The findings of this study relating to the clinical domain of the specialist nurses' roles can be triangulated with several other sources including: the core job descriptions identified at a national level (Appendix 14, Call for applications) and studies of specialist practice internationally (Begley 2010; Ramis et al. 2013; CSEHWRRS 2014), that encompassed the clinical domain; patient advocacy, education and training, consultation, research and audit. Other studies including Manley 1997; Gibson and Bamford 2001; Read 2001 and Ball 2005, may be thought to be outdated, but the issues they study and highlight are still very relevant both for the Maltese and International scenes. Furthermore, their findings and arguments have been supported by later studies and authors discussing the subject, especially the clinical focus of their roles. For example, the SCAPE (Specialist Clinical and Advanced Practitioner Evaluation) (2010) study carried out in Ireland by Begley et al. (2010) revealed that nurses in both roles were seen as having the autonomy to manage their caseloads, which ensured smoother transition of patients/clients through the healthcare system. Similarly DiCenso and Bryant-Lukosius (2010) in a Canadian study exploring the development of clinical nurse specialist (CNS) and advanced nurse practitioner (ANP) roles found that clinical practices through a direct relationship or supportive and consultative interactions were the focus for these nurses. Furthermore, a survey of 18 countries carried out by Pulcini et al. (2010), although illustrating various roles and contexts that applied to advanced practice internationally, further mandated that any ANP needed to engage in direct clinical practice, defined as direct care. Given the close links between ANPs and specialist nurses worldwide it could be concluded from this that Maltese specialist nurses appear to be following the international trend of focusing their role on direct clinical practice with the aim improving care quality.

In addition to their role in clinical practice, my study findings highlighted the importance of their professional leadership. Most participants agreed that a specialist nurse in Malta should be both a role model and change agent to develop standards of care through guidelines and standard operating procedures. This was further supported in other studies in the UK (Ball 2005), Australia (Ramis et al. 2013) and across the World (Pulcini et al. 2010). Delamaire and Lafortune (2010) found that internationally, including mostly European countries but also Australia, the USA and Japan, specialist nurses' roles had professional responsibilities for improving nursing practice and the delivery of health services requiring competencies related to collaboration, education, research, leadership, change management,

and professional development. In another methodologically strong study, DiCenso and Bryant-Lukosius (2010) undertook a detailed scoping review of 468 published papers (both Canadian and international studies), 62 interviews and four focus groups with national and international key participants, and supported the growing international consensus related to the specialist nurses' professional leadership role outlined in this study. Although it seemed that the majority of specialist nurses in Malta embraced the professional leadership role, it was evident that some found it more difficult than others to fulfil this element of their role. One factor that was emphasised was the lack of time due to an increasing work load and occasionally the lack of involvement from the directorate of nursing. This would suggest that further investigation needs to be carried out to establish the extent of specialist nurses' strategic involvement and opportunities to lead change, identifying any enablers of leadership in their role.

On the whole, the evidence gained from this study and that of the international literature indicates an agreement with the core role components of a specialist nurse. The four main pillars of advanced nursing practice described by Hamric's model (1989) – expert practitioner, educator, researcher, and consultant – and later supported by Manley's (1997) conceptual framework, were all highlighted in this study by all participants. More recently these same roles were also supported by an international systematic review carried out by Sastre-Fullana et al. (2014) and in the transformational advanced professional practice (TAPP) model in the US (Elliott and Walden 2014). These competencies were also consistent with the conceptualization of the role of an advanced practice nurse who, according to the International Council of Nurses (ICN) (2002), would be a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice. Sastre-Fullana et al. (2014) conducted a systematic review and content analysis of 119 relevant articles and 97 documents of grey literature from 29 countries. Using five APN models of professional competencies and four APN competency assessment instruments as reference frameworks they revealed 17 worldwide communal competency domains. These domains included research, clinical and professional leadership, mentoring and coaching and expert clinical judgement that were present in 16 countries. Although the findings of Sastre-Fullana et al.'s (2014) study point towards common competencies across various countries that help shape the role of advanced practice nurses internationally, it is important to note methodological difficulties in reviewing international studies. As Scott (2008) states, there is still a conceptual weakness of instruments used globally to assess APN

roles and secondly there are differences in competency definitions (Scott 2008). Additionally, competencies in health professions, as Epstein and Hundert (2002) explain, are subject to contextual and local elements that make it difficult to extend them to other contexts and countries. Nevertheless, the review (Sastre-Fullana et al. 2014) is important since it identifies a minimum set of competency domains attributed to the APN roles that can act as a benchmark in the implementation process of new APN, roles independent of the legislative, regulatory and professional context of each country.

While the roles identified in this present study in Malta were similar to roles and competencies identified in other studies internationally (Begley et al. 2010; Delamaire and Lafortune 2010; DiCenso and Bryant-Lukosius 2010) there were inconsistencies in the perceptions and practice related to research. For example, this study found that although research and auditing were identified as important components of the role of specialist nurses, they did not feature highly in their daily activities. Specialist nurses stated that it was hard to find the time to perform research due to limited resources, knowledge and an increased patient case load. The issue of funding to train in research skills and lack of secretarial support were particularly mentioned as barriers to carrying out these roles. Notwithstanding this, the participants, although minimally participating and carrying out research directly, spoke about how they utilized, critiqued and shared research in their work. They also provided examples of them disseminating updated evidence with their colleagues and developing evidence-based guidelines. According to Hodgman (1983) the researcher's role has three levels, including the first of utilizing, evaluating and communicating research, the second as translating and applying research into protocols and the third as replicating and generating original ideas and undertaking collaborative research.

Thus, from this study it emerged that Maltese specialist nurses needed to further develop the third aspect of this role of conducting and participating research. This result was similar to other UK based studies that found only a minority of these nurses initiated or participated in research (Ball 2005; Gibson and Bamford 2001; Reed 2001). Although these studies were over a decade old the issues they highlighted still make them relevant to the Maltese context. For instance, Gibson and Bamford (2001) found that in their focus group discussions with specialist nurses there was much debate surrounding the research component of their role and although seen as essential they often presented difficulties when allocating time and identifying priorities. Gibson and Bamford (2001) also found similar anxieties to those expressed by specialist nurses in Malta in their abilities regarding undertaking and

publishing papers. Additionally, more recent studies including Whittaker et al. (2014) still report that the majority of specialist nurses are not involved in research but would welcome the opportunity. Whittaker et al. (2014), in a UK community-based study on palliative specialist nurses, further reported that limited resources including, inadequate staffing levels, lack of time and limited financial support, were barriers to the development of their role. These issues were also reported in a recent Canadian synthesis report (Bryant-Lukosius et al. 2016) that identified the need for protected time for non-clinical activities including research. Therefore, it could be suggested that specialist nurses world-wide need to invest more time in education and development of research skills as well as gaining financial and organisational support for them to carry out this important element in their role.

5.2.1 Roles that could be deployed

This present study found that specialist nurses in Malta were expected to undertake non-clinical duties such as the procurement of equipment, clerical duties and the organising of clinics for consultants. Procurement and training staff for new equipment were seen by specialist nurses as a 'hidden' part of their role that took a great deal of their time. Conversely, consultants were pleased to be 'rid' of this chore and were happy to transfer this responsibility on toward specialist nurses. Moreover, although the specialist nurses agreed with their involvement in procuring new equipment and, to an extent, the training that goes with it, they opposed the lack of support from the organisation to perform such duties since it took them away from their patients and other important roles, including audits and research. Belling et al. (2008) in the UK and Ramis et al. (2013) in Australia reported similar findings and stated that it seemed that the world over (Jones 2005), specialist nurses were expected to undertake non-nursing duties such as administration work, which removes them from patient care. Ramis et al. (2013) carried out a systematic review of qualitative evidence on the experience of being an advanced practice nurse in Australia and added that the undertaking of non-nursing duties led to working above contracted hours and potentially contributed to exhaustion and burnout.

With regards to the procurement and training being offered for new equipment, these were not specified in either National or in International role outlines of the specialist nurse. However, it was found that in the UK, specialist nurses were employed as Clinical Procurement Nurse Specialists (CPNS). According to Horkan (2009), CPNS could lead nursing and other clinical teams through change management and decision making processes

to have products in use that have the best available evidence for use in practice. These CPNS led on the patient safety agenda, introducing safer products and impacting patient care through a clinically developed project plan that improved the quality of care and patient experience. Horkan (2009) further explained that these specialist nurses had been successful using a managed approach to the introduction of innovation into the NHS with proven outcomes and a significant cost savings achieved in both Trust and regional roles. Although Ford (2015) explained how one nurse saved a Devon Hospital over 400,000 Pounds Sterling through a project to buy best-value for money equipment, no scientific studies were found on the outcomes of these specialist nurses in the literature. Taking this into consideration it would be advisable to perform a needs analysis of the situation in Malta due to the shortage of nurses, and also to see if this was the best option to utilise specialist nurses' experience. Further consideration would need to be taken with regards to the employment of CPNS or to the introduction of procurement officers who would undertake the administrative work for specialist nurses. Also, staff nurses could be deployed with their team to help support the training and education, or the companies providing the equipment would be obliged to offer training within the contract. Similarly, specialist nurses would need to discontinue organising consultants' clinics in a traditional 'handmaiden' role with all the clerical duties involved, transferring this role to appropriately trained clerks. Such action was supported by the Royal College of Nursing (RCN) (2010), which insisted on not wasting valuable time of specialist nurses that would in the end maximise their value for money and ensure that they did not spend time on activities that could be undertaken by lower-band or administrative staff. This study recommends the re-evaluation of these aspects of specialist nurses' roles to ensure that a substantial proportion of time could be redirected to more appropriate specialist work and to carry out more significant duties, including research and professional leadership-related roles with the necessary support of time and human resources.

5.2.2 Attributes of Specialist Nurses

This study found that the specialist nurse's role was one that was described as patient-focused and concerned with being the patients' advocate and 'being there', meaning being available and accessible to their patients and their families to improve care quality. Thus, one of the attributes that was emphasized by all participants was that of being a good communicator, essential to a person-centred approach and vital to facilitate and build relationships both with the patients and their families as well as with other healthcare professionals especially

physicians. In this study, there was also consensus about certain core qualities both from the specialist nurses themselves and also from their stakeholders. To recapitulate on the findings, most participants felt that specialist nurses needed to ‘love’ their job, be passionate and motivated about their work. It was also mentioned by most participants that specialist nurses needed to have the ‘right’ personality and attitude encompassing attributes of being: caring; empathic, approachable and determined, a risk taker to change practice, trustworthy and assertive. From these findings, the attributes of a specialist nurse could be divided into two perspectives: interpersonal and transformational personality characteristics.

The interpersonal attributes highlighted in this study were found to be important in other international studies (Ball 2005; Begley et al. 2010; Ramis et al. 2013). Sellgren et al. (2007) state that the nature of nursing emphasizes the relationship and humanistic values required of the specialist nurse, thus interpersonal attributes were seen as vital within people-oriented professions. According to Coates and Gilroy (2012, p.30) a specialist nurse had to have a ‘big heart, broad shoulders and be approachable’. Ramis et al. (2013) found that having the knowledge and skills to provide expert nursing care was essential, but the analysis within their Australian review additionally uncovered attributes of caring such as trust, empathy, diplomacy and being a confidante as being an essential part of the nurse-patient experience.

In another study Belling et al. (2008) explored stakeholders’ perceptions of specialist nurses. The study was carried out in the UK and focused on 139 qualitative descriptions of patients with Inflammatory Bowel Disease (IBD) and their families’ perceptions of the specialist nurses’ role. After thematic analysis, 24 role behaviours and 12 personal attributes were identified including being kind and caring and understanding and emphatic. The Belling et al. (2008) study, however, added an important dimension of the attributes from a patients’ perspective. They placed a considerable value on empathic understanding, communication and providing advice and reassurance. It was also apparent that the patients valued the elements of continuity of care and accessibility. Belling et al. (2008) studied only one type of specialist nurse (IBD) and in one country (UK), making transferability of their findings limited because of being specialty- and country-specific. But their findings are meaningful since they highlighted a range of behaviours and attributes that were emphasized by patients and their families. Begley et al. (2010) further supported this element of the role and found that patients in their study valued feeling respected and involved. Thus, it may be possible to conclude that the findings of this Maltese study that emphasized the caring dimension of

specialist nurses, embedded in a therapeutic relationship and the attributes needed for those nurses to be in a position to carry them out, would not only be important in Malta but also supported internationally.

This study also found that specialist nurses needed to be keen to learn and advance their practice and that of others and not to deskill professionals. They needed to be open to change and improve practice, suggesting transformational leadership qualities. Transformational leadership is a concept that was discussed nearly 20 years ago by Manley (1997) in the context of advanced nursing practice. She found that the process used by these practitioners required leadership attributes to be able to develop other nurses to provide quality nursing services. Manley (1997) identified processes that included developing a vision, valuing and caring for others, and creating opportunities and support for others in their development. This leadership attribute of specialist nurses was supported by more recent studies including: Belling et al. (2008) in England, Begley et al. (2010) in Ireland, and Ramis et al. (2014) in Australia. In a further analysis of the SCAPE study carried out by Begley et al. (2010) in Ireland, Higgins et al. (2013) reported that the personal attributes of practitioners were a critical factor affecting their ability to enact leadership roles. They found that ANPs had to be visionary, change agents and committed to personal and professional development if they had to keep the respect of the multi-disciplinary team. This validated the previous findings of Manley (1997) and also supported the findings of this study that showed the importance of specialist nurses being transformational leaders. Moreover, as Ramis et al. (2013) explained; personal attributes not only help in overcoming challenges of their role including frustrations with relationships and increasing confidence in practice, but mostly contributed to providing patient-centred and evidence-based care. Por (2008) also acknowledged that the success of the specialist nurse depended upon their whole 'package', including personality, to see them through the process of working alone and taking responsibility for their actions in, at times, unknown territory. Thus, these findings correlate with the discoveries of the present study that highlighted the importance of the personality of specialist nurses to fulfil their leadership role. Clancy et al. (2006) also emphasized the importance of personality when studying addiction nurses in the UK. They highlighted the need to acknowledge this important element for the success of specialist nurses since support and training was needed in preparing these nurses for the environment they will work in and particular training was needed in developing good interpersonal and counselling skills.

5.2.3 Specialist Nurse Preparation

In this study, there was unanimous agreement that specialist nurses needed to be prepared and educated to operate successfully within the main roles and to develop person-centred practice and services. There was a strong feeling that it was not enough to be a brilliant practitioner, but further education, training and experience were pre-requisites for this advanced nursing role. Furthermore, it was evident that specialist nurses in Malta had a variety of different educational and experiential backgrounds, ranging from informal courses to a role-specific Master's degree. There was no standardised level of preparation and/or training. Once again, the Maltese situation is not unique because according to Ranchal et al. (2015), internationally there is still no agreement on the preparation of specialist nurses.

In a cross-sectional, descriptive web-based survey, Pulcini et al. (2010) found that a formal programme was available in 71% of the 31 countries responding to this item, with 50% identifying the Master's degree as the most prevalent credential. In another international based study, Delamaire and Lafortune (2010) reviewed the development of advanced practice nurses in 12 countries (Australia, Belgium, Canada, Cyprus, Czech Republic, Finland, France, Ireland, Japan, Poland, United Kingdom and United States) and found that the education and training requirements to become an advanced practice nurse varied across countries, and in some cases within countries. Notwithstanding this, they found that in most countries, a higher degree in nursing (e.g., a Master's degree or above) was now recommended or required to qualify as an advanced practice nurse. This was the educational requirement established, for instance, in the United States and Canada. According to the National Association of Clinical Nurse Specialists NACNS (2004) in the US, a specialist nurse needed to have a Master of Science in Nursing or Doctor of Nursing Practice (DNP) and would need to be prepared from a programme that prepares them for their specialist role. They may also be prepared in a post-master's certificate programme recognized by a national nursing accrediting body as preparing graduates to practise as a CNS for a specialty population. Unlike the US, no formal education programme in Canada or the UK has been developed specifically to meet the needs of CNSs. Moreover, in the UK, except for Wales, the RCN (2012) pointed out that they still did not have a standardised level of entry at Master's level for specialist nurses and advanced nurse practitioners, but the Department of Health (England) (2010) recommend a Masters level of study but fell short of recommending a full masters level degree.

Notwithstanding this, this study found that stakeholders and specialist nurses thought that a Master's Degree, with its problem-solving and decision making skills, was the minimum qualification needed for this role and that this was the beginning of a journey to becoming a specialist nurse. Nearly two decades ago, Manley (1997) explained the rationale behind the need for a Masters level of education, and had the foresight to predict that in the future this was likely to be extended to a doctoral level. According to Manley (1997) this academic preparation was needed by specialist nurses to be able to operate in all the three levels of research as stipulated by Hodgman (1983), namely evaluating and communicating research, translating and applying research, and undertaking research. Additionally, a Master's degree, as Manley (1997) pointed out, would allow an understanding of the three paradigms of research that are the positivist, interpretive and critical science research types, that would enable the specialist nurse more confidence and ability in underpinning research.

Thus from the study findings, the arguments raised and from the trend in the majority of countries, it may be concluded that specialist nurses should steer towards a Master's degree as the minimum entry level of education. This is also in agreement with the direction offered by the International Council of Nurses (ICN 2001) which stated that a Master's degree is the starting point for taking up advanced nursing practice.

This study further found that specialist nurses expressed the need for more ongoing professional development and identified the need for specific training in their area of specialisation, interpersonal skills, research and business skills that were thought to help them in setting up a new service or system and develop as individuals. These findings were similar to specialist nurses in international studies that reported the need for ongoing education (Por 2008; Ball 2005; Begley et al. 2010; CSEHWRRS 2014). Por (2008, p.84) in fact emphasised that the process of becoming a specialist nurse was ongoing and used "*expanded knowledge, clinical expertise and research to further the scope of practice*". Manley (1997) envisioned that this knowledge base should be continuous and strengthened by a strong nursing and leadership foundation combined with the educator and research functions. This is still valid today and has been supported in this study, subsequent and very recent international literature (Kucera et al. 2010; Bryant-Lukosius et al. 2016; Gray 2016). In fact, in a recent article, Gray (2016) pointed out that the preparation of the specialist nurse as an advanced nurse practitioner would not only focus on the 'clinical' aspects of the role but would be ambitious in setting a wider scope of practice and would involve preparation of the multi-dimensional roles of nursing and advancing nursing practice. Bryant-Lukosius et al. (2016) further

explained that advanced nurse practitioners should be able to question current practices, create new knowledge and lead care delivery.

Another important finding in this study, expressed by all participants, was that specialist nurses do not become 'specialist' overnight. This was one of the biggest criticisms from the doctors and most of the specialist nurses themselves in this study, who emphasized that without this evidence of progress in education, training and competence, credibility of specialist nurses would be difficult to attain. This was supported by Manley (1997, p. 187) who stated that, "*To operate successfully within all four sub roles, and to develop the expertise, skills and processes required, will involve more than merely undertaking a theoretical course*". As Manley (1997) further explained the biggest challenge would be the identification of practice outcomes as a basis for accreditation since theoretical and academic results were much easier to recognise.

Clarifying the experience of the four main roles of clinical expert, educator, researcher and consultant would be much more difficult since it would depend on the context of where the practice was carried out and by whom. Thus, using a model to offer guidance on the introduction and monitoring of these roles to determine how they would be implemented and assessed in practice is recommended in the literature (Elliott and Walden 2014). Manley (1997) and later Por (2008) and Gray (2016) suggested that a framework be developed that would go beyond the description of the roles and promote the importance of the impact of the role being dynamic rather than static. In fact, Por (2008, p. 84) proposed the term 'advancing' in contrast to 'advanced' practice since she described it as an "ongoing process using expanded knowledge, clinical expertise and research to further the scope of practice". Thus, it is recommended by this present study that the model chosen would take into account the much broader scope of practice than that of simply being a model of advanced skills to act as a substitute for doctors. One such model was described by the Scottish Executive Health Department (2005, p.V) in the position paper called *Framework for Developing Nursing Roles* that pointed out:

"...bolstered by appropriate education and management support, can extend, expand and develop their roles to enhance their skills, knowledge and professional identity, strengthen their influence on the design, delivery and evaluation of services, and increase their impact on improving the health and well-being of the people of Scotland."

Although one may criticise this as being grandiose, Kucera et al. (2010) found in their research that advanced nurse practitioners had this ability to be innovative and leaders to

advancing nursing practice whilst still keeping the nurse-patient relationship central to their role. Moreover, the strength of this suggested approach of using a model is that it would facilitate strategic evaluation of the impact of advanced practice roles in Malta. As was found in this study, minimal evaluation of specialist nurses' services and outcome of their role was carried out in Malta. As Bryant-Lukosius and DiCenso (2004) explained, the future role of specialist nurses depends on their evaluation, both of the frequency and the quality of patient interactions, and which, if not assessed, may result in specialist and advanced practice related outcomes not being revealed. **Interesting and valid work on this subject has been carried out by Professor Alison Leary, Chair of Healthcare & Workforce Modelling in the UK. Professor Leary undertook projects around the modelling of complex systems in advanced nursing practice and provided the much needed work to describe what Cunningham (2004 p. 220) explains as the "interactions and activities" that occur between advanced practitioners and clients in their care that is critical to understanding the impact of such practitioners (Cunningham 2004). Professor Leary's work looked more broadly at identifying some of the "success factors" of advanced practice nurses in areas including; hemoglobinopathy care (Leary and Anionwu 2014), rheumatology (Oliver and Leary 2010), lung cancer (Leary et al. 2013), breast cancer (Warren et al. 2011) and cancer and surgery (Keenan et al. 2010).**

In these studies, Leary and colleagues confirmed that the specialist nurses' role is complex and multidimensional and is likely to contribute to the quality of care in a cost-effective way. This vital evidence-based understanding, apart from highlighting the "bottlenecks" to introduce changes in clinical practice, can be used as an "underpinning to establishing key performance indicators, optimum caseload calculations, and economic evaluation" (Leary and Anionwu 2014, p. 277). Moreover, although challenging and requiring sophisticated statistical methods (Delamaire and Lafortune 2010), Leary and colleagues through the use of a database called Pandora (Leary et al. 2008) managed to establish the cost benefit of these specialist nurses. Leary (2007) explains that Pandora is a database designed to articulate the complexity of the CNS role by collecting data in various forms including narratives that may be subjected to content analysis. The Pandora research further showed hidden elements connecting the impact of CNS work to patient and organisational outcomes (Leary et al. 2008). Thus, a pressing recommendation for specialist nurses in Malta is to perform studies on the outcome of their roles, using a conceptual model and/or a system like Pandora (Leary 2007) to involve their clients, as this is a missing element in their role development and justification for their roles.

My study also found that there was difficulty to further train and develop specialist nurses since going abroad was the only way for them to gain this experience. But they found it hard to go abroad both for family and professional reasons. The expense of the course, travelling alone, living away from the family home and being away from young children, were mostly mentioned as impeding factors. Furthermore, the fact that most of these nurses worked in single occupancy posts, the paucity of Masters Degrees in specialization and the lack of role models in Malta were all identified as obstacles to their development. Thus, the study raised a number of implications for practice, particularly in relation to the preparation and accreditation of specialist nurses as advanced practitioners. Schober and Affara (2006) identified similar challenges as those identified in this study as they noted that limited access to educational programmes and insufficient nursing education all contributed to hindering the development of advanced nursing roles.

It is appropriate to point out that due to Malta's size, the demand for specialist nurses will always be particularly small, thus creating a cost-effective supply for the demand may be difficult. Notwithstanding this, authorities would need to consider succession planning and the expanding of the services, that was also pointed out in this study as being lacking. Moreover, the feasibility of adopting such an approach would need to take the education and training of these nurses earnestly. Alternative strategies and support would need to be planned. The issue of funding was also a source of concern in the context of the introduction of this system especially due to the potential need of either training to be carried out abroad or in collaboration with foreign education institutions offering the relevant programmes. Other foundations of funding could also be sourced, such as the EU funds for continuing professional development and the private sector. Again, programmes, as Fenech Adami (2001) stated, need not be offered on a regular basis and one programme may not need to run completely independently from another post-registration programmes offered at the University of Malta. Additionally, the University could offer a range of continuous practice development (CPD) modules that collectively could make up a Master's degree that students could take a 'pick and mix' approach to support their practice.

