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A qualitative multi-method study to explore the relevance of Benner's 'novice to expert' nursing theory in contemporary post-registration wound care higher education

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Declaration of Originality

'This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.'

Signed: 

Date: 2nd December 2020

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ABSTRACT

AIM

The aim of this thesis is to explore the relevance of Benner's 1984 five-stage 'novice to expert' nursing theory of skills acquisition and development in post-registration wound care nursing higher education in one institute in south west Scotland.

BACKGROUND

Since 1984, the fundamental assertions and learning and teaching strategies associated with each stage of Benner's theory have continued to inform pre- and post-registration wound care nursing education. However, in the last four decades, numerous influential governmental, political, economic, regulatory and practice policy developments have taken place and indications suggest that Benner's theory may now no longer best serve the unique needs of wound care education and that use of this approach to curriculum development would benefit from review.

METHOD

Through the prism of advocacy-participatory research, a qualitative sequential multi-method research design was used to review Benner's theory in three distinct phases. First, a critical analysis of the effects of policy discourse on education and practice was undertaken, followed by a directed investigation to identify particular characteristics of regular everyday wound care practices able to enlighten curriculum design. Finally, the thesis moves to understand how incorporating the informed and

deliberated views of students themselves in theory development itself might benefit future provision.

FINDINGS

The findings challenge many of Benner's original assertions and uncover deficiencies in contemporary approaches to curriculum design thought to contribute to the extensive unacceptable levels of variation and inequitable standards in patient wound care. Ambiguity is inherent in wound care and, although undesirable and thought to compromise professional accountability, it is an intrinsic and essential feature for practitioners to manage the extremely unpredictable nature of such care. As an adjunct to the learning and teaching strategies associated with Benner's theory and an alternative to standardising and loading the curriculum, it should be accepted that, in wound care, there are never enough resources and information that is available to direct practice is often inconclusive or incomplete. Learning should therefore instead develop particular cognitive, meta-cognitive and attitudinal skills for practitioners to arrive at the 'best answer' possible by adapting Wood's 'build-bridge-extend' (BBE) approach to the wound care context.

CONCLUSIONS

Benner's theory no longer adequately characterises wound care education provision and should be developed to represent the influences of policy, practice and student voices.

TABLES AND FIGURES

ABBREVIATIONS

Academic Health Science Network	AHSN
adapted deliberative discussion	ADD
black, Asian and minority ethnic	BAME
Build-Bridge-Extend	BBE
Clinical Commissioning Group	CCG
Cumulative Index to Nursing and Allied Health Literature	CINAHL
continuing professional development	CPD
Council for Healthcare Regulatory Excellence	CHRE
critical discourse	CD
critical discourse analysis	CDA
deliberative discussion	DD
directed content analysis	DCA
Doctorate of Education	EdD
Evidence Based Medicine	EBM
Doctorate of Philosophy	PhD
fellow of the Higher Education Academy	FHEA
General Data Protection Regulation	GDPR
knowledge translation	KT
multi-disciplinary team	MDT
National Health Service	NHS
National Institute for Health and Care Excellence	NICE
National Wound Care Strategy Programme	NWCSP
NHS Education for Scotland	NES
Nursing and Midwifery Council	NMC
Participant Information Sheet	PIS
postgraduate certificate in learning and	

teaching in higher education	PGCLTHE
Professional Standards Authority	PSA
Royal College of Nursing	RCN
three-minute thesis	3MT
Tissue Viability Leading Change	TVLC
tissue viability nurse	TVN
tissue viability specialist	TVS
United Kingdom	UK
University of the West of Scotland	UWS
virtual learning environment	VLE

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CHAPTER 1: INTRODUCTION

It is inevitable that everyone, during their lifetime, will sustain some kind of physical wound – a break in the skin's surface which may be accidental, surgical or perhaps even deliberate – and many people live with visible and sometimes disfiguring scars as memories of a traumatic surgical operation, a burn or a major life event such as childbirth by caesarean section.

Under normal circumstances, these wounds usually heal without much difficulty, occasionally with the help of antiseptic and dressings, as the four phases of wound healing – haemostasis, inflammation, proliferation and maturation – naturally occur over several days and usually leave no major visible signs.

Unfortunately, this is a rather simplistic portrayal of the wound healing process because it does not account for the increasing number of instances when the natural process breaks down and the wound does not heal naturally. Factors associated with delays in wound healing include patient age, type of wound, infection, chronic diseases, poor nutrition, lack of hydration, poor blood circulation, patient behaviours and lifestyle choices such as smoking and excessive alcohol intake. In addition, although healing is the primary objective in the care of the majority of people with wounds, for malignant or non-healing wounds, it may not be as important as effectively managing the physical symptoms.

The knowledge and skills required to prevent and manage the number of increasingly complex chronic wounds, including leg ulcers as a consequence of type 2 diabetes (Bakker, Apelqvist, Lipsky, Van Netten, & Schaper, 2016), pressure ulcers caused by immobility (Kottner et al., 2019) and the fungating lesions that are occasionally found in patients being treated for cancer (Robinson & Holloway, 2019), are becoming increasingly challenging to assess, diagnose and manage.

Healing chronic wounds – wounds that have not progressed through systematic and timely healing to anatomic and functional integrity after three months (Kyaw et al., 2018) – is often particularly difficult because of confounding co-morbidities caused by modern-day sedentary lifestyles. These include obesity and age-associated factors such as poor circulation, malnutrition, depression, reduced mobility and increased risk of infection, affecting the natural healing process (Hess, 2011).

While the physical parameters of wounds include direct factors such as size, depth, location and duration, parameters indirectly linked to the state of a wound such as pain, irritation, odour and leakage caused by excessive or mismanaged levels of exudate can negatively affect patient quality of life, leading to, for example, inability to climb stairs, walk or use public transport. Some patients avoid social contact because of poor exudate control or poor nutrition, while others experience worsening obesity as a result of immobility or lack appetite because of depression, sleep disturbance and fatigue from pain at night (Augustin et al., 2012). In relation to mental health, odour and excessive exudate associated with leakage can also lead to

feelings of disgust, self-loathing and low self-esteem, and poor symptom management can cause patients to become non-concordant with therapy.

Those living with chronic wounds often have other conditions that affect their ability to function independently, potentially leading to greater dependence on family members, unexpected hospital admissions and necessary adaptations in living arrangements to self-manage their condition at home. It is therefore easy to understand why people living with a wound might spend more time alone and unoccupied with the prospect of social isolation and depression resulting from fewer opportunities to interact socially at work or through recreation. An expert working group review on optimising wellbeing in people living with a wound indicates that living with a chronic wound can be extremely disruptive and many individuals find it difficult to organise their daily routines around their wound care and feel unable to live their lives as they would like, struggling for control and independence (Augustin et al., 2012).

