The experiences of educational preparation for the minor injury nurse role: A Hermeneutic Phenomenological study

In partial fulfilment of the degree of Clinical Doctorate in Nursing

Craig Adamson
Student Number 2432081

Doctor of Nursing

Date – 31st of May 2023

Word count: 68244

University of Stirling

Supervisors:

Dr Purva Abhyankar

Dr Kath Stoddart

Dr Joyce Wilkinson

Declaration

I declare the work in this thesis to be my own, except where otherwise stated.

Craig Adamson
27/02/2024

Acknowledgements

I would like to acknowledge the valuable support I have received over the past eight years of my clinical doctorate journey. In particular, I thank those closest to me, having the support and encouragement of family is a gift. I am also grateful to my clinical doctorate supervisors, Dr Purva Abhyankar, Dr Kathleen Stoddart and, Dr Joyce Wilkinson. The patience and support they have shown has been immense. I would also like to thank my study peers for the guidance, the kin-ship and the laughs. In addition, I would like to thank the study participants and my wider professional network of support for making this research possible. Lastly, I would like to acknowledge and dedicate this thesis to my late mother, Anne Adamson (1955-2001). Much of my endeavours in life have been driven by her encouraging words that are forged in my memory.

Contents page

Tables and Figures 9
Minor injury nursing – Titles 10
Abstract 11
Chapter one - Introduction 15
1.1 Background 15
1.2 Healthcare pressures 16
1.3 Meeting healthcare demand by advancing nursing practice 17
  1.3.1 A historical overview of advanced nursing practice 17
  1.3.2 Scottish education standards of advanced nursing practice 18
  1.3.3 Regulation of advanced nursing practice 18
1.4 Minor injury nursing – How does it align with advanced nursing practice? 21
1.5 An overview of minor injury nursing in Scotland 23
1.7 Chapter one summary 27
Chapter two – literature review 28
2.1 The approach to the literature 28
2.2 Search strategy 30
  2.2.1 Searching 32
  2.2.2 Sorting 32
  2.2.3 Selecting 34
  2.2.4 Acquiring 34
  2.2.5 Reading 35
  2.2.6 Identifying 36
  2.2.7 Refining 36
2.3 The hermeneutic phenomenological review of the literature 37
  2.3.1 Overview of included studies 37
2.4 Conceptualising preparedness 38
  2.4.1 Preparedness – communication and interpersonal skills 39
  2.4.2 Preparedness – clinical competence 43
2.5 The role of education in supporting practice preparedness 46
2.6 Chapter two summary 50
2.7 The need for further research 51
2.8 Research aim 51
2.9 Research questions 51
Chapter three - methodology and methods 52

3.1 Introduction 52
3.2 Considering a quantitative or mixed methods methodology 53
3.3 Choosing a qualitative approach 54
3.4 Phenomenology 55
3.5 History of Phenomenology 56
3.6 Philosophical underpinnings 56
3.7 Justification for using Hermeneutic Phenomenology 57
3.8 Philosophical concepts of Heidegger 59
3.8.1 Dasein and being in the world 59
3.8.2 Ready-at-hand/Unready-at-hand 60
3.8.3 Time/Temporality 60
3.8.4 Thrownness 61
3.8.5 Pre-understandings/fore-structures 61
3.8.6 The hermeneutic circle 63
3.9 Theoretical framework 63
3.10 Patricia Benner 64
3.11 Examples of phenomenological studies using Benner's theory 67
3.12 Ethical approval 68
3.13 Target population 68
3.14 Sample size 69
3.15 Participant inclusion/Exclusion criteria 71
3.15.1 Inclusion criteria 71
3.15.2 Exclusion criteria 71
3.16 Recruitment and consent 72
3.17 Data collection 73
3.18 Pilot study 77
3.19 Field notes 78
3.20 Memoing 79
3.21 Data management 79
3.22 Data analysis 80
3.23 Data analysis – tools 81
3.24 The six phases of reflexive thematic analysis 81
3.24.1 Working with the data 83
3.24.2 Familiarising yourself with your data 84
3.24.3 Generating initial codes 85
3.24.4 Semantic and Latent coding 86

3.24.5 Coding diary ... 88
3.24.6 Merging codes ... 89
3.24.7 Coding frequency ... 90
3.24.8 Generating themes ... 92
3.24.9 Reviewing potential themes ... 95
3.24.10 Defining and naming themes ... 98
3.24.11 Producing the report ... 98
3.25 Rigour ... 98
3.26 Chapter three summary ... 102
Chapter four - findings chapter ... 103
4.1 Introduction ... 103
4.2 Participant characteristics ... 105
4.3 Overview of the findings ... 108
4.4 Findings ... 109
4.5 Theory and Practice – from learning to development ... 109
4.6 Those that understand should teach ... 119
4.7 It was more than just an assessment ... 125
4.8 Thrown in to practice ... 134
4.9 The preparedness continuum ... 138
4.10 Chapter four summary ... 142
Chapter Five – Discussion ... 143
5.1 Introduction ... 143
5.2 Key findings ... 144
5.3 Returning to the hermeneutic phenomenological concepts ... 145
5.4 Returning to Benner's novice to expert framework ... 148
5.5 Theme one – Theory and Practice – From learning to Development ... 149
5.5.1 Theory-based education ... 150
5.5.2 Practical-based education ... 153
5.6 Theme two - Those that understand should teach ... 155
5.7 Theme three - It was more than just assessment ... 158
5.7.1 Singular assessment strategy ... 158
5.7.2 Multi-method assessment strategy ... 159
5.7.2.1 Coursework assignment ... 160
5.7.2.2 Observed Structured Clinical Examination (OSCE's) ... 161
5.8 Theme four - Thrown in to practice ... 163
5.9 Theme five - The preparedness continuum ... 166

Chapter six – Conclusion 170
6.1 Introduction 170
6.2 Implications 170
6.2.1 Implications for clinical practice 170
6.2.2 Implications for education 173
6.2.3 Implications for policy 173
6.2.4 Implications for future research 174
6.3 Strength of this study 175
6.4 Limitations 178
6.5 Reflexivity 180
6.6 Reflections on the research journey 180
6.7 The impact of COVID-19 on this study 182
6.8 Dissemination of findings 183
6.9 Conclusion 185
References 186
Appendix 1 - Participant Information Leaflet 221
Appendix 2 - Interview guide 227
Appendix 3 – Consent form 228
Appendix 4 – Ethics approval 230
Appendix 5 – Minor amendments (Ethics) 233
Appendix 6 - Draft journal for publication 237

Glossary of abbreviations

ENP – Emergency Nurse Practitioner

NP – Nurse Practitioner

ANP – Advanced Nurse Practitioner

SHO – Senior House Officer

MIU – Minor Injury Unit

ED – Emergency Department

NMC – Nursing and Midwifery Council

CHRE - The Commission for Healthcare Regulatory Excellence

DoH – The Department of Health

HEI – Higher Education Institute

UK – United Kingdom

Tables and Figures

	Page Number
Table 1	34
Table 2	84
Table 3	85
Table 4	89
Table 5	90
Table 6	91
Table 7	93
Table 8	95
Table 9	107
Table 10	108
Table 11	110
Figure 1	32
Thematic map 1	96
Thematic map 2	99

Minor injury nursing – Titles

The title Emergency Nurse Practitioner (ENP) was adopted by emergency department nurses in the UK undertaking extended role positions in minor injuries nursing (Walsh 2000). To clarify, this research will refer to the titles Emergency Nurse Practitioner (ENP) and minor injury nurse interchangeably as the context of practice (nurse-led minor injuries) is the same regardless of title. The ENP title can be confusing as it is better known internationally for a scope of practice more comprehensive than the minor injuries scope of practice it is known for in the UK. ENPs, for example, are known more so in North America as a graduate nurse practitioner where their scope of practice encompasses a wide range of emergency trauma, not limited to minor injuries (Walsh 2000).

Abstract

Background

The care of minor injuries in the United Kingdom (UK) is delivered by nurses with an extended scope of practice. Undertaking this role typically involves some form of minor injury nursing education. In Scotland, minor injury nursing education is unregulated which results in courses that are designed and delivered in a wide variety of formats. Within published research, very little is known about how minor injury nursing courses prepare nurses for minor injury nursing practice. No previous research has explored the lived experience of minor injury nursing education and considered how different courses are preparing minor injury nurses for practice.

Aim

To explore the experiences of undertaking minor injury nursing education and how it prepares nurses for minor injury nursing practice.

Research questions

- How do minor injury nurses experience minor injury nursing education?
- How do minor injury nurses experience preparedness for minor injury nursing practice following minor injury nursing education?

Design and Methods

This research was underpinned by the philosophy of hermeneutic phenomenology. Data were collected by conducting twelve semi-structured interviews. The participants were twelve nurses with a minor injury background, purposively sampled from four Minor Injury Units (MIU) in Scotland, two rural and two urban. Three participants were recruited from each of the four units. Data was analysed within the hermeneutic circle. However, as this was a time-limited doctoral project, the Braun and Clarke six phases of reflexive thematic analysis were used to structure the analysis. The representation of the participants lived experiences was a

co-constitution of the understanding and experience of both the researcher (myself), the participants and is underpinned by relevant literature.

Findings

Five themes were generated from the participants experiences. 1- Theory and practice – From learning to development, 2-Those that understand should teach, 3- It was more than just an assessment, 4- Thrown in to practice, 5- The preparedness continuum. Minor injury nursing education started with theory-based education which allowed the participants to underline their personal learning journey. For some, practical-based education experiences then followed that which guided development as a skilled minor injury nurse. Within the learning environment a number of learning and teaching methods created a supportive platform for the study of minor injury nursing. For a number of participants, these learning and teaching methods were absent which emphasised how minor injury nurses need sound theory and practice-based educational experiences. Following these varied learning experiences, the participants underwent course assessment and felt more informed and aware of further learning needs when assessment of competence was taken with a broader overview. For some, a narrowed approach to assessment left participants feeling uncertain about their level of practice preparedness and ongoing learning and development needs. Following assessment, the participants started their journey as minor injury nurses and had varied practice preparedness experiences. The varied experiences of practice preparedness show what that meant for the participants. Experiences varied from feeling prepared by being supported and protected in practice to feeling anxious, alone and not prepared for practice.

Conclusion

Giving voice to minor injury nurses regarding their educational experiences revealed key educational experiences that best support learning, development and practice preparedness in minor injuries nursing. These findings can be used for the review and development of minor injury nursing education. Due to the nature of the research methodology, the findings are not generalisable, however, they are transferrable to areas of practice and education in a similar context.

Overview of thesis

This research explored the experiences of undertaking minor injury nursing education and preparedness for minor injury nursing practice. In chapter one, the field of minor injury nursing is introduced by firstly giving a brief historical overview of minor injury nursing. Secondly, pressures on the health service are outlined with a discussion on how they impact upon emergency and unscheduled care and how they have acted as a catalyst for the advancement of nursing practice. Thirdly, a broad and historical overview of how nursing practice has advanced is introduced. This section also includes an overview of Scottish advanced nursing practice education standards and initiatives that move towards regulating advanced nursing practice before specifically looking at how minor injury nursing aligns with advanced nursing practice. As this study was conducted in Scotland, a general synopsis of Scottish minor injury nursing practice is then presented. To conclude, my clinical background in minor injury nursing practice and education is outlined to clarify how I am positioned within this research.

In chapter two, a hermeneutic literature review on the research interest (minor injury nursing) is presented. The chapter outlines the search strategy used and explains how the literature was reviewed, questioned and critiqued. Following the review of literature, a gap in the research is discussed and research aim and questions presented.

In chapter three, the philosophy, methodology and methods are explored. The line of inquiry is discussed and other possible methodologies considered. This chapter then introduces phenomenology to include a history of phenomenology, the philosophical underpinnings, a justification for using hermeneutic phenomenology and follows with an overview of hermeneutic phenomenological philosophical concepts that are used throughout the research. I then introduce my pre-understandings before introducing the hermeneutic circle. The theoretical framework is then presented including a discussion surrounding how it informs this research. Included in this chapter are examples of nursing education research that used hermeneutic phenomenology underpinned by Benner's (1984) theoretical framework in order to demonstrate the value that approach has for nursing research. To follow, I outline the methods used to undertake this research.

Chapter four will focus on the findings from the research. Firstly, the participant pseudonyms and characteristics are detailed before the findings are presented in a brief summary. Thereafter, the findings are presented as themes. The representation of the participants' lived experiences was a co-constitution of the understanding and experience of both the researcher and the participants. The interpretation draws upon relevant literature, hermeneutic phenomenological concepts and theory where appropriate. The findings comprise of five themes that capture the overall meaning within the participants lived experiences, 1- Theory and practice – From learning to development, 2-Those that understand should teach, 3- It was more than just an assessment, 4- Thrown in to practice, 5- The preparedness continuum. Each theme has an excerpt from the interviews so that the reader can see and understand the interpretation behind the thematic analysis within the hermeneutic circle.

In chapter five, the findings are brought forward into a discussion. The discussion begins with a summary of the key findings that briefly outlines how the themes answer the research questions. From there, the parts that make up the interpretive whole are discussed. This part of the discussion starts with a return to hermeneutic phenomenology, outlining the concepts that were presented in chapter three and used in the analysis. From there, the underpinning theoretical framework is critically discussed. Thereafter, the discussion explores the research findings and considers where the findings sit within wider literature. This chapter concludes with a summary of the new interpretive whole.

In the concluding chapter, the implications of the research for practice, education, policy and further research are presented. Thereafter, the strengths and limitations of the research are highlighted. The role of the researcher is then discussed with a reflexive and reflective account. There is also a discussion explaining how COVID-19 impacted upon this research journey before detailing the plan for dissemination of the findings. The chapter then closes with a concluding summary of the research

Chapter one - Introduction

The aim was to explore the educational and practice preparedness experiences of minor injury nurses. In minor injury nursing there are many aspects of the role that are not governed by a particular standard, including education. Despite an established understanding that the educational preparation of minor injury nurses is vastly different across Scotland (Fotheringham et al. 2011), there is little research that explores what it is to experience education and how that may impact upon practice preparedness. In terms of minor injury nursing research that is available, most studies are quantitative and many focus on studying the competence of ENPs in clinical practice. Although useful, there is a scarcity of in-depth research that explores how minor injury nursing education is experienced and how practice preparedness is achieved or experienced.

In this chapter the broader context of my study is presented. Firstly, the chapter provides a brief history regarding minor injury nursing in the UK and a snapshot of how emergency nursing has advanced and developed in to minor injury practice. Secondly, some of the healthcare pressures that unscheduled care currently face is presented with a brief discussion on how the Scottish Government plan to address the present and future demand. Advanced nursing practice roles form a part of modern healthcare delivery. The history, education and governance of advanced nursing practice is explored to provide understanding in to how nursing has developed towards more advanced practice. The practice of minor injury nursing involves a level of clinical practice that is beyond the level of practice at initial nursing registration. Despite that, it remains unclear if minor injury nursing is considered to be an advanced nursing role. On that basis, there is a discussion that considers where minor injury nursing is placed in terms of advanced nursing practice. As my study was conducted in Scotland, a synopsis of ENP services across Scotland is then offered to understand the variances surrounding the role that currently exist. To conclude, I present the clinical context of my research, giving an overview of my own lived experiences of minor injury nursing and education.

1.1 Background

In the UK, the first formal minor injury nurse practitioner role was founded in an English hospital in 1992 and given the title Emergency Nurse Practitioner (ENP) (Bache 2001). Within

emergency/unscheduled care, nursing roles have a long history of change and advancement to meet the needs of the population. These changes have seen nurses advance into and adopt roles and functions that were traditionally the sole preserve of medical staff (Macduff et al. 2000, Tye and Ross 2000, Bright et al. 2002 and Fotheringham et al. 2011). The treatment of minor injuries has since evolved over a number of years to become a clinical speciality in its own right with its own practitioners, specific training, and specific healthcare settings (Purcell 2010).

1.2 Healthcare pressures

Thousands of minor injuries are sustained every day in the UK, despite the term "minor" patients do not view their injuries as such and therefore seek the treatment of emergency/unscheduled services (Bright et al. 2002). Since 2008, emergency and unscheduled healthcare delivery has been governed by waiting time standards (Audit Scotland 2015). Emergency and unscheduled care departments have been expected to see, treat and discharge or refer 98% of patients within four hours (Audit Scotland 2015). More recently, Scottish emergency and unscheduled care departments have struggled to meet that standard, with the current national performance seeing the average standard only reaching 71.6% (The Scottish Government 2022).

In managing the increasing pressure on health care services, specific guidance now aims to direct patients towards the most appropriate health professional to meet their specific healthcare needs (The Scottish Government 2021a). The Scottish Government have launched the redesign of urgent care programme which is aimed at helping the public access the right care in the right place at the right time, often as close to home as possible. The Scottish Government anticipate that educating the public on how to access healthcare will facilitate patients to be treated by the right professional with the right skill set for the patients' specific needs (The Scottish Government 2021a). For nursing, the Scottish Government pledge the right support and education to meet the increasing health needs of the population moving forward (The Scottish Government 2017, The Scottish Government 2019, and The Scottish Government 2021a).

1.3 Meeting healthcare demand by advancing nursing practice

Educating and extending the scope of practice for nurses to meet the health demands of the public is not a new phenomenon. Advanced nursing roles have developed over a number of years and are an example of an emerging global phenomenon introduced to meet the demand placed upon modern healthcare delivery (Schober 2006 and King et al 2017). As minor injury nursing practice goes beyond the scope of practice verified at the point of registration and achievement of the undergraduate academic qualification (Brook and Crouch 2004 and Cooper 2011) the boundary lines between enhanced minor injury nursing practice and advanced practice are worthy of discussion. Internationally, the demand for advanced nursing roles has been influenced by similar factors that drove the emergence of the minor injury nurse such as, medical staff shortage, efficiency savings, a need to improve access to patient care, government policy, nurse education and, from positive evaluations of the role (Hill 2017 and King et al. 2017).

The International Council of Nursing (2013) define an advanced nurse practitioner (ANP) as 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 she/he practices within. The International Council of Nursing (2013) suggests a Master's degree is recommended for entry-level, however, they recognise this level is at the discretion of each country. Similarly, the advanced nurse practitioner role can be assigned a variety of titles. For example, advanced nurse practitioner (ANP) and nurse practitioner (NP) are referred to and used.

In the UK, the role of the advanced nurse practitioner has developed at a slower pace, this is especially evident when compared to countries like the United States and Canada for example, where the role has been developing since the 1960s (Hill 2017).

1.3.1 A historical overview of advanced nursing practice

American in origin, the nurse practitioner role was pioneered in 1965 by Ford and Silver (1967). The role was founded on the principles of specialist nurses' extended role and incorporated traditional medical diagnostic skills, established due to the demand from social issues and a shortage of paediatricians (Barton et al. 2012).

From a UK perspective, the nurse practitioner role was founded on Stilwell's work (1985), who introduced the role into primary care. As seen internationally, improving patient care access and reduced availability of medical staff led to the implementation of the advanced nurse practitioner role in the UK (King et al. 2017). Stilwell (1985) defined the nurse practitioner (NP) as an experienced nurse who uses extensive nursing skills in health assessment with developed diagnostic skills to manage patient presentations autonomously. This innovative work served as a landmark for the development of the advanced nursing role in the UK (Barton et al. 2012). Advanced nursing practice in the UK is now more commonly known for core capabilities across what is known as the four pillars: clinical practice, leadership and management, education and research (The Royal College of Nursing 2020).

1.3.2 Scottish education standards of advanced nursing practice

In Scotland, educational standards have been introduced which are intended as a means of governing the education and practice of advanced nursing (NHS Scotland 2016). Advanced nursing practice education is now receiving recognition that it should be set at Master's degree level (The International Council of Nursing 2013). Duffield et al (2020) support a movement towards Master's level education suggesting it is essential for higher level performance in areas of advanced nursing practice. This is now accepted in Scotland and advanced nursing practice education is recommended to include, clinical assessment, anatomy and pathophysiology, clinical reasoning, judgement and diagnostic decision making, non-medical prescribing, leading, delivering and evaluating care and, practice learning/transferable work-based learning processes (Transforming Nursing Roles, Developing Advanced Practice in NHS Scotland 2016. P.6)

1.3.3 Regulation of advanced nursing practice

As modern healthcare adopts more advanced nursing roles worldwide, the global perspective on the governance of advanced nursing practice appears to be country-specific (Carney 2015). Internationally, the regulation of advanced nursing practice varies widely. A number of countries differentiate between the regulation of advanced nursing practice and the regulation of nursing and midwifery (Carney 2015). Australia, Canada, Hong Kong, Ireland, New Zealand, Norway, Singapore, Spain and the United States all regulate advanced nursing

practice (Carney 2015). Denmark, Finland, France, Germany, Italy, Japan, Netherlands, Sweden, Switzerland, and the UK do not regulate advanced nursing practice, suggesting that regulation is not followed with any consistency from an international perspective (Carney 2015). It is unclear, in this breakdown, what specific registration would offer over the current approach used in countries that do not regulate advanced practice. This issue is long debated and, in the UK specifically, has sparked conflicting debate (Brook and Rushforth 2011, Rolfe 2014 and York 2021). It has previously been suggested that ANPs in the UK be registered in a different sub-part of the register in order to differentiate between practice from that at initial registration (Rolfe 2014). However, this was never implemented, with the NMC stating that each registrant on the NMC register should be practicing within their level of competence, concluding that separate registration would achieve little in governing advanced nursing practice (Rolfe 2014). To date, this remains the case in the UK, with no plans for the regulation of advanced nursing practice by the NMC (York 2021 and Henderson 2021).

For some, the decision by the NMC to not regulate advanced nursing practice leads to governance issues across the advanced nursing practice movement (York 2021). York (2021) contends that a lack of regulation leads to confusion for employers, educators and the public, with a risk of the title advanced nurse practitioner being used by individuals not qualified to use the title. The Commission for Healthcare Regulatory Excellence (CHRE 2009) recognised concerns such as these, stating that concerns about the governance of advanced nursing practice roles are both prudent and understandable. Nonetheless, CHRE (2009) supported the NMC and emphasised that the activities that professionals undertake at advanced level practice do not lie beyond the scope of existing regulation, unless, they suggest, the nature of their practice changes to such a significant extent that their scope of practice is fundamentally different from that at initial registration. In response to that, Brook and Rushforth (2011) argue that statements such as these, leave a sense of ambiguity, especially in roles that practice closely to advanced practice. Brook and Rushforth (2011) feel that roles such as the nurse specialist can carry out tasks that were traditionally allied to medicine. Consequently, Brook and Rushforth (2011) suggest that the closing statement of the CHRE (2009) is actually a contradiction of their own argument, as practices at an advanced level are often far removed from nursing practice at initial registration (Brook and Rushforth 2011).

Although specific registration is not undertaken in the UK, there is a credentialing process offered by the Royal College of Nursing (RCN) (The Royal College of Nursing 2023). RCN

credentialing refers to a formal process and was designed to recognise the expert level of practice of nurses working in more advanced nursing roles. The recognition spans across all four pillars of advanced nursing practice, clinical, management/leadership, education and research. The four pillars can combine in different ways depending on where a practitioner works or how they practise (The Royal college of Nursing 2023). To obtain RCN credentialing a practitioner must have, a relevant Master's degree, a non-medical prescribing qualification, experience and expertise mapped against the four pillars of advanced nursing practice, a job plan that demonstrates current advanced level practice verified by a senior nurse/employer, a clinical reference verifying the applicant's clinical competence, evidence of continued professional development related to advanced nursing practice over the previous three years and a qualification in health assessment/clinical examination (The Royal college of Nursing 2023). For nurses currently in an advanced nursing practice role and who are unable to meet the requirements, specific transitional pathways also exist (The Royal college of Nursing 2023).

In the absence of specific NMC registration, the credentialing process offers a publicly accessible register of advanced nurses. For the wider nursing population this supports a move towards formal recognition of nursing expertise and strengthens the professionalism of advanced nursing practice. For the individual practitioner it gives them a basis for enhancing their professional development and a framework to utilise in the advancement of practice. That said, the realities of implementing this formal process may present challenges. Although this process is clear, structured and detailed, there are implications for both cost and time. In terms of cost implications, to credential involves an initial fee and subsequent fees for renewal at three yearly periods (The Royal college of Nursing 2023). It is unclear if employers or practitioners are responsible for this fee. If practitioners are responsible, this would have to be a considered cost in addition to existing NMC re-registration fees. Furthermore, to meet the required education outlined in RCN credentialing would involve meeting the cost of each specific course. Again, meeting that requirement may be dependent on the financial means of the individual practitioner or whether financial educational support is available. In addition to a financial demand, there would also be a demand on time. The time required to undertake the educational requirements that meet the credentialing standards would have to be considered and again, how that is or is not supported would have to be discussed between an employer and practitioner. Overall, it is clear that credentialing is a defined process of formally recognising advanced nursing practice. However, as this process is not mandatory, employers may be less

inclined to offer the support required to fulfil the credentialing process. The practicalities of implementing the process could be challenging with implications for nurses that may render it a path that is too difficult for them to follow.

1.4 Minor injury nursing – How does it align with advanced nursing practice?

Currently there is no evidence that minor injury nurses are governed by standards of advanced nursing practice. Moreover, there is no additional professional registration required to practice in an advanced or extended minor injury nursing practice role. In addition, there is no indication that minor injury nursing education will need to comply with a basic standard such as the requirements outlined in the education requirements set out by Transforming Nursing Roles, Developing Advanced Practice in NHS Scotland (2016).

Further perspective in this context is offered in a study by McConnell et al (2013) who explore the role and scope of practice of ENPs in a region in the UK and aim to determine how close to the criteria of the ANP role the ENP role is. The conclusion from this exploration is that the ENP role is not aligned to the four pillars of advanced nursing practice. McConnell et al (2013) determined that much of the ENP role is dominated by clinical activities, is overseen by protocols that govern the clinical care they deliver and is unregulated in terms of education standards.

In discussion of the findings, McConnell et al (2013) claim that advanced nursing practice areas such as research and development are not fulfilled within an ENP role as it is heavily pre-occupied with clinical duties. McConnell et al (2013) also argue that a lack of standardised education prevents the role from progressing towards the advanced nursing practice domain. Following an established trend seen in the wider field of practice, McConnell et al (2013) also conclude that the role has been aligned to meet local needs and therefore has had to meet local organisation standards (Bright et al. 2002, Cooper 2011 and, Dawood and Gamston 2019). That has meant the opportunity to standardise and govern the ENP role using advanced nursing practice guidelines, according to McConnell et al (2013), has been missed. They suspect that in all probability, the role, the title, scope of practice, and education of ENPs will continue to be unregulated and therefore, only required to meet standards dictated by the local organisation. It could be argued that aligning minor injury nursing to the standards of advanced nursing practice would support a more governed approach to aspects of the role, especially education.

Despite that, some argue, that this approach would not benefit the needs of UK minor injury services. Supporting the add-hoc approach to minor injury nursing education, Cooper (2011) explains that how the ENP role is prepared and practices is relative to the needs of each specific area. Cooper (2011) states that a standard approach to education should not be the overarching focus in educating future minor injury nurses. He argues that the focus should be directed towards adequate educational preparation of minor injury nurses for practice, emphasising that a standard approach may not suit the clinical needs of different departments.

Cooper (2011) underlines his argument by referring to advanced nurse practitioner levels of practice and explains that ENP roles are used differently across departments. The differences in scope of practice mean that some roles are advanced and others are more in keeping with a senior practitioner role. He explains that the different roles are valued by the area they serve and are often created to meet a specific need. Cooper (2011) advises that the focus should be upon education and remuneration that matches the scope of practice for each specific area. If an area requires an ENP at an advanced level then that should be the aim of educational preparation. However, if an area does not require that level of practice, he argues that care can and has been delivered by a suitably educated practitioner that does not fulfil the criteria for advanced nursing practice (Bright et al. 2002, Cooper. 2011 and Dawood and Gamston, 2019).

Cooper (2011) presents a valid argument on the departmental advantages of the ad-hoc approach to minor injury nursing education. However, this argument is short-sighted and the ad-hoc approach to minor injury nursing education must be considered from a number of perspectives. Firstly, skill discrepancy. Educating minor injury nurses to meet local demand may mean that their skill-set is specific to that department and locality and therefore not transferrable to other departments and localities. In times of increasing healthcare demand, an approach to education that is considerate of both a specific and general scope of practice could facilitate a workforce that is transferrable across wider areas according to demand. Secondly, in terms of a lack of educational standardisation, this raises the question of how practice aligns with patient care standards. Educating minor injury nurses to a different standard may mean that there are differences in clinical practice. That may well translate into standards of care that vary between each department. The issues in that context are that patients may be at risk of sub-standard care and employers and practitioners are open to litigation. Lastly, stepping back and looking at this again from the perspective of Cooper (2011), this approach may have implications in terms of staff retention. As an organisation, areas may want to consider the

competitive advantage of other clinical areas in terms of recruitment and retention of staff. Recruitment challenges may arise from staff pursuing employment in areas where there are more advanced and formally educated roles with enhanced remuneration. The effect of that may result in areas that are understaffed and unable to provide a minor injury service. Overall, the ad-hoc approach to educating minor injury nurses may have advantages for specific areas. However, it is necessary to acknowledge that these advantages may also come with wider and longer-term implications.

1.5 An overview of minor injury nursing in Scotland

The demand that has seen nursing move towards more advanced levels of nursing and clinical practice is reflected in Scottish minor injuries services (Schober 2006, King et al. 2017 and Fotheringham et al. 2011). Fotheringham et al (2011) undertook a survey of all emergency departments in Scotland and found extensive endorsement of the ENP role. They concluded that 89% of Scottish emergency/unscheduled care departments had practicing ENPs at the time of their study, a figure that had risen sharply from 47% in 1998 (Fotheringham et al. 2011). In terms of how the role was used, there were some differences in the extent of practice. However, the scope of practice appeared to be well established within a minor injuries' context. Despite an established scope of practice and the increasing demand for the role in most Scottish departments, the role appears to have emerged free from nationalised guidance and structure. In particular, divergence exists in three key areas, including pay, title and, educational preparation (Fotheringham et al. 2011). Exploring these differences show that the breadth of differences is extensive. Differences included pay bands ranging from band 5 to band 8a, varied titles such as ENP, Advanced Nurse Practitioner (ANP) or minor injury nurse and varied education ranging from no formal education to Master's level education (Fotheringham et al. 2011).

Although the breadth of these differences throughout Scotland is clear, why those differences exist is less clear. In terms of pay bands, it is not apparent if pay band diversity reflects differing levels of education or associated professional responsibility within a specific role. Fotheringham et al (2011) imply that the higher banding roles had some form of joint managerial function, suggesting that remuneration comes with more responsibility within the

department. However, the context of that responsibility is not offered so concluding this is not possible.

Moving on to role title, of those that assign the title ENP, they were generally found in larger hospitals or paediatric hospitals. However, again, the associated functions of this title are unclear such as specific education requirement or level of practice, so, it is difficult to fully understand how titles are assigned (Fotheringham et al. 2011).

Lastly, when looking at ENP education, more detail is presented regarding levels of educational preparation. The level of detail further illustrates the wide variance in this context. (Fotheringham et al. 2011). Fotheringham et al (2011) state that only 4.7% (n=21) of nurses employed as ENPs were educated with a Master's level qualification (subject not disclosed). They then state that the majority, 67% (n=298) had received a formal stand-alone ENP qualification by an educational institute at diploma, bachelors, or Master's level. 11% (n=48) of ENPs had received no formal training, stating their educational training to be on the job or in-house only (Fotheringham et al. 2011). In addition, the number of years a nurse had to be qualified before they were eligible to train as an ENP was also included in the study. Prior experience requirements were also widely different with 6% specifying no years up to 25% asking for 5 years post-registration experience (Fotheringham et al. 2011).

Overall, it is evident that there has been a demand for the ENP role in the vast majority of emergency departments in Scotland and current pressures on healthcare services would suggest that demand will only rise (Fotheringham et al. 2011 and The Scottish Government. 2022). The Fotheringham et al (2011) study underlines the extent of how unregulated minor injury nursing practice is and confirms that the ENP role has been introduced in the absence of an agreed standard. In the time since this paper was published, there is no evidence that this trend has changed. In terms of minor injury nursing education, how minor injury nurses are educated is overseen locally and based upon meeting local healthcare demand (Fotheringham et al. 2011, McConnell et al. 2013 and Dawood and Gamston, 2019). This appears to be the overarching reason why minor injury nursing has not developed in alignment with standards of advanced nursing practice (Bright et al. 2002, Fotheringham et al, 2011, Cooper, 2011, McConnell et al. 2013 and Dawood and Gamston. 2019).

1.6 Clinical background

Chapter two explores the literature on minor injury nursing practice and education. As the literature was reviewed and questioned using an interpretive hermeneutic approach, my clinical background is now presented to show how my prior experiences have influenced the interpretive line of inquiry.

My education and career in minor injury nursing started in 2009 after working for 2 years as a staff nurse in an urban Emergency Department that started its own nurse-led minor injuries service in 2000. I worked as an ENP in that department until 2015. In 2015, I was seconded to a rural MIU that worked under the same Health Board as the lead nurse practitioner. In line with published research in Scotland, it was evident that the department I had left and the department I joined had differences in title, pay band, scope of practice and education standards. Despite that, both departments were similar in their responsibility to provide a minor injury nursing service. An awareness of the differences surrounding the role existed from both experience of working in both departments and from an awareness of published literature within this area of practice having studied my MSc in advanced clinical practice.

After working in my new role in the rural MIU for some time and making comparison between my experience of the urban ENP role and my new role in the rural MIU, I could see differences in minor injury nursing education standards. I could see that there were differences in the length of education, depth of content, support for learning and mentorship and assessment process. I gained insight into these differences as the minor injury nurses from the rural MIU and I would share and demonstrate our learning experiences. We did that through daily practice in the rural MIU and it was evident that our different learning experiences had translated in to different levels of practice preparedness. This subsequently affected the quality of patient care that was delivered. Ultimately, varied levels of preparedness for practice meant that patient care standards were different despite working under the same health board.

There was a noticeable difference in educational preparation between the ENPs in the urban unit and the minor injury nurses in the rural units and I suspected that this manifested from having different educational experiences. I also questioned whether the differences in educational experiences were affecting how nurses experienced preparedness for minor injury

nursing practice. In addition, varying levels of practice preparedness had the potential to affect the quality of patient care being delivered. This acted as the driving force for me to undertake research that explores the experience of minor injury nurse education and how it prepares for minor injury nursing practice.

1.7 Chapter one summary

Nursing is changing to respond to healthcare demands but is approaching that change in a varied format, especially in terms of governance. For minor injuries nursing, the ENP role has emerged with an unregulated approach to minor injury nursing practice and education. In Scotland, it would appear that this impacts upon the progression of the role, the extent of the scope of practice, the education opportunities and the remuneration of the role. The unregulated approach may be necessary to meet local service needs. However, it remains unclear if it affects education experiences and practice outcomes, specifically practice preparedness.

Chapter two – literature review

This chapter will discuss how the methodology of hermeneutic phenomenology influenced how the literature review was undertaken. The purpose of a hermeneutic phenomenological literature review is to make the phenomenon more visible (Crowther et al. 2015). The researcher has to stay attuned to the literature, bringing their own horizons of understanding to the phenomenon (Crowther et al. 2015). To review hermeneutically is to question, remain engaged and to allow the phenomenon to be revealed. To identify appropriate literature, a search strategy was adopted and this process is discussed in this chapter. In engaging with the literature hermeneutically, I asked questions of the literature. These are presented with a synthesis of the findings. The synthesis then moves on to identify a gap in the research that led to the development of my research aim and questions.

2.1 The approach to the literature

Undertaking a review of literature in the grounded theory and phenomenological methodologies has been the subject of debate. Some argue that the literature review should be avoided entirely to prevent an influence on the research findings (Fry et al. 2017). In contrast, others argue, especially in a hermeneutic study, that a literature review supports the researcher in gaining a depth of understanding of the research area (Boell and Cecez-Kecmanovic 2010). In terms of my own research, a literature review was a key part of understanding where the gap in research was. In addition, a literature review was a requirement in the development of my doctoral thesis.

Hermeneutics is concerned with the process of interpretive understanding (Boell and Cecez-Kecmanovic 2010). Therefore, applying a hermeneutic framework to a literature review puts interpretation at the centre point of the review (Boell and Cecez-Kecmanovic 2010). Hermeneutic phenomenology sees that our understanding is embedded in the phenomenon and derived from past and current experiences (Smythe and Spence 2012). In the context of this research, my clinical background has led to many pre-conceptions that are developed from previous research and practice experiences. My lived experiences have shaped my understanding of minor injury nursing and will, in some way, affect my approach to and interpretation of the literature.

It is said that collective approach of past experiences, seeking new knowledge and developing new interpretations from literature guides a hermeneutic process of dwelling, thinking, pondering and questioning a phenomenon (Smythe and Spence 2012). A hermeneutic literature review needs a place of departure, an assumption (Crowther et al. 2014). For my research, my clinical background was that assumption and I assumed that preparedness for minor injury nursing practice was affected by education experiences. However, how minor injury nursing education and practice preparedness is experienced had remained unexplored and therefore concealed.

These assumptions lead to questions being asked of the literature (Crowther et al. 2014). The questions being asked of the literature were firstly: *How is practice preparedness conceptualised in minor injury nursing literature?* I wanted to immerse myself in the literature that explored minor injury nursing practice, to interpret the literature specifically to further understand more about practice preparedness in minor injury nursing. Secondly, I asked: *What is the role of minor injury nursing education within the context of practice preparedness?* Here, I wanted to explore further and go deeper in to how preparedness is experienced. Specifically, I wanted to understand how preparedness experiences could be influenced by minor injury nursing education.

Hermeneutics is well suited towards supporting the interpretation of research literature (Boell and Cecez-Kecmanovic 2010). In a hermeneutic literature review the focus is on provoking thinking, not on just telling a story, and on encouraging the reader to act as a partner in dialogue engaging in their own interpretation and understanding (Smythe and Spence 2012). To engage in the literature hermeneutically, I entered the hermeneutic circle of interpretation moving from the whole to the parts and back to the whole, which is a cyclical process that aims to improve understanding (Boell and Cecez-Kecmanovic 2010). Applying the hermeneutic approach to my literature review involved looking at the whole body of relevant literature on minor injury nursing. The whole body of literature consisted of individual texts (parts). The individual texts were reviewed by applying the questions to the literature and, the findings from each new paper contributed to the overall understanding. That cycle collectively led to a new overall interpretation (whole) (Boell and Cecez-Kecmanovic 2010).

The hermeneutic framework was an approach that helped to identify the majority of publications that were relevant to my research (Boell and Cecez-Kecmanovic 2014). One

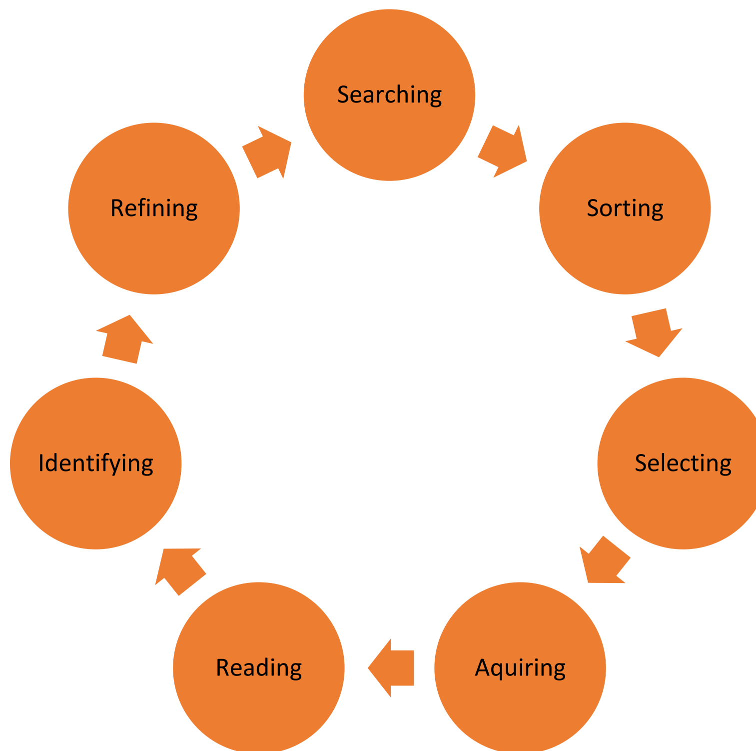
difficulty of entering the hermeneutic circle of interpretation is not knowing where the end point is within that cycle. As this research project has to achieve a sensible end point, the end point of the hermeneutic literature review was reached when any additional papers made only a marginal difference to further understanding of the phenomenon (Boell and Cecez-Kecmanovic 2014).

2.2 Search strategy

In order to identify the whole body of literature the following steps by Boell and Cecez-Kecmanovic (2010) were used as a search strategy (figure 1). The application of this search strategy supports a review of literature within the hermeneutic circle. This search strategy has different techniques that can facilitate further progress. The strategy maps out stages of searching for and reviewing literature in an organised manner. The strategy has the additional benefit of allowing shortcuts or feedback loops through the steps as individual searches dictate (Boell and Cecez-Kecmanovic 2010).

Figure 1 – Search strategy cycle

Adapted from (Boell and Cecez-Kecmanovic 2010).



2.2.1 Searching

The search for literature was undertaken in two phases using three key concepts that related to my research aim and questions: 1 - minor injury nursing. 2 - education and 3 - practice preparedness. The first phase of the literature search was initially undertaken using the following search terms in isolation, with similar terms combined with the operator "OR" to expand the search (Bramer et al. 2018): emergency nurse practitioner, ENP, minor injury nurs*, minor injury unit, MIU, emergency department, accident and emergency, minor injury nursing education and minor injury practice preparedness. The second phase was undertaken by using the operator "AND" (Bramer et al. 2018) to combine the results from three concepts to narrow the search to relevant literature. Electronic database sources were used in the search for literature; The Cochrane Library, CINAHL Complete, Health Source, Medline via EBSCO, Google Scholar, RCNi and, Internurse.

2.2.2 Sorting

The literature search was conducted using inclusion and exclusion criteria (Table 1). Searches were limited to literature published in English. No date restriction was applied to the search as the area of research is limited, therefore, all research was relevant to my overall understanding. Literature that looked at advanced nursing practice unrelated to minor injuries was not included as this was beyond the scope of the research. Literature that looked at minor injury practice without a nurse-led component to the study was also excluded. Searches that encompassed the search term emergency nurse practitioner and ENP brought a large number of results from international papers. Papers out with the UK and Ireland were excluded because the scope of practice for this title varies internationally and is different from the scope defined within the UK and Ireland. Internationally, the role of the ENP is known for practice that is not specific to minor injuries.

Table 1

Inclusion Criteria	Exclusion Criteria
• Published research literature in English language. • Relevant government policy. • No date restriction was applied to allow inclusion of literature that allowed understanding of the ENP/minor injury nurse role from inception to current developments. • Literature relating to nurse-led minor injury practice • Literature relating to UK/Ireland minor injury practice in all healthcare settings. • Articles that focused on the two questions being asked in the literature review were included.	• Literature published in non-English language. • Literature that reviewed advanced clinical practice in the general sense. i.e., not specific to minor injury practice. • Physician and/or non-nurse led minor injury practice. • International literature regarding the emergency nurse practitioner or minor injury nursing.

2.2.3 Selecting

After the search was undertaken (n=86) papers were identified. The titles and abstracts were examined to identify their relevance using the inclusion and exclusion criteria. From those, (n=57) papers were excluded as the majority were either international papers where ENP practice is not minor injury related or papers that did not encompass practice related to nurse-led minor injuries.

Applying the hermeneutic search strategy to the phenomenon under study (the whole), identified (n=29) articles that appeared to meet the inclusion criteria. Full texts of all (n=29) articles (the parts) were then individually reviewed. A further fifteen papers were excluded as they did not address the questions being asked of the literature, leaving (n=14) articles in the review. Some of the excluded articles provided a useful overview on minor injury nursing and these were used in chapter one.

2.2.4 Acquiring

Access to the full-texts of the included research articles was acquired through the university library services and personal subscriptions to professional journal archives. Where access via this method was unsuccessful, on one occasion, an email was sent to the author directly requesting access. No reply was received but access to the research article was eventually gained through subscribed professional archives.

2.2.5 Reading

Full texts of the 14 articles were examined to identify and extract information that could address the questions being asked of the literature.

How is practice preparedness conceptualised in minor injury nursing literature?

Questioning the literature in this way took me towards (n=11) research articles that looked at specific clinical skills that I used to conceptualise practice preparedness. The search revealed studies that specifically explore patient satisfaction. However, in their findings, they reveal the communication and interpersonal skills of ENPs (n=5). I also found studies that explored competence in clinical skills, often, by comparing minor injury practice competence across the health and medical professions (n=6)

What is the role of minor injury nursing education within the context of practice preparedness?

The second question then took me closer towards the phenomenon of preparedness following minor injury nursing education experiences. This revealed (n=3) research articles that consider the role of education in supporting minor injury nursing practice preparedness. In addition to answering the first question, (n=1) article was used in answering both questions.

2.2.6 Identifying

In reading the literature, the opportunity was also used to identify further pertinent literature. Scanning the reference lists of published literature helped to identify further relevant literature not highlighted in the initial search. This method is often used as published research pertinent to the area of interest is often based on previous research (Boell and Cecez-Kecmanovic 2010). However, using this method of identifying further literature will inevitably return literature that pre-dates the existing paper. When the findings of those previous studies provided no additional understanding, they were not included in the review as they were felt to only contribute marginally to the overall understanding of the phenomenon (Boell and Cecez-Kecmanovic 2010). In the context of this research this occurred predominantly in literature that reviewed the clinical competence of minor injury nurses.

2.2.7 Refining

The last phase of refining the search had largely been undertaken in the earlier stages of the search strategy (Boell and Cecez-Kecmanovic 2010). However, I remained aware of the key authors in identifying further relevant papers and additional search terms that may have helped identify further literature. In order to refine the search for relevant literature, the literature search was undertaken again after the findings were analysed and prior to completing the discussion chapter to determine if new publications had emerged during that time.

2.3 The hermeneutic phenomenological review of the literature

Reviewing the literature hermeneutically identified papers that I used to conceptualise practice preparedness and understand the role of education in the context of practice preparedness. This section of the literature review will begin with a brief overview of the included studies. The studies will be described in the following sections: interpersonal and communication skills, clinical competence and education.

2.3.1 Overview of included studies

Five studies undertook patient satisfaction surveys as an indicator of minor injury healthcare quality (Mabrook and Dale 1998, Byrne et al. 2000, Cooper at al. 2002, Sandhu et al. 2009 and McDevitt and Melby 2015). Three of the five studies were conducted in a nurse-led MIU (Mabrook and Dale 1998, Byrne et al. 2000 and McDevitt and Melby 2015). One of the five studies extended their exploration across three different clinical sites all with different models of emergency care, 1- traditional accident and emergency care (physician-led). 2- ENP-led care delivered in an MIU attached to a main physician led accident and emergency department. 3- Care delivered by ENPs in a nurse-led MIU (Byrne et al. 2000). Two of the five studies take a different approach and consider if there are differences in patient satisfaction levels with ENP-led or physician-led care (Cooper at al. 2002 and Sandhu et al. 2009). Although all five studies use the subjective perspective of their patient participants, two of the five studies consider the patient responses using methods intended to increase objectivity. Sandhu et al (2009) use a roter interaction analysis system in order to measure the quality of the consultation. McDevitt and Melby (2015) consider demographic and clinical variables that may have influenced the patient's responses for example, waiting times.

Six studies explore the clinical capability of ENPs (Meek, Kendal, and Freij. 1998, Sakr et al. 1999, Megahy and Lloyd. 2004, Ezra et al. 2005, Ball et al. 2007 and Thompson and Meskell. 2012). Five of the six studies compare the practice of ENPs with that of physicians (Meek, Kendal, and Freij. 1998, Sakr et al. 1999, Ezra et al. 2005, Ball et al. 2007 and Thompson and Meskell. 2012). Three of the six studies compare ENPs and SHOs only (Meek, Kendal, and Freij. 1998, Sakr et al. 1999 and Ezra et al. 2005) and two of the six studies extend that

comparison to ENPs and wider medical and health professional colleagues (Ball et al. 2007 and Thompson and Meskell. 2012). One study by Megahy and Lloyd (2004) took a different approach presenting a holistic overview of a new ENP service in a south Glasgow Hospital. One of the six studies explores ENP competence in ophthalmology care and offers more insight in to how education can support an increase in competent practice. On that basis, this paper is referred to in both section 2.4.2 and in section 2.5 (Ezra et al. 2005).