In a world where advancements in IT are increasingly facilitating educational opportunities, distance education or partial distance learning approaches (blended learning) could be considered as options (Fenech Adami 2001). One such course described by Koskinen et al. (2011) was an international on-line course that would enable the development

of global APN competences through the students engaging in a network and encouraged to inquire into various relevant subjects in cross-cultural online student groups.

Another approach would be to twin with a country, such as Ireland, that has a dynamic policy to develop advanced practice nursing. Twinning would be an alternative approach that would consider another important element in specialist nurse training, that of hands-on practice and competence. Although theoretical aspects of teaching could be delivered through the IT media, clinical practice could not. Therefore, twinning with another institution that had already adopted such approaches would offer more accessibility. Nevertheless, the hands-on aspect of programmes would still necessitate attendance abroad. As Fenech Adami (2001) stated, possibilities need to be explored with either short periods of attendance by students overseas or periodic short attendance by visiting practitioners to Malta. However, this will need to be accompanied by the development and assessment of competencies (Scottish Executive Health Department 2005).

To conclude this first section, identifying the roles and attributes of Maltese specialist nurses provided information about their functions and implications for future preparation and accreditation. The findings of this study also helped reduce specialist nurses' role ambiguity and clarified that the roles and attributes identified in this study were similar to international perceptions and requirements. However, in the future, it is recommended that patients/clients would be involved in studies on specialist nursing as their perception would make an important contribution to help support and develop these roles further. Without such evidence, managers and directors might be compromised when committing resources and recommending such advancements to the authorities, both for funding of new roles as well as support in sustaining and developing services run by specialist nurses. Furthermore, it is evident, both from the findings of this study and international literature, that specialist nurses would need to enter advanced nursing practice with Master's level education and would be trained following a programme that would allow development in research, evaluation of their work and involvement in policy and wider health and nursing issues. It was also apparent that some roles would need to be devolved to administrative employees thus enabling more time to be allocated to advanced nursing roles such as research and time for ongoing professional and organisational development. This study finally recommends that the development of advanced nursing practice roles would follow a model or conceptual framework to guide and evaluate competence and development (Manley 1997; Scottish Executive Health Department 2005; Elliott and Walden 2014).

The next section of this chapter will analyse, discuss and put forward recommendations relating to the issues of the development of specialist nurses in Malta. This was thought important because without an understanding of what helps or hinders progress it would be impossible to move forward and enhance the development of these nurses in practice.

5.3 The Development of Specialist Nurses in Malta

This section will explore and discuss the most common experiences of the specialist nurses in the study, including the issue of job satisfaction, support and burnout, and will put forward recommendations for future development. Burnout was not discussed in the Literature Review in Chapter 2 and will be given due attention in this section. The legislative/regulatory challenges including the regulation of specialist nurses, their titles, scope of practice and job description will follow, and recommendations to guide and provide a foundation to start the process of getting accredited and registered will be put forward.

5.3.1 Job Satisfaction

Under the broad theme of the development of specialist nurses the first interpreted consideration to emerge from the data was a sense of achievement. This experience was fundamental to the phenomenon under study and encompassed several distinct aspects, including the actual account of their development and transition, their relationship with patients and their families, the acceptance by other professionals, and their increased knowledge and experience. While specialist nurses reflected on their past, present and future challenges surrounding their role within the healthcare team and system, there was sufficient indication of an underlying satisfaction with their role and position. This could be due to a correlation between job satisfaction and individual positive identity since it was evident that these specialist nurses had a high profile within their professional associations and with nurses and allied health professionals in general. They also felt that they had learnt and developed personally and as a group of individuals to offer quality, evidenced-based services.

Mills and Blaesing (2000) suggested that nurses' satisfaction was associated with a strong sense of professional status and pride. This view was similar to that reached by this study and that of Read (2001) when exploring innovative roles in the UK, who found that the scope for extended and personal development in their innovative role made it rewarding. Begley et al.'s (2010) national study in Ireland also conveyed this sense of satisfaction to

increased education and opportunities to develop further. Additionally, in a study that focused on specialist nurses' role stress and job satisfaction in Taiwan, Chen et al. (2007) also found that training significantly predicted job satisfaction, thus further supporting previous experiences reported in this study, in Ireland (Begley et al. 2010) and the UK (Read 2001).

Notwithstanding this, this study found that the most important element for specialist nurses' satisfaction in Malta was the care they provided and the relationship they built with their patients and their families. They felt they were making a difference in the patient's life and the appreciation they felt from the patient was what kept them in the job. Read (2001) also found this element in her study and added that professionals including specialist nurses related their job satisfaction to the challenging nature of the role, and making a difference. In addition the CSEHWRRS (2014) study on the retention and recruitment of healthcare staff found that job satisfaction was related to being in a better position to influence the course of daily work with patients.

5.3.2 Barriers for Development

This study found that despite a positive sense of job satisfaction, supported by the fact that none of the specialist nurses intended to change their career direction, they paradoxically reported a large amount of negative experiences. In this study, specialist nurses and most stakeholders felt that the system did not facilitate the 'specialist nurse's' journey. It was apparent that specialist nurses were under-resourced in terms of accommodation, equipment and support staff that they felt would hinder effective working. The findings related to the perceived lack of support and resources were not exceptional to Malta. Large National/International studies, including Read (2001), Ball (2005), Begley et al. (2010), Ramis et al. (2013) and the Consortium for the Study of Effective Health Workforce Recruitment and Retention Strategies (CSEHWRRS 2014), mentioned similar barriers to specialist nurses' development in Malta. Parallel to the findings of this study, they found that organisational pressures, lack of resources, professional support and role ambiguity were amongst the negative experiences.

Organisational challenges were experienced by most specialist nurses in this study. Most held single occupancy posts that they felt affected their opportunities to participate in research, courses and professional development since clinics were a priority and the patient came first. Higgins et al. (2013), reporting on the SCAPE study (Begley et al. 2010) in Ireland, also found that this 'solo post' affected the ability to engage in leadership activities

because their clinical caseloads took priority. Brooten et al. (2011) explained this as the 'dose effect' that relates to the number of practitioners within the same unit to support and facilitate in the clinical setting for them to be able to enact clinical leadership. Higgens et al. (2013) further explained that although focusing on the clinical aspect short term could solve the immediate problem of maintaining patient activity, ultimately it might lead to dissatisfaction over time as practitioners were not allowed opportunities for clinical leadership work.

Role complexity in Malta was in part compounded by the organisational structure of nursing, whereby the participants were line-managed by a nursing manager, but they were also influenced and professionally accountable to a Consultant or Consultants. An element of division between the specialist nurses and their line managers was detectable. The specialist nurses were keen to deliver and maintain the focus on improvements to patient care, whereas the nursing managers were not aware of their needs of education and support. This was particularly seen when they were still expected to run and organize the consultant's clinics and were not allowed to venture into the community to increase awareness of their job or when they still had to work Sunday duties. The latter issue was also noted because of a lack of awareness and clarity on their job description. The distance that the specialist nurses placed between their roles and the achievement of corporate goals was noticeable and of concern, especially since some specialist nurses managed nursing units as well as being practitioners. Once again these problems were also found in international studies and included restricted work schedules, role boundary issues with nursing staff and lack of support from administration and physicians (van Soeren and Micevski 2001, Hoffman et al. 2004). Additionally, in a survey assessing international trends of nurse practitioners-advanced practice nurses (NP-APNs), Pulcini et al. (2010), found that respondents from 31 countries identified a number of barriers related to NP-APN practice, including access to educational programmes globally, lack of understanding of the NP-APN role and lack of respect from the nursing profession. Mason (2013), an American professor of nursing, also acknowledged that organizational policies and cultures that did not understand what advanced nurses could safely do limited their development. However, this could also be due in part to the litigious society in which the US nurses function. Ramis et al. (2013) concurred with this and found that professional isolation, the lack of involvement in the organisation and negative professional relationships were a major concern for Australian APNs.

Thus the findings of this study call for more openness to barriers in advanced nurses' development and more research to guide advocacy for change. Moreover, financial resources

were felt to be needed to implement the changes in organisations, provide nurses with additional educational qualifications, and see the development of specialist nurses through the whole process to sustain their professional roles.

5.3.3 Medical Dominance

The findings revealed that specialist nurses thought that their role was recognised by nurses and patients but was less acknowledged by medical staff. Moreover, the specialist nurses and also nurse participants in the focus groups suggested that the medical profession was a big stumbling block in their development and felt that doctors were not allowing them to develop and gain more autonomy to work to their full potential. These perceptions were attributed to a range of experiences related to their extended roles including interpreting blood results, referrals and adjusting treatment medications, plus the lack of support and involvement in the organisation. In addition, they believed that their role was being hampered by the medical profession for various reasons, including the private sector, medical dominance and the lack of respect given to nursing and other professions. This view was a common finding in the international literature (Chen et al. 2007; Begley et al. 2010; Pulcini et al. 2010; CSEHWRRS 2014). In most of the 12 countries covered by Delamair and Lafortune's (2010) study on the experiences of advanced practice nurses, the opposition of the medical profession was identified as one of the main barriers to their development. The main reasons for this resistance included *"a potential overlap in the scope of practice and loss of activities, the degree of autonomy and independence of advanced practice nurses, concerns about legal liability in cases of malpractice under teamwork arrangements, and concerns about the skills and expertise of advanced practice nurses"* (Delamair and Lafortune 2010, p.10). Schober and Affara (2006) further identified the lack of respect toward the nursing profession, lack of understanding of the NP-APN's capacity, and dominance of the medical profession as challenges to APN role development.

Conversely the doctors in this study felt that specialist nurses did not assert themselves enough within the healthcare team and that the lack of standardization and regularization were the barriers to specialist nurse development. As one consultant stated *"No Taxation without Representation. They want to be professionals but they don't want the responsibility"*. In opposition, specialist nurses felt that doctors were influencing the authorities not to give them the necessary endorsement to practise and become regulated. I did not feel this resistance from the Consultants during the focus groups. On the contrary I

found them to be supportive of the concept and the role of specialist nurses, but I could not understand why nurses may have felt this way. First of all, this perception was not directed to the consultants they worked with, but mostly to doctors' attitude in general. Seeing that this study involved a small group of consultants and not general practitioners (GP), this could have influenced the results towards a 'positive' discussion. Primarily, the consultants were chosen because they were working directly or indirectly with specialist nurses, so this in itself could have favoured the results since they were knowledgeable of the specialist nurses' capabilities and outlooks. Additionally, consultants might not be threatened by the specialist nurses in the way that GPs might due to the threat to their income and livelihood. This is supported by a significant body of research that indicates that individual-based fee-for-service payments for doctors can act as a barrier to the development of specialist nursing roles in primary care (Bourgeault et al. 2008; CSEHWRRS 2014). Thus in future studies, it might be relevant to study the perceptions of GPs since these might reveal further considerations such as the overlap of roles and the needs as perceived by another group of stakeholders in the community. This is supported by Pulcini et al. (2010) who recommend that it was important to understand why others, such as physician organizations and individual physicians, tended to be in opposition.

The consultants in this study further believed that specialist nurses' development was being affected because they were not 'taking' on more responsibilities to expand their job. This perception was confirmed by some specialist nurses' accounts since some stated that they did not feel comfortable and 'safe' without the sanction of a doctor. It was found that although the specialist nurses were knowledgeable and capable, they still needed something in writing from a doctor or their manager to protect themselves from direct criticism or the threat of litigation. The perceptions of specialist nurses in Malta found in this study were similar to the experiences reported in a UK study (Mercer 2007) on Nurse Practitioners. Mercer (2007) found that the level of autonomy was compounded by the feelings of inferiority in inter-professional contexts. However, it was not clear whether these feelings of inferiority were perceived by participants to be the cause of their diminished opportunities to maximise professional autonomy, or whether it was their lack of autonomy that generated this supposed inferiority. Additionally, Jones (2005) found that a lack of resources, educational or managerial opportunities plus organisational issues also influenced specialist nurses' role development to reach their full potential, whilst legislative support was found to be equally important to sustain both roles and individuals.

From the discussions I felt there was a more covert area of doubt that was ongoing, and the tendency of specialist nurses to defer to others, particularly doctors, in their reflections on working practices needed further investigation. Once again these were important issues to be considered when introducing new positions for specialist nurses in Malta because, depending on the type of activity the specialist nurse would be providing, she/he might affect the role that the doctor previously carried out (CSEHWRRS 2014). Thus, role conflict could occur without this necessary planning and involvement of different professions prior to the initiation of the post (Delamaire and Lafortune 2010; CSEHWRRS 2014).

5.3.4 Burnout

This study further indicated that a few specialist nurses were under great stress and the majority felt helpless in changing the system. This was evident during the interviews, with some specialist nurses who were visibly upset and emotional about their situation of not being able to influence change in practice and the organizational culture within their area of practice. The feeling that was portrayed was that they could not do anything about their circumstances because nothing would change in Malta. According to Chen et al. (2007) international literature showed that work role-related stress experienced by staff nurses predicted role strain, which in turn influenced job satisfaction and an intention to leave the job. Limited research was found on job stress and burnout in specialist nurses and APNs and the few studies found were from the 1990s in countries such as Australia (Bull and Hart 1995) and the UK (Hicks and Hennessy 1999), when advanced nursing practice was first developing. Nonetheless, studies on the role development of APNs indicated barriers that facilitated, impeded or contributed to stress and job strain of APNs' experience (Jones 2005; Gerrish et al. 2011; Ramis et al. 2013). In Australia, Ramis et al. (2013) found that APNs appeared to be at risk of burnout due to overwhelming demands and increased pressures with minimal organisational support. Moreover, in England Gerrish et al. (2011) found that the organisational context was important for the well-being and development of practitioners. Workload, the resources available and the organisational culture to promote evidence based practice were factors found by Gerrish et al. (2011) to be influential on nurses' stress levels. Ramis et al. (2013) further explained that due to the nature of their jobs, especially in providing frequent support to their patients, families and staff, APNs were at high risk of burnout.

In addition, several specialist nurses within this study sample specifically stated that they felt they were heading for burnout. They described the environment and outlook of demotivation, and stated that they felt tired of ‘fighting’ the system alone. Moreover, most participants in this study felt that their colleagues on the wards were also overtired and at risk of burnout. This was established by a psychologist (Galea 2014) who reported that burnout among Maltese nurses was ‘a worrying reality that requires immediate attention’. Although this study (Galea 2014) did not focus on specialist nurses specifically, participating nurses came from three main hospitals in Malta and where nurses in all grades. This study reported high emotional exhaustion or being emotionally overextended and over stressed at work. Galea (2014) stated that nurses reported very high depersonalization, feeling an impersonal response towards their patients, whilst less than half the sample reported high personal and professional accomplishment. Galea’s (2014) study had limitations that need to be considered. Primarily, the study was not specifically related to specialist nurses so extrapolations can only be made to the situational context of nursing in Malta generally; and also in supporting the beliefs of specialist nurses. Methodologically, this study was correlational in nature and therefore, no inferences of causality can be made. Second, the study’s reliance upon self-reported and recalled data may have introduced sources of error, because individuals’ responses may have become distorted over time. Despite these limitations, this study also had strengths that are noteworthy. The exploratory nature of the impact of burnout on Maltese nurses was an important strength. Burnout remains a novel area in research in the Maltese Islands and in nursing, despite the extensive focus it has received in other Western countries. According to Galea (2014) this research indicated two important suggestions to counter burnout issues among nurses. First, was the active participation of nurses themselves in their self-care, and second the need for organizational strategies to promote personal resilience and wellness. Feedback from this study highlighted the need for more psychological assistance to professional nurses, that would be extended to the group of specialist nurses. This latter point was supported by one of the only studies specifically found on the direct relationship of role stress in specialist nurses carried out in Taiwan by Chen et al. (2007).

Chen et al. (2007) surveyed 129 nurse specialists (response rate 81%) from five acute care teaching hospitals in Taiwan focusing on personal characteristics using the Five Factor Model of personality traits (Costa and McCrae 1987), role stress and job satisfaction. They used a modified version of Kahn et al.’s (1964) tool to measure role stress that included

ambiguity, conflict, overload and incompetence. Job satisfaction used an adapted and translated McCloskey/Mueller Satisfaction Scale (MMSS) (1990) and data was analysed using hierarchical regression models. This study showed that personal characteristics such as personality traits and training, significantly predicted job satisfaction. Moreover, it found that organizational structure and support were important to reduce role stress that was found to be an important predictor of job satisfaction especially relating to role ambiguity and role overload. Thus Chen et al. (2007) recommend that further research needed to be carried out on areas including the relationships among role stress, job satisfaction and organisational consequences including intent to leave the workplace and adverse patient outcomes. Data were analysed using descriptive statistics and hierarchical regression models. A limitation of this study was the generalizability of the findings due to the sample size, geographical target but especially due to the cultural and professional context, particularly noting the collectivist Chinese culture of respect for tradition, authority and harmony. Notwithstanding this, the findings were important because they specifically studied specialist nurses, they supported similar earlier studies in other countries (Jones 2005) and also highlighted the complexity of the role that calls for more research, preferably qualitative in nature, to improve the understandings of the challenges faced by these professionals.

Thus, from these findings and the literature it is evident that role stress and job satisfaction in specialist nurses in Malta needs further recognition and exploration. As the Scottish Executive Health Department (2005) states, staff who have developed their role to specialist level have a high level of autonomy and responsibility and may be at risk of 'burnout' unless they are adequately supported. Moreover, Scotland not only recognises this level of stress in specialist nurses but actually suggests that staff should be able to take a break from their role, or to move posts without detriment, to allow them to refresh themselves. This document further recommends that they are supported, supervised and provided with continuing professional development to prevent isolation. The health system in Malta needs such strategies for all nurses to encourage their well-being. At this time of nursing shortages it is important to retain and support nurses in whatever grade or position they hold, so a plan to empower these nurses is called for. Although the findings of this present study cannot be generalised to the whole of the Maltese nursing situation due to the small sample size, it gives a sense of what the situation of nursing is in Malta. Furthermore, it was evident that controlling influences arising from statutory controls and organisational

restrictions, for training and regularization, account for some of these perceived barriers since specialist nurses felt that they were not given direction, support or legal backing.

5.3.5 Legislative /Regulatory Challenges

This study established that specialist nurses, now called practice nurses in Malta, could be appointed to work as a specialist in certain types of diseases (such as diabetes or cardiovascular disease), medical environments (such as an operating room or primary healthcare), procedures (such as surgical or wounds) or patients (Midwifery or Mental Health)¹ x. This was exactly what was found in the study by Read (2001) on new roles in the UK, thus indicating that Malta seemed to follow the UK's direction in this area of nurse specializations. Ranchal et al. (2015) explained that the most confounding problem in Europe was the fact that there was direct entry into specializations, such as mental health and paediatrics in some EU countries (UK, Austria and Germany), that created a lack of common academic foundation and a multiplicity of routes towards levels of nurse specialisations. Moreover, the different models of qualification and registration levels in Europe according to Dury et al. (2014) and outside the EU (Ranchal et al. 2015) illustrated the confusion surrounding specialist nursing. Although it was evident that these challenges were not unique to Malta, they indicated a need for standardization and global agreement on:

1. *“In what health- related areas nursing should be allowed to specialize,*
2. *The academic level associated with specialist nursing,*
3. *The scope or ‘advanced-ness’ of specialist nursing, and*
4. *Whether direct entry specialist courses should be permitted.”*

(Ranchal et al. 2015)

In this study, all stakeholders and specialist nurses agreed that challenges existed regarding regulation and standardization of specialist nurses. It was found that due to the lack of standardization in the specialist nurses' roles and preparation the situation was not perceived as favourable and was even called 'expedient' by one participant. This was similar to the UK situation as expressed by Gray (2016), who explained that the proliferation of specialties lacked common legal recognition and title protection resulting in an unregulated environment. This situation was exacerbated by the creation of new roles and titles in a chaotic rather than planned way, with little uniformity or clarity about what could be

¹ The latter category was not included in this study because Midwifery and Mental health did not fall into the inclusion criteria of this study since these two types of specialists have direct entry into their specialization and are not considered to be in the same category/grade of a specialist nurse in Malta. A specialist nurse in Malta is a general nurse who was appointed in a specialist area of practice and who should have furthered her studies on the subject and who is promoted to a higher grade than those of a specialist nurse in mental health or midwifery at entry level.

expected from them (Dowling et al. 2013). Gray (2016) stated that this situation was not helped by the absence of a regulatory body led by the UKCC or its successor, the Nursing and Midwifery Council (NMC).

In fact, a study involving 12 developed countries conducted by Delamaire and LaFortune (2010) reported that in most countries where APN roles had been established these initiatives required some changes to legislation and regulation related to nurses' scope of practice. Pulcini et al. (2010) found that countries had varied in the speed with which they had been able to expand their scope of practice and add prescriptive authority. For example, the Netherlands, with its relatively new roles, had already developed a clear scope of practice and had provided NPs with prescriptive authority (Sheer and Wong 2008; CSEHWRRS 2014). The American system seemed to be the one that was most prescriptive and regulated. As Fotsch (2016) stated, a specialist nurse in the US needed to have a graduate or postgraduate education, certified at an advanced level from an accredited programme, licensed and registered in one of the four roles (clinical nurse specialist, CNS, certified nurse practitioner, CNP, certified nurse anaesthetist, CRNA and certified nurse midwife, CNM). Notwithstanding this, the National Council of State Boards of Nursing (NCSBN) was campaigning for all states to align their Advanced Practice Registered Nurse (APRN) regulation with the major elements of the Consensus Model (Elliott and Walden 2014) for APRN Regulation, thus indicating that more work was needed even in the USA. In Quebec, Canada, the regulatory body, Ordre des Professions, determined each professional group's scope of practice and regulated the use of the title "Specialist" (Bussi eres and Parent 2004). Professionals needed to complete specialized training in a recognized university programme to use the title "specialized" or "specialist" (Kaasalainen et al. 2010). As Ranchal et al. (2015) stated, formal recognition of advanced practice nurses was still in its infancy whilst Gray (2016) explained why countries like the UK could have been reluctant to set standards for advanced practice. He insisted it was not out of not recognising the need for continuing professional development or for accreditation and regulation, but was related to setting standards that could be restrictive to the autonomy and innovation of these new roles. Por (2008) agreed with this justification and stated that defining advanced nursing practice too narrowly could specifically limit the scope and diversity of nursing practice.

With regards to Malta, the Healthcare Professions Act, chapter 464, that regulates the practice of healthcare professions in Malta (Amended 2008), stipulated that any professional that used the word specialist needed to be registered on a specialist register in their respective

discipline register and kept for the registration of specialists by the relevant Council. This specialist register, to date (2016) is still not set up and thus, was the reason why specialist nurses had to cease using the word ‘specialist’ in their title. In the future a legal framework similar to Scotland could be taken into consideration since it captures the main issues that were raised in this study: mainly that specialist nurses will be expected to have undertaken sufficient training and preparation to ensure that they are competent to perform the role to the required standard. In fact, the Scottish Executive Health Department (2005, p.24) stipulated that nurses will be judged by two legal standards:

- The “rule of law” which requires a nurse to act within the law.
- The “rule of negligence” which requires a nurse who takes on roles/tasks currently undertaken by another healthcare professional to perform that role or task to the same standard of ordinary skill.

5.3.5.1 Titles

This study found that most of the participants and stakeholders were dissatisfied with the title change from ‘specialist nurse’ to ‘practice nurse’. One reason given was that the title was not in line with international nomenclature and also did not signify the role of specialist nurses because according to them everyone was a practising nurse and it did not identify their role in any way. This line of thought was similar to other writers on the subject who stated that *“Based on title alone, patients should understand that they are seeing an advanced practice nurse who has been educated in and has acquired advanced clinical skills to practice at an advanced RN level”* (Scheuermann 2016, p.74). As explained previously, in 2013 there was a new sectoral agreement that changed the title of specialist nurse to that of Practice Nurse. At this point it is pertinent to explain what this agreement relates to. As defined by Galea (2015), the General Secretary of the Malta Union of Midwives and Nurses (MUMN) (personal correspondence, 8 October 2015, see Appendix 15), there are two types of agreements that the government in Malta approves, namely a collective and/or a sectoral agreement.