The organisation and management of wound care has also become more complex because of the relatively recent United Kingdom (UK) legislation in 2016 integrating National Health Service (NHS) legislation with social care impacting on how services and structures are managed (Miller & Glasby, 2016; Pearson & Watson, 2018). The health and social care integration agenda, designed around helping meet the needs of individuals, their carers, and other family members, demands that dynamic communication and care delivery mechanisms between very different organisations

are in place and that a range of health and social care professionals are available to ensure continuity when caring for wounds. However, N. Evans (2017) suggests that this ambition often goes unrealised.

Given the nature of these challenges, the public, and perhaps even healthcare professionals working in unrelated disciplines, will therefore be surprised to know that current availability and quality assurance mechanisms for wound care education and practices are extremely inconsistent and inequitable across the UK and very little is understood about the nature of wound care itself. While there has been growing concern over the inadequacy of pre-registration nursing wound care education provision for some time (Dugdall & Watson, 2009; Ousey, Poole, Holloway, & Harris, 2011) and this has resulted in some promising new approaches to curriculum development (Redmond et al., 2018), there is still a shortage of research associated with post-registration nursing education. Similarly to pre-registration, in post-registration, Benner's (1984) 'novice to expert' nursing theory, now almost four decades old, is still the theory often used to inform nursing curriculums across the UK today. However, since Benner's time, many wound care-related political, , economic, regulatory, education and practice developments have occurred and the extent to which Benner's assertions can continue to be used to direct a wound care curriculum that satisfies the challenges faced by chronic wound management in the future is now questionable.

Through the prism of an advocacy and participation world view, the goals of this thesis are to identify factors that change how Benner's theory is currently understood and then develop it in such a way that it better informs those who have responsibility for developing wound care in higher education and for practitioners delivering direct patient care. This thesis contributes to knowledge in the discipline by challenging traditional educational theory and practice and identifying new ways to meet the progressively challenging demands of wound care practice in the next decade.

Following this explanation of the motivations behind this thesis, Chapter 2 outlines to the reader the extensive economic and personal consequences of delayed wound healing, which are believed to be caused, in part, by inadequate education and inconsistencies and misunderstandings about its role. Benner's theory is critiqued and the findings from the background literature are used to generate the thesis aim and objectives. Justification is also given for taking the route of Doctorate in Education (EdD) rather than that of Doctorate of Philosophy (PhD) to address the research problem.

Chapter 3 then outlines the research paradigm through an explanation of my personal understanding of what knowledge is and how it is created, detailing the relationship between this and the choice of research methodology, which consists of three consecutive phases, each using different research methods to address the respective research objectives: critical discourse analysis (CDA), directed content

analysis (DCA) and deliberative discussion (DD). The practical decisions taken to enhance trustworthiness and rigour and ensure ethical conduct are also included.

Chapters 4, 5 and 6 address in turn each of the three research phases and explain that the results from these are used to integrate and guide the next investigative phase of the thesis. To assist the reader, each chapter is similarly structured and includes a justification for choice of research method, data handling technique, data analysis procedure, findings and discussion.

Chapter 7 concludes the thesis with a general discussion to bring the findings from all three phases to bear on the way Benner's theory is currently construed and specifying several ways in which it should be developed for the unique purpose of wound care education and practice. Recommendations for future research directions, study strengths and limitations and a personal reflection on how carrying out a practice-led doctorate has transformed my professional practice and prompted a potential change in career direction are set out, alongside a wide-ranging strategy intended to disseminate the thesis findings, some of which have been realised, including material submitted for refereed journal publication ahead of thesis completion.

CHAPTER 2: BACKGROUND TO THE RESEARCH

Chapter 1 explained the motivations behind this thesis. Through an analysis of relevant published literature, Chapter 2 now provides the reader with the necessary context of the thesis, as well as explaining the key concepts, theories and terminology guiding the choice of methodology and analysis of the thesis findings.

Economic and Personal Cost of Variations in Wound Care Nursing Education and Practice

Wound care has always been important to nursing. However, it is reasonable to ask why, in the current strained economic climate in the NHS, when far greater strategic healthcare priorities including cancer, stroke, maternity and neonatal health, diabetes, mental health and respiratory care (Alderwick & Dixon, 2019) are competing for limited resources, wound care should now take on more significance.

Wound care has more recently attracted attention because of the vast economic costs attached to its management, which have only relatively recently been identified. These costs relate mainly to the chronic wounds described earlier and the often devastating and damaging effects of living with a wound on a person's quality of life (Guest, Ayoub, et al., 2017). This economic burden is still considered to be an under-estimated 'guestimate'. Supported by the research findings of others (Järbrink et al., 2017; Nussbaum et al., 2018; Phillips et al., 2016; P. Vowden & Vowden, 2016), this has focused the minds of government and healthcare managers.

The increasing cost of chronic wounds to the UK economy and patient quality of life are now thought to be significant (Phillips et al., 2016) and are also being recognised elsewhere. In Australia, for example, Kapp and Santamaria (2015) view such costs as a largely hidden and poorly supported problem. The current cost to the UK health service is £5.3 billion and, in 2012/2013, approximately 2.2 million wounds were being managed in the UK (Guest et al., 2015). The need for effective wound management is now believed to be a priority healthcare agenda item in the UK (Courtenay et al., 2018), and Guest (2017, p. 292) recommends that 'strategies are required to improve the accuracy of diagnosis and healing rates' because 'clinical and economic benefits could accrue from improved systems of care' (Guest et al., 2015, p. 1).

Wound care is complex (K. Vowden, 2005). It is well established that many factors are responsible for effective wound management (Hess, 2011). A number of key academics and opinion leaders, and, more recently, health economists, believe that a fundamental cause of this excessive financial burden is the substantial variation that exists within wound care practice and the lack of role definition. Guest, Ayoub, et al. (2017, p. 302), for example, recommend that 'the role of healthcare professionals including practice nurses, community nurses, tissue viability nurses (TVNs), podiatrists, GPs and other medical professionals needs to be clearly defined within the patient care pathway', the consequences of which are exacerbated because, as observed by Ousey et al. (2015, p. 43), 'there is no recognised national job title for the tissue viability role' and 'no nationally recognised criteria, or

educational level, for the role'. Such discrepancies are thought to be contributing factors to upholding professional standards in wound care (Ousey, Atkin, Milne, & Henderson, 2014; Ousey et al., 2015; R White, 2008; Richard White et al., 2016).

What's in a Name?

Wound care roles, grades, job descriptions, wound care knowledge, experience, skills and academic accreditation prerequisites lack correlation across the UK and the variety of job titles in these areas often has little relationship to the scope of a nurse's wound care practice.