The literature that explored minor injury nursing education consisted of three studies (Ezra et al. 2005, Mason et al. 2005, and Neary 2014). The study by Ezra et al (2005) was outlined above. Two studies offer more exploration in to the effect of an educational intervention on competence (Mason et al. 2005 and Neary. 2014). Mason et al (2005) undertook a prospective study of 17 ENPs in an urban emergency department. The study undertook a pre-test of clinical competence, followed by an educational intervention to then re-test in order to determine competence changes. The third study by Neary (2014) was an evaluation of the impact an educational program had on ENP participants minor injury documentation skills.

2.4 Conceptualising preparedness

In health literature, many synonyms are used to describe preparedness for practice like competence, fitness for practice and suitability (Ottrey et al. 2021). In assessing competence, it must be viewed from a holistic perspective with understanding that competence can be measured across a wide combination of skills and practices (Taylor 2021). Practice preparedness, within a clinical role, is often conceptualised through technical skills that can include clinical skills such as patient assessment and communication and interpersonal skills (Ottrey et al. 2021).

Collins English Dictionary (2012) describe preparedness as a state of readiness. When exploring the concept of preparedness, the literature often underlines the concept in the context of being ready for disaster. Even within those discussions, conceptualising preparedness is challenging as there is understood to be a lack of terminological coherence with words such as readiness and planning both illustrative of preparedness (Staupe-Delgado and Kruke 2017). As preparedness is abstract and multifaceted it can be difficult to define (Staupe-Delgado and

Kruke 2017). This is true in the context of education preparedness and suggests that the aim should perhaps be to understand preparedness rather than conceptualise or define it (Bugford and Vance, 2014). In education, preparedness is used to assess the success of an educational intervention. Preparedness in education has many interpretations and is a co-construction between the student and the educators (Bugford and Vance, 2014). As preparedness is a complex phenomenon, the aim in research should perhaps be to explore it and try to understand preparedness rather than attempting to measure or quantify it. Preparedness may have various meanings to those who experience it.

When discussing practice preparedness, the minor injury nursing literature focussed on practitioners' competence in their clinical skill-set in real-world clinical settings. The studies explored competence in two broad areas, communication and interpersonal skills and minor injury practice clinical skills. The interpretation of that literature will now be presented in two sections. Firstly, preparedness surrounding communication and interpersonal skills and secondly, preparedness and clinical competence.

2.4.1 Preparedness – communication and interpersonal skills

Communication and interpersonal skills are an essential professional competency and an integral interaction between the health professional and the patient (O'Keefe 2001 and Boschma et al. 2010). For minor injury nursing, communication skills are a significant part of the role. Understanding how well minor injury nurses communicate in practice is useful for appreciating how prepared they are for that aspect of their practice. From that perspective, research that primarily explored patient satisfaction with minor injury nursing care was also useful for understanding how competent minor injury nurses are in communication and interpersonal skills (Mabrook and Dale 1998, Byrne et al. 2000, Cooper at al. 2002, Sandhu et al. 2009 and McDevitt and Melby 2015).

In terms of communication practices, skills now undertaken by minor injury nurses such as history taking and discussing a diagnosis would have been undertaken by a physician. Therefore, exploring how ENPs communicate in clinical practice is useful for understanding practice preparedness in that specific context. Five studies explore patient satisfaction with ENP minor injury care (Mabrook and Dale 1998, Byrne et al. 2000, Cooper at al. 2002, Sandhu

et al. 2009 and McDevitt and Melby 2015). These studies collectively explore the effectiveness, the quality and patient satisfaction with minor injuries care delivered by ENPs. Each study is approached using different methodologies and undertaken from different perspectives providing a broad overview on how ENPs communicate in their daily practice (Mabrook and Dale 1998, Byrne et al. 2000, Cooper at al. 2002, Sandhu et al. 2009 and McDevitt and Melby 2015).

In terms of similarities between the five studies, patient satisfaction is explored specifically in two of the five studies (Mabrook and Dale 1998 and McDevitt and Melby 2015). Both of the studies recognise that ENP-led services are seen as part of the solution for the demands on emergency and unscheduled care services and both utilise the views of patients who have presented with a minor injury, to determine the quality of care delivered by ENPs. Exploring patient satisfaction continues in the third study but with consideration of the impact different healthcare setting may have on the quality and effectiveness of minor injuries care. Byrne et al (2000) expand perspective by undertaking a comparative study that explored three models of care, 1- traditional accident and emergency care (physician-led). 2- ENP-led care delivered in an MIU attached to a main physician led accident and emergency department. 3- Care delivered by ENPs in a nurse-led MIU. The two remaining studies by Cooper et al (2000) and Sandhu et al (2009) again explore patient satisfaction but also adopt a comparative approach in their studies and undertake a direct and clear comparison of the practice between ENPs and physicians. In terms of the grades of physicians, Sandhu et al (2009) extend that comparison to include SHOs, registrars and GPs, whereas the Cooper et al (2002) study compare ENPs with SHOs only.

In terms of findings, common themes across all of these five studies are that ENPs provide high quality and effective minor injury care. These findings are evidenced by exploring levels of patient satisfaction, by considering if different healthcare settings have an impact on care quality and by comparing ENP practice with physicians (Mabrook and Dale 1998, Byrne et al. 2000, Cooper at al. 2002, Sandhu et al. 2009 and McDevitt and Melby 2015). In exploring patient satisfaction with ENP-led care. Mabrook and Dale (1998) undertook a patient satisfaction survey and found that 263 of 269 patients were satisfied with the care ENPs delivered. The most recent study that also utilised that approach by McDevitt and Melby (2015)

show that this perspective has continued as ENP-led care is consistently perceived as high by patients. Expanding perspective by considering the possible impact specific healthcare settings may have on patient satisfaction with minor injuries care, Byrne et al (2000) found that patients were substantially more satisfied with care delivered in the ENP-led units. However, it is worth noting that satisfaction levels were still high with the other models of care. In the studies that compare ENP and physician practice, from the perspective of the patient, ENPs were viewed favourably in comparison to their medical counterparts in both studies (Cooper et al. 2002 and Sandhu et al. 2009).

Despite the general agreement that ENPs provide high quality and effective minor injury care, the reliability of the findings in these studies can be challenged when explored further. For example, the earliest study by Mabrook and Dale (1998) is entirely descriptive in presenting how patients perceive the communication skills of ENPs which lacks a depth of understanding beyond the subjective view of the patients. Gaining more depth and offering more perspective, McDevitt and Melby (2015) undertook a retrospective review of the case notes of the patient participants who undertook their satisfaction questionnaire. This additional analysis gives more understanding as they have outlined and explored the demographic and clinical variables that may have influenced the patient's responses and perception of care like department waiting times. For the Byrne et al (2000) study, ENP-led care was found to be perceived as higher quality in comparison to other models of emergency care delivery. The Byrne et al (2000) study was the only study to extend their research beyond one study site which was useful for considering contextual influences on care quality. However, as the ENPs in the study were involved in distributing the pilot questionnaire, the ENP participants may have adjusted their approach in the study. This awareness could have then altered how patients experienced the consultation which suggests an element of bias. In terms of objectivity, the Sadhu et al (2009) study stands aside from the other studies by using a roter interaction analysis system in order to measure the quality of the consultation. On one hand, Sandhu et al (2009) claim a more objective conclusion by explaining that a later review of the recorded consultations found no difference in consultation quality between ENPs and physicians, despite the patients perceiving the ENP consultations as higher quality. However, on the other hand they also explain that all of the participants were aware of being recorded during the consultation. With that awareness, adjustments in consultation approach could have played a part. Therefore, the level of objectivity they claim to achieve may not be entirely reliable.

In exploring what shaped the patients' experiences in these studies, the perceived value with ENP-led care appears to lie with how minor injury nurses communicate to the patient regarding their injury. All of the studies concluded this similar finding. They all showed that in particular, detailed injury and discharge advice is highlighted as an indicator of quality care (Mabrook and Dale 1998, Byrne et al. 2000, Sandhu et al. (2009) and McDevitt and Melby. 2015). If levels of patient satisfaction can reliably represent how skilled minor injury nurses are in communicating with patients it appears that minor injury nurses are particularly well prepared for this aspect of their clinical practice. This finding is highly relevant for clinical practice as being skilled in communication and interpersonal skills is necessary as it can enhance the overall patient experience and, these interactions are associated with positive health outcomes and adherence to prescribed treatment (O'Keefe 2001, Saaranen et al. 2015 and Feo et al. 2017).

Despite the variances in the approach these studies took and the potential debate surrounding objectivity, all five studies combine to infer a key message that is relevant in the context of this research. The findings highlight that minor injury nurses are prepared and skilled in the context of communication and interpersonal skills (Mabrook and Dale 1998, Byrne et al. 2000, Cooper at al. 2002, Sandhu et al. 2009 and McDevitt and Melby 2015). Reviewing these studies highlighted that ENPs can communicate effectively in practice and they outlined why that is significant. The studies did not however, indicate why or how they were prepared to practice that specific skill. Sandhu et al (2009) do suggest that minor injury nurses may have an approach to their practice that medical counterparts may not have. That approach is one of enthusiasm and engagement with their field of practice. What Sandhu et al (2009) appear to mean is that doctors may be more invested in treating patient presentations of higher acuity and therefore not so invested in the whole experience of caring for patients with a minor injury. Although that is a possibility, this is a suggestion based on the clinical experience of the authors and is not supported by study evidence. Although this is only suggested, it does point to the fact that minor injury nurses are already experienced nurses and may already be skilled in communication and interpersonal skills. Nurses have always been an active part of discharge advice and health promotion and this may be indicative of why they scored high in that particular area of patient care. The accomplished skills seen in these studies may be related to the experience nurses have in communicating with patients, rather than any specific education

related to minor injuries nursing. Despite possibilities, it remains unclear from these studies what contributed to minor injury nurses developing the skillset that was seen in the findings.

2.4.2 Preparedness – clinical competence

Clinical practice competency standards are agreed professional standards that are a measurable method of assessing ability in specific work-related tasks and they assess the ability of a person to fulfil their nursing role adequately (Cairns 2000 and Ramitru and Barnard 2001). Within minor injury nursing research, a number of studies research the clinical competence standards of ENPs (Meek, Kendal, and Freij 1998, Sakr et al. 1999, Megahy and Lloyd 2004, Ezra et al. 2005, Ball et al. 2007 and Thompson and Meskell 2012). Overall, these studies highlight the legitimacy of the ENP role, revealing a competent workforce within the samples they researched (Meek, Kendal, and Freij 1998, Sakr et al. 1999, Megahy and Lloyd 2004, Ezra et al. 2005, Ball et al. 2007 and Thompson and Meskell 2012).

All six studies explored in this part of the review use clinical skills that represent a minor injuries scope of practice to base their analysis (Meek, Kendal, and Freij. 1998, Sakr et al. 1999, Megahy and Lloyd 2004, Ezra et al. 2005, Ball et al. 2007 and Thompson and Meskell. 2012). The key strength of that approach is an ability to demonstrate that minor injury nurses can be prepared for clinical minor injury nursing practice.

In terms of similarities between all of the studies, x-ray interpretation is the most widely researched clinical skill across all six studies. As the scope of practice in minor injuries is largely focussed on musculoskeletal injuries, this specific skill broadly represents a large proportion of the skill level expected of a minor injury nurse. In general, the studies collectively conclude that ENPs are clinically competent and prepared for clinical practice. To determine that, some studies explore x-ray interpretation skills by comparing x-ray interpretation skills of ENPs and physicians (Meek, Kendal, and Freij 1998, Sakr et al. 1999, Ezra et al. 2005, Ball et al. 2007 and Thompson and Meskell 2012). As undertaken in the Cooper et al (2002) and Sandhu et (2009) studies, comparing minor injury nurse practice with the practice of medical counterparts is commonly used in this field of research (Meek, Kendal, and Freij 1998, Sakr et al. 1999, Ezra et al. 2005, Ball et al. 2007 and Thompson and Meskell 2012). Comparing both professionals provides researchers with a competence baseline to refer to as many of the

clinical skills that are now seen as minor injury nursing practice were traditionally undertaken by physicians.

Although x-ray interpretation skills represent a large proportion of the skill level expected of a minor injury nurse, a number of the studies broaden perspective into wider ENP clinical skills and capabilities using varied approaches that offer more perspective. Two of the six studies retrospectively audit emergency department case notes to explore ENPs and physicians' skills in x-ray interpretation and in the pain management of patients (Ball et al. 2007 and Thompson and Meskell. 2012). Sakr et al (1999) also use ENPs and physicians as a method of comparing clinical skills, however, their study design ensures a more thorough evaluation by utilising a broader scope of clinical minor injuries practice in their exploration. One study by Megahy and Lloyd (2004) is intended as a service review of a new ENP service in South Glasgow. Although it is a small study that is specific to one clinical site, it is useful for highlighting the value of a new ENP-led minor injuries service. A study by Ezra et al (2005) follows the common approach of exploring and comparing the competence of ENPs and SHOs. However, Ezra et al (2005) compare ENP and SHO competence in assessing ophthalmic presentations which unlike x-ray interpretation, only represents 6% of emergency department presentations (Ezra et al. 2005).

In terms of relevance, each of the studies are clinically relevant as they emphasise the evolving role of ENPs in emergency care and to varying levels, showcase the ability of ENPs to undertake clinical practices with competence and capability. These findings are underscored by evidence that ENPs perform as well as, if not better, than other healthcare practitioners (Meek, Kendal, and Freij. 1998, Sakr et al. 1999, Megahy and Lloyd 2004, Ezra et al. 2005, Ball et al. 2007 and Thompson and Meskell. 2012). Although useful for showcasing the competence of ENPs, consistently, there is little exploration within these studies that considers what supports competent practice. For example, although Meek, Kendal, and Freij (1998) state that experience was shown to increase competency across all of their study participants more so than education, specific contextual details are absent so the significance of this can only be implied. The ENP participants in the Meek, Kendal, and Freij (1998) study demonstrated a good depth of knowledge and skill. Used within that study were minor injury related x-rays that had complexities within the radiographs (normal variants). To interpret those x-rays would have challenged the ENP participants' depth of skill in detecting what was clinically significant. However, the understanding gained in that context is limited. In the absence of

more perspective on education and experience, acknowledging how competence was achieved is restricted. Furthermore, any understanding is limited to the practices and education of the clinician group from the specific clinical area sampled as the Meek, Kendal, and Freij (1998) study was conducted on one study site. This is a theme that continues across other studies with Sakr et al (1999) and Megahy and Lloyd (2004) both stating that good ENP education resulted in the high standards of clinical practice their studies found. However, again, there is little contextual understanding offered in either study and no exploration that would emphasise this correlation. The only study to detail the content of ENP education courses was the study by Sakr et al (1999). Although more context is offered in terms of education for that specific study site, there is no direct correlation with the findings so the depth of understanding is restricted. A little more context is presented by Ezra et al (2005) who demonstrated that their ENP participants were significantly more competent than the SHO participants in assessing ophthalmic injuries. In drawing conclusions, they suggest that it is likely due to the ENPs having had experiential learning sessions within an ophthalmology clinic. Although an understandable correlation, again, it is not explored with specific detail to allow further understanding.

One notable similarity across all studies is how ENPs are clinically competent in interpreting x-rays. Despite the consistently high levels of competence in x-ray interpretation, there are other areas of practice that do not achieve that same consistency. Two studies highlighted a specific area of clinical practice where the ENPs were found to be less competent. In looking at pain management specifically, Ball et al (2007) found that the ENP group were less likely to give analgesia and more likely to use structural support (bandages/strapping) than their medical counterparts as a form of pain relief. Similarly, Thompson and Meskell (2012) found that their ENP group only had an "awareness" of pain management, suggesting that ENPs were not as skilled or as willing in administering analgesia as some of their medical counterparts. Given that the context of practice of minor injuries is related to physical trauma and experiences of pain, this finding is highly clinically relevant. These studies imply that ENPs may be less competent in pain management. However, these findings should be considered within the context of the methods used in each study. It is worth emphasising that the Ball et al (2007) study was a retrospective review of notes, it could be argued that pain management consulting may have taken place but may not have been documented. In addition, during the Thompson and Meskell (2012) study, the data allocated to one of the physician groups was not analysed

due to human error so the results from a comparative perspective in their study may not be reliable.

Overall, the studies on clinical competence legitimise the role of the ENP in emergency care. They show that ENPs are competent in the care and practices associated with minor injuries care and they emphasise that by demonstrating and comparing their competence levels with other healthcare practitioners. Despite the insight gained from these studies on clinical practice preparedness, all of the 11 studies that explore communication and interpersonal skills and clinical competence do not delve in to what supports the level of competence their findings demonstrate (Meek, Kendal, and Freij. 1998, Mabrook and Dale. 1998, Sakr et al. 1999, Byrne et al. 2000, Cooper at al. 2002, Megahy and Lloyd 2004, Ezra et al. 2005, Ball et al. 2007, Sandhu et al. 2009, Thompson and Meskell. 2012 and McDevitt and Melby. 2015). Overall, what these studies can conclude is a means of conceptualising practice preparedness in minor injury nursing skills. Out with that they lead to more questions being asked regarding how practice preparedness is achieved and what role education plays within that context.

2.5 The role of education in supporting practice preparedness

A consensus in literature is that a better understanding of what prepares for clinical practice would reduce the negative outcomes of not being prepared for practice (Dijkstra et al. 2015, Dijkstra et al. 2017 and Woods et al. 2015). For nurse practitioners who are new to their role, experiencing feelings of being overwhelmed and inadequately prepared for practice is not an uncommon phenomenon (Hart 2016). The literature review so far has revealed that minor injury nurses possess the necessary skills for many aspects of their clinical practice.

Studies that explore the key role of educational opportunities reveal that this can move students forward in terms of competent practice (Mason et al. 2005, Ezra et al. 2005, and Neary 2014). Drawing similar conclusions to the study by Ezra et al (2005) that explored competence in ophthalmic practice, Mason et al (2005) and Neary (2014) found that certain practice-focused educational experiences can determine a marked improvement in practice preparedness. Mason et al (2005) undertook a prospective study of 17 ENPs in an urban emergency department. The study design involved a pre-test of competence to determine a baseline, followed up with an

educational intervention with subsequent re-testing to determine if the educational intervention had improved competence levels. The competence tests were Observed Structured Clinical Examinations (OSCEs) and were developed and validated by senior clinicians involved in clinical education. The findings from this study showed that competence levels at re-test had improved in communication, clinical skills, knowledge and intention with statistically significant improvements in overall performance from the initial baseline and follow-up OSCE assessments. It was evident that students had responded well to the initial awareness the baseline OSCE had offered in terms of their competence levels. Moreover, the follow-up OSCE was shown to drive students forward in engaging with the educational intervention to motivate them towards learning and development.

Neary (2014) followed students through their ENP education and explored their development in undertaking clinical documentation and also found that educational opportunities can support improvements in competence. An understanding of the role of experiential learning became evident as the students improved by gaining clinical experience through their learning journey (Neary 2014). Although this study is specific to one skill-set the findings are relevant as skilled documentation is a requirement for the patient care communication and legal aspects of the minor injury nurse role. Both the Mason et al (2005) and the Neary (2014) studies are useful for considering the role of specific educational opportunities and how they support competent practice. However, it is worth noting that the Neary (2014) study was conducted with a relatively small sample size (n=10) and the participants had studied the same ENP course. Similarly, the Mason et al (2005) study was also conducted on one study site so the understanding gained from these studies is only specific to the practice and education undertaken in their study sites. The findings are not reflective of the diversity that exists in ENP practice and education. Moreover, neither study explored all of the learning experiences the participants had in their ENP education. Therefore, it is difficult to determine how proportionate their specific learning opportunities and other methods of ENP education were in supporting the ENP competence.

Nonetheless, this small body of evidence infers that educational opportunities can improve competence in minor injury nursing (Ezra et al. 2005, Mason et al. 2005 and Neary 2014). In the early years of the ENP role, Tye (1997) recognised that the role was developing at pace. In recognising this he suggested that the role needed a structured approach to education. However, the role emerged quickly and regulation did not follow (Tye 1997). The need for a fast-paced

approach to implementing minor injury nursing services appears to occur for several reasons but mainly relate to organisational factors such as cost, staffing issues and local patient demand and needs (Bright et al. 2002 and Dawood and Gamston 2019). The interpretation of the literature that was used to conceptualise practice preparedness and consider the role of education in practice preparedness showed that competence is achievable and that education can support competence. However, it is unclear if the unregulated approach to education is having an impact on practice preparedness.

The unregulated approach to minor injury nursing education was studied by Marsden (2003) who found that this may mean that courses exist at a standard that does not prepare nurses for minor injury nursing practice. Marsden (2003) recognised that there is a lack of consensus within the UK regarding ENP education standards and her research was significant as it highlighted a number of key issues. Marsden (2003) undertook her study at an emergency nursing conference. In her two-part questionnaire, she probes the perception of educational preparation following different ENP courses by distributing questionnaires to 400 delegates at an emergency nursing conference. The aim of her study was to firstly establish the type of minor injury nursing education undertaken, then gain a deeper perspective on how participants perceived their course related to and supported practice. Of the 400 questionnaires distributed, only 38 were returned or partially returned, exact numbers are not detailed but the questionnaire consisted of questions that could stand alone so all questionnaires partially completed were still appropriate to include in the analysis. All participants were involved in minor injury nursing and all were employed in an unscheduled care setting. All participants had undertaken some form of minor injury nursing education and the findings in the Marsden (2003) study reflected the UK trend of fragmented education courses.

Marsden (2003) reported that several participants felt their course enhanced their learning, particularly in examination and diagnostic skills, providing a logical framework for examination and awareness of practice issues such as accountability. However, most participants also felt the courses were too short and learning time could have been increased. Marsden (2003) also found evidence that certain courses may not be preparing ENPs for clinical practice. Overall, (n=23) participants felt prepared, six did not and four had reservations. Of the respondents who reported feeling less prepared, all had undertaken courses with limited clinical practice education, suggesting this was the cause of a lack of preparedness

for practice. Marsden (2003) suggests a lack of preparedness is associated with "in-house" training programmes.

Despite the insight this study offered, it is noteworthy to mention that this was a small study, with a low response rate and, one that does not offer a rigorous analysis that can be generalised to the broader context of practice (Marsden 2003). In addition, the responses were mostly quantified and not subject to further exploration or in-depth explanation so it is difficult to understand the nature of educational experiences, the specific components that were found helpful or unhelpful and their impact on preparedness. Despite some limitations, this study is still the most influential paper within this literature review for a number of reasons. From an education perspective, Marsden (2003) starts by underlining the national variations in ENP education. From there, she emphasises the lack of structured guidance on education and the implications this has. Marsden (2003) also emphasises a need for formal ENP education and from a legal perspective she considers how the current approach has professional legal implications through a lack of practice prepared ENPs. From a clinical practice perspective, Marsden (2003) then presents findings that have significant implications for clinical practice. The most notable finding in that context is that a number of ENPs did not feel prepared to practice. The potential impact of this upon patient care and safety although not explored directly are potentially significant. In terms of research implications, Marsden (2003) acknowledged that there is no central register of ENP education, arguing that this shows that ENP education is poorly understood. The lack of understanding exists because of a lack of comprehensive studies that explore ENP education (Marsden 2003). These findings combine to inform my aim and methodological approach. There is a depth of understanding missing because of a gap in this field of research. The Marsden (2003) and indeed many of the papers explored do not explore the lived experience of practice preparedness or explore minor injury nursing education. Without an in-depth exploration, it is difficult to fully grasp the phenomenon of minor injury nursing education and practice preparedness experiences.

2.6 Chapter two summary

Engaging with and questioning the literature has led to a developed understanding of the phenomenon under study. To summarise, it appears that ENP led care can be delivered safely and effectively (Meek, Kendal, and Freij 1998, Sakr et al. 1999, Ball et al. 2007 and Thompson and Meskell 2012), with high levels of patient satisfaction (Mabrook and Dale 1998, Byrne et al. 2000, Cooper et al. 2002, Sandhu et al. 2009 and McDevitt and Melby 2015), all of which allow a conceptualisation of minor injury nursing practice preparedness. It was implied that delivering safe and effective minor injury care can only follow from an adequate education, but again, that was not a conclusive finding (Sakr et al. 1999 and Megahy and Lloyd 2004). In terms of education, it was evident that educational experiences can support practice preparedness (Mason et al. 2005, Ezra et al. 2005, and Neary 2014). However, this was not explored with in-depth, experience-based descriptions. Marsden (2003) offers more insight in to the phenomenon of minor injury nursing education, suggesting that the fragmented and unregulated approach to minor injury nursing education may mean that preparedness for practice is not achieved. However, in that, there is no unpacking of those experiences and perceptions surrounding preparedness. Therefore, there is a gap in the research, as we do not gain a depth of understanding in to the experiences of undertaking minor injury nursing education and how education affects practice preparedness experiences. Having reviewed, questioned and critiqued the literature included in this hermeneutic literature review (the parts) and gained a wider, overall understanding of minor injury nursing research (the whole) I could see that there was a gap in this field of research.

2.7 The need for further research

The literature review has revealed a gap in minor injury nursing research. No previous research has undertaken an in-depth exploration into the lived experience of minor injury nursing education. No research has opted to look at the experience of undertaking different minor injury nursing education courses and consider the learning experiences within that context and how they relate to practice preparedness.

2.8 Research aim

The review of the literature and my experiences related to my clinical background within the field of minor injury nursing combined to inform and shape my research aim and questions. This study aimed to explore the experiences of nurses who had undertaken minor injury nursing education and to explore how they experienced preparedness for practice following minor injury nursing education. My research also aimed to address the following questions:

2.9 Research questions

- How do minor injury nurses experience minor injury nursing education?
- How do minor injury nurses experience preparedness for minor injury nursing practice following minor injury nursing education?

Chapter three - methodology and methods

3.1 Introduction

My research study aimed to explore the experiences of nurses who had undertaken minor injury nursing education and to explore how they experienced preparedness for practice. My prior clinical experiences and the literature review collectively informed the aim of my research. Together, my background, the gap in the literature and my research aim were the main determinants of choosing a qualitative approach. This study aimed to address the following research questions:

- How do minor injury nurses experience minor injury nursing education?
- How do minor injury nurses experience preparedness for minor injury nursing practice following minor injury nursing education?

In the following chapter, the philosophy, methodology and methods are explored. The line of inquiry is discussed and other possible methodologies considered. To follow, phenomenology is introduced to include a history of phenomenology, the philosophical underpinnings, a justification for using hermeneutic phenomenology and an overview of hermeneutic phenomenological philosophical concepts that are used throughout the research. I then lay out my pre-understandings before introducing the hermeneutic circle. Benner's (1984) theoretical framework is then presented including a discussion surrounding how it informs this research. Included in this chapter are examples of nursing education research that used hermeneutic phenomenology underpinned by Benner's (1984) theoretical framework. The objective of that is to demonstrate the value of this approach for nursing research. To follow, I outline the methods used to undertake my research.

The methodological approach was informed by a number of combining factors and my thinking developed in the following way: From a practice perspective, I observed that my wider minor injury nursing colleagues had different educational preparation experiences. Interactions with them stimulated my thinking about the phenomenon of minor injury nursing education and I started to consider the different educational preparation experiences of my colleagues. From an education perspective, I also reflected upon my own experience of minor injury nursing education and preparedness for practice experiences. My perspective at that stage was more

than simply observing the phenomenon. Through my own experiences and active involvement in minor injury nursing and education, I was an integral part of the phenomenon. Therefore, I knew that these experiences were likely to be an integral part of the research process. My experiences at the outset led me towards the literature which subsequently alerted me to a gap in this field of research. I found that no previous research had undertaken an in-depth exploration of the lived experiences of educational preparation for the minor injury nurse role. These experiences were part of a whole, a phenomenon in which I was situated within and this was influential in directing me towards this research. From a philosophical perspective, I assumed that the phenomena I wanted to explore could be answered using a constructivist approach, where the world is perceived as socially constructed and it is interpreted by individuals in their interactions (Tuli 2010). In health research, when an in-depth understanding of participant perspectives and experiences is required, qualitative approaches are often the most suited methodological choice (Squires and Dorsen 2018). As the educational preparation experiences of minor injury nurses involves in-depth lived and contextual experiences, this suggested that my approach would not be amenable to a quantitative approach.

3.2 Considering a quantitative or mixed methods methodology

There were a number of reasons for not following a quantitative or mixed-methods methodology. From the perspective of a quantitative approach, it was evident that this approach was unsuitable which was concluded for two reasons. Firstly, my research was not looking to compare or assess the effectiveness of an intervention (Seers and Critleton 2001 and Khalid et al. 2012). And, secondly, as my research is an area that is largely unexplored, a hypothesis could not be formed on which to base new research (Holt 2009 and Rutberg and Bouikidis 2018). Although I concluded that a quantitative approach was unsuitable as a methodology alone, I did consider the strength of a quantitative approach within a mixed-methods methodology. In discussion with my doctoral supervisors, it was highlighted that a mixed-methods approach could offer strength in exploring a phenomenon. For my research, that could have involved a first phase quantitative exploration, for example, by survey or focus groups to support a second-phase qualitative exploration. In the context of my own research area, I could see the strength this approach would have offered. However, having undertaken a review of existing research and knowing where the gap in research was, I concluded that a qualitative methodology alone was the most suitable approach. Marsden (2003) has already surveyed

minor injury nurses on their perceived levels of practice preparedness following minor injury nursing education. Her quantitative approach concluded that courses exist without an agreed standard and result in varied practice preparedness levels. Having already been studied, undertaking another quantitative exploration of this phenomenon, in my opinion, would add little to this area of existing research. I acknowledge that the Marsden (2003) findings are outdated. However, more recent studies have shown that the fragmented approach to education she explored has not changed in the time frame since that study (Fotheringham et al. 2011 and Dawood and Gamston 2019). On that basis, the findings remained pertinent in supporting my research decisions. Having identified that specific gap in research, my research aim could be achieved by using a qualitative approach alone (Edmonds 2010 and Doody and Bailey 2016).

3.3 Choosing a qualitative approach

Nursing research is a systematic inquiry designed to develop evidence surrounding topics pertinent to nursing such as education and clinical practice (Routberg and Bouikidis 2018). For my research, qualitative methodologies were considered the most suitable to facilitate and guide my study. Orientation to the methodologies typically available in qualitative research supported an informed decision about which methodology was most appropriate for achieving the research aim (Dew 2007). However, navigating through possible qualitative methodologies was challenging as many are identified, the extent of available methodologies appears to vary greatly (Bailey 1997, Salvador 2016 and Squires and Dorsen 2018).

For the qualitative health researcher, Dew (2007) states that the methodologies typically available are grounded theory, discourse analysis, ethnography, ethnomethodology, action research and phenomenology. Grounded theory works inductively with the data, using a systematic and comparative method of analysis to understand patterns of social process to generate a theory (Urcia 2021). Discourse analysis focuses on the features of language and draws meaning from that within the social context. Ethnography is undertaken in a cultural context and attempts to understand cultural beliefs and understanding. Ethnomethodology looks at how social order is produced and lastly, action research, looks to taking an action and subsequently researches the outcomes of that action (Dew 2007, McNiff 2013 and O'Gorman 2013).

Although I was initially drawn to phenomenology, it was evident that grounded theory also aims to illuminate individual experiences in seeking to understand phenomena (Gelling 2011). That premise made choosing between phenomenology and grounded theory a difficult decision. Donalek (2004) argues that the same phenomenon can be studied by using many of the qualitative methodologies. The blurred boundaries between qualitative methodologies such as phenomenology and grounded theory can make choosing a methodology particularly difficult (Baker et al. 1992 and Burns et al. 2022). The choice between grounded theory and phenomenology can be perceived as challenging for several reasons. Both are inductive, follow similar steps, are not philosophically contradictory and delve in to the meaning behind an experience. Collectively, this makes them both similar and useful for health research (Masoodi, 2017, Chance et al. 2020 and Burns et al. 2022). It was clear that both methodologies lend themselves to exploring a phenomenon. Nonetheless, Gill (2020) suggests that reaching a decision between grounded theory and phenomenology is straightforward. To achieve this, a researcher must decide if they want to provide an account of a lived experience or generate a theory (Gill 2020). As grounded theory is more focused on generating a theory and less concerned with capturing the meaning or essence of an experience (Kompa 2008), phenomenology was chosen as the research methodology for my research. I was further reassured that phenomenology was more suitable as it looks to enhance comprehension of the meanings of experience (Burns et al. 2022), and is particularly useful for researching a phenomenon that is poorly understood (Reiners 2012 and Burns et al. 2022)

3.4 Phenomenology

Phenomenology is a philosophical movement that originated in the 20th century (Mabaquiao 2005) and is described as a philosophic attitude and research approach (Flood 2007). Rooted in philosophy, phenomenology is inextricably linked to the exploration of experience, by examining and exploring experience, we can further understand how it is lived (Dahlstrom 2010, Van Manen. 2016, Neubauer et al. 2019).

3.5 History of Phenomenology

Historically, phenomenology can be traced back to the German philosopher Edmund Husserl (1859-1938), whose goal was to make philosophy worthy of the title “the most rigorous science” (Lauer 1965 p8). Husserl’s work suggested that exploring the essence of human phenomenon should take a descriptive approach (Frechette et al. 2020). Husserl argued that the lived experiences of others can develop a rich understanding of human lived experiences (Mapp 2008 and Frechette et al. 2020). Husserl (1859-1938) is known as the grandfather of phenomenology, and various philosophers have adapted his philosophy over the years. Post Husserlian phenomenologists have both critiqued and given merit to his philosophy (Ohlen and Friberg 2023). The most notable to follow on from Husserl’s philosophy are Heidegger, Gadamer, Ricoeur, Schultz and Satre (Ohlen and Friberg 2023). Reading about phenomenology can be challenging, with those new to the subject struggling to grasp how the philosophy informs research (Dowling and Cooney 2012). In order to understand phenomenology, it is necessary to acknowledge that there are two primary branches of phenomenology, that have two different philosophical schools of thought - Descriptive (Husserlian) and Interpretive following hermeneutic (Heideggerian) phenomenology (Dowling and Cooney 2012, Neubauer et al. 2019, Frechette et al. 2020).

3.6 Philosophical underpinnings

Edmund Husserl believed that phenomenology is the philosophical study of experience (Armstrong 2005). As a philosophical method, Husserl describes phenomenology as a process where presuppositions are set aside. Once this process is undertaken, Husserl believed that one arrives at knowledge that is clear or “apodictically” certain (Mabaquiao 2005). This objective stance is described as bracketing by Zahavi (2003) and called epoche or phenomenological reduction in descriptive phenomenology (Morley 2010). The bracketing of presuppositions takes place within the framework of the relationship between consciousness and the objects towards which the consciousness is directed. Husserl claimed that by being conscious *of* something, we are conscious *towards* something “directedness” (Zahavi 2003). Husserl describes this as “intentionality”. Human experiences are directed towards objects or phenomena and that interaction between consciousness and the world is required to understand the essence of human perception (Zahavi 2003). Husserl believed that we are drawn into a way

of knowing through perceptible things "the things themselves". Understanding "the things themselves" means getting to the essence of the lived experience (Dibley et al. 2020)

Hermeneutic phenomenology (meaning interpretive) is based on the work of Martin Heidegger, who was a student of Husserl. Hermeneutics is termed as the study of methods of interpretation. Hermeneutics was originally the study of scripture and other texts, but has broadened to any form of human actions amenable to understanding (Cammell 2014). Phenomenology is described as being the study of one's immediate perceptions and lived experiences (Cammell 2014). Heidegger moved beyond describing the essences of phenomena, towards looking for the meaning within everyday lived experiences. For Heidegger, the Husserlian themes of consciousness and perception were rejected for interpretation that has both fore-structures (presuppositions) and as-structure (meaning) (Johnson 2001). Interpretive phenomenology aims to uncover a phenomenon by pulling away layers of forgetfulness or hiddenness that exist and are present in human everyday existence (Frechette et al. 2020). For Heidegger, a phenomenon can only be uncovered ontologically through "dasein" meaning existence (Frechette et al. 2020). Heidegger believed that we are already immersed in our world, we exist (being there) and constantly interpret our surroundings (dasein). Heidegger believed that dasein was always already situated within a context "being in the world" meaning human existence is not detached or isolated, but embedded in a world of interaction and experiences. (Miles et al. 2013). This existential perspective meant that Heidegger (1962) diverged from Husserl's notion of setting aside prior experiences or pre-suppositions (bracketing) in phenomenology (Eddles-Hirsch 2015). When used to inform research, Heidegger's phenomenological perspective means that the researcher's contribution in interpreting data cannot be ignored, claiming it is an essential part of the research process (Eddles-Hirsch 2015).

3.7 Justification for using Hermeneutic Phenomenology

Within nursing research, hermeneutic phenomenology is ideally situated in nursing as there is often a necessity to understand the experience of others (Wilson 2015 and Johnston et al. 2017). Hermeneutic phenomenology supports the researcher in bringing their ideas and concepts to the research and to interpret or enhance the data (Mapp 2008). Wilson (2015) advocates hermeneutic phenomenology as a robust methodology for qualitative nursing research and,

argues that, by way of their education, training, and experience, nurse researchers are deeply involved and imbedded in the environment or context in which they study.

Bracketing, would involve the suspension of these prior experiences (Frykman 2004). It is argued that bracketing one's thoughts and experience can allow for the data to be constructed without the prior assumptions of the researcher (Hamil and Sinclair 2010). A key feature of bracketing is that it allows the phenomenon to be viewed with a fresh eye, to see its true essence or key characteristics (McNarry et al. 2019). However, others argue that bracketing can be particularly challenging, suggesting that detachment from one's prior life experiences is impossible (Gregory 2019). Moreover, some view the inclusion of preconceptions from lived experiences as legitimate components in developing an in-depth understanding of the lived experience of others (McConnell-Henry et al. 2009 and Wilson 2015). In discussion with my supervisors, it was decided that hermeneutic phenomenology was the most appropriate branch of phenomenology to follow as my prior experience was so wedded to minor injury nursing that bracketing would have been difficult to achieve (Gregory 2019).

Phenomenology justifies a position in nursing and health professions research by its ability to deliver significant contributions to knowledge (Earle 2010 and Neubauer et al. 2019). Phenomenology is increasingly popular in nursing research as it is seen to provide an in-depth understanding of lived experiences that has the potential to enhance patient care (Patton 2020). Despite an increase in adopting phenomenological methods in nursing, phenomenology was not without its critics in previous years (Earle 2010). Some offered a critique of phenomenology that suggested that the nurse researcher should have avoided it entirely (Paley 2005). Paley (2005) argued that phenomenology is detached from the scientific forms of inquiry by its emphasis on studying subjective experience. Paley (2005) claimed that the uniqueness of personal experience and the small sample sizes used in phenomenology meant that the results of this type of research could not be objective or generalised to other areas (Paley 2005). As phenomenology gains more recognition for what it can deliver (Patton 2020), qualitative researchers responded to critiques such as Paley's by explaining that the unique context of phenomena and individuals being studied mean that generalisability is not achievable (Ramsook 2018). Instead, the focus is on making the context, research journey, findings and conclusions sufficiently clear so transferability of the work can be reasonably considered (Ramsook 2018). One major advantage of phenomenology is that it can be key in unlocking and unpacking phenomena and can deliver rich and informative data (Matua 2015).

Earle (2010) adds that many of the critiques surrounding phenomenology were based on views that phenomenological studies in nursing are disconnected from its philosophical beginnings. In terms of my research, I acknowledge the ontological and epistemological positions of hermeneutic phenomenology and how it relates to my research. Hermeneutic phenomenology is committed to listening and seeking an in-depth understanding and on that basis, this research was guided by hermeneutic phenomenology.

3.8 Philosophical concepts of Heidegger

An awareness of some of the key Heideggerian philosophical concepts is useful for understanding how they may inform the research process and how they may be applied practically throughout the research process (Finlay 1999). To follow, is a brief introduction and overview of some of Heidegger's philosophical concepts.

3.8.1 Dasein and being in the world

Heidegger saw himself as an ontologist, studying the "meaning of being" (Mc-Connell et al. 2009). Dasein is the term Heidegger used to describe human existence (Moran 2014), it is characterised by self-awareness, which involves the capacity for introspection and in having the ability to engage in the world in meaningful ways. Dasein also involves an individual's existence in the world and their lived experiences that surround that (Moran 2014). Dasein is a key aspect of "Being in the world". Dasein is always within the world and the world is influenced and shaped by the connection between both of them. Although they are distinct concepts they are closely related and a central concept of Heidegger's philosophy (Stapleton 2009). The concept of dasein emphasises the existence and the lived experiences of an individual. In research, both the researcher and participants come to the research with their own lifeworld and experiences that encapsulates their dasein (Wilson 2015 and Chesterton and Jack 2021). The importance of understanding a person's lifeworld is critical to understanding the person and how they experience their everyday life. Through this, the ordinary and often taken for granted of another's lifeworld can be uncovered and explored which offers new understanding and perspective (Chesterton and Jack 2021).

3.8.2 Ready-at-hand/Unready-at-hand

For Heidegger, dasein was not simply limited to grasping itself as mere existence but also to the implements it uses in actions and experiences within the world (Zovko 2020). Heidegger argued that most human activities comprise of skilful engagement with the world. What Heidegger argues is, when we are coping skilfully with the world, we experience the entities that surround us as "ready at hand" (Dotov et al. 2010). Heidegger illustrates this by describing how we use a hammer. Our everyday use of a hammer, for example, is to drive nails in to wood. Heidegger explains that we do not see the hammer itself i.e., the size shape or colour of the hammer. Rather we see through the hammer and our attention is directed towards the task in hand. We have no explicit awareness of the hammer therefore it is ready at hand (Dotov et al. 2010). On the other hand, there is "unready at hand". That is where our awareness changes when the tools we used to complete a task become deficient. Therefore, our focus changes from the task to the tool, for example a broken hammer that is unable to fulfil our task or is now unready at hand (Dotov et al. 2010). Ready-at-hand/unready-at-hand illustrates how we engage in our experiences with a sense of directedness and it emphasises how the human experience of meaning and relevance can change within specific contexts (Dotov et al. 2010).

3.8.3 Time/Temporality

When we are absorbed in a skilful task we are "future-driven" (Cammell 2014). Heidegger explains that dasein is not "in time" like other things are in the world. For Heidegger, human existence is in a constant temporal movement between past, present and future. For Heidegger, we are not simply in a present moment but we are influenced by a past that shapes our understanding, we are in a present where our actions and experiences unfold and a future where our aspirations and possibilities hold significance for our actions in the present. In effect, a future can direct or pull the present out of its past (Cammell 2014). Heidegger's temporality is not just a chronological sequence of events but a central concept of being in the world (Scott 2006). This concept provides a holistic perspective on time that take you beyond the typical understanding of clock time. This concept emphasises how those temporal experiences interconnect with human existence and acknowledges that an individual's perspective and experiences can change with the experience and influence of time (Cammell 2014).

3.8.4 Thrownness

In terms of time, as human beings we have no choice over the time or indeed the place or context in to which we are born (Withy 2014). When we are thrown, we usually mean that we are thrown by something i.e., emotionally knocked by something (Wilthy 2014). Heidegger's concept of thrownness is different. Thrownness means that we are thrown in to something or given over to something from which we have to start and deal with. Thrownness does not necessarily mean that it is a surprising or alarming situation, nor does it necessarily mean that it did not involve choice or deliberation at some point (Wilthy 2014). Thrownness emphasises the fact that we find ourselves in the world with all its complexities and challenges that we need to make sense of (Wilthy 2014). Thrownness means that situations can determine our range of possibilities, what makes sense to us and what action we can take; our thrownness is always ongoing, we are always at a starting point within the world (Wilthy 2014, Roth 2018). Thrownness acknowledges how contextual circumstances can make each individual and their experiences unique. This concept underlines the uniqueness of existence and the uniqueness of each individual and their lived experiences (Wilthy 2014, Roth 2018 and Chesterton and Jack 2021).

3.8.5 Pre-understandings/fore-structures

Hermeneutic phenomenological research requires that the pre-understandings of the researcher are brought to consciousness in order to provide the phenomenon under investigation with the greatest opportunity to reveal itself (Geanellos 1998). Thus, my pre-understandings that evolved from my own prior experiences were not set aside and were made explicit. Bringing the pre-understandings to consciousness and into the research allows interpreters of the research the opportunity to consider how the pre-understandings sit within the interpretations constructed (Geanellos 1998). Historicity is what Heidegger describes as one's background and interpretation involves the unfolding our own lived self-understanding (Pernecky and Jamal 2010). Formed from past experiences, the researcher comes with prior understanding of a phenomenon which are known as the fore-structures, fore-having, fore-sight and fore-conception (Geanellos 1998, Warnke 2011). Fore-having accepts that we enter a situation with familiarity from previous practices that make interpretation possible. Fore-sight dictates that we make an interpretation from a point of view because of our past experiences. Fore-

conception is when we have expectations of what we might anticipate in an interpretation (Geanellos 1998).

Fore-having - I approached this research as a nurse with extensive knowledge, experience and understanding about the minor injury nurse role within Scotland. I was aware of how the role has evolved and had an understanding about the education, scope of practice and standards that surround the various roles in minor injury nursing. In addition, I had an awareness about the available research that existed within this field of practice.

Fore-sight - I brought an understanding about minor injury nurse education. This was an understanding developed from my personal experience of having undertaken and completed ENP education. I had lived experience of my own ENP education and how I was prepared for the role. I have also educated and mentored minor injury nurses and ENPs, who have undertaken either an ENP or minor injury nurse theory course.

Fore-conception - I anticipated that minor injury nurses will have had different educational experiences. I expected to recruit minor injury nurses with different experiences of minor injury nursing education. I anticipated that different experiences of minor injury nursing education would offer diverse lived experiences on how they were prepared for the minor injury nurse role.

A new understanding of a phenomenon depends on the ability to relate new phenomena to an already existing set of understandings (Parsons 2010). To enter the hermeneutic circle requires interpreters to work out their fore-structures in terms of the phenomenon under investigation. Interpretation, taken from the vantage point of pre-understandings, means that we develop new understanding within the hermeneutic circle (Parsons 2010).

3.8.6 The hermeneutic circle

The hermeneutic circle is described as

> *"That of the whole and its parts: we can only understand the parts of a text, or any body of meaning, out of a general idea of its whole, yet we can only gain this understanding of the whole by understanding its parts"* (Grondin 2015. p1).

In research, the hermeneutic circle is a process of reflective practice which works through data in a circular relationship acknowledging the interpretation of the investigator and the experience of participants (Kezar 2000, Wilson 2015 and Guerrero-Castaneda et al. 2019). The hermeneutic circle creates a deeper understanding and offers new insights by moving from the whole to the details and then back to the whole, with experience and contextual interpretations involved in this process, it is described as the overlapping of horizons, encompassing data gathering and analysis (Malqvist 2015). Analysis involves painstaking immersion in the data, reading and re-reading transcripts, and applying intuition. The end product is rich and informative phenomenological descriptions of participant experiences that capture the meaning within the phenomenon being studied (Wilson 2015). Debesay, Naden, and Slettebo (2008) support the hermeneutic circle as an interpretive device, claiming that the cyclical process involved in interpretation allows the researcher to constantly move through the data positively, gaining opportunities to develop new understanding.

3.9 Theoretical framework

Sinclair (2007) acknowledges that research is a journey moving towards an endpoint, where new knowledge through research can contribute to practice. Using a theoretical framework can guide how to structure research inquiry (Sinclair 2007 and Green 2014). Theoretical frameworks have been described as the map for a research study. They provide a rationale for the development of research questions or hypotheses, to support researchers in ensuring that their research is logical and following a clear aim (Green 2014 and Imenda 2014). In applying a theoretical framework to research, Sinclair (2007) prompts the researcher to consider the current understanding of the phenomenon under study. Current literature shows that minor injury nurse education is unregulated and inconsistent. It is also evident that minor injury

nursing education is poorly understood. Little was known about the learning journey within minor injury nursing education and how it prepared nurses for practice. Having identified a gap in the research, Sinclair (2007) then suggests that the researcher should consider the types of knowledge available to answer the research question/aim.