“A Collective Agreement is addressed to the workers in general who pertain to different categories and classes in the civil service. For example in Malta a Collective Agreement is signed by seven different unions on behalf of all the 30,000 Public Service employees. On the other hand a Sectoral Agreement will be addressed to a section of the workers who normally pertain to the same category and class.” (Galea 2015, personal correspondence, 8 October 2015, see Appendix 15)

The new agreement that led to the title of Practice Nurse now encompasses two previously distinctive roles under one title, namely that of specialist nurse and of Practice

Development Nurse (PDN). This, according to the participants in this study, further created confusion in titles and role expectations. One of the identifying differences between these two groups of nurses, as was found in a study carried out in Malta, was that PDNs did not have a direct role in the delivery of patient care (Petrova 2011). Conversely, specialist nurses' core role as found in this study and also in international literature (RCN 2012; Delamaire and Lafortune 2010; CSEHWRRS 2014) encompasses clinical practice surrounding patients and their family. Notwithstanding this, and to add to this complex situation, this study found that there were a number of specialist nurses in Malta who did not have an element of direct patient practice but who were more involved with staff development and changing culture and practices. These include the informatics nurse, infection control nurses and the occupational health nurse. Such findings further add to the difficulty in role identification and role expectations. This confusion and lack of clarity surrounding specialist and advanced practice roles was found in previous international research and considered to be a barrier for the development of these roles (Ball 2005; Brooten et al. 2011). Spross and Lawson (2009) also noted the conceptual confusion which they argued had stalled the development of advanced nursing practice and mentioned the lack of well-defined and consistently applied terms and the clarity regarding conceptualizations that differentiate between and among levels of practice and roles. The Canadian Nurses Association (CNA) (2006) further supported this declaration and added that standardizing the CNS role was needed by developing clear role definitions and promoting the use of similar job descriptions and position titles (CNA 2006).

Taking into consideration the findings of this study and also the literature, another type of title could be suggested, capturing the specialist nurses that had direct patient contact and others that did not. The CNM in Malta would need to provide a definition of a specialist nurse or practice nurse and the related concepts as discussed in Chapter 2, including competence/expertise, extended and expanded practice, since the present terminology used in relation to the subject remains ambiguous and confusing. Keating et al. (2010) recommend a framework to support the development of advanced nursing roles that included the process and clinical governance. Moreover, quality assurance would be reflected in the patterns of accreditation and regulation with innovations in the organisation and delivery of care. As Read (2001) in England explained, modes of accreditation and regulation ought to be based on 'appropriate' models of behaviour and practice and would need to move with the pattern of service delivery that would be transformed accordingly. This was deemed important since

as Begley et al. (2010) reported from the SCAPE study in Ireland, role uncertainty decreased following their regulatory council's implementation of a framework and criteria that accredited nurses to practise as specialists.

5.3.5.2 The Scope of Practice and the Council for Nurses and Midwives in Malta

This study showed general consensus that there needed to be professional responsibility and consequent accountability of individual practitioners. Specialist nurses felt that their contribution was different to that made by other nurses mainly due to the responsibility that they had both in patient care and in professional initiatives that were mainly led by themselves with minimal support and supervision. As is evident in the literature (Read 2001; Por 2008; Begley et al. 2010; CSEHWRRS 2014; Dury et al. 2014; Ranchal et al. 2015; Gray 2016), there were a number of statutory restrictions on nurses' clinical practice, and this clearly varied from country to country, but all related in some way to the scope of practice, which Read (2001) stated was more closely defined within the USA than in the UK. This was supported by Ranchal et al. (2015) who stated that it was important for any profession to be clear about what it was and to have its legitimate practice protected by law. In Malta, registration with The Council for Nurses and Midwives (CNM) confers the legal right to practise as a nurse in the Maltese Islands. This entails registration in either of two categories; (a) First Level Nurses (Registered Nurses) and, (b) Second Level Nurses (Enrolled Nurses). A Second Level Nurse requires the supervision of a First Level Nurse in the performance of nurse duties. Table 12 shows the list of titles on the Maltese nursing register.

Table 12. List of Titles Found in the Maltese Nurse Register

Maltese Nurse Register
Registered Nurses
Enrolled Nurses
Registered Nurses for the Mentally Sick
Enrolled Nurses for the Mentally Sick
Registered Nurses for the Mentally Handicapped
Enrolled Nurses for the Mentally Handicapped
Registered Nurses for Sick Children
Enrolled Nurses for Sick Children
Registered Nurses for Adults
(CNM, accessed 2015)

The above list, * excluding midwives and mental health nurses (See footnote page 191), has no indication of specialist nurses (Practice Nurses) that were appointed between

2003-2015, and the nomenclature used is outdated and no longer used in healthcare. Furthermore, this study established that to date there was no live register and no specialist register of nurses practising in Malta. It was revealed that the CNM in Malta did not have an updated record of its practising nurses and that no nurse needed revalidation to practice. Once on the register, a nurse remains on it even after death. In 2001, Fenech Adami, in her doctoral studies in Malta, had suggested that the establishment of a live register was needed. Fenech Adami (2001) was one of the lecturers at the University of Malta who carried out the study on Maltese nurse education as part fulfilment of her doctorate degree. She emphasized the need to have a register more than 15 years ago because it would have provided an accurate picture of the active supply of nurses. Nevertheless, she suggested that research of a detailed role/job description for different nurses would need to complement this register if any demand or supply evaluation exercises were to be undertaken successfully. Having a live register in Malta would also allow for data to be available about where nurses were and what they were doing. This concept is supported by the Scottish Executive Health Department (2005) that states that data showing the number of clinical nurse specialists allow a degree of transparency that will enable trends, gaps and areas for development to be identified, helping role development at regional and local level. Thus a register in Malta will enable nurse leaders to plan their strategy and focus on areas that need investment and support, such as a framework to ensure a common standard for practice and expectations of specialist nurses. Finally, if the CNM in Malta followed the NMC (2015) in the UK, to ensure that the nurse was fit to practise *“by having the skills, knowledge, good health and good character to do their job safely and effectively”*, this would dramatically increase the efficacy of both the register and the clinical work of the nurses listed therein.

Participants were consistently keen to provide examples of their work which they considered went beyond the scope of practice of the registered nurse. These included: individual consultations; assessment and monitoring of their patients' condition; psychological support; referral to other professionals and services; and providing person-centred care autonomously, thus taking on 'more' responsibility than other nurses in similar grades that were able to make referrals. Although only one specialist nurse directly spoke of the scope of practice and the nursing council, most felt insecure about their role and felt that more direction was needed about the legitimacy of their extended roles. In addition, the study found that their role was not clear and there was confusion about their role expectations. Similar findings were reported by Jones (2005). In a meta-synthesis study Jones (2005)

reviewed 14 UK and US studies on the role development and effective practice of specialists including nurse practitioners in acute hospital settings. According to Jones (2005), these studies found that inter-professional relationships and role ambiguity were the most important factors that would enhance or hinder role performance. Similarly, Pulcini et al. (2010) found that from their web-based survey from 32 countries worldwide, role clarity and the need to educate other members of the multidisciplinary team about the scope and functions of these nurses reduced unrealistic expectations and facilitated the nurses' role development. Additionally, a recent international study (CSEHWRRS 2014) reported common legal issues in all the 21 countries that participated. It was reported that legal barriers existed as the scope of practice was enshrined in law, and legislative changes were often highly politicized and took time. Legal changes were just a first step in the process and the importance of registered nurses acquiring the necessary competencies and special training prior to the advanced practice/new roles was seen as imperative. Task restructuring is a sensitive topic in healthcare and requires a broad partnership if it is to be successful. In a recent study in Singapore, Schober et al. (2016) highlighted the importance of developing clear role/job descriptions and scope of practice prior to role implementation.

*“Healthcare services are expected to remain constantly changing, expanding, extending and developing. This means that the scope of professional practice of nurses would constantly need to be adjusted according to the context within which a nurse practices. Adequate support for such adjustments, central to which is appropriate educational opportunities, needs to be provided if standards of professional practice are to be maintained in the prevalent context of flux in which nurses practice.” (The Scope of Professional Practice 2002-
https://health.gov.mt/en/regcounc/cnm/.../scopeofpractice_cnm.pdf.)*

The above quote was taken from the Maltese Scope of Professional Practice for Nurses in 2016, 14 years after its presentation. As demonstrated in this study specialist nurses were officially introduced over a decade ago and just after this statement was written. In 2013, a new sectoral agreement was signed on behalf of nurses and there was a change in title for most nursing categories including specialist nurses. However, at no stage was the scope of practice updated to take into consideration the new roles and practice that specialist nurses were undertaking. Thus, this study recommends that the Council for Nurses and Midwives (CNM) in Malta needs to be clear, transparent and communicative/active with the people on the register. Newly enacted laws, documents and policies need to be given to each individual nurse on the Register, and there should be a system in place to see that registered specialist nurses are in fact competent and updated. In light of developments in the knowledge base of

nursing, and the profession's growing sense of autonomy and professional accountability for 'extended roles' the Council (CNM) needs to offer guidance through an updated 'Scope of Professional Practice'. Furthermore, more work needs to be done on the definition of these nurses since the issue of hands-on practice was not clear. This role ambiguity and problems with titling should be discussed and outlined in policy. This will not only provide the much needed definitions but could retain their role identity. The development of a new regulatory model should be sought to alleviate these problems and at the same time enhance patient safety, improve consumer understanding of these advanced roles, provide ease in regulation and ultimately move towards similar standards within the EU.

5.3.5.3 Job Descriptions

An important finding associated with the specialist nurses' scope of practice was related to their job description. The survey results showed that nearly half of the specialist nurses never had their job description updated even though they were involved in extended and expanding practice including carrying out diagnostic tests, interventions, prescribing or adjusting treatment and initiating nurse-led clinics with no medical cover. Although most specialist nurses embraced these roles, all participants including the stakeholders, voiced their concern that they were not covered in law and thus created uncertainty and stress. This situation was similar to that discovered by Read (2001) in their study of innovative roles in the UK, where it was found that nearly 10% of the respondents did not have, or were not aware of, their job description for their current role. Read (2001) stated that the failure of job descriptions to reflect adequately the content of the post holder's work placed both them and their hospitals at risk. Moreover, Whittaker, et al. (2014) explained that job descriptions were important to help define the roles and responsibilities of specialist nurses. Notwithstanding this, Read (2001) insisted that job descriptions of specialist nurses needed to be reviewed and altered as roles developed to ensure maintenance of cover for indirect liability.

This study therefore recommends that the roles are clearly defined and follow international frameworks and definitions of tasks undertaken by advanced nurse positions such as those developed by the Scottish Executive Health Department (2005) and the Department of Health (England) (2010). These frameworks have been developed to address these inconsistencies providing national guidance on capabilities expected to undertake this role for each of the four pillars of practice

- clinical/direct care practice;
- leadership and collaborative practice;

- improving quality and developing practice; and
- developing self and others.

This study also recommends that rather than specific task recognition the concept of advanced nursing incorporates “the social, economic and political context of healthcare” (Department of Health (England) 2010). Moreover, it should be generic to all clinical nurses working at an advanced level regardless of area of practice, setting or client group since according to the position statement on advanced nursing practise it describes a level of practice, not specialty or role. Finally, specialist nurses’ job description should reflect their role well, given that a mismatch between the post holders’ activity and the job description may have serious medico-legal consequences. Furthermore, their continuous professional development needs should be reflected in the development of their roles and competencies, preferably following the development and introduction of a framework and their scope of practice.

This section looked at the developments of specialist nurses in Malta and discussed issues that could have affected their journey. The following section will consider the wider aspects that were found to have influenced this development.

5.4 The Influences on Advancements of Specialist Nursing Practice in Malta

This study revealed important contextual and wider influences that were perceived as limiting the development of specialist nursing in Malta. Sharples (2005), at the time Nurse Director for Malta, stated that it was important to take note of the contextual factors that moulded the development of nurse specialisations in a country that included:

“...the number of nurses working on the Maltese Islands, and the ever-changing health needs of the Maltese population such as disease or demographic changes...There is lack of transparency with regards to where these posts are commissioned as to what expectations might be of the role.” (Sharples 2005,p. 6)

The following section will consider the related factors that influenced, and continue to influence, the development of specialist nursing in Malta as analysed and inferred in this study. Topics to be discussed are the general situation of the nursing profession, the issue of shortage of nurses, the education level of nursing in Malta and the feeling that there is no correlation between the advancement of nursing and the improvement of care at the bedside.

5.4.1 Nursing context in Malta

Emphasized in most data sets most participants felt that there was a need for a structure in nursing that was strong, transparent and supportive of the nurses. It was noted that the system of promotion and the lack of a career plan for senior nursing staff allowed for loss of expertise that could leave the wards with no leader and mentor, affecting the working environment and potentially demotivating the staff. These issues were also thought to be a factor leading to the shortage of nurses in Malta. As Gess et al. (2008) stated, nurses were difficult and costly to replace and the high turnover had a direct impact on the work environment due to the loss of experience. This was in line with the CSEHWRRS (2014) study that found nurses were not only leaving for higher paid jobs, but as a result of a ‘cul-de-sac’ career trajectory that did not allow them to expand their role in practice.

The feeling of helplessness and lack of empowerment were voiced and observed by specialist nurses. Phrases like; ‘who shouts loudest gains’, ‘blue eyed person’ and ‘even the worst somebody will be handpicked’ pointed towards the situation in Malta that things were not transparent and that insecurities existed. Moreover there seemed to be a lack of curiosity in nursing and amongst the specialist nursing group themselves. For example, an interesting finding was that none of the specialist nurses knew why their title had been changed to practice nurse and what was in effect the result of the lack of regularization of the nursing profession. Moreover, none had seen the new sectoral agreement and only knew of the obvious facts such as their change in titles and that there was an increase in a salary scale right across the nursing hierarchy. Once again this could have been due to the document not being easily accessible, or because each specialist nurse had to ‘survive’ with minimal support and thus had to concentrate on getting his/her patch organized rather than looking at the wider picture. This could also have explained why most of the stakeholders and specialist nurses wanted one manager to support them. This was not supported in the literature but was a common request amongst most of the specialist nurses in this study sample. I interpreted this ‘need’ as a cry for a leader, for a voice and for empowerment (empowerment will be discussed in section 5.3.6). These interpretations were supported by a study carried out in Malta on the power in nursing that specifically explored the socio-political obstacles to empowerment (Buttigieg 2012). Buttigieg (2012) concluded that the nursing structure was becoming more directive and less consultative in its approach and as having an agenda that was not established with nurses in the clinical area. He further found that nursing was lacking a sense of ownership and professional proactivity that needed to be addressed. Farrell et al.

(2001) in the UK attributed the feeling of lack of autonomy and motivation as a consequence of the 'dual oppression' of gender and medical domination. Medical dominance was discussed previously but the issue of gender in relation to the medical profession was another interesting influence to explore.

5.4.2 Gender

This study noted the lack of professional equality between doctors and nurses when specialist nurses explained that doctors had more money for continuous professional development, did not wear uniforms, had more influence even within the nursing sphere and were seen as the largest impediment to the advancement of nurses. These differences may have been examples of patriarchal oppression as mentioned in feminist literature (Witz and Annandale 2006). As Witz and Annandale (2006) explained patriarchal oppression in society was mirrored in the relationship between the male-dominated medical profession and the predominantly female world of nursing. Pulcini et al. (2010) also explained that progress in development of advanced nursing positions depended on the status of nursing practice in that country, especially in relation to other providers, such as physicians. Thus, as Brown (2007) emphasized, when developing new roles in nursing, one needed to appreciate the location of nursing especially due to the gender division of labour that shaped the organisation and structure of healthcare.

Most of the specialist nurses in this study stated that they had to refer to doctors since there were no legal or organizational policies in place to guide them, especially in extended roles such as in the adjustment of treatment or when interpreting and informing patients of their results. Additionally, they felt like the 'go between' of the patient and the doctor as Stein (1967) suggested more than five decades ago. Stein's seminal work (Stein 1967) on occupational games discussed how nursing and medicine portrayed domestic relationships of husband and wife, evident in modern healthcare settings, whereby the nurse assumed a submissive demeanour. Communication within this relationship adopted a subtle and subservient manner from the nurse towards the doctor. Stein (1967) acknowledged that the power within the relationship rested with the doctor, as the nurse was nearly always required to defer to the doctor for a final decision or change of treatment.

Another interesting point that emerged from this study was related to why and how specialist nurses developed in Malta. Most stated that the doctors or nurses felt the need related to the gap in care, the need for psychological care and patient-centred services –

considered the softer skills of caring. Patient-centred care emphasizes female essentialism as an inherent trait displayed in the gentle and sensitive approach to care. However, according to Mercer (2007), the advent of advanced practice roles, in which power derived from knowledge and authority, was for the first time a defining characteristic of a nursing role, and may have played a part in redressing this imbalance, particularly as more and more advanced practice nurses challenged the established status of other professional groups in the workplace. Witz and Annandale (2006) suggested that the lack of clarity and the position of nursing in leadership roles continued to be debated and influenced by how the nursing and medical professions interacted with each other. Nursing was seen as being restricted by the position it maintained in relation to medicine and other traditionally male healthcare roles. Thus, as Brandi and Naito (2006) stated, nurses needed advanced education, mentorship and support from the organisation to enact their roles in patient-centred care and be in a position to challenge and break traditions. They further insisted that nurses needed to raise their awareness of being an oppressed group by understanding feminism as a political and cultural means of valuing women and thus being in a position to challenge inappropriate stereotypes, organisational practices and to work within legal boundaries.

From the issues raised within this study, gender and medical dominance were seen as influencing factors that may have been affecting the development of specialist nurses in Malta and merit further scientific exploration. Moreover, it was felt that nurses needed to increase their awareness of feminism by providing the necessary education to be in a position to challenge the perceived inequality among Maltese professions.

5.4.3 Nursing Care at the Bedside

Another area that emerged as potentially influencing the broad development of specialist nursing in Malta related to the general standard of nursing. This study found that specialist nurses felt that although the profession of nursing advanced, the bedside care did not improve proportionally and as expected, with some even feeling that it regressed over the past few years. The reasons given focused on the shortage of manpower, nurses handing over the bedside care to ill-trained carers, people not coming into nursing for the right reasons and the focus of the nurses' attention being taken away from the patients and more concentrated on administrative duties. One direct influence was the generalised acceptance that nurses were becoming deskilled, or as one participant explained, nurses are using the services of the specialist nurse like a 'take-away'. It was felt that the fundamentals of care, as expressed by

the specialist nurses and other nurses, were being missed. This was an unpredicted finding and although not intentioned it was important for the participants to express because they felt it was affecting the way they worked.

The atmosphere and concerns brought up in this study seemed similar to the situation that was made public in the UK a few years ago in a Staffordshire Hospital where patients were subjected to systematic poor standards of nursing and medical care, leading to higher than expected mortality rates (Department of Health 2010). A concern of the Inquiries, both of the Department of Health (2010) and Francis (2013) was the ambivalence and disconnected approach in which nursing staff appeared not to relate to patients in a vocational fashion. In the UK, the reasons behind these failings were wide-ranging, but nurses stated that they were often caught in a dilemma and that they tried hard to continue to provide care for patients amid oppressive and restrictive working conditions, such as the lack of access to additional staff to cover workforce shortfalls. Francis (2013) provided extensive recommendations for the English NHS to improve nurse education, increased staffing on wards and ensuring that senior sisters were able to work in a supervisory capacity to oversee the quality of patient care. Moreover, gaining assurances of clinical practice was recommended by direct engagement with staff, patients and relatives, observation of practice and policy review to provide a triangulated and holistic perspective of healthcare provision. As Brown (2007) explained, the onus for poor patient care was directed towards nursing and nurse leadership, but there was a deeper perspective to be considered including dialogue regarding the environment and context, both of which impacted upon the way in which nursing care was delivered. Although it would be naïve to expect these recommendations to be transferred to Malta, mainly due to the context and background of the case, they were noteworthy and an opportunity to learn both from the process of investigation and also from their recommendations.

In this study, one area that was mentioned as affecting nursing care was the chronic shortage of nursing on the wards. The Government of Malta's measures taken to retain/recruit nurses back into the profession included providing all those nurses who had to resign in the past to be able to enter the profession at exit point (salary wise) without losing the years of experience they had attained (Xuereb 2014a) and including family-friendly measures including flexible working hours and child care centres (Xuereb 2014b). This information was taken from a well-designed case study that was commissioned by the EU and was recently published (CSEHWRRS 2014). Although the identified initiatives by the

government of Malta were commendable from the outlined study, it seemed that Malta, unlike other countries, did not look at the wider picture of recruitment and retention of its nurses or the wider issues of why nurses were leaving their profession. Moreover, there was no mention of whether these measures were indeed successful since no statistical evidence, assessment or cost analyses were found in the report.

This EU case study called Consortium for the Study of Effective Health Workforce Recruitment and Retention Strategies (CSEHWRRS 2014) involved 21 countries and eight case study topics to gain further insight into how global recruitment and retention interventions in healthcare were developed and implemented. Based on the review of the findings (CSEHWRRS 2014), country correspondents and experts on recruitment and retention, a clear horizontal theme for the case studies emerged about matching professional needs and health system priorities. Whilst exploring what the facilitators and barriers were throughout the process of recruiting and retaining nurses, the study highlighted how one of their major areas was to develop specialist nursing positions to retain its senior nurses in practice. Because of the diversity in cases and professionals included in this study (CSEHWRRS 2014), the different levels at which they were situated and the considerable influence of legal frameworks on these kinds of initiatives, it was difficult to establish general criteria for replication. However, this study offers wide and practical experiences of countries that have been successful at retaining and recruiting nurses. Countries like the Netherlands, the Czech Republic and Finland found that the nurses were not only leaving for higher paid jobs but also because of opportunities at work and organisational and relationship issues on the wards. The focus on creating a good working environment by providing employees with professional autonomy and a high degree of participation in the organisation (relative to their position within the organisation) was a significant finding in the EU's CSEHWRRS (2014) study and was also mentioned by Fenech Adami (2001) as a major measure to improve the quality and quantity of nurses in Malta. The CSEHWRRS (2014) study quoted Buurtzorg (Netherlands) as an example of how the working system could be changed characterized by the high level of professional autonomy and responsibility that its home care teams established. Read (2001) explained another approach to the process of healthcare delivery that had gained prominence prior to their study, namely 're-engineering'. According to Hammer and Champney (1993) re-engineering was a fundamental re-thinking and re-design of the processes to achieve intense improvements in performance such as quality and cost effectiveness. A more recent approach of re-engineering in healthcare was the concept of

'person-focused care' that as McCormack et al. (2011) state involved ideas about changing professional roles and creating a culture that influenced the quality of care through a safe and compassionate environment where staff felt supported and valued. This is particularly relevant to the local scene since this study found that specialist nurses felt devalued by management and doctors and lacked the necessary support in their role. Additionally, this was supported by an ethnographical study exploring power in nursing on the medical wards in the acute general hospital in Malta, where Buttigieg (2012, p.138) found that "*these nurses even felt objectified as a human institutional resource, which they expressed when they described themselves as 'numbers' in the hands of management*".

From the issues raised in this study it was evident that nurses were not satisfied with how nursing was developing both from an organisational and professional stance. The lack of a transparent framework to advance in their career, the shortage of nurses, the lack of autonomy to practise and the quality of care on the wards pointed towards a need to think about nurses' future working environment and culture. From this study, it was identified that there were various barriers within the system to enable nurses and specialist nurses to conduct their role fully with regard to care quality. This pivotal role of culture in relation to quality of care and the consequences when cultures are poor was not a new insight and was found to be a major contributor for nurses to exit their profession (Hahtela et al. 2015). As Smith (2008) emphasized workplace culture was constructed by the organisation, as well as by the personal attitudes, manners and knowledge of the employees. It was about work experiences, job satisfaction and particularly stress levels that, as McCormack et al. (2010) found, were related to workload and resources. McCormack et al. (2011) further asserted that workplace cultures were shaped by core values such as person-centeredness and learning to influence practice on the frontline. Some years earlier, Manley et al. (2008) concurred and stated that developing effective healthcare cultures that were person-centred and evidence-based across teams had been key to improving the quality of care for patients. Manley (2004) further explained that an effective culture, which she termed a transformational culture, was recognised by the presence of practice development that focused on person-centred and evidence-based care, staff empowerment and work place characteristics that included a transparent learning culture with shared beliefs that value stakeholders and leadership at all levels.