This observation is readily evidenced by an internet search for 'wound care nursing vacancies', which I undertook during the background research for the thesis, retrieving a wide range of terms, including TVN, 'tissue viability specialist' (TVS), 'wound care nurse', 'wound care link nurse' and 'wound care specialist'. These findings support Ousey's mixed methods study (Ousey et al., 2015, p. 40) in exploring the role and key responsibilities of the TVN in the UK, where 'although the majority of respondents described themselves as TVNs, a variety of titles were used in respondents' organisations, including "Tissue Viability Nurse Specialist", "Lead Nurse Tissue Viability" and "Wound Care Nurse'". For the purposes of this research, the term 'wound care nurse' is used. Worryingly, there have also been a number of examples of unregistered health carers adopting specialist wound care titles (Dutton, Chiarella, & Curtis, 2014; Ousey et al., 2015). It is not therefore surprising that Guest, Ayoub, et al. (2017) advocate that the role of healthcare professionals, including

practice nurses, community nurses, TVNs, podiatrists, GPs and other medical professionals, needs to be clearly defined within the patient care pathway.

With 'no universally accepted national role definition or knowledge and skills framework from which to benchmark services', Ousey et al. (2014, p. 55) supports Guest's earlier concerns regarding the financial consequences and undesirable effects for quality of life, leading to the conclusion that there is an urgency to account for the numerous deep-rooted existing organisational and clinical differences and to identify viable options in higher education. Throughout the academic year, I receive many enquiries from prospective students about the wound care course I co-ordinate. Most are in a similar vein to the following statement from a student in 2018, effectively highlighting the real-life professional and student life problems that exist for academics working in UK higher education, who, like myself, have a professional responsibility to provide fit-for-purpose wound care:

> **'I am currently working as a community nurse and would love to advance in my career but there seems to be very mixed information about studying towards it, Master's, modules etc., and I'm not sure what information is right or wrong.'** (Personal communication from prospective wound care management course at the University of the West of Scotland, February 5th 2018)

Aggravated by the absence of a nationally agreed wound care education structure, significant confusion exists over what kind of education best matches the needs of everyday wound care nurses.

Justification for Choice of Research Topic and Choice of EdD Study as an Alternative to a PhD

My motivation for this thesis chiefly relates to attempting to find a resolution to the very real problem described in the previous section of improving wound care education for both educators and students. As this problem is embedded in educational practice (Crow, Lomotey, & Topolka-Jorissen, 2017), my decision was to take a contemporary professional EdD route and not a PhD.

EdDs are intended to specifically focus on applying research and foundational knowledge to real-world organisational, leadership and educational issues rather than focusing on developing new research as with PhD programmes. In this respect, EdD candidates, similar to myself, use existing research to inform decisions around specific issues that lead to improved practices within their areas of study. I wanted to carry out research that contributed to my professional knowledge and practice and therefore needed a practice-based solution, and since 'research questions, techniques, and thesis requirements for the PhD are expected to be more theoretical than for the EdD' (Shulman, Golde, Bueschel, & Garabedian, 2006, p. 26), I deemed the EdD to be the most suitable route for my academic study.

Additionally, as a nurse, from a professional perspective, it was important that I, as a registrant of the nursing and midwifery regulator, the Nursing and Midwifery Council (NMC), with a duty of care as a registered nurse, nurse educator and academic, was able to uphold my own practice in my research and meet the required professional nursing standards.

Moreover, in order that I, as co-ordinator for the wound care module, meet the regulations for programmes of study leading to the university's taught academic awards (University of the West of Scotland, 2017), I am obliged to annually review the module content. The findings from this thesis will bring this routine up to date when the existing wound care curriculum is revised accordingly.

Outline of the Tissue Viability and Wound Care Module Used For The Thesis

This Tissue Viability and Wound Care module is a 15-week Scottish Credit and Qualifications Framework Level 9 (Scottish Qualifications Authority, 2012) undergraduate 20-credit eLearning module that runs from January to April each academic year. The module routinely attracts 25 to 35 post-registration students who can select to either study the subject as a stand-alone continuing professional development (CPD) activity or as academic credit towards a BSc (Hons) in Professional Health Studies.

For me, there is some degree of urgency involved in obtaining and implementing the thesis findings. Over the last three years, I have observed an obvious shift in the usual student profile attending the module. Previously, students were mostly experienced hospital-based adult nurses, many with decades of nursing experience, who had not studied for some time. This profile contrasts remarkably with that of current students. The student profile is diverse and takes in multi-disciplinary staff including midwives, physiotherapists, podiatrists and moving and handling co-ordinators as well as nurses representing a more extreme range of healthcare settings such as

domiciliary, nursing care homes, paediatrics, mental health, the prison service, learning disabilities, operating departments, dental nurses specialising in maxilla facial surgery and nurse outreach workers whose roles involve delivering care to difficult-to-reach intravenous drug users whose injection sites have broken down and become infected. The existing curriculum no longer meets the diverse learning needs of the students.

With over 20 years teaching in higher education, five devoted to eLearning wound care education, I am NMC accredited as a lecturer/practice educator, hold a postgraduate certificate in learning and teaching in higher education (PGCLTHE) and am a fellow of the Higher Education Academy (FHEA). I am therefore considered to be a specialist in the field of nursing education. This thesis is based on my understanding of the practice of wound care education, my concerns regarding the current unsatisfactory state of wound care education for my students and the proliferation of untested courses of unassured quality available online. As with any professional doctorate (Fulton, Kuit, Sanders, & Smith, 2012, 2013), the over-arching aim of this educational thesis is one of practical application: to improve wound care nurse education to ultimately manage wounds better and improve patient care.

The Organisation and Development of Wound Care Education in the UK

Overview of Literature Search Strategy

I carried out a systematic and explicit literature database search in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest, MEDLINE and the Cochrane Database of Systematic Reviews, using key context-related words,

inclusion/exclusion criteria and Boolean logic, together with a manual hand search of references and guidance from the last two decades to identify the background literature for the thesis. Most of the publications associated with wound care education identified by the search strategy were small-scale qualitative descriptive studies and quantitative surveys, with the majority professional debates and editorials that failed to exhibit the quality indicators expected of qualitative research (Critical Appraisal Skills Programme (CASP) UK, 2018; Varai, Dehghan Nayeri, Hosseiny, & Ahmadi Chenari, 2020). My expectation is that this doctorate-level research will help expand the limited quality research that is currently available.

It appears inconceivable that, despite obvious and widespread unanimity on the positive difference education makes to wound management, with some experts even going so far as to advocate for a view of wound care as a specialised segment of healthcare that therefore 'requires clinicians with specialist training to diagnose and manage [it] appropriately' (Guest et al., 2015, p. 1), there is no standardised approach to wound care education in the UK. Zulkowski, Ayello, and Wexler (2007) and Holloway (2017) have previously suggested that wound care certification and education positively affects nursing knowledge. Similarly, Dugdall and Watson (2009, p. 1) believe that, because better education has been associated with better healing outcomes, the need for trained wound care nurses is critical and 'better general education and better specific training in wound care could lead to better wound care'.