3.10 Patricia Benner

Interpretive phenomenology was introduced to nursing by Patricia Benner (Johnson 2001). Benner made a number of contributions to nursing education, clinical practice and research through her work. Benner's most notable contributions include her novice to expert framework (Benner 1984). The novice to expert framework provides a theoretical framework on the passage from novice to expert through five levels; novice, beginner, competent, proficient, and expert. Benner's (1984) framework is based on earlier work of the Dreyfus and Dreyfus (1980) model of skill acquisition. The novice to expert framework has been influential in nursing education, clinical practice and research. Progression through the levels of the framework relies upon sound educational experiences. More specifically, educational development must involve both theory and clinical practice for successful progression through the development stages (Benner 1984). A key strength of the framework is that it guides an understanding into how nurses develop and emphasises how they expand their knowledge as they gain experience and undertake education.

In terms of clinical practice, Benner emphasised the importance of reflective practice, continuous learning and the development of expertise (Field 2004). Benner's work was instrumental in acknowledging the educational and development needs of nurses. For the development of novice nurses, Benner advocated a strong theoretical foundation and practice-based learning to complement and enhance that journey of learning towards development. Practice-based learning, Benner argued, is where clinical knowledge was embedded in practice (Field 2004). Benner envisaged and advocated the value of sharing knowledge; she believed knowledge was embedded in expertise and that novice nurses should work alongside experts as they reflect upon and develop their own clinical expertise (Field 2004).

The contributions of Benner's work to nursing continued beyond education and clinical practice and her work was also influential for nursing research. Specifically, qualitative

research. Benner's work has primarily focused on better understanding nursing practice. She studied how nurses learn, develop, and enabled them to describe, uncover, and share their expertise (Darbyshire 1994). Benner's approach has emphasised the valuable knowledge that is embedded in the everydayness of nursing and she has paved the way for exploring the experiences of nurses in clinical practice as a valid approach to research. The many contributions that Benner has made to nursing was a principal feature that drew me closer to her influential work. From a philosophical perspective, Benner believed that nurses have undervalued clinical experience and observations as a source of knowledge development and, therefore, deprived nursing theory of the unique knowledge embedded in experience exploration (Tomey 1994). From that philosophical perspective, I could see that her approach of exploring and understanding human experiences can provide rich and in-depth perspectives of a phenomenon (minor injury nursing educational preparation) which reinforced my decision to follow a constructivist approach.

Benner's approach to research has emphasised the value in understanding the experiential and contextual aspects of nursing practice and education (Johnson 2001). Methodologically, exploring Benner's work underlined my decision that my research aim and questions would be better suited to a qualitative methodology. In addition to that, as I was exploring a lived experience in which I was myself firmly situated within (minor injury nursing), my decision to use an interpretive phenomenological approach was also reinforced.

Theoretically, Benners novice to expert framework provided a number of key strengths. At the outset, it influenced my thinking by allowing me to think about how minor injury nurses may learn and develop through the stages of her framework. Benner's framework provided a conceptual framework that I used to think about how nurses move through learning towards the development of expertise. In addition, as an experienced minor injury nurse, her framework inspired me to reflect back upon my own educational experiences and how I moved through the stages within the framework. This was particularly effective in terms of "laying out" my pre-understandings (fore-sight) (Pernecky and Jamal 2010). In terms of wider nursing research, through general reading in to nursing research and using that broad overview, I could see that Benner's framework is widely used in education research and the contributions of her work were clear. It was evident that the novice to expert framework can support researchers to investigate educational experiences, to inform the development of education that can have

positive implications for the enhancement of clinical care within practice (Callaghan 2011 and Martin and Wilson 2011

Despite the perceived strength of Benner's framework has had for nursing, her work has been challenged from philosophical and methodological perspectives (Padgett 2000, Gobet et al. 2008 and Oshvandi et al. 2016). Despite widespread popularity, English (1993), Paley (1996) and Gobet et al (2008) suggest that Benner's novice to expert framework does not fully explain stages of competence, suggesting that much of what the framework represents is based on superficial research that used small sample sizes with subjective and interpretive analysis. Gobet et al (2008) argue that the framework is superficial in the sense it will categorise a nurse to a particular stage of competence, when in reality, a nurse may have a range and varied depth of skill across a wide spectrum of competence in certain sub-fields of practice. In addition, English (1993) and Paley (1996) explain that the framework does not consider the social and political influences on nursing practice and only offers superficial definitions of each stage in the framework.

Altmann (2007) acknowledges that Benner's framework is not without limitations. However, Altmann (2007) suggests that much of the criticism stems from a misunderstanding of the methodological approaches in the framework. Altmann (2007) argues that Benner's framework has been critiqued from a quantitative perspective. This absence of quantitative validation is therefore seen as a major limitation. As the framework is based on subjective narrative, this, for some, challenges the quality of evidence it is based upon (Altmann 2007). Understanding the scholarly debate surrounding Benner's framework was necessary. However, the limitations of Benner's framework did not detract from the value it had in supporting experience based qualitative research (Altmann 2007). In that sense it was useful, it served as a basic, guiding framework for my nursing research (Oshvandi et al. 2016). Benner's framework offered an understanding of how nurses may learn, allowing them to reflect upon and describe their learning experience, highlighting perceivable characteristics of different learning levels, thus illuminating learning needs that may or may not have been satisfied by an educational experience (Altmann 2007 and Oshvandi et al. 2016).

3.11 Examples of phenomenological studies using Benner’s theory

In order to appreciate how Benner’s framework supports phenomenological research and for illustrative purposes, I looked at two published studies, that follow a similar study design to my nursing research. One study by Callaghan (2011) reviewed student nurses' perceptions of learning in a perioperative placement. Data were collected through in-depth interviews with third-year student nurses following their clinical placement in perioperative care. Analysis involved exploring student nurses' learning experiences, looking to understand the learning embedded in that placement area. Applying Benner's novice to expert framework in the data analysis was essential to understand the learning environment experiences (Callaghan 2011). Benner's framework offered the researcher a lens through which to view the learning experiences from the perspective of a novice learner (Callaghan 2011). This perspective allowed the researchers to establish what supported learning and development from the standpoint of a novice learner within the perioperative environment. Overall, Benner’s novice to expert framework was useful as a clinical assessment tool for education (Callaghan 2011). Using the learning experiences of student nurses offered the researchers an opportunity to elucidate the learning effectiveness of that environment and make recommendations for ongoing placement development.

A similar phenomenological study by Martin and Wilson (2011) looked at newly registered nurses' (RN) experience in the first year of practice. This study also used Benner's framework finding that it was particularly useful in articulating the progression of a nurse in achieving professional and clinical expertise. Martin and Wilson (2011) reported similar findings to the Callaghan (2011) study, thus reinforcing the virtues of Benner's framework in supporting nursing education research. Their exploration and analysis of RN experiences demonstrated that under and post-graduate nurse education should focus on real-world situations and clinical experience in order to enhance practice preparedness. Applying Benner's framework to the responses in the exploration revealed that new graduate nurses could not even function at a "competent" level. This developed understanding of nurse competence allowed the authors to suggest and further explore avenues for professional and competence development. Martin and Wilson (2011) found that progression through Benner's novice to expert continuum could be achieved by prolonged supportive activities, such as mentorship. This meant that these findings could be used as recommendations to inform future education and practice.

Both of these studies followed a phenomenological methodology underpinned by Benner's novice to expert framework. Using this approach offered a constructed and pragmatic line of inquiry that manifested valuable research data, which played an essential role in highlighting areas for nurse education development. Neither of these studies claim to present findings that can be generalised to a wider area of practice. Nonetheless, they provided a rich and in-depth account of competence within a specific context of practice. The studies show the value in interpretive, experienced based research and both studies demonstrated methodological rigour by clearly outlining the methodology and methods used in their interpretive analysis (Errasti-Ibarrondo et al. 2018). Interpreting experiences of learning developed research knowledge, the essential expressions within those experiences were extracted and synthesised into a developed understanding, all of which was facilitated by the structure and guidance provided by Benner's novice to expert framework (Callaghan 2011 and Martin and Wilson 2011). These studies demonstrate that using phenomenological methods and Benner's novice to expert framework can support the development of research knowledge with a nursing education context.

3.12 Ethical approval

The University of Stirling agreed to act as a sponsor for this study. In addition, an ethics application was sent to the NHS, Invasive or Clinical Research Panel (NICR) at the University of Stirling in 2018. The application was approved and approval to proceed with an application for NHS REC was granted. This was sought as conducting research that relies on the involvement of NHS staff requires ethical approval and research and development consent from NHS Scotland (NHS Research Scotland 2017). Before recruiting and interviewing minor injury nurse participants, I discussed the proposed research with and gained consent from relevant Health Boards. Each NHS research and development (NHS R&D) department were contacted individually (NHS Research Scotland 2017).

3.13 Target population

The target population consisted of nurses working in a clinical area that provides a minor injury service, employed in a role responsible for caring for patients with minor injuries. Selecting study participants specifically for the information they can offer is described by Holloway and Wheeler (2002) as purposive sampling. Purposive sampling plays a key role in small-scale

qualitative studies. Purposive sampling is divided in to various forms. Heterogeneous sampling, is a purposive sampling technique that is useful for capturing participants that relate to the area of interest (Creswell 2014). Heterogeneous sampling meant that I could target participants with the lived experiences of minor injury nursing education that would help answer my research aim and questions. Twelve minor injury nurses were recruited from dedicated minor injury units (MIUs) in two Scottish Health Boards selected to reflect variation in population size, demographic diversity, and urban/rural mix. All clinical areas were a dedicated minor injury unit (MIU) either operating as a stand-alone unit or as a unit attached to an emergency department. The minor injury nurses had various levels of clinical responsibility and titles ranging from minor injury nurse, advanced nurse practitioner to emergency nurse practitioner. Study participants had undertaken different minor injury nurse education programmes.

3.14 Sample size

In determining a sample size, guidance for my phenomenological research was not clear. Gill (2020) argues that determining sample size in qualitative research is challenging as there are no set rules to follow. Discussion surrounding phenomenological sample sizes appears to vary. A sample size of up to 10 appears to achieve wider agreement (Starks and Brown 2007, Flynn and Korcuska 2018 and Bartholomew et al. 2021). Some, suggest a wider range of participants ranging from as few as eight and up to 52 participants (Guetterman 2015). Others, have found evidence that recommend a sample size consisting of no less than 60 participants (Flynn and Korcuska 2018). Considering the larger sample size, it has been shown that those who have interviewed 60 participants found a degree of saturation was achieved after 12 participants. Therefore, it is suggested that 12 participants should be the recommended sample size for a phenomenological study (Guest et al. 2006). However, this is interpreted cautiously as saturation is not well supported in phenomenological research as lived experience is so individual that reaching a point of saturation is said to be unachievable (Hale et al. 2008 and Van-Manen et al. 2016)

In exploring the literature on sample size, it became clear that determining a number is not the key consideration but rather, it should be to focus on the task at hand and consider what is needed to achieve the research aim (Malterud et al. 2016, Vasileiou et al. 2016). The sample

size for a qualitative study should be large enough for rich and in-depth understanding but small enough for specific in-depth analysis (Vasileiou et al. 2016). Vasileiou et al (2016) argue against using decontextualised sample size guides in qualitative studies to instead exercise judgement, suggesting methodological knowledge is used to critically consider how pertinent the parameters that dictate sample size sufficiently are (Vasileiou et al. 2016).

In reaching a decision for my own research on sample size I had to consider the methodological arguments and recommendations but also consider the practicalities of my time-limited doctoral project. In terms of my doctoral research 60 participants would have been a challenge to undertake due to the sheer volume of work and time involved. For phenomenological doctoral projects Bartholomew et al. (2021) suggest three to six participants is sufficient. From that perspective I felt that those numbers were too few. Heidegger put forward an argument that dasein's understanding of one's being and the being of others is achieved through concernful interactions with everydayness and that this serves as a point of departure in researching dasein's being (Horrigan-Kelly et al. 2016). My prior experience of being in the world of minor injury nursing meant that I had a deep awareness of the lifeworld of my participants. My understanding of what potential participants could bring to my research and an in-depth knowledge of their context of education and practice meant I was able to apply judgement to my decision on sample size.

For the qualitative researcher, Malterud et al (2016) outline information power as a means of deciding whether a sample size is sufficient. To do that, they outline five dimensions of analysis. In applying this to my study: 1- Aim. My research aim was fairly broad so I sampled across different departments and minor injury nurses who had undertaken different educational courses in minor injuries nursing. 2- Specificity. I targeted a specific group (nurses) who had undertaken different courses but within a specific subject (minor injuries nursing). 3- Theory. The literature review I had undertaken informed my approach (research aim and questions). In addition, Benner's theory was influential from a philosophical, methodological and theoretical perspective. The influence of Benner's research on my study was that the study should be large enough for rich and in-depth understanding but small enough for specific in-depth analysis (Vabileiou et al. 2016). 4- Dialogue. Again, my aim was to gain a rich, in-depth and specific analysis of a lived experience. 5-Analysis. My hermeneutic phenomenological study data was analysed using reflexive thematic analysis. How reflexive thematic analysis sits with

hermeneutic phenomenology and the specific steps I undertook will be outlined later in this chapter.

After consideration and with discussion with my doctoral supervisors, I opted for 12 participants. Twelve participants were manageable and allowed me to expand my exploration to include three participants from four departments across Scotland. This also meant that I could sample six participants from urban MIUs and six participants from rural MIUs. It was anticipated that conducting the study Scotland-wide would enrich the study data giving a broader account of experiences. I was aware that different clinical areas follow different programmes for minor injury nurse education, this again, was intentional to facilitate a deeper exploration of the experiences of minor injury nurse education.

3.15 Participant inclusion/Exclusion criteria

3.15.1 Inclusion criteria

- Registered nurses who have completed a minor injury nursing qualification.
- Minor injury nurses who work in a department that is responsible for delivering a minor injury service.

3.15.2 Exclusion criteria

- Minor injury unit practitioners from out with a nursing role i.e., Physician associates, paramedic practitioners.
- Registered nurses who have a minor injury nursing qualification but no longer work in a department that is responsible for delivering a minor injury service.
- Registered nurses who are undergoing but have not completed their minor injury nursing qualification.
- Registered nurses who work in a department that is responsible for delivering a minor injury service but have not undertaken a minor injury nursing qualification.

The inclusion criteria did not include a required level of minor injury nursing education. It was anticipated that setting a required level of minor injury education could have restricted the emergence of data so was left unrestricted.

3.16 Recruitment and consent

In the recruitment of participants, the nurse managers/clinical leads for each MIU were notified in writing, detailing the proposed research aims, allowing a discussion and the opportunity to raise concerns. All line managers contacted responded and no concerns were raised. Involvement of relevant individuals of authority (gatekeepers) is a consideration for the researcher (Creswell 2014). Creswell (2014) suggests that potential departmental disruption, estimated time, and research outcomes are of particular importance to gatekeepers. Therefore, I was explicit in these details of the proposed research. The letter sent to line managers requested that they invite potential study participants into the research. All line managers fulfilled that request. The participant information sheet (Appendix 1) was included in the letter and given to potential participants by their line manager. My email and telephone contact details were available, and potential participants were asked to contact me if they wished to be considered for inclusion in the study and/or make inquiries. The line managers were not informed of who was included in the study.

Once recruited and before interviewing the participants, I issued a consent form in person. A complete outline of the study was given to each participant as a participant information sheet (PIS) (Appendix 1). Participants were made aware of their right to privacy, and that involvement in this study was entirely voluntary with no obligation to participate. Participants were assured of confidentiality and could have withdrawn at any time without detriment. Participants were not subjected to any burden or potential harm (Denzin and Lincoln 1998). Participants were informed that there was no direct benefit from participating in the research. However, they were informed that the research may help develop knowledge and understanding of minor injury nurse education. The participants who opted for inclusion to the study contacted me directly using the details provided. The only details of participants the researcher required were name, role title (minor injury nurse), area of work (minor injury unit), and qualification, for example (minor injury theory certificate). I also required an email address and workplace address in order to arrange the interviews. These details were known to me only,

all data were held securely on the University of Stirling server. Personal identifying information was stored separately, de-linked from the interview data and destroyed when data collection was completed. All participants' details (NHS staff only) were anonymised by using a pseudonym (Scottish Islands).

3.17 Data collection

Reflecting on the experience of undertaking education is commonly used as a line of inquiry, and previous research has demonstrated this (Den Brok, Brekelmans and Wubbels 2006). Students' perspectives on a learning experience can be studied to explain, evaluate, and develop education (Den Brok, Brekelmans and Wubbels 2006). Exploring student experience is multidimensional, reliable, stable, relatively valid, and useful in understanding and development (Ginns, Prosser, and Barrie 2007). In addition, qualitative feedback from students can be more beneficial than quantitative findings, as it focuses on what students have to say, in their own words which can be incorporated as evidence for priorities in education development (Grebennikov and Shah 2013).

Collection of data was conducted via digitally recorded face-to-face semi-structured interviews. Digitally recorded interviews ensured accuracy and allowed me to return to the study data, enabling immersion in the data (Harding 2013). In terms of the role of semi-structured interviews in hermeneutic phenomenological research, there has been debate on whether any structure should be applied given the inductive nature of phenomenological research (Ray and Locsin 2023). However, Ray and Locsin (2023) suggests that rather than looking at this as an issue in hermeneutic phenomenology, a semi-structured approach to interviews must be viewed from an interpretive perspective where the interview guide is seen as parts of the interpretive whole.

Qualitative research findings are constructed through a co-construction between the participant and the researcher (Frechette et al. 2020). Interpretive phenomenology anchors its research tradition in a unique understanding of dasein, the being of the researcher and of the participant (Frechette et al. 2020). I undertook my interviews using guiding open-ended questions (appendix 2) for example, *could you tell me about your minor injury education?* This guide was used to support the interaction following an open structure. Referring back to my pre-

understandings, I had myself undertaken minor injury nursing education. Therefore, I had an awareness of how to structure the questions in relation to the educational experiences I suspected the participants may have had. For example,

> Interviewer - *Could you now tell me about how your competency/skills were assessed on the course?*

Although these questions were used as a guide that encouraged the participants to reflect back upon and share their lived experiences, they were kept open. In keeping with hermeneutic phenomenological interviewing, I adopted active listening where appropriate and adjusted my questions when deeper engagement with a participant was required (Dibley et al. 2020). For Heidegger, existence and lived experiences are based on interpretation and understanding and language is the house of "being" (Pernecky and Jamal 2010). For example, in engaging with the participant, an open-ended question I used was:

> Interviewer - *So, looking back on your minor injury education, how do you feel your minor injury education prepared you for practice?*

> Participant - *No, I remember sleepless nights wondering if this was the right job and one of my colleagues on the course, I remember her texting me one night at midnight because she was still awake and she was worrying about a patient that she'd seen that day that she'd asked me about and we both knew that this patient had very little wrong with them but every imaginable outcome was going through our heads.*

This participant responded with their experience of not being prepared for practice and the burden of responsibility from being an autonomous ENP. They illustrated what that meant for them in a description of negative feelings. They described the high levels of stress and sleepless nights. The hermeneutic conversation continued and by using active listening, at that point, I then moved the conversation forward to draw out what they thought about how minor injury nurses are prepared for practice by using their experience as the basis of that conversation. I then asked:

Interviewer - *Do you think they could have taught that responsibility, you could have been better prepared for it? Or, is it something you just have to go through?*

By conversing about this specifically, the participant then spoke about how minor injury nurses develop practice preparedness in the general sense. At that point, I took the participant back to their own lived experience and asked:

Interviewer - *When you eventually became more autonomous and more comfortable, what do you think it was that helped you do that?*

Participant - *Oh I can tell you it happened very clearly because I'd been practising for about 2 or 3 years, I was finding my feet and thought I knew what I was starting to talk about when our health board employed a nurse educator for minor injuries. Educator came in to post and educator's focus was to get a couple minor injuries up and running, educator wasn't really charged with my hospital we were much further down the list of priorities back then but educator instigated a whole series of training for the 2 hospitals educator was focused on, they were open to everyone. So, I remember turning up to XXXX hospital one day to meet this educator we had heard about to talk about wrist assessments and scaphoids and I sat there for 2 hours and my jaw just hit the floor, why did I not know this 2 years ago, this was an experienced ENP, who knew what my job was, who knew what I needed to do and I wasn't getting out of that room until I could do it.*

By using active listening and engaging in a hermeneutic conversation we were able to take the participant back to a time when they had different experiences of practice preparedness. By adjusting my questioning, we uncovered what practice preparedness had meant for that participant and how it changed and developed, we pulled their varied experiences out to explore them and uncovered the meaning, showing the phenomenon of practice preparedness as something that is or can be supported and developed as an on-going process.

During the interviews I used co-constitution (Dibley et al. 2020) which emphasises the interactive and dialogical nature of hermeneutic phenomenological interviews. In the absence of member-checking, co-constitution allows for a clear representation of the participants

meaning during the interviews (Dibley et al. 2020). This is undertaken by using recapping phrases. For example:

> Participant - *That's why I just phone because as I said often things changes all the time. You don't know… we were still giving revaxis* (inactive tetanus vaccine) *for tetanus and that's been out for ages.* (should be active tetanus immunoglobulin for high-risk wounds)

The participant shares an experience of outdated practice that has been continued due to a lack of practice updates. Here I take the opportunity to recap what they meant by asking:

> Interviewer - *So that didn't filter down here?*

At this point, the participant not only confirms what they meant but then expands on more experiences of this nature:

> Participant - *No, there is a lot of things that don't filter down. We are… ok… other smaller units… they didn't even know you did VTE* (blood clot risk assessment in lower limb immobilisation) *for a full boot. But the only way we knew that is because the fact that we had occasional ENPs on shift and they are they're doing it all the time. So, I think we're more at an advantage because of that, but a lot of other things they were like "oh I didn't realise that". We've had a lot of ruptured Achilles so I said to a colleague we will have to get the shoes they get put in to. My colleague said no they need to go to the major MIU. I was like, we just need to get the shoes, we can fax the referral to the specialist. There is no point in travelling all the way to the main hospital just to put thingies* (supports) *in their soles and get a pair of crutches. It's all different. But you see… I just pick up the phone. I would just ask, you know, if you don't ask you don't know, if they turn around and say no… fine. Because like me and (name) went through to see the plaster technician in the plaster room. They showed us how to do various casts. Equines cast and a short cast, it used to be the scaphoid cast and now it's the brunners cast. We only got that because something had gone wrong with putting on a cast here. I'd been asking for ages for training!!!*

Taking the time to recap the participants experiences was useful to confirm our shared understanding. However, engaging in that dialogue also enhanced the overall understanding of that particular experience as we uncovered what "being" in an environment where there is a lack of practice updates means for the participants in their everyday practice.

The Interviews took place on NHS premises so no risk to myself had been identified. The interviews took place at a time that had the least potential to disrupt the MIU. Interview time slots were approximately 1 hour, which allowed time for introductions, pleasantries, the interview process and any questions post interview. Semi-structured interviews can last from 30 minutes up to several hours and require flexibility to allow the inductive nature of qualitative data to develop (Denzin and Lincoln 1998, DiCicco-Bloom and Crabtree 2006 and Jamshed 2014). The recorded interviews lasted approximately 35 minutes and used an element of structure to keep the participants close to the phenomenon under study, but also allowing data to emerge without constraint (Denzin and Lincoln 1998, Horton et al. 2004).

Prior to the interviews I read out a standard introduction that acknowledged my role (Clinical Doctorate Student) but also highlighted my area of interest as minor injury nursing. Before undertaking interviews, showing a shared interest in research can often facilitate accessibility, help build a rapport and identify persons suitable as informants or gatekeepers (Denzin and Lincoln 1998). Identifying potential barriers in the research process and potential facilitators was helpful. However, in the context of this research, recruitment was achieved with no difficulty. It appeared that many minor injury nurses were keen to share their experiences and all expressed an interest in seeing the final research findings on completion. Exactly 12 participants were recruited so selection from an excess of participants was not required. It is also worth noting that the I was fortunate in having completed all the research interviews prior to the COVID-19 pandemic restrictions.

3.18 Pilot study

Before undertaking the research interviews, I undertook a pilot study consisting of two semi-structured interviews. I interviewed two ENPs from an urban MIU (colleagues) to refine my interview skills and technique. Both pilot study participants met the inclusion criteria. Pilot interviews allowed me to test and refine the proposed data collection methods before starting

research (Chenail 2011). Chenail (2011) explains that undertaking pilot interviews allow the researcher to interview participants that meet the inclusion criteria, test and refine the interview schedule and request feedback from the pilot study participants to determine if any changes to the process are required. The data is then transcribed and analysed to help the researcher practice those skills prior to undertaking the actual research. The pilot study data is not typically included in the main body of research (Chenail 2011). Undertaking the pilot interviews allowed me to review my interview structure which was deemed suitable after the pilot study. In addition to that, the most valuable experience was having an opportunity to practise transcribing interview data. Firstly, from a practical perspective, that allowed me to acknowledge the amount of work and time involved in transcribing. And, secondly, from a methodological perspective, to experience how interpretation starts at the point of data collection. Overall, this experience reaffirmed that outsourcing data transcribing was not in keeping with my methodological approach. I was reassured that despite the volume of work, I needed to transcribe all transcripts to support full immersion in the data.

3.19 Field notes

Qualitative research begins with the particular and moves towards the general (Harding 2013). I began with data collection using face to face semi-structured interviews, being mindful of allowing the development of views and experiences to build freely. It is believed that face to face interviews generate qualitative data through the observation of the interviewee, gaining visual cues and responses are a valuable component of face-to-face interviews that cannot be achieved in telephone interviews or surveys (Sturges and Hanrahan, 2004, Knox and Burkard 2009, Creswell 2014 and Saarijarvi and Bratt 2021). As the nature of this research was explorative, the non-verbal cues offered in a face-to-face interview were pertinent when participants emphasised particular experiences (Creswell 2014). Hermeneutic research favours when a researcher pays close attention to the non-verbal cues of the participant. Non-verbal cues offer a window in which to view the participants mood and can emphasise the meaning of a particular experience (Frechette et al. 2020). Throughout the interviews notes were taken when it was felt that visual cues were used to emphasise a point, noting cues such as voice tone and body language can result in highly personalised data (Affleck et al. 2013). For my research, notes were taken to document expressions that enhanced the transcript, supported contextual understanding and emphasised meaning (Logan and Dormine 2018 and Phillippi and

Lauderdale 2018). For example, I integrated this in to my analysis as the following quotation illustrates. By using upper case and exclamation marks to highlight this participant experience, where the participant emphasised a particular experience. Using upper case and exclamation marks underlines the depth of feeling in the experience shared. During their lived experience of minor injury nursing education this participant demonstrated competence by supporting fellow students. The participant subsequently failed their first attempt at the summative coursework assignment. For the participant, they were bewildered and frustrated that the coursework assignment took, in their experience, an unfair view of their competence and capability:

> *"A year and a half before doing my course I'd been working here and had picked up a lot of skills. The ENP teaching us was like, WOW!!!, you're really good. Come on, she said, you show the quines (girls) how to stitch (wound closure). Perfect, no problem for me. THEN… I get thrown an essay AND fail the essay and they are all shocked. Because I CAN'T WRITE ESSAYS!" (Eday)*

3.20 Memoing

Memoing throughout the research process is integral for noting significant descriptions, thoughts, and reflections (Groenewald 2004). In hermeneutic phenomenology, field notes, journal entries and memos are part of the interview data (Ramsook 2018). It is a method of managing and storing ideas for retrieval later, and also acts as a reminder for the researcher during the writing up phase of the research (Cronin 2012). I gathered notes throughout the data collection and analysis process, notes were taken during the interviews to emphasise expressions (Crist and Tanner 2003 and Affleck et al. 2013). After completing each interview, I transcribed the interview and also completed a participant summary that noted initial thoughts regarding the process. During analysis and coding, I kept notes for each code that included an excerpt from the data that represented that code and the thoughts/decisions behind assigning each code. During the thematic analysis I also kept a journal of my thoughts and decisions showing how my themes were generated and refined.

3.21 Data management

All data gathered during the course of the study was handled and stored in accordance with the General Data Protection Regulation (2018) (GDPR). The interview data were anonymised and only the researcher had access to participants personal details which were kept separate from interview data. Supervisors had access to anonymised transcripts, anonymised summaries, anonymised data excerpts, field notes and memos. Anonymised, transcribed documents were uploaded to NVivo 11 (QSR 2015). Using NVivo 11 (QSR 2015) was discussed with my supervisors and it was concluded that this would afford a method of storing data in an organised platform. Personal data were stored for three months following completion and anonymised data will be stored securely by The University of Stirling for ten years following completion of the clinical doctorate.

3.22 Data analysis

Sims and Smythe (2020) as cited by Dibley et al (2020) explain that hermeneutic phenomenological research can be challenging to conduct as detailed and prescriptive steps can undermine the methodology where its strength is attuned in finding its own path. Despite that, it is also negligent for a novice researcher to be sent on a research journey without a guiding light (Sims and Smythe 2020 as cited by Dibley et al. 2020). For me, reflexive thematic analysis was that guiding light (Table 3) (Braun and Clarke 2021a).

In considering my decision to integrate thematic analysis into my hermeneutic phenomenological study, it became evident that other hermeneutic phenomenological studies had used it successfully (Chang and Wang 2021 and Badakhsh et al. 2020). Despite that, thematic analysis is often challenged when applied to doctoral research projects (Braun and Clarke 2014). Braun and Clarke (2014) find it is often challenged as being unsophisticated and this, they argue, is because it is misunderstood. To be clear and to tie it in to the context of my research, thematic analysis is theoretically flexible (Braun and Clarke 2014). Thematic analysis can apply across a wide range of theoretical approaches. The key to its success is how it is used. Thematic analysis can be used for straightforward descriptions or, as within the context of this research, be used in exploring lived experiences and seeking to understand the hidden meaning (Braun and Clarke 2014). As with hermeneutic phenomenology, thematic analysis puts the researcher at the centre of the research and does not detract from the interpretive approach as it is often misunderstood to do. McLeod (2011) supports this and explains that

thematic analysis is a method used to identify themes, which is an interpretive act. Thematic analysis is relevant to phenomenology as it explores subjects' feelings, perceptions, and experiences (Chang and Wang 2021).

Thematic analysis is a process of identifying themes or patterns in the data (Braun and Clarke 2006). A thorough thematic analysis interprets and makes sense of data. It uncovers the meaning behind data and, is more than merely categorising, summarising and presenting the data (Clarke and Braun 2013). An advantage of using thematic analysis in a hermeneutic phenomenological study is the flexibility it offers. Braun and Clarke (2006) argue that thematic analysis is more of a method than a methodology. Therefore, it is flexible in how it can apply to many qualitative studies. It does not stand with any particular epistemological or theoretical perspective (Braun and Clarke 2006). Clarke and Braun (2013) claim that thematic analysis does not dictate how data is collected and it can answer any research question or analyse any data. In particular, Braun and Clarke (2013) offer a perceived advantage relatable to this research, suggesting that thematic analysis is an excellent method for those new to qualitative methods and students undertaking research who need to reach a suitably timed conclusion for a doctorate journey.

3.23 Data analysis – tools

The Data analysis followed the six stages of reflexive thematic analysis and used an inductive approach. Braun & Clarke (2006) advise that an inductive approach allows for analysis of the data from the bottom up, which means that analysis starts at a basepoint and themes are created by the researcher and their analysis of the data. Braun & Clarke (2006) explain that themes do not emerge, they are developed by the researcher using their interpretations and judgement.

3.24 The six phases of reflexive thematic analysis

Firstly, section 3.23 starts with table two that illustrates the six phases of reflexive thematic analysis. Secondly, table three is a diagram that illustrates each stage of data analysis. Lastly, each stage is brought forward in to a discussion with examples of data analysis that provide more detail into how the data was analysed and interpreted through each stage towards the final themes.

Table 2

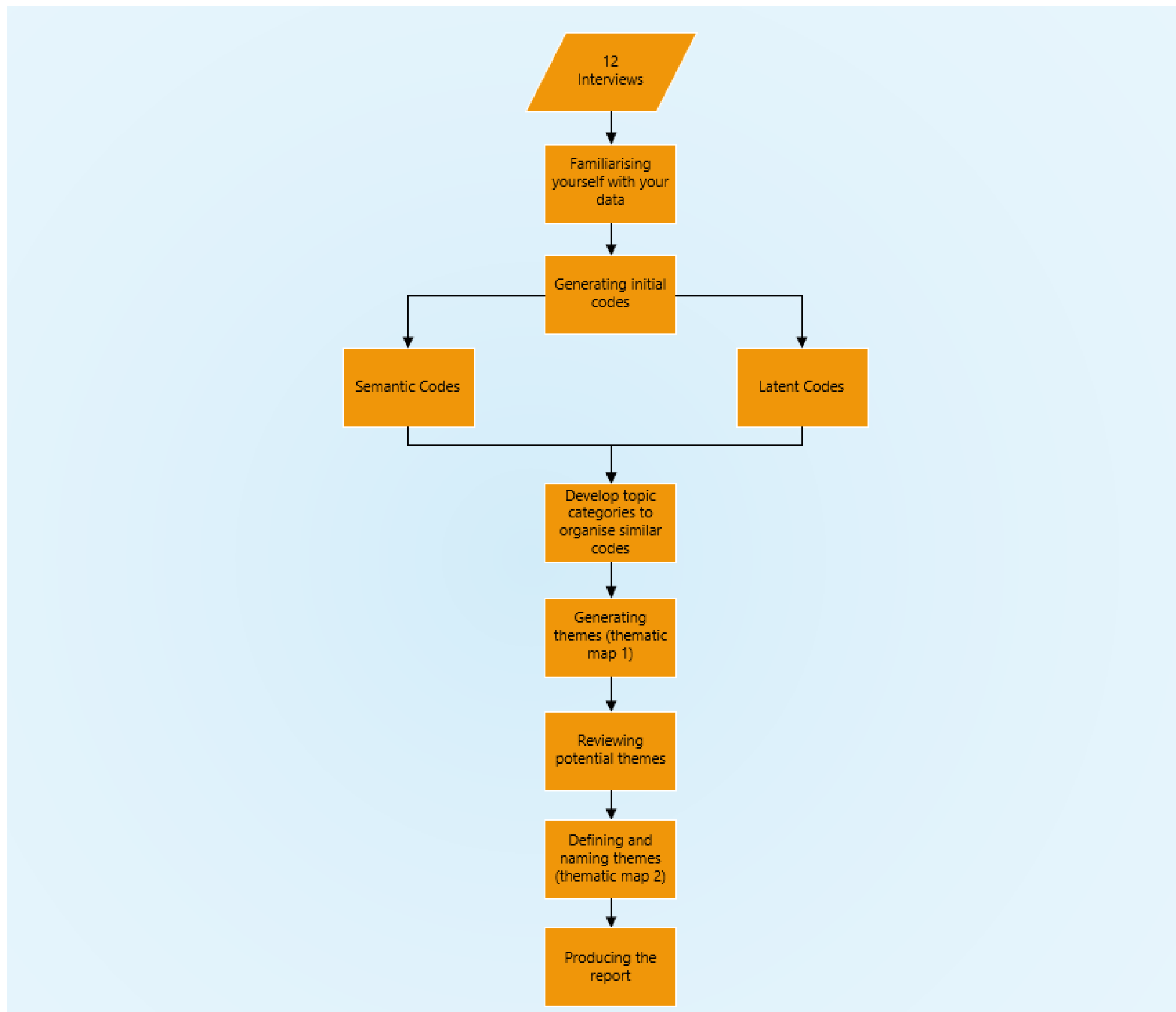
Reflexive thematic analysis
1 - Familiarising yourself with your data
2 - Generating initial codes
3 - Generating themes
4 – Reviewing potential themes.
5 - Define and naming themes.
6 - Producing the report

Braun and Clarke (2021b)

3.24.1 Working with the data

The following table is illustrative of the data analysis stages from undertaking the interviews through to defining and naming themes and producing the report.

Table 3



3.24.2 Familiarising yourself with your data

To familiarise myself with the data set I started by listening to each interview recording prior to transcribing the data. Listening to the recordings required an active listening approach, listening to the interviews with a purpose of becoming familiar with the data and in attempt to understand the primary areas addressed in each interview (Louw et al. 2011 and Byrne 2021). The added benefit of this exercise was being able to listen and get close to the data free from the duties of note taking and noting gestures and body language cues (Byrne 2021). After listening to each transcript, I then manually transcribed each interview verbatim. In addition to manual transcription, I generated individual interview summaries of each participant. These were anonymised summaries of each interview. As a novice researcher, this allowed me to practice managing a whole data set, breaking it down in to parts to get a sense of the major findings. This also allowed my supervisors to familiarise themselves with my data on a manageable level. Within each summary I organised the data in to different headings, for example "assessment" or "the minor injury course". That organised and managed all the relevant data under subject headings that represented initial trends in the data. I predominantly tried to remain close to the participants experiences summarising their lived experiences and how that made them feel. Following that I also documented my thoughts and feelings regarding the interview. With each summary I supported them with data excerpts so that there was a clear audit trail of the interpretive process (Carcary 2009 and Cope 2014).

Familiarising yourself with your data - summary example - Eday describes the experience of being assessed by an assignment. Eday felt that this assignment was a negative experience. Eday describes having to undertake a case study on one minor injury case. Eday concluded that this was a poor reflection of their overall competence and capability across the entire minor injuries' curriculum. Eday described a feeling of unease that this was the only method of demonstrating competence.

> *"So, I had to do an essay on an ankle injury. Yes, but what, you're not assessing my shoulder injury examinations, not assessing head injuries how do you know I'm competent?" (Eday)*

"So, you're getting me a bit of paper. Anybody can go in and write an essay. If you get this bit of paper you can see, treat and discharge minor injuries! That's a bit of an issue" (Eday)

Familiarising yourself with your data - memoing of thoughts example - Eday's experience shows quite a narrow perspective on competence was undertaken in their course. This form of assessment in isolation may be inadequate to determine levels of preparedness for minor injury nursing practice that encompasses the whole curriculum and/or range of clinical skills.

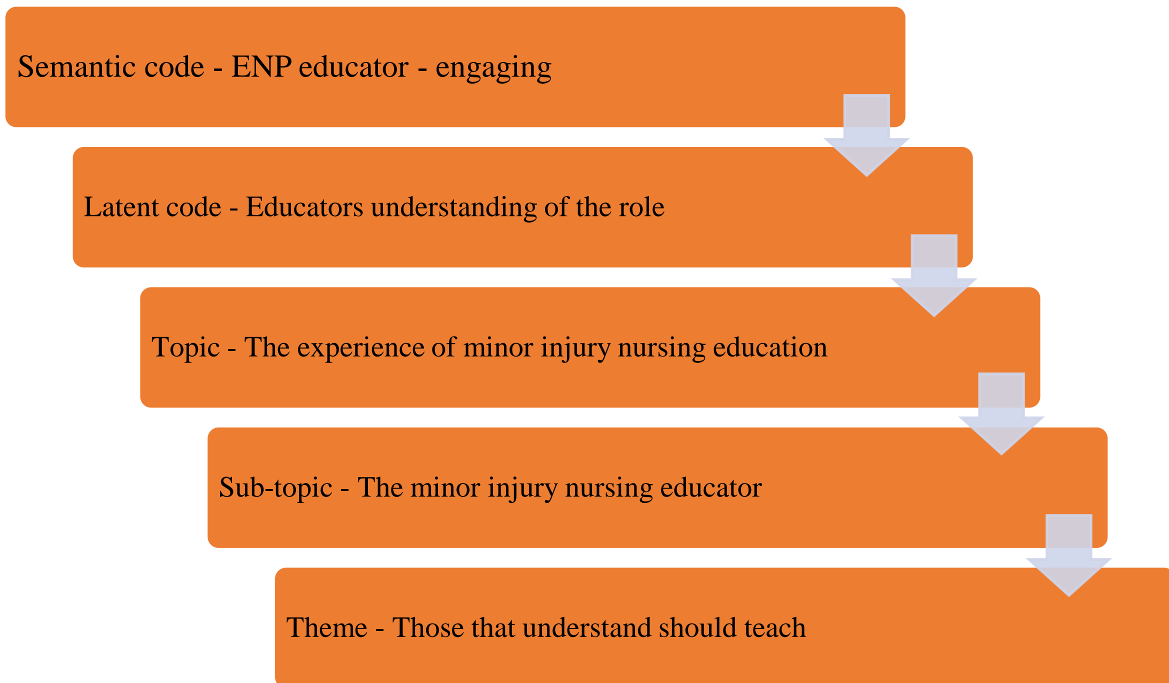
3.24.3 Generating initial codes

After initial familiarisation, the entire data were broken down into parts consisting of both semantic and latent codes. Semantic codes are described as capturing the surface and obvious meanings in the data and latent codes capture the implicit meaning in the data (Braun and Clarke 2021b). This process generated 118 codes. Initial coding involved reading each transcript line-by-line, reading closely and assigning codes to parts of the data that had meaning that was potentially relevant to the research (Braun and Clarke, 2021a). Coding was data driven, using an inductive approach, giving voice to the participants experiences, staying close to the meaning within the participants experiences. Coding in reflexive thematic analysis is open and organic with no use of a coding framework (Byrne 2021 and Braun and Clarke 2021b). Semantic coding involves staying close to the descriptions within the participants experiences (Braun and Clarke 2012). Semantic coding is often used predominantly in the early stages of coding, with more latent codes developing with further immersion in the data and as research experience is gained (Braun and Clarke, 2021a). Although latent coding involves more interpretation, it is necessary to understand that latent coding is not superior to semantic coding (Braun and Clarke 2021a).

3.24.4 Semantic and Latent coding

An example of how I worked through the coding process towards naming and defining a theme is illustrated in table 4. In generating theme four “Those that understand should teach” I started by using semantic codes in the early stages of coding. The semantic code “ENP educator – engaging” is an example of how I stayed close to the participants’ engaging experience of an ENP educator. As I became more familiar with the data and more immersed in the experiences, the underlying meaning of the phenomenon was revealed and I used latent codes to reflect more meaning surrounding the experiences. The latent code “Educators understanding of the role” is an example of coding in more depth. It represents a number of relevant factors that shaped the overall participant experiences. For example, educators with lived experience of minor injury nursing were more effective as educators, they used that experience to “understand” the student experience, communicate more effectively and act as a role model in teaching. This manifested a more effective and memorable learning experience. These codes were then organised in to a topic category “The experience of minor injury nursing education”. This allowed me to view my codes in an organised format so that I could search for and see patterns in the data. From that, a more specific sub-topic was developed and the codes were organised in to that sub-topic “The minor injury nursing educator”. Having organised the data in this way I was able to generate and name theme four “Those that understand should teach”.

Table 4



3.24.5 Coding diary

Throughout the coding process I kept a record of how codes evolved. I kept a coding diary, comprising of a list of all codes that included an excerpt from the data and the coding thoughts/decisions. An example of this is shown in Table 5.

Table 5

Code	Excerpt	Thoughts/Decisions
Course content - poor reflection of minor injury nurse role	*"And I think it's a couple of things on the course…we did that were a bit… we had a session on the sexual assault nurse examiner's role, which was interesting but was completely irrelevant to our role"*	Aspects of course curriculum did not reflect the role and practice of the MIU nurse. This suggests teaching time was directed to content that was irrelevant. This may have implications for future course preparation.

3.24.6 Merging codes

During the coding process, when appropriate, certain codes were merged in to one code where they were found to have a common meaning. This allowed me to reduce the overall number of codes. For example, physician support was merged in to clinical decision support as the key experience in the data was having an experienced practitioner at hand for support, regardless of the professional background of that practitioner. An example of this is shown in Table 6.

Table 6

Codes	Excerpts	Thoughts/Decisions
Clinical decision support "Physician support" code merged in to clinical decision support	*"So, I found that really tricky initially and so I think having support when you first qualify so important, it's essential and just get your confidence up as well, you know… knowing especially here… knowing that you can… you can come away from a patient and you can ask anybody and you feel like you get good advice here. This is fine, I'm confident and you learn from that as well. I think… where as if you're just thrown in the deep end, right… That's you qualified off you go… you never know"*	The participants talk about receiving support when gaining experience as MIU nurses, support with clinical decisions was seen as fundamental when qualifying and helpful with learning. Physician support code merged in to clinical decision support as it reflects similar experiences where clinical practice is supported by a more experienced practitioner. Whether that is a physician or experienced ENP is less of a concern. The key experience here is the importance of that support network.

3.24.7 Coding frequency

Recurring codes can be a sign of emerging patterns, but may also be a warning that codes are too broad and more detailed analysis is required (Elliot 2018). I was aware that qualitative methods do not ask for a numerical analysis but to instead ponder, interpret, connect, reflect and synthesise (Saldana 2021). Nonetheless, I did keep a record of coding frequency because this allowed me to glance at the number of times a particular code was used. An example of this is shown in Table 7. I did not want to quantify any aspect of my qualitative data. I used this method so I could consider the significance of particular recurring experiences which allowed me to be close to and fully familiar with my data. An example of a recurring code was "educators' preparedness for lectures", which was coded across five interviews. This highlighted a recurring learning experience. Noting this frequency drew me closer to the data which emphasised a relevant finding.

Table 7

Code	**Frequency**	**Thoughts**	**Excerpt**
Educators' preparedness for lectures	Coded across 5 interviews	The participants share experiences of learning and feel that it is imperative that lecturers have fully prepared the intended curriculum prior to commencing. Being prepared for upcoming lectures would allow for self-study and preparation prior to class. Allowing students to self-study and prepare could result in better understanding of the planned curriculum and an opportunity to clarify gaps in knowledge.	*"We were given the topics that we were going to cover and ideally in a perfect world if they had said this month, we're going to do hands and elbows and then we would have been able to prepare for it, but as it was, she would turn up on the day and say, oh no that's changed. We're going to do something completely different. So, it was a bit awkward."*

3.24.8 Generating themes

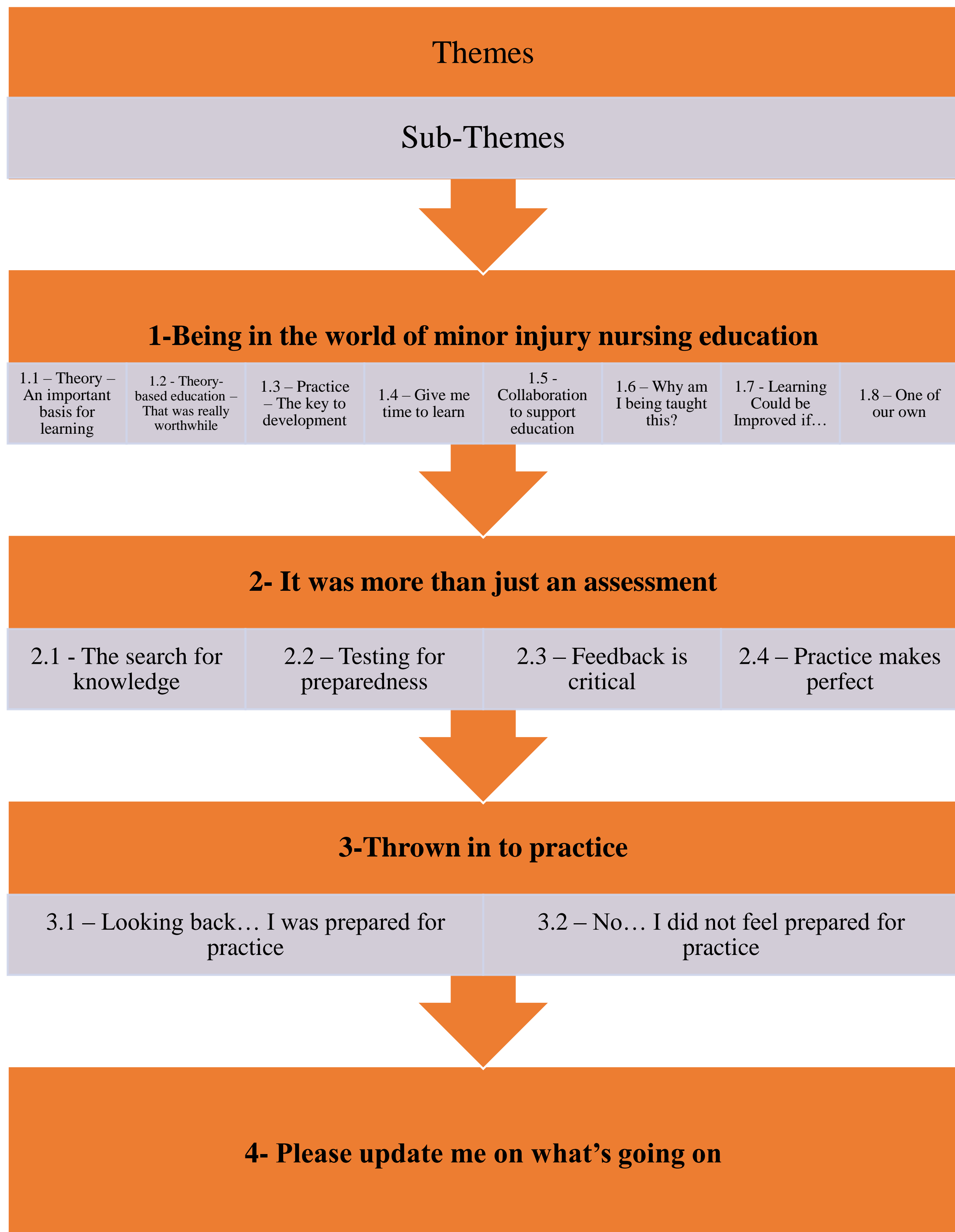
In generating initial themes, reflexive thematic analysis guides the researcher to undertake the analysis in a manner that is useful but not prescriptive (Braun and Clarke 2021a). To help make sense of and organise the data, I clustered the codes in to topic categories (Table 8) (Brauna and Clarke 2021a). This allowed me to organise all related codes with a common meaning together. The first phase of this developed four broad topic categories. From there, the topic categories were organised in to sub-topics that described the codes in more detail. Organising the codes in this way allowed me to take a broader overview of the entire data set in the search for patterns, overall meaning and potential themes and sub-themes (Braun and Clarke 2021a).