Consequently, more insight was felt needed to explore the situation of care and the shortage of nurses on the Island, which may enable nursing staff to refocus and deliver the fundamental elements of nursing care. This study recommends that due investment is given to

the issue of what an effective workplace culture ‘looks and feels’ like, and how to develop and sustain effective cultures in Maltese hospitals.

Several issues related to the educational level of nursing were highlighted during the interviews with specialist nurses. Although the increased opportunities to pursue courses both part-time and full-time were noted and more clinically based nurses were undergoing degrees and PhD studies, the increased level of education was not sensed on the wards. Concerns were raised with regards to the way students were being taught, the less ‘hands-on’ practice and the shorter undergraduate degree course of three, rather than the previous four years. These were thought to lead to novice nurses being overwhelmed once graduating. The lack of mentorship both as students and also once qualified, and the absence of revalidation of their registration to prove ongoing development were thought to further hinder professionalism and the provision of up-to-date nursing practice. This finding was similar to that found by Fenech Adami (2001) nearly 15 years ago when she explored the educational system of nursing in Malta, and highlights the need for more investigation into the education of nursing students. This should be accompanied by an assessment of the quality of nursing to identify any unmet continuous professional development needs. This is important because as the RCN (2010) stipulated, inappropriate educational and CPD strategies had a damaging effect on the quality of patient care, supporting Fenech Adami’s (2001) assertion that the educational system would influence quality and number of nurses.

5.4.4 Window of Opportunity

The importance of expanding specialist nurses’ roles and taking their expertise out to into the community was mentioned by most stakeholders. According to the participants this expansion would provide ‘outreach’ services that could improve the services in general and reduce bed occupancy. Ironically this study noted the paucity of specialist nurses in the community or primary healthcare, with four specialist nurses mainly working in screening programmes. Although it was positive that the stakeholders and specialist nurses themselves showed awareness of this potential expansion into primary health and community care, they also pointed out that to do so they would need to be supported with the necessary resources. The Nursing Directors’ focus group idea of sharing resources was commendable, but what failed to transpire was how this would be achieved and what resources were needed to carry out such a plan. Moreover what was evident in this study was that some managers did not approve of an expansion into the community and even prohibited specialist nurses from going

out and expanding their services. It showed that there was a need for consultation with all stakeholders on this matter in an attempt to address it properly with a view to developing the service. Aranda and Jones (2008) agreed with this stance and explained that creating or adapting nursing roles in primary healthcare needed consultation and understanding of local conditions before the implementation of new roles. Following such an understanding, according to Drennan et al. (2011), specialist nurses would be in a better position to engage with all stakeholders to ensure their expertise and contribution was recognised.

In Malta, the National Health System's document (2014) stated that it was committed to increasing and consolidating the role of the primary healthcare and community nurse with the expansion of specialised nurse-led clinics and services. It specifically pointed out that there would be support for "training nurses in specific chronic disease management particularly in patient education, monitoring of the condition and evaluation of patient's care" (National Health Systems 2014, p.81). Although the document lacked the necessary information as to how this would happen in nursing, it still signalled a window of opportunity that specialist nurses needed to embrace. It represented an opportunity to showcase the specialist nurse's role in Malta since it was doubtful that the Department of Health had considered the optimum context within which specialist nurses could operate to achieve successful implementation of the above goal, mainly because the information about them was not available.

Notwithstanding this, as previously discussed, Malta has a strong private medical market especially in the community serviced by General Practitioners, thus the potential effect on their livelihood with the introduction of more specialist nurses in the community should not be underestimated. Additionally, studies in other countries identified physicians as barriers when they were not involved in the process of new specialist nursing roles (CSEHWRRS 2014). Pulcini et al. (2010) also found that countries were successful in introducing APN roles when they were able to transform support into political will and to advocate for the development of educational programmes, clear APN education, practice, regulations and scope of practice. Finally, the immediate involvement of the unions would be needed not only because of their strong position in Maltese nursing but because of their ability to facilitate the agenda with politicians, managers and colleagues. The EU CSEHWRRS (2014) study supported this recommendation since it was found that nursing associations and unions were vital during negotiations for the development and sustainability of these roles.

Additionally, the CSEHWRRS (2014) study found that where review and expansion of nursing practice had been most successful, certain support measures had been present and were considered essential. These included guidelines, policies or protocols that had been developed collaboratively with practising nurses using legislation and research-based literature where this was available. Proposing a new role for nurses as Schober et al. (2016) suggested would need to be accompanied by the presence of appropriate policies to fully support their practice. While there were many descriptions of role implementation within the existing literature (Bryant-Lukosius and Dicenso 2004; Hamric et al. 2014), according to Schober et al. (2016) no evidence was found describing the process of policy development relevant to APNs or the subsequent realization of policy in practice. Notwithstanding this, both the findings in this study (particularly indicated by the Consultant group) and also international literature, (Elliott and Walden, (US) (2014); Begley et al., (Ireland) (2010); Department of Health, (England) (2010)) recommend that to begin with a framework should be proposed as a guide for a coordinated approach to policy development and implementation for specialist nurses in advanced practice in Malta. This would assist in a strategic approach to inform future development (Schober et al. 2016).

A key part of the process for development of policies was the consideration of how they may be implemented and the resources needed to implement them. This was another important reason why specialist nurses needed to become involved in national policy because they would be the ones who would help in formulating the needs of a service or role at an early stage. Brown (2007) explained that nurses needed to be empowered to use windows of opportunity through policy development activities in two different circumstances; a crisis or an anticipated change of direction. The drive from the Maltese Ministry and hospital management is for patients to be discharged sooner; the National Health Strategy System (NHSS) (2014) document emphasised the need to develop nurse-led clinics, and the planned private hospitals all point to an opportune time for specialist nurses to get involved and share how their services can be expanded into the community, and what investment is needed for this to happen. This study itself could also be viewed as providing a window of opportunity that could be utilised as an intelligence source on the roles and experiences of specialist nurses. Such moves would support the clear direction from the government that there was a drive towards specialised nursing roles in chronic disease management including: diabetes, heart failure, older people, mental health and rehabilitation. It was evident within the literature that political involvement and commitment were associated with the success of

many projects relating to specialist nurses. The EU (CSEHWRRS 2014) study found that the lack of investment in these roles could be caused by the lack of conviction that specialist nurses were needed and worth the investment. In the EU-based studies (Delamaire and Lafortune 2010; CSEHWRRS 2014) it was evident that in nearly all countries where APN had been implemented, nurse associations played a key role in putting the issue on the policy agenda first and then mobilizing the required political support. The associations also made proposals for extending the scope of practice of nurses, as well as defining the additional education and training requirements. Furthermore, the nurses' associations supported the implementation of any adopted reform. From these studies (Delamaire and Lafortune 2010; CSEHWRRS 2014), it was evident that nurse organisations in countries like the UK and the USA were well organized and had more influence than in other countries and appeared better able to exert pressures for reforms, develop reform proposals and support implementation.

In addition, this present study recommended that all stakeholders be on board with developmental activities and that the issue of maintenance of continuing professional development and expectations about specialist nurse competence must be outlined specifically in policy through the CNM. As Jones (2005) suggested, clear objectives communicated to all staff groups would reduce role ambiguity and negative consequences. Moreover, the debate on the Scope of Practice and regulation of specialist nurses in Malta would need collaboration between the relevant political, organisational, educational, professional bodies and the public. This would be a means of getting stakeholders on board to discuss and communicate expectations since without clear communication Schober et al. (2016) stated that ambiguity, conflict and frustration may result, ultimately challenging progress.

A recent study by Schober et al. (2016) described the process of the introduction of policy for advanced practice nurses in Singapore and highlighted how policymakers, nursing leaders and medical champions focused their attention on addressing policy such as regulations and standards for APNs. A receptive environment supported the initiative but the research further revealed that progress from intent of policy to implementation was complex. The study verified elements of a rational approach to policy development consistent with principles of legitimacy, feasibility and support proposed by Hall et al. (1975). The healthcare quality of its citizens and the allocation of competent providers were a legitimate concern that caught the attention of policymakers. A level of feasibility occurred following lengthy discussions and after policymakers in positions of power and authority spearheaded action.

Once the initiative was viewed as achievable techniques for gathering support followed with increased confidence in the existence of a common interest. The research was important since it provided important steps for consideration when policy proceeded implementation and served to draw attention to the complex and complicated nature of such an initiative. Evidence from Schober et al. (2016) stipulated the need for recognition of the position of APNs in the healthcare workforce along with identification of a protected title, scope of practice, reporting mechanisms and evaluation. Most importantly it emphasised the importance of communication with all parties including managers, medical directors, consultants, other nurses and ancillary staff in discussions prior to implementation. This approach was supported in the literature (Begley et al. 2010; Delamaire and Lafortune 2010; CSEHWRRS 2014) since important stakeholders that were not on board could halt the system of progression for advanced nurses mainly due to overlapping roles and the potential loss of income for some other members of the healthcare team. (Delamaire and Lafortune 2010; CSEHWRRS 2014). Begley et al. (2010) found the proactive preparation of the site for the introduction of nurses with new roles not only enhanced role clarity but reduced opposition from other members of the team.

5.4.5 Leadership

This study revealed contextual results for specialist nurses that warranted further discussion. These included issues such as knowing the nurse prior to employing her/him within the team; having one manager to co-ordinate specialist nurses, becoming a strong group, needing a transparent fool-proof system of recruitment and a structure to develop career pathways with training, research and certification with registration.

Although these issues were important to specialist nurses and shed light on their immediate situation, no literature was found pertaining to having one manager, and knowing 'a colleague' prior to employment. Notwithstanding this, these findings pointed toward paucities within the leadership structure of nursing at an individual, organisational and national level.

Higgins et al. (2013) explained that the literature had mainly focused on the barriers that limited specialist nurses to enact their clinical and professional leadership. Assuming that the barriers such as role confusion, role isolation and deficiencies in the support network were removed, then leadership would be enabled. However, the SCAPE (2010) study, as reported by Higgins et al. (2013), revealed specific support structures that influenced the

leadership component of their role. Higgins et al. (2013) reported findings from the Irish SCAPE case study that explored clinical specialists' (CSs) and advanced nurse practitioners' (APs) ability to fulfil their leadership role. 23 CSs and APs working in Ireland and multidisciplinary team members working with them were interviewed and observed and the data also included documentary analysis. Higgins et al. (2013) found that formal training sessions could provide in-depth knowledge and understanding of the subjects related to leadership. In fact, Aquilina (2010), a practice development nurse in Malta, recommended leadership initiatives including group coaching that could provide a gelling effect within the group and a forum for sharing common concerns and aspirations to energize and engage the participants towards a shared vision. One-to-one coaching sessions were seen as being able to help in the self-exploration process, identifying personal strengths, areas of growth and the development of personal and professional goals with set and agreed time-frames. However, nearly two decades ago, Manley (1997, p187) in the UK, pointed out that *"however much practical and theoretical expertise and advanced practitioner/consultant nurse possesses, this on its own has little value. The context has to be conducive and the basic ingredients need to exist, namely shared values and a non-hierarchical, open management style."*

The 'context and ingredients' that Manley (1997) referred to in the above statement were reinforced by Higgins et al. (2013). They reported that the presence of a framework for professional development of the role and planned opportunities to act and sustain these leaders and the personal attributes of practitioners, such as being committed to professional development and having a vision for change, were found to enable leadership in CS/AP roles in Ireland. Moreover, a dedicated body, in this case the National Council for the Professional Development of Nursing and Midwifery (NCNM) in Ireland, was not only vital in establishing a clear framework for professional role development but also in providing opportunities to act as leaders and bringing CS/APs together to showcase their work. Management was identified as having a role in preventing barriers, such as role isolation and pressures of workload. Managers were also found to be key in proactively increasing opportunities for CS/APs to influence the policy agenda both at national and international levels. Although Higgins et al.'s (2013) study had its limitations due to the relatively small sample size and the non-generalizability of the findings to other contexts and groups, it did use various sources of data and stakeholders' views to decrease some of these limitations. Moreover, rather than providing information on barriers to leadership roles, practical mechanisms were identified to sustain the leadership capacity within the CS/APs roles.

5.4.6 Power in Nursing

This study highlighted the hierarchical and bureaucratic system that does not involve specialist and general nurses in matters either on an organisational or professional level. This was seen to be hampering the efficiency and morale of nursing within the Health Department. These findings further support previous studies carried out in Malta (Johns Hopkins 2012; Buttigieg 2012; Dalli 2014). One of the medical consultants in the focus groups specifically pointed out that the ‘power distance culture’ in Malta discourages people to take responsibility. This consultant further explained that specialist nurses in Malta that are well trained and actively embrace responsibility are actually seen as being arrogant or ‘pushy’. Buttigieg (2012) concluded that the nursing structure was becoming more directive and less consultative in its approach and as having an agenda that was not established with nurses in the clinical area. He further found that nursing was lacking a sense of ownership and professional proactivity that needed to be addressed. Buttigieg’s (2012) study on medical nurses in the acute hospital in Malta also found that nurses in his study felt disillusioned by not having their voice heard and lacked trust in managerial initiatives that were seen as exploitive and divisive.

Kanter (1993, p. 166) defines power in nursing as “the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet”. As Manojlovich (2007) states there are at least three types of power that nurses need to be able to make their optimum contribution: control over the content of practice, control over the context of practice and control over competence. Content of practice refers to the nurses’ use of their professional preparation which focuses on autonomous practice and independent decision making (Manojlovich 2005); control over the context of practice represents nurses’ power when being meaningfully involved in the running of hospitals (Manojlovich 2005) and power in competence (Kramer and Schmalenberg 1993) is related to educational preparation that is maintained through knowledge and skills development (Rafael 1996). As voiced by the SNs themselves and the stakeholders in this study, there was an increased level of responsibility without equivalent increases in practice autonomy or institutional influence. This could be frustrating and demoralizing SNs by contributing to a disillusioning professional role experience (Manojlovich 2005; Buttigieg 2012). In addition, the study established a lack of support for education and training of these specialist nurses. Moreover, the fact that there are multiple-level nurses practising in Malta, ranging from Enrolled, Diploma, Degree and Masters level

nurses, may contribute to nurses' powerlessness (Griscti 1999; Fenech Adami 2001). Griscti (1999), a Maltese lecturer at the time, proposed that one graduate level education would not only help in uplifting the status of nursing to the educational level of other professions but would further help with the public's recognition of professional nursing. The statement, "Being less well-educated than other groups within the hospital puts nursing at a serious disadvantage in organizational politics" (Prescott and Dennis 1985, p. 355), is still valid today more, than twenty years since it was written.

Manojlovich (2005) further explains that nurses' power may arise from three components: a workplace that has the requisite structures that promote empowerment; a psychological belief in one's ability to be empowered; and acknowledgement that there is power in the relationships and caring that nurses provide. As discussed previously, this study's findings demonstrated that there was continued lack of control over all these aspects of power of nursing work suggesting that power remains an elusive attribute for many nurses in Malta (Manojlovich 2005). This study established that the SNs did not feel that the workplace and management involved them in decisions and did not feel valued by the management and the organisation. The findings further highlighted SNs' feelings of disempowerment when they stated phrases like 'in Malta nothing changes', 'you have to be blue-eyed' or 'somebody will be put in that role' with no interview. Thus, I could conclude that SNs did not feel empowered since the components described by Manojlovich (2005) were not evident within this group of nurses in Malta.

Another finding was related to SNs' perception of a loss of control of nursing. Nurses in the focus group and also SNs in the interviews voiced a strong medical dominance within nursing and felt that doctors still exerted control over nurses' professional lives. Equally they felt that nurses are surrendering their direct caring roles to unlicensed healthcare personnel such as carers. The lack of curiosity that was evident when no one of the SNs read the sectoral agreement or challenged the authorities on why this document was not made public further indicates oppressive roots with a local paternalism remaining within the structure and culture (Darmanin 2006). Viewing empowerment through a feminist lens may help explain findings of disempowerment and on overcoming oppressive working conditions brought on by the patriarchal structure of medicine and healthcare organisations in Malta. As mentioned previously nurses' lack of power may be rooted in societal expectations since nurses may be more reluctant than most to discuss power because nursing is predominately a female profession (Spratley et al. 2000), and women have not been socialized to exert power (Rafael

1996). Consequently, power is viewed as an outcome of masculinity and in direct opposition to caring, which is seen as the essence of nursing and traditionally aligned with femininity (Manojlovich 2007).

Notwithstanding this, there are other important elements that need to be examined in Malta that include the dominant patriarchal ideology of the Roman Catholic identity (Darmanin 2009) and the female position in society. Darmanin (2013) an Associate Professor, at the Faculty of Education, University of Malta, explains that empowerment of women is still a contentious issue within Catholic social teaching. She further points out that until recently, Malta was a country in which males were considered the family breadwinners and the entry of women to the work-force was considered a threat. Measures such as married women giving up work on marriage, or women not being able to fill a post that had been previously occupied by a man and women being paid at a fraction of what men were paid for the same work, were strategies of closure on women's access to the labour market that served both the interests of the colonial pre-capitalist mode of production and patriarchal Maltese society (Darmanin 2006). The situation today is slightly different from that in the 1960s and 1970s since pressure from women's groups and women in politics has slowly eroded the basis behind patriarchal protective legislation (Darmanin 2009). However, the effects of earlier social and economic planning are still evident in the participation of females and in the segmentation and segregation in the labour market that still prevails. Moreover, Darmanin's (2006) concern is related to key education policy-makers who have some power in setting policy direction but who accept the status quo, and appear to be led rather than leading in policy formation.

Fletcher (2006, p. 50) also points out that, years after the feminist movement, "many nurses do not feel empowered, and what we do as nurses does not seem to be working". According to Manojlovich (2005) hospital strategies should aim at increasing action against oppressive constraints to nursing practice that could contribute to the empowerment of nurses while advancing the effectiveness of direct-care nursing. This was also suggested by Buttigieg (2012, p.137) following a local study who found that nurses in his study felt disillusioned and lacked trust in managerial initiatives that were seen as 'exploitive and divisive'. Notwithstanding this, Buttigieg's (2012) study was carried out only on medical wards in Malta thus limiting its generalizability. Therefore, there remains a need for research to examine the power in nursing and in particular specialist nurses in Malta. Understanding nurses' power more explicitly could help nurses to become empowered and use their power

for their practice and for better patient care. Further investigation on empowerment could expose forces of injustice and oppression by examining the power relationships and imbalances within the social structure of nursing in Malta to work toward liberating change through collective social action.

This section of the chapter explored the wider aspects that were found to have influenced the development of advanced nursing practice in Malta, such as the overall nursing situation, health strategy and issues such as gender and nurse education. It was evident from this study that further research is needed to determine the role of specialist nurses from different perspectives and hear the voices of those involved in the delivery of the services and the assurance of quality. In the environment where there are increased demands on the Health system, one needs to challenge attitudes and systems to provide a quality care service for the Maltese people. Within the UK, Darzi (2010) in the report '*Front line-care: the future of nursing and midwifery in England 2010*', states that nurses are well placed by being close to patients and their families to identify where innovations are needed and to make change happen, and they should continue to be empowered to improve services. Darzi (2010) further emphasizes that these changes cannot be left only to nurses, or to one profession, but by all including nurses, midwives, doctors, surgeons, managers, policy-makers, politicians and other stakeholders.

On a realistic note, it must be acknowledged that this is not a simple venture. However, there needs to be both a short and long term plan that would bring all the specialist nurses and their stakeholders on board and in line with whatever planned system was developed. The specialist nurses themselves noted the lack of motivation to be united as a group of professionals with the same interest. They felt the need to have collective meetings, structure, a vision and leadership. Although in Malta, there has been progress in the development of advanced nursing practice including specialist nurses, further investment and governmental commitment to further develop them would benefit any future strategic activities. This study identified that it was currently difficult for nurses to progress in their present speciality or to gain promotion, unless they were prepared to move into nurse management and subsequently away from clinical work. Rectifying this situation would require appropriate professional development opportunities to be put in place. Additionally, there would be a need to implement a systematic approach to strategic and all-systems approach workforce planning, and to understand how the role of the specialist nurse fitted within the overall healthcare workforce framework in Malta. Consequently it is

recommended that this ‘drive’ and direction from the Ministry be shared and discussed by all stakeholders and a plan outlining the resources needs be drawn up before its implementation. As Fenech Adami (2001) aptly stated, the challenge today lies in finding the best way of ensuring an adequate supply of nurses, based on the belief that tomorrow’s services may be shaped by today’s strategic thinking.

5.5 Implications

To summarise this discussion chapter, the following section will outline the implications for the health department, specialist nurses, nurse leaders, and research in Malta.

5.5.1 Implications for the Health Department

The longer-term implications of having non-regulated specialist nurses require serious deliberation by the professional regulating bodies.

- Guidelines from the nursing council with regard to the required preparation for specialist and advanced practice need urgent clarification.
- There needs to be clarification as to the definitions of specialist nurses and practice development nurses’ roles.
- National standards of practice or minimum requirements for specialist nurses need to be considered and all stakeholders involved in their development.
- In order to safeguard the public, nurses need to have a system that recognises their abilities. An updated and maintained register should be set up with all nurses registered in Malta; this should also be in public domain. Moreover, a system for revalidation to practice needs to be considered.

5.5.2 Implications for Specialist Nurses

Specialist nurses have managed to go beyond establishing themselves but they need to think about proving their worth, as in cost-effective and high quality care, but also in seeing how to bring the stakeholders on board to make the case for specialist nursing positions permanent and stronger. This study has identified that the roles and services of specialist nurses had great expectations, but in fact the guidance was self-limiting. Specialist nurses, together with the main stakeholders, should drive action and get involved strategically. Specialist nurses need to get involved in:

- Developing a framework to encompass the legal, ethical and competency elements of their role that is relevant to Malta.
- Competency frameworks should be written verification that their employers are aware of and accept this practice and should be included in an up-to-date job description that is reviewed regularly.

- Clarifying their role boundaries and awareness within the multi-professional team is needed in order to ensure smooth working relations, with clear role boundaries for them, other team members and most of all their patients. Lines of accountability and responsibility should also be stipulated into the job descriptions, for both professional and medico-legal reasons.
- Looking for ‘windows of opportunity’ to get involved in policy and the nursing profession both nationally and internationally.
- Participating and initiating research in their areas of expertise and services provided, including patient satisfaction surveys.
- Supporting and acting as role models to other new colleagues.
- Investing in teaching sessions and other educational opportunities to create an awareness of the specialist nurse’s role and functions.
- Networking locally and internationally
- Using the Pandora database to demonstrate the complexity and multiplicity of components of the CNS role and its impact on care by untangling events, and considering the work covered, which are often innate in many CNSs’ daily activity (Leary et al. 2008)

5.5.3 Implications for Nurse Leaders

It was evident that specialist nurses were being mis-used on the wards and by management, but there was never an evaluation of their needs and outcomes. Although common roles were identified, there still seems to be lack of clarity amongst the directors/managers of nurses and other stakeholders on the purpose and functions of these roles. Thus:

- The purpose and functions of the post needs to be transparent to both the people who work within the organisation and the patients for whom the service is established.
- Ensure that such specialist nurses do not get into a career cul-de-sac and formal clinical and academic pathways are recognisable.
- Develop of a transparent specialist nurse policy on recruitment and retention to guide future developments.
- Care should be taken to ensure that all consultants involved with the service provided by the specialist nurse should reach a consensus as to their view of how the role should function.
- Single-occupancy posts should be discouraged, for the benefit of both the service and the specialist nurse, unless the specialist nurse works within an appropriate multi-professional team. If these are inevitable, managers need to consider how they will cover the service in the post-holder’s absence (study leave, annual leave, maternity and sick leave).

- Supportive management attitudes to help ensure that relevant staff are aware of specialist nurses' functions and can see the benefits to the patient and them as professionals.
- Ensure, through a well-developed induction process, a good knowledge base of the hospital and of key personnel.
- Establish a suitable collegial support and management framework from the outset to ensure that the posts do not become isolated.
- Plans should take into account the specialist nurse's longer-term needs for personal development as well as the immediate needs of the role. To attend such events, appropriate financial support and clinical cover should be made available to enable them to do so.
- Specialist nurses should be given adequate access, from the outset, to IT equipment, telephone, library resources and teaching materials in order to support their clinical work, their teaching and their participation in audit and research activity.
- There should be adequate provision of administrative and clinical support staff to ensure that the specialist nurse's time is not spent on undertaking work which could more appropriately be done by others.
- Thought should be given at the outset to which outcomes or processes should be measured, and consensus reached by all relevant parties as to what is important, and why. Staff should be made aware of these systems and what they can offer.
- Identify and encourage leadership in nursing and specialist nurses through strategic systems of support (Begley et al. 2010).