The wound care remit can take many forms. Wound care can be integral to a nurse's everyday nursing duties, or incorporate 'add-on' tasks similar to those of the 'wound care link nurse'. The practice can also attract exclusive specialist responsibilities, such as those of the TVN or TVS. These titles should be interpreted with a degree of caution given the obvious muddle highlighted in the 'What's in a Name?' section. Regardless of remit, over 20 subject-related topics, some of which are outlined in Table 1 below, have been suggested for inclusion pre- and post-registration (Ousey et al., 2011). Of course, the topics are all pertinent to wound care, and, while commendable, they represent a rather ambitious 'wish-list' for inclusion in a wound care curriculum given that, in nursing, other competing educational demands always need to be satisfied so that professional currency can be maintained.

Table 1: Suggested Topics for Inclusion in Wound Care Education

- Physiology of normal and abnormal wound healing
- Systematic assessment and diagnosis of patient and wound
- The wound healing process
- Holistic and wound assessment
- Wound bed preparation
- Recognising risk factors
- Identifying underlying aetiology
- Wound infection
- Pressure ulcer prevention/treatment
- Recognising evidence-based care
- Implementing evidence-based care
- Care planning and goal setting
- Wound product selection and application
- Extensive therapy knowledge
- Management options for common wound aetiologies
- Patient education/health promotion
- Follow-up
- Resource management and allocation

Others, meanwhile, believe that this still does not go far enough and that the topics for inclusion should be extended even further to address microbiology, asepsis, pain management, pharmacological practice, psychosocial factors, ethics, law, communication strategies, advanced clinical problem-solving, and business and marketing and leadership skills (Dutton et al., 2014; Ousey, 2010; Ousey et al., 2015; R White, 2008; Richard White et al., 2016). In the absence of an approved educational framework, individual educators must arrive at their own decisions relating to academic level, content, curriculum design and learning and teaching strategies to best accommodate their students' scope of practice.

In 2019 a published debate over the role and responsibilities of the Tissue Viability Nurse between leading clinicians and academics (Mahoney, cited in Holloway, Ousey, Moore, Schofield, and Mahoney (2019, p. 23) suggested that all TVNs should demonstrate skills and knowledge in clinical practice, although they state that they are, 'not sure how exactly, maybe MSc level for lead nurses, BSc for Band 5/6 nurses should also have a competency programme', and all Trust staff (non-TVNs) have attended a wound management programme run by TVNs and have had competencies signed off. Ousey and Blackburn (2019) argue that without adequate education pressure ulcer prevention and management practice, for example, will become static and ritualistic.

Defining the 'Scope of Practice' in Wound Care?

In nursing, 'scope of practice' remains a woolly concept. Despite the NMC placing increased emphasis on the idea that nurses must work within this 'scope of practice'

as detailed in 'The Code; Professional standards of practice and behaviour for nurses and nursing associates' (Nursing and Midwifery Council, 2015), failure to include any kind of shared definition is unhelpful. The Health and Care Professions Council (Health & Care Professions Council, 2018) do nevertheless define a registrant's scope of practice as 'all the activities they undertake within their professional role, limited to the areas in which they have the knowledge, skills and experience necessary to practise safely and effectively' (Health & Care Professions Council, 2018, p. 4)

The 'scope of practice' varies from registrant to registrant, but it is expected that each must keep within their own scope of practice by only practising in the areas in which they have appropriate knowledge, skills and experience. Ultimately, with no consensus on knowledge, skills and experience, it remains a matter of personal judgement what an individual scope of practice is and, indeed, if is being acted upon in wound care. Without awareness of the knowledge actually needed to do their jobs effectively or, in other words, definition of their 'scope of practice', nurses are wrongly expected to make important and frequently complex and legally challenging clinical decisions. This leaves them pre-disposed to professional negligence and misconduct claims, demonstrated through the number of wound care-related NMC fitness to practise cases (Nursing & Midwifery Council Fitness to Practice Committee, 2018; Nursing & Midwifery Council Fitness to Practice Committee Substantive Hearing, 2018), as a consequence of failing to perform their responsibilities to the required standard.

For nurses providing wound care, this situation is clearly untenable. The situation is wholly unacceptable, detrimental and unfair and is not solely restricted to post-registration wound care education. Nationally and internationally, concerns have also been expressed over the adequacy of the preparation of undergraduate nurses for the clinical skill of wound care (Zulkowski et al., 2007), with Moore and Clarke (2011) previously exposing significant gaps in education that have remained unchanged over many decades.

It is nevertheless reassuring to know that work is currently underway to establish a national wound care framework (Academic Health Services Network [AHSN], 2019). However, for the moment, there is still no clear indication of what the best arrangement will look like but there is currently thought to be a focus on free-to-access, online bite-sized learning opportunities. Wound care curriculums in UK higher education institutes tend to be arranged by subject content, focusing initially on anatomy and physiology, the stages of healing, wound assessment and management of pain and infection, as shown in Table 1, but the approach for delivery is far from settled. In a journal debate (Ousey et al., 2011) between a university research lead in wound care, a senior professional tutor/course director of a wound course, a senior specialist nurse in wound management and an industry medical affairs specialist, some expressed the view that it is essential that curriculum development is a joint approach between higher education institutes and clinical practice. It was conceded that, in reality, this is not generally the case. Others thought that only clinicians should lead on curriculum content and implementation and that nursing academics

in universities should be left to lead on the development of critical thinking skills. Additionally, since first identifying the research problem for this thesis, the European Wound Management Association (EWMA) has recently finalised the first curriculum in a series of several curricula intended for use in levels 5 to 7 of the European Qualifications Framework (EQF) (Pokorná, Holloway, Strohal, & Verheyen-Cronau, 2017; Probst, Holloway, Rowan, & Pokornà, 2019). The post-registration qualification in wound management – EQF Level 6 – totals 275 hours and includes 116 hours of face-to-face teaching, 50 hours of supervised practice, 59 hours of work-based learning and an exam. Its 19 units include prevention, evidence-based practice, patient education, promoting self-care, case management, wounds and wound healing; nutrition; moist wound healing, microbiology, antimicrobial agents, acute wounds, debridement, alternative treatment options, pressure ulcers, diabetic foot syndrome, lower leg ulcers, skin tears, palliative wound care, healthcare delivery and health economics, and documentation. The aim of these is to support a common approach to post-registration qualification in wound management for nurses across Europe, and the EWMA hopes to work towards a close collaboration with European nurse organisations as well as educational institutions to implement these common curricula. However, as this curriculum is proposed for incorporation into existing programmes in different European countries, specific details of the teaching and learning methods and assessment and evaluation methods are not included. It is recommended that these should follow the structure used by each education provider while incorporating the content and learning objectives provided in this curriculum according to local legislation and procedures.

Regardless of the format eventually settled upon for a national framework, getting wound care education right is essential because education is fundamental to nursing care and provides practitioners with the competence and confidence needed for clinical interventions, decision-making and critical thinking (Ousey & Blackburn, 2019) and, one way or another, this problem needs to be resolved.