Table 8

Topic categories			
The experience of life in the minor injury unit	The experience of minor injury nursing education	The experience of minor injury nursing assessment	The experience of preparedness for minor injury nursing practice
Topics			
MIU Nursing – role details	The minor injury nursing educator	Assessment - clinical	Prepared for practice
Delivery of care in the MIU	The minor injury nursing course	Assessment - theory	Not prepared for practice
Experiences of working in an MIU	The study of minor injury nursing		Qualifying as a minor injury nurse

I worked with and reviewed the data under each topic and sub-topic and devised a number of candidate themes and sub-themes (Thematic map 1). The candidate themes and sub-themes were generated to describe and illustrate the learning experiences, displaying their individual meaning but to also tie together to produce a clear picture of the entire data set and overall preparedness for practice experience (Byrne 2021).

Thematic map - 1



3.24.9 Reviewing potential themes

This phase involved reviewing and refining each of the candidate themes and sub-themes. Level one involved reading all the data in relation to each candidate theme and sub-theme to determine if they formed a coherent pattern that was a good representation of the overall narrative of that data (Braun and Clarke 2006 and Byrne 2021). Level two involved reviewing the themes and sub-themes in relation to the entire data set, looking at how well they interpret the data in relation to the research aim and questions (Braun and Clarke 2006 and Byrne 2021).

Level one review

The level one review showed that a number of changes were required. The themes and sub-themes initially generated in thematic map one were changed to five themes, which I felt overall was a better representation of the data. I removed all sub-themes as I felt the meaning within the participants experiences could be captured within five themes. In addition, I felt the revised themes offered more simplicity in describing the overall experiences captured in my analysis. The changes were:

1. Theme 1 – changed from "Being in the world of minor injury nursing education" to "Theory and Practice – from learning to development" to illustrate the journey through these learning experiences. Theory was the foundation to "learn" about minor injury nursing and practice supported "development" in clinical minor injury nursing practice.
2. Sub-themes 1.1 – 1.4 were removed as I felt these were captured in theme one.
3. Sub-themes 1.5 to 1.8 were moved under a new theme. The theme was named "Those that understand should teach" to reflect the importance of minor injury nursing courses that are designed and delivered by educators with experience and involvement in minor injury nursing.
4. Sub-themes 2.1 to 2.4 had a common meaning so I felt the theme "it was more than just an assessment" was enough to capture of all those experiences.
5. Theme 4 was renamed "Preparedness continuum" as it was closer to the experience of how preparedness was an ongoing concern for minor injury nurses.

Level two review

This was undertaken by reviewing the themes alongside my research questions (Byrne 2021). As a brief overview:

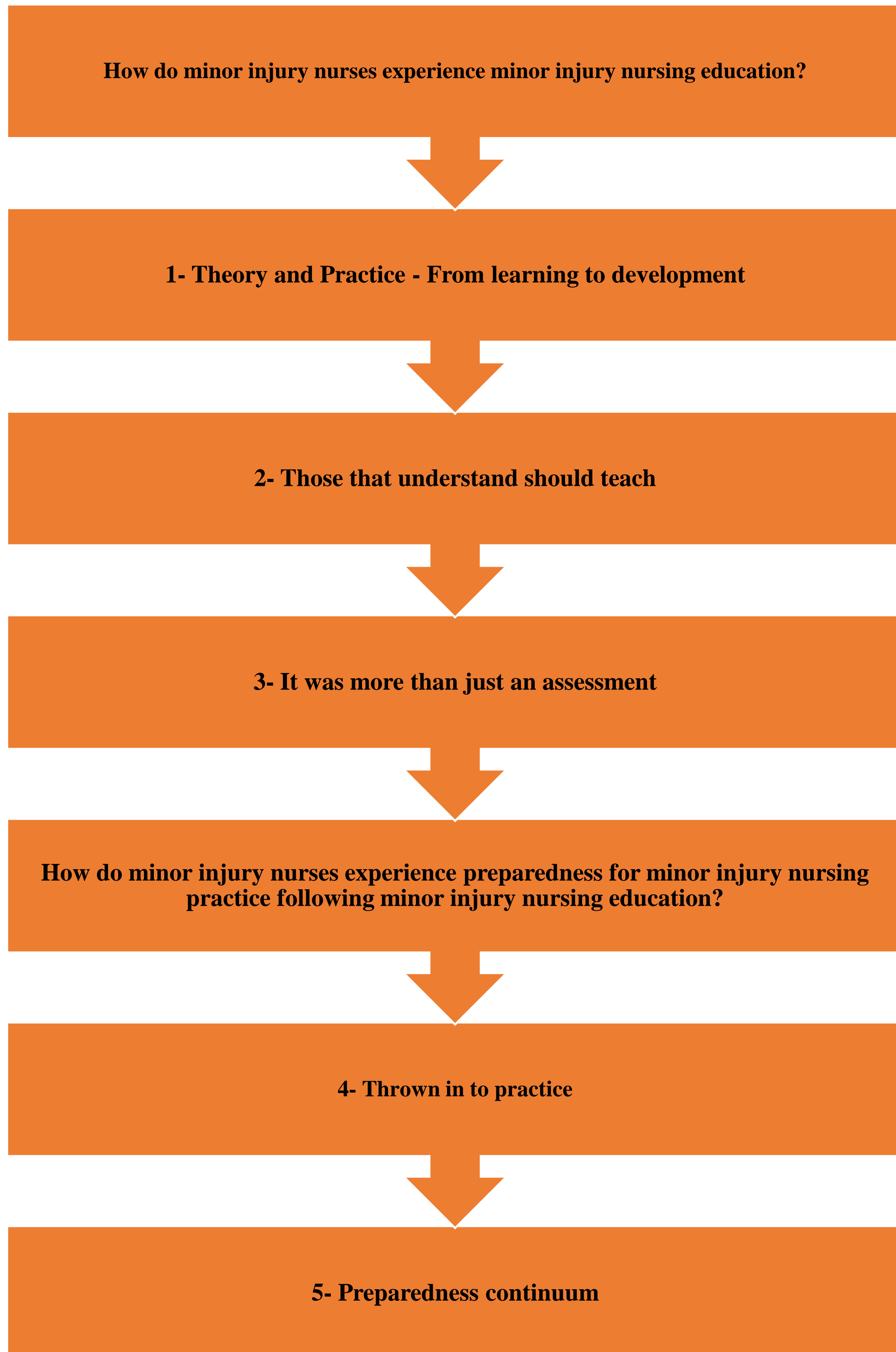
- *How do minor injury nurses experience minor injury nursing education?*

Themes one to three in thematic map two answer the first research question. They represent the data that revealed how both theory and practical-based education was experienced. They also unearth the role and experience of assessment in minor injury nursing education and highlight impactful learning and teaching methods within minor injury nursing education.

- *How do minor injury nurses experience preparedness for minor injury nursing practice following minor injury nursing education?*

Theme four of thematic map two answers the second research question. Theme four draws closer to how preparedness is experienced as the participants moved in to practice. In addition, theme five captures how the experience of preparedness is an ever-evolving phenomenon.

Thematic map - 2



3.24.10 Defining and naming themes

This phase begins when a satisfactory thematic map (Thematic map – 2) is completed (Braun and Clarke 2006). After defining the themes, I conducted and wrote a detailed analysis for each theme. I undertook that by using data extracts and providing an accompanying narrative (Braun and Clarke 2006). The results of this process are presented in chapter four.

3.24.11 Producing the report

One consideration in producing the report is how to display the themes (Byrne 2021). I have presented my themes in what I feel was a logical manner as displayed in thematic map two. This takes the reader through the journey of experiences from the start of the learning journey and throughout completion towards practice. The key at the writing up stage is in selecting the most representative narratives from the data set and presenting them with analytic narrative that goes beyond description and makes an argument in relation to the research question (Braun and Clarke 2006).

3.25 Rigour

Qualitative research focuses on rigour to ensure the trustworthiness of the research process (Henry 2015). Phenomenological researchers must focus more on accuracy in interpreting the participant experiences so the reader can see the process by which the researcher reached their conclusions. (DeChesnay 2014).

The construct of reflexivity supports the application of rigour within phenomenological research (Jootun 2009, Peireira 2012 and, Henry 2015). Reflexivity relates to critical reflection on the degree of influence that the researcher exerts, either intentionally or unintentionally, on the findings (Jootun 2009). Reflexivity enhances the quality of research by offering an awareness and understanding of how the interests and potential bias of the researcher affect the process of the research (Jootun 2009). Reflexivity involves a process of reflecting on oneself, examining and consciously acknowledging the assumptions and preconceptions you bring into the research that shapes the research outcome (Harding 2013). When applying this to my

research, I have been clear in highlighting my prior experiences throughout the research. For example, in detailing my clinical background and how that drew me towards the literature and the subsequent development of my research aim and questions. I have also highlighted my pre-understandings, acknowledging the experiences I bring into this research and how these have been applied philosophically and methodologically. For example, in conducting my interviews I practiced reflexivity, reflexivity during the interview process means understanding the effect the researcher has on the research process and the possible outcomes of the research. From this perspective, the researcher's own background, assumptions and dasein affect the way the research is conducted (Robinson and Kerr 2015). In the context of my research, my pre-understanding supported the development of the interview guide. Having my own lived experience of minor injury nursing education, I was able to actively listen to the participants experiences and guide the hermeneutic conversation and question in ways that uncovered experiences where the participant and I would draw out the meaning within those experiences.

In a continued debate regarding methods for applying rigour, member checking was another method I considered for my phenomenological study (McConnell-Henry et al. 2011 and Henry 2015). Unlike reflexivity, member-checking does not achieve the same level of agreement. It is accepted that member checking allows the qualitative researcher to return to the interview participants to ensure that the initial interpretations are a good representation of the data (Bradbury-Jones et al. 2010 and Henry 2015). However, McConnell-Henry et al (2011) are unyielding in their argument that member checking is unsuitable for interpretive phenomenological studies. Member checking does not align with the philosophical principles of hermeneutic phenomenology (interpretation). Member-checking is unsuitable as human understanding is ever-evolving (McConnell-Henry et al. 2011). Therefore, returning to the participants to confirm an interpretation has little resonance with the interpretive domain and in fact, has the potential to exert bias, by encouraging the participant to agree a direction of interpretation (McConnell-Henry et al. 2011 and Crowther et al. 2017). On that understanding, member-checking was not undertaken, instead, as discussed earlier in this chapter I undertook my interviews using co-constitution to recap and ensure that I had gained a clear representation of the participants meaning within their narratives (Dibley et al. 2020).

With such a wide debate on achieving quality in phenomenological studies it was difficult to know what guidance was best to follow (Pereira 2012). As this was a time-limited doctoral project, undertaken by a novice researcher, a framework was applied for structured guidance,

(De Witt and Ploeg 2006). Having been used in a number of previous phenomenological studies (Shepherd 2014, Stayt et al. 2016, Dunwoody et al. 2019, Lucchese et al. 2021 and, Thomas et al. 2021), De Witt and Ploeg (2006) offer a framework for rigour which is a five-stage approach, described as – balanced integration, openness, concreteness, resonance and actualisation. In the absence of clear guidance, I justified my choice as I could see it had been used widely in previous studies (Shepherd 2014, Stayt et al. 2016, Dunwoody et al. 2019, Lucchese et al. 2021 and, Thomas et al. 2021). From a logical perspective, it offered a clear step-by-step approach that I felt was easy to follow and apply.

The first stage, balanced integration, relates to integration between the philosophical principles of phenomenology, the topic, the methods and the voice of the participants. To achieve this balanced approach, I had to remain aligned to the voice of the participants in drawing out and highlighting their lived experiences. I had to also align with the philosophical principles of hermeneutic phenomenology and maintain an interpretive stance, funnelling the individual experiences of the participants in to the meaning of the overall nature of the experience under study. The objective was to capture the individual lived experience, acknowledging what that meant to the individual, but also uncovering and pulling out in to the light, what that experience represented in the wider context of minor injury nursing, in order to contribute to overall understanding of minor injury nursing education and practice preparedness. As a brief example:

> *"We are essentially Googling and speaking amongst ourselves." (Jura)*

This individual explains that they quite often experience the use of information technology as an information resource to support clinical practice. However, this experience also denotes a phenomenon of isolation in terms of educational support. This experience features a lack of individual clinical knowledge and practice preparedness, with an impression of an underlying anxiety at a lack of preparedness, almost an element of fear. This experience adds to our overall understanding of minor injury nursing education. It is expressive of a need to review the minor injury nursing education strategies so adequate practice preparedness is achieved and thus avoiding experiences such as these.

The second stage, openness, is understood to be achieved by the orientation and attunement towards the phenomenon under study (De Witt and Ploeg 2006). This was achieved by maintaining an open process during the data analysis. Firstly, the interviews were audio-

recorded in order to record all the responses. Throughout, I remained open to all the possibilities within the data and what the data would bring. All interviews were transcribed verbatim. I also had regular meetings with supervisors who guided the coding and thematic analysis process. This process was kept transparent and open to scrutiny. In collaboration with my supervisors, it was decided that data analysis would follow the (Braun and Clarke 2006) reflexive thematic analysis steps for data analysis. In addition, a coding diary was maintained, this accounted for the decisions made for each code assigned during the data analysis and serves as a record should this process need to be reviewed/audited.

The third stage, concreteness, was achieved and is presented in depth within the findings chapter. The findings chapter is a presentation of the data analysis findings. It consists of five themes. The interpretations given in the findings chapter are discussed under each theme. Following each analytical interpretation is a data excerpt that illustrates each interpretation (De Witt and Ploeg 2006).

The fourth expression of rigour is resonance, which relates to the experience of the reader. It is understood to be when the interpreted meaning presented in the study findings are read and understood by the reader. This experience is known within hermeneutic phenomenology as the phenomenological nod (Peireira 2012). In a phenomenological study, the researcher anticipates that the findings have an effect on the reader, one where they step back in contemplation with an affirming nod, where they see the interpretations and acknowledge the developed understanding that has been achieved (Peireira 2012).

The fifth stage, actualisation is an ongoing and evolving process (Peireira 2012). This points to the philosophical principles of phenomenology where there is said to be an ever-interpretation of the world. It is said that interpretation does not end at the conclusion of a phenomenological study, interpretation is ever-changing and this thesis will be subjected to re-interpretation beyond submission and examination (De Witt and Ploeg 2006). Human understanding is an evolving process and thus open to ongoing revision and interpretation. From that phenomenological stance, this research will continue to be re-interpreted gaining different meaning every time it is read (Crowther et al. 2017).

3.26 Chapter three summary

This chapter presented a justification for applying a qualitative approach. Appropriate literature was critiqued outlining the decisions that supported the use of a qualitative methodology. After exploring the most common qualitative methodologies in health research, Hermeneutic phenomenology was explored, discussed and was identified as the most suitable approach to support my research. Hermeneutic phenomenology was chosen as it recognised my prior clinical and research experiences within the field of minor injury nursing as an integral part of the research process. From there, Benner's theoretical framework was explored and her contributions to nursing practice, education and research considered in the context of this study. Furthermore, the most appropriate methods that would support the undertaking of this research were also considered. Various research methods were explored using literature and in addition, previous hermeneutic phenomenological studies were reviewed to further support my decision to use Hermeneutic Phenomenology. Following a review and critique, the methods applied were presented. The findings are now be presented in Chapter four.

Chapter four - findings chapter

4.1 Introduction

This chapter explores: How do minor injury nurses experience minor injury nursing education and how do minor injury nurses experience preparedness for minor injury nursing practice following minor injury nursing education. These research questions arose from a combination of my prior clinical practice experience in minor injury nursing and a gap in the existing research literature. The questions were designed to address the gap in the literature by exploring the lived experience of minor injury nursing education and practice preparedness.

Originating from philosophy, phenomenology offers a unique opportunity to capture the lived experience of research participants. Hermeneutic phenomenology allows the unearthing of phenomena from the perspective of how people interpret and apply meaning to their existence (Pernecky and Jamal 2010). Twelve interviews were undertaken and themes were developed by following the six phases of reflexive thematic analysis within the hermeneutic circle. As Heidegger was a philosopher, he did not propose methods for undertaking research (Gale 2022). Therefore, researchers are tasked with choosing appropriate data analysis methods (Gale 2022). For me, a key strength of reflexive thematic analysis was the structure and guidance it offers a novice researcher. In addition, the interpretive approach of reflexive thematic analysis supported the development of interpretively rich descriptions, understanding and meanings of the participants lived experiences (Pernecky and Jamal 2010).

The participant pseudonyms and characteristics are outlined in tables 9 and 10. To follow is a more detailed description regarding participant characteristics. The participants varied in terms of their job title, types of minor injury nursing education undertaken, the scope of minor injury practice, and particulars related to their place of work. These characteristics were drawn from participant reports in the interviews.

The representation of the participants' lived experience was a co-constitution of the understanding and experience of both the researcher (myself) and the participants and is underpinned by relevant literature (Dibley at el. 2020). Co-constitution refers to the idea that both the researcher and the participants shape the meaning making process. At the outset, my clinical background drew me towards the literature which then identified a gap in the literature.

The literature reinforced my observations that minor injury nursing education is unregulated and fragmented. This stance drew me closer to the phenomenon and encouraged me to take a hermeneutic phenomenological approach. I then engaged in a dialogue with the research participants interpreting their narratives and experiences of minor injury nursing educational preparation. The participants recalled their experiences and perspectives which contributed to the construction of the findings. In presenting the findings, where appropriate, I draw upon relevant literature, the underpinning theoretical framework and hermeneutic phenomenological concepts to help show up meaning. These findings are presented as five themes.

Table 11 presents each of the themes. From there, a summary of the findings is presented. Thereafter, each theme is presented in turn. In exploring each theme, verbatim participant quotes have been selected carefully. Firstly, to acknowledge the language of the participants and to demonstrate understanding of their experiences and secondly, to show the similarities and differences in participants experiences. Some quotes are longer in length than others where more insight in to a particular experience is required. In addition, the exploration within each theme varies in length. For example, theme three "it was more than just assessment" is discussed in more length as the experiences that represent that theme were greater in number. In addition to this, certain participants are quoted more frequently than others. In the interviews, some participants were more forthcoming with their lived experiences. I did try to quote across all the participants to "give voice" to each of their experiences. However, despite using an interview guide and methods to conduct the interviews as effectively as possible, there were participants that shared more than others.

4.2 Participant characteristics

Twelve participants were recruited in to this study. Anonymised details of those participants are included in tables 9 and 10.

Table 9

Participant pseudonyms – Scottish Islands
1- Arran 2- Barra 3- Canna 4- Danna 5- Eday 6- Fara 7- Gairsay 8- Hoy 9- Islay 10- Jura 11- Kilegray 12- Lewis

Table 10

Participant characteristics	
Age range in years	**Number of participants**
18-25	1
25-34	2
34-45	6
45-55	3
55-65	0
65+	0
Years since completion of minor injury nursing course	**Number of participants**
Less than 3	2
3-5	3
5-10	6
10-15	1
15+	0
Minor Injury Unit (MIU)	**Number of participants**
Rural MIU	6
Urban MIU	6
Job Title	**Number of participants**
Emergency Nurse Practitioner (ENP)	6
Advanced Nurse Practitioner (ANP)	2
Minor Injury Nurse	4
Minor injuries qualification	**Number of participants**
Emergency Nurse Practitioner in Minor Injuries	5
Minor Injuries theory	7

All of the participants were registered nurses employed in an emergency/unscheduled care setting. Their role, to varying levels, involved the care of minor injury patient presentations. All participants had undertaken and completed minor injury nursing education delivered by a higher education institute (HEI). The length of experience as minor injury nurses ranged from approximately one year to fifteen years.

All of the participants recruited worked in Scottish minor injury units (MIU). The participants came from two urban MIUs and two rural MIUs. A total of three participants were recruited from each MIU. The Urban MIUs operated in partnership with a major Emergency Department that is physician-led. The urban MIUs were staffed by Emergency Nurse Practitioners (ENP), who are autonomous practitioners who can see, assess, examine, order, and interpret diagnostic tests, diagnose and refer and/or discharge patients over the age of five that present to an MIU, generally with an injury, but scope of practice can extend beyond minor injuries. The ENPs worked in an urban MIU and had primarily undertaken an Emergency Nurse Practitioner course in minor injuries that consists of two weeks of minor injury theory, two weeks of clinical placement in an MIU and some form of support in an MIU workplace. Their competency levels were assessed by Observed Structured Clinical Examinations (OSCE) stations, coursework assignments, and clinical placement logbook.

The rural MIUs were stand-alone units that are nurse led with GP support at certain times. For clinical decision support, they can link to the urban MIUs via telemedicine with an ENP or physician. The rural MIUs are staffed by minor injury staff nurses or advanced nurse practitioners who are extended role nurses with a minor injury qualification. In treating patients with minor injuries, they can see, assess, examine minor injury presentations, refer for limited diagnostic tests but cannot interpret the diagnostic tests. They can formulate a diagnosis, but this scope is less than the ENPs from the urban MIUs and is guided by protocols. Rural MIU nurses can see patients over the age of two. Rural MIU nurses can refer/discharge, but that scope is different from that of the ENP participants who have a greater scope in this area. The rural MIU nurses had primarily undertaken a minor injury theory course that is one week long and is predominantly theory-based with some practical education. They received no clinical placement, and a few reported having some support when working/practicing in their MIU workplace; others reported no support. Competency was assessed by a case study coursework assignment.

In order to preserve the anonymity of participants a more detailed account of characteristics has not been provided to avoid identification of participants by deduction. A breakdown of the gender of participants has been withheld as revealing the exact numbers may allow for identification of participants by deduction. However, the ratio of gender in the participant group did reflect the wider nursing profession where only 11.4% of registered nurses are male (Clifton et al. 2020).

4.3 Overview of the findings

Table 11

Themes
1- Theory and practice – From learning to development
2- Those that understand should teach
3- It was more than just an assessment
4- Thrown in to practice
5- The preparedness continuum

Minor injury nursing education started with theory-based education and this allowed all the participants to shape and underline their personal learning journey. For some, practical-based education experiences then followed that which supported developing as a skilled minor injury nurse. Within the learning environment a number of learning and teaching methods created a supportive platform for the study of minor injury nursing. For a number of participants, these learning and teaching methods were absent. In the absence of these learning and teaching methods, the overall understanding that minor injury nurses need sound theory and practice-based educational experiences was emphasised. Following these varied learning experiences, the participants underwent course assessment and participants felt more informed and aware of further learning needs when assessment of competence was taken with a broader overview. In contrast, a narrowed approach to assessment left participants feeling uncertain about their level of practice preparedness and ongoing learning and development needs. Following assessment, the participants started their journey as minor injury nurses and had varied practice preparedness experiences. The varied experiences of practice preparedness show what that meant for the participants. Experiences varied from feeling prepared by being supported and protected in practice to feeling anxious, alone and not prepared for practice.

To clarify, in presenting the findings, practical based-education is used to describe teaching that involves a hands-on approach. For example, practical-based education can be learning clinical skills within the clinical environment or class-based teaching of hands-on clinical skills, undertaking examinations on fellow students or via simulation.

4.4 Findings

Heidegger saw understanding as interlinked with pre-understandings (Pernecky and Jamal 2010). Therefore, there is an interpretive play of back and forth between the researcher, the participants and theory (Pernecky and Jamal 2010). Heidegger believed pre-understanding shapes our experiences (Pernecky and Jamal 2010). For me, my pre-understandings played a substantial role in shaping how this research developed. During analysis, as I came to this research firmly situated within minor injury nursing, my pre-understandings highlighted that I did not need to understand the context of practice i.e., what is a minor injury nurse? What is their context of clinical practice? Neither, did I need to understand some of the terminology they used. As I had my own lived experiences (my dasein), I was able to underline my study from that pre-understanding. My own lived experiences meant that I could engage in a hermeneutic conversation with participants and draw out their experiences of everydayness that were covered in layers of forgetfulness (Frechette et al. 2020). What I needed from my participants was to explore their dasein. Having established that minor injury nursing education is fragmented and unregulated, I purposively sampled nurses who had undertaken different educational courses to uncover what differences in educational preparation may mean for minor injury nurses. Together, we elucidated the conditions in which understanding of the phenomenon under study took place (Pernecky and Jamal 2010).

4.5 Theory and Practice – from learning to development

Theory and practice – from learning to development reflects the lived experiences of theory and practical-based education within minor injury nursing education. For the participants, theory-based education offered a foundation for the onward study of minor injury nursing. Theory empowered the participants to manage their own learning. Theory connected with their prior experiences, which tailored and established the participants individual and ongoing learning needs. In teaching minor injury nursing theory, particular methods created more in-

depth learning experiences such as self-directed learning and visual learning methods. As the participants moved forward towards practical-based education, they could see that theory had reinforced and supported that transition. The participants felt that their overall development was enhanced when theory and practice were taught in partnership. However, as a lived experience, practical-based education was experienced as a key component of overall development.

Theory-based education offers students a foundation to explore and learn their specialty by asking the right questions and practical-based education is where authentic learning starts, where the complexities and realities that cannot be captured through theory-based education alone are revealed (Benner 1984). The foundational role of theory and the transitional role of both theory and practice and what that meant for the learning and development of the minor injury nurse was captured in the theme *Theory and Practice – from learning to development*. The journey through minor injury nursing education started with a foundation in theory-based education. The experience of theory-based education was widely similar, with all participants concluding that it was predominantly a starting point. It offered the participants a baseline to use for the learning journey ahead as illustrated in the following quotations:

> *"You definitely need the theory to support and back up your practice." (Jura)*

> *"I think you need to understand your theory before you do practical." (Islay)*

These experiences represent a broader understanding among all the participants that there needs to be a good foundation in theory-based education. Theory-based education played a fundamental role for the participants who were embarking upon this new learning journey as experienced nurses. Having a theoretical component as part of the course had several benefits towards learning. Firstly, it allowed participants to underpin their learning needs. Secondly, to explore the field of minor injury nursing and thirdly, by supporting the transition towards practical-based education. The guidance from theory in that context was invaluable as the following quote illustrates:

> *" I don't think you can do the practice well without the theory." (Benbecula)*

For many, embarking upon minor injury nursing education was part of a development opportunity for nurses established within emergency and unscheduled care. As shown in the following quote, the participants, all established in the world of emergency nursing, were entering education to extend their current level of emergency nursing practice:

> *"When I started here you had to have two years' experience in the minor injury unit." (Lewis)*

In terms of Benner's (1984) novice to expert framework the participants had experience of emergency nursing which meant they were not starting their learning journey as novices. Given this, their foundational experience may have placed them on the advanced beginner stage of the novice to expert framework (Benner 1984). Benner (1984) describes advanced beginner's as having enough experience to recognise the recurrence of a meaningful situation. From that standpoint, the participants recognised the value of theory-based education in acknowledging their prior experience which allowed them to explore minor injury nursing, consolidate their experiences, test their current knowledge and acknowledge where they were in terms of learning needs. As Gairsay illustrates, with theory, the participants could focus on specific areas of the curriculum that they needed to learn, which was about supporting their individual direction of learning:

> *" You needed the… you needed the module course (theory) to allow you to focus the areas that you were learning." (Gairsay)*

Within the theory-based component of minor injury nursing courses were lectures that were delivered using various methods. The type of learning methods utilised by a course influenced the perceived quality of the learning experiences and outcomes for many participants. Participants indicated the use of particular methods in their education was a key feature for more in-depth understanding and retention of the learning. Within minor injury nursing education, a dominating feature in the curriculum is the study of anatomy and physiology. Participants were aware that having an in-depth knowledge of surface anatomy was necessary for the examination responsibilities of their clinical role. The importance of being able to explore and grasp anatomy and physiology is captured by Eday who shares their experience:

"Yes, you need to know the structures, I mean stuff like that, you need to know well, clinical experience… this is a mechanism of injury or it's definitely going to be that. You need to know the structures behind it. You can't x-ray a foot and say the foot is sore, you need to know the structures and the bones. What attaches to what and what moves what and what could be affected." (Eday)

At the outset of their educational journey the participants appeared to be at an advanced beginner stage. However, in addition to that, they also showed characteristics that are in keeping with the competent stage of Benner's (1984) novice to expert framework. Benner (1984) highlights competent characteristics in terms of a nurse's ability to recognise longer term learning goals. The participants demonstrated that skill through their understanding that a good grasp of anatomy and physiology improved clinical assessment practice and skills. It may have been that they drew upon their skills that were developed from their experience from "general nursing" and transferred these capabilities across to their new role in minor injury nursing. The participant's pre-understanding in this context meant the participants interpreted this particular learning experience as an essential method of grasping the theoretical teachings of anatomy and physiology. Interwoven throughout that awareness was a more engaged approach to learning methods that enhanced the learning and understanding of anatomy and physiology theory. Anatomy and physiology teaching was delivered in many forms with varying experiences. The following quote demonstrates that of the varying methods used, there were certain methods more supportive of in-depth learning:

"You know, I actually think the one that I found very thought-out and detailed was about the fractures and bones was (ENP name). I know she had done all the drawings. I remember somebody actually drew in the bones in quite good detail." (Danna)

Visual learning is a method of allowing the recognition and the realisation of patterns (Chicca and Chunta 2020) A key feature of visually learning the structures of anatomy was learning and understanding of musculoskeletal anatomy at a deeper, more practical level:

"You can see below the surface, to see what's going on (human anatomy)." (Hoy)

The visual approach to learning theory meant participants were able to develop what was theoretical knowledge into practical knowledge. In practice that allowed the participants to use their developed theoretical understanding to develop physical examination skills, thus effectively closing the theory and practice gap. Danna's experience was shared by Hoy but in a slightly different context. Hoy had a unique experience of an anatomy and physiology lecture that involved the use of medical cadavers. As a learning experience, like diagrams, it was used for delivering a foundational understanding of anatomy and physiology. However, this method of teaching was distinctive as it provided both a theoretical and practical perspective of anatomy. Students were taught anatomy demonstrations on cadaver limbs which involved visualising the structures but also seeing the physical movement that those structures are involved in. Students were able to understand the principles of anatomy and physiology from a visual perspective and then relate that knowledge to the mechanisms of physical human movement. This offered substantial learning, which was evidenced by the enthusiastic descriptions of the experience:

> *"Really really useful and yeah. Because especially if you do things like hands, so you literally get to stand there and you're going right… We've been taught what this is… this is the extensor tendon and you'll perhaps get to pull on it to see what it does, there is visual learning but there's also hands-on learning." (Hoy)*

Like visual diagrams studying cadaver limbs offer learning methods with a mixture of both theory and practical-based learning. However, the use of cadaver limbs took the practical approach a step further and offered more in-depth learning of the relationship between musculoskeletal anatomy and physical movement.

Minor injury nursing courses used podcasts to record aspects of the course content, and these were available as a learning resource for students to access as they required. Described as freedom of access to learning, self-directed learning is said to positively influence student learning (Nordmann and McGeorge 2018). When given responsibility for their own learning, adult learners will experience improved outcomes in terms of learning attainment (Knowles et al. 2005). The participants favoured the convenience of having lectures delivered via a podcast because it offered particular benefits over the traditional style of face-to-face lectures. This method of delivery and self-directed access was particularly beneficial for students as Canna explained:

"Yeah, I think it's just having it as a reusable sort of resource (podcasts) that you can go back and look at it again to make sense." (Canna)

This experience underlines a sense of freedom in self-directing learning, to engage in learning at a pace that suited each individual. Podcasts allowed the participants to explore and view the content at their own learning pace and enhance their learning by re-visiting the learning content as much and at any time the learner needed to. It became clear that self-directed learning was a positive learning experience for the participants.

Another method of supporting self-directed learning was to deliver the course by following a specific timetable. Although courses varied in delivery, generally, courses were delivered either as a block of classes over a week or two or, as odd days over a few weeks/months. Each participant's experience of this nature was individual. Personal preference did play a key role in how course structure was perceived. However, the following quote represents the views of most of the participants. Courses delivered over an extended period of a few weeks were found to be a more guided and incremental way of learning:

"They give you time to research each subject. So, I was ready when I went in and you got subjects you were going to cover that week. So, we do a bit of reading up and then could follow it through afterwards. I think that's better than being too intense and lots of subjects being thrown at you at once." (Fara)

For Heidegger, we are in a present where our actions and experiences unfold and a future where our aspirations and possibilities hold significance for our actions in the present (Cammell 2014). Human existence is in a constant temporal movement between past, present and future (Cammell 2014). The participants experiences were shaped by the perspective of time. For the participants, time between classes meant there was an opportunity to self-direct their learning. Learning occurred in the gap between classes. This perspective of time was situated in the present as in, they were learning the theoretical underpinnings of minor injury nursing. That present moment was an opportunity to pause, reflect on the new learning, to explore it and seek to understand it. However, there was also the temporal experience of looking towards the future and directing the learning towards that learning experience. To study and prepare for the curriculum that lay ahead. In contrast, participants who studied their course as a block of classes experienced a sense that they were overwhelmed:

"So much was crammed in to a short space of time it was difficult to retain everything." (Killegray)

In the absence of time for self-study, the participants found that much of the curriculum, delivered over a short period was overwhelming. Nonetheless, although staggered learning was largely the preferred way to study minor injury nursing, a minority of participants did support block learning. As Jura explained, block learning offered the opposite to staggered learning and for some full immersion was the preferred way to learn:

"I thought by condensing it and just saying do you know what, this whole week we're going to do minor injuries and you were in the zone." (Jura)

The extended period in class was intense and meant "being present". All the lectures were crammed in to a tight, defined period and that intensity was a catalyst for learning. The intensity of learning allowed students to take in as much learning as possible within the defined time period, which offered an opportunity to fully engage in the subject and get fully immersed in the task at hand. Learning this way reduced distractions and kept up the momentum for learning.

Blum (2010) explains that range and depth of learning is necessary in education as they can be key factors in facilitating the student through the Benner (1984) competence stages. Theory-based education played a key role in the initial learning stages and its contribution was made clear. Within those experiences, it was evident that the delivery of theory was more meaningful if integrated in to methods that captured attention and taught using a structure that supported self-directed learning. Theory also supported the transition towards practical-based education. Theory connected with practical-based education by informing and supporting the theory that underpins clinical minor injury skills. Although that relationship was acknowledged, there appeared to be a precarious balance between the two learning methods. When theory dominated the overall learning experiences, participants felt it limited their overall learning and development. Participants of minor injury nursing courses that were seen as heavily theory-based, expressed concern and frustration from limited access to practical-based education. Participants were mindful that an over-emphasis on theory-based education did not support minor injury nursing skills development:

"I think they both have to come together, but I think at the moment nursing has been concentrating too much on the theory side and academic side, you know, you've got to have this qualification. That doesn't make me an experienced practitioner." (Danna)

Arbon (2004) explains that nursing practice is more than a set of skills, it is a way of being, and gaining practice experience allows for interaction within that lived world. For the participants, their dasein meant they were all experienced emergency nurses situated within the world of emergency nursing and therefore knew that minor injury nursing demands a high level of practice-based skills. As outlined by Islay, the participants dasein within emergency nursing meant that they could understand the context of practice (their lifeworld) and that understanding meant they interpreted their learning needs and concluded that any learning should reflect those needs:

"The course itself is a theory-based course, for the role that I do I don't think it was enough. I felt I wasn't competent to see a lot of the patients that I was then expected to see." (Islay)

It was evident that theory-based education served a necessary function in the initial stages of learning minor injury nursing. However, although theory was a key learning experience, practical-based education was the principal feature within minor injury nursing education for developing the participants in to skilled minor injury nurses.

The following quote captures the value of practical-based education. The quote shows that the participants found practical-based education to be much more meaningful. Canna describes a forward movement in their development, an experience where development seems to flow when they engaged in practical-based education. The enriched learning experience from practical-based education manifests from a strong association with clinical practice:

"I think. I think the practical. Because it's, that how… it's having that confidence to go, go and put your hands on somebody and start. That's what I think, once you've, once you've got over that. I think everything else comes." (Canna)

Participants enthusiastically shared their hands-on practice experiences, underlining their experiences with narratives of substantial developmental gains. Hands-on practice had a real-life element to it, and that was a central concept in how practical-based education was experienced:

> *"I think like… we're… getting yourself… that you're feeling a bit more like a practitioner when you're actually doing it. So, I think that's a really important part… is how special… hands on yeah, definitely." (Benbecula)*

The students found that they had the opportunity to practice in an environment similar to a minor injury nurse's daily practice. One where they could explore their skills safely, connecting to what it feels like to be a practicing minor injury nurse but in the safety of a supportive environment. For example, Danna felt that learning in this way was much more supportive than attending lectures and reading study books:

> *"So, I can read books, I can sit and listen to a lecture, but I prefer and learn better within the clinical environment." (Danna)*

Within practical-based education, the participants could explore the role and scope of practice and gain a sense of fortitude that they could bring to actual clinical practice. In the same way that theory-based education had a place as a foundation for learning, practical-based education was fundamental in developing minor injury nurses for the clinical practice requirements of the role.

Experiences from participants who did not receive practical-based education as part of their course emphasised that overall, participants viewed practical-based education as a central pillar in developing minor injury nurses. Experiences where practical-based education was lacking in some courses would stir up feelings of frustration in participants during the interviews. This experience is illustrated in the following quote, Eday emphasises her concern at a lack of practical-based education:

> *" I could've learned more in a day working with an ENP in a busy MIU!!! Its likes of knees, a lot of the girls here don't do knees, but I can do knees as I learned it from an ENP." (Eday)*

Gaining experience in practice, participants experienced a sense that their course had not taught them all aspects of minor injury nursing that they felt it should have. Eday explicates this significance for them by drawing comparisons to a short time spent working with an experienced ENP in an MIU. This experience, not in any way planned as an educational intervention, reinforced a higher level of practice development. Development was underlined by this experience so much so that Eday would have opted for this learning experience versus their entire minor injury nursing course.

The participants all had varying levels of practical-based education within their minor injuries nursing course, despite that, the perceived value of practical-based education was consistent:

> *"Minor injuries education does need to be practical…Hands-on." (Lewis)*

A number of participants were cognisant that practical-based education was lacking in their course. The following quote highlights the frustration surrounding this:

> *"So… like on the day they were doing musculoskeletal. The lecturer even then just came about and put a hand on to one of the students (brief clinical examination demonstration). Yeah. So even just seeing that, it let you see what was going on and just showing how to examine instead of... like it's PowerPoint, you can't tell somebody how to examine till you've seen it." (Islay)*

When participants had few experiences of practical-based education it sparked further debate regarding the balance between theory and practical-based minor injury nursing education. Opting for theory-based traditional lectures versus practical-based education was seen as a less effective learning experience. Participants felt practical-based education would have been a more worthwhile commodity. Participants felt that learning from lectures had a threshold in terms of development. In clarifying their experiences, participants made clear that the key role of theory as a foundation was not disputed. However, the absence of practical-based education was obvious for many and this was encountered as an inability to progress towards development.

4.6 Those that understand should teach

Theobald et al (2021) state that there is substantial evidence that deep learning can only occur if academic and professional partners are explicitly engaged in course development. When minor injury nursing education was designed and delivered on the basis of an understanding of the scope and context of minor injury nursing practice, participants experienced courses that were centred around student learning, clinically relevant and engaging. Being taught in this way captured the attention of students and experiences of this nature reveal how beneficial this was in terms of learning and development.

The importance of understanding a person's lifeworld is critical to understanding the person and how they experience their everyday life. Through this, the ordinary and often taken for granted of another's lifeworld can be uncovered and explored which offers new understanding and perspective (Chesterton and Jack 2021). The strength of that interpretive approach was evident when educators themselves had experience of "being in the world" of minor injury nursing. The interpretation through that particular dasein and situatedness translated in to more effective learning experiences for the students. In sharing their experiences, the participants felt learning outcomes were improved when the minor injury nursing course was developed and delivered with a partnership between the academic (HEI) and professional partners (MIU). The following quote shows that this collaborative approach kept the students updated and informed, where the learning experience of the participant was a priority for the educators:

> *"I think when I did mine after (nurse manager) had set up the minor injury units and the university was such a part of that. She was still very involved with the university and the course and everything. That was such a huge advantage to me because she kept me up to date with everything." (Fara)*

Participants found that collaboration between the HEI and the MIU allowed the direction of learning to remain focused and aligned between the HEI and the MIU. With a collaborative approach, the course content could be tailored between the HEI and MIU to reflect the current focus and stage of learning. This sentiment is heightened and echoed in the experience of other participants but from an alternative perspective. The participants undergoing courses that did not have open lines of communication between the HEI and the MIU experienced missed

opportunities for feedback and development. The lack of collaboration gave a sense of disjointed and disorganised learning experiences:

> *"I mean if the course in (University)… it would be quite nice if it could be linked better to your mentorship here (practice placement). Even if the teachers (HEI) were to even email the mentors here and say this week, we're going to cover such and such it might give the mentors here that heads up as to what to prepare their students for." (Gairsay)*

Participants who had an MIU workplace mentor reflected on that and accepted that communication between the HEI and the MIU would have provided better direction for their learning. Participants explained that the HEI and MIU did not have a mutual understanding of what the professional and academic partners were teaching the trainee minor injury nurse. Neither stakeholder was aware of the development stage of the trainee or indeed of any development issues.

The participants also spoke about their course content and curriculum, and many felt that aspects of that was irrelevant to their role and/or scope of practice. Benner (1984) outlines that nurses on the proficient stage of the novice to expert framework will demonstrate skills in being able to understand a situation and apply significance to a given situation. In terms of a proficient nurse, the participants displayed this characteristic through their ability to recognise that certain aspects of the course content were irrelevant to their role and context of practice. On occasion, their learning time was used to teach subjects they felt did not reflect what they understood to be clinically relevant to minor injury nursing practice. Time spent teaching what the participants felt was irrelevant subjects left the participants with a sense of bewilderment. The participants understood their lifeworld which meant they were able to interpret the "irrelevant" learning experiences and understand the significance of it. Participants felt teaching could have been more pertinent and connected to the role and the scope of practice that they would eventually be undertaking. This was so frustrating for the participants that it left them feeling disconnected, with a sense that the course they undertook was not constructive. Essentially, as Islay explains, it was, to all intents and purposes, a course not worth undertaking:

"The training itself, I wouldn't recommend. I feel there was… there was a lot of information given on one day of musculoskeletal and the week wasn't utilised to cover the whole of the minor injuries." (Islay)

For Heidegger, we are not simply in a present moment but we are influenced by a past that shapes our understanding, we are in a present where our actions and experiences unfold (Cammell 2014). The concept of temporality also illustrates how, with time, the meaning surrounding a particular experience can change. In the present moment, the participants were able to take a past experience and recollect it, peeling away the layers of forgetfulness (Frechette et al. 2020). This temporal experience revealed how their present understanding had shaped what was an understanding of the past. In terms of the relevance of course content, participants did not have the experience or insight to realise that the course they were undertaking was, at times, irrelevant in what it was teaching:

"I thought It was okay at the time. I was just a year in but when you go on it was, it was… What they are teaching now it wasn't adequate at all. Nobody taught you how to examine, nobody showed you how to examine a limb or nothing… Like this is what you should be doing, you were just expected to know." (Lewis)

Participants who were oblivious to this, with experience, now realise that the course they undertook had what they now consider as substantial inadequacies and shortcomings. Having now qualified and gained experience as a minor injury nurse, participants see that their course was taught on the assumption they had already accomplished a foundational knowledge of clinical examination skills. As they had not, what they were taught had little relevance and the participants were unable to close the theory and practice gap. With hindsight, the participants appreciated more what minor injury nursing courses should be teaching. This was expressed in a number of the interviews. Many participants from both the ENP and minor injury theory courses found that their course had irrelevant subject matter in the course content. The perceived level of irrelevance varied amongst the participant experiences. Certain participants found they were taught subjects unrelated to the minor injury nurse role. The following quote illustrates that others found the level of teaching they received was above the scope of practice they would eventually undertake:

"The stuff they do teach you is the stuff that you're like not doing. They are teaching about nerves on the back and everything, but then we're not allowed to do that here." (Eday)

An air of discontentment with course content was evident. Participants were confused by their experience. Participants argued that their course should have focused more on injuries, specifically injuries that they would typically see in their locality:

"But there's a few things I thought, I thought with being remote and seaside… fish injuries and stuff. So, pulling a fish hook out of somebody or something. You do that here. So, what antibiotics do you give. What do you do different, even your likes of telling me about tetanus and stuff, ye know, relevant stuff you use." (Eday)

Participants acknowledged that injuries that present to an MIU could vary depending on location so felt that this should have been considered within the format of teaching. For example, local industry can dictate the types of injuries they would be expected to see. Participants felt it would have been more sensible and beneficial had this been a consideration in the design of the course. Had participants been taught a mix of both the general injuries and specific injuries they could be expected to see, a better level of preparedness for practice would have been achieved, with the skills obtained more congruous to the practice that is demanded of their service.

Some participants could foresee the reason for irrelevant teachings within the minor injury nursing course. Participants suggested that the irrelevance of aspects of the course is related to who teaches on the course:

"We were taught about earache, toothache, a Dermatology reg (physician) came and filled in two hours with slides looking at rashes, yeah, lot of interesting stuff but the scope of our job wasn't understood and probably wasn't implicit in what we learned." (Arran)

The qualities of an educator go beyond simply having expertise in a specific field (Cook 2016). Necessary skills such as effective communication and the ability to act as a role model support

educators in engaging with students (Asio and Riego de Dios 2019, Summers 2017 and Mulholland et al. 2006). Heidegger explained that dasein is characterised by self-awareness, which involves the capacity for introspection and in having the ability to engage in the world in meaningful ways (Moran 2014). When educators who taught minor injury nursing education had lived experience of the minor injury nurse role, they utilised the uniqueness of that existence, drawing upon their own experiences to facilitate teaching. The ENP educators understood the students dasein, meaning that they understood the context of practice and the learning journey of the student through their own learning journey and from being a practicing ENP. From that, the ENP educators used that shared existence to connect with students. The participants' felt lectures were more in-depth, relevant to their role and engaging. The Participants feel that these courses should be delivered by experts who fully understand the minor injury nurse role. Participants who experienced this were keen to share that experience and underlined their experience with positive reflections. So much so, they talked about how gratifying these experiences were. The participants show the ENP educators level of understanding by using terms like "incredible" to illustrate how engaging they were:

> *"It seized ENPs early on and they did come and they taught and their sessions were incredible and they involved looking at each other's limbs and touching each other and they knew what the job was and what we needed to know." (Arran)*

The participants continued to share multiple experiences of this nature and all were very supportive of the concept of the ENP as an educator. There was a wider consensus that ENPs could teach at an engaging level that other professionals could not match as the following quote shows:

> *"ENPs because they've got… that they've gone through it before they've got their hands-on experience, they're more likely to break it down… doctors make it very… very medicalised (pauses to ponder "medicalised")… medicalised, yeah. Having been taught by both. Yeah, I would much prefer to be taught by an ENP." (Hoy)*

The participants did not discount the value of inter-professional teaching. The key strength of the ENP educators was their own lived experience of minor injury nursing education and practice. Those experiences meant they could approach the teaching with more direction and

meant they knew what to teach and when. The ENP educators had a way of communicating the lectures, a familiarity that meant they taught nurse to nurse as Danna explains:

> *"Well, I think it's because the language they (nurses) use, because doctors are taught... I think at… a different level, the language they use we might not grasp as well." (Danna)*

Dasein can be characterised by an ability to comprehend and interpret its surroundings (Sherman 2009). The ENP educators used a shared understanding to engage with students and to facilitate teaching. In addition to ENP educators, participants were also taught by medical staff. Being taught by medical staff offered fewer affirmative influences on learning and development than was experienced after being taught by ENPs. The experiences that made being taught by ENPs so positive were the experiences that made being taught by medical staff less constructive. Medical staff were disconnected from the "being with" or "being-in-the world" of minor injury nurses. Although as physicians, they had an awareness of the context of practice, it was evident that they did not have that understanding or interpretation that the ENP educators had as Benbecula expressed:

> *"The Consultants came in. I feel they just didn't gauge it appropriately or I just felt that it wasn't as good a quality lecture." (Benbecula)*

Communication and understanding of the minor injury nurse role were the main determinants surrounding the experience of the medical delivered lectures. Participants felt that many of the physicians who delivered the lectures did not understand the minor injury nurse role, the level of practice the minor injury nurses would have, nor did they understand any prior knowledge they had. The ENP lecturers were at an advantage and had grasped this by way of their personal lived experience. The medical staff who delivered the lectures were unable to teach as effectively and the content of their lectures had less impact than the ENP delivered lectures. The perception medical staff had regarding the nurses' prior knowledge seemed to impact upon how they delivered the lectures. In terms of the prior knowledge and understanding of the students, the participants felt that the medical staff undertaking the lectures judged the students to have prior knowledge and understanding similar to junior doctors, looking to them to have a similar knowledge base as captured in the following quote:

"A consultant came in to teach and expected ENPs to be at the same level as junior doctors, to have that anatomy knowledge which they don't. It's much more digestible when you are taught by one of your own, an experienced ENP, more approachable to ask. Because you know that they've come through the same process." (Canna)

For the participants, that was not the case. The participants felt that a medical model of education did not fit their role as nurses, their prior experience of learning was very different to that. This meant that their experience was one where they felt less able to relate to the medical staff teachings, and the learning experience as a whole was not constructive. This experience seemed to enhance further the support given to ENP delivered lectures.