5.5.3.1 Implications for further research

This study highlighted areas that need further investigation as outlined below:

- Specialist nurses need a framework for competences, preparation and career advancement.
- Burnout, stress and demotivation amongst specialist nurses and general nurses in general need further investigation.
- Evaluations on patient satisfaction and audits on the cost-effectiveness/quality are needed on specialist nurses' roles and services.
- The Nursing care at the bedside should be investigated in Maltese hospitals.
- Attention to the environment and organisational elements of work affecting staff motivation, and retaining nurses should be explored further. Particular consideration is needed on the Power in Nursing.
- The hierarchical system in healthcare and the medical and nursing divide together with Leadership in Nursing needs further investigation.

6 Conclusions and Recommendations

This final chapter will identify the unique contributions of this study to new knowledge and outline the recommendations already discussed throughout the previous chapter. The final section will reflect on the study's limitations and will close with a personal reflection and concluding remark.

6.1 Contribution to new knowledge and understanding

This study was the first of its kind in Malta and provided in-depth knowledge on the country's specialist nursing experience. Most significantly the information of this study contributed to this innovative area of healthcare by providing rich data on the perceptions of these specialist nurses that provide a service to the Maltese population and the stakeholders who use their services. This emanated from the direct accounts of nurses, nurse leaders, consultants, allied health professionals and specialist nurses regarding the positive elements, concerns and potential improvements needed to facilitate the development of the specialist nurse's role. Data conveyed important insights into the services provided by specialist nurses and thus, could alert the authorities to explore the nature of specialist nursing practice in the context of quality patient care both at an organisational and national level.

6.1.1 Recommendations for Nurse Empowerment in Malta

The experiences of the specialist nurses and their stakeholders in the study sample were discussed from the cultural and socio-political context of nursing in Malta that provided an understanding on the wider issues these nurses faced, such as gender positioning, their perceived inferiority, the shortage of nurses, burnout and the work culture that could be influencing the advancement of nursing and specialist nurses. This thesis thus provided a deeper and contextual understanding of the nature and reality of the influences that may be both helping and hindering specialist nurses functioning in their role. However, other phenomena that came to light, including their fear of development and the lack of structure to provide training and demonstrate competence, need further exploration. This study further pointed out the challenges to the statutory nursing body, professionals, organisations and the health department. It echoes the need to develop a career pathway in which specialist nurses' skills and knowledge could be acknowledged and developed, from standardised specialist titles to a framework of levels of competence and expectations of care.

In order to safeguard the public, nursing as a professional group needs to urgently consider requirements for the initiation and maintenance of a generalist and specialist register. Systems of accreditation and regulation, which underlie the processes of quality assurance, need to be firmly based on the core principles of nursing and their future role in healthcare. Nurses in Malta need to take responsibility for regulating themselves on criteria based on 'appropriate' models of behaviour, practice, education and training. Although Malta often follows the UK in relation to nursing policy and education it is wise at this stage to look elsewhere since the USA and other countries like Australia and The Netherlands seem to be the ones that provide more clarity on the elements and structure of the specialist nurse's role. Malta should aim at outlining the primary criteria of advanced practice in postgraduate education as well as certification in a specialty with a focus on clinical practice.

The collective findings will contribute to the local health scene by not only raising the profile of advanced nursing practice and specialist nursing but by providing a common evidence-based foundation for discussion. Having this evidence could enable specialist nurses to benchmark their services and roles with the findings of this case study and could be a catalyst in initiating policies to standardize a system for the development of advanced nursing practice. This study further highlighted areas that need strategic, national and political attention and recommends that there should be consultation to stimulate thinking in professional leaders about the challenges. As discussed nursing in Malta, at national level and amongst all levels of nursing, needs to have the information and invest time and resources for policy change and research. This empirical evidence will then need to be shared with policymakers, professionals, government and the public. However, this policy change will only occur through the emergence of strong individual leaders who will need to be encouraged and empowered. One of the biggest revelations in this study was the lack of curiosity of nurses in Malta, as illustrated by their lack of knowledge concerning sectoral agreements. Additionally their feeling of lack of motivation, the absence of professional leadership and perceptions concerning medical dominance were all tangible. This suggests that further research is needed in these areas because the future depends on what is done today in nursing and just having a complacent workforce with little drive to challenge the status quo will affect nursing and specialist nurses' development. Thus it is imperative that nurse leaders, specialist nurses included, need to be aware of the development of policy to ensure that the nursing voice is heard at the early stages of policy development. What is encouraging is that specialist nurses have progressed past the point of simply establishing

themselves, either as post holders or as the leaders in certain clinical services. However, this momentum needs to be maintained and supported through a modernized Scope of Practice. Specialist nurses in collaboration with the nursing union and other key stakeholders including the Medical Association of Malta, the College of Family Physicians, the Directorate of Nursing, the University and the Council of Nurses and Midwives, need to lead on the changes identified in this study. Moreover, establishing a specialist nurse sub-committee within the CNM is essential if it is to start functioning as the regulator for specialist nurses.

6.1.2 Recommendations to Future Nurse Researchers

The case study presented in this research is meant to provide nurses with a constructivist methodology which centralizes the importance of the participants' perspective on the issues surrounding the development of specialist nurses in Malta. However, methodological research activities in the future should include action research to instigate the change needed in areas identified in this study. Another recommendation is to study the outcome and impact of these nurses on the quality of life and their cost benefit by incorporating the use of the Pandora database. This will not only demonstrate the complexity of their role that is often hidden, but will re-enforce their worth (Leary et al. 2008). This study has implications for future nursing development in Malta. The study findings indicated that the experience of specialist nurse was influenced by the power, politics and the general progress of nursing in Malta. The meaning that was constructed from these experiences created unique trajectories, and further research into refining these dimensions would be useful to extend the findings. The power issues in nursing and the definition of nursing in Malta are a couple of examples that need exploration.

For future researchers using a constructivist case study approach I recommend transparency, honesty and reflexivity in undertaking and reporting the research. It is acknowledged that it is very difficult to separate one's own interpretations and feelings from the study (Merriam 1998) but one must defend their conclusions by being aware of the perspectives from which they approached the task and be transparent about how that perspective potentially influenced the conclusions made. The philosophical background to the study and one's own ethical convictions need to be defined and must constantly question ongoing intellectual work to provide a more virtuous place for social science researchers to stand.

6.1.3 Recommendations for The Wider Body of Knowledge

While this case study is unique and the results may not be generalizable to other healthcare systems, the outcomes of the study are important locally and to an extent internationally. Moreover, in line with the constructivist inquiry, the findings could be transferable (Appleton 2002) to other settings or individuals reading this study. The design of this study could be replicated elsewhere and any learning derived from it might be used as a comparator in other similar settings, like Southern Europe with similar cultural tendencies, or small states like Luxemburg or Iceland, that have a similar population to Malta. This study identified various developmental issues that influenced the development of specialist nursing in Malta and which differ from international trends. Worldwide, most roles in advanced nursing practice were developed mainly due to the shortage of doctors, but this did not seem to be the case in Malta. The main reason why specialist nurses developed was either due to a gap in services or to a policy that demanded the role of a specialist nurse, as in the case of screening nurses, breast care nurses and the occupational health nurse. It was also seen as a means for nurses to continue progressing within a specialised field of nursing rather than entering into managerial or educational positions to gain a wage increase or further their career. Therefore, this study could offer the opportunity for the government of Malta to consider the key role that SNs could play in the delivery of a quality health service vis-à-vis the number of medical personnel to enhance the cost effectiveness of the health service.

This study inferred that specialist nurses have the unique potential to affect the changing needs of healthcare in Malta, but are restricted in care provision by varying regulations and lack of policies and support for their development. It is recommended that all stakeholders including the nurse managers, patients, ministry and doctors understand the role, needs, aspirations and visions of these nurses, thus these stakeholders must be involved from the beginning in any developmental activities. If the concept of specialist and advanced nursing practice is not understood, then the development of these nurses will be halted since they would not be in a position to be supported in basic needs, such as training and the provision of resources, to develop services and credibility, and finally to gain recognition.

Finally, this case study is not intended to have a significant impact on broader health policy, although it does have implications for health authorities and professionals working with specialist nurses in Malta. Study conclusions will also inform practitioners who are able to compare similarities between this case and their own practice (Hyett et al. 2014).

Moreover, the issues highlighted in my study build on current debates on the topic of specialist nurse literature and case study design internationally.

6.2 Strengths and Limitations of this Study

The results of the study and the end report provide valuable insight into the experience and development of specialist nurses in Malta highlighting areas that could be improved and others that need radical overhaul for further progress to be achieved. Certain conclusions arising from the data analysis were different to those found within the international literature and further helped to critically evaluate the context of specialist nurses working within a small Island state. Throughout the thesis I described and discussed my thoughts, reasoning and decisions about all aspects of the research process not only to provide clear understanding for the reader but also for transparency and rigor (Merriam 2009). Notwithstanding this, the study has its limitations.

6.2.1 Exclusion of Patients

Although rigorous consideration was taken to identify the professional stakeholder groups that included health practitioners, policy makers, and managers that worked with specialist nurses to represent views equally, patients were not included in this case study. This is the first limitation of this study since patients are important stakeholders and their experiences of specialist nurses could have added valuable information about the outcomes of these nurses' activities, roles, and services. Although I purposefully did not include the patients and provided reasons for their exclusion, I would strongly suggest their involvement in future studies. This is especially important to further complement this study and continue to help practitioners and policy makers to deliver person-centred care, by learning more about the patient as an individual. Patients and their relatives could also provide rich information about their experiences with specialist nurses and could ensure that changes are patient-generated.

6.2.2 Inclusion of only Medical Consultants

Secondly, medical consultants were used as part of the focus group participants; however on reflection the results might have been different if general practitioners or more junior medical staff had participated. This should be taken into consideration in future studies since consultants might not have felt threatened by these nurses, either because they understood their role more than other junior doctors or because they were not perceived as being a threat

to their livelihood, as in the case of general practitioners who have a private practice and could be affected by the services of specialist nurses.

6.2.3 Positionality and power

Although I used reflectivity throughout the study to understand my own experiences of the world and to make explicit what could have affected the research process, my position as a senior nursing manager and also my values that lean towards feminism need to be taken into consideration. While my feminist lens has helped explain the findings of disempowerment and on overcoming oppressive working conditions brought on by the patriarchal structure of medicine and healthcare organisations in Malta, this view may have overlooked other interpretations of the phenomena occurring in the study findings.

My position as an ex-colleague and, at the time of the study, a senior nursing manager within the hospital, could have created power issues. As an ex-specialist nurse, my experience and knowledge was a vital part of the case study approach since these were key determinants of the quality of this case study research. Notwithstanding this, these positions and knowledge could have impacted the findings of this study both positively and negatively. In a positive way, as an ex-colleague participants may have been more open to this study and thus participated more **responsively**. Adversely, my position could have restricted the participants' 'real' expression of feelings and perspectives since I was a senior manager. Due to my senior position in the hospital, participants could also have felt obliged or 'pressured' to contribute in this research. Moreover, as I explored the contextual experiences of specialist nurses I was confronted with further constraints. Due to the perceived familiarity with the situation of specialist nurses, participants often assumed that I was fully aware of particular events. As a result, I had to make a concerted effort to encourage participants to amplify details of these events during interviews. Finally, the risk of bias due to my construction of the data around issues I judged, no matter how rigorous I strived to be, reflect my own drives within the interpretations of the findings. To counterbalance these facts, throughout the study I was aware of the power relationships (as explained in section 3.8.3) within this qualitative research and consciously acted on this understanding to minimize the power dynamics during the research process which aimed at making the study more trustworthy. Moreover, I shared my interpretations with my supervisors at each stage to ensure that I was not misrepresenting the data in my analysis.

6.3 Reflection and concluding remark

The whole of this Doctoral study was a journey both on a personal and academic level and the next section will outline important reflective thoughts that I learnt during this process. Reflection is “a turning back onto a self” (Steier 1995, p. 163) and is different to what I discussed in the reflexivity section in 3.4.3 where I used reflection to legitimate and validate my research procedures in a transparent way while carrying out the research and not after (Mortari 2015). I was personally motivated to conduct this primary research because of my passion for nursing and curiosity about a role which was making history in my profession. I started this study as a specialist nurse myself and then was promoted to a senior nursing manager at the main hospital. Thus, the first thing I had to learn was to direct my passion and not let it affect how I saw or interpreted what I was doing. This was done through learning about reflectivity (Dahlberg et al. 2002) and through direction from my supervisors. Initially, some comments were not always welcomed because I thought my personality was being criticized, however, I realized that was not the case and that this process was essential for carrying out the work involved. As Mortari (2015) explains, being reflective is not a natural course in one’s mind and life, but in qualitative research it is essential.

This study also taught me resilience. Some of my energy was put into action on things that were not directly related to the study but were important for me to start and complete this thesis. During the process of this PhD, right from the very beginning, e.g. applying for an EU Scholarship, arguing a case to be supported during this study, applying for study leave, and taking unpaid leave to work on this project, there were things that were difficult to deal with and added to the complexity of the task at hand. I was breaking new ground in Malta as a nurse and there were many obstacles. However, it made me stronger and more determined to complete this thesis not only for myself but as an example and role model for other nurses. Being one of the first PhD nurse candidates within the civil service in Malta to go through this process might also increase the understanding within hospital and government entities that nurses in practice should continue to research and move the profession forward. Malta needs more nursing research and this should not be carried within the confines of the University alone.

Academically, apart from developing a better understanding of the issues around specialist nurses, not only in Malta but globally, the process of this PhD was enlightening in helping me develop the skills needed to complete academic and scientific research (Holloway et al. 2009). I feel that from planning the research study, collecting and analysing the data to

writing up the thesis was an instructive process. Initially I needed to learn how to focus on what I really wanted to achieve at the end of this study and gain a thorough understanding of different approaches/paradigms in research to ensure as Creswell (2009) states, that the most appropriate approach is adopted to achieve the study objectives. This was particularly challenging for me but also very rewarding when an understanding of the philosophy of research started to unfold. In addition, this understanding transcended on to a personal level as this process gave me the opportunity to really identify myself and be comfortable with who I am as described in section 3.4.2

This case study has enabled me to appreciate the true nature of exploratory research within a constructivist worldview. The findings of this case study aim for a better understanding of specialist nursing in Malta and intend to make way for the much needed research in other areas that would complement this case study. As stated previously this study was a journey of learning in many ways and I feel that the passage now continues by being true to the participants and disseminating the exploratory findings. I feel that it is part of my responsibility to see that the 'voice' of my participants will be heard for the benefit of their patients, profession, and themselves.

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Appendix 1 Table 1(A) An outline of Case Studies exploring Advanced Practice Nurses and Specialist Nurses

Table 1 (A) An outline of Case Studies exploring Advanced Practice Nurses and Specialist Nurses

Reference	Aim of study	Design	Country	Method of collecting data	Analysis
Reed, Inglis, Cook, Clarke, Cook (2007) Specialist nurses for older people: implications from UK development sites	To explore the development of specialist staffing for older people in six sites.	Case Study	UK	Interviews with specialist nurses, service providers, patients and informal carers. These followed questionnaire responses	QSR NVivo 2 for Windows 2000, XP & ME -themes were coded to identify key aspects of the specialist nursing role under two themes: the role and personal characteristics.
Zurmeily (2007) A Qualitative Case Study Review of Role Transition in Community Nursing	To describe existing community nurse practices and to explore factors associated with transition to community practice from acute care settings.	Qualitative Case study	USA	Interviews with community care nurses	NUDIST computer program after initial clustering of data, concurrent themes were produced and relationships among concepts were identified.
Elliott et al. (2012) The identification of clinical and professional leadership activities of advanced practitioners: findings from the Specialist Clinical and Advanced Practitioner Evaluation study in Ireland	To report a case Study that identifies how leadership is enacted by advanced practitioners in nursing and midwifery. Differentiates between clinical professional leadership and advanced practice	A multiple case study	Ireland	Non-participant observation of advanced practitioners, interviews with key stakeholders and documentary evidence including audits, policies and guidelines.	The qualitative data used a framework that was developed by an expert panel and the data were managed by NVivo 8 for Windows 2000.
Begley et al. (2012) Differences between clinical specialist and advanced practitioner clinical practice, leadership, and research roles, responsibilities, and perceived outcomes (the SCAPE study)	To report a study comparing the roles, responsibilities and perceived outcomes of Clinical Nurse Specialist, Clinical Midwife Specialists, and Advanced Nurse Practitioners	A mixed-method Case Study	Ireland	Non-participant observation, interviews of clinicians and Directors and a survey by service-users	For the qualitative data The logic Model and framework were used and NVivo 8 for Windows 2000. SPSS was used for the data of the survey.
Lalor et al. (2013) Using case study within a sequential explanatory design to evaluate the impact of specialist and advanced practice roles on clinical outcomes: the SACPE study	To illustrate how case study was used to strengthen a sequential explanatory Mixed Methods Design in a study that evaluated the role of clinical nurse and midwife specialists.	Instrumental Case Study	Ireland	Observation, documentary evidence and interviews	The logic Model, PEPPA Framework and QSR NVivo 8 for Windows 2000, XP & ME was used and was coded to identify key aspects

Reference	Aim of study	Design	Country	Method of collecting data	Analysis
Aspinal et al. (2012) Promoting continuity of care for people with long-term neurological conditions: the role of the neurology nurse specialist	To identify service models that provided care co-ordination for people with long-term neurological conditions in the UK.	Qualitative Case Study	UK	In-depth (qualitative) case studies including telephone and face to face interviews	The Framework technique including the Freeman model of continuity of care.
Gerrish et al. (2011) The role of advanced practice nurses to knowledge brokering as a means of promoting evidence-based practice among clinical nurses	To identify approaches by advanced nurses to promote evidence-based practice among nurses.	Multiple instrumental Case Study	UK	Interviews and observation of advanced nurses and Interviews with clinical nurses and other health care professionals	The Framework approach outlined by Ritchie et al. (2003).
Kilpatrick (2013) How do nurse practitioners in acute care affect perceptions of team effectiveness?	To describe how nurse practitioners in acute care affect perceptions of team effectiveness.	Descriptive multiple case study	Canada	Interviews, time and motion study, non-participant observation, documents and field notes. Interviews were also conducted individually or in groups using a semi-structured interview guide.	Content analysis was used. The methods by Miles and Huberman (1994) and Langley (1999) were used to gain an understanding of processes. Coding was also used.
McCarthy (2006) Translating person-centred care: a case study of preceptor nurses and their teaching practices in acute care areas.	To explore how preceptors interpret, operationalize, document and teach person-centred care	Qualitative Case Study	Ireland	Participant observation, review of nursing notes and semi-structured interviews.	Two stages: one involved identifying themes and the other was by using propositions.
Chaney et al. (2007) Stoma coloproctology nurse specialist: a case study	To provide insight into the role of this specialist nurse	Case Study	UK	Semi-structured interviews with post holders and their managers. Non-participant observation of post-holders	Content analysis was used to identify key issues
Offredy (2000) Advanced nursing practice: the case of nurse practitioners in three Australian states	To give an account of some of the types of cases/patients who consult with nurse practitioners and to offer insight into one of the policy changes surrounding the nurse practitioner role.	Case Study	Australia	Semi-structured interviews with nurse practitioners and with non-nursing personnel	No detail

Appendix 2 Personal Correspondence (Email from Sharples, 2012)

From: Sharples Jesmond at MHEC
Sent: 06 June 2012 22:01
To: Ward Corinne at MDH
Subject: RE: Specialist nurses

Well, some developments - ghandek ragun the Sexual health nurse is now working at the Health Promotion Department on Sexual Health matters. GU will need its own one eventually.

I know about the cardiac rehabilitation. It is not yet a position - sort of like the nurses working in tissue viability so I would not count that as one.

Jesmond
-----Original Message-----
From: Ward Corinne at MDH
Sent: Wed 06/06/2012 9:45 PM
To: Sharples Jesmond at MHEC
Subject: RE: Specialist nurses

Dear Jesmond,

Thanks so much for the list. Appreciate it. I have two queries: is there not one nurse at Boffa as Sexual Health nurse? Also, I heard Ms Bonanno Talk about a cardiac rehab nurse- is this correct?

regards
Corinne

Mrs. Corinne Ward MSc.(UK)
Departmental Nursing Manager
Administration Block
Mater Dei Hospital

Tel: 2545 4207
Mobile: 79847048

From: Sharples Jesmond at MHEC
Sent: Wed 06/06/2012 15:15
To: Ward Corinne at MDH
Subject: RE: Specialist nurses

This is the list

Diabetes Nurse

Diabetes Nurse

Ear, Nose & Throat Nurse

Informatics Nurse

Interventional Cardiology Nurse

Nuclear Medicine Nurse

Orthopaedics Nurse (Theatre)

Pain Nurse

Support & Counsellor Nurse

Urology Nurse (Theatre)

Breast Care Nurse

Clinical Nutrition Nurse

Clinical Nutrition Nurse

Infection Control Nurse

Ophthalmic Nurse

Rheumatology Nurse

Stoma Care Nurse

Stoma Care Nurse

Breast Care Nurse

Infection Control Nurse

Haematology Nurse

Infection Control Nurse

Breast Care Nurse

VACANT - Tissue Viability, Pain, Occupational Health, PDN Theatres.

VACANT - Continence Nurse

VACANT - Infection Control Nurse

Infection Control Nurse

Infection Control (covers SPBH)

Breast Cancer Screening Programme - Screening Nurse

***Names removed for confidentiality**

Regards,

Jesmond

From: Ward Corinne at MDH
 Sent: 06 June 2012 14:36
 To: Sharples Jesmond at MHEC
 Subject: RE: Specialist nurses

Dear Jesmond,

Sorry to bother you again but I am eager to go ... All I need are the official contacts of the specialist nurses from your end and I will start my Study.

regards

Corinne

Mrs. Corinne Ward MSc.(UK)
 Departmental Nursing Manager
 Administration Block
 Mater Dei Hospital

Appendix 2 Personal Correspondence (Email from Galea, 2016)

-----Original Message-----

From: mumn@go.net.mt [mailto:mumn@go.net.mt]

Sent: Saturday, 09 July 2016 00:28

To: Ward Corinne at MDH-Health

Subject: Re: Definition of Position of Trust

Hi Corinne,

The definition can be that the administration would need to fill up certain key positions with people whom they trust and with this tool they would adopt a fast track to eliminate the bureaucratic process of the public service without infringing any collective agreement.

The level of a Head Nurse is the same of that a Chief Nursing Manager.