The Relevance of Benner's 1984 'Novice to Expert' Theory to Wound Care Nursing Education in 2020 and Beyond

While the previous section highlighted differing approaches to wound care curriculum development, one aspect of wound care education remains generally uncontested and this feature underpins this thesis. This relates to the widespread recognition (Holloway et al., 2019; McLuskey & McCarthy, 2012; Ousey & Blackburn, 2019), relevance and contribution that Patricia Benner's 'novice to expert' theory (Benner, 1984) has made to the way in which learning and teaching strategies are incorporated into the design of nursing curriculums generally and wound care specifically. Since the time of its publication, many schools of nursing have adopted the theory as a basis for providing education. Nursing administration has also utilised it to develop career ladders, staff development and recognition and reward schemes (Nelson & McGillion, 2004), and many research studies have been based on its concepts.

Although a few concerns were raised over the quality of the research and the Heideggerian interpretive phenomenological research methodology Benner used to explain the lived experience of the study participants (Altmann, 2007; Benner, 1996;

Cash, 1995; Darbyshire, 1994; English, 1993; Gobet & Chassy, 2008), the 'novice to expert' theory remains the gold standard in curriculum design. Oshvandi et al. (2016) systematic review confirmed that the theory's principles remain embedded in nursing education today and continue to be respected by researchers worldwide. Oshvandi's findings support Altmann's (2007) earlier research proving the theory to be a useful and effective tool used worldwide by various related bodies including nursing faculties, hospitals, community organisations and nursing CPD.

Benner's theory is believed to be important because it explains that nurses develop skills and understand patient care over time, through proper education and from a variety of experiences. Experience in the clinical setting helps nurses develop and gain more knowledge and skills in providing efficient, competent and excellent patient care.

The theory has always been depicted as a variation on much the same theme (Figure 1). The basic tenet is that, as nurses develop, they progressively and consecutively reach each of five 'stages of clinical competence': 'novice', 'advanced beginner', 'competent', 'proficient' and 'expert'. At each of the stages, described in detail in the following section, it is expected that the nurse will exhibit unique performance characteristics. Particular 'teaching and learning needs' (inverse to the 'learning and teaching strategies' commonly referred to today) are attributed to each stage and act as useful guidelines for educators, 'to design their curriculum in a more effective manner for both undergraduate students and registered nurses' (Oshvandi et al.,

2016, p. 3018). The expectation is that ***within ten years*** of ***nursing in the same nursing specialist area***, the nurse will ***progress through each stage*** to, ultimately, achieve ***'expert' status.***

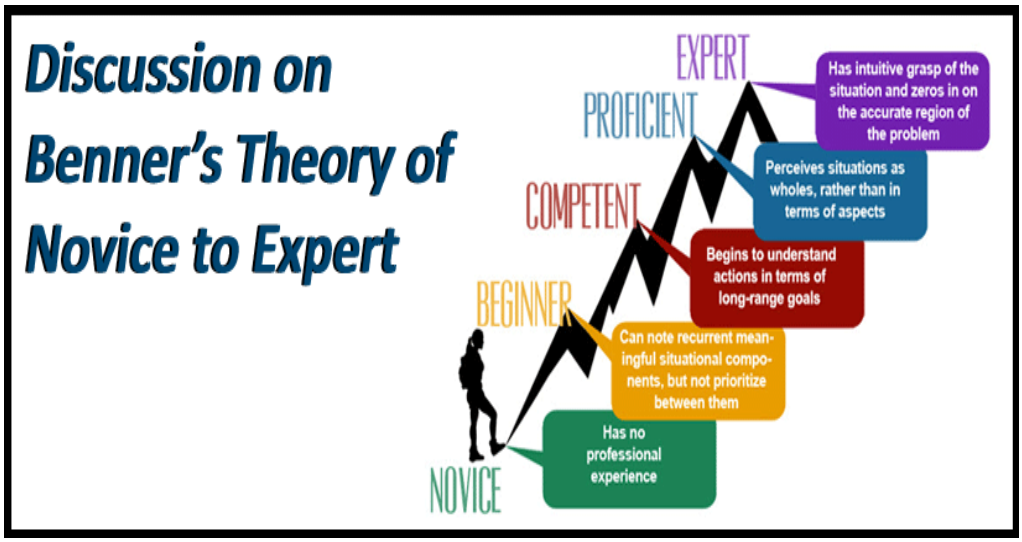


Figure 1. Variations on a theme – depiction of Benner's 'novice to expert' theory. Melrose and Swettenham (n.d). Retrieved from https://www.needassignmenthelp.com/blog/discussion-benners-theory-novice-expert/

Stage 1 – Novice

When the goals and tools of patient care are unfamiliar, Benner argues that any nurse, not only pre-registration students, entering a clinical setting where they have no experience with the patient population, may be limited to this novice level of performance. This proviso is central to the thesis and will thus be useful for the reader to recall because of the bearing it will have when considering the theory for use in a wound care context.

To provide entry to these new situations, relevant skills such as measuring weight, temperature, blood pressure and other measurable parameters are taught as context-free objective attributes. Novices are given rules to guide their performance, but, at this stage, these rules do not tell them the most relevant tasks to perform in actual clinical situations.

In wound care, the equivalent skills include using clinical tools to assess, measure and grade a range of very different wounds including complex, chronic, infected and difficult-to-heal wounds such as diabetic foot ulcers, burns, pressure ulcers and dehisced post-operative surgical wounds.

Stage 2 – Advanced Beginner

Advanced beginners demonstrate 'marginally acceptable performance' or are those who have 'coped' with enough real situations that they are able to observe recurring meaningful situations, or 'aspects of the situation', in contrast with the context-free procedures described in the previous stage. Identifying such 'aspects' is important because this requires the student to have prior experience in actual clinical situations.

In wound care, these 'aspects' might include assessing subtle signs or 'gaining clues' that the patient is experiencing pain, detecting changes in their wound or recognising the signs and symptoms of infection. In terms of associated learning and teaching strategies, advanced beginners are introduced to principles and guidelines of practice

such as local health board and national wound management guidelines and wound dressing formularies, which can help dictate their actions.

However, adherence to these guidelines depends on nurses knowing what the particular 'aspects' look like in patient care situations – experience is required before a nurse can apply guidance to individual patients. As well as supporting learners with 'aspect recognition', the important feature here is the need for support in the clinical setting because nurses are frequently unable to set priorities or identify recurrent meaningful patterns in their practice.

Benner argues that it is important for students to be mentored at this stage by nurses who have reached at least Stage 3 – a competent level of skill and performance. This recommendation has been adopted across education provision in the UK throughout pre-registration and first-year post-registration, where preceptors are appointed to help less experienced nurses identify priorities and situational aspects and to ensure that patients are cared for safely and nurses practise safely (Myers et al., 2010; Nielsen, Lasater, & Stock, 2016).

Stage 3 – Competent

Competence is reached after being in the job in the same or similar situations for two to three years, although it is unclear from the original text how this timeframe is arrived at and the exact interpretation of 'same or similar situations' is frustratingly vague. At this stage, a wound care nurse could be expected to be able to plan a

patient's wound care based on 'considerable conscious, abstract, analytic contemplation of the problem', (Benner, 1984, p. 26) and, consequently, their practice should be organised and efficient.