4.7 It was more than just an assessment

This theme discusses the experiences the participants had regarding the assessment process as part of their minor injury nursing course. The experiences regarding assessments were varied, not just in how they were perceived but also in the types and numbers of assessments undertaken. The experiences revealed that participants who underwent multiple assessment strategy (coursework assignment, Observed Structured Clinical Examinations (OSCEs) and clinical placement logbook) felt they demonstrated their competence more comprehensively. The same participants also found that the preparation leading up to the assessments offered extra opportunities to learn. On the other hand, participants who undertook singular assessment strategy (coursework assignment only) as part of their course were left with an impression that they had not had their clinical skills and competence subjected to any assessment.

When we are coping skilfully with the world, we experience the entities that surround us as "ready at hand" (Dotov et al. 2010). Conversely "unready at hand" is where our awareness changes when the tools we used to complete a task become deficient. The participants who undertook singular assessment strategy (coursework assignment only) as part of their course gave a distinct impression that there were inadequacies in undertaking singular assessment strategy. The following quotation summarises the collective perception that singular assessment strategy does not confirm clinical competence in minor injury nursing. This quote outlines what that experience meant for the participants. The participants experienced a

disruption at this point in their learning journey leaving the participants "unready-at-hand". Although deemed "competent" to practice minor injury nursing on successful completion of the coursework assignment. The participants, at that point, became very aware of a lack of competence:

> *"Apart from me writing an essay how do you know? I could be a writer for all you know and I could write an essay for minor injuries, get an A, perfect! But I've never touched an ankle or I've never touched a knee before." (Eday)*

The awareness that this experience manifested came from a recognition that the coursework assignment was the only method of assessment that would determine achievement of a minor injury nursing qualification. As a learning experience, the participants who undertook singular assessment method only were concerned by the realisation that the coursework assignment would be the only summative assessment for their course. Participants could not understand how this, in isolation, could verify their level of clinical competence:

> *"I didn't have anything or anyone signing me off clinically." (Danna)*

> *"Once you've passed your assignment, it seems you are legally seen as being competent to practice minor injuries." (Killegray)*

To the participants, minor injury nursing practice is a mainly "hands-on" clinical role. It was evident that developing a written piece of work undertook no inquiry into their clinical capability or indeed inability. This caused the participants to feel frustrated, as they could see the drawbacks of this solitary assessment method. The participants argued that a written assignment that focuses on one injury does not consider the clinical skills required to be a safe and competent minor injury nurse. Assessment by coursework assignment in isolation left too many unanswered questions and missed opportunities to measure learning and development. For participants of the singular method of assessment, being deemed minor injuries qualified was a fearful experience. The impact this had on participants is expressed in the following quotation:

"Because I'm here myself and although and people say to me… remember you are minor injuries trained and I'll say yeah, all I did was an essay on an examination." (Jura)

The participants who went through this experience felt they were at professional risk. This feeling was underlined by an awareness that they had not had their clinical skills subjected to any form of verification. This vulnerability meant they were practicing in areas unfamiliar to them and beyond their scope of skills and practice. Participants voiced their frustration repeatedly about a singular assessment method, time and again, relating their concerns to their clinical practice:

"Anybody can go in and write an essay, if you get this bit of paper you can see, treat and discharge minor injuries! That's a bit of an issue." (Eday)

"I haven't done any of the other practical things. I would say my minor injuries skills aren't great." (Jura)

"It's all well sitting an essay, anybody can sit with books and rewrite what's written but you need to know that it's been retained." (Fara)

It was inconceivable for participants that a practitioner, having never undergone an assessment of their clinical ability, could be deemed competent and able to practice minor injury nursing. In exploring this experience further, the participants continued to share an unease at singular assessment strategy. In addition to verifying competence, participants also found that it was quite restrictive as a learning exercise. In terms of the whole minor injuries' curriculum, the participants who undertook the course assessed by singular assessment strategy only, felt it did not cover the entire minor injuries' curriculum:

"It was on one injury (the assignment)." (Killegray)

"I have never had my practice checked." (Lewis)

Adding to their apprehension, the participants also felt that the main objective of their learning was steered towards academic writing as Killegray expressed in the following quote. This was

raised as a concern as they felt it was a diversion from more pertinent areas such as clinical competency and/or education in clinical minor injuries nursing:

> *"A lot of its being focused on the academic writing style." (Killegray)*

Despite the underlying concerns surrounding this assessment method, the participants did have positive experiences concerning the coursework assignment. Although restrictive in assessing overall clinical competence, the experience of writing an assignment offered an opportunity to focus on and research one clinical aspect of minor injuries nursing as shown in the following quote:

> *" To be honest because of the essay (knee examination case study) that's one of the main things that I remember about my minor injuries is knee examinations". (Jura)*

Having the time and direction to study one aspect of the minor injuries' curriculum, the participants were able to engage in in-depth study. This experience was one of gain, achieving real in-depth knowledge and understanding of that subject area. Despite some of the concerns the participants expressed, the coursework assignment did deliver skills in self-study and allowed the participants to fully grasp certain aspects of the curriculum, skills that they could use to direct and broaden their own learning.

In contrast, the participants who undertook a course with multiple assessment strategy had entirely different experiences concerning the coursework assignment. With different and additional assessment experiences, their view of the coursework assignment was more positive. The following quote highlights how different the experience of the coursework assignment was in that context:

> *"I think it makes you appreciate everything you do in practice is for a reason. So, there's evidence to support why you're doing something why you're sending somebody away in a cast or why you're using a splint. There should be evidence to support this and I think it also made me recognise that you can challenge things as well. If I think that something's not right. You can then go away and find out for yourself and look at that." (Benbecula)*

The participants who underwent multiple assessment strategy reflected more upon the skills the assignment could represent rather than what it did not represent. The experiences shared showed that they found it useful for teaching skills such as searching for and applying evidence to inform their clinical practice. It was experienced as an exercise that gave the practitioners valuable skills that could be transferred in to future learning and practice updates.

Heidegger argued that most human activities comprise of skilful engagement with the world (Zovko 2020). The participants who underwent multiple assessment strategy had the reassurance that other methods of assessment would verify their clinical competence and were therefore experiencing this as "ready-at-hand" (Dotov et al. 2010). The skilful engagement of multiple assessment strategy meant the participants viewed the coursework assignment from a different standpoint. The coursework assignment was helpful in what it represented. Participants embraced it as an opportunity to develop their evidence-based practice skills. When a coursework assignment was integrated in to other methods of assessment, the strengths of this learning experience were much more evident to participants. Participants shared examples of how the coursework assignment taught them skills that they could use in the clinical environment to update knowledge and enhance patient care as the following quotations show:

> *"Yeah, I did wonder why I spent so much of my career using it (Tubigrip sprain support), when you shouldn't probably have been." (Arran)*

> *"I chose water versus saline for wound cleaning which is quite interesting and to be fair we probably use a bit more water for cleaning than we used to because we used to use saline for everything whereas now it's probably more run your hand under the tap and give a good wash because evidence suggests it didn't really make a huge amount of difference for wound cleaning." (Gairsay)*

The process of researching evidence and applying that evidence to their clinical practice gave the participants a sense of confidence in the treatments they were undertaking. It gave them the ability to look at their practice more autonomously, to decide when treatments needed to change to fall in line with the latest evidence.

Participants who underwent multiple assessment strategy continued to advocate the strength of this approach. Those participants felt that multiple assessment strategy was more effective at demonstrating overall competence and preparedness. The collective value of this approach was captured by Canna as the following quotation shows:

> *"So, the OSCEs are your… your actual ability to do a safe examination, but then your log book is actually what you are like in practice with real people, real professionalism and things like that and then the essay looks at your understanding and your ability to critique and use evidence and sort of bring together an argument. So, they're all relevant." (Canna)*

Canna illustrates that assessing competence from different perspectives offered a more rounded appraisal of competence and practice preparedness in minor injury nursing. Multiple assessment strategy viewed competence through a wider lens. Within that, the participants had the opportunity to receive feedback which allowed the participants to be updated on their progress during the learning journey. The addition of this as part of their learning was predominantly a reassurance for the participants. The participants welcomed the opportunity to have their learning and development reviewed. For some, they received feedback at different stages along the learning journey:

> *"It was definitely a log book, we did one on placement. You had like your initial, your, your middle one and then you're end assessment I think when you first qualify." (Benbecula)*

In the learning environment, Oermann (2006) states that feedback allows the students to re-think and revise upon their learning progress. Regular check-ins regarding their progress meant that participants were reassured that their learning was following the intended trajectory with an opportunity to tackle issues had they arisen. Completing a logbook on placement was one way of receiving feedback. Participants that had to undertake this supported the feedback at different stages during the course. The following quotes show that feedback was informative, constructive, and supportive. Informative, as it allowed them to see where they were with their level of knowledge and skill. Constructive, as it was an opportunity to pause and look at areas

that may have needed correction. Supportive as it would highlight areas to develop or indicate where to direct future teaching and learning opportunities.

> *"It gave me that kind of feedback to think. All right (pause) Okay, so I should be doing this in my notes, right… Okay, that's perfect and everything. Yeah. Yeah. That's a good idea. Yeah. It was really good." (Benbecula)*

Participants were assessed at the initial stage of placement with follow-up at the midpoint and endpoint. Completion of the logbook meant that there needed to be a process of assessment and feedback. Doing this at various stages throughout the learning journey allowed the trainee and the supervisors an opportunity to share their experiences and check in on the trainee's progress. As well as a feedback exercise, having a logbook in place encouraged the process of assessment and feedback to actually take place. The logbook encouraged everyone to stop, take stock, track the development of the trainee and provide evidence of skills development as they progressed.

The absence of feedback during learning was evident for some. Experiences such as the following from Eday show that students felt opportunities to connect with educators were absent. When asking the participants from courses of singular assessment strategy about receiving feedback, they recognised that feedback would have supported their further progress and development. These participants did not have to undertake a logbook as part of their course. Despite that, they could envisage the depth of contribution it could have had:

> *"A competency book, not just a book that's shoved in the back of a cupboard, a book that has somebody to come and look at it… this can make you feel safe and safe for the public feel safe because somebody can pick up and can look. To see if you actually know. How do you know everyone is still doing as they were taught? "(Eday)*

Having a logbook was seen as a key to connecting with a senior clinician. It was a means of encouraging the allocation of time and resources to consider assessment and feedback. Despite Eday's experience being particular to them, the sense that participants felt isolated and detached from constructive feedback was a consistent experience. The participants of singular assessment strategy shared their experiences of assessment, much of which were overshadowed

by feelings of frustration at what they felt was a poor overview of their competence and learning attainment. Overall, the majority of participants experiences of assessment strategy were of them being left with an awareness that they had received very little constructive clinical feedback.

OSCEs are an opportunity to allow the student to learn, explore clinical practice in safe, life-like scenarios where they have the freedom to map their progress and gain confidence as their experience grows (Sola et al. 2020 and Bani-issa et al. 2019). OSCEs were part of the courses that assessed using multiple assessment strategy. OSCEs were a method of summative assessment intended to assess the students' clinical skills prior to completion of their course. Despite the requirement to undertake OSCEs for assessment purposes, their experience of them was one of more than just assessment. Participants spoke about the experiences they had leading up to their OSCEs. They found that having to plan and prepare for them was in itself a driver towards development. Explaining a little further, the participants would, for example, undertake six OSCE stations that assessed different clinical aspects of minor injury nursing. For example, a wrist injury or a knee injury. These six stations could have been focused on any part of the minor injuries' curriculum. Due to a level of uncertainty, the trainees were under pressure to revise and prepare for the whole minor injuries' curriculum. The following quotes represent wider opinion that OSCEs were a driver for learning as much as they were a means of assessment, this experience allowed the participants to gain confidence and competence:

"Yeah, actually, by also having your OSCEs. I think you definitely think well… I've done that. Because you obviously will learn more than just, you didn't know which six you were going to get so you obviously learnt most of them. So, you knew that you could do those things to start with." (Benbecula)

"Definitely having the pressure of having to do your OSCEs made you certainly buckle down and learn what you had to learn. So, you have to study hard because you didn't know what was going to be… was going to be there." (Gairsay)

The pressure of upcoming OSCEs carried a level of anxiety, but the anxiety was a positive driving force for learning. It directed the trainees in their progression. The anxiety and pressure were well received as the participants found that it encouraged them to learn where they may have otherwise not been encouraged to. Additional gains from OSCEs were the confidence it afforded the trainees regarding their clinical skills and ability. Participants found that having to practise for them prepared them for real-life clinical practice:

"I think the run-up and the actual practicing of our OSCEs and the doing your OSCEs got you prepared for the real-life stuff." (Benbecula)

As the participants gained experience through OSCE practice, they found the gradual exposure and opportunity to explore minor injury nursing practice in the form of a simulated patient consultation helped prepare them for when they eventually started treating patients in the MIU. This experience gave them a safe environment to explore, yet it was similar to actual clinical practice. Practice with a simulated patient brought them a step closer towards preparedness for practice.

Progression through the levels of the novice to expert framework relies upon sound educational experiences (Benner 1984). Overall, the participants experiences show how both theory and practice enhance the learning and development experiences of a minor injury nurse. Upon completion of that stage in learning, the experience of undertaking multi-method assessment strategy is more positive than singular assessment strategy. Multiple-assessment strategy assessed competence from a broader perspective which meant that ongoing learning needs are highlighted. That perspective is encouraging and supports further learning and development

which moved the participants towards the competence stage of Benner's (1984) novice to expert framework.

4.8 Thrown in to practice

Thrown into practice is an exploration of the experiences of the transition from completion of the course into autonomous minor injury nursing practice. This theme encompasses the point in the participants learning journey where they were now qualified and undertaking a qualified minor injury nurse role. All the participants expressed different levels, interpretations and experiences of practice preparedness. Exploring and understanding the experiences that participants had throughout their learning journey revealed how preparedness is achieved. The participants lived experiences show that preparedness is a journey and is incremental in how it is achieved. The perceived levels of practice preparedness were dependent on the opportunity to access the following learning experiences: A foundation of theory-based education, practical-based education, multiple learning methods, academic and professional partners collaboration, teaching from experienced ENPs, assessments that involve multi-method assessment strategy and supervision within the MIU workplace and practice updates. When certain learning opportunities within that context were not available in various minor injury nursing courses, the perceived levels of practice preparedness were lower.

Heidegger introduced the concept of thrownness, thrownness is always ongoing which means we are always at a starting point within the world (Wilthy 2014, Roth 2018). When asking the participants to reflect back upon their starting point in practice; where they were "thrown in to practice", and consider what experience they felt supported a transition towards being prepared to practice, they often looked specifically to the provision of workplace support and supervision. Across the participants, the transition in to practice was experienced differently. How their transition in to practice was experienced was dependent on the provision of workplace support/supervision. Making that leap towards practice preparedness was reliant on supervision as the following quote illustrates:

> *"To be in a supportive environment. So, I don't think if I was dropped in the deep end, I probably wouldn't have got on very well. Although I felt capable, I wouldn't have been confident, you know?" (Benbecula)*

In clinical practice, a lack of supervision in the workplace leads to a lack of refined professional skills and this experience creates a sense of anxiety at a perceived inability to undertake the requirements of the role (Tham and Lynch 2014 and Sharif and Masoumi 2005). For the participants, supervision in the workplace offered a sense of safety. It was reassuring that they had colleagues who would support them in clinical decision-making should they come upon a case they felt they did not have the knowledge, skills and experience to deal with autonomously. A number of participants who worked in units with experienced minor injury nurses spoke of their positive influence and the invaluable clinical support:

> *"Having good support is so important and I think that's what's fantastic about this unit. Everybody here is so experienced, all the band sevens are static here they are excellent at their jobs and you know when you're over here working if you have any problems, you've got everyone to ask." (Benbecula)*

Having this support in the early stages was instrumental in their development and seen as a necessity to support practice. Not only was having workplace supervision a support to participants, it was also an opportunity to verify their clinical practice and an opportunity to receive feedback on performance. More than that, the network of support also provided safety for practitioners and patients in their care by supporting clinical care and decisions:

> *"I mean there's always another minor injury nurse at the time when I did mine, everybody here was minor injury trained so there was always somebody else, so you had kind of supervision. I mean quite probably they did in the first few weeks you know like double check that I was doing things right and yeah yeah there was always somebody for you." (Fara)*

The provision of supervision within the MIU indicated an environment of support that was central in the early stages of qualified minor injury nursing practice. These experiences enhanced practice preparedness experiences at this stage in the learning journey.

In contrast, for the participants who were thrown in to practice and felt they were not prepared for practice, experienced an uncomfortable transition with negative feelings. The following quote shows a level of fear amplified by a clinical expectation that they felt could not be met:

"I certainly I felt I wasn't competent to see a lot of the patients that I was then expected to see." (Islay)

Charlette et al (2019) state that practitioners new to an area of practice can worry that they are expected to be at the competent stage of Benner's (1984) framework when they are not. An inability to cope skilfully with the world is where we become aware of the task in hand as "unready-at-hand" (Dotov et al. 2010). Participants described the experience where a lack of practice preparedness was amplified by the demands their role set upon them. They explained that they felt they did not have the required competence to see the minor injury patients they were expected to see. Experiencing a perceived lack of clinical competence is echoed across the participants who felt they were not prepared for practice. These participants are anxious about their lack of knowledge, and they admit that this forces them to look towards any available resource to fill the knowledge gaps, as the following quotation shows:

"We are essentially Googling and speaking amongst ourselves." (Jura)

Participants who felt that their course did not prepare them for practice, evidently did not feel competent on completing the course. Despite that, the course did still play a part in their learning as Killegray describes:

"It's just been a case of I learned on the job. I would say the course didn't make me competent. It's just that it's helped give me some theory towards the practice that's being done. I don't feel like it was not worthwhile, my course was worthwhile, but it certainly could have been better with more support." (Killegray)

Educational development must involve both theory and clinical practice for successful progression through the development stages (Benner 1984). Participants who felt less prepared for practice felt their course offered them a theoretical foundation. That foundation did have the potential to build upon. However, the course failed to make that leap towards preparing them thoroughly for minor injury nursing practice. Again, workplace support/supervision is seen as a key factor for supporting practice preparedness and the absence of that meant participants did not feel practice prepared. Minor injury nurses who work in rural MIUs especially, feel that their workplace support/supervision could be improved. By way of support,

the following quote from a participant working in a rural MIU reveals that facilitating better communication channels would improve the opportunities the minor injury nurses have to develop. For the participants, this provision would support their minor injury knowledge and help remain abreast of any changes in minor injury clinical practice, with the opportunity to ensure practice is uniform amongst the MIUs:

> *"And we feel we are behind a lot of practice and you know, we're (distance in miles) from the main MIU. There's no communication and then what happens is we get, we get… not shouted at, we get pulled up because they're saying well, you're not keeping with current… but we're… it's not being communicated to us!… the current practice." (Jura)*

The experience rural MIU nurses have, leaves them feeling that they are detached when it comes to minor injury nursing practice changes. This reveals a sense of isolation that resonates with the feeling that they are not included in any updates or development. This experience opens up these units to risks of clinical practices becoming outdated. It is frustrating for participants to see the value support would have if adopted in practice:

> *"I think that's probably what is lacking here. We don't get support. We have a lot of experience now; it wouldn't take much to go over something. Maybe just all the grey areas, the little niggles." (Lewis)*

Some participants felt they practiced with a continued feeling of being unsupported. It was evident that this feeling dominated their work as they had considered possible solutions to this perceived problem. The possible solutions they considered were, in their view, reasonable and something that would not involve significant investment. Support and mentorship are not just about feedback, teaching and development. Participants detached from support in the MIU also struggle with the fact it is as much about patient safety as the following experiences illustrate:

> *"Because the thing is who is there to tell you? because me on duty just now, so I'm on here minor injuries trained with a nurse who isn't or I'm on nights by myself with an auxiliary (unregistered nurse)." (Eday)*

"But I think the only time you learned really is when you do something wrong and then you learn…you go… I should have really oh, I didn't realise that was wrong." (Eday)

Being new to an area of practice is a worrying time and the experiences show that unsupported practice can involve a level of risk. Participants had experiences where they felt that they only learned after making mistakes. In the absence of a network of support, participants describe their feeling of isolation:

"We were unsupported, Och, it wasn't a great time" (Arran)

Participants are aware that lone working meant that mistakes and errors in care could go unnoticed without support and supervision. Participants feared they were practicing with a level of unknowing incompetence. This leaves a continuous background sense of vulnerability for the minor injury nurses and opens a level of avoidable risk for the patients in their care. Having support and supervision, in their opinion, could have reduced the potential incidence of error.

4.9 The preparedness continuum

The preparedness continuum describes how preparedness is experienced beyond completion of minor injury nursing education. At the outset, I sought to understand how minor injury nursing education was experienced and how education supported practice preparedness. This was achieved. However, it became evident that practice preparedness is an ongoing lived experience, one that follows the participants beyond their studies. To maintain and continue developing preparedness for practice, it transpired that receiving practice updates is necessary for maintaining practice preparedness. This was especially relevant in smaller MIU departments where fewer patients are presenting with minor injuries as Jura highlighted:

" So, I think possibly having some period of consolidation afterwards. Going through to minor injuries (Main MIU) and just seeing minor injury after minor injury. Since then, one of our colleagues has been through so that was amazing. In our department, you'll see something, you won't see anything like that for two to

three months and then you have kind of forgotten how you managed it and forgotten how you dealt with it." (Jura)

In nursing, there is a need for knowledge to be expanded constantly (Oshvandi et al. 2016). For minor injury nurses, a need for practice updates was more apparent in participants where the minor injury nurse may work alone and may not have the network of experienced minor injury nurses that a busier MIU may have. Participants working in a rural MIU all highlighted this. Participants feel that opportunities to update practices should be made available to them. The wider concern in this context, as Jura highlighted, is that a lower number of patients presenting with minor injuries mean that practice may become outdated:

"Here you can get a spate of the same thing where you get really up to it. Then it could be a year down the line until you get it again and you are like… Oh!" (Lewis)

This experience means the opportunity to maintain skills is reduced and thus confidence decreases. The participants concede that this position indicated a necessity for practice update opportunities to maintain clinical skills. The merit of these opportunities was shared by participants who attended a minor injury nursing practice update. Arran shares an experience which involved a practice update by an experienced ENP. It is evident in their description that this experience added to and reinforced their knowledge, practice and skills. Arran describes the shock from the realisation that they unwittingly had significant gaps in knowledge:

"So, I remember turning up to XXX hospital one day to meet this man we had heard about to talk about wrist assessments and scaphoids and I sat there for 2 hours and my jaw just hit the floor, why did I not know this 2 years ago, this was an experienced ENP, who knew what my job was, who knew what I needed to do to do it and I wasn't getting out of that room until I could do it." (Arran)

Participants found, that opportunities of this nature, delivered by an experienced ENP, can enhance and maintain knowledge and skills. In addition to providing an opportunity to learn and develop, these events provided opportunities for minor injury staff to network amongst the wider MIU teams. Despite the MIUs all being governed by the same health board, participants found that staff from MIUs were unaware of clinical practice changes and updates:

"There is a course (delivered by ENP) set up and it was in (location) and there was a minor injury refresher and that was really interesting because there were girls from other areas. There were things that they didn't realise had changed and things that we didn't realise had changed." (Fara)

Facilitating practice updates was a chance for teams to connect, to communicate and share their experiences. The following quote illustrates a level of enthusiasm for learning that was seen across all the participants. Participants speak about the occasions when they work with an experienced ENP. Their experiences are so descriptive about how they engage with and absorb this learning opportunity:

"Well, it's great having... like when ENPs come to do shifts because we just… we are like sponges." (Fara)

The experience of working alongside an experienced ENP is so positive, the participants would like to see a dedicated ENP educator role in their area:

"The likes of an ENP lead, we don't have that, we don't have that teaching." (Fara)

The value of practice updates and the sense of a need to keep learning is clear. However, not all participants receive this opportunity. The following quote represents the wider opinion that practice updates should become a regular feature of minor injury nursing education beyond completion of the course:

"I think we should have refreshers every two years as an ENP because we don't get revalidated on our ENP. I think we perhaps should have OSCEs every two years. " (Hoy)

Many participants in both rural and urban MIUs stated that practice updates are rare or absent in minor injury nursing. Participants were frustrated by this absence. Their frustration is heightened as participants often see that opportunities for practice updates are disproportionately allocated to their colleagues from other health/medical professions:

"As ENPs we don't have protective learning time. We do not have a set time like the doctors do on a weekly basis and the PA's (physician associates) do on a weekly basis and the ANPs that come in will have their protected learning time, whereas we here don't." (Gairsay)

The participants showed characteristics that were in keeping with the proficient stage of Benner's (1984) novice to expert framework. In that, they were able to interpret the significance of the lack of practice updates and envisage the impact this would have in what they would likely encounter in their future practice. This reflects Heidegger's concept of temporality where our aspirations and possibilities hold significance for our actions in the present (Cammell 2014). Participants found it difficult to accept that they have no protected learning time that supports practice updates, a provision that other colleagues in similarly autonomous roles receive. In illustrating this, Hoy expresses their anxiety surrounding the inevitable future progression towards the education and mentorship of upcoming trainee minor injury nurses. They underline their concern by highlighting that educating other junior minor injury nurses without themselves receiving adequate provision for knowledge development is not feasible:

" I don't think, I don't think that… we probably shouldn't be teaching ENP trainees if we're not up to speed on our own training." (Hoy)

Providing educational support and development is necessary to reduce professional isolation and is known to support personal and professional growth (Cummins 2009). The quotation from Hoy illustrates an experience of vexation. Hoy underlines a recurring experience amongst minor injury nurses. Minor injury nursing education is unregulated and fragmented and the varied approach courses take towards educating nurses manifests varied practice preparedness experiences. The language that Hoy uses "not up to speed" captures the disconnectedness that exists in supporting practice preparedness in minor injury nursing. It captures the meaning this has for many of the participants that a lack of support for learning and development is a burden on minor injury nurses. It emphasises the concern that ongoing development of minor injury nurses appears to be of a low priority in some organisations

4.10 Chapter four summary

Five themes were generated from the participants experiences of minor injury nursing education and experiences of practice preparedness. 1- Theory and practice – From learning to development, 2-Those that understand should teach, 3- It was more than just an assessment, 4- Thrown in to practice, 5- The preparedness continuum.

In summary, the findings explore the entire journey through minor injury nursing education; connecting with the varied lived experiences of the participants and seeking to understand the meaning within the participant experiences. Minor injury nursing education typically started with theory-based education. Theory was used to emphasise individual learning needs by connecting with prior experiences in practice. To develop clinical minor injury nursing skills, practical-based education was essential. For some, a practical-based approach to education did not form part of their course. The exploration of educational experiences of the participants uncovered and revealed the key strengths of different methods and approaches to delivering minor injury nursing education. In addition to that, the process of assessment was then highlighted, revealing that a broad approach to assessment had many benefits for supporting learning and development. Conversely, this part of the exploration showed how singular assessment strategy disrupted the learning journey, impeding competence, understanding and onward learning and development. In concluding the findings, experiences of practice preparedness were explored, revealing the strength of supervision and clinical support within the transition in to practice and how support with learning and development remain pertinent beyond completion of minor injury nursing education. In the absence of this provision of support in practice, minor injury nurses expressed concern about their level of practice preparedness. Overall, my analysis shed light on the entire learning journey, exposing fundamental learning experiences that enhanced the transition in to prepared minor injury nursing practice. In chapter five, the findings are discussed in relation to the new knowledge they contribute and the discussion is underlined by philosophical concepts, the theoretical framework and existing research evidence and theory.

Chapter Five – Discussion

5.1 Introduction

This chapter aims to demonstrate how the findings sit within the wider literature whilst also walking alongside the underpinning philosophy and the theoretical framework. The participants had all undertaken minor injury nursing education. The participants and the researcher (myself) discussed the participants educational preparation experiences using semi-structured interviews. During that interaction, the participants experiences of educational preparation emerged, highlighting how minor injury nursing education and practice preparedness was experienced by the participants. Through co-constitution, the participants and the researcher drew out the meaning of those experiences and this offers new understanding and perspective of the phenomenon of minor injury nursing educational preparation

Five themes that describe how minor injury nursing education and practice preparedness is experienced were generated. The themes are: 1 Theory and Practice – From learning to development. 2 Those that understand should teach. 3 It was more than just assessment. 4 Thrown into practice. 5 The preparedness continuum.

This chapter will begin by summarising the key findings and give a brief overview of how the themes answer the research questions. From there, the chapter will then explore the parts that contribute to the whole by starting with a return to hermeneutic phenomenology by outlining how the philosophical concepts introduced in chapter three helped to surface the meaning behind the participants experiences (Crowther and Thomson 2020). From there, the Benner (1984) novice to expert theoretical framework will be discussed considering how it underpinned this research, how it supported interpretation and in understanding the meaning behind some of the lived experiences of the participants. Thereafter, this chapter will present each theme in turn firstly by presenting a summary of that theme followed by an interpretive discussion of the findings in relation to existing research. Due to the individual nature of each theme, certain themes have more experiences within them and the discussion surrounding some themes is therefore longer than others. The chapter will then conclude with a summary that represents the developed understanding and new interpretive whole.

5.2 Key findings

The key findings were that nurses experienced minor injury education as having vastly different educational experiences. For some, there were sound educational experiences that supported and moved nurses through learning towards development in minor injury nursing practice. For others there were a number of useful learning experiences. However, there were also absent educational experiences that impeded upon the development of minor injury nursing skills. On embarking upon minor injury nursing practice, the experience of being prepared for practice was dependent on the presence of workplace support. In addition, practice preparedness was experienced as an ongoing phenomenon. My findings emphasised what ongoing development in clinical practice meant for supporting minor injury nursing practice preparedness over the longer term.

In chapter two, I presented a hermeneutic phenomenological literature review that identified a gap in the existing research, in combination with my prior clinical experiences in this field of practice, this led to two research questions that guided my study:

1- How do minor injury nurses experience minor injury nursing education?
2- How do minor injury nurses experience preparedness for minor injury nursing practice following minor injury nursing education?

Themes one to three answer the first research question by denoting key stages of learning throughout minor injury nursing education from the early stages of undertaking theory-based education, towards practical-based education and then to the final stages of undertaking course assessments. Within each theme are different experiences the participants had and each - learning experience is explored to gain insight in to exactly how they support learning and development. Themes four and five answer the second research question and indicate what the experience of practice preparedness was for the participants following minor injury nursing education. The key experiences that support a prepared transition in to minor injury nursing are revealed with an emphasis on viewing practice preparedness as an on-going concern as minor injury nurses move forward in their career.

5.3 Returning to the hermeneutic phenomenological concepts

Hermeneutic phenomenology provides researchers with a way of valuing stories that express the experiences of others and researchers use this approach to unpack and repack the experiences of others so they can explicate the meaning (Miles 2013). The application of hermeneutic phenomenological concepts in research can allow the meaning of other's lived experiences to emerge and can offer deep understanding of a phenomenon (Miles 2013). I will now discuss the hermeneutic phenomenological concepts introduced in chapter three and outline how they supported and helped uncover meaning within the some of the participants lived experiences. By starting this chapter with a return to the hermeneutic phenomenological concepts, I aim to show how this formed part of the interpretive whole.

In hermeneutic phenomenology, there is no finite interpretation, multiple concepts could have been used as they can surface the overflowing meaning that dwells within each lived experience (Crowther and Thomson 2020). For Heidegger, the fundamental basis through which human beings come to know and understand their world is essentially hidden, forgotten and covered up (Crowther and Thomson 2020). For my research, dasein emphasised the unique experience of "being in the world" of minor injury nursing. Dasein emphasised the importance of uncovering and understanding both my own and the participants lifeworld and how our existence is deeply intertwined in the world. Dasein recognised that both myself and the participants were situated within minor injury nursing and accepted that holistic understanding involved unique background experiences (Suddick et al. 2020).

In the very early stages, it was my dasein or my "being-with" my minor injury nursing colleagues that alerted me to the need to undertake this research. My dasein was an integral part of the phenomenon that I studied. My situatedness within minor injury nursing led me to a place of awareness that minor injury nurses had different educational experiences. This then took me to a place of questioning. I considered both my own and the participants educational preparation experiences. It was that existence that drew me towards a hermeneutic phenomenological study. Dasein encouraged the reflective practice of acknowledging my pre-understandings that I brought to this research (Chesterton and Jack 2021). My pre-understandings or (fore-structures) comprised of, fore-having, fore-sight and fore-conception

(Geanellos 1998, Warnke 2011). Fore-having acknowledged that I was situated within minor injury nursing and considered that familiarity would make interpretation possible. Fore-sight dictated that I made an interpretation from a point of view because of my past experiences and fore-conception was what I might anticipate in the interpretation. Being situated in the world of minor injury nursing also meant I had an understanding of the participants I wanted to interview, hence my purposive sampling approach. I understood the participants dasein, which meant I knew that they had lived experiences of the phenomenon I wanted to explore.

The concept of dasein not only underpinned this research it also supported the interpretation of specific participants lived experiences. Dasein involves an individual's existence in the world and their lived experiences that surround that (Moran 2014). The concept of dasein was also useful for understanding the ENP educators' lifeworld and what that meant in their approach to teaching and why that was so effective. During teaching, ENP educators incorporated dasein into education. By emphasising their own lived experiences, they were able to form effective connections with students. The meaning of that for minor injury nursing education is that ENP educators could use their situated understanding of "being in the world" of minor injury nursing to facilitate education. Their own journey through a similar experience underpinned and informed how and what to teach. That shared understanding and interpretation resulted in teaching that created transformative learning experiences that the physician educators could not manifest. Dasein also revealed how the participants used their understanding of their own lifeworld (emergency nursing) in how they interpreted and experienced parts of their minor injury nursing education. For example, using their prior emergency nursing experience to engage with theory-based education and focus on parts of the curriculum that they felt were key for supporting their specific learning needs.

The concepts of ready-at-hand and unready-at-hand held significance for understanding how the participants skilfully engaged with their educational journey (Dotov et al. 2020). More specifically, these concepts underlined how the participants experienced their perceived levels of competence and preparedness for practice. For example, when participants were faced with assessment that, in their mind, did not have the assessment methods that would measure their understanding and skills effectively, their learning journey became disrupted. The participants were left with a sense that they were not aware of their level of competence or their ongoing

learning and development needs. The concept of unready-at-hand explained what the participants were experiencing in that context. In contrast, the participants of multi-method assessment strategy felt they were “ready-at-hand” as the broad perspective from multi-method assessment meant that they had the tools to understand their competence levels, giving them a sense of flowing forward with awareness of their learning and development needs (Dotov et al. 2020).

For Heidegger, we are not simply in a present moment but we are influenced by a past that shapes our understanding, we are in a present where our actions and experiences unfold and a future where our aspirations and possibilities hold significance for our actions in the present (Cammell 2014). Understanding the concept of temporality was relevant in acknowledging that I was asking the participants to recall experiences from their past and consider the meaning of those experiences in the present. It became apparent that this was more than simply recalling a specific group of experiences. The temporal experience of time can change the significance of an experience (Cammell 2014). For example, there were participants who at the time of their minor injury nursing education felt their course was adequate. However, with time and more understanding through experience, they could now see the course as having substantial shortcomings and they now understood what that meant. Temporality was also considered within the participants experiences of continuity of learning. The participants were able to envisage their future practice and that temporal experience meant that they could understand, situate and prioritise their present learning needs. Temporality emphasised how the participants knew that practice updates were integral for continuity of learning and they knew that this was something that should be a continued component of and throughout their career.

Heidegger’s concept of thrownness was particularly useful for understanding how the participants experienced the transition from education towards practice. Thrownness means that we are thrown in to something or given over to something from which we have to start and deal with (Wilthy 2014). Thrownness emphasised the fact that the participants were thrown in to practice when they completed their minor injury nursing education. This concept outlined that the participants found themselves at the start of a new experience, one where they had to deal with (minor injury nursing practice). For some of the participants they were thrown towards practice with educational experiences and support within practice that allowed them

to deal with practice in a prepared way. For others, those possibilities were not available and inadequate educational experiences and a lack of support in the workplace meant they were dealing with this new practice in an unprepared way.

5.4 Returning to Benner's novice to expert framework

Using Benner's (1984) novice to expert as my theoretical framework, the lived experiences of the participants were articulated and the learning process that was embedded in the lived experiences of the participants were uncovered and explored. This exploration has manifested more awareness of the learning and development transitional needs of minor injury nurses in moving them through the stages of competence and in preparing them for practice. Benner's framework, at the outset offered an understanding of how nurses learn. Benner's framework was also a useful conceptual framework that mapped out stages of development to show that competence increases as learning experiences are gained. The framework also offered a lens through which to view the data. In applying the framework during analysis determined that it supports the orientation of levels of practice preparedness. Benner's (1984) novice to expert framework offers a tool to articulate a level of preparedness i.e., the minor injury nurse reached the competent level after their minor injury nursing education. Conversely, the framework helped to determine that when minor injury nursing education does not prepare for practice, students who feel they are not prepared to practice may remain below the competent part of the framework. In that context, the framework also allowed articulation of how specific learning experiences could support and accelerate nurses through the stages of competence.

Despite the strength of Benner's (1984) framework, there were some limitations. For example, in the framework, movement towards competence is based on the assumptions that there will be adequate learning and experience opportunities to support the transition through the developmental stages. In contrast to that, my findings determined that learning opportunities that support movement through development stages were often absent for many of the participants. In that context, Benner's framework is limited in the guidance in can give practitioners who do not receive the learning and development experiences that support movement through the stages of competence.

In addition, it became clear that the participants revealed characteristics that were in keeping with more advanced stages of the novice to expert framework. For example, the participants were all experienced emergency nurses prior to starting their minor injury nursing education so started with varying levels of experience in minor injury care. Given the prior experience of the participants they may have started their educational journey beyond the novice stage of the framework. Changing a role within nursing can, for some, see the practitioner go from expert in one area of practice, to novice in another (Spencer 2013). Given the prior experiences of the participants in emergency nursing, they could have been placed on the advanced beginner stage in recognition of their prior clinical experiences. In addition to that, the participants were also able to move beyond that and demonstrate competent and proficient characteristics during their journey of learning. This more advanced perspective was demonstrated by how they acknowledged and engaged with learning, showing that they understood the significance of what they were learning despite being in the early stages of education. This does raise the question of whether a new learning journey is affected by starting at different stages on the framework and, should the approaches to education be different in that context. A further limitation in that context is that the adjustment within the stages of competency is ambiguous given the lack of specific guidance. Overall, Benner's (1984) framework appears to be more focused on undergraduate and newly graduated nurses. As my participants were post-registration nurses who are advancing their skills in an area they are already experienced in, the framework is arguably too generic to offer specific guidance. Nonetheless, Benner's framework has still guided this research by articulating skills acquisition that supports practice preparedness in minor injury nursing. This has helped to give voice to minor injury nurses regarding their minor injury nursing education and practice preparedness experiences. Benner was part of the interpretive whole, underpinning and guiding the process as I drew upon her work to inform my own research.

5.5 Theme one – Theory and Practice – From learning to Development

The first theme reveals how theory and practical based education are experienced within minor injury nursing education. Theory and practice – from learning to development, encompasses the journey through both theory and practice, highlighting the key experiences where the participants transition from learning about minor injury nursing towards developing minor injury nursing skills.

5.5.1 Theory-based education

Minor injury theory established the learning journey by introducing the basic principles of minor injury nursing. The significance of theory and how it was experienced in minor injury nursing education was framed by the way the participants connected theory with their prior learning and practice experiences. Receiving a foundation in theory meant the participants could explore their previous knowledge, experience and understanding which empowered them to determine their own individual learning and development needs at the start of their course. Following theory-based education, the participants had a general understanding of the field of minor injury nursing, specific insight in to their own level of knowledge and experienced a more informed transition in to practical-based education.

Showing characteristics at different and more advanced stages of the Benner's (1984) novice to expert framework the participants were able to recognise a meaningful learning experience and understood how to use each experience to enhance their learning and development. As experienced emergency nurses, the participants showed advanced beginner (Benner 1984) characteristics by using their prior experience to connect with theory-based education which meant that they could direct their own learning in a very specific and needs based way. One of the most notable learning experiences in minor injury theory that supported this approach was self-directed learning. A key strength of self-directed learning was that it allowed the participants to manage their own learning. This was significant for how the participants approached their learning journey as it motivated the participants to learn and experience improved knowledge retention. To support self-directed learning within minor injury nursing education, courses timetabled classes a day at a time over a number of weeks and used podcasts to convey educational content. Staggered classes offered for many, a vital period of time between classes that allowed time for self-study and podcasts supported access to learning material at a time and pace suitable to their specific needs. This approach to learning was experienced temporally by the participants. With an awareness of the upcoming curriculum, the participants were able to, in that present moment, consolidate learning that was previously covered for clarity of prior learning and also prioritise and emphasise their learning through awareness of the learning that lay ahead. By engaging in the learning with a temporal awareness of the learning of the past, present and future, the participants experienced a more guided learning experience.

The value of self-directed learning is already known, with an established understanding that when given responsibility for their own learning, adult learners will experience improved outcomes in terms of learning attainment (Knowles et al. 2005, Lee et al. 2020, Hwang and Oh 2021). Understanding what self-directed learning offers in minor injury nursing education is a new finding for minor injury nursing research. Empowering minor injury nursing students to capitalise on their time and engage in self-directed studying was a key feature of the positive perspective this particular learning method gained. Considering the strength of self-directed learning, Nordmann and McGeorge (2018) undertook research that gives a good outline of how lecture capture has pedagogic value, can personalise the learners journey and can support student performance. A principal feature of freedom of access is that it allows students to manage their learning according to the demand of their individual situation (Nordmann and McGeorge 2018). Although Nordmann and McGeorge (2018) address various factors on the impact this approach has on learning, they do not delve in to the complexity of an individual student's situation so cannot confidently consider how those change how the learning journey is experienced. Exploring minor injury nurses' educational experiences achieved that depth and a more nuanced understanding is gained. It has shown how prior experience of a student can be used as a foundation to engage with self-directed learning in order to facilitate learning at a pace that is suitable to a student's needs and cognitive abilities which offers students clarity and comprehension of learning (Scutter et al., 2010 and O'Bannon et al. 2011).

In addition to self-directed learning, visual learning methods also had a positive impact upon how minor injury nursing theory-based education was experienced. Visual learning is a method that is an aid to both learning and practice development in minor injury nursing education. As a strategy for learning, this approach was necessary for the participants to firstly gain a baseline understanding of musculoskeletal anatomy and secondly to feel more competent in undertaking a clinical examination. The role of visual learning was specific with an emphasis on one area of the curriculum (surface anatomy education). With advanced beginner characteristics (Benner 1984), the participants could see the value and contribution of visual learning and were able to understand what that meant for the development of clinical examination skills. The ability to interpret that particular approach to learning meant the participants gained a sense of empowerment as they were able to better understand the process of musculo-skeletal clinical examination skills. To develop an anatomical knowledge base meant the participants became more confident and competent in their clinical practice.

The literature on visual learning acknowledges that it is a method of allowing the recognition and the realisation of patterns and the study of anatomy involves understanding spatial relationships within the human body (Keenan and Awadh 2019, Chicca and Chunta 2020). Gross et al. (2017) studied the effect of image-based learning on the understanding of anatomy highlighting the value of a visual learning approach to understanding anatomy. Gross et al (2017) emphasise the value of a visual approach when the student is in the early stages of a learning journey. That could explain why visual learning was positively experienced by the participants in the early stages of minor injury nursing education. However, Gross et al (2017) did not consider certain contextual factors that the minor injury nurses revealed. My study adds depth in that particular context by showing how visual learning was recognised by a student and what that meant for their learning. By connecting with their prior experience, the participants understood how meaningful visual learning was for their specific learning needs. The participants used that specific learning method in a specific context of practice (minor injury clinical examination) and this emphasised how the knowledge acquired visually could be an effective method of closing the theory and practice gap in minor injury nursing education.

A gap between theory and practice can be commonplace in nursing education and when this occurs, the learning experiences involve theory that does not accurately inform clinical practice (Happel et al. 2020). Happel et al (2020) undertook a qualitative study that explored how to integrate nursing theory and practice. Happel et al (2020) conclude that an awareness of the relationship between theory and practice when devising theory-based education is effective in closing the theory and practice gap. They establish that a "realistic" perspective is necessary to inform theory-based education which is similar to how the visual learning of anatomy in my study gave the participants that "realistic" perspective that they used to inform their practice-based clinical examination. Collectively, this underscores how realism and relevance can make the learning process more relatable and relevant to clinical practice. The minor injury nurses revealed what that meant for them not just in terms of developing clinical skills but also in enhancing their self-confidence in their own clinical ability.

The value of theory-based education in minor injury nursing education become more evident as the participants progressed towards practical-based education. Bridging the gap towards practice, minor injury theory played a key role in informing the transition in to practical-based

education. For many, aspects of the practical-based learning component of the course would have been challenging to grasp in the absence of theory. Closing the gap between theory and practice was key for moving students from learning about minor injury nursing towards the development of minor injury nursing skills.

Theory in nursing is known to be foundational in how it informs nursing practice as it allows students to map out their own critical support needs which then act as a guide in their individual transition through developmental stages (Benner 1984, Dyess et al. 2010 and McEwan 2014). As experienced nurses in emergency care, the participants had very specific foundational learning needs. These were an assortment of prior experiences, current skill set and future learning needs. For the participants, theory was particularly flexible in that context. A good foundation in theory will support students to take a more active learning approach and is a means of testing prior knowledge and understanding established in their prior experiences (Colley 2003 and Antisham and Jacoline 2015). Following theory-based education, participants felt their learning was more focused, individual to their needs, had direction and was relevant to the stages of learning that came thereafter.

5.5.2 Practical-based education

Practical-based education situated learning within the clinical context. As an experience, practical-based education was essential for developing the minor injury nursing skills that would be needed in everyday minor injury nursing practice. Participants completed courses with varied levels of theory and practical-based education and the various experiences showed that the depth of learning and development was increased when the appropriate balance between theory and practice was realised. Exploring experiences of this nature found that learning and development suffered when the balance tipped more in favour of theory than practice. As experienced nurses in emergency nursing, the participants were aware that minor injury nursing demands a wide variety of practical skills. From that perspective the participants were keen to undertake learning that would support development in that context. The participants who experienced practical-based education were clear that it was a predominant part in contributing to their development. From the alternative perspective, participants who did not experience practical-based education were equally as clear that the absence of learning in this way obstructed their opportunity to fully develop the skills demanded of the minor injury

nurse role. The findings, regardless of specific experiences, concluded that practical-based education is a fundamental approach to supporting minor injury nursing practice development.