Regards,

Colin Galea
MUMN

Appendix 3 Questionnaire for Specialist Nurses

Section A. General information

1. Gender: Male Female
2. Age: 20-29 30-39 40-49
 50-60 61+

Section B. Type of post / role

3. What was your job title, prior to being called a practice nurse? _____
4. How many years have you been in your current post / role? _____
5. Did your post / role exist before you took the job? Yes No
6. Were you involved in establishing the post / role? Yes No
7. Where are you based? (please do not specify name of hospital/centre)
- Acute General Hospital Primary Healthcare Other
8. Do you visit patients? Yes No
9. If yes, where do you see your patients? (please tick \surd all that apply)
- Acute General Hospital Governmental Residential Homes
- Rehabilitation Hospital Elderly Residential/Hospital Community
- Mental Health Hospital Outpatient clinics Other

Section C: Education and Training

10. What qualifications do you hold? *(please tick ✓ all that apply)*

- Diploma
 First degree
 Master's degree
 Postgraduate diploma
 Postgraduate certificate
 PhD
 Other

11. Are you currently enrolled on a degree course? Yes No

12. How were your course fees and expenses funded? *(please tick ✓ all that apply)*

- Own funds
 Governmental scholarships
 Partly funded
 EU scholarships
 Other

13. If you answered 'Yes' to question 11, have you been allocated any paid study leave for this course? Yes No

14. Which of the following skills *(See below and please tick ✓ all that apply)*

do you think are essential to your role?have you received training in?do you require further training in?
Specialist clinical skills			
Financial management			
Teach/train staff			
People management			
Undertaking research			
Audit			
IT/computer skills			
Time management			
Inter-personal skills			
Negotiation skills			

15. Are there any barriers to obtaining that education /training?

- Yes
 No
 Don't Know

16. If you answered 'yes' to Question 15, what are those barriers in obtaining education/training? (Please number according to priority: 1= Highest priority 8 =Lowest priority)

- Cost felt to be too high Unable to cover post in absence Distance
 Funding not available Department does not think it is relevant to post
 Lack of time No appropriate course available Other

Section D: Role and responsibilities

17. How is your time divided out of 100% between the following activities? (Please enter percentages - rough estimates would suffice)

Clinical work	%
Management	%
Education/Training	%
Research	%
Other	%
Total	100%

18. How are clients/patients referred to you? (please tick \surd all that apply)

- Self-Referral Consultant General Practitioner
 Nurse Health Professional Other

19. Who do you refer patients to? (please tick \surd all that apply)

- Consultants Specialist Nurses General Practitioners
 Healthcare Professionals Other

20. Have you had a referral refused because you are a nurse? Yes No

21. Do you order investigations like bloods, X-Rays and wound swabs?

- Yes No

22. Which of the following do you undertake as part of your role? (Please tick \surd one option from 'always' to 'never' for each of the statements below)

	Always	Sometimes	Rarely	Never
Assess Healthcare needs of patients				
Take a comprehensive history				
Undertake physical examination				
Make diagnosis				
Organise Clinic for Medics				
Screen patients for disease risk factors or signs of illness				
Develop plans of care in collaboration with clients				
Order investigations				
Refer clients/patients to other healthcare providers				
Provide counselling				
Undertake health promotion and provide health education				
Admit/discharge patients from caseload				
Initiate research				
Undertake specialist procedures				
Support people to enable them to manage/live with their illness				
Make autonomous decisions				
Provide specialist advice to other healthcare professionals				
Provide education/training to staff				

23. Are there any activities you would like to do as part of your post / role, but that you

do not do at the moment? Yes No Don't Know

Section E: Managerial/development issues

24. At work, which of the following..... (Please tick \surd all that apply)

were you provided when you came into post?do you currently have?do you need but not have?
Desk			
Filing cabinet			
Office			
Telephone			
Beeper/pager			
Computer			
Printer			
Appropriate software			
Specialist equipment			
Adequate secretarial support			

25. Do you have a job description for your current post / role?

Yes No Not sure

If you answered no 23 as 'No' or 'Not sure' please go to Question 26

26. Do you feel your job description reflects your current post / role?

Very Well Reasonably Well Not Very Well Not at all Not sure

27. When was your job description last updated?

Within the last 2 years Never Don't Know

28. Do you work following protocols in any aspect of your role?

Yes No

29. If you answered 'Yes' to Question 28, who issued those protocols?

- Yourself Nurse Manager Medical staff

30. How many hours are you contracted to work per week? (hours)

31. Do you regularly work more than your contracted hours? Yes No

32. If you answered 'Yes' to Question 31, on average how many extra hours a week do you work? (hours)

33. When you are on leave, does someone else cover your work?

- Usually Sometimes Never

Section F: Career Development

34. What was your previous post / role before this one?

- Staff Nurse Deputy Nursing Officer Nursing Officer Other

35. Why did you take up your current post / role?

- Advance career Money incentive Convenient hours Other

36. What do you see as your next career step?(choose and tick \surd only one option that best applies to you)

Continue in same or similar post / role as this	
Move to a higher grade post / role in same field	
Become more specialised in this field	
Return to more generalist area of practice	
Lateral move to different area of specialism/expertise	
Move into a more managerial post / role	
Move into nurse education	
Retire	
Other	

37. Do you think working in this post / role has enhanced your career prospects?

Yes No

Section G: Your views

(Please tick \surd one option from 'strongly agree' to 'strongly disagree' for each of the statements below)

		Strongly Agree	Agree	Neither	Disagree	Strongly Disagree
38.	I have access to the professional training and development I need.					
39.	A high level of autonomy is required in my role.					
40.	My nursing skills are important in my role.					
41.	I feel part of a team.					
42.	I sometimes feel I am expected to work beyond my level of competency.					
43.	I am given the support I need to do my job well.					
44.	My role is evolving.					
45.	Research is part of my role.					
46.	My role has expanded beyond my job description.					
47.	I am happy with the way my role is evolving.					

48.	My professional judgement is respected by nurses.					
49.	My professional judgement is respected by medical staff.					
50.	My role is not understood by nursing managers.					
51.	My role is understood by other nurses.					
52.	I work primarily on my own.					
53.	Patients value my role.					
54.	Other staff make appropriate use of the services in my role.					
55.	As a specialist nurse I can progress in my career.					

Thank you very much for taking part in this survey.

Appendix 4 Interview Guide for Specialist Nurses



**Bournemouth
University**

Interview Guide with Specialist Nurses

Introductions of researcher and the study – Following the Participant Information Leaflet

1. Could you kindly state your title and how long you have been a specialist nurse? Also give a background of your experience as a nurse prior to becoming a Specialist nurse.
2. How would you explain your role as a specialist nurse?
3. Could you give me an idea of a day as a Specialist nurse, so I could try and understand what you do?
4. Could you kindly help me understand how this role developed?
5. How has the title change affected you?
6. How have your perceptions changed your role?
7. How do patients / clients benefit from the role you undertake?
8. What changes have you been able to influence since being in the current position?
9. What are the most challenging aspects of your role?
10. How are these supported by you and your organisation?
11. What in your opinion constitutes an effective specialist nurse?
12. If you had to choose a specialist nurse for your area. how would you choose her/him? (qualities, characteristics and experience)
13. How were you prepared for your role? And did this training enable you to work differently?
14. What are your educational and developmental needs?
15. How do you demonstrate the benefits of your role to patients/clients?
16. What would you like to achieve in the near future?

Concluding question

17. Thank you ... Are there any other issues or comments about specialist nursing that you would like to add?

Appendix 5 Guide Used During Focus Groups

1. Could you share your general view on specialist nurses?
2. What, in your opinion, are the roles of specialist nurses in Malta? (In your area how do you interact with specialist nurses?)
3. What, in your opinion are the idealized qualities and attributes of an effective specialist nurse?
4. What are your expectations of specialist nurses?
5. What education and training should be offered to these specialist nurses prior to taking on the post as specialist nurses? How should specialist nurses be prepared for the post?
6. How could their development be enhanced?
7. How do you think new roles for specialist nurses should develop? (Nationally, departmentally, professionally, individually according to patient need?)
8. What do you think is the strongest driver for the initiation of posts in specialist nursing?
9. What criteria should be used to choose a specialist nurse?
10. How should they be monitored for competency and safety to practice?

Appendix 6 Changes Made to Ball's (2005) Tool

For the purpose of this exercise the two questionnaires will be called Ball and Ward. Ball is the original tool designed by Ball in 2005 and Ward is the researcher for this tool.

Ball's (2005) Questionnaire had 8 sections (A-H). For this study, sections D was completely removed. Section D (*Who do you work with?*) was thought to be irrelevant to the Maltese situation since all specialist nurses (SNs) would have been identified and all nurses are managed by nurse managers, so these questions were deemed to be of no use to gaining information for this study. The researcher decided to include a whole section on the education and preparation of SN training and this was added in Section C. Another short biographical section was added as Section A, and Section B pertained to the type of post. Ward's tool had 9 Sections with 66 questions, 13 of which were open ended. Furthermore, after feedback from a group of nurses and the statistician, the headings were all changed to statements rather than questions since it was thought that this could cause confusion.

Section A - Biographical

In this section the researcher added a couple of questions on biographical data on age and gender. These were deemed important to outline a full picture, including the biographical identity of SNs in Malta.

Section B Type of Post/ Role

Question 2 was removed since there is only one employer in Malta, being the Ministry of Health.

Question 4 and 8 were removed since in Malta, there is only one type of SN and no other category of SN is available. These were replaced with relevant questions for the Maltese nurses and Hospital names and locations were included in the question to help categorise and direct the participant.

Question 9 and 10 were amended since the statements used by Ball would not be identified by Maltese nurses.

Questions 11 and 12 were moved to Section B of the questionnaire since more questions were focused on the preparation and training of SN.

Questions 13-14 were removed since in Malta, there is no extended role course.

Section C - Education and Training

This section was not in Ball's tool. Thus, section B of Ball's questionnaire became Section D in Ward's tool. Section C focused on the education and training and preparation of SNs in Malta. It used Questions 11 and 12 of Section A from Ball's (2005) tool but also looked at the Read's (2001) work. Section C had 7 questions in all.

Section D – Role and responsibilities

Question 1 in this section was removed because it seemed repetitive and was covered in question 12 of Ball's tool and question 8 in Ward's tool.

Questions 2-5 were covered in Section B of Ward's tool and were thus removed from this section.

Question 12 in Ball's tool had 19 statements allowing one statement to be added by the participant. This question in Ward's tool became question 6 and had 21 items each allowing nurses to add a couple of their roles. The only difference was in that the last item 'Other' in

Ward's tool was given a letter T and U so that in the next question these roles could also be included in the 5 key activities outlined by the participant. Additionally, item E in this question was changed since this activity was not considered to be identified by Maltese SN and another activity on organising clinics for Medics was included instead since this was more related to the situation in Malta. Furthermore, a Likert scale was used in this section to further provide information and the extent to which they perform these activities. This Likert scale was to identify the frequency of the stated role from always to never. The instructions given were also amended to try and make it clearer to what they were expected to do.

Section E – Managerial/development issues

This section was added to Ward's tool since Ball's tool did not cover logistics and contractual hours of work. This was covered in Read's (2001) tool and was thought to be of great relevance to SNs in Malta. Employing SNs needs to be planned both logistically and also with regards to coverage in the absence of the SN involved. 3 questions on role description were taken from Ball's tool (questions 2-4).

Section F– Career Development

Section F of Ward's tool pertains to Section C of Ball's tool, relating to career development. Question 2 of Ball's tool was removed because this was asked in Section A of both tools. Question 3 was slightly altered in Ward's tool (question 2) to give direction to the participant. Ward's question was not open ended and gave them 4 statements to choose from. Ball's question 4 was also removed since this would be covered in the last section of Ward's tool. Two questions were added on enhancing career prospects since this is very relevant in Malta because there are no avenues to further their career in specialist nursing.

Section G- Your views

Section G of Ward's tool was section E in Ball's. This section had minimal changes. One statement was added to the section. Item 18 was added as an item to see if the participants would be consistent. This statement was covered in the previous section on career advancement and was consciously added on.

Also, the numbers that were added into the Likert scale (from 1-5) were removed and the participant was instructed to tick rather than circle a number. This was thought to decrease the confusion with the numbers that were of no meaning to the participant.

Section H – Specialist Nursing Role

Section F and G of Ball's tool were amalgamated in Ward's tool as Section H. These were all open-ended questions and related to the role of the SNs. The only change made to this section was the removal of questions 6-9 because they were covered in Section C in Ward's tool. Thus, the end result of this section had 5 open-ended questions.

Section I –Further Research

This section is exactly like Ball's Section H and asks for the participants' details if they are interested in taking part in further research.

Appendix 7 Letter of Invitation to all Specialist Nurses (Survey)



Dear Colleague,

A Survey on the Roles and Development of Specialist Nurses in Malta

I am currently a part-time PhD student at Bournemouth University (BU) in the United Kingdom (UK). As part fulfilment of this doctoral degree I would like to explore the role of the specialist nurse in Malta. Presently we know very little about the nature of these posts, their impact on patient care and what is needed to make these roles work well. I would like to find out more about your experience and your views as a specialist nurse and would like to invite you to participate in this study.

You are kindly asked to complete the enclosed questionnaire. Many of you are in complex and unique roles; it is this complexity and variation that I need to be able to describe. There is no right or wrong answer.

The Research Governance Committee at BU, UK and the University Research Ethics Committee (UREC) (Malta) has reviewed this project to protect your safety, rights, wellbeing and dignity. I will follow ethical and legal practice and ensure all information about you will be handled in confidence.

The researcher will use the results in part-fulfilment for the award of a PhD, and may be published and presented at conferences. You will not be identifiable in these publications or presentations.

I thank you once again for your kind co-operation, and if there are any queries please do not hesitate to contact me.

Yours sincerely,

Corinne Ward
Corinne.ward@gov.mt
Tel: 79386750

Appendix 8 Participation Information Sheet and Consent Form



PARTICIPANT INFORMATION SHEET

**Bournemouth
University**

Dear Colleague,

Study Title: A qualitative case study of specialist nurses in Malta

Introduction

I am Corinne Ward, a Senior Nursing Manager at Mater Dei Hospital and I am a part time PhD student at Bournemouth University (BU) in the United Kingdom (UK). As part-fulfilment of this doctoral degree the programme incurs a research study and I would like to explore perceptions about the role of the specialist nurse in Malta.

Purpose of the research

Presently we know very little about the nature of these posts, their impact on patient care and what is needed to make these roles work well. I would like to invite you to participate in an interview to find out more about your experience, your views and to explore your journey as a specialist nurse. Many of you are in complex and unique roles; it is this complexity and variation that I need to be able to describe.

In-depth Interview/Focus Groups

The purpose of these interviews is to allow the researcher to find out more detailed information that is not possible to attain from a questionnaire. The interview will last for 1-1 ½ hours and will be held in a comfortable place of your choice. To facilitate the data collection process the interviews will be audio-taped and transcribed verbatim for data analysis.

Confidentiality

I will follow ethical and legal practice and ensure all information about you will be handled in confidence. No one else but me will be present during the interview. The information that I will collect from this research project is confidential and no one else will have access to the information documented or taped during your interview. Any information about you will have a number on it and I will only be the person who has your name.

Your confidentiality will be safeguarded during and after the study in the following ways.

- Your name and personal details will not be recorded on any of the data that were collected.
- Your contact details and the data collected will be stored in a locked filing cabinet which is accessible only to the Researcher.
- The interview sessions will be audio taped and transcribed but individuals will only have a unique identifying number so that they will not be identified.
- Your name will not be on the audio tape of the interview or mentioned in any way.

Your Participation

Your participation in this research is entirely voluntary. It is your choice whether you participate or not and you are free to withdraw from the study at any time. The choice you make will have no bearing on your job or any work-related evaluations and reports.

Sharing the results of the research study

The researcher will use the results in part-fulfilment for the award of a PhD, and may be published and presented at conferences. You will not be identifiable in these publications or presentations. The researcher will send you a summary of the research for your information.

Ethical approval

The Research Governance Committee at BU, UK and the University Research Ethics Committee (UREC) (Malta) has reviewed this project to protect your safety, rights, wellbeing and dignity.

If you choose to participate in this study you will be given a copy of this participant information sheet and asked to sign a consent form.

In case of a problem

It is very unlikely that this study would cause any harm. If you find the experience of participating uncomfortable or upsetting, you are free to withdraw at any time without giving a reason. If you would like any further information you are welcome to contact me:

Senior Nursing Office (SNO's)
Administration Block,
Mater Dei Hospital
San Gwann

Tel: 79386750

Email: corinne.ward@gov.mt

You may also like to contact my supervisor:

Professor Elizabeth Rosser
Deputy Dean (Education)
Bournemouth University
Lansdowne Campus
Royal London House
Christchurch Road
Bournemouth
BH1 3LT
Dorset
Tel: 01202 967280
Email: erosser@bournemouth.ac.uk

Thank you for reading this information.

Corinne Ward



Participant Identification Number for this Study

CONSENT FORM

Title of Project: A qualitative case study of specialist nurses in Malta

Please initial box

1. I confirm that I have read and understood the information sheet for the above study.
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without suffering any disadvantage whatsoever.
4. I understand that the interview will be audio taped and that confidentiality will be maintained in the analysis and reporting of the results.
5. I the undersigned, hereby agree to take part in this study on specialist nurses in Malta.

.....
Name of Participant

.....
Date

.....
Signature

Corinne Ward

.....
Name of Researcher

.....
Date

.....
Signature

Prof. Elizabeth Rosser

.....
Name of Supervisor

.....
Date

.....
Signature

Appendix 9 Table 2 (A) Developing Categories

Category: General Nursing Issues	Category: Perceptions of Specialist Nursing/nurses in Malta	Category: Managerial issues	Category: National influences	Category: Organisational support	Category Roles: Education	Category Roles: Practice	Category Roles: Research and Administration
<p>Lack of support in the nursing stream</p> <p>Appreciation of the role</p> <p>Not being respected and acknowledged</p> <p>Lack of understanding and support for education</p> <p>Empathy and training</p> <p>Losing the essence of nursing</p> <p>Union influence on fear</p> <p>Medical dominance and the development of nursing</p> <p>Abdicating roles</p> <p>Need for more nurses</p> <p>Paradigm shift</p>	<p>Lack of structure</p> <p>Tired/Burnt out</p> <p>Satisfaction of role</p> <p>Satisfaction from patients</p> <p>Education and CPD Keeping updated / Academia and experience needed to ensure quality</p> <p>Working in isolation and no investment in role and without managers input</p> <p>Taking decisions on your own and role ambiguity</p> <p>Lack of appreciation of role from the University</p> <p>Meeting other specialist nurses</p> <p>Getting consultants on board-Pushing the service</p> <p>Gradual development of role-one things leads to another</p> <p>Role development through job shadowing and training</p> <p>Medical dominance and the development of nursing</p> <p>Need for Outreach and Community services</p> <p>Link nurses and part of the development of the role</p> <p>Development as specialist nurses –an</p>	<p>Management need to be on board</p> <p>Lack of acknowledgement for their work/on call</p> <p>Vision of a manager</p> <p>Lack understanding of for their work and function</p> <p>One manager for all specialist nurses</p> <p>Audits could be carried out by managers</p> <p>Intrinsic motivation needed</p> <p>Management initiative (of education of staff)</p>	<p>System of choosing specialist Nurses</p> <p>Promotional systems</p> <p>Inequality within professions</p> <p>System of Nursing and Midwifery council</p> <p>Legal requirement so they cannot ignore</p> <p>Culture – nursing is not professional</p> <p>Public service commission/ System of incentives</p> <p>Union influence on fear</p> <p>Culture –</p>	<p>Lack of support and resources</p> <p>Lack of strategic direction</p> <p>Other professionals do not accept specialist nurses' referrals</p> <p>Theory practice gap</p> <p>Union influence on fear</p> <p>Monitoring and prevention of admissions need investment</p> <p>Legal backing/prescribing</p> <p>Resistance to follow SOPs</p> <p>Hospital policy not supporting the role</p> <p>Lengthy decision making/</p> <p>Bureaucracy –</p>	<p>Education and staff training</p> <p>Education of the population</p> <p>Awareness/ health promotion</p> <p>Education of patients and relatives</p> <p>The need for mandatory lectures?</p> <p>Reducing conflicting information and thus reducing confusing the patient</p> <p>Initiate change</p> <p>Developing guidelines</p> <p>Develop educational</p>	<p>Authority to correct</p> <p>Deskilling</p> <p>Nursing Resistance of staff</p> <p>Advertising ones role enough</p> <p>Nurse led clinics</p> <p>Give support/Cas e manager/ Co-ordination</p> <p>Being accessible /help line</p> <p>Providing Holistic Care</p> <p>Building relationships /multidisciplinary</p> <p>Collaborate with other specialist</p>	<p>Perform research</p> <p>Learning how to critique research</p> <p>Journal clubs</p> <p>Audits</p> <p>Reflective practice</p> <p>Administration</p> <p>Administration of the department</p> <p>Planning</p> <p>Involved in hospital committees</p> <p>Audit</p> <p>Lobbying in parliament</p> <p>Collaboration with associations</p> <p>A voice for patients / Advocate and advisor to authorities</p> <p>International presentations</p>

<p>Culture – nursing is not professional Not allowed to do things .. Nursing has developed but the basic is lacking LACK OF CARE Students experiential learning</p>	<p>individual development Paradigm shift Ownership from wards Through the Master’s degree came progress Independence Related to the area of speciality Appraisals needed Exposure to other health care systems Needing training in elated areas like time management and skills Networking/benchmarking Role ambiguity or lack of clarity DEFINITION Working with people to reach standards Role related to staff and not patients Interaction and communication Changing behaviour by making your case</p> <p>Qualities of SNs: Be: A Leader Accountable Responsible Respectful to the Patient Patient centred A risk Taker Determined Committed Passionate for the job Wanting to learn in more depth Motivated Trustworthy Dedicated</p>		<p>Private practice Culture – change in CEO or government and things stop Mixed feelings about the system of having free treatment but not all is free and feeling lucky ... Lack of litigation Confusion in title/nomenclature The sectoral agreement Title –some do not deserve the title</p>	<p>waste of time and money Waste of resources Lack of litigation Maltese Culture The environment is not motivating Specialist Nurses can help the system: Decrease gaps in care Decrease patients turning up without appointments Decreasing waiting time for doctors Culture/abuse of system/competence</p>	<p>material and hand-outs for patients and staff to use as visual aids Journal clubs Sharing experiences Training doctors Organising conferences Looking after link nurses</p>	<p>nurses Develop better care/ Written information Patient Safety, Safer practice Patient compliance More prevention and less hospital admissions Time for patients - Talking with patients Involving relatives Explaining procedures A liaison (point of reference) Performing specialist tests for diagnosis See follow ups Summer camps Prescribing</p>	<p>Travelling abroad Comparing/benchmarking with other countries Procurement Salesman Introducing change or policy Quality control Risk assessments Defining and shaping role</p>
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	<p>Disciplined Assertive Ready to accept correction Perseverant Proactive A team-player Open to feedback Open minded Charismatic Able at working in isolation, moving on their own initiative, and enjoying one's own company Focused Professional maturity Have: The right personality Professional attitude Critical thinking skills Experience Managerial Skills clinical Communication skills Drive and motivation and Enthusiasm</p>					<p>and altering treatment Responsibility of giving advise Interpreting results HAVING Boundaries ? Introducing new equipment</p>	
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Appendix 9 a) Table 3 (A) Interpreting the Constructed Categories into Themes/sub themes

Category -Development of Nursing	Interpretation		Themes and sub-themes
<p>Lack of support in the nursing stream Appreciation of the role Not being respected and acknowledged Lack of understanding and support for education Empathy and training</p> <p>Union influence on fear Medical dominance and the development of nursing Students experiential learning Culture –nursing is not professional</p> <p>Abdicating roles Need for more nurses Paradigm shift Not allowed to do things.. Losing the essence of nursing Nursing has developed but the basic is lacking LACK OF CARE Tired/Burnt out Satisfaction of role from patients</p> <p>CPD- Keeping updated Academia and experience needed to ensure quality care Through the Master’s degree came progress Independence related to the area of speciality Role development through job.</p>	<p>Understanding the role to support its development</p> <p>Appreciating external influences on the development of Nursing</p> <p>Losing the essence of care in general nursing</p> <p>Wellbeing of Specialist Nurses</p> <p>Education, training and experience to ensure quality care and professional independence</p>	<p>External and internal influences affect the development of Nursing</p> <p>A holistic approach is needed to empower specialist nurses in their role</p>	<p>The influences on the advancement of specialist nursing practice in Malta.</p> <p>National and organisational Investment to support the role of specialist nurses</p> <ul style="list-style-type: none"> • National structure for the development and maintenance of roles including a framework for career advancement • Organisational support – ‘fitting in the system’ • Having a legal foundation • Evaluating and Consolidating roles and services before starting new ones • Investing in General Nursing • Education and training for Nursing • Empowerment of Nurses

Appendix 9 b) Table 4 (A) Illustration of Theme and Case Study Data Convergence/Synthesis

Theme	Survey	Interview	Focus Group	Case Study objectives
Roles and Attributes of Specialist Nurses	<p>Less than 50% of their time was dedicated to clinical work, 18% was dedicated to education and training and 14% to management.</p> <p>16% was categorised as other but no specifics were given.</p> <p>Specialist nurses responded that a very small amount of time dedicated to research (7%).</p>	<p>Education: patients and relatives, Staff</p> <p>Role ambiguity or lack of clarity</p> <p>Authority to correct</p> <p>Attitude towards the role and not advertising ones role enough</p> <p>Nurse led clinics</p> <p>Give support/Case manager</p> <p>Help line</p> <p>Being accessible both to staff and patients</p> <p>Holistic Care</p> <p>Building relationships/multidisciplinary</p> <p>Develop better care/ Written information</p> <p>Patient compliance and safety</p> <p>Safer practice committee</p> <p>Conflicting information</p> <p>More prevention and less hospital admissions</p> <p>Time for patients</p> <p>A liaison (point of reference)</p> <p>Knowledgeable</p> <p>Talking with patients</p> <p>Involving relatives</p>	<p>Specialist Nurses serve as a continuity of care and are gap fillers</p> <p>Advocate, mediator</p> <p>Need to concentrate more on patients and relatives</p> <p>They act as case managers to ensure continuity, coordination of care.</p> <p>They are effective since when I had my specialist nurse on sick leave there was a lacuna</p> <p>Nurses cannot be experts in everything and so specialists are needed</p> <p>Generalists do first line care and specialists fill gap with knowledgeable care</p> <p>They keep updated on new developments so as to provide patients with best treatment</p> <p>Mix of patients including outliers in wards makes it even more important to have someone to refer to.</p> <p>They are up to date and nurses are now learning to trust them and consult them</p> <p>Role ambiguity.</p> <p>Specialist nurses are still fragmented and are mostly structured in areas like Infection control (due possibly to having a Medical Doctor directing the department or due to importance of issue of infection control).</p> <p>knowledgeable and reinforce education and info given to patients thus providing clinical input</p> <p>Up to date with research and knowledge, experts</p> <p>Knowledge sharing resources and reference points, fount ain of information but Deskillling may happen</p>	<p>Common roles exist amongst specialist nurses although coming from different backgrounds.</p> <p>These include: patient and staff education, research, management and administration</p>

Appendix 10 Sample of part of an Interview of SN 4th July 2014

C.W. Thank you very much for coming and accepting to participate in my research.