As an immature, almost, juvenile quality is exhibited at this stage, Benner suggests that students learn from participation in decision-making games and simulations that provide practice in planning and co-ordinating multiple, complex patient care demands. To ensure clinical currency, evidence of CPD is required at this stage, similar to the NMC revalidation CPD requirements whereby nurses have to undertake 35 hours of CPD, of which 20 must be participatory learning. This needs to be relevant to their scope of practice in the three years since their registration was renewed (Nursing and Midwifery Council, 2016), alongside an appreciation of developments in the field.

Stage 4 – Proficient

A period of between three and five years is given for nurses working with a similar patient population to become proficient. Nurses present with the ability to see situations as a whole based on previous experience and have long-term goals of care in sight. As a result of their experience, they know what to expect, enabling them to modify care plans accordingly.

Decision-making involves greater ability to accurately assess problems and consider the most feasible options. Use of maxims, short statements expressing general truth, or rules of conduct, relating to, for example, 'wound bed preparation' and 'negative

pressure therapy', are evident and the situational aspects described in Stage 2 stand out in each context to facilitate prioritisation of care. This experience means that proficient performers often feel restricted by the theory upon which their skills and practice were originally based, and learning and teaching strategies should be adjusted accordingly.

These strategies should use context-related problem-based learning from multiple perspectives and be conducted in small groups where students' knowledge can be challenged and developed through incorporating their own experience and using exemplars that provide them with opportunities to broaden their perspective and care expectations for clinical situations.

Stage 5 – Expert

'Expert' nurses generally develop skills and understanding of patient care over a ten-year period. The intuition witnessed here is based on experience, not rules, guidelines or maxims and is the foundation for expertise, where a focused appraisal can take place of the available options, rationale decision-making can be observed, and 'the performer is no longer aware of features and rules, and his/her performance becomes fluid and flexible and highly proficient' (Benner, 1984, p. 34).

Students should be given access to educational approaches that are specifically designed to develop and encourage the acquisition and integration of theoretical and practical knowledge such as describing critical incidents from practice to illustrate expertise or a breakdown of performance, reflection and identification of new areas

of clinical knowledge for further study. Crucially, becoming an 'expert' relies heavily on a sound educational base as well as a multitude of experiences, and ongoing and advancing educational opportunities are a necessity here (Latham & Fahey, 2006).

Mapping Benner's Model against Wound Care Education and Practice in 2020

Thus far, the background literature has revealed that the current nature of wound care education provision is unsatisfactory and the wound caring role is complex and surrounded by confusion. As a direct consequence, wound care nurses' professional accountability is compromised.

These grave conclusions make me cautious about the ease with which Benner's theory continues to be the 'go-to' for current wound care curriculum development because, as suggested, the wound care context is much more complex than Benner's theory accommodates for and, on the basis of these findings, its relevance for such conditions should arguably be appraised. This is opportunistic because, as Altmann (2007) and Cash (1995) also point out, a further unexplored limitation of the theory is that its main focus is on gaining knowledge through experience, rather than education, and the role of education is not currently considered as important as it probably should be.

An Appraisal of Benner's Theory – The Meleis Framework

To set about appraising the relevance of Benner's work, I used Meleis's model for the evaluation of theory (Meleis, 1991) with respect to its application to wound care nursing and not the underlying theory itself. Although I felt that the study could have

benefited from addressing all eight of Meleis's aspects, I believed that 'simplicity verses complexity', 'visual representation', 'usefulness (in practice, research, education and administration)', 'values (personal, other professionals and social)' and 'social significance', discussed in the following section, were the most pertinent and excluded the others – 'clarity', 'consistency' and 'contagiousness'.

It is important for the reader to understand that my critique of Benner's theory does not in any way invalidate it. However, I found that engaging in the exercise of rethinking led me to some valuable insights and to highlight areas of most concern. Like Neto, Marques, Fernandes, and da Nóbrega (2016), I found Meleis's model invaluable because it gave me the opportunity to reflect in considerable depth on its use and revalidate it to support a more theoretical and practical application of the theory's development in wound care.

Simplicity versus Complexity

According to Meleis, 'simplicity verses complexity' relates to the number of phenomena a theory considers and the relationships which could develop. This depends on the purpose of any given theory and whether simplicity or complexity is preferred.

The problem with persisting with application of Benner's theory to wound care is that the issues underlying effective wound care education are complex and multi-factorial and, as the theory currently stands, it is limited and too simplistic to represent these effects. External organisational, political, economic, ethical and professional factors

are ignored. These phenomena must be factored in because one of the key premises of Benner's theory (1984) is that a nurse will only perform at expert level in a clinical situation on the proviso that they have innate ability, adequate educational preparation and are:

- highly experienced
- motivated to perform well
- in possession of the usual resources and constraints associated with that situation

However, the literature suggests that satisfying these pre-conditions in wound care is almost unattainable, thus compromising the application of the theory. This is particularly the case because, with the exception of Varga and Holloway (2016) study of the lived experiences of five wound care nurses caring for individuals with pressure ulcers, very little is known about the precise nature of caring for wounds in a politically charged and financially restricted healthcare environment. While the essence of the model may therefore be easy to understand and describe and its structure might be relatively simple with regard to the five stages of skill acquisition, it lacks the capacity to effectively portray the wound care education context.

A further consideration is the extent to which the theory addresses the way in which relationships develop. In the wound care education context, complex interdisciplinary social associations also arguably affect education provision and this should also be accurately represented.

Power, Control and Policy

Although Benner does briefly acknowledge that clinical knowledge is 'socially embedded' and that knowledge is 'situated historically' and in a community context, her work does not examine nursing from a social perspective to a sufficient extent. Nursing care can be thought of as a political event and the power of nursing practice is in the generation of knowledge. The theory does not currently have the scope to fully consider or show the influence of these relations and their role in reproducing social conventions, social knowledge and arrangements of power (Purkis, 1994; Rudge, 1992; Thompson, 1990).

Power and control have particular relevance here in relation to the inability of governments, professional bodies and experts to reach agreement on a way forward and the simultaneous power of the regulatory body to impose severe penalties should standards not be upheld and where professional accountability is compromised. To this end, Flanagan (2005, p. 76) provides a valid, yet grossly under-rated, perspective, believing that inter-professional conflict and 'organisational and inter-professional rivalry' represent a root cause of the current lack of expert opinion consensus and absence of standardised accepted practice.

Holloway echoes Flanagan's somewhat contentious opinion by noting that, while many national and international examples of wound care curriculums exist and the pursuit of agreeing a skillset is essential to providing an adequate level of education, tactfully suggesting that reaching such a consensus does, however, 'pose challenges'

(Holloway, 2014, p. 3). As indicated in the statement below, it is becoming clear that the policy processes involved in wound care education and practice, including how they are created, enacted and implemented, are more central to the wound care education problem than previously recognised.