Exploring the theory and practice experiences in minor injury nursing education permitted an appreciation of the contribution theory and practice make both individually and in partnership to nurses' learning. Blum (2010) explains that range and depth of learning is necessary in education as they can be key factors in facilitating the student through the Benner (1984) competence stages. Range and depth of learning inspired the learning and development of minor injury nurses, and this was more evident in courses that had both theory and practical-based education. Theory offers students a foundation to explore and learn their specialty by asking the right questions and practical-based education is where authentic learning starts, where the complexities and realities that cannot be captured through theory-based education alone are revealed (Benner 1984). The learning partnership of theory and practice was fundamental in minor injury nursing education, with an emphasis that theory was necessary to take the student through stages of foundational learning and practice was essential for development in clinical practice. My findings go further and highlight how the balance within that relationship must be considered to ensure that education is supporting both learning and development in minor injury nursing.

Participants experience of gaining clinical experience through practical-based education during minor injury nursing education was that it was necessary for developing the skills required of a minor injury nurse. Previous studies have also shown that this is a key theme where competence development in minor injury nursing is explored. Concluding similar findings to my research, a number of studies have shown that with clinical experience, minor injury nurses can develop their clinical competency (Meek, Kendal, and Freij 1998, Ezra et al 2005 and Neary 2014). However, these previous studies have not achieved the depth of understanding that was achieved in this study. Meek, Kendal, and Freij (1998), Ezra et al (2005), Neary (2014) all concluded that minor injury nurses demonstrated higher levels of clinical competence through experiential learning. However, these studies did not explore that finding specifically and were unable to provide in-depth experience-based descriptions to support understanding. The minor injury nurses shared their experiences of practical-based education. That insight gave a level of depth and detail that has not been previously achieved in minor injury nursing education research. Arbon (2004) explains how nursing practice is more than a set of skills, it

is a way of being, and gaining practice experience allows for interaction within that lived world. The participants shared their immersive experiences of that nature where they not only developed their skill set but also their mindset, gaining reassurance that they were preparing themselves to become a skilled minor injury nurse. This finding emphasises the value of how understanding a person's lifeworld is critical to understanding the person and how they experience their everyday life. (Chesterton and Jack 2021).

5.6 Theme two - Those that understand should teach

The second theme reveals how a number of characteristics surrounding the course structure and methods supported an enriched learning experience. Approaching the education of minor injury nurses with an understanding of the role and context of practice was found to be a key aspect in enhancing overall learning experiences.

A collaborative approach to minor injury nursing education between academic and professional partners had considerable benefits for learning and development. The participants studied courses that were designed by the academic institution alone and others with collaboration between the academic and professional partners. Revealing this showed that both approaches created two very different learning platforms. Of both approaches, when courses were delivered with collaboration between the academic and professional partners, the open lines of communication between the two supported a number of benefits. Firstly, the content of the course was more aligned to the daily practice of the minor injury nurse role with a curriculum that coexisted with the skills required or demanded by the patient demographic for that area. Secondly, the students, all with an understanding of their clinical environment, were aware of the relevance of what they had to learn so were more invested in the whole learning experience. And thirdly, when it came to updates, the students, the academic and professional partners were all updated regarding student progress and development.

A collaborative approach was not consistent across all courses. In the absence of an academic and professional partner collaborative approach to minor injury nursing education, participants experienced discontentment and disillusionment with the course curriculum. Participants who studied a course that was not delivered with academic and professional partner collaboration studied course content that involved practices that they felt were unrelated to the minor injury

nursing scope of practice. For example, classes that taught sexual health and dermatology were undertaken, which does not fall under a minor injuries' context of practice.

Where a collaborative approach to education is explored in other clinical studies, findings confirm that this can facilitate a student to feel their progress and development is adequately supported. Dev et al (2020) and Theobald et al (2021) provide rich and in-depth perspectives on a collaborative approach to education and conclude that it is useful for engaging and supporting students in their learning journey. Using a qualitative methodology, both studies provide rich and in-depth understanding emphasising how a collaborative approach to education enhances the students learning experience. Adding perspective, Dev et al (2020) expand the exploration to include the educator's perspective. However, this does not change the consensus. There appears to be a general agreement that a collaborative approach to education supports student progress and development. Essentially, the opinions that surround a collaborative approach to education are the same regardless of specific experiences. An academic and professional partner collaborative approach to minor injury nursing education is essential for supporting learning and development. Whether the participants experienced this or not, they still understood and had the foresight to see what it meant for their learning and development.

Dasein is characterised by self-awareness, which involves the capacity for introspection and in having the ability to engage in the world in meaningful ways (Moran 2014). Dasein offers an understanding in to why having professional involvement and lived experience of minor injury nursing supported superior teaching and learning experiences for participants. The interface between students and ENP educators was experienced as more meaningful in a learning context than was experienced between students and educators from a medical background. This experience occurred for two reasons: communication and understanding of the minor injury nurse role. Firstly, within the context of communication, the ENP educators had experienced much of the learning that the participants were undergoing. This meant they taught in a way that students would understand. The ENPs had their own awareness of minor injury nursing education and therefore knew how to effectively communicate and taught with examples specific to the students' context of practice and stage of learning. Secondly, understanding the minor injury nurse role meant ENP educators could approach teaching in a more engaging way and used their own lived experiences to act as a role model for students. These qualities were

perceived to be less accomplished in the educators from a medical background. Tied into that perception, the participants felt the medical staff either did not understand the role the minor injury nurse would be undertaking and did not understand the background knowledge they had. This resulted in teaching content that was irrelevant to the minor injury nurse role and difficult for the participants to grasp. For example, lectures on dermatology delivered by physicians were found to be a result of a lack of awareness of the ENP role and scope of practice. The participants felt that the intra-professional communication was not as accomplished as it was with nurse-to-nurse communication.

The qualities that support educators in delivering effective minor injury nursing education are reflected in wider literature, highlighting necessary skills such as effective communication and the ability to act as a role model (Asio and Riego de Dios 2019, Summers 2017 and Mulholland et al. 2006). The participant narratives revealed that the ENP educators had many of these skills, which is considerate of why the experience of ENP educators was positive. In considering the clinical expertise of a physician, it was surprising to find that clinical expertise was not considered by the participants as a foremost attribute in an educator. Research by Cook (2016) offers some understanding in this context. Cook (2016) presents research surrounding a clinical education toolkit that was designed to support nursing educators in enhancing learners clinical reasoning and skills acquisition. The findings highlight how a "real-world" approach to teaching is effective. The ENP educators achieved that "real world" approach by considering their own "dasein" to engage with the students. That approach meant the ENP educators were able to approach teaching in more meaningful ways. Cook (2016) concluded that the qualities of an educator go beyond simply having expertise in a specific field (Cook 2016). This was evident when the comparison was made between physician and ENP educators. Although expertise is necessary, optimum teaching and learning experiences will occur when educators can adopt pedagogically sound approaches to education (Cook 2016). Prior experiences in practice and education meant that the ENP educators could engage students in learning and teaching that they could relate to. The ENP educators understood the trajectory of learning and development which manifested more worthwhile teaching experiences in comparison to the physician delivered lectures.

5.7 Theme three - It was more than just assessment

The third theme shows that as teaching concluded and summative assessments were undertaken, a more comprehensive assessment of learning objectives was necessary for establishing achievement of learning objectives, supporting further learning and informing ongoing learning and development needs.

5.7.1 Singular assessment strategy

Assessment strategies used within minor injury nursing education were implicit in shaping the success of the overall learning experience and determining future learning needs. I found that the participants of the singular method of assessment experienced the coursework assignment as a narrow, restrictive and a poor representation of the course learning objectives and their learning and development. The participants all experienced a variety of assessment experiences. Minor injury nursing courses assessed learning objectives using either a singular method or multi-method assessment strategies. Both strategies were as different in how they were experienced as they were in how they assessed course learning objectives. Singular methods of assessment consisted of a coursework assignment to assess course learning objectives which typically involved a 2500-word case-study on one minor injury patient presentation. Largely, the participants who experienced this form of assessment were predominantly concerned that this was the only form of competence assessment they would undertake. This experience raised a number of concerns. Firstly, in the absence of clinical skills assessment, the participants felt they received no opportunity to demonstrate their clinical skills competency. This created feelings of concern as they felt they had not been verified as competent in applying the necessary clinical skills to treat patients presenting with a minor injury. Secondly, the participants also felt they had not been given the opportunity to receive feedback on their clinical skills, meaning they could not orientate themselves to a level of competence or plan their future learning needs.

It is well established within nursing that the role of assessment is a process that allows the learner and the educator to determine if the learning activity has had the intended learning outcome (William 2011 and Sturge 2014). For minor injury nurses who undertook singular-assessment strategy this approach to assessment meant that expectation was not met. As experienced nurses they had an awareness of what assessment normally involved and what that normally meant for them. The participants who undertook singular assessment strategy were

clear that although successfully completing this method of assessment meant they were deemed competent, the reality of that was somewhat different. The participants described this experience as a disruption within their learning journey, it was a point where they suddenly felt that they were expected to be competent but were not. Their experiences can be recognised as what Heidegger describes as “unready-at-hand” (Dotov et al. 2010).

The coursework assignment focused on specifically assessing the application of evidence-based practice which in nursing education is said to be useful for teaching broader skills of critical thinking (Oerman 2006). This particular skill is said to be useful as nursing staff need to assess the validity and reliability of knowledge, to evaluate and assess it before an application to practice (Fowler 2020). In research that explores the value of written assignments, Oerman (2006) concludes that they are useful for enhancing the student’s ability in communication and critical thinking skills and supports their theoretical understanding of clinical practice. Similarly, Fowler (2020) also conclude that coursework assignments are useful for the advancement of theoretical nursing knowledge. Both studies look towards the advantages of a coursework assignment. However, in looking at what a coursework assignment offers as a learning exercise they fail to see what it lacks as a summative assessment. Despite offering evidence-based practice skills that are transferrable to clinical practice (Gullick et al. 2019), in terms of the wider minor injuries’ curriculum, a coursework assignment did not address the broader clinical capability of minor injury nurses. Oerman (2006) and Fowler (2020) describe how coursework assignments advance theoretical knowledge. For the participants of singular assessment strategy, advancing theoretical knowledge was not enough and that is what underlines the anxiety that the minor injury nurses who undertook singular assessment strategy experienced. As an assessment process it was inadequate, uninformative and left them feeling “unready-at-hand”. Essentially, it was unable to support them in understanding their level of competence in clinical practice. On that basis, it is clear that the participants’ perception of singular assessment strategy was that it was largely ineffective experience in terms of broader assessment.

5.7.2 Multi-method assessment strategy

Comprehensive assessment of learning and development came only by courses that undertook multi-method assessment strategy. Unlike singular assessment strategy, multi-method assessment strategy also used OSCE examinations and a clinical placement logbook in addition

to a coursework assignment. This approach offered a broader perspective on assessment and the participants experiences determined that this learning experience was far more positive. Using a multi-method assessment strategy meant that course objectives and overall competence were viewed and analysed through a wider lens. As in singular assessment strategy, the participants who undertook multi-method assessment strategy could demonstrate the application of evidence-based practice through coursework assignments. However, multi-method assessment strategy offered additional and broader evaluation over singular assessment strategy with further assessment methods. Firstly, they could verify their clinical skills through OSCEs and secondly, they were able to incrementally orientate their stage of development through the clinical placement logbook. The participants who underwent this more detailed assessment of competence felt they were more informed in terms of their progress as the broader approach to assessment considered the wider capabilities required of the minor injury nurse role. This experience was evident in a more conscious awareness of their level of capability, which meant they could orientate themselves to a level of competence and forward plan their development needs.

5.7.2.1 Coursework assignment

Many learning experiences came from each method of assessment within multi-method assessment strategy. However, singular and multi-method assessment both offered a coursework assignment as part of the assessment process. What is unique in the findings from my study is how the meaning of this changed depending on whether singular or multi-method assessment strategy was undertaken. The participants of multi-method assessment strategy enthusiastically shared examples of how this assessment method updated their clinical practice to fall in line with evidence. The key difference between the participants of singular and multi-method assessment strategy was that those who undertook multi-method assessment strategy were reassured that the additional forms of assessment would allow them to demonstrate clinical skills development.

My findings in this context now reflect that understanding of how a coursework assignment can enhance theoretical nursing knowledge (Oermann 2006, Gulick et al. 2019 and Fowler 2020). In addition to recognising this relevant skill, a number of participants also used the opportunity to inform real changes in practice. The experience of the participants who underwent multi-method assessment strategy emphasises the disruption or “unready-at-hand”

experience the singular assessment strategy participants had. Multi-method assessment strategy was broad and informative which meant the participants were "ready-at-hand" (Dotov et al. 2010). Multi-method assessment strategy supported ongoing learning and development and allowed the participants to enter clinical practice with a broader awareness of their clinical competence.

5.7.2.2 Observed Structured Clinical Examination (OSCE's)

As part of multi-method assessment strategy, the participants undertook OSCEs. The pressure of studying for OSCEs was a point of emphasis for participants. The intention of OSCEs from an academic perspective was to verify clinical skills competence. However, as a lived experience in minor injury nursing education, they were as much a supportive learning experience which was an opportunity to encourage and support the learning and revision of clinical minor injury nursing skills. As the OSCEs were set to reflect the scope of practice the minor injury nurses would undertake as part of their role, the participants felt they needed to study the entire curriculum to improve their chances of passing. Although this experience involved a level of anxiety, that meant their anxiety did encourage the participants to seek a number of opportunities to practice and refine their clinical skills.

The value of OSCEs is evident within wider literature, they are well regarded for the positive influence they have on learning and development and are accepted by students as an effective means of measuring clinical practice competence (Pugh et al. 2018 and Sola et al. 2020). Mason et al (2005) used OSCEs to establish learning attainment in ENPs following an educational intervention, revealing that OSCEs were as much an impetus for learning as they were an assessment process. Although my findings do not explore how OSCEs measure minor injury nursing competence, they offer more depth and uncover more of the individual learner's perspective highlighting what the experience of OSCEs mean for learning and development. For minor injury nursing education, OSCEs encourage engagement with clinical minor injury nursing practice. What that meant for the participants was that OSCEs encouraged learning and development simply by their presence. The pressure of having to undertake OSCEs was a persuasive force that moved the participants into a place where they were aware of a need to learn and develop their minor injury nursing skills. The participants described this as a feeling of anxiety. However, the anxiety was not experienced in the negative sense. For the participants, anxiety meant they were more driven, directed towards and encouraged in their

learning and development. Despite that being seen as a positive driving force, experiences of anxiety have not been viewed as a supportive foundation to learning in other studies. A study by Bani-issa et al (2019) also looked at the experience of undertaking an OSCE and concluded that OSCEs are an effective opportunity for students to explore clinical practice in safe, life-like scenarios. However, the participants in the Bani-issa et al (2019) study associated their feelings of anxiety with concern that it may hamper performance. Overall, this emphasises how the perspectives of learning are individual and specific to different contexts. Moreover, this again emphasises the value of how understanding a person's lifeworld is critical to understanding the person and how they experience their everyday life. (Chesterton and Jack 2021).

5.7.2.3 Clinical Placement Logbook

The clinical placement logbook was a formative assessment method that involved an interactive approach to assessment and feedback charting development through the participants whole education journey. The clinical placement logbook method of assessment was an opportunity to enter in to a dialogue of mutual feedback between student and workplace mentor within the clinical learning environment. One key difference in this method of feedback was that it spanned across the whole clinical placement learning journey. Participants kept this logbook throughout their learning from commencement of the course towards completion of the course. Periodically, students and mentors would review progression and log the learning and development journey in the logbook. An integral experience within this interaction was the opportunity for the educator and student to engage in feedback through incremental stages of development, where both had the opportunity to share their perspective and formulate a plan for further learning and development.

A key strength of a clinical placement logbook is that it provides the opportunity to reflect on and discuss progress (Sherwin and Muir 2011). In the learning environment, Oermann (2006) states that this allows the students to re-think and revise which underlines the benefit of having a formative process of assessment in minor injury nursing education. Lai (2017) describes the logbook as an informative method of feedback that is already advocated in emergency nursing development. In minor injury nursing education this process of feedback tied in well with the development stages of learning within courses (initial, mid and final). The participants drew

upon their experiences of the structure of the feedback, seeing that as an essential component of how beneficial the experience was. It is evidently useful to consider what stages feedback may be offered. A study by Mackintosh-Franklin (2021) evaluated the impact of formative feedback on student nurse academic achievement. Using a quantitative methodology, Mackintosh-Franklin (2021) concluded the value of formative feedback in education drawing similarities to what the minor injury nurses experienced. Mackintosh-Franklin (2021) emphasised the value of feedback from a practical orientation, highlighting the key strength of timely and constructive feedback. In contrast however, Mackintosh-Franklin (2021) argues that student's willingness to seek and engage in feedback can differ, which was not apparent amongst the minor injury nurse participants. Mackintosh-Franklin (2021) suggests that the strength of formative feedback was dependent on the student's ability to seek and engage with feedback. The participants who shared their experience of feedback all emphasised that the incremental delivery of feedback meant they received informative, constructive, and supportive feedback. This experience was emphasised by the participants who felt they received little feedback. They consistently highlighted a need and desire to have more feedback surrounding their learning and development progress.

5.8 Theme four - Thrown in to practice

Theme four explores the lived experiences of practice preparedness when embarking upon minor injury nursing practice following minor injury nursing education. This theme shows that in the early stages of practice, all participants had experienced varied levels of practice preparedness.

To consider the competence stage of Benner's (1984) novice to expert framework, the experience of being prepared to practice minor injury nursing was influenced in two ways. Firstly, through what Benner may describe as sound educational experiences (Benner, 1984) and secondly, by workplace support/supervision. The experience of minor injury nursing education involved a number of learning and development experiences. For some of the participants, they experienced a course that supported their learning, development and practice preparedness. For other participants, a number of learning and development experiences were absent and that impacted upon how they felt their course had prepared them for the transition in to practice. Those experiences have been discussed in more detail earlier in this chapter.

At the point of competing minor injury nursing education, the participants found themselves at the start of a new experience in their career. The participants were now deemed as qualified to practice as a minor injury nurse. All the participants experienced what Heidegger described as "thrownness". Thrownness means that situations can determine our range of possibilities, what makes sense to us and what action we can take; our thrownness is always ongoing, we are always at a starting point within the world (Wilthy 2014, Roth 2018).

When participants qualified and were "thrown" in to minor injury nursing practice, the benefits of workplace supervision were myriad. The participants expressed the key role this had in supporting them in practice. Some participants felt their transition into practice would have been far more difficult and challenging without the level of support they received. Many shared experiences that really highlighted how supervision supported them in consolidating and sharpening their minor injury nursing skills. The strength of supervision was emphasised by participants who did not receive that support, where they were thrown towards a situation where a supported transition to practice was not a possibility. Those participants shared experiences of fear, anxiety and feelings of isolation. In practice, the participants experienced making clinical decisions that they did not feel prepared to make. Collectively, these experiences demonstrate that workplace supervision should be a principal goal in effectively supporting minor injury nurses.

Although gaining new insight into the importance of workplace supervision is an entirely new finding regarding practice preparedness specifically related to minor injury nursing, the importance of supervision is mirrored in a wider professional nursing context. A lack of supervision in the workplace leads to a lack of refined professional skills and this experience creates a sense of anxiety at a perceived inability to undertake the requirements of the role (Tham and Lynch 2014 and Sharif and Masoumi 2005). Some of the participants used terms such as "not competent" to express their perceived lack of practice preparedness. This finding represented a level of inability to undertake the role of the minor injury nurse. However, it also reflected an experience that was overshadowed by fear and anxiety. In describing their perceived levels of practice preparedness, the participants also shared experiences of how that felt. For many, it was an upsetting time. Describing that time as "not great" and having "sleepless nights" which signify the impact a lack of practice preparedness had. Relating this finding to Benner's (1984) novice to expert framework, Charlette et al (2019) state that

practitioners new to an area of practice can worry that they are expected to be at the competent stage of Benner's (1984) framework when they are not. When that is the case, literature supports my findings that supervision is well established in supporting practice preparedness, especially for the support it can give practitioners new to a role (Brunero 2008, Pop 2017 and Butterworth 2022). Providing this level of support is necessary to reduce professional isolation and is known to support personal and professional growth (Cummins 2009).

Being a new minor injury nurse or "thrown" towards that role carried a number of anxieties and for some, that starting point included feelings of isolation as a direct result of a lack of support. In a qualitative study that explored nurses' experiences of practice preparedness by Wolff et al (2010), their findings included key themes such as direction, guidance and senior support as the key components of facilitating a practice prepared experience. The findings from Wolff et al (2010) underscore what the minor injury nurses felt were central to feeling prepared for practice. In addition, Wolff et al (2010) also suggest that the initial stages in practice should involve simple and straightforward cases. In that context, the participants were not always supported by having their scope of practice focused to simple and straightforward cases. A number of participants shared their experiences of being expected to see patient presentations they were not competent to see. In addition, some reported experiences where they only learned by making mistakes and many of these experiences were related to a lack of workplace support.

What some of the minor injury nurses experienced and what the Wolff et al (2010) study outline is how a lack of support can impact upon the prepared transition within clinical practice. Understanding how that can be experienced is useful for understanding the implications that has for minor injury nurses as they embark upon practice. Although Wolff et al (2010) conclude similar findings on practice preparedness experiences, they do not achieve the breadth of understanding into that phenomenon that my study gained. My study explores the education journey that preceded the point where the participants were thrown in to practice. From that standpoint, is an ability to see more of the journey towards practice preparedness and that offers a depth understanding that is entirely new. It is evident that practice preparedness is not just part of the educational journey, being prepared to practice is not an end-point or a goal. The findings show that preparedness is something that is part of the minor injury nurse, something that walks alongside them and changes with them through stages of learning, development and

in to their career, whether that stage of practice is as a student or as an experienced minor injury nurse.

5.9 Theme five - The preparedness continuum

Theme five emphasises the findings that practice preparedness was experienced as a continuum even as the participants went on to gain experience in practice. Theme five highlights that practice preparedness is experienced as a continuing and progressive lived experience. For the participants, practice development updates are a key element that support and enhance ongoing practice preparedness.

The findings have shed light upon practice preparedness being a continued and progressive lived experience which was a new and unexpected finding. Practice preparedness went beyond the education journey and remained with the minor injury nurses as they moved along their career pathway. Many experiences of practice updates were shared by the participants. All the experiences of this nature were positive in showing the benefit this had on their continuing learning and development. However, some participants attributed their experience of practice updates with more enthusiastic reflections of learning. For them, these experiences had far more impact upon their experiences of practice preparedness than their course or their journey into practice did. For example, one participant described shock at the depth of learning they achieved from attending a practice update session with an experienced ENP educator even after being in their qualified role for two years. Another participant felt that a day spent working with an experienced ENP had taught them more than their entire minor injury nursing course.

In contrast to these experiences were the experiences where participants felt they were not supported in updating their practice. These experiences show that feelings of isolation and frustration emerge amongst the wider team as practices that are outdated continue. Moreover, frustration at a lack of practice updates were amplified because many felt time for practice development was disproportionately allocated to teams from the allied and medical professions. For participants who did not receive professional development opportunities, they reported this as an issue that impeded ongoing development and preparedness which only amplifies the importance of supporting practice preparedness.

In terms of the wider literature, finding that practice updates are not widely supported is not new. Lloyd-Rees (2016) and Bagley (2018) found that ENP development often lacks funding and support, despite widespread support for updates from practitioners. My research presents further evidence that professional development opportunities greatly contribute to not only increasing preparedness for practice but also in maintaining preparedness for practice. Oshvandi et al (2016) undertook a systematic review of the literature on the application of Benner's (1984) novice to expert framework. Their broad approach in exploring evidence concluded that the framework has been used widely throughout nursing and reflect the theme "*the preparedness continuum"* by highlighting the significance of a supportive learning environment in nursing and emphasising that there is a need for knowledge to be expanded as an ongoing concern (Oshvandi et al. 2016). Practice preparedness in minor injury nursing is a continuing and progressive lived experience. Exploring the lived experiences of minor injury nursing education and practice preparedness offer a new understanding in to how knowledge in minor injury nursing should be expanded constantly and understanding the implications of this could change how the transition into minor injury nursing practice is supported.

5.10 Chapter five summary (The whole)

My research set out to answer how minor injury nursing education is experienced and how practice preparedness is experienced following minor injury nursing education. Largely, these questions have been answered from the findings. By exploring the lived experiences of minor injury nursing education, the participants learning and preparedness experiences within that context have been unearthed and provide a new and significant contribution to this field of research. The hermeneutic phenomenological philosophical concepts were useful for understanding the meaning behind some of the participants experiences. In addition, the Benner (1984) novice to expert framework inspired thinking and understanding about how nurses learn and how learning experiences contribute to nurses learning and development.

My findings have demonstrated both the function and the importance of receiving a foundation of theory-based education. Theory was a valuable stage in learning as it supported, underpinned, outlined and informed the ongoing learning journey. In terms of enhancing that experience, learning theory was enriched by particular learning methods. My study has highlighted what methods best support the study of theory and outlined the specific role each method has.

Exploring the journey through minor injury nursing education, my findings contribute to understanding the role of practical-based education. To experience practical-based education involved learning and development that was more related to clinical practice of a minor injury nurse and that was found to be much more substantial in terms of overall development than theory-based education alone. This finding was particularly relevant in the context of participants who felt their course lacked practical-based education opportunities. My study has highlighted the impact a lack of practice has on the ability to develop skills needed for minor injury nursing practice.

Within the design and delivery of the minor injury nursing courses, my findings highlighted a number of distinctions that affected the experience of being taught. Predominantly, my findings highlighted the value of collaboration between academic and professional partners which is a relationship that is centred around and focused on student learning and development. Collaboration between academic and professional partners in course design also supported a

curriculum that correlates to the scope of practice that is demanded of the role. In addition to collaboration, my study revealed the merit of educators from an ENP background. When educators on a minor injury nursing course had lived experience of minor injury nursing, they tended to facilitate a more engaging learning experience. The consequence of that was a student group who experienced enhanced learning and development.

My study explored two assessment strategies undertaken as part of minor injury nursing education. This exploration meant that the key strengths and value of different methods of assessment could be explored and highlighted. Courses used either singular assessment strategy or multi-method assessment strategy. The latter was found to take a much more comprehensive overview of learning achievement and had the added benefit of supporting continued learning and development of practice.

As the participants concluded their studies and embarked upon their clinical practice, various levels of practice preparedness were experienced. My study explored each participant's learning journey and drew out all of their experiences. In looking specifically at the point of being qualified as a minor injury nurse, the exploration features the experiences that are central to that specific phenomenon. Workplace supervision was found to be a key element of supporting practice preparedness and provided clear evidence of the virtue that a support provision has towards practice preparedness. In addition to this, it was also revealed that practice preparedness was experienced along the career trajectory of the participants, with practice updates featuring as a key aspect of maintaining practice preparedness.

This chapter has discussed the findings. Next, chapter six will conclude the thesis.

Chapter six – Conclusion

6.1 Introduction

This chapter begins with a discussion on how my research can inform clinical practice, education, policy and future research. Thereafter, there is a discussion surrounding the strengths and limitations of my research. Following that, there is a statement on reflexivity, detailing how the researcher's prior experience contributed to the research journey. From there, is a brief acknowledgement of how the COVID-19 pandemic had an impact upon my research. Finally, a plan for dissemination of the findings is presented before the thesis is then concluded by highlighting the original contribution to knowledge.

6.2 Implications

My research findings have implications for clinical practice, education, policy and future research. Uncovering the participants entire journey through minor injury nursing education unearthed what the participants experiences meant for their learning, development and practice preparedness. These findings are relevant for clinical practice, education, policy and future research and many of the implications are inextricably linked and overlap. However, in presenting the implications, the findings that have most impact for a particular area will be presented to avoid repetition.

6.2.1 Implications for clinical practice

First and foremost, my findings have uncovered and explored how minor injury nurses experience practice preparedness for minor injury nursing. The findings have highlighted that not all nurses feel they are prepared to practice as a minor injury nurse following education. That finding is significant for clinical practice as many experiences were explored where the participants felt they did not have the required competence to see and treat the patients they were expected to see. The perceived lack of practice preparedness was common across a number of the participants which raises the concern that there may be a risk of harm to patients being treated by a minor injury nurse who feels they are not prepared for practice. To underline the significance of this, I will provide a hypothetical example of a patient with a specific injury

that can typically present to an MIU. I will then reflect back upon some of the experiences shared during the interviews and discuss what the potential outcomes could be if that hypothetical patient was to be treated by a nurse who feels they are not practice prepared.

Patients who have sustained a minor injury may present to a nurse-led MIU for assessment and treatment. An example of a typical injury can include a laceration to the palmer aspect of a finger. The main objective of assessing a wound is not just wound care and closure but to determine that no underlying structures have been injured. As an ENP myself, who felt he was adequately prepared for practice, I feel I would have sufficient knowledge of anatomy and physiology to consider the underlying structures that may have been injured. I feel I would have the skills and ability to examine the wound bed and confidently detect or rule out underlying damage. If for example, there was an incomplete division of a flexor tendon, that patient may well have function in that finger at the time of examination. However, it is likely that the division would extend through continued use of the hand. The flexor tendon would eventually rupture and retract proximally (towards upper arm) up the limb. The result of that is extensive surgery and recovery and involves complications associated with extensive surgery. The significance of these injuries is amplified when the social and professional history of the patent is brought into consideration. What if they are a professional musician for example? If a minor injury nurse does not feel prepared to practice as many of my participants did not, clinical practice areas should consider what that means for the delivery of safe patient care. If the minor injury nurse does not feel they have the adequate knowledge and skills outlined in this hypothetical scenario, they may feel that they are unable to detect a partial tendon division. Detection of a partial division would involve referral to a hand surgeon and restorative surgery would take place. Early recognition and treatment are critical here for the best chance of recovery and return of function. The emphasis here is to outline the implications for patient safety in clinical practice. However, not only does it outline this, it alerts clinical practice areas to a risk of litigation against the Health Board and against the treating practitioner. It is unacceptable for minor injury nurses in an autonomous role to be tasked with delivering patient care when they feel they are not prepared to practice.

With an understanding of how significant my findings are for clinical practice; practice areas could now look at how they could support and improve the educational preparation of minor injury nurses. To do that, clinical practice areas could start by considering a collaborative approach to education. My findings have demonstrated that when a collaborative approach

between academic and professional partners was achieved, the course content was found to be more relevant, learner engaging and in keeping with the demands of the minor injury nurse role. It is abundantly clear that this is an approach that clinical areas and educators could adopt when considering the design and delivery of minor injury nursing education to support and enhance the educational preparation of their minor injury nurses. With both partners in collaboration, education could be designed to encompass both general and specific injuries that typically present within a given clinical area. This approach would equip the minor injury nurses with the necessary skills to undertake their jobs safely and could go some way in reducing the risk to patients of being seen by a minor injury nurse who does not feel they have the required level of practice preparedness to undertake their role. This implication is emphasised with acknowledgement of the current political arena. The education of nurses is at the forefront of political agenda with current guidance from the Nursing 2030 Vision (The Scottish Government 2017) pledging that nursing will be given the right support and education to meet the needs of the population. With that in mind, academic and professional partners need to consider if the education their minor injury nurses will undertake offers the appropriate support and education to meet the needs of their patient population. If both partners were to review this, the review could use the findings from my research to base an analysis and recommendations.

In addition to a collaborative approach, practice areas need to consider their responsibility in the ongoing support of practice preparedness. My findings revealed that following completion of the course and in practice, supervision and practice updates were particularly influential in supporting practice preparedness. In addition to this, participants were concerned that, in the absence of practice updates, their clinical practices and ability to teach trainee minor injury nurses effectively was affected. Again, this comes back to the concern that a disregard for educational preparation is a risk of harm put upon patients and a risk of litigation put upon the practitioner and employing Health Board. From a departmental perspective, steps should be taken to implement practice updates within the clinical areas. The need for practice updates and to maintain practice preparedness is amplified by the findings of my study. My research has emphasised that practice preparedness is part of minor injury nursing, it is an ongoing phenomenon that is career long.

6.2.2 Implications for education

My findings uncovered and explored the educational preparation experiences of minor injury nurses. My research has achieved an in-depth perspective of minor injury nursing education that has never been achieved before. Education providers should review these findings, consider the transferability of the findings and use them as a basis for the review and development of an education course. In terms of experiencing sound educational experiences and being prepared to practice as a minor injury nurse, I found this involved courses consisting of a foundation of theory-based education, multiple learning styles, time for self-directed learning, practical-based education, collaboration in course development between the academic and professional partners, teaching from experienced ENPs, assessments that involves multiple assessment strategy, supervision within the MIU workplace and practice updates. These findings are entirely new to this field of research and are transferrable to area of a similar clinical context. This new in-depth understanding should be used by educators to maximise the breadth and quality of learning within minor injury nursing courses and other courses from different fields of practice where there is a similar extended scope of practice. In using my findings to review, develop and enhance the educational preparation experiences of minor injury nurses would be an investment in patient care and safety. It has been demonstrated that not all minor injury nurses feel they are prepared for practice. That finding is taken forward and offers an understanding in to why that is and what that means. Educators should acknowledge this and accept their responsibility in taking action towards improving minor injury nursing educational preparation.

6.2.3 Implications for policy

My findings have implications for both health and nursing education policy. In terms of health policies that are concerned with accessing urgent care services, recently, the Scottish Government developed the redesign of urgent care (The Scottish Government 2022). The redesign of urgent care aims to help the public access the right care in the right place at the right time, often as close to home as possible. The Scottish Government anticipate that educating the public on how to access healthcare will see patients being treated by the right professional with the right skill set for the patients' specific needs (The Scottish Government 2021a). Given that the key words within this policy are "right professional" and "right skill set" in the delivery of urgent care, policy makers may want to consider the findings from my

study. It is evident from my findings that not all minor injury nurses feel they are prepared for practice. In that context policy makers must ensure they can safeguard patients with an adequately prepared for practice workforce. If practitioners are not adequately prepared for minor injury nursing practice, health and education policy makers should consider strategies to support minor injury nursing practice preparedness.

Given the significance of the patient safety implications raised from the findings, it is reassuring to see that from an education policy perspective, The Scottish Government have pledged to meet the health needs of the population and transform service delivery. For nursing, that means the right support and education to meet the needs of the population as pledged within the nursing 2030 vision (The Scottish Government 2017, The Scottish Government 2019 and The Scottish Government 2021a). Policy makers in this context must ensure that minor injury nurses are part of that pledge. It is evident that minor injury nurses urgently need to be given the appropriate education to develop the skillset that their role demands. To do that, they should consider my findings and use that as part of a considered approach to delivering the right support and education to meet the needs of the population. If these policies were to align with my findings, these policies could ensure that education courses and clinical practice areas are supporting minor injury nurses to achieve practice preparedness, an approach that could safeguard patient care quality.

6.2.4 Implications for future research

A follow-on study could look at how different education courses may impact upon patient care and outcomes. A study of minor injury nurses who are undertaking different minor injury nursing courses, using patient care outcomes to base a comparison would add more to the research that has been undertaken. Conducting this research would help further understand the possible impact different minor injury nursing education courses may have on minor injury patient care delivery and outcomes. My research has identified that varied practice preparedness experiences follow on from different minor injury nursing education courses. Although relevant and useful findings, further understanding would be valuable in determining how patient care may be affected by this phenomenon.

One other area that would benefit from further research is how minor injury nursing is situated within the wider domain of advanced nursing practice. Minor injury nursing goes beyond general nursing practice that is undertaken upon initial registration. However, in research, minor injury nursing practice is not considered to be part of the advanced nursing practice movement. It would be beneficial to explore this further and understand what level of practice minor injury nursing is considered to be. The McConnell et al (2013) study concluded that the role of the ENP is predominantly clinically focused meaning that it does not fulfil all four domains of advanced nursing practice. However, this may be worth re-considering given the more recent publication of government guidance - Advanced nursing practice - transforming nursing roles: phase two (The Scottish Government 2021b) which contains guidance that 10% of the pro-rata working week should be assigned to fulfilling non-clinical pillars of advanced nursing practice. Future research could explore the feasibility of implementing this guidance in to practice areas.

In terms of future research, a local Health Board clinical academic lead nurse has now been appointed in my area and there is a clear line of support for clinical-academics to pursue research interests. At present, there is motivation to give post-doctoral researchers, funded time, support and encouragement to engage in ongoing research and to partner up with wider research teams. In terms of my own clinical-academic future, I have met with the clinical academic lead nurse and further meetings will take place on completion of this doctorate. The meeting after submission of this doctorate will be an outline of the opportunities available and what the local Health Board can facilitate to support that aspect of career development.

6.3 Strength of this study

This study has several strengths which includes the contribution of new and significant knowledge to this field of research. This study was also underpinned by a philosophy that informed a methodological approach and methods which supported a unique insight in to the lived experiences of minor injury nursing education and preparedness for practice. In addition to that, engaging in hermeneutic phenomenology exploration has provided the researcher with valuable knowledge and skills that can be applied to future research activities.

Firstly, a key strength of my study is that it contributes a number of key findings that are entirely new in this field of research. Educational preparation in minor injury nursing has been previously explored (Marsden 2003). The findings in that study offered a snapshot of the phenomenon of practice preparedness which was useful for underlining how the fragmented approach to minor injury nursing education in the UK is having an impact upon educational preparation. Marsden (2003) did not undertake an in-depth exploration in to how education and practice preparedness were experienced. Through my understanding of this literature, I took that gap and used that as the basis of my research aim and questions. My findings have gained a depth of understanding in to preparedness for practice following minor injury nursing education that has not been previously achieved. Although previous studies have also explored and revealed competent clinical minor injury nursing practice, which infer that minor injury nurses can be prepared for practice (Meek, Kendal, and Freij. 1998, Mabrook and Dale. 1998, Sakr et al. 1999, Byrne et al. 2000, Cooper at al. 2002, Megahy and Lloyd 2004, Ezra et al. 2005, Ball et al. 2007, Sandhu et al. 2009, Thompson and Meskell. 2012 and McDevitt and Melby. 2015), my research unpacks the phenomenon of minor injury educational preparation and achieves a depth of understanding that is not within these studies. My research is unique as it explored the entire journey through varied minor injury nursing courses outlining the key experiences along that journey that support practice preparedness. Unearthing the lived experiences through that journey and uncovering the meaning behind those experiences achieves an entirely new perspective achieving an understanding that is significant for clinical practice, education, policy and for future research.

Secondly, hermeneutic phenomenology encompassed my prior experiences, using them as a strength to facilitate and enhance both the quality and the unique approach of my study. Although at the outset of my research journey, the breadth of phenomenological approaches was a challenge that left me feeling that I had to carve out my own path of phenomenological research. Exploring hermeneutic phenomenology involved broadening my reading. That exploration concluded that there were many versions and approaches to hermeneutic phenomenology with each study having a unique and individual approach. Since that time, the guidance available to novice researchers has improved with literature that offers a practical guide which makes the philosophy, methodology and methods understandable and accessible for researchers (Dibley et al. 2020). Despite the confusion I experienced, I was still reassured that hermeneutic phenomenology was the correct guiding philosophy.

Phenomenology creates a rich tapestry of opportunities that allows researchers to discover an individual path towards knowledge which allows the application of flexible activities that help describe and gain understanding of human experiences. (Langbridge 2007, Alhazmi and Kaufmann 2022). In hermeneutic phenomenology, interpretation is ever-evolving as there are always more unique perspectives to uncover (Crother and Thomson 2020). As the approaches to undertaking hermeneutic phenomenological research were many, I now consider how my approach was unique.

In terms of the uniqueness of my own research, my prior experiences were extensive, I was firmly situated within minor injury nursing and had extensive experience of minor injury nursing practice and education. My dasein meant that I brought my own lived experience of minor injury nursing education and practice preparedness in to this research to support interpretation. In addition, my hermeneutic phenomenological approach to the literature review with specific questioning was also unique in the context of my research. One aspect that required consideration was my approach to data analysis. I had to consider how I was a novice researcher that would benefit from guidance and I also had to be mindful that this was a time-limited doctoral project. In hermeneutic phenomenology it is understood that it is negligent for a novice researcher to be sent on a research journey without a guiding light (Sims and Smythe, 2020 as cited by Dibley et al. 2020). My approach to data analysis was unique as it incorporated reflexive thematic analysis. In making that decision, utilising reflexive thematic analysis offered a methodologically flexible means of analysing my data in a guided and timely manner. I felt my approach sat well with the interpretive approach of hermeneutic phenomenology, yet, it gave me that structure and guidance that as a novice researcher I needed.

Thirdly, although not generalisable to a broader nursing population, this research gained a broad understanding of minor injury nursing education and preparedness for practice. This could inform understanding in clinical areas and education institutes that employ and educate minor injury nurses. Generalisability is not commonly applied to qualitative studies due to the small sample sizes, different frameworks and approaches used (Kitto et al. 2008). However, the findings can be transferred to areas of a similar context or situation (Houghton et al, 2013). In order to achieve transferability, the researcher must ensure that detailed descriptions of the research methods with examples of raw data are used so that readers can consider the interpretations and then consider if the findings are transferable to their situation (Houghton et

al. 2013 and Cope 2014). To ensure transferability, I followed a number of steps to ensure that my findings are transferable as discussed in chapter three and demonstrated in chapter four.

Lastly, another strength was the sample of participants used for this research. By understanding what dasein meant for the participants, I acknowledged that the participants were unique and that they came to this research with their own experiences. I selected my participants based on my knowledge that the participants were able to represent the phenomenon under study, which can be viewed as a means of ensuring transferability (Forero et al. 2018). I purposively sampled participants from Scottish Health Boards that serve two demographically different areas, which encompassed two urban MIUs and two rural MIUs. All participants worked in departments with varying levels and scope of practice and approaches to minor injury nursing education. Sampling across four departments and two demographic areas allowed me to explore the experiences from different clinical contexts. More specifically, I wanted to capture lived experiences across different minor injury nursing education courses. Using purposive sampling, I was able to interview nurses who had undertaken either a minor injury theory course or an Emergency Nurse Practitioner – minor injuries course. As highlighted in chapter one and in the participant characteristics section of chapter four, both offer different learning experiences. Purposive sampling meant I could seek out these experiences and explore them.

6.4 Limitations

My research is not without its limitations. Firstly, although the interviews I undertook generated rich and in-depth experiences of minor injury nurse education, it remains pertinent to highlight that the experiences of my participants cannot be generalised to the wider nursing practice population. Nonetheless, my research was undertaken with transparency throughout and the findings do have the potential for transferability to similar groups of minor injury nurses working and studying in similar practice areas and education institutes.

Secondly, from a sampling and participant perspective, in presenting my participant details, I did consider including a more detailed participant profile including the gender of participants. This may have allowed for more cross-referencing and interpretation of the findings for the reader in that particular context. However, within the field of minor injury nursing there are close connections in what is a small community of practitioners. Therefore, there could have

been an opportunity for identifying participants by deduction. On that basis, I decided that gender details would be withheld. In addition, in terms of how I selected which participants to quote during the analysis and in presenting the findings, I did try to quote across all the participants to "give voice" to each of them. The interviews were successful and I was satisfied with the breadth and depth of experiences the interviews generated. However, despite undertaking pilot interviews to prepare for the interviews and using an interview guide and methods to conduct the interviews as effectively as possible, there were participants that shared more experiences than others. On that basis, there are more data excerpts from some participants than others.

Thirdly, the literature review that informed this research was based on minor injury nursing from a UK and Ireland perspective only. Expanding the literature to include international studies may have been informative. However, this would have created confusion. Internationally, there are differences between the roles in education and scope of practice and differences in how the role is included in the advanced nursing practice movement. Maintaining a clear line of inquiry allowed this doctorate to construct a defined and manageable study.

Lastly, hermeneutic phenomenology supports the past experiences of the researcher in undertaking and interpreting the research findings. However, in terms of transparency, there was the potential for my past experiences within this field of practice and education to influence the interpretation of the findings. From the start of this research, I have acknowledged my position in minor injury nursing and past experiences that I have in this field of practice. By way of my education, training, and experience, I am deeply involved and imbedded in the environment and context in which I studied and therefore, bracketing was impossible (Wilson. 2015). To that effect, I have practiced reflectively and reflexively so that the reader can clearly see how my contributions may have had an impact on the interpretations made. In terms of the influence my dasein may have had on this research there is the possibility that I may have over-interpreted responses within the interviews based on my prior experience in this area of practice. Again, to ensure quality and trustworthiness, the steps I took to reduce this were discussed in chapter three.

6.5 Reflexivity

Being in the hermeneutic circle means that you do not read or hear something from the position of nowhere. It is read and heard from an endless spiral of personal life experiences, knowledge, and presuppositions. Formed from past experiences, the researcher comes with pre-understanding of a phenomenon which are known in hermeneutic phenomenology as the fore-structures, fore-having, fore-sight and fore-conception (Geanellos 1998). I outlined my pre-understanding in chapter three. I will now reflect upon my pre-understandings having now undertaken the analysis and interpretation.

Whilst everyone has a level of prejudice, that does not mean we are trapped by our pre-understandings. Our pre-understandings provide the gateway into how we question, understand and respond (Crowther and Thomson 2020). I feel that my fore-structures that I brought in to this interpretive research supported my research. In terms of fore-having, I had an awareness of this field of practice. I understood how the minor injury nurse role and education had developed throughout Scotland and had an awareness about potential gaps in this field of research. That stance meant that I was clear when it came to the aim and the participant sampling. In terms of fore-sight, as I had been educated as a minor injury nurse and had been involved in educating other minor injury nurses, I was aware that there were different approaches to minor injury nursing education. With that in mind, again, I was able to purposively sample minor injury nurses who had undertaken varying minor injury nursing courses and achieve a deeper exploration into that phenomenon. Lastly, in regards to fore-conception, I anticipated that different minor injury nursing courses would result in various practice preparedness experiences. With that, came the potential for my influence in the interpretation of the data. Despite that, I was mindful to give voice to the participants experiences throughout but to also align with the philosophical principles of hermeneutic phenomenology and maintain an interpretive stance. In order to remain transparent, I aimed to enhance quality and trustworthiness which was discussed in more detail in chapter three.

6.6 Reflections on the research journey

Reflecting on my pre-understandings, having now completed my research, I would conclude that my experience was an integral part of the research process. My prior experiences were key to unlocking these phenomena and were a strength throughout the entire research journey. I

felt that this area of practice is largely under-represented in terms of research because of my involvement in minor injury nursing and, I knew where to focus upon in this unexplored area of practice. In doing so I was able to uncover new and substantial findings that can be used to inform clinical practice, education, policy and future research.

Moreover, from a methodological perspective, I have developed knowledge regarding hermeneutic phenomenology and gained skills that I can take forward in to future research. A key strength of hermeneutic phenomenology was how it encompassed my prior experience. At the start, I was aware of the different approaches to minor injury nursing education. Had I not had that experience, I may not have been alerted to the gap in the research or compelled to explore it further. In addition, my prior experience was valuable throughout the interviews in gaining a connection with the interview participants. I felt I could connect with the experiences they shared having had my own lived experience of minor injury nursing education and practice preparedness.

Uncovering the experiences of minor injury nursing education and practice preparedness was an exciting journey, a phenomenon I had wanted to explore for years but was not quite sure where to start. When I look back on my initial standpoint, I was merely observing the phenomenon with no real depth of insight or understanding. Having now explored this phenomenon, I feel I have gained a depth of understanding in to how minor injury nursing education and practice preparedness is experienced. This discovery is described in hermeneutic phenomenology as the clearing. The clearing is described as a compelling image of a clearing in a darkened forest. Heidegger (1962) uses that metaphor to symbolise shining light on to something that was there but was previously concealed.

When I qualified as an ENP I was wholly prepared for practice, I perceived that my practice was safe and competent and I associate that with my ENP education experiences. My experience of that education journey was positive. I saw my ENP education as an investment in my development and it was central to the competence I achieved. From my own experiences, I could also see amongst my wider minor injury nurse colleagues that there were wide-ranging differences in their experiences. They appeared to experience less opportunities for the development of knowledge and skills and I associated these differences to the varying format in minor injury nursing education. Essentially, I could see from the side lines there was an issue but I couldn't articulate my concerns as there was no insight or understanding in to this

phenomenon in the research literature. There lies a key strength of my research journey. I have interpreted and now understand and to a greater extent, can explain that phenomenon. I have a new understanding developed from both experience and my research.