SN 3: You are welcome.

C.W. I sent you information by email with regards to the consent form and the guide and also the information sheet, I don't know if you had time; if not we can go through them now.

SN 3: Shall we go through them and fill them in?

C.W. I think the most important thing is that although you know me as a colleague and as a specialist nurse and now as a manager, the most important thing is today I am a student at Bournemouth University and I'm doing this research as part-fulfilment of my PHD. I hope you feel comfortable enough and that you feel that I am not judging you in any way. The main purpose of this research is actually to come up with important experiences of specialist nurses because as you know over the past 20 years since we have had specialist nurses nothing has been done on the subject. So we will be looking into the roles and the development of specialist nurses and your experience also. It is an interview that might take between one and one and half hours. I will ensure confidentiality as much as I can and I will also try not to mention the specialization because you are so few that if we talk about, let us say, nutrition and there are only two of you, so we have to be very careful and I will do my best to do this. After the interview I will also send this transcription to you to see if what we said is correct. Obviously at the end of the research it will be done for my PHD, but I may also publish and present it in conferences. Ethical approval has been sought both from Malta and the UK, and your participation is completely voluntary and you can stop at any time. If there is anything afterwards, or you think that there was a problem, you also have the contact details of my professor in the UK. So that is the information leaflet in a nutshell. The Guide as I mentioned is not there to keep very strictly to, however it is sort of the subjects that are of interest. However it is about your experience, so I would like you to talk about your experience as a specialist nurse. Em... But before that we have the consent form over here that, if you don't mind, you can have a look at. There are these 5 points.

SN 3 reading the 5 points

1. I confirm that I read and understood the information sheet for the above study.
2. I have had the opportunity to consider the information and ask questions.
3. I understand that my participation is voluntary and I am able to withdraw at any time.
4. I understand that the interview will be audio taped and that confidentiality will be maintained.
5. I agree to sign - confirmed the 5 points – yes, ok, and signed

C.W.: Thank you very much.

C.W. You might also see me jot down some things; it is just for me as an aide-memoire if you are saying something that I might need to probe on, something that was about something of interest.

C.W: Could you kindly explain your role as a specialist nurse?

SN 3: I got into this because it was definitely an area of interest for me, so I was working in something totally different, but this was something that I was very interested in and wanted to get into, and at that time it was something that was quite new, so the role was not (how should I say?) really defined, yet and the person who was working in the clinic before I came into it, although she was not yet appointed, she was already doing quite a lot of work, but she used to tell me what the work involved, and the work sort of at that time seemed to be involving (em) a lot of support that you offer patients throughout their journey, and to me this was something very interesting because we all know that patients going through certain episodes in their life are very very stressed and whilst in a lot of situations the medical care is always the optimum that the country or the hospital can offer, perhaps support is sometimes lacking, and having had experience of a family member myself, I felt that, it would be something that I would have appreciated if my relative had had that support. So it was something I was really very into, em so it was much like the idea was I would be giving support, coordinating care, and that is something that is still part of my role. However (long exhale breath) it is the usual however, whilst we are expected and we do give support and we do a lot of care coordination, there is always other work involved which is not directly in my opinion the remit of a specialized nurse. Don't take me wrong, I think that everything is important and one of the things I stress at the clinic is that the most minor role/job/role/scale, whatever it is, sure that we have is important for the patient. But because the patient care cannot just be giving support and ignoring other things, so obviously if we had somebody in the clinic who was to take care of the things that do not need the specialized nurse, then the specialized nurses would have more time to develop better care for patients, like for instance, if I take myself, one of the things that we definitely need to develop is more written patient information. We give a lot of patient information, we give them our mobile number, meaning our pager mobile number, so that is that since we had these new pagers these are a really good thing because we can give them those and at the same time that's our work number so they can call us directly, and that way we sort of keep, you know, we're more of a life line to patients. But because sort of we don't have the time to sit down and to do certain things, like as I said develop more written information, carry out research, research not only. People think when you say research you look things up, and not only that, we do our own research audit and even research *research*, I mean if you look at our remit in our case, part of our remit is like all specialized nurses to carry out research, the other thing is to do awareness. Now I am involved in awareness but I don't have as much time as I would like to be able to develop that part of my job, because I feel that in our case, in our specialization, one of the things which would be really good would be able reach out to the public to, you know sort of, create more awareness, and awareness not only because people are not aware of the problem, but to give the correct information, because in a lot of cases there is awareness but there is not the correct information. Now this would require quite a lot of time because obviously I'm thinking of like for instance getting hold of all the local councils and arranging to do talks in every locality for the local councils, say you know sort of once a month, you go and give a talk somewhere. But to do this, you need, firstly, the clerical support to have someone to organize this; secondly the time to be able to leave the clinic to

be able to go and do this kind of work. And we are being emm weighted down sometimes with work which can be done by someone else and does not allow us to develop our role as much as we would like to develop. So whilst I feel that the fulfilling of support of patient and co-ordination of care...we are doing that don't get me wrong, we can do it more because our patients come to us but then move on to another unit. Now when they move to the other unit we cannot go with them, hopefully this will be a bit easier in future because obviously logistically when the oncology hospital opens we will be able to be nearer so, 'cause at the moment if I decide that a patient has an appointment at ten o'clock if I want to go to the oncology hospital in Floriana that means thinking about an hour before because of parking, this, that and the other, so a half an hour appointment would take ...

C.W Two hours at least

SN3. At least, whereas if the oncology department ...when the oncology department comes here at least we can arrange with the patient, listen, when the patient...before you go he goes in ...gives me a call and I'll come and I'll go in with you. So like we can arrange something like that and then half an hour appointment will be an hour because we need to speak to patients as well. So that might be something that we can do, but again we can only do that if we are doing our specialist role only because at the moment, apart from doing the support, the co-ordinating of care, we take care of outpatients' clinic as well. So if I have on a Tuesday patients who come in for outpatients then...for follow-ups...and those patients don't need specifically – because they're routine follow-ups – don't specifically need a specialised nurse, I'm not saying that there are times when they don't, but if they don't need a specialized nurse, but I still need to oversee that that work gets done, because we don't have a nurse who comes in to take care of that, and that is obviously something which is taking time from us. If on a Monday I have the...sort of like patients who are coming to see a consultant for the first time, follow-ups and whatever, if there isn't a file and they're one of our patients, there isn't someone who says that's my responsibility to get the file. Where are the specialist nurses? why isn't there a file? And the specialist nurse has to spend time looking for that file – trying to find out where that file is. Now as I said, the file is essential for the patient's care, but using the time of a specialized nurse to do these things, is in my opinion a waste of resources...and taking time away from something which can be better utilized.

C.W. How do you think that the organization can support this?

SN 3. Well in my opinion there should be ...emm...like I worked in a clinic abroad for a short period of time, and I'm not saying that there is anywhere which...where its perfect but something that they had which I thought was really good was that the outpatients clinics were not the responsibility of the specialist nurses. Sorry I've just said where we are but anyway...

C.W. It's ok it's fine if I will take captions I will actually cut out the area

SN 3. So what they do is that the specialized nurses are there to look after the patients who need them. The other patients are being looked after by a nurse who does the outpatients clinics, and this is in a unit which is a specialized unit so again it's a unit, basically. But they have nurses who actually look after the patients. So if a patient comes in and the patient has ..emm..pain, and she's being seen because of pain, she doesn't even need to see the

specialized nurse unless there is a problem. Now I know that the patient in pain would still ...how should I say it...might still need support, but then nurses are trained to support patients anyway, you don't need somebody who's got the specialization to be dealing with that job. I mean one of the most important things in my opinion as specialized nurses is that we do not de-skill ..emm.. you know sort of ...the other nurses . I mean every nurse knows how to deal with an anxious patient. In our case we've got more information about the particular area, which makes us, you know sort of, and we should be having more time to be able to give the support. It's not because we know it and the ward nurses don't know it or the other nurses don't know it. So like in this case the situation is that the patient is seen by, I mean ...the clinic is run by the nurse. If they see that there is going to be bad news then the nurse...the specialized nurse comes in and the specialized nurse then takes over with the support and whatever. So the specialized nurse has absolutely nothing to do with ensuring that there are files for the other patients, with seeing that the other patients are seen by this doctor or that doctor, because they have nothing to do with that. Their only focus is on the patient who actually needs their specialized care. Now that is something that I have suggested before that it could be something that we could do here, but you know how it is, it's not always easy to get things working the way you want them. In our case what we're different is that when patients come with a referral and it's an urgent referral, especially the urgent referral, then they are seen directly by a specialized nurse. So there is the advantage that the patient really sees the specialized nurse from beforehand so like if I have a problem, I am seen by the specialized nurse when I go for the results, the specialized nurse is there not necessarily, although we do try to do that because we do try to work with the named nurse – but as you can imagine - your named nurse might be looking after someone else at that time...*jew*...she might be sick or something. But at least they don't see the specialist nurse and automatically they say right it's a bad result because she's involved. So there is that advantage and we take it to the other extreme that we are spending time dealing with issues that can easily be dealt with by people who ..emm.. have the knowledge, have the skill to do that and can do that without needing the specialization per se.

C.W. Ok, all right. It is important when you mentioned de-skilling...

SN 3. And I can see it happening if we're not careful because obviously I can see ..emm..from sort of in our role ...I'm sure that before we came into existence whenever there was a stress...distressed patient in the ward somebody would talk to the patient. Would take the time to talk to the patient. Now whenever they see that there is a patient who has ..emm..you know a problem in my specialty they would then call the specialist nurse. But what happens when the specialist nurse is not there? So it's important that nurses still feel involved and you know if I were working in a ward I wouldn't be the one who calls that person, that person, that person and have nothing to do with patients. I mean if we're going to do that we're going to lose the essence of nursing. Because the essence of nursing is not calling the special person and you doing nothing ... I mean nurses are not trained ?...

C.W. Why do you think this is happening? What do you think?

SN 3. Well I think ...unfortunately...this is the way I see it – when I started nursing quite a long time ago it was all task allocation and we knew no other way. You know sort of like if the nursing officer will tell you to do the parameters you did the parameters...

Appendix 10 a) Table 5 (A) Categories and Codes with Direct Quotes (Interviews)

SN	Categories and Codes	Quotes
SN1	Lack of support and resources	<p><i>I feel as if, we are building castles that look lovely but we are not giving them any foundation. And they are going to topple. I know it is a cliché but it is the way I see it. It is important to advance and to improve and to and come up with new services, but unless we are going to have the foundation for these services and unless we are going to make sure that these services are built properly, with all the support they need, we are wasting time and money.</i></p> <p><i>I would very much like to be in a situation where we would have resources, physical and human resources; to be able to see patients.....</i></p> <p><i>"I had problems to be released from work to go and give talks on awareness outside hospital. I had problems when I was actually stopped from going so I used to go on my off day!! So and then they wonder why there is burnout in nursing!"</i></p>
SN3	<p>Lack of support in the nursing stream</p> <p>Lack of structure</p> <p>Support of Manager</p> <p>Funds</p>	<p><i>The other disadvantage is that we do encounter difficulties within the nursing stream that unless we get Doctor involved, to push things they would not go forward. It is really frustrating for me, because I believe that as specialists, a nurse specialist, why should we in the nursing Directorate wait for the push from the medical doctor to approve things,</i></p> <p><i>The hospital does not see investment in these roles as a priority. And also we as a specialist nurse/practice nurse whatever, I don't think that we ever had a meeting together with the director of nursing or assistant director, as a group so actually we are a number of individuals working in isolation</i></p> <p><i>I believe that there still needs to be a bit of structure to ensure that we are meeting the goals within the time-frame, giving some allowance, which would have been established before. This is where we lack at times.</i></p> <p><i>Well, there is really very minimal scope for this manager..... First of all, it depends on the particular individual. So, we only liaise with this individual when there are issues related to the clinical areas otherwise, ok they give feedback on what we are doing, but there is no input in any way, motivational or constructive criticism or any type of feedback or linking in with what is going on. Overall in the hospital nothing of this goes on so personally I don't really need her.</i></p> <p><i>There are funds locally, for training, it is very difficult to understand who manages these funds and even when we personally made contacts for job shadowing,</i></p>
SN5	<p>Lack of acknowledgement for SNs work/on call</p> <p>Lack of direction/one manager for all specialist nurses</p>	<p><i>We also have a voluntary on-call system No we do not get paid for it, I asked to be compensated, I asked a year and a half ago, before the elections, so (laughing) and till now we had no compensation given. I raised the issue again two weeks ago but I find closed doors.</i></p> <p><i>Well I don't know, well I don't think there is support whenever I needed something I rarely found it –listen, we have to ask no one tries to give us something we always have to ask for it. No one would dare to ask us what our needs are or what are our education needs. No one looks at our needs and I think we are left alone But unfortunately we are split. Having one person leading us would obviously be beneficial for us and nursing, if we have one manager, the only manager, that is, would be more focused on our needs and would know better our individual needs of all specialist nurses so that he could act accordingly. As I said before, we need direction and having one manager this can be provided as the direction would be there for all. I don't have to ask for direction, we need someone to direct and lead us and most of all to bring us together, so that the patient would benefit more.</i></p>
SN9	Lack of Understanding	<i>The lack of understanding from management is not because they don't want to but because they are not aware of how different things are in my speciality</i>

Appendix 11 Sample of Part of Focus Group 4 with Nurses

Anthony – Medical Wards (FG4. N1)
 Patricia – Orthopaedics (FG4. N2)
 Karl – Surgical Ward (FG4. N3)
 Emily – Discharge Liaison team (FG4. N4)
 Philip – Neurosurgical (FG4. N5)
 Alison – Day Care Unit (FG4. N6)
 Mary – Paediatrics (FG4. N7)

CW: Thank you all for being here, I had to do this group on an ad hoc basis because we all know the situation of the wards and I had to see who is available or not and I had to pick up people from all areas. We have got people from orthopaedic, discharge liaison, neurosurgical, medical and paediatrics too and a staff nurse coming from day care too. The idea is to have a variety from different areas and the focus of this focus group is mainly because I am doing my PhD and it is on specialist nurses. Today I am a student and not a manager. Now the meaning of specialist nurses, the specialist nurses that we knew of. Now they are called practice nurses but we are looking at those that are stoma nurses, tissue viability, pain, nutrition, breast care. So that is the focus so we will not get entrapped into thinking about specialisms. So it is about what we used to regard as specialist nurses that are now called practice nurses and that is the focus. The focus is on your views on them, your perceptions on them, what you would like to know more of them, if you aspire to become a specialist nurse, do you know how to go about it? So this is the focus of the group. In front of you, you will find these tags, these are especially so you will not, and you will never be named, so I will not be saying Reggie Aquilina from PDN, Reggie is our moderator, Reggie is here to help me. I will follow a guide and also to help me with probing and things like that, and you will also see him take notes and that is for us to help with the process. So you have got these tags and I would like you to invent a name, preferably not Batman or something like that! Something simple, and when we go around the table you will say I am Jane from orthopaedic, I am Mary from wherever, but it will never be somebody saying who it is and even if it is a pseudo-name and I will quote you, what I will be saying is a group opinion, because Malta is very small and you can be easily identified like if we say a charge nurse from X Ward. So I will never actually quote your name so that is very important especially when you are signing for confidentiality because you are being recorded. You are never going to be quoted directly or indirectly, it is always a group opinion. I will say one of the groups of staff nurses, stated that It will never be Jane from Day care. Ok so are you clear on that and are there any questions after reading the participation information? If the Information is ok, so I would like you to sign the consent form and we can begin the focus group. *Collecting the consent forms and writing the names on the Tags.* So the next step we are going to do is going round the table, you have to write the pseudo-name and direct it at me although everybody needs to know your name, because even when you say, I agree with Patricia try not to use their original names. So the first thing we are going to go around, we will start off with Mary and you will just say where you come from and then you say a bit of what your opinion is about a specialist nurse. Shall we start from Anthony, giving you some time? Anthony? Anthony is still ..ok we will start with Patricia, please state where you come from and your opinion about specialist nurses. So let us start with that, what do you think of them?

Patricia: So I am Patricia and I come from the Orthopaedic section, I think it is very important to have specialist nurses around the wards because as nurses we are mostly general nurses and you cannot be really into something, so for example we wouldn't know everything about stoma care, or breast care. So it is very important and even for us nurses to always liaise with someone else who knows the subject really well.

CW: Ok that is a very interesting point. Ok now we have Karl...

Karl: I am Karl, I come from the surgical area, basically I agree with Patricia about what she said and I would like to add being a specialist nurse you will have more time to do research and focus on that particular area that time that we as general nurses don't have, so that they can relate that knowledge they acquire to us that work on the field.

CW: Excellent thank you, now we have Philip...

Philip: Yes the same thing really, I come from the neurosurgical side, the neuro-sciences, as they said they can acquire more knowledge on the subject, on their area and also not only knowledge, as regards to treatment, new research, new developments and for us as general nurses we don't waste time, sort of, and not only waste time but you will not have the proper skills and thus the patient will not have the proper treatment, so you will be able to give that particular patient the proper treatment needed, in a short period of time and in the best way.

CW: Ok now we have Emily...

Emily: I am Emily from the Discharge liaison nurses. For me a specialised nurse is an extension of a service, of a specialised service, obviously nurses on the ward are already doing most of the first line management as in nursing care, but there is always that gap to be filled when a condition or a specific medical treatment is needed and you need to be more in depth for it. So the specialised nurses for me, so they present a more accurate, specific and more to the ground academic in teaching and research. Like Karl has mentioned.

CW: Ok so mainly we are looking at education, hands on work, yes Philip?

Philip: Can I add something else?

CW: Sure

Philip: The other thing is in our situation in our hospital, since we have outliers, I have 8 neurosurgical patients, the rest of the patients, ten, are all outliers, so I have stoma patients, I have patients with a chest infection, I have from the areas and specialities, so you cannot concentrate on all the areas. Like today I had to call the stoma nurse, not because I do not know how to do or change a stoma but maybe there is something new or a new treatment or a new technique. I would not know about that for sure so in our situation they are very much needed and helpful because we are not as before, neurosurgery and that is it. Nowadays I have patients from all the corners of the hospital. So at least they will be having the proper treatment, they will be exposed to the proper treatment. Not because I used to do it like that and I will do it...

CW: a very particular and interesting situation, so if we could come to Alison and go around the table so we could hear all, then we could come back to Patricia who would like to add something. Reg could you make a note please? Alison?

Alison: Alison coming from Day Care, I am a medical nurse working in Day care, I agree with everyone else, they have the knowledge far beyond what we have because we are looking after so many patients, but what I find is missing is yes, we call them in and we need some care but then it seems that it stops there because it seems to have become a routine that they are called in for every stoma patient, for every NG tube, instead of us being taught or updated. Because being a general nurse you can't learn everything, as Philip said, but sometimes I would like us to be kept up to date and there is more feedback to us, and once they come into the ward area and there has been a problem they actually do some teaching. So that we can get more updated and we learn. And another point I know is that consultants quite often refer to them routinely, so if there is for example any wound, they would call Tissue Viability, they are brought in no matter what. Which makes the nurse kind of feel that she is not able to do it, and maybe would actually get into trouble for attempting to do something that she may have the knowledge to actually manage.

CW: So Alison is it about de-skilling?

Alison: Yes and the way specialist nurses are perceived by other healthcare professionals.

Emily: Because they are supposed to be just an extension of the service and not to replace that actual care and service.

Philip: There is the other side to the situation because you might lose skills. What I do is, if I have this sort of problem, I see the wound, I do it, and if I have a problem then I will call.

Alison: The only other problem is that there is no continuity of care so the next person might decide.

Philip: Not always...

Alison: Not always in your area, but in my area there are a lot of relievers coming.

CW: Please don't talk together because I will have difficulty understanding.

Alison: So for two days you might have a particular care plan and that would change because somebody else thinks that they prefer this dressing...

CW: So you are talking about the ward nurses right?

Alison: Even when the TVN come in, there are no protocols there to enforce them to continue.

Reggie: So you are saying that specialist nurses come in and give advice and then it is not always followed through by the next shift.

Alison: Yes.

Mary: Yes, not a particular shift, but because they are relievers and they move around.

Alison: For example the insertion of an NG tube, you have some nurses who will not even try it and would say it is not my job and they would call in the nutrition nurse to insert an NG tube, but...

Philip: Come on.

Alison: Yes this is what is happening, so their time is being deployed in other things.

CW: Ok good points Alison, and now we have got Mary...

Mary: I am from paediatrics, I think that specialist nurses are important because they know more in depth the case or the intervention they do. But I think they need to allow other nurses to explain them, do some short courses, if they are not there, a specialist nurse, it is usually only one, sometimes, thus we need to see if the other nurses know what is going on. And they know what they are going to do every day, so if they are absent or missing or something we can continue to do them as well.

Philip: But it has to come from the individual.

CW: We will go back to that Philip.

Emily: But educating and teaching and empowering others is one of the roles of the specialist nurse.

Patricia: But I think most of them do teach.

CW: Could we please give a chance to Anthony and then we will go around again? I like the way the discussion is evolving. Mary do you have anything to add? Ok Anthony.

Anthony: I am Anthony, I work in a Medical ward and I agree with all that was said, their validity themselves helping the ward, and the de-skilling factor and most of all the abuse of the system which is sometimes rampant, and I agree 100% that this should be changed. Their academy and also the research part, that is very interesting because we have no time. What I need to add is for those people who have become a specialist nurse, there has never been a sound structure of training people to be a specialist nurse. Because you may be excellent in performing the skill of your speciality, but starting something like this altogether without any structured system and some extra help especially from administration is just unacceptable.

CW: There are no right or wrong answers, I think this is also important. The roles that are coming out without even knowing, we are talking a lot about the education, the hands-on, the working with the staff, the research, so these we do not need to really go into again. And then there is the scope of practice and this is where Anthony has touched on and the strategy. But before going on this I think there is something we might need to go into a bit more detail. I think Alison mentioned it and to an extent Philip mentioned it, and now Anthony mentioned it: that the system is being abused. Could you maybe explain this a bit further on what you mean there Anthony?