> **'Currently there are guidelines and best practice statements available as educational resources, but staff need to be aware of their existence in order to provide evidence-based care' and 'must ensure all practitioners are familiar with this and integrate it into educational programmes.'** (Ousey et al., 2011, p. 147)

It can be deduced from this that, while numerous valuable wound care educational resources exist, these policies, or 'action plans, positions, and/or guidelines which influence decisions based on a set of processes, preferences and choices' (Mwije, 2013, p. 1), normally intended to implement a programme of reform or change, are for some reason not filtering down to, or being implemented by, those who need them most. Policy-making processes do not appear to be operating as efficiently as they should and this merits further scrutiny.

Although the policy-making process is often reduced to six stages – problem identification, agenda setting, policy-making, budgeting, implementation and evaluation – this is a simplification. 'Policy' can have different interpretations and its definition in education and health contexts varies significantly (Ball, 1993, 2017). The process is also understood to be a very 'incoherent and ill-defined complex concept with long-term processes involving a vast of inputs and outputs' (Mwije, 2013, p. 1), and such complexity does not bode well for policy in healthcare, which is notoriously multi-faceted. As indicated by Bowen and Zwi (2005) policy does not therefore

operate in isolation because it consists of political, social, historical and economic elements that are particularly relevant to the healthcare system context

For the purposes of this research, I will define policy as 'courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health system' (Buse, Mays, & Walt, 2005, p. 6). In this context, policy can be made within government, by non-government actors, and by organisations external to the health system (Walt & Gilson, 1994) with an impact on health.

In line with Oliver's ideals (Oliver, Innvar, Lorenc, Woodman, & Thomas, 2014; Oliver, Lorenc, & Innvær, 2014), I adopted a policy perspective for the first phase of the research because it offers a credible line of enquiry for the complex processes that lie behind policy change in order to show its effect on the theory when applied to the wound care context.

Visual Representation

Although Benner has never visually represented her theory, as shown in the following examples (Figures 2 and 3) and Figure 1 above, many others have done so. Its five stages are always depicted as along a linear continuum, as demonstrated in the examples, where progress is sequential from 'novice' to 'expert'.

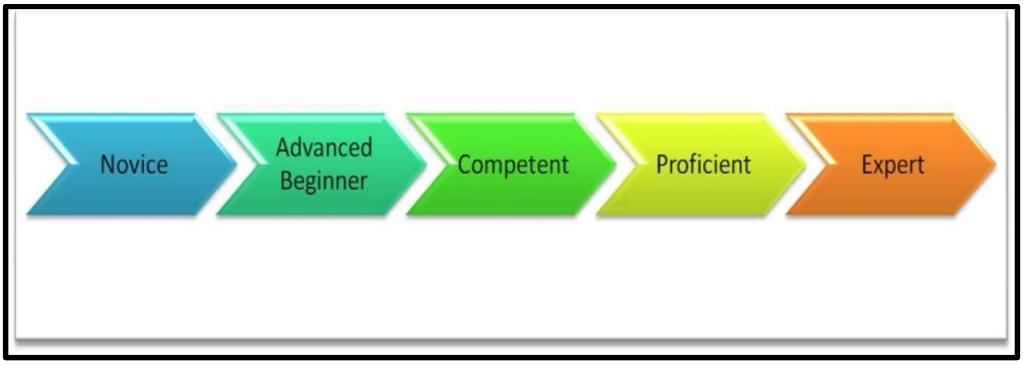


Figure 2. Image of Benner's 'novice to expert' nursing theory depicting one-way movement from left to right). Retrieved from https://www.slideshare.net/xenna_85/patricia-benner-38508791

Figure 3. Image of Benner's 'novice to expert' nursing theory depicting one-way movement from bottom to top. Retrieved from http://theclinicalpreceptor.weebly.com/novice-to-expert.html

These types of image are deceiving because they misrepresent the idea that the movement is only one way when it can also be regressive when the nurse encounters unfamiliar situations. This possibility is not widely known. Even when reading the original text, it is difficult to distinguish between the stages and to identify exactly which factors prompt progression or regression.

This alternative path has substantial bearing on the theory's application to wound care because the literature demonstrates that wound care education and the process of delivering wound care is inconsistent, unpredictable and often chaotic.

At 'proficient' – Stage 4 – for example, Benner states that the nurse 'will regress to the more analytic competent level when novelty is introduced or the demand for an analytic procedural description is required' (Benner, 1984, p. 31). If, as Benner suggests, 'it is reasonable to expect a nurse to perform at the expert level for example in familiar situations and at the competent or even advanced beginner level in less familiar ones' (Benner, 1984, p. 179), a question therefore must arise over the theory's sequencing in the very real event that the ideal conditions to reach expert status in wound care do not exist. It is reasonable to ask whether there might even be occasions where nurses providing wound care might never meet any of the conditions already outlined for each of the stages to gain the experience and skills necessary for each stage, perhaps remaining static.

Essentially, not enough is known about wound care practice delivery processes to reliably claim these visualisations and the learning and teaching strategies Benner associated with each stage, accurately characterising what takes place in wound care. What can be surmised, however, is that its context is more sophisticated than Benner's theory currently tolerates.

Usefulness (in Practice, Research, Education and Administration)

Two concerns were identified in relation to the usefulness of the theory. Since its inception in 1984, Benner's theory has been universally adopted in many schools of nursing as a basis for providing education. However, one obstacle to applying its distinct sequential and prescribed learning and teaching strategies at each stage of wound care education is, as the literature has clearly shown, that there is no consensus on knowledge, extent of experience, subject content or level of accreditation in post-registration nursing. As with pre-registration training, where some institutions include tissue viability to varying degrees and in other areas it is not addressed at all, post-registration wound care education opportunities are also very vague. In post-registration, this can range from accredited higher education modules and Master's degrees through to commercially sponsored study days, conferences and self-development through journals or online learning packages, all of which depend on personal preference and ability to pay. Free, certificated online products are also increasingly available, where the number of attempts at assessment can be unrestricted and the academic level attained is unclear.

As a result of the lack of a wound care education framework, it cannot be claimed with any degree of confidence that the pre-requisite learning and teaching strategies laid down by Benner to allow nurses to continue from novice to expert status in wound care can be satisfied, casting doubt over the theory's usefulness.

Doubt also emerges in relation to the extent to which Benner's theory remains relevant because, while nurses still lead on wound management, wound care has expanded beyond adult nursing and become multi-disciplinary in nature. Dependent on particular patients' needs, care might now also involve input from surgeons, physicians, dermatologists, general practitioners, occupational therapists, moving and handling co-ordinators, dieticians, podiatrists, care home managers, physiotherapists and paediatric and mental health nurses. Benner's qualitative data was collected from 109 newly qualified and experienced hospital-based nurses working in general medicine and surgery, intensive care, oncology, mental health and midwifery. I maintain that the learning and teaching strategies contained within a theory whose data is based solely on hospital nursing can no longer represent the changing needs of the present day. Such requirements are readily demonstrated using two of my students' reflections – a podiatrist and a midwife – on how adequately prepared they feel for their roles in caring for wounds and their concerns over the implications of knowledge deficiencies for patient safety.