Reflecting back on the last eight years as a researcher I would say that I have achieved far more from my clinical doctorate journey than I expected to. I have developed a substrate of research skills that I can now carry forward in to the second half of my career. My time studying has been full and varied and, there are a number of positive experiences that are too many to list exhaustively. Some examples include, the annual contact days at Stirling University where scholarly debate and sharing your research interests were encouraged in a safe and supportive space. There was also my hermeneutic phenomenology study week at the University of Central Lancashire where I was able to interact with researchers interested in hermeneutic phenomenology and, to share and debate our ideas with the wisdom and support from professors with a deep interest and expertise in the methodology. Overall, it is humbling to have been surrounded by so many colleagues that have taken the time to support my development and my research interest. This whole experience has changed my way of thinking. It has expanded, deepened and enhanced my thought process and has positively changed my perspective and my approach. Overall, the clinical doctorate has improved me both professionally and personally.

6.7 The impact of COVID-19 on this study

The COVID-19 pandemic has been an infection of high consequence which has claimed many lives and changed the way of life for many (Magan et al. 2020). The COVID-19 pandemic and the enforcement of social distancing measures have been catalysts for significant disruption within societal life and higher education has experienced major disruption due to the pandemic (Carolan et al. 2020). As COVID-19 emerged during this study and given its impact, it is necessary to acknowledge how COVID-19 was experienced within the context of my research journey.

Fortunately, the data collection had been completed before the pandemic so participant access was not an issue. Initially, for approximately 8 weeks, as a front-line ANP, I worked extended hours preparing my service area for the potential impact of COVID-19. The time allocated to

study was disrupted, and the research was at the data analysis stage, which did slow. However, soon after, the need for an increase in hours reduced. From that, my work commitments were reduced to pre-pandemic levels and the time allocated to study not only reverted to pre-pandemic levels but increased substantially. Because of social restrictions, more time could be dedicated to studying, and I used this opportunity to focus on my research. Overall, the pandemic offered an opportunity to withdraw from many of life's social obligations and direct all that time towards my research commitments. In terms of support and guidance, despite the restrictions, the support from doctoral supervisors, the course director and study peers at the university was maintained. Every opportunity to maintain communication was used and I felt as supported during the pandemic as I was prior to the pandemic.

6.8 Dissemination of findings

The process of dissemination of these findings will begin with the submission of my doctoral thesis. As part of the clinical doctorate programme, the findings will also be developed in to a draft journal article as part of this thesis (Appendix 6). In addition, if required, the article will be formatted to meet specific journal requirements and submitted for possible publication in a peer reviewed journal. It is anticipated that a journal with an emergency/unscheduled nursing care or nursing education audience will be the intended journal.

On conclusion of my doctoral thesis, my research will be disseminated to colleagues and departments interested in minor injury practice and education. It is intended that I will contact each relevant stakeholder and offer a meeting where I can summarise the findings in a presentation. Where required, the findings can also be summarised in to a report. The findings have highlighted implications for clinical practice, education, policy and research. Therefore, relevant areas must be allowed to consider how pertinent my research is to their area of practice. It is intended that dissemination will be undertaken by any necessary means and suitable to all receptive parties.

In addition, my findings will be presented at conferences interested in this field of research for example, the advanced practice academy conference in my local Health Board and national emergency nursing conferences. I have been contacted by the local Health Board Advanced Practice Nurse Consultant and invited to present my research at the next advanced nursing practice academy conference upon completion of my doctorate. More recently (September

2023), concerns in clinical practice have signalled how my research findings are new and of current significance. Senior clinicians and managers have been alerted to concerns within a number of clinical areas that minor injury nurses may not be prepared for practice. The senior clinicians and managers within those clinical areas were made aware that new research had emerged following my viva examination. Since then, I have been contacted and asked if I would share my research findings given the relevance they have. I have responded in agreement and explained that the thesis is still under revision and subject to review. I have agreed to make contact once the revisions are complete and look forward to my findings having a positive impact in this field of clinical practice.

6.9 Conclusion

Hermeneutic phenomenology underpinned and guided this study. The findings have given voice to minor injury nurses, exploring their experiences of minor injury nursing education and practice preparedness. Hermeneutic phenomenology alerted my mind to the phenomenon of minor injury nursing education and practice preparedness and allowed me to view that phenomenon through different windows of experience (Willis 2001). Overall, this study has contributed a depth of new understanding in to how minor injury nursing education and practice preparedness is experienced and what that means, which is entirely new to this field of research. These findings have implications for clinical practice, education, policy and future research. My findings can be used to improve the educational and practice preparedness experiences of minor injury nurses.

References

Affleck, W., Glass, K.C. and Macdonald, M.E. (2013) The limitations of language: Male participants, stoicism, and the qualitative research interview. *American Journal of Men's Health,* 7 (2), pp. 155-162.

Alhazmi, A.A. and Kaufmann, A. (2022) Phenomenological qualitative methods applied to the analysis of cross-cultural experience in novel educational social contexts. *Frontiers in Psychology,* 13, pp. 1-12.

Altmann, T.K. (2007) An evaluation of the seminal work of Patricia Benner: theory or philosophy? *Contemporary Nurse,* 25 (1-2), pp. 114-123.

Ahtisham, Y. and Jacoline, S. (2015) Integrating Nursing Theory and Process into Practice; Virginia's Henderson Need Theory. *International Journal of Caring Sciences,* 8 (2), pp. 443-450.

Arbon, P. (2004) Understanding experience in nursing. *Journal of Clinical Nursing,* 13 (2), pp. 150-157.

Armstrong, P. (2005) *Phenomenology. John Hopkings guide to literary theory and criticism.* The Johns Hopkins University Press.

Asio, J.M.R. and Riego de Dios, E. (2019) The college students' perspective on what makes an educator well-qualified. *Journal of Pedagogical Research,* 3 (3), pp. 126-138.

Audit Scotland (2015) *Accident and Emergency – A Briefing Paper to the Public Audit Committee*. Audit Scotland. Available: http://www.auditscotland.gov.uk/uploads/docs/report/2014/briefing_151126_ae.pdf. [Accessed 6/3/17].

Bache, J. (2001) Establishing an emergency nurse practitioner service. *Emergency Medicine Journal,* 18 (3), pp. 186-189.

Badakhsh, M., Hastings-Tolsma, M., Firouzkohi, M., Amirshahi, M. and Hashemi, Z.S. (2020) The lived experience of women with a high-risk pregnancy: A phenomenology investigation. *Midwifery,* 82, pp. 1-7.

Bagley, S. (2018) Exploring emergency nurse practitioners' perceptions of their role. *Nursing Standard,* 32 (26), p. 41.

Bailey, P.H. (1997) Finding your way around qualitative methods in nursing research. *Journal of Advanced Nursing,* 25 (1), pp. 18-22.

Baker, C., Wuest, J. and Stern, P.N. (1992) Method slurring: The grounded theory/phenomenology example. *Journal of Advanced Nursing,* 17 (11), pp. 1355-1360.

Ball, S.T.E., Walton, K. and Hawes, S. (2007) Do emergency department physiotherapy Practitioner's, emergency nurse practitioners and doctors investigate, treat and refer patients with closed musculoskeletal injuries differently? *Emergency Medicine Journal: EMJ; Emerg Med J,* 24 (3), pp. 185-188.

Bartholomew, T.T., Joy, E.E., Kang, E. and Brown, J. (2021) A choir or cacophony? Sample sizes and quality of conveying participants' voices in phenomenological research. *Methodological Innovations,* 14 (2), pp. 1-14.

Bani-issa. (2019) Experiences of nursing students and examiners with the Objective Structured Clinical Examination method in physical assessment education: A mixed methods study. *Nurse Education in Practice,* 35, p. 83.

Barton, T.D., Bevan, L. and Mooney, G. (2012) Advanced nursing. Part 1: The development of advanced nursing roles. *Nursing Times,* 108 (24), pp. 18-20.

Benner, P. (1984). From novice to expert, excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley.

Blum, C.A. (2010) Using the Benner intuitive-humanistic decision-making model in action: A case study. *Nurse Education in Practice,* 10 (5), pp. 303-307.

Boell, S.K. and Cecez-Kecmanovic, D. (2010) Literature reviews and the hermeneutic circle. *Australian Academic & Research Libraries,* 41 (2), pp. 129-144.

Boell, S.K. and Cecez-Kecmanovic, D. (2014) A hermeneutic approach for conducting literature reviews and literature searches. *Communications of the Association for Information Systems,* 34 (1), p. 12.

Boschma, G., Einboden, R., Groening, M., Jackson, C., MacPhee, M., Marshall, H., Magee, K.O., Simpson, P., Tognazzini, P. and Haney, C. (2010) Strengthening communication education in an undergraduate nursing curriculum. *International Journal of Nursing Education Scholarship,* 7 (1), pp.1-3.

Bradbury-Jones, C., Irvine, F. and Sambrook, S. (2010) Phenomenology and participant feedback: convention or contention? *Nurse Researcher,* 17 (2), pp.25-33.

Bramer, W.M., De Jonge, G.B., Rethlefsen, M.L., Mast, F. and Kleijnen, J. (2018) A systematic approach to searching: an efficient and complete method to develop literature searches. *Journal of the Medical Library Association: JMLA,* 106 (4), p. 531.

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3 (2), pp. 77-101.

Braun, V. and Clarke, V. (2014) What can "thematic Analysis" Offer Health and Wellbeing Researchers?. *International Journal of Qualitative Studies on Health and Well-being* , 9 (1), p. 26152–26152.

Braun, V and Clarke, V. (2021a) Thematic analysis: A practical guide. Sage, London.

Braun, V. and Clarke, V. (2021b) One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology,* 18 (3), pp. 328-352.

Bright, S., Bradbury, E., McGrane, P. and Dale, A. (2002) Injury management in the community. *Emergency Nurse,* 10 (7), pp. 28-32.

Brook, S. and Crouch, R. (2004) Doctors and nurses in emergency care: where are the boundaries now? *Trauma,* 6 (3), pp. 211-216.

Brook, S. and Rushforth, H. (2011) Why is the regulation of advanced practice essential? *British Journal of Nursing,* 20 (16), pp. 996-1000.

Brunero, S. and Stein-Parbury, J. (2008) The effectiveness of clinical supervision in nursing: an evidenced based literature review. *Australian Journal of Advanced Nursing, The,* 25 (3), pp. 86-94.

Burford, B., Whittle, V. and Vance, G.H. (2014) The relationship between medical student learning opportunities and preparedness for practice: a questionnaire study. *BMC Medical Education,* 14, pp. 1-8.

Burns, M., Bally, J., Burles, M., Holtslander, L. and Peacock, S. (2022) Constructivist Grounded Theory or Interpretive Phenomenology? Methodological Choices Within Specific Study Contexts. *International Journal of Qualitative Methods,* 21, pp. 1-13.

Butterworth, T. (2022) What is clinical supervision and how can it be delivered in practice. *Nursing Times,* , pp. 20-22.

Byrne, G., Richardson, M., Brunsdon, J. and Patel, A. (2000) An evaluation of the care of patients with minor injuries in emergency settings. *Accident and Emergency Nursing,* 8 (2), pp. 101-109.

Byrne, D. (2021) A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity,* , pp. 1-22.

Cairns, L. (2000) The process/outcome approach to becoming a capable organisation. *Australian Capability Network Conference.* Sydney , pp. 1-14.

Callaghan. (2011) Student nurses' perceptions of learning in a perioperative placement. *Journal of Advanced Nursing (John Wiley,* 67 (4), p. 854.

Cammell, P. (2015) Relationality and Existence: Hermeneutic and Deconstructive Approaches Emerging From Heidegger's Philosophy. *The Humanistic Psychologist,* 43 (3), pp. 235-249.

Carcary, M. (2009) The research audit trial—enhancing trustworthiness in qualitative inquiry. *Electronic Journal of Business Research Methods,* 7 (1), pp. 11-24.

Carney, M. (2015) Regulation of advanced nurse practice: its existence and regulatory dimensions from an international perspective. *Journal of Nursing Management,* 24 (1), pp. 105-114.

Carolan, C., Davies, C.L., Crookes, P., McGhee, S. and Roxburgh, M. (2020) COVID 19: Disruptive impacts and transformative opportunities in undergraduate nurse education. *Nurse Education in Practice,* 46, pp. 1-3.

Chance, S., Duffy, G. and Bowe, B. (2020) Comparing grounded theory and phenomenology as methods to understand lived experience of engineering educators implementing problem-based learning. *European Journal of Engineering Education,* 45 (3), pp. 405-442.

Chang, C. and Wang, Y. (2021) Using phenomenological methodology with thematic analysis to examine and reflect on commonalities of instructors' experiences in moocs. *Education Sciences,* 11 (5), p. 203.

Charette, M., Goudreau, J. and Bourbonnais, A. (2019) Factors influencing the practice of new graduate nurses: A focused ethnography of acute care settings. *Journal of Clinical Nursing,* 28 (19-20), pp. 3618-3631.

Chenail, R.J. (2011) Interviewing the investigator: Strategies for addressing instrumentation and researcher bias concerns in qualitative research. *Qualitative Report,* 16 (1), pp. 255-262.

Chesterton, L. and Jack, K. (2022) Using Heidegger's philosophy of dasein to support person-centred research. *Nurse Researcher,* 30 (3).

Chicca, J. and Chunta, K. (2020) Engaging students with visual stories: Using infographics in nursing education. *Teaching and Learning in Nursing,* 15 (1), pp. 32-36.

Chillón, J.M. (2017) Ready-to-hand in Heidegger. Philosophy as an everyday understanding of the world and the question concerning technology. *The Hand: Perception, Cognition, Action,* , pp. 115-126.

Clarke, V. and Braun, V. (2013) Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist,* 26 (2), pp120-123.

Colley, S. (2003) Nursing theory: its importance to practice. *Nursing Standard,* 17 (46), pp. 33-38.

Collins English Dictionary (2012) *Preparedness*. Complete and Unabridged Edition. Available: Preparedness Definition & Meaning | Dictionary.com. [Accessed 20/09/2021].

Cook, C. (2016) A 'Toolkit' for Clinical Educators to Foster Learners' Clinical Reasoning and Skills Acquisition. *Nursing Praxis in New Zealand,* 32 (1), pp. 28-37.

Cooper, M.A., Lindsay, G.M., Kinn, S. and Swann, I.J. (2002) Evaluating emergency nurse practitioner services: a randomized controlled trial. *Journal of Advanced Nursing,* 40 (6), pp. 721-730.

Cooper, M. (2011) Climate Change and the Emergency Nurse Practitioner role. *International Emergency Nursing; Int Emerg Nurs,* 19 (3), pp. 111-112.

Council for Healthcare Regulatory Excellence. (2009) Advanced practice: report to the four UK health departments.

Cope, D.G. (2014) Methods and meanings: credibility and trustworthiness of qualitative research. *Oncology Nursing Forum.*41 (1), pp. 89-91.

Crist, J.D. and Tanner, C.A. (2003) Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing Research,* 52 (3), pp. 202-205.

Cronin, C. (2012) Memoing: An active tool in research. *The Reflective Researcher.* p.1.

Creswell, J.W. (2014) *Research design : qualitative, quantitative, and mixed methods approaches.* Los Angeles, California: SAGE.

Crowther, S. and Thomson, G. (2020) From description to interpretive leap: Using philosophical notions to unpack and surface meaning in hermeneutic phenomenology research. *International Journal of Qualitative Methods,* 19, pp. 1-11.

Crowther, S., Ironside, P., Spence, D. and Smythe, L. (2017) Crafting stories in hermeneutic phenomenology research: A methodological device. *Qualitative Health Research,* 27 (6), pp. 826-835.

Crowther, S., Smythe, E. and Spence, D. (2014) The joy at birth: An interpretive hermeneutic literature review. *Midwifery,* 30 (4), pp. 157-165.

Crowther, S., Smythe, E. and Spence, D. (2015) Kairos time at the moment of birth. *Midwifery,* 31 (4), pp. 451-457.

Cummins, A. (2009) Clinical supervision: The way forward? A review of the literature. *Nurse Education in Practice,* 9 (3), pp. 215-220.

Dahlstrom, D.O. (2010) Hermeneutic ontology. In: *Theory and applications of ontology: Philosophical perspectives.* Springer, pp. 395-415.

Darbyshire, P. (1994) Skilled expert practice: is it 'all in the mind'? A response to English's critique of Benner's novice to expert model. *Journal of Advanced Nursing (Wiley-Blackwell),* 19 (4), p. 755.

Dawood, M. and Gamston, J. (2019) An intervention to improve retention in emergency nursing. *Emergency Nurse,* 27 (2), pp. 21-25.

Debesay, J., Naden, D. and Slettebo, A. (2008) How do we close the hermeneutic circle? A Gadamerian approach to justification in interpretation in qualitative studies. *Nursing Inquiry,* 15 (1), pp. 57-66.

De Chesnay, M. (2014) *Nursing research using phenomenology: Qualitative designs and methods in nursing.* Springer Publishing Company.

Den Brok, P., Brekelmans, M. and Wubbels, T. (2006) Multilevel issues in research using students' perceptions of learning environments: The case of the Questionnaire on Teacher Interaction. *Learning Environments Research,* 9 (3), p. 199.

Denzin, N.K. and Lincoln, Y.S. (1998) *Collecting and interpreting qualitative materials.* Thousand Oaks, Calif.: Sage Publications.

Dev, M.D., Rusli, K.D., McKenna, L., Lau, S.T. and Liaw, S.Y. (2020) Academic-practice collaboration in clinical education: A qualitative study of academic educator and clinical preceptor views. *Nursing & Health Sciences,* 22 (4), pp. 1131-1138.

Dew, K. (2007) A health researcher's guide to qualitative methodologies. *Australian and New Zealand Journal of Public Health,* 31 (5), pp. 433-437.

De Witt, L. and Ploeg, J. (2006) Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing,* 55 (2), pp. 215-229.

Dibley, L., Dickerson, S., Duffy, M. and Vandermause, R. (2020) *Doing hermeneutic phenomenological research: A practical guide.* Sage.

DiCicco-Bloom, B. and Crabtree, B.F. (2006) The qualitative research interview. *Medical Education,* 40 (4), pp. 314-321.

Dijkstra, I.S., Brand, P.L.P., Pols, J., Delwig, H., Jaarsma, Debbie A. D. C. and Tulleken, J.E. (2017) Are graduated intensivists prepared for practice? A case study from the Netherlands. *Journal of Critical Care; J Crit Care,* 42, pp. 47-53.

Dijkstra, I.S., Pols, J., Remmelts, P. and Brand, P.L. (2015) Preparedness for practice: a systematic cross-specialty evaluation of the alignment between postgraduate medical education and independent practice. *Medical Teacher,* 37 (2), pp. 153-161.

Donalek, J.G. (2004) Choosing among qualitative traditions. *Urologic Nursing,* 24 (5), pp. 409-410.

Doody, O. and Bailey, M.E. (2016) Setting a research question, aim and objective. *Nurse Researcher,* 23 (4), pp. 19-23.

Dowling, M. and Cooney, A. (2012) Research approaches related to phenomenology: Negotiating a complex landscape. *Nurse Researcher,* 20 (2), pp.21-27.

Dreyfus, S.E. and Dreyfus, H.L. (1980) *A five-stage model of the mental activities involved in directed skill acquisition*. California Univ Berkeley Operations Research Center.

Dotov, D.G., Nie, L. and Chemero, A. (2010) A demonstration of the transition from ready-to-hand to unready-to-hand. *PloS One,* 5 (3), p. 9433.

Dunwoody, D.R., Jungquist, C.R., Chang, Y.P. and Dickerson, S.S., 2019. The common meanings and shared practices of sedation assessment in the context of managing patients with an opioid: A phenomenological study. *Journal of Clinical Nursing*, *28*(1-2), pp.104-115.

Dyess, S., Boykin, A. and Rigg, C. (2010) Integrating caring theory with nursing practice and education: connecting with what matters. *JONA: The Journal of Nursing Administration,* 40 (11), pp. 498-503.

Earle, V. (2010) Phenomenology as research method or substantive metaphysics? An overview of phenomenology's uses in nursing. *Nursing Philosophy,* 11 (4), pp. 286-296.

Eddles-Hirsch, K. (2015) Phenomenology and educational research. *International Journal of Advanced Research,* 3 (8), 251-260.

Edmonds, M.L. (2010) The lived experience of nursing students who study abroad: A qualitative inquiry. *Journal of Studies in International Education,* 14 (5), pp. 545-568.

Elliott, V. (2018) Thinking about the coding process in qualitative data analysis. *The Qualitative Report,* 23 (11), pp. 2850-2861.

English, I. (1993) Intuition as a function of the expert nurse: a critique of Benner's novice to expert model. *Journal of Advanced Nursing,* 18 (3), pp. 387-393.

Errasti-Ibarrondo, B., Jordán, J.A., Díez-Del-Corral, M.P. and Arantzamendi, M. (2018) Conducting phenomenological research: Rationalizing the methods and rigour of the phenomenology of practice. *Journal of Advanced Nursing,* 74 (7), pp. 1723-1734.

Ezra, D.G., Mellington, F., Cugnoni, H. and Westcott, M. (2005) Reliability of ophthalmic accident and emergency referrals: a new role for the emergency nurse practitioner? *Emergency Medicine Journal : EMJ; Emerg Med J,* 22 (10), pp. 696-699.

Feo, R., Rasmussen, P., Wiechula, R., Conroy, T. and Kitson, A. (2017) Developing effective and caring nurse-patient relationships. *Nursing Standard (2014),* 31 (28), p. 54.

Field, D.E. (2004) Moving from novice to expert–the value of learning in clinical practice: a literature review. *Nurse Education Today,* 24 (7), pp. 560-565.

Finlay, L. (1999) Applying phenomenology in research: Problems, principles and practice. *British Journal of Occupational Therapy,* 62 (7), pp. 299-306.

Flood, A. (2010) Understanding phenomenology. *Nurse Researcher,* 17 (2).

Flynn, S.V. and Korcuska, J.S. (2018) Credible phenomenological research: A mixed-methods study. *Counselor Education and Supervision,* 57 (1), pp. 34-50.

Ford, L.C. and Silver, H.K. (1967) The expanded role of the nurse in child care. *Nursing Outlook*, *15*(9), pp.43-45.

Fotheringham, D., Dickie, S. and Cooper, M. (2011) The evolution of the role of the Emergency Nurse Practitioner in Scotland: a longitudinal study. *Journal of Clinical Nursing (John Wiley & Sons, Inc.),* 20 (20-21), pp. 2958-2967.

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S. and Aboagye-Sarfo, P. (2018) Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Services Research,* 18 (1), pp. 1-11.

Fowler, J. (2020) Academic essays part 1: the importance of academic writing. *British Journal of Nursing,* 29 (12), p. 718.

Frechette, J., Bitzas, V., Aubry, M., Kilpatrick, K. and Lavoie-Tremblay, M. (2020) Capturing lived experience: methodological considerations for interpretive phenomenological inquiry. *International Journal of Qualitative Methods,* 19, pp. 1-12.

Fry, J., Scammell, J. and Barker, S. (2017) Drowning in muddied waters or swimming downstream? A critical analysis of literature reviewing in a phenomenological study through an exploration of the lifeworld, reflexivity and role of the researcher. *Indo-Pacific Journal of Phenomenology,* 17 (1), pp. 1-12.

Frykman, J. (2004) Bracketing. *Ethnologia Europaea,* 35 (1), pp47-52.

Gale, E. (2022) Using Heideggerian hermeneutic phenomenology for midwifery research studies. *The Practising Midwife,* 25 (1), pp. 8-10.

Geanellos, R. (1998) Hermeneutic philosophy. Part II: A nursing research example of the hermeneutic imperative to address forestructures/pre-understandings. *Nursing Inquiry,* 5 (4), pp. 238-247.

Gelling, L. (2011) What is the difference between grounded theory and phenomenology? *Nursing Times,* 107 (4), p. 25.

Gill, M.J. (2020) How can I study who you are? Comparing grounded theory and phenomenology as methodological approaches to identity work research. *The Oxford Handbook of Identities in Organisations,* pp. 295-310.

Ginns, P., Prosser, M. and Barrie, S. (2007) Students' perceptions of teaching quality in higher education: The perspective of currently enrolled students. *Studies in Higher Education,* 32 (5), pp. 603-615.

Gobet, F. and Chassy, P. (2008) Towards an alternative to Benner's theory of expert intuition in nursing: a discussion paper. *International Journal of Nursing Studies,* 45 (1), pp. 129-139.

Grebennikov, L. and Shah, M. (2013) Student voice: using qualitative feedback from students to enhance their university experience. *Teaching in Higher Education,* 18 (6), pp. 606-618.

Green, H.E. (2014) Use of theoretical and conceptual frameworks in qualitative research. *Nurse Researcher,* 21 (6), pp. 34-38.

Gregory, K. (2019) Lessons of a failed study: Lone research, media analysis, and the limitations of bracketing. *International Journal of Qualitative Methods,* 18, pp. 1-10.

Groenewald, T. (2004) A phenomenological research design illustrated. *International Journal of Qualitative Methods,* 3 (1), pp. 42-55.

Grondin, J. (2015) The hermeneutical circle. *A Companion to Hermeneutics,* , pp. 299-305.

Gross, M.M., Wright, M.C. and Anderson, O.S. (2017) Effects of image-based and text-based active learning exercises on student examination performance in a musculoskeletal anatomy course. *Anatomical Sciences Education,* 10 (5), pp. 444-455.

Guest, G., Bunce, A. and Johnson, L. (2006) How many interviews are enough? An experiment with data saturation and variability. *Field Methods,* 18 (1), pp. 59-82.

Gullick, J., Lin, F., Massey, D., Wilson, L., Greenwood, M., Skylas, K., Woodard, M., Tembo, A.C., Mitchell, M. and Gill, F.J. (2019) Structures, processes and outcomes of specialist critical care nurse education: An integrative review. *Australian Critical Care*, *32*(4), pp.331-345.

Guerrero-Castañeda, R.F., Menezes, Tânia Maria de Oliva and Prado, M.L.d. (2019) Phenomenology in nursing research: reflection based on Heidegger's hermeneutics. *Escola Anna Nery Revista De Enfermagem; Esc.Anna Nery,* 23 (4), pp. 1-7.

Guetterman, T. (2015) Descriptions of sampling practices within five approaches to qualitative research in education and the health sciences. *Educational Psychology Papers and Publications,* 16 (2), pp. 13-14.

Hale, E.D., Treharne, G.J. and Kitas, G.D. (2008) Qualitative methodologies II: a brief guide to applying interpretative phenomenological analysis in musculoskeletal care. *Musculoskeletal Care,* 6 (2), pp. 86-96.

Hamill, C. and Sinclair, H.A. (2010) Bracketing–practical considerations in Husserlian phenomenological research. *Nurse Researcher,* 17 (2), pp. 16-24.

Happell, B., Waks, S., Horgan, A., Greaney, S., Manning, F., Goodwin, J., Bocking, J., Scholz, B., Hals, E. and Granerud, A. (2020) "It is much more real when it comes from them": The role of experts by experience in the integration of mental health nursing theory and practice. *Perspectives in Psychiatric Care,* 56 (4), pp. 811-819.

Harding, J. (2013). *Qualitative Data Analysis From start to Finish.* London, Sage Publications.

Hart, A.M. and Bowen, A. (2016) New nurse practitioners' perceptions of preparedness for and transition into practice. *The Journal for Nurse Practitioners,* 12 (8), pp. 545-552.

Heidegger, M. (1962). Being and Time. Oxford: Blackwell Publishing.

Henderson, C. (2021) Advanced practice education and development. *Practice Nursing,* 32 (11), pp. 443-448.

Henry, P. (2015) Rigor in qualitative research: Promoting quality in social science research. *Res J Recent Sci ISSN,* 2277, p. 2502.

Hill, B. (2017) Exploring the development and identity of advanced practice nursing in the UK. *Nursing Management,* 24 (5).

Holloway, I. and Wheeler, S. (2002) *Qualitative research in nursing.* Wiley-Blackwell.

Holt, J. (2009) Quantitative research: An overview. *British Journal of Cardiac Nursing,* 4 (5), pp. 234-236.

Houghton, C., Casey, D., Shaw, D. and Murphy, K. (2013) Rigour in qualitative case-study research. *Nurse Researcher,* 20 (4), pp. 12-17.

Horrigan-Kelly, M., Millar, M. and Dowling, M. (2016) Understanding the key tenets of Heidegger's philosophy for interpretive phenomenological research. *International Journal of Qualitative Methods,* 15 (1), pp. 1609406916680634.

Horton, J., Macve, R. and Struyven, G. (2004) Qualitative research: experiences in using semi-structured interviews. In: *The real life guide to accounting research.* Elsevier, pp. 339-357.

Hwang, Y. and Oh, J. (2021) The relationship between self-directed learning and problem-solving ability: The mediating role of academic self-efficacy and self-regulated learning among nursing students. *International Journal of Environmental Research and Public Health,* 18 (4), p. 1738.

Imenda, S. (2014) Is there a conceptual difference between theoretical and conceptual frameworks? *Journal of Social Sciences,* 38 (2), pp. 185-195.

International Council of Nursing (2013) *What is an Advanced Practice Nurse?.* International Council of Nursing. Available : *What is an Advanced Practice Nurse? – International Advanced Practice Nursing (internationalapn.org)* [Accessed 28/05/2018].

Jamshed, S. (2014) Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy,* 5 (4), p. 87.

Johnson, M.E. (2001) Heidegger and meaning: Implications for phenomenological research. *Nursing Philosophy,* 1 (2), pp. 134-146.

Johnston, C.M., Wallis, M., Oprescu, F.I. and Gray, M. (2017) Methodological considerations related to nurse researchers using their own experience of a phenomenon within phenomenology. *Journal of Advanced Nursing,* 73 (3), pp. 574-584.

Jootun, D., McGhee, G. and Marland, G.R. (2009) Reflexivity: promoting rigour in qualitative research. *Nursing Standard,* 23 (23), pp. 42-47.

Keenan, I.D. and ben Awadh, A. (2019) Integrating 3D visualisation technologies in undergraduate anatomy education. *Biomedical Visualisation,* , pp. 39-53.

Kezar, A. (2000) The importance of pilot studies: Beginning the hermeneutic circle. *Research in Higher Education,* 41 (3), pp. 385-400.

Khalid, K., Abdullah, H.H. and Kumar M, D. (2012) Get along with quantitative research process. *International Journal of Research in Management,* 2 (2), pp. 15-29.

King, R., Tod, A. and Sanders, T. (2017) Development and regulation of advanced nurse practitioners in the UK and internationally. *Nursing Standard,* 32 (14), pp. 43-50.

Kitto, S.C., Chesters, J. and Grbich, C. (2008) Quality in qualitative research. *Medical Journal of Australia,* 188 (4), pp. 243-246.

Kleiman, S. (2004) Phenomenology: to wonder and search for meanings. *Nurse Researcher,* 11 (4), pp. 7-19.

Knowles, M.S., Holton, E. and Swanson, R. (2005) The adult learner: the definitive classic in adult education and human resource development (6th). *Burlington, MA: Elsevier*.

Knox, S. and Burkard, A.W. (2009) Qualitative research interviews. *Psychotherapy Research,* 19 (4-5), pp. 566-575.

Kompa, J.S. (2013) An introduction to grounded theory and phenomenology. *Retrieved March,* 28, p. 2018.

Lai, A., 2017. Clinical teaching strategies that inspire and get the most out of your learners. *Canadian Journal of Emergency Nursing*, *40*(2), pp.14-15.

Langdridge, D. (2007) *Phenomenological psychology: Theory, research and method.* Pearson education.

Lauer, Q. (1965). Phenomenology: Its Genesis and Prospect. United States: Harper & Row.

Laverty, S.M. (2003) Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods,* 2 (3), pp. 21-35.

Lee, S., Kim, D.H. and Chae, S. (2020) Self-directed learning and professional values of nursing students. *Nurse Education in Practice,* 42, pp. 1-6.

Lloyd-Rees, J. (2016) How emergency nurse practitioners view their role within the emergency department: A qualitative study. *International Emergency Nursing,* 24, pp. 46-53.

Logan, R.M. and Dormire, S. (2018) Finding my way: a phenomenology of fathering in the NICU. *Advances in Neonatal Care,* 18 (2), pp. 154-162.

Louw, S., Todd, R.W. and Jimarkon, P. (2011) Active listening in qualitative research interviews. *Proceedings of the International Conference: Research in Applied Linguistics, April,* pp. 71-80.

Lucchese, S.P., Bishop, S., Guruge, S., Zanchetta, M.S. and Pirner, D. (2021) Finding the Silver Lining: Aging Well Amongst Older Brazilian Women in the Post-Migration Context. *Canadian Journal of Nursing Research*, pp. 155-167.

Mabaquiao, N.M. (2006) Husserl's Theory of Intentionality. *Philosophia: An International Journal of Philosophy*, 34 (1), pp. 24-49.

Mabrook, A.F. and Dale, B. (1998) Can nurse practitioners offer a quality service? An evaluation of a year's work of a nurse led minor injury unit. *Journal of Accident & Emergency Medicine,* 15 (4), pp. 266-268.

Macduff, C., West, B.J.M. and Lawton, S. (2000) An evaluation of the impact of developing nurse-led treatments for minor injuries in community hospital casualty units. *NT Research,* 5 (4), pp. 276-284.

Mackintosh-Franklin, C. (2021) An evaluation of formative feedback and its impact on undergraduate student nurse academic achievement. *Nurse Education in Practice,* 50, pp. 2-7.

Magan, A.A., Plastow, R. and Haddad, F.S. (2020) Impact of COVID-19 on Research. Journal of bone and joint research. (9), pp. 531-533.

Malterud, K., Siersma, V.D. and Guassora, A.D. (2016) Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research,* 26 (13), pp. 1753-1760.

Målqvist, M. (2015) Preserving misconceptions or a call for action?–A hermeneutic re-reading of the Nativity story. *Global Health Action,* 8 (1).

Mapp, T. (2008) Understanding phenomenology: The lived experience. *British Journal of Midwifery,* 16 (5), pp. 308-311.

Marsden, J. (2003) Educational preparation for ENP roles. *Emergency Nurse,* 10 (10), pp. 26-31.

Martin, K. and Wilson, C.B. (2011) Newly Registered Nurses' Experience in the First Year of Practice: A Phenomenological Study. *International Journal for Human Caring,* 15 (2), pp. 21-27.

Masoodi, M. (2017) A comparative analysis of two qualitative methods: Deciding between grounded theory and phenomenology for your research. *Profesinis Rengimas: Tyrimai Ir Realijos,* (28), pp. 23-40.

Mason, S., Fletcher, A., McCormick, S., Perrin, J. and Rigby, A. (2005) Developing assessment of Emergency Nurse Practitioner competence - a pilot study. *Journal of Advanced Nursing; J Adv Nurs,* 50 (4), pp. 425-432.

Matua. (2015) Choosing phenomenology as a guiding philosophy for nursing research. *Nurse Researcher,* 22 (4), p. 30.

McConnell-Henry, T., Chapman, Y. and Francis, K. (2009) Husserl and Heidegger: exploring the disparity. *International Journal of Nursing Practice,* 15 (1), pp. 7-15.

McConnell, D., Slevin, O.D. and McIlfatrick, S.J. (2013) Emergency nurse practitioners' perceptions of their role and scope of practice: Is it advanced practice? *International Emergency Nursing,* 21 (2), pp. 76-83

McConnell-Henry, T., Chapman, Y. and Francis, K. (2011) Member checking and Heideggerian phenomenology: A redundant component. *Nurse Researcher,* 18 (2), pp. 28-37.

McDevitt, J. and Melby, V. (2015) An evaluation of the quality of Emergency Nurse Practitioner services for patients presenting with minor injuries to one rural urgent care centre in the UK: a descriptive study. *Journal of Clinical Nursing,* 24 (3-4), pp. 523-535.

McEwen, M. (2014) Overview of theory in nursing. *Theoretical Basis for Nursing,* , pp. 23-48.

McLeod, J. (2011) *Qualitative research in counselling and psychotherapy.* Sage.

McNarry, G., Allen-Collinson, J. and Evans, A.B. (2019) Reflexivity and bracketing in sociological phenomenological research: Researching the competitive swimming lifeworld. *Qualitative Research in Sport, Exercise and Health,* 11 (1), pp. 138-151.

McNiff, J. (2013) *Action research: Principles and practice*. Routledge.

Meek, S., Kendall, J., Porter, J. and Freij, R. (1998) Can accident and emergency nurse practitioners interpret radiographs? A multicentre study. *Emergency Medicine Journal,* 15 (2), pp. 105-107.

Megahy, A. and Lloyd, M. (2004) Managing minor injuries. *Emergency Nurse,* 12 (5), pp. 14-16.

Miles, M., Francis, K., Chapman, Y. and Taylor, B. (2013) Hermeneutic phenomenology: A methodology of choice for midwives. *International Journal of Nursing Practice,* 19 (4), pp. 409-414.

Moran, D. (2014) What does Heidegger mean by the transcendence of Dasein? *International Journal of Philosophical Studies,* 22 (4), pp. 491-514.

Morley, J. (2010) It's always about the epoché. *Les Collectifs Du Cirp,* 1 (1), pp. 223-232.Mulholland, S., Derdall, M. and Roy, B. (2006) The student's perspective on what makes an exceptional practice placement educator. *British Journal of Occupational Therapy,* 69 (12), pp. 567-571.

Neary, A. (2014) Do emergency nurse practitioners provide adequate documentation? *Emergency Nurse,* 22 (4), pp 34-40.

Neubauer, B.E., Witkop, C.T. and Varpio, L. (2019) How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education,* 8 (2), pp. 90.

NHS Research Scotland (2017) *NHS Research Scotland.* NHS Scotland. Available: https://www.nhsresearchscotland.org.uk/contact/regional-nodes. [Accessed 19/4/17].

NHS Scotland (2016) *Transforming nursing roles – developing advanced practice in Scotland.* NHS Scotland Available : http://aape.org.uk/wp-content/uploads/2016/10/Transforming-Roles-Advanced-Practice-Paper-June-2016.pdf. [Accessed 6/4/17].

Nordmann, E. and McGeorge, P. (2018) Lecture capture in higher education: time to learn from the learners. *PsyArXiv*.

O'Bannon, B.W., Lubke, J.K., Beard, J.L. and Britt, V.G. (2011) Using podcasts to replace lecture: Effects on student achievement. *Computers & Education,* 57 (3), pp. 1885-1892.

Oermann, M.H. (2006) Short written assignments for clinical nursing courses. *Nurse Educator,* 31 (5), pp. 228-231.

Öhlén, J. and Friberg, F. (2023) Empirical Phenomenological Inquiry: Guidance in Choosing Between Different Methodologies. *Global Qualitative Nursing Research,* 10, pp. 1-14.

O'Gorman, C.S., Macken, A.P., Cullen, W., Saunders, J., Dunne, C.P. and Higgins, M.F. (2013) Research confuses me: what is qualitative research & what is the difference between grounded theory and phenomenology?, 106 (2). pp. 8-10.

O'keefe, M. (2001) Should parents assess the interpersonal skills of doctors who treat their children? A literature review. *Journal of Paediatrics and Child Health,* 37 (6), pp. 531-538.

Ottrey, E., Rees, C.E., Kemp, C., Brock, T.P., Leech, M., Lyons, K., Monrouxe, L.V., Morphet, J. and Palermo, C. (2021) Exploring health care graduates' conceptualisations of preparedness for practice: A longitudinal qualitative research study. *Medical Education,* 55 (9), pp. 1078-1090.

Oshvandi, K., Moghadam, A.S., Khatiban, M., Cheraghi, F., Borzu, R. and Moradi, Y. (2016) On the application of novice to expert theory in nursing; a systematic review. *Journal of Chemical and Pharmaceutical Sciences,* 9 (4), pp. 3014-3020.

Padgett, S.M. (2000) Benner and the critics: promoting scholarly dialogue. *Research and Theory for Nursing Practice,* 14 (3), p. 249.

Paley, J. (1996) Intuition and expertise: comments on the Benner debate. *Journal of Advanced Nursing,* 23 (4), pp. 665-671.

Paley, J. (2005) Phenomenology as rhetoric. *Nursing Inquiry,* 12 (2), pp. 106-116.

Patton, C.M. (2020) Phenomenology for the holistic nurse researcher: Underpinnings of descriptive and interpretive traditions. *Journal of Holistic Nursing,* 38 (3), pp. 278-286.

Pereira, H.R. (2012) Rigour in phenomenological research: Reflections of a novice nurse researcher. *Nurse Researcher,* 19 (3), pp. 16-19.

Pernecky, T. and Jamal, T. (2010) (Hermeneutic) phenomenology in tourism studies. *Annals of Tourism Research,* 37 (4), pp. 1055-1075.

Phillippi, J. and Lauderdale, J. (2018) A guide to field notes for qualitative research: Context and conversation. *Qualitative Health Research,* 28 (3), pp. 381-388.

Pop. (2017) Mentoring Nurse Practitioners in a Hospital Setting. *Journal of Nursing Research (Lippincott Williams,* 25 (4), p. 304.

Pugh, D., Desjardins, I. and Eva, K., 2018. How do formative objective structured clinical examinations drive learning? Analysis of residents' perceptions. *Medical teacher*, *40*(1), pp.45-52.

Purcell, D. (2010). Minor Injuries: a Clinical Guide. 2nd ed. Elsevier Churchill Livingstone: Edinburgh.

QSR International Pty Ltd. (2015). NVivo (Version 11). https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home.

Ramritu, P.L. and Barnard, A. (2001) New nurse graduates' understanding of competence. *International Nursing Review,* 48 (1), pp. 47-57.

Ramsook, L. (2018) A methodological approach to hermeneutic phenomenology. *International Journal of Humanities and Social Sciences,* 10 (1), pp. 14-24.

Ray, M.A. and Locsin, R.C. (2023) Toward an Adequate Understanding of Phenomenological and Hermeneutic-Phenomenological Nursing Research. *Nursing & Health Sciences*, 25 (1), pp. 3-8.

Reiners, G.M. (2012) Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing & Care,* 1 (5), pp. 1-3.

Robinson, S. and Kerr, R. (2015) Reflexive conversations: Constructing hermeneutic designs for qualitative management research. *British Journal of Management,* 26 (4), pp. 777-790.

Rolfe. (2014) A new vision for advanced nursing practice. *Nursing Times,* 110 (28), p. 18.

Roth, B. (2018) Reading from the middle: Heidegger and the narrative self. *European Journal of Philosophy,* 26 (2), pp. 746-762.

Rutberg, S. and Bouikidis, C.D. (2018) Focusing on the fundamentals: A simplistic differentiation between qualitative and quantitative research. *Nephrology Nursing Journal,* 45 (2), pp. 209-213.

Saaranen, T., Vaajoki, A., Kellomäki, M. and Hyvärinen, M. (2015) The simulation method in learning interpersonal communication competence—Experiences of Masters' degree students of health sciences. *Nurse Education Today,* 35 (2), pp. 8-13.

Sakr, M., Angus, J., Perrin, J., Nixon, C., Nicholl, J. and Wardrope, J. (1999) Care of minor injuries by emergency nurse practitioners or junior doctors: a randomised controlled trial. *Lancet,* 354 (9187), pp. 1321-1326.

Saldaña, J. (2021) *The coding manual for qualitative researchers.* sage.

Salvador, J.T. (2016) Exploring quantitative and qualitative methodologies: A guide to novice nursing researchers. *European Scientific Journal,* 12 (18), p. 107.

Sandhu, H., Dale, J., Stallard, N., Crouch, R. and Glucksman, E. (2009) Emergency nurse practitioners and doctors consulting with patients in an emergency department: a comparison of communication skills and satisfaction. *Emergency Medicine Journal,* 26 (6), pp. 400-404.

Saarijärvi, M. and Bratt, E. (2021) When Face-to-Face Interviews are Not Possible: Tips and Tricks for Video, Telephone, Online Chat, and Email Interviews in Qualitative Research.*European Journal of Cardiac Nursing,* (20). pp. 392-396.

Schober, M. (2006) Advanced nursing practice: an emerging global phenomenon. *Journal of Advanced Nursing,* 55 (3), pp. 275-276.

Scott, D. (2006) The "concept of time" and the "being of the clock": Bergson, Einstein, Heidegger, and the interrogation of the temporality of modernism. *Continental Philosophy Review,* 39 (2), pp. 183-213.

Scutter, S., Stupans, I., Sawyer, T. and King, S. (2010) How do students use podcasts to support learning? *Australasian Journal of Educational Technology,* 26 (2), pp. 181-191.

Seers, K. and Critelton, N. (2001) Quantitative research: Designs relevant to nursing and healthcare. *NT Research,* 6 (1), pp. 487-500.

Sharif, F. and Masoumi, S. (2005) A qualitative study of nursing student experiences of clinical practice. *BMC Nursing,* 4 (1), pp. 1-7.

Shepherd, J.M. (2014) Younger children's nursing students are uniquely placed to provide emotional care for young people in hospital and promote for them a sense of normalcy. *Nurse Education Today,* 34 (6), pp. 1034-1039.

Sherman, G.L. (2009) Martin Heidegger's concept of authenticity: A philosophical contribution to student affairs theory. *Journal of College and Character,* 10 (7), pp. 1-8.

Sherwin, S. and Muir, F. (2011) Assessing and evaluating students on placement. *British Journal of School Nursing,* 6 (5), pp. 233-236.

Sinclair, M. (2007) A guide to understanding theoretical and conceptual frameworks. *Evidence Based Midwifery,* 5 (2), p. 39.

Solà-Pola. (2020) The usefulness and acceptance of the OSCE in nursing schools. *Nurse Education in Practice,* 43, pp. 1-6.

Smythe, E. and Spence, D. (2012) Re-viewing literature in hermeneutic research. *International Journal of Qualitative Methods,* 11 (1), pp. 12-25.

Starks, H. and Brown Trinidad, S. (2007) Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research,* 17 (10), pp. 1372-1380.

Staupe-Delgado, R. and Kruke, B.I. (2017) Preparedness: Unpacking and clarifying the concept. *Journal of Contingencies and Crisis Management,* 26 (2), pp. 212-224.

Stayt, L.C., Seers, K. and Tutton, L. (2016) Making sense of it: intensive care patients' phenomenological accounts of story construction. *Nursing in Critical Care,* 21 (4), pp. 225-232.

Sturges, J.E. and Hanrahan, K.J. (2004) Comparing telephone and face-to-face qualitative interviewing: a research note. *Qualitative Research,* 4 (1), pp. 107-118.

Stone, R., Cooper, S. and Cant, R. (2013) The value of peer learning in undergraduate nursing education: a systematic review. *International Scholarly Research Notices,* 27, pp. 45-62.

Spencer. (2013) From bedside to classroom: From expert back to novice. *Teaching,* 8 (1), p. 13.

Squires, A. and Dorsen, C. (2018) Qualitative research in nursing and health professions regulation. *Journal of Nursing Regulation,* 9 (3), pp. 15-26.

Stilwell, B. (1985) Health Education: Opportunities in General Practice. *Nursing Mirror,* 161 (19), pp. 30-31.

Sturge, S.A. (2014) Is there a need for placement evaluations for specialist practice students? A proposal. *Community Practitioner,* 87 (10), pp. 30-33.

Suddick, K.M., Cross, V., Vuoskoski, P., Galvin, K.T. and Stew, G. (2020) The work of hermeneutic phenomenology. *International Journal of Qualitative Methods,* 19, pp. 2-14.

Summers, J.A. (2017) Developing competencies in the novice nurse educator: An integrative review. *Teaching and Learning in Nursing,* 12 (4), pp. 263-276.

Sturge, S.A. (2014) Is there a need for placement evaluations for specialist practice students? A proposal. *Community Practitioner,* 87 (10), pp. 30-33.

Taylor, I., Bing-Jonsson, P.C., Finnbakk, E., Wangensteen, S., Sandvik, L. and Fagerström, L. (2021) Development of clinical competence–a longitudinal survey of nurse practitioner students. *BMC Nursing,* 20 (1), pp. 1-15.

Takase, M. (2013) The relationship between the levels of nurses' competence and the length of their clinical experience: A tentative model for nursing competence development. *Journal of Clinical Nursing,* 22 (9-10), pp. 1400-1410.

Tham, P. and Lynch, D. (2014) Prepared for Practice? Graduating Social Work Students' Reflections on Their Education, Competence and Skills. *Social Work Education,* 33 (6), pp. 704-717.