Anthony: Let me clarify especially in the creation of these specialist nurses it was even more rampant but this has changed over the years especially with sectors of specialist nurses, who with patience explained to us more what was their intention, what was their role. So but you will get, especially novice nurses working who think that this is like a 'Take away' thing. Which is not on, but in time they will understand that we get specialist nurses for expert advice

Appendix 11 a) Table 6 (A) Categories and codes with Direct Quotes (Focus Groups)

Specialist Nurses' Roles	Quotes
Expanding Practice	<i>I don't have any specialist nurses within the department but we come into contact with lots and we do get lots of requests by specialist nurses so that they can use our services and they also request that they can be given the permission that they request that they can take decisions to request their investigations themselves. (FG 3. Cons, 4)</i>
Thrown in the deep end	<i>So you graduate as a nurse, or become a specialist nurse or a practice nurse and then you are sent to do the job, you are thrown in the deep end... what I am saying is that nurses usually have to learn on the job. There should be mentorship. (FG 3. Cons, 1)</i>
System of appointments	<i>....And this is the result of the system because ultimately everyone has the system that they develop. So if you have developed a system where nurses are being appointed specialists basically on the basis of an interview alone, then obviously you will not have a filter ...(FG 3. Cons, 2)</i>
Appreciated by nurses But not by managers and administration	<i>I think that nurses in general are appreciating their services nowadays. Not like twenty years ago or even fifteen years ago. They struggled so much. (FG4.N, 4)</i> <i>Again it is about having managers that have a passion toward these specialist nurses, a passion to not calling people names because we had managers themselves calling people names and that is unfair. Leaders should be led by leaders. (FG4.N, 1)</i>
Qualifications vs experience	<i>Yes you need academic qualifications but experience is most important. (FG1. MDP,5)</i> <i>But I am really confident that every speciality is up to scratch and up to date. I am sure of it, I have never seen anybody where I can complain that they don't know what they are doing. They do know what they are doing, they are specialist and they are knowledgeable ... moreover I can TRUST them, all of them. (FG4.N, 5)</i>
Fountain of knowledge and information	<i>What I have found in our experience of specialist nurses, they are the fountain of information, they are the experts, they are the resource they are a huge resource and our interaction with specialist nurses has always been on an individual patient but it then goes beyond that because that is the beauty of it. (FG1. MDP, 2)</i>
Experts	<i>They would be subject matter experts tough not necessarily leaders. Let me tell you why: for a system to accommodate specialists there has to be another framework and a good framework with good leaders who obviously have to acknowledge the experts, so the two have to exist simultaneously. (FG1. MDP, 1)</i>
Leaders and team players and compatible	<i>Specialists they need to be leaders every specialist nurse must be a leader...(FG 3. Cons, 2)</i> <i>If they have done all the training and practice and they are not team players with the medical consultant then for sure that specialist nurse will be a flop and the last thing which has driven me today is that they also need leadership skills because they need to teach the rest of the nursing profession the same policies which are being used by that particular department throughout the hospital. I think these are structure issues, team players, leadership, but it has to be really, the management has to give a rubber stamp that this is the way forward to have a structure to have specialist nurses. (FG 3. Cons, 4)</i>
They need to be leaders but in different ways!!	<i>You need them to be a leader because you need them to be charismatic, they need to attract people to their ideas, and there are ways and ways. It does not mean that you have to be a loud mouth, but you can be assertive, and you make your point in very different ways, and amongst our specialist nurses... you find the assertive ones, the not so assertive ones, the quiet ones and the ones that work in silence but then they produce lots of good material the belittled ones. But those are all are part of being a leader I suppose. And some people learn in the role, I think. (FG 2.D,2)</i>

Appendix 12 Approval of Directors of Nursing, Mater Dei Hospital and Malta



Dion Court, Apt 7,
Birkirkara Road,
St Julian's STJ 1300
1st September 2011

Ms. Charmaine Attard
Director Nursing
Mater Dei Hospital

Dear Ms. Attard,

An exploratory study of the role of Specialist Nurses in Malta and the development of a career framework.

I am currently a part-time PhD student at Bournemouth University, UK and I am writing to request your permission to access nurses in your Directorate. As part fulfillment of this doctoral degree I would like to survey specialist nurses' (SN's) perception of their role. Presently we know very little about the nature of these posts and their impact on patient care. I would like to find out more about their experiences and views to have a better understanding of the work of SN's. The aim of this study is to develop a national framework for SN's working in Malta. Prior to applying for ethical approval I would need the necessary permission from the management and directors of the departments where I would be carrying out this research. I would like to start data collection in November 2011

All SN's will be given a questionnaire to fill in that will take approximately one hour, a further three SN's will be asked to participate in an-depth interview for another hour. Additionally, there will be 4 sets of focus groups aimed at invited nurses including; nurse directors, managers, educationalists, specialist and staff nurses. These will be in groups of 6-8 participants and will not be longer than 2 hours. The data collection will be carried out over a period of 6 months in different stages.

The final phase of the study will be the development of an evidenced based framework for SNs in Malta and this will be reviewed and developed by 5 SNs in a working group.

I have attached the research proposal that has been approved by the Research Governance Committee at Bournemouth University.

I thank you in advance for your time.

Yours sincerely,


Corinne Ward


Approved
5.9.11
Mrs Charmaine Attard MSC Nursing (Manchester)
Director Nursing Services
Mater Dei Hospital



Mr. Jesmond Sharples
Director Nursing Services Standards
Fafner House, Floor 2, National Road, G'Mangia, Malta

*Approved
A. M. M. M. M.
5/9/2011*

Dion Court, Apt 7,
Birkirkara Road,
St Julian's STJ 1300
1st September 2011

Dear Mr. Sharples,

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I am currently a part-time PhD student at Bournemouth University, UK and I am writing to request your permission to access nurses in your Directorate. As part fulfillment of this doctoral degree I would like to survey specialist nurses' (SN's) perception of their role. Presently we know very little about the nature of these posts and their impact on patient care. I would like to find out more about their experiences and views to have a better understanding of the work of SN's. The aim of this study is to develop a national framework for SN's working in Malta. Prior to applying for ethical approval I would need the necessary permission from the management and directors of the departments where I would be carrying out this research. I would like to start data collection in November 2011

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The final phase of the study will be the development of an evidenced based framework for SNs in Malta and this will be reviewed and developed by 5 SNs in a working group.

I have attached the research proposal that has been approved by the Research Governance Committee at Bournemouth University.

I thank you in advance for your time.

Yours sincerely,

Corinne Ward
Corinne Ward

Appendix 13 Approval of Ethical/Research Governance Boards



**Bournemouth
University**

School of Health and Social Care

Research Governance Review Group

Feedback to student and supervisors

Student: Corinne Ward

Title: An evaluative study of the role of specialist nurses in Malta and the development of a career framework

Reviewers: Dr Ann Bevan; Dr Martin Hind

Report prepared by: Martin Hind.

Date: 31.08.11.

Dear Corinne

Thank you for submitting your study to the research governance review group (RG2). The review panel felt this was a well-articulated proposal with no major ethical concerns. There are two advised amendments which can be discussed and agreed with your supervisory team, there is no need to respond to us at RG2 in respect of these (2) advisory points;

- 1) Please add on to your participant information sheet (PIS) under the section '*What will happen to the results of the research study*' a comment that you will be submitting this study for your PhD award.
- 2) It is advisable to work-up an agreed timescale with your supervisory team; this will help you manage the study as it unfolds.

As you are seeking ethical approval from the appropriate Maltese ethics committee please ensure that you send Eva Papadopoulou (epapadopoulou@bournemouth.ac.uk) a copy of your final approval letter from Malta, for our records.

Thank you for taking the time to submit your study to the research governance review group.

Please do not hesitate to contact Martin Hind (RG2 co-ordinator) if you have any queries, or need further clarification in relation to this feedback on your study proposal.

Yours sincerely

Dr. Lee Ann Fenge, Chair of School Postgraduate Committee.

Dear Corinne

Thank you for your message.

I have compared your amendments to your original submission and approval (dated 31.08.11.), NB. That *approval* is under your 'Ward' surname. (Which is not a problem).

The minor amendments to your questionnaire and the change of wording of the cover letter look fine and do not require a re-review; please take this message as approval to proceed with those changes.

Thank you for advising us of this, please forward us at Rg2@bournemouth.ac.uk a copy of your finalised questionnaire when that is complete. That is just for record keeping only.

I have also compared your revised research questions to your original submission;

a) The main research question remains consistent to your original expression.

b) Revised sub-questions 1, 2, 3 and 4 all relate closely to original objectives 1a, 1b and 2.

c) The 4th objective on the original proposal has now been dropped; this raises no ethical concerns whatsoever.

This therefore means there is no need for any further RG2 review of these advised amendments.

Thank you for taking the time to advise RG2 of these amendments and all the very best with your data collection.

Martin Hind (RG2 coordinator)

Cc; Supervisors & Rg2 files

Martin Hind

Senior Lecturer

School of Health & Social Care (HSC)

Floor 1 Royal London House

Bournemouth BH1 3LT

01202 524111

mhind@bournemouth.ac.uk

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original

187/2011

UNIVERSITY OF MALTA

UNIVERSITY RESEARCH ETHICS COMMITTEE

Check list to be included with UREC proposal form

Please make sure to tick ALL the items. Incomplete forms will not be accepted.

1a.	Recruitment letter / Information sheet for subjects, in English
1b.	Recruitment letter / Information sheet for subjects, in Maltese
2a.	Consent form, in English, signed by supervisor, and including your contact details
2b.	Consent form, in Maltese, signed by supervisor, and including your contact details
3a.	In the case of children or other vulnerable groups, consent forms for parents/ guardians, in English
3b.	In the case of children or other vulnerable groups, consent forms for parents/ guardians, in Maltese
4a.	Tests, questionnaires, interview or focus group questions, etc, in English
4b.	Tests, questionnaires, interview or focus group questions, etc, in Maltese
5.	Other institutional approval for access to subjects: Health Division, Directorate for Quality and Standards in Education, Department of Public Health, Curia...
6.	Other institutional approval for access to data: Registrar, Data Protection Officer Health Division/Hospital, Directorate for Quality and Standards in Education, Department of Public Health...
7.	Approval from person directly responsible for subjects: Medical Consultants, Nursing Officers, Head of School...

Received by Faculty office on	05.09.11
Discussed by Faculty Research Ethics Committee on	04.10.11
Discussed by university Research Ethics Committee on	09.10.11

Approved.
By email.

-----Original Message-----

From: Bertha Darmanin [mailto:bertha.darmanin@um.edu.mt]

Sent: Wednesday, 09 November 2011 11:19

To: Ward Corinne at MDH

Subject: Research proposal

Dear Corinne,

Your research proposal has now been approved. You can call for your proposal tomorrow, Thursday from 10.30am to 12 noon and from 2.00pm to 4.00pm.

Regards,

Bertha

Bertha Darmanin

Secretary

FREC

Faculty of Health Sciences

University of Malta

Msida MSD2080

MALTA

Tel: 00356 2340 1576

=====

-----Original Message-----

From: Bertha Darmanin [mailto:bertha.darmanin@um.edu.mt]

Sent: Thursday, 21 June 2012 09:58

To: Ward Corinne at MDH

Subject: Re: Research proposal changes

Dear Corinne,

Changes have been approved by FREC. Kindly send all amendments by e-mail at your earliest conveniences to update my files.

Regards,

Bertha

Bertha Darmanin

Secretary

FREC

Faculty of Health Sciences

University of Malta

Msida MSD2080

MALTA

Tel: 00356 2340 1576

=====

Ward Corinne at MDH wrote:

Dear Bertha,

Thank you for your help and comments. Please find the 11th version of the questionnaire attached. In line with your suggestions of not identifying names of hospitals I have also changed number 8.

Regards

Corinne

Mrs. Corinne Ward MSc.(UK)

Departmental Nursing Manager

Administration Block

Mater Dei Hospital

Tel: 2545 4207

Mobile: 79847048

 From: Bertha Darmanin [mailto:bertha.darmanin@um.edu.mt]

Sent: Fri 01/06/2012 11:29

To: Ward Corinne at MDH

Subject: Research proposal changes

Dear Corinne,

FREC finds no objection to the changes other than the following: No 6. Change to: In which hospital are you based? Specific names of hospitals are not allowed. Perhaps can you ask them to tick a type of hospital, e.g., acute general hospital.... Kindly be more general in this question, re-word and re-send please.

Regards,

Bertha

Bertha Darmanin

Secretary

FREC

Faculty of Health Sciences

University of Malta

Msida MSD2080

MALTA

Tel: 00356 2340 1576

=====

Ward Corinne at MDH wrote:

Dear Bertha,

I made slight changes to the questionnaire and wrote to BU University for approval. I received the below email that I do not need to seek any further permission. However, I would like to know if I need further approval from your end.

Thanking you in advance

Kind regards
Corinne

=====

-----Original Message-----

From: Corinne Pevac [mailto:corpev@yahoo.com]
 Sent: 14 May 2012 21:07
 To: Martin Hind
 Cc: Elizabeth Rosser; Sid Carter; Liz Norton
 Subject: Slight changes made to Questionnaire

Dear Dr Hind,

I was given approval for my study a few months ago but since then I had a change in my team of supervisors who suggested a couple of amendments. I was wondering if I had to submit the whole proposal before I start my study?

The change was mainly on the *The emphasis of the development of a framework because it was felt to be preconceived and leading. *

* Also the addition of one question to the questionnaire was added and the objectives were changed to questions/sub-questions. *

The aim of this study is to explore the roles of specialist nurses (SNs) in Malta.

Research Question

What are the roles of Specialist Nurses in Malta?

Sub-questions

1. What role do they undertake? (Phase 1 &2)
2. What services do they provide? (Phase 1 &2)
3. What preparations do they have for their role? (Phase 1 &2)
4. To what degree do the roles and services of SNs in Malta correlate with those of Stakeholders? (Phase 3)

Questionnaire changes

Slight changes made to the covering letter _*

- * Change the word 'describe' to 'investigate'.
- * The second paragraph was changed to:

If you would like to take part in the other elements of the study including an in-depth interview and/or a focus group, please complete the enclosed contact form and return to me in one of the pre-paid envelopes provided. The other envelope is provided for the questionnaire. Keeping them separate will secure your anonymity in the survey.

Changes in Questionnaire

* No 6. Change to: In which hospital are you based?

* One question in Section H number 5 was added -

If you had to choose a specialist nurse for your area what qualities and characteristics would you look for in this individual?.

* Section I title: Further Research - Contact Form

Thanking you in advance for your time and looking forward to hearing from you

kind regards

Corinne

=====

Dear Corinne

Thank you for your message.

I have compared your amendments to your original submission and approval (dated 31.08.11.), NB. That /approval/ is under your 'Ward' surname. (Which is not a problem).

The minor amendments to your questionnaire and the change of wording of the cover letter look fine and do not require a re-review; please take this message as approval to proceed with those changes.

Thank you for advising us of this, please forward us at Rg2@bournemouth.ac.uk a copy of your finalised questionnaire when that is complete. That is just for record keeping only.

I have also compared your revised research questions to your original submission;

- a) The main research question remains consistent to your original expression.
- b) Revised sub-questions 1, 2, 3 and 4 all relate closely to original objectives 1a, 1b and 2.
- c) The 4th objective on the original proposal has now been dropped; this raises no ethical concerns whatsoever.

This therefore means there is no need for any further RG2 review of these advised amendments. Thank you for taking the time to advise RG2 of these amendments and all the very best with your data collection.

Martin Hind (RG2 coordinator)
Senior Lecturer
School of Health & Social Care (HSC)
Floor 1 Royal London House
Bournemouth

=====

Appendix 14 Call for Applications for a Practice Nurse

HR/MFSS/31/2016 Circular No. HR/MFSS/33/2016

POST OF PRACTICE NURSE (ELDERLY CARE) AT ST VINCENT DE PAUL LONG TERM CARE FACILITY IN THE PARLIAMENTARY SECRETARIAT FOR THE RIGHTS OF PERSONS WITH DISABILITY AND ACTIVE AGEING IN THE MINISTRY FOR THE FAMILY AND SOCIAL SOLIDARITY (as per Ministry's HR Plan for the year 2016)

In accordance with clause 3.1(l) of the current Collective Agreement, nomenclatures importing the male gender include also the female gender.

1. The Director (Human Resources Management), Ministry for the Family and Social Solidarity and the Director (Resourcing and Employee Relations Ministry for Health, invite applications from Public Officers in the Malta Public Service for the post of Practice Nurse (Elderly Care) at St Vincent De Paul Long Term Care Facility, in the Parliamentary Secretariat for the Rights of Persons with Disability and Active Ageing in the Ministry for the Family and Social Solidarity. Public Officers in the Malta Public Service who are on secondment/on loan/detailed with/deployed with/on attachment to Public Sector Organisations may also apply.

Terms and Conditions

2.1 The salary for the post of Practice Nurse (Elderly Care) is Salary Scale 7, currently €22,043.98 per annum, rising by annual increments of €531.17 up to a maximum of €25,231.00.

2.2 A Practice Nurse (Salary Scale 7) shall be entitled to an annual training allowance of €500. This training allowance shall be payable in two equal installments every year.

2.3 The appointee shall fill the vacancy at St Vincent De Paul Long Term Care Facility, The management shall reserve the right to deploy the Practice Nurse (Elderly Care) to other sections/ entities according to exigencies of service.

Duties

2. The duties of Practice Nurse (Elderly Care) within St Vincent De Paul Long Term Care Facility include:

- a) Being an active member of the interdisciplinary professional team and works in collaboration with all members of the multidisciplinary team in the respective contexts;
- b) Executing the business plan for the respective contexts in line with the business plan of St Vincent De Paul Long Term Care Facility;
- c) Contributing towards improving the efficiency of his/her department;
- d) Leading the drafting and implementation of departmental nursing policies with regards to the delivery of health care in the respective contexts;
- e) Spearheading, encouraging, and facilitating the setting, monitoring and maintenance of optimal standards of professional practice within the respective contexts;

- f) Compiling timely and accurate completion of data;
- g) Performing regular audits and keeping the SVP management informed of any discrepancies;
- h) Participating in team meetings;
- i) coordinating with other units and sections in the execution of tasks entrusted to him/her or his/her subordinates;
- j) Monitoring progress and reporting on problems that may arise;
- k) Submitting regular reporting to the Chief Executive Officer including annual report and business plan;
- l) Making use of the Information Technology systems which may be in operation within the Ministry for the Family and Social Solidarity;
- m) Any other tasks that may be required by the St. Vincent de Paul Long Term Care Facility's management from time to time;
- n) Any other duties according to the exigencies of the Service as directed by the Principal Permanent Secretary.

Further details of the job description of the post may be obtained from the Human Resources Management Directorate of the Ministry for the Family and Social Solidarity, 38, Ordnance Street Valletta, which may also be contacted by email at recruitment.mfss@gov.mt or from the Resourcing and Employee Relations Directorate of the Ministry for Health, Palazzo Castellania, 15, Merchants Street Valletta, VLT 1171, which may also be contacted by email at recruitment.health@gov.mt.

Eligibility requirements

4.1 By the closing time and date of this call for applications, applicants must be Public Officers in the grade of:

- a) Staff Nurse with an aggregate of five (5) years satisfactory service in the grade;
OR
- a) Charge Nurse (Salary Scale 7);
OR
- b) Deputy Charge Nurse (Salary Scale 8).

Reference is made to the Sectoral Agreement signed by Government and Malta Union of Midwives and Nurses (MUMN) on the 6th February 2013 especially to the eligibility criteria for the filling of vacancies within the nursing and midwifery stream. In the spirit of Clause 5.8 of the same agreement and for the avoidance of doubt, it is hereby being clarified that any years of satisfactory service in the previous grades i.e. Deputy Nursing Officer, Nursing Officer, Departmental Nursing Manager, Manager Nursing Services, Practice Nurse and Speciality Nurse would be considered also as years of satisfactory service in the new grade i.e. Deputy Charge Nurse, Charge Nurse, Senior Nursing Manager, Chief Nursing Manager, and Practice Nurse respectively.

All applicants should be in possession of a recognised, appropriate Masters degree at MQF Level 7. If the selected candidate does not have the qualification stipulated in the particular call for application, the candidate shall be obliged to undertake studies which will lead to successfully obtaining the relevant qualification stipulated in the respective call for application within four (4) years from being appointed in this grade, which may be extended to six (6) years in case of exceptional and justified circumstances. The employee may also request the Management's direction when

choosing the qualification's subject matter prior to embarking on the specific postgraduate course.

The department of Health will evaluate the extent of progress made in the undertaking of the specific qualification on a yearly basis. If the progress made in the undertaking of the specific qualification is not to the satisfaction of Management, appointment may be terminated. Should the appointee fail to successfully complete the specific qualification deemed necessary, the appointee shall revert back to the applicable grade which the applicant would have had prior to applying for the grade of Practice Nurse (Salary Scale 7).

Cognisance is taken of the fact that the grade of Practice Nurse is a new grade which emanates from the Sectoral Agreement dated 6 February 2013. To this effect, officers in the grade of Practice Nurse (Salary Scale 7) reserve the right to request to revert back to the applicable salary scale and relevant step of the grade they would have had prior to applying to the grade of Practice Nurse, (i.e. taking into consideration, notionally, the years of service performed in the grade of Practice Nurse, subject that the nomenclature shall correspond to the grading structure as per the aforementioned Sectoral Agreement. It is hereby being clarified that upon being successful when applying to another grade, or when being promoted to a higher grade, the Practice Nurse will be considered as having automatically relinquished any previous grades these may have held, as per PSC regulations. It is also being clarified that upon relinquishing the grade of Practice Nurse, the officer would no longer be entitled to the training allowance mentioned in the aforementioned Sectoral Agreement.

It is hereby being clarified that officers in the grade of Practice Nurse (Salary Scale 7) who are in possession of the appropriate, recognised postgraduate Masters degree at MQF Level 7, or who attain such appropriate qualification stipulated in the respective call for application after the date of appointment as per above provision, will not be eligible to benefit from a qualification allowance, given that the qualification would be a prerequisite.

Once Article 29(4) of the Health Care Professions Act (Cap 464) comes into force upon the setting up of the relevant Specialist Accreditation Committee, the requirement to enter into the grade of Practice Nurse (Salary Scale 7) shall be that of a specialist nurse as determined by and upon due accreditation as a specialist by the Specialist Accreditation Committee, and the minimum number of years of nursing service specified in the above provisions.

4.2 Due consideration will be given to applicants who, besides the requisites indicated in paragraph 4.1, have proven relevant work experience.

4.3. Prospective applicants should note the requirement to produce MQRIC recognition statements in respect of their qualifications from MQRIC, or other designated authorities, as applicable, as per provisions applicable to this call for

applications (see link below).

Submission of supporting documentation

5.1 Qualifications and experience claimed must be supported by certificates and/or testimonials, copies of which should be attached to the application. Scanned copies

sent electronically are acceptable.

5.2 Original certificates and/or testimonials are to be invariably produced for verification at the interview.

Selection procedure

6. Eligible applicants will be assessed by a Selection Board to determine their suitability for the post. The maximum mark for this selection process is 100 and the pass mark is 50.

Submission of applications

7. Applications, together with an updated Service and Leave Record Form (GP47) and a detailed Curriculum Vitae (Europass Format), will be received by the Director (Human Resources Management) at the Ministry for the Family and Social Solidarity, 38, Ordnance Street Valletta by not later than **noon (Central European Time) of Tuesday 16th August 2016**. Applications can also be submitted through the Online Government Recruitment Portal on <http://recruitment.gov.mt> by the said closing time and date of this call for applications. Further details concerning the submission of applications are contained in the general provisions referred to below.

Other general provisions

8. Other general provisions concerning this call for applications, with particular reference to:

- other applicable conditions;
- reasonable accommodation for registered persons with disability;
- submission of recognition statements in respect of qualifications;
- publication of the result;
- the process for the submission of petitions concerning the result;
- access to application forms and related details
- retention of documents

may be viewed by accessing the website of the Public Administration HR Office at the address <http://opm.gov.mt/en/PAHRO/RESOURCING/Pages/Forms%20and%20Templates/Forms-and-Templates.aspx> or may be obtained from Human Resources Management Directorate, Ministry for the Family and Social Solidarity, 38 Ordnance Street, Valletta. These general provisions are to be regarded as an integral part of this call for applications.

The website address and e-mail address of the receiving Directorate are <http://mfss.gov.mt/en/Pages/MFSS%20EN%20homepage.aspx> and recruitment.mfss@gov.mt

Chiara Borg

Director (Human Resources Management)

Maureen Mahoney

Director (Resourcing and Employee Relations)

Appendix 15 Personal Correspondence (Galea, 2015, Sectoral Agreement Definition)

On 08 Oct 2015, at 7:03 PM, "mumn@go.net.mt" <mumn@go.net.mt> wrote:

Hello Corinne,

A Collective Agreement is addressed to the workers in general who pertain to different categories and classes. For example in Malta a Collective Agreement is signed by seven different unions on behalf of all the 30,000 Public Service employees.

On the other hand a Sectoral Agreement will be addressed to a section of the workers who normally pertain to the same category and class. MUMN signs Sectoral Agreements on behalf of Nurses.

Regards,

Colin Galea
MUMN