The Department of Health (2016) *Department of Health: shared delivery plan 2015 to 2020*. The Department of Health. Available : *[Withdrawn] Department of Health: shared delivery plan 2015 to 2020 - GOV.UK (www.gov.uk)*. [Accessed 05/06/2018].

The Royal College of Nursing (2020) *RCN credentialing for Advanced Level Nursing Practice.* The Royal College of Nursing. Available: Credentialing-Handbook (1).pdf. [Accessed 24/09/21].

The Royal College of Nursing (2023) RCN credentialing for Advanced Level Nursing Practice. RCN Credentialing for Advanced Level Nursing Practice Handbook for applicants. The Royal College of Nursing. Available: Credentialing-Handbook-April-2023.pdf [Accessed 03/10/2023].

The Scottish Government (2017) *NURSING 2030 VISION : PROMOTING CONFIDENT, COMPETENT AND COLLABORATIVE NURSING FOR SCOTLAND'S FUTURE*. The Scottish Government. Available: *Nursing 2030 Vision: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future (www.gov.scot)*. [Accessed 29/09/21].

The Scottish Government (2019) *NHS in Scotland 2019.* The Scottish Government. Available: NHS in Scotland 2019 (audit-scotland.gov.uk) [Accessed 29/09/21].

The Scottish Government (2021a) *Record investment to transform Scotland's NHS* . The Scottish Government. Available: *Record investment to transform Scotland's NHS - gov.scot (www.gov.scot)*. [Accessed 29/09/21].

The Scottish Government (2021b) *Transforming nursing, midwifery and health professions roles: advanced nursing practice.* Chief Nursing Officer Directorate. Available. [Accessed 14/10/21].

The Scottish Government (2022) NHS Scotland performance against LDP standards. The Scottish Government. Available: Accident and Emergency waiting times - NHS Scotland performance against LDP standards - gov.scot (www.gov.scot). [Accessed 30/05/2022]

Theobald, K.A., Coyer, F.M., Henderson, A.J., Fox, R., Thomson, B.F. and McCarthy, A.L. (2021) Developing a postgraduate professional education framework for emergency nursing: a co-design approach. *BMC Nursing,* 20 (1), pp. 1-10.

Thomas, J.S., Smart, D., Severtsen, B. and Haberman, M.R. (2021) The Lived Experiences of Highly Mobile Military Adolescents in Search of Their Identity: An Interpretive Phenomenological Study. *Journal of Adolescent Research*, 0(0), pp. 1-21.

Thompson, W. and Meskell, P. (2012) Evaluation of an Advanced Nurse Practitioner (Emergency Care)—An Irish Perspective. *Journal for Nurse Practitioners,* 8 (3), pp. 200-205.

Tomey, M. and Alligood, M.R. (1994) Nursing theorists and their work . St. Louis, Mosby-Year Book.

Tuli, F. (2010) The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education and Sciences,* 6 (1).

Tye, C.C. and Ross, F.M. (2000) Blurring boundaries: professional perspectives of the emergency nurse practitioner role in a major accident and emergency department. *Journal of Advanced Nursing; J Adv Nurs,* 31 (5), pp. 1089-1096.

Urcia, I.A. (2021) Comparisons of Adaptations in Grounded Theory and Phenomenology: Selecting the Specific Qualitative Research Methodology. *International Journal of Qualitative Methods,* 20, pp. 1-14.

Van Manen, M. (2016) *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing.* Routledge.

Vasileiou, K., Barnett, J., Thorpe, S. and Young, T. (2018) Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology,* 18, pp. 1-18.

Vessey, D., 2009. Gadamer and the Fusion of Horizons. *International Journal of Philosophical Studies*, *17*(4), pp.531-542.

Walsh, M. (2000) The emerging role of the nurse practitioner in A&E. *Emergency Nurse,* 7 (10), pp. 20-24.

Wiliam, D. (2011) What is assessment for learning? *Studies in Educational Evaluation,* 37 (1), pp. 3-14.

Willis, P. (2001) The “things themselves” in phenomenology. *Indo-Pacific Journal of Phenomenology,* 1 (1), pp. 1-12.

Wilson. (2015) A guide to phenomenological research. *Nursing Standard,* 29 (34), p. 38.

Withy, K. (2014) Situation and limitation: Making sense of Heidegger on thrownness. *European Journal of Philosophy,* 22 (1), pp. 61-81.

Woods, C., West, C., Mills, J., Park, T., Southern, J. and Usher, K. (2015) Undergraduate student nurses’ self-reported preparedness for practice. *Collegian,* 22 (4), pp. 359-368.

Wolff, A.C., Regan, S., Pesut, B. and Black, J. (2010) Ready for what? An exploration of the meaning of new graduate nurses' readiness for practice. *International Journal of Nursing Education Scholarship,* 7 (1), pp. 9-11.

York, R. (2021) Perceptions and beliefs about the regulation of advanced nurse practitioners. *Nursing Management,* 28 (4), pp. 30-35.

Zahavi, D. (2003) *Husserl's phenomenology.* Stanford University Press.

Zovko, J. (2020) Expanding hermeneutics to the world of technology. *AI & Society,* , pp. 1-12.

Appendix 1 - Participant Information Leaflet

Study Title

An exploration of the experiences of minor injury nurses of their educational preparation for the minor injury nurse role.

Invitation to participate:

You are being invited to take part in a research study. This study forms part of a Clinical Doctorate in Nursing being undertaken at The Faculty of Health Sciences and Sport at the University of Stirling.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to contact me if anything is unclear or if you would like more information (contact details are at the end of this leaflet). Take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

This study will explore your views on minor injury nurse education and how it prepared you for clinical practice. Several studies exist that look at minor injury nursing care; these studies show minor injury nurses in a positive light. However, very little research looks at minor injury nurse education in great depth. No previous studies have explored the views of minor injury nurses on minor injury education and how it prepares them for their role. Exploring the views of minor injury nurses on minor injury education will hopefully highlight areas/ideas for future development of minor injury nurse education.

Why have I been asked to take part?

We are seeking views and experiences of registered nurses who are employed to deliver minor injury care in dedicated minor injury units within NHS Scotland. You have been invited to take part as your health board area is one of the Scottish health boards selected for the study.

Do you have to take part in the study?

It is entirely up to you whether you decide to take part. If you decide to take part, you will be asked to sign a consent form. You can change your mind and withdraw from the study at any time, without giving reason. Your line manager is aware of what this study involves and has indicated their support. However, information about your participation, non-participation or withdrawal will not be shared with your line manager or any other colleagues.

There Is no professional obligation to take part in the study. The researchers do not want you to feel any obligation to participate, this study is a Scotland wide study and is being conducted across several different clinical areas across different Health boards. The research is not limited to one workplace. Your decision to not participate will not affect this research process or the

success of this research. Your line manager has been used as a point of contact only. There is no instruction or obligation from your manager or employing organisation to participate.

What will happen if I agree to participate?

You will be invited to take part in an interview. The interview will be held at your workplace in a convenient and quiet location e.g., a consultation room or meeting room. The interview is entirely informal and will last approximately 1 hour. The interviews will be audio-recorded with your consent. To make sure your responses are confidential, a study number will be used to identify the interview information.

Please note that you are free to withdraw from the study at any time.

Are there any risks in taking part?

We do not anticipate any risks to you from being involved in the study. We do appreciate and thank you for sacrificing your time for this study.

What are the potential benefits of taking part?

There is no guarantee that the study results will benefit you. However, the information gathered will be used to help us better understand minor injury nurse education. This could help inform future developments of minor injury nurse education.

How is my personal information managed?

The University of Stirling is the sponsor for this study based in Scotland. We will be using information from you and in order to undertake this study and Craig Adamson will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Craig Adamson will keep identifiable information about you until the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting Craig Adamson (researcher).

Will the information I provide be kept confidential?

All information collected from you will be kept strictly confidential. We will audio-record the interviews and have these typed up into a word document for analysis by the researcher. All participants and their workplace will be allocated a code so that names, addresses and any other personally identifiable information will not be attached to these transcripts or used in any other reports. The link to the personal details will be stored separately from the interview data on a password protected computer. All data, including the audio recordings and their transcripts, will be kept in a password protected secure University of Stirling server and only the researcher will be permitted access to any of the files or data. Once the study has ended, any identifying information will be destroyed and the audio files of interviews will be archived in a password protected file on a secure computer at the University of Stirling for a period of 10 years after which time they will be destroyed.

The information collected through this study will be used to inform the preparation of a report. Your comments will be looked at together with the replies from other participants. When the results of the study are written up, individuals who have taken part will not be identified. However, we do acknowledge that some clinical roles may be identifiable locally. To minimise this possibility, we will anonymise the study hospitals when publishing findings, findings that have any potential to identify participants will not be used.

Craig Adamson will keep your name, contact details, job title and location confidential and will not pass this information to The University of Stirling. Craig Adamson will use this information as needed, to contact you about the research study and to oversee the quality of the study. Certain individuals from The University of Stirling and regulatory organisations may look at your research records to check the accuracy of the research study. The University of Stirling will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Craig Adamson will not keep identifiable information about you from this study after the study has finished.

Who is doing this study?

This study is being carried out as part of the researcher's clinical doctorate in nursing. The researcher is a minor injury nurse currently undertaking a clinical doctorate. He is supervised by a team of two experienced health researchers at the Faculty of Health sciences and Sport, University of Stirling. The Clinical doctorate programme has been half funded by the University of Stirling and half funded by the researcher.

Who has reviewed this study?

The research has received approval from NHS, invasive or clinical research (NICR) and NHS R&D permission.

Will my information be used in the future?

When you agree to take part in a research study, the information you provide may be provided to researchers running other research studies in this organisation and in other organisations. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social Care Research.

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you.

Further information

If you require further information or have concerns regarding the study at any stage please contact the researcher, Craig Adamson (Tel 07468 466 432). Email craig.adamson@stir.ac.uk or the research supervisors Joyce Wilkinson (Tel 01786 466364). Email j.e.wilkinson@stir.ac.uk or Purva Abhyankar (Tel 01786 466 401). Email purva.abhyankar@stir.ac.uk

The research team would like to thank you for taking the time to read this information leaflet.

<u>Appendix 2 - Interview guide</u>

Hi, thank you for participating in this research. We are looking to explore your own experience of having undertaken minor injury nursing education.

I am Craig, I have worked as an ENP for many years. I am currently studying a Clinical Doctorate in Nursing with a research interest in minor injury nursing.

- Could you please start by telling me about yourself? (Role, title, scope of practice etc)
- Could you tell me about your minor injury education?
- Could you talk a little about your experience of your minor injury education? What aspects were useful? What wasn't?
- Could you now tell me about how your competency/skills were assessed on the course?
- Looking back, how well do you feel your minor injury education prepared you for practice?
- Going forward, how do you think minor injury nurse education can be improved?

Appendix 3 – Consent form

- IRAS ID: **IRAS Project ID: 236271**

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: ***An exploration of the experiences of minor injury nurses of their educational preparation for the minor injury nurse role.***

Name of Researcher: Mr. Craig S Adamson

Please initial box

1. I confirm that I have read the information sheet dated.................... (version............) 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, without detriment to me and my employment. ☐
4. I understand that relevant personal details will be held securely by Mr. Craig S Adamson (Chief Investigator) only, during the study. I understand that these details will be destroyed at the end of the study ☐

5. I understand that the information collected during the interviews is completely confidential and my details will be anonymized. ☐

6. I consent to digital audio recordings being made of these sessions and to these recordings being used to aid the research. ☐

7. I consent to the anonymised excerpts from these recordings, or descriptions of them, being used by Craig Adamson for the purposes of research. ☐

8. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature

____________________	____________________	____________________
Name of Person taking consent	Date	Signature

Appendix 4 – Ethics approval

FH/TB

May 22nd 2018

Craig Adamson

Myrtle Cottage

Hatton

Peterhead

AB42 0SH

Dear Craig

An exploration of the experiences of minor injury nurses of their educational preparation for the minor injury nurse role.

NICR REFERENCE 17/18 042

Thank you for your recent submission, which was discussed at the Committee meeting on May 22nd 2018

The Committee would request that you address the following points, and email your revised documentation to the above address prior to your application receiving formal approval:

1. Recruitment: further explanation should be provided as to how participants will be recruited without the potential for them to feel obliged to participate, given that they will be identified

by their line managers. If recruiting from your own workplace, additional steps must be taken to ensure that colleagues do not feel any obligation to take part.

2. Confidentiality and anonymity: given that line managers will likely know who has taken part, it is important to consider how anonymity can be maintained in these circumstances. For instance, it may be necessary to avoid linking participant quotes to particular sites.
3. You are advised that 1 month is too long a time between providing information sheets and seeking consent (A30-1). Please consider how this will be managed.
4. A51, we suggest that you also tick 'peer reviewed scientific journals' and 'conference presentation'.
5. Information sheet: you suggest that after analysis participants will have the opportunity to review what has been written. This is an onerous process and committee experience suggests that this is ill-advised, although this decision ultimately rests with you and your supervisors. If you wish to use participant checking, then you must clarify this sentence as it is not clear what you will share with participants. You also should state that transcripts will be archived in addition to audio files. Please revise the section 'who has reviewed this study' to clarify that you have received APPROVAL from NICR and NHS REC (if applicable). If NHS approval is not required then remove the reference to NHS REC as this is misleading.

When re-submitting your documentation, please ensure:

a) the version number and date has been changed on all documentation;
b) you include a covering letter advising how you have addressed each point raised by Committee.

We look forward to receiving your revisions.

NICR 17/18 042

Please quote this number on all correspondence

Yours sincerely

Dr Fiona Harris

(Depute Chair)

Appendix 5 – Minor amendments (Ethics)

Craig Adamson

Myrtle Cottage

Hatton

Peterhead

AB42 0SH

NICR 17/18 042

Dear Dr. Harris,

Thank you for taking the time to review my request for ethical approval and providing detailed feedback. I accept all the responses and have found them to be most informative and helpful in developing my research, thank you.

Below are my responses/revisions using quotes from the letter dated 22/5/18 as a guide;

6. "Recruitment: further explanation should be provided as to how participants will be recruited without the potential for them to feel obliged to participate, given that they will be identified by their line managers. If recruiting from your own workplace, additional steps must be taken to ensure that colleagues do not feel any obligation to take part."

    - I have re-considered how I can address this issue and have decided to add further information to the participant information sheet (PIS). The information now states that the researchers do not wish participants to feel any obligation to participate. The PIS now states that the study is a Scotland wide study and is being conducted across several different clinical areas across different Health Boards. The PIS now states that the study

is not simply limited to one work area. The PIS now states that any decision to not participate will not affect this research process or the success of the research. The PIS now states that the line manager has been used as a point of contact only and that there is no instruction or obligation from management or the employing organization to participate. The IRAS has been updated.

7. "Confidentiality and anonymity: given that line managers will likely know who has taken part, it is important to consider how anonymity can be maintained in these circumstances. For instance, it may be necessary to avoid linking participant quotes to particular sites."

   - This has been considered and I have added that any quotes from participant responses that has the potential to identify participants or their workplace will not be used. As well as direct quotes, any indirect quotes that have the potential to make participants or their workplace identifiable by any process of deduction by persons known to the participants will not be used. This information has been added to the PIS.

8. "You are advised that 1 month is too long a time between providing information sheets and seeking consent (A30-1). Please consider how this will be managed."

   - I have re-considered this point and reduced the time frame to 1 week to avoid a delay and ensure that the details of the study remain clear to potential participants prior to seeking consent.

9. "A51, we suggest that you also tick 'peer reviewed scientific journals' and 'conference presentation'."

   - This has been added to the IRAS form.

10. "Information sheet: you suggest that after analysis participants will have the opportunity to review what has been written. This is an onerous process and committee experience suggests that this is ill-advised, although this decision ultimately rests with you and your

supervisors. If you wish to use participant checking, then you must clarify this sentence as it is not clear what you will share with participants."

- I have discussed this with my supervisors and there is agreement that participant checking is not advised. Therefore, this will not take place. This has been removed from the PIS. The IRAS form has been updated to state that participants will have access to conference presentations, the thesis and journal articles once published if they wish.

11. "You also should state that transcripts will be archived in addition to audio files."

- This has been added to IRAS and the PIS confirming that all data and methods of recording data will be held securely.

12. "Please revise the section 'who has reviewed this study' to clarify that you have received APPROVAL from NICR and NHS REC (if applicable)."

- This has been updated on the PIS.

I hope my revisions are satisfactory, please do not hesitate to contact me with any queries and/or further revisions. I do appreciate the time the committee have taken to review this application.

Best wishes and kind regards,

Craig Adamson

Clinical Doctorate Student
The University of Stirling

Appendix 6 - Draft journal for publication

Background

Nurse-led care in minor injury units (MIU) is commonplace within Scotland. Nurses working in this field of practice will typically have undertaken a level of minor injury nursing education. In Scotland, minor injury nursing education is fragmented and lacks cohesion. Few studies have explored the experience of undertaking a minor injury nursing course or considered how they prepare minor injury nurses for practice.

Aim

This study explored the experience of undertaking minor injury nursing education and preparedness for practice.

Methods

The study was conducted using hermeneutic phenomenology. As this research formed part of a time-limited doctoral project, the Braun and Clarke six phases of reflexive thematic analysis was used to structure the analysis. Twelve minor injury nurse participants from across Scotland were purposively sampled from four minor injury units, two urban and two rural.

Findings

The interpretative analysis of data generated five major themes, Theory and practice – From learning to development, those that understand should teach, it was more than just an assessment, thrown into practice and, the preparedness continuum. Minor injury theory provided the founding principles of minor injury nursing that supported further stages of learning. Learning that was embedded in clinical practices reinforced the development of minor injury nursing practice skills. When educators were experienced in and connected to the field of minor injury nursing, students felt course content was more relevant and engaging. Participants felt more informed and aware of further learning needs when assessment of competence was taken with a broader overview. To feel prepared for minor injury practice, support, guidance and practice updates in the workplace were fundamental.

Conclusion

This study led to knowledge of how minor injury nursing education is experienced. Learning experiences have been explored and the contribution these experiences have in supporting learning, development and practice preparedness has been revealed. These findings have potential to develop minor injury nursing education and clinical practice.

Keywords

Hermeneutic phenomenology, minor injury nurse, ENP, preparedness, minor injury nursing education.

Introduction

Emergency/unscheduled care nurses are increasingly adopting roles and functions that were traditionally the sole preserve of medical staff (Fotheringham et al., 2011). Minor injuries nursing has evolved over a number of years to become a clinical speciality in its own right, with its own practitioners, specific training, and specific healthcare settings (Purcell 2010). During that time, minor injury nursing education has developed in an ad-hoc manner, with little or no standardisation or governance (Cooper et al. 2001 Bright et al. 2002, Fotheringham et al., 2011 and Dawood and Gamston. 2019).

Despite an established understanding that minor injury nursing education is not governed by a specific standard, there is little research that explores minor injury nursing education specifically. There is only a small amount of research that acknowledges the role of education in supporting practice preparedness (Sakr et al. 1999, Marsden 2003, Megaghy and Lloyd. 2004, Mason et al. 2005, Ezra et al. 2005, and Neary 2014). The scope and depth of understanding offered in these studies varies, with some studies suggesting that minor injury nurses can be well prepared for practice following adequate education (Sakr et al. 1999 and Megaghy and Lloyd. 2004), and others that specifically consider the positive impact educational interventions can have on improving clinical competence (Mason et al. 2005, Ezra et al. 2005, and Neary 2014). One of the most insightful studies explores minor injury nursing

education and practice preparedness in a little more depth and concludes that the unregulated approach to minor injury nursing education may mean that certain courses are not preparing nurses for practice (Marsden 2003). However, in that research, Marden (2003) does not explore the responses with in-depth experience-based descriptions. Collectively, these studies only offer a superficial understanding of minor injury nursing education and practice preparedness.

Currently, there is a gap in the research as no previous research has undertaken an in-depth exploration of the experiences of minor injury nursing education and practice preparedness. On that basis, the aim of this study was to undertake an exploration of the experiences of minor injury nurses of their educational preparation for the minor injury nurse role. The overarching research aim was sub-divided and developed into focused research questions: How do minor injury nurses experience minor injury nursing education? and, how do minor injury nurses experience preparedness for minor injury nursing practice following minor injury nursing education?

Methodology

Phenomenology was developed by Husserl (1859-1938), who believed that the lived experiences of others can develop a rich understanding of human lived experiences (Mapp 2008 and Frechette et al. 2020). In phenomenology, there are two primary branches - transcendental (Husserlian) and hermeneutic (Heideggerian) phenomenology (Dowling and Cooney 2012 and Neubauer et al. 2019). Hermeneutic phenomenology (meaning interpretive) is based on the work of Martin Heidegger, who was a student of Husserl. Within hermeneutic phenomenology the researcher is supported in bringing their ideas and concepts to the research to interpret or enhance the data (Mapp 2008). Conversely, transcendental phenomenology is more focused on describing the phenomena. In contrast to hermeneutic phenomenology, transcendental phenomenology does not support the use of ideas and concepts by the researcher, suggesting that the researcher takes a more objective stance by suspending one's prior experiences and judgements in order to undertake the research without interpretation (Hamil and Sinclair 2010). The objective approach to research in transcendental phenomenology is described as bracketing (Zahavi 2003).

This study was conducted by an experienced minor injury nurse with extensive lived experience of minor injury nursing education and practice preparedness. These experiences were so wedded to minor injury nursing that bracketing would have been difficult to achieve (Gregory 2019). On that basis, a methodological approach that acknowledged the researcher's previous experiences was used. Hermeneutic phenomenology was used as it is the key to unlocking and unpacking phenomena and advocates the prior experiences of the researcher as a component part of the interpretation of data (Mapp, 2008 and Matua, 2015).

Ethical considerations

This study was a project undertaken as part of a doctor of nursing degree. The University of Stirling agreed to act as the sponsor and approval was received from the NHS, Invasive or Clinical Research Panel (NICR) at the University of Stirling on the 22nd of May 2018 (NICR REFERENCE 17/18 042). Conducting research that relies on the involvement of NHS staff requires ethical approval and research and development consent from NHS Scotland (NHS Research Scotland, 2017). The research and development departments from participating Health Boards were also contacted and permission granted. Informed consent was obtained prior to each participant interview and all data and participant details were stored following policy and guidance.

Sampling and participants

The target population consisted of nurses working in a clinical area that provides a minor injury service. The participants included in the study had to be registered nurses, working in an MIU who had completed a minor injury nursing qualification. Non-nursing minor injury practitioners i.e., physician associates and nurses who worked in an MIU but did not hold a minor injury nursing qualification were not included in the study. Selecting study participants for the information they can offer is described by Holloway and Wheeler (2002) as purposive sampling which plays key role in small-scale qualitative studies. Heterogeneous sampling, is one example of a purposive sampling technique that is useful for capturing participants that relate to the area of interest (Creswell 2014). Heterogeneous sampling meant targeting participants with the lived experiences of minor injury nursing education that would help answer the research aim and questions.

In considering a sample size Gill (2020) argues that determining sample size in qualitative research is challenging as there are no set rules to follow. A minority of phenomenological studies suggest no less than 60 participants (Flynn and Korcuska 2018). Whilst the majority suggest 10 to 12 participants (Starks and Brown 2007, Guest et al. 2006, Flynn and Korcuska 2018 and Bartholomew et al. 2021) In order to recruit participants, a participant information sheet was issued to potential participants and the researcher's contact details were available for those wishing to be included in the study. The line managers were not informed of who was included in the study.

Participant characteristics

Twelve participants were recruited in to this study. Anonymised details of those participants are included in tables 1 and 2.

Table 1

Participant pseudonyms – Scottish Islands
1- Arran
2- Barra
3- Canna
4- Danna
5- Eday
6- Fara
7- Gairsay
8- Hoy
9- Islay
10- Jura
11- Kilegray
12- Lewis

Table 2

Participant characteristics	
Age range in years	**Number of participants**
18-25	1
25-34	2
34-45	6
45-55	3
55-65	0
65+	0
Years since completion of minor injury nursing course	**Number of participants**
Less than 3	2
3-5	3
5-10	6
10-15	1
15+	0
Minor Injury Unit (MIU)	**Number of participants**
Rural MIU	6
Urban MIU	6
Job Title	**Number of participants**
Emergency Nurse Practitioner (ENP)	6
Advanced Nurse Practitioner (ANP)	2
Minor Injury Nurse	4
Minor injuries qualification	**Number of participants**
Emergency Nurse Practitioner in Minor Injuries	5
Minor Injuries theory	7

Data collection and analysis

12 participants were recruited in to the study. Data collection occurred over six months using semi-structured interviews undertaken within the participants' workplaces, which lasted an average of 35 minutes. Collection of data was conducted via digitally recorded face-to-face semi-structured interviews. The interviews were undertaken by the researcher using an interview guide which allowed some structure but also allowed the data to emerge without constraint. The interview guide consisted of general questions surrounding minor injury nursing education such as course content, learning experiences and experiences of practice preparedness. Two pilot interviews were undertaken to test and refine the proposed data collection methods and practice interview techniques before starting the interviews (Chenail 2011). During data analysis, NVivo 11 (QSR 2015) was used as a platform to store and organise the data.

In phenomenological research, the hermeneutic circle creates a deeper understanding by breaking down the phenomenon under study from a whole, to details then back to a new whole/understanding (Malqvist, 2015). As the hermeneutic circle can be an ongoing cyclical approach and this research was a time-limited doctoral project, Braun and Clarke’s (2021) six phases of reflexive thematic analysis was used to structure the analysis (Table 3).

The six phases of reflexive thematic analysis

Table 3

Thematic analysis
1-Familiarising yourself with your data
2-Generating initial codes
3-Searching for themes
4-Review themes.
5-Define and naming themes.
6-Producing the report

Braun and Clarke (2021)

After each interview, the audio recordings were listened to in order to start getting close to the data. All data were transcribed by the researcher verbatim. In addition, a summary of each transcript was developed for further immersion in the data and to gain a sense of the whole data. The summaries were also developed to allow the research doctoral supervisors to gain an overview of the data. After initial familiarisation, the data were broken down into parts which generated 118 codes. From there, the codes were clustered into categories and subcategories in order to search for themes. Four categories were developed and each category had a number of subcategories. From there a thematic map was devised before defining the final theme names (Braun and Clarke, 2021). To achieve rigour a framework was applied to this research for structured guidance (De Witt and Ploeg 2006). De Witt and Ploeg (2006) offer a framework for rigour which is a five-stage approach, described as – balanced integration, openness, concreteness, resonance and actualisation. In addition, during analysis, regular meetings with doctoral supervisors were undertaken and discussion, support and guidance offered. Although from a methodological perspective, prior experiences of the researcher were seen as a

fundamental part of the data interpretation (Mapp, 2008 and Matua, 2015), in terms of reflexivity, relevant prior experiences of minor injury nursing were made clear throughout the process of research to maintain transparency. In addition, records of thoughts and decisions were kept during the data analysis.

Findings

12 participants met the inclusion criteria and were recruited from four departments across Scotland, two urban MIUs and two rural. 12 participants were deemed as a manageable sample and six were recruited from urban MIUs and six from rural MIUs (three from each department). All participants had undertaken one of two minor injury nursing courses, an ENP course in minor injuries or a minor injuries theory course. The data analysis generated five themes (Table 4).

Table 4

Themes
1-Theory and practice – From learning to development
2-Those that understand should teach
3-It was more than just an assessment
4-Thrown in to practice
5-The preparedness continuum

1- Theory and Practice – from learning to development

Theory-based education was a point of departure when studying minor injury nursing. It was categorised as an essential foundation for the participants in their learning journey. Theory connected with the prior learning and the clinical experiences of the participants which meant they could focus on learning that was specific to their individual needs as Gairsay illustrated:

" You needed the… you needed the module course (theory) to allow you to focus the areas that you were learning." (Gairsay)

In the study of theory, there were particular methods of learning that encouraged more in-depth learning experiences. In particular, methods such as visual learning were useful and applicable as it taught skills that were transferrable to clinical practice as Eday explained:

"Yes, you need to know the structures, I mean stuff like that, you need to know well, clinical experience this is a mechanism of injury or it's definitely going to be that. You need to know the structures behind it. You can't x-ray a foot and say the foot is sore, you need to know the structures and the bones. What attaches to what and what moves what and what could be affected." (Eday)

In addition to visual learning, time for self-directed learning was also a noteworthy learning experience. One example of this was delivering the theory-based educational component of the course over several weeks, a day at a time. A staggered approach to classes allowed participants time to engage in study preparation and consolidation of learning in the time between classes as Fara explained:

"They give you time to research each subject. So, I was ready when I went in and you got subjects you were going to cover that week. So, we do a bit of reading up and then could follow it through afterwards. I think that's better than being too intense and lots of subjects being thrown at you at once." (Fara)

For some, practical-based education followed a foundation of theory-based learning. For the participants, achieving the correct balance between theory and practice was essential to support and enhance learning and development. Theory was imperative to learn and understand the founding principles of minor injury nursing. However, development only came with practical based education as it taught the skills needed in everyday practice:

"I think. I think the practical. Because it's, that how… it's having that confidence to go, go and put your hands on somebody and start. That's what I think, once you've, once you've got over that. I think everything else comes." (Canna)

2 – Those that understand should teach

When educators had an understanding and personal lived experience of minor injury nursing education, their lived experiences translated into qualities that facilitated a more enriched learning environment as Arran described:

"It seized ENPs early on and they did come and they taught and their sessions were incredible and they involved looking at each other's limbs and touching each other and they knew what the job was and what we need to know." (Arran)

In addition, courses that were developed with collaboration between the academic and professional partners meant the course content was more aligned with the role of the minor injury nurse and therefore more clinically relevant. Facilitating that approach enabled courses to focus on both the specific and general injures that could present to a clinical area. When course content did not co-exist with the practices that were relevant to the minor injury nurse role, participants felt disconnected from their course:

"But there's a few things I thought, I thought with being remote and seaside… fish injuries and stuff. So, pulling a fish hook out of somebody or something. You do that here. So, what antibiotics do you give. What do you do different, even your likes of telling me about tetanus and stuff, ye know, relevant stuff you use, looking at x-ray and stuff like that would be handy." (Eday)

3– It was more than just an assessment

Summative assessments were undertaken in two distinct strategies. Firstly, a number of participants underwent multiple assessment strategy (coursework assignment, OSCE examinations and workplace clinical logbook). The experience of multiple assessment strategy resulted in the participants feeling more able to demonstrate their competence across a broad

range of skills. Moreover, participants felt the OSCEs in particular, were as much a developmental opportunity as they were a summative assessment as they motivated students to learn and prepare for the assessments as Gairsay shared:

> *"Yeah, they are terrifying but um, yeah definitely having the pressure of having to do your OSCEs made you certainly buckle down and learn what you had to learn. So, you have to study hard because you didn't know what was going to be there. You had a rough idea that the cranial nerves, being the biggest and most complicated one, was 100% going to be in the exam. But other than that, you didn't know until you turned up on the day." (Gairsay)*

Secondly, a number of participants undertook singular assessment strategy (coursework assignment only). Conversely, singular assessment strategy experiences left participants feeling they were unable to demonstrate their overall clinical competence as Eday explained:

> *"But there was none of that, apart from me writing an essay how do you know? I could be a writer for all you know and I could write an essay for minor injuries, get an A, perfect! But… I've never touched (examined) an ankle or I've never touched a knee before." (Elsie)*

4 – Thrown in to practice

Thrown into practice is an exploration of the experiences of the transition from completion of the course into autonomous minor injury nursing practice. All the participants expressed different levels, interpretations and experiences of practice preparedness. Exploring and understanding the experiences that participants had throughout their learning journey revealed that preparedness is a journey and is incremental in how it is achieved. The perceived levels of practice preparedness were dependent on the opportunity to access various learning experiences that are discussed in themes one to three. When certain learning opportunities within that context were not available within certain minor injury nursing courses, the perceived levels of practice preparedness were lower.

When asking the participants to reflect back upon the point where they were "thrown in to practice" and consider what experience they felt supported a transition towards being prepared they often looked specifically to the provision of workplace support/clinical supervision. The value of clinical supervision in supporting practice preparedness is illustrated in the following quote:

> *"To be in a supportive environment. So, I don't think if I was dropped in the deep end, I probably wouldn't have got on very well. Although I felt capable, I wouldn't have been confident, you know?" (Benbecula)*

Clinical supervision offered a sense of safety. The participants were reassured by the presence of experienced colleagues who would support them in clinical decision-making should they come upon a case they felt they did not have the knowledge, skills and experience to deal with autonomously.

In contrast, for the participants who were thrown in to practice and felt they were not supported in becoming prepared for practice, the following quotes highlight experiences that show a level of fear and isolation:

> *"The course itself is a theory-based course, for the role that I do I don't think it was enough. I felt I wasn't competent to see a lot of the patients that I was then expected to see." (Islay)*

> *"We were unsupported, Och, it wasn't a great time" (Arran)*

This illustrated that a lack of support manifested an intensely negative experience of transitioning in to practice. Moreover, it carried a deep concern that practitioners were having to practice minor injury nursing with a sense that they were not adequately prepared to undertake the role expected of them.

5 – The preparedness continuum

A surprising and unexpected finding from the study was that the experience of preparedness for practice continues beyond completion of the minor injury course. It was revealed that preparedness is a phenomenon that requires regular and ongoing development. Participants explain how attending minor injury nursing practice updates can contribute to ongoing preparedness for practice. Participants believe that a period of consolidation after qualifying as a minor injury nurse could support the development of more prepared minor injury nurses:

> *"So, I think possibly having some period of consolidation afterwards. Going through to minor injuries (Urban MIU) and just seeing minor injury after minor injury." (Jura)*

In the small number of participants who have engaged in minor injury nursing practice updates, participants explained that the experience was significant in enhancing their ongoing preparedness for practice:

> *"So, I remember turning up to XXX hospital one day to meet this man we had heard about to talk about wrist assessments and scaphoids and I sat there for 2 hours and my jaw just hit the floor, why did I not know this 2 years ago, this was an experienced ENP, who knew what my job was, who knew what I needed to do to do it and I wasn't getting out of that room until I could do it." (Arran)*

There was a sense of an ongoing desire to continue learning. For some participants, practice updates facilitated more of a sense of moving towards practice preparedness than the learning experiences they gained from minor injury nursing education courses.

Discussion

The purpose of this hermeneutic phenomenological study was to explore how minor injury nursing education and preparedness for practice is experienced. Previous research has explored competence in minor injury nursing clinical practices and briefly considered both the format and role of minor injury nursing education in facilitating competence (Sakr et al. 1999, Marsden 2003, Megaghy and Lloyd. 2004, Mason et al. 2005, Ezra et al. 2005, and Neary 2014). In the UK, a fragmented approach to minor injury nursing education is well established (Marsden 2003 and Fotheringham 2011). No studies have explored how that fragmented approach to education may have manifested in varying experiences of minor injury nursing education and practice preparedness

Although this study was conducted using a small sample size that may not be generalisable to the wider nursing context, the findings are still unique and offer new understanding and perspective to a depth that has never been seen in previous research (Sakr et al. 1999, Marsden 2003, Megaghy and Lloyd. 2004, Mason et al. 2005, Ezra et al. 2005, and Neary 2014). By exploring nurses lived experiences of minor injury nursing education, the findings from this study have given minor injury nurses the opportunity to express their educational preparation journey. This study has uncovered the entire journey through minor injury nursing education towards qualified minor injury nursing practice. In the exploration of that journey, lived experiences of learning and development were brought forward and examined and provide understanding of what it is to learn and develop as a minor injury nurse and become prepared for practice.

Minor injury nursing education typically started with a foundation of theory-based education. The role of theory is to provide a general and foundational outline that informs nursing practice and allow the student to explore and learn a specialty. (Benner, 1984, Dyess et al., 2010 and McEwan, 2014). Although general in its approach by providing the founding principles of minor injury nursing, a more specific role of theory in minor injury nursing education was that it allowed the participants to take a lead role in their learning. Engaging in learning at a pace that was suitable to a student's needs and cognitive abilities will offer students clarity and comprehension of learning (Scutter et al., 2010 and O'Bannon et al., 2011). Minor injury theory supported that approach to learning by using methods such as self-directed learning. The self-

directed approach supported learning that was individual and specific to each students needs and external demands.

Theory-based education was also shown to bridge the gap between theory and practice, especially in the study of anatomy. Visual learning is a method of allowing the recognition and the realisation of patterns (Chicca and Chunta 2020). In the context of minor injury nursing, visual learning took theory (surface anatomy) and provided learning that was transferrable to clinical practice (musculoskeletal clinical examination). These two approaches provided key strengths that were well suited to minor injury nursing education, especially in the transition towards practical-based learning.

Despite accepting the foundational role of theory and understanding how it informed minor injury nursing practice, the participants felt practical-based education had more impact upon their overall development. Gaining practice-based experience is fundamental for the development of clinical minor injury nursing skills (Meek, Kendal, and Freij, 1998, Ezra et al, 2005 and Neary, 2014). In minor injury nursing education, where participants were not supported to develop practice-based skills, there were experiences where this impacted upon overall preparedness for practice. As practical-based education was more relatable to the minor injury nurses' daily practice, the participants judged that approach to learning with a greater appreciation. The appreciation they gained came from reassurance that they were preparing for the skills that the role would eventually demand when transitioned in to qualified minor injury nursing practice.

In the context of how minor injury courses are designed and delivered, approaching the education of minor injury nurses with an understanding of the role and context of practice was found to be a key aspect in enhancing learning experiences. Communication was central to that whole experience. Having an open dialogue between the academic and professional partners regarding the student's development through the course is central to ensuring that student progress is highlighted and supported moving forward (Dev et al 2020). Communication meant that learning and development was prioritised with an invested awareness of the student's progression. Similarly, communication also played a pivotal role in how participants experienced the educator's approach to teaching. In terms of qualities in an educator, adopting effective communication skills can be more effective for teaching than clinical expertise alone

(Asio and Riego de Dios, 2019, Summers, 2017 and Mulholland et al, 2006). When educators had lived experience of minor injury nursing, they used that prior experience to relate to students in presenting course content. Students were more responsive to ENP educators as they felt they communicated learning in a way that was easy to understand, clinically relevant and engaging.

As courses concluded, taking a broad approach to assessment in minor injury nursing education was imperative for students to demonstrate their overall learning and clinical competence. The process of assessment should fully determine if the education journey has been successful (Sturge, 2014). In minor injury nurse education, there were distinct differences in this context amongst courses. Courses used either singular (coursework assignment only) or multiple assessment strategies (coursework assignment, OSCE examination and workplace logbook). The latter allowed students to demonstrate their learning and competence in a much broader way. Singular assessment strategy meant participants could not demonstrate their leaning and competence in any depth. The transition in to practice was more straightforward when the participants had received a more comprehensive overview of their development and competence as participants had more awareness of their ongoing developmental needs.

Exploring minor injury nursing education has revealed how being new to minor injury nursing carries a number of anxieties and for some, feelings of isolation as a direct result of a lack of support. The findings from this study reinforce the fundamental role of senior clinical support in achieving practice preparedness. Key words such as direction, guidance and senior support are often associated with supporting practice preparedness (Wolff et al. 2010). In addition, practice preparedness was shown to be a continuing and progressive lived experience. In nursing, knowledge should be expanded constantly (Oshvandi et al. 2016). Despite that, ongoing support for updates and development is not a widely adopted practice in minor injury nursing (Lloyd-Rees 2016 and Bagley 2018). For many of the participants in this study, opportunities to consolidate learning was amiss. This study demonstrated that to be well prepared for minor injury nursing practice, clinical support and practice updates are essential.

Conclusion

This study has made an original contribution to knowledge bringing new understanding of how minor injury nursing education and practice preparedness is experienced. The findings explore the entire journey through minor injury nursing education towards practice and unpack the different experiences within that context that support learning, development and preparedness for practice. The findings from this study are relevant and transferrable to areas of a similar clinical and educational context and could be used to improve the educational and practice preparedness experiences of minor injury nurses.

Acknowledgements

This study was supported by NHS Scotland who allowed access to the participants who were included in the study. Thank you to the participants for sharing their lived experiences of minor injury nursing education. I would also like to thank the University of Stirling and my supervisors, Dr Purva Abhyankar, Dr Kath Stoddart and Dr Joyce Wilkinson

References

Asio, J.M.R. and Riego de Dios, E. (2019) The college students' perspective on what makes an educator well-qualified. *Journal of Pedagogical Research,* 3 (3), pp. 126-138.

Bagley, S. (2018) Exploring emergency nurse practitioners' perceptions of their role. *Nursing Standard* (2014), 32 (26), p. 41.

Bartholomew, T.T., Joy, E.E., Kang, E. and Brown, J. (2021) A choir or cacophony? Sample sizes and quality of conveying participants' voices in phenomenological research. *Methodological Innovations,* 14 (2), pp. 1-14.

Benner, P. (1984) From novice to expert: Excellence and power in clinical nursing practice. Addison-Wesley, Menlo Park.

Braun, V. and Clarke, V. (2021) Thematic Analysis: A Practical Guide. Sage, London.

Bright, S., Bradbury, E., McGrane, P. and Dale, A. (2002) Injury management in the community. *Emergency Nurse,* 10 (7), pp. 28-32.

Chenail, R.J. (2011) Interviewing the investigator: Strategies for addressing instrumentation and researcher bias concerns in qualitative research. *Qualitative Report,* 16 (1), pp. 255-262.

Chicca, J. and Chunta, K. (2020) Engaging students with visual stories: Using infographics in nursing education. *Teaching and Learning in Nursing,* 15 (1), pp. 32-36.

Cooper, M.A., Hair, S., Ibbotson, T.R., Lindsay, G.M. and Kinn, S. (2001) The extent and nature of emergency nurse practitioner services in Scotland. *Accident and Emergency Nursing,* 9 (2), pp. 123-129.

Creswell, J.W. (2014) *Research design : qualitative, quantitative, and mixed methods approaches.* Los Angeles, California: SAGE.

Dawood, M. and Gamston, J. (2019) An intervention to improve retention in emergency nursing. *Emergency Nurse,* 27 (2), pp. 21-25.

Dev, M.D., Rusli, K.D., McKenna, L., Lau, S.T. and Liaw, S.Y. (2020) Academic-practice collaboration in clinical education: A qualitative study of academic educator and clinical preceptor views. *Nursing & Health Sciences,* 22 (4), pp. 1131-1138.

De Witt, L. and Ploeg, J. (2006) Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing,* 55 (2), pp. 215-229.

Dowling, M. and Cooney, A. (2012) Research approaches related to phenomenology: Negotiating a complex landscape. *Nurse Researcher,* 20 (2), pp.21-27.

Dyess, S., Boykin, A. and Rigg, C. (2010) Integrating caring theory with nursing practice and education: connecting with what matters. *JONA: The Journal of Nursing Administration,* 40 (11), pp. 498-503.

Ezra, D.G., Mellington, F., Cugnoni, H. and Westcott, M. (2005) Reliability of ophthalmic accident and emergency referrals: a new role for the emergency nurse practitioner? *Emergency Medicine Journal : EMJ; Emerg Med J,* 22 (10), pp. 696-699.

Flynn, S.V. and Korcuska, J.S. (2018) Credible phenomenological research: A mixed-methods study. *Counselor Education and Supervision,* 57 (1), pp. 34-50.

Fotheringham, D., Dickie, S. and Cooper, M. (2011) The evolution of the role of the Emergency Nurse Practitioner in Scotland: a longitudinal study. *Journal of Clinical Nursing (John Wiley & Sons, Inc.),* 20 (20-21), pp. 2958-2967.

Frechette, J., Bitzas, V., Aubry, M., Kilpatrick, K. and Lavoie-Tremblay, M. (2020) Capturing lived experience: methodological considerations for interpretive phenomenological inquiry. *International Journal of Qualitative Methods,* 19, pp. 1-12.

Gill, M.J. (2020) How can I study who you are? Comparing grounded theory and phenomenology as methodological approaches to identity work research. *The Oxford Handbook of Identities in Organisations,* , pp. 295-310.

Gregory, K. (2019) Lessons of a failed study: Lone research, media analysis, and the limitations of bracketing. *International Journal of Qualitative Methods,* 18, pp. 1-10.

Guest, G., Bunce, A. and Johnson, L. (2006) How many interviews are enough? An experiment with data saturation and variability. *Field Methods,* 18 (1), pp. 59-82.

Hamill, C. and Sinclair, H.A. (2010) Bracketing–practical considerations in Husserlian phenomenological research. *Nurse Researcher,* 17 (2), pp. 16-24.

Holloway, I. and Wheeler, S. (2002) *Qualitative research in nursing.* Wiley-Blackwell.

Lloyd-Rees, J. (2016) How emergency nurse practitioners view their role within the emergency department: A qualitative study. *International Emergency Nursing,* 24, pp. 46-53.

Marsden, J. (2003) Educational preparation for ENP roles. *Emergency Nurse,* 10 (10), pp. 26-31.

Målqvist, M. (2015) Preserving misconceptions or a call for action?–A hermeneutic re-reading of the Nativity story. *Global Health Action,* 8 (1).

Mapp, T. (2008) Understanding phenomenology: The lived experience. *British Journal of Midwifery,* 16 (5), pp. 308-311.

Matua. (2015) Choosing phenomenology as a guiding philosophy for nursing research. *Nurse Researcher,* 22 (4), p. 30.

Mason, S., Fletcher, A., McCormick, S., Perrin, J. and Rigby, A. (2005) Developing assessment of Emergency Nurse Practitioner competence - a pilot study. *Journal of Advanced Nursing; J Adv Nurs,* 50 (4), pp. 425-432.

McEwen, M. (2014) Overview of theory in nursing. *Theoretical Basis for Nursing*, pp. 23-48.

Meek, S., Kendall, J., Porter, J. and Freij, R. (1998) Can accident and emergency nurse practitioners interpret radiographs? A multicentre study. *Emergency Medicine Journal,* 15 (2), pp. 105-107.

Megahy, A. and Lloyd, M. (2004) Managing minor injuries. *Emergency Nurse,* 12 (5), pp. 14-16.

Mulholland, S., Derdall, M. and Roy, B. (2006) The student's perspective on what makes an exceptional practice placement educator. *British Journal of Occupational Therapy,* 69 (12), pp. 567-571.

Neary, A. (2014) Do emergency nurse practitioners provide adequate documentation? *Emergency Nurse,* 22 (4), pp. 34-40.

Neubauer, B.E., Witkop, C.T. and Varpio, L. (2019) How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education,* 8 (2), p. 90.

NHS Research Scotland (2017) *NHS Research Scotland.* NHS Scotland. Available: https://www.nhsresearchscotland.org.uk/contact/regional-nodes. [Accessed 19/4/17].

O'Bannon, B.W., Lubke, J.K., Beard, J.L. and Britt, V.G. (2011) Using podcasts to replace lecture: Effects on student achievement. *Computers & Education,* 57 (3), pp. 1885-1892.

Oshvandi, K., Moghadam, A.S., Khatiban, M., Cheraghi, F., Borzu, R. and Moradi, Y. (2016) On the application of novice to expert theory in nursing; a systematic review. *Journal of Chemical and Pharmaceutical Sciences,* 9 (4), pp. 3014-3020.

Purcell, D. (2010). Minor Injuries: A Clinical Guide**.** 2nd ed. Elsevier Churchill Livingstone: Edinburgh.

QSR International Pty Ltd. (2015). NVivo (Version 11). https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home.

Sakr, M., Angus, J., Perrin, J., Nixon, C., Nicholl, J. and Wardrope, J. (1999) Care of minor injuries by emergency nurse practitioners or junior doctors: a randomised controlled trial. *Lancet,* 354 (9187), pp. 1321-1326.

Scutter, S., Stupans, I., Sawyer, T. and King, S. (2010) How do students use podcasts to support learning? *Australasian Journal of Educational Technology,* 26 (2), pp. 181-191.

Starks, H. and Brown Trinidad, S. (2007) Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research,* 17 (10), pp. 1372-1380.

Sturge, S.A. (2014) Is there a need for placement evaluations for specialist practice students? A proposal. *Community Practitioner,* 87 (10), pp. 30-33.

Summers, J.A. (2017) Developing competencies in the novice nurse educator: An integrative review. *Teaching and Learning in Nursing,* 12 (4), pp. 263-276.

Wolff, A.C., Regan, S., Pesut, B. and Black, J. (2010) Ready for what? An exploration of the meaning of new graduate nurses' readiness for practice. *International Journal of Nursing Education Scholarship,* 7 (1), pp. 9-11.

Zahavi, D. (2003) *Husserl's phenomenology.* Stanford University Press.