> **PODIATRIST: 'I am a community specialist podiatrist. I work mainly in domiciliary. The profession has greatly changed over the past few years and wound management is 90% of the workload.'**

> **MIDWIFE: 'When Anne was re-admitted, the staff in this acute area failed to adhere to hospital policy on wound infections which is easily accessed through the staff net system. Only some aspects of this policy were fully followed.**
>
> **Anne spent a significant amount of time in the recovery bay in labour ward after delivery and, although there is clear and regular documentation of observations and uterine tone and blood loss, there was no mention of assessment of the trauma sustained to the perineum. This indicates that either the midwife felt it was not necessary at the time or the midwife had little or no experience as to**

how quickly wounds can deteriorate, the factors that can affect this and how it should be managed.

Not only were the midwives not practising within the boundaries of the Code of Practice but they also failed to complete routine documentation and plans of care for the patient and her family.'

The Commission on Education and Training for Patient Safety (2016) states that lack of appropriate training and expertise has a direct correlation with poor patient outcomes and harm to patients. Given this profound statement, it is reasonable to challenge how Benner's theory, informed entirely by general nurses, can be generalisable to increasingly diverse educational needs.

Values (of the Theorist, Critics, Other Professions and Society)

Although Benner acknowledges that the knowledge level of the practising nurse is important to the individual receiving the care and thus to society, her theory does not explicitly identify values or acknowledge that nursing practice depends on and re-produces social conventions, social knowledge and arrangements of power (Altmann, 2007). In contemporary wound care, it is essential that this theory now gives a fair and accurate representation of events, while student advocacy, maintaining educational standards and safeguarding professional accountability are also considered in the analysis.

Fair and Accurate Representation

Benner used interpretive phenomenology to inform her theory. This research methodology is used when the research question asks for the meaning of the phenomenon and the researcher does not bracket their biases and prior engagement with the question at hand (S. Mackey, 2005). An important observation here is that

recording of the narratives for Benner's study was preceded by asking participants to think only of exemplary, not ordinary or unpleasant, situations in which they made a positive difference (Nelson & McGillion, 2004), meaning that the data emphasises excellence, success and beneficence and is biased towards the positive. As a result of this bias, I argue that the theory does not capture the real nature of wound care practice and seek to explore the extent to which the theory can be improved by including the negative aspects of wound care practice outlined above.

Participant Advocacy

The theory is dated, in that it does not consider how the advent of 'activist education' – 'intentional educational practice in which participants engage in guided learning activities that help them understand themselves as capable of effecting change for social and ecological justice' (Niblett, 2017 para. 2) – might also change its representation. Through undertaking this research, I now consider myself a teacher activist to some degree, trying to shape education and support educational justice and challenging detrimental policies and practices that hamper teaching, thus helping to meet the needs of my students.

In much the same way as Altmann (2007) observed, despite patients' interests always being the focus of Benner's work, the patient perspective is never expressed. Neither does Benner meaningfully engage with her research participants in a way that could empower them – what is now commonly referred to as the 'student voice'. Respecting the contribution that the 'student voice' makes and the benefits when students and staff work in partnership in curriculum development are accepted in

contemporary education (Bovill, Cook-Sather, & Felten, 2011; Brooman, Darwent, & Pimor, 2015).

However, at the time of Benner's work, the idea of actively involving research participants in Heideggerian interpretive research was unpopular and any attempts by the researcher to validate data interpretation with participants were not consistent with the approach. If a description was considered plausible by the researcher in question, it was 'valid'. Even if another researcher or research participant produced another version, this did not nullify the researcher's version, simply adding another plausible description (C Webb, 2003; C. Webb & Kevern, 2001).

In stark contrast to nursing research today, discussing developing interpretations with participants is consistent with the hermeneutic cycle in Heideggerian interpretive phenomenology, which requires constant movement between interpretation and text, or, in the case of member checking, a return to interaction with participants. Member checking is now used in phenomenological studies to verify data interpretation, validate themes and test categories, interpretation and conclusions with participants (Arpanantikul, 2004; Corben, 1999; Doyle, 2007; Dunne, Sullivan, & Kernohan, 2005; Lillibridge, Cox, & Cross, 2002; H. A. Milne & McWilliam, 1996; Prowse & Lyne, 2000), with Sandelowski (1998) and, more recently, Bush, Singh, and Kooienga (2019), finding that it also helps to ensure interpretive validity and enhance study rigour. Since Benner, predominantly over the last two decades, qualitative research is increasingly expected to demonstrate rigour, with De

Witt and Ploeg (2006) and Pereira (2012) recommending a framework for interpretive phenomenology in nursing research that explicitly recognises participant sanctioning. As well as member checking providing an opportunity to yield additional rich new data, Doyle (2007, p. 890) also argues for its place in interpretive phenomenology because it 'encourages negotiation of meaning between participants and researcher and the analysis involves the convergence of the perspective of the participants and researcher'.

However, today, in Heideggerian interpretive phenomenology, it is believed that the researcher viewpoint cannot be suspended from the research process and is an integral part of understanding the meaning of the phenomenon being studied. Co-operative exploration through participant feedback now appears to have a legitimate place in phenomenology and can enhance the trustworthiness of a study, and participant feedback in phenomenological research should be conventional rather than a point of contention (Bradbury-Jones, Irvine, & Sambrook, 2010). Wound care nurses, as an under-represented group in education research, should therefore have their voices heard, with the effects on Benner's theory publicised.

Upholding Educational Standards

A further principle of Benner's theory (1984) is that a nurse will only perform at expert level on the basis that there is 'adequate educational preparation' (p. 178). Use of the loose term 'adequate' is unacceptable because it assumes that standards for wound care education already exist, when they do not yet. Determining and

upholding educational standards that facilitate knowledge is a value that lies at the heart of nursing practice, but, instead, difference, inconsistency and inequity have been found to be the norm.

The theory does not factor in the disruptive effect of the increasing influence, or marketisation, of the wound care industry on education provision, by virtue of the growing range of CPD eLearning resources and services. Many of these resources are competitively priced at a fraction of the cost of many traditional seminar courses, which are often tailored to specific groups of professionals or even free of charge, regardless of educational background. Their learning and teaching strategies and accreditation are generally incohesive and it is not apparent how their content aligns with 'novice to expert' progression. Many online multiple-choice test assessment strategies do not seek to determine a student's ability to handle the often dynamic complexities implicit in wound care management. Successful completion can often be arbitrary and marked by, for example, passing a 'knowledge test' with an 80% pass mark, and can sometimes be taken 'until-you-pass'. The Royal College of Nursing (RCN), the main professional nursing body, also recognises that the effectiveness of CPD should be measured in relation to learning outcomes achieved (Royal College of Nursing, 2016, 2018) and not by minimum hours spent on dubious development activities. A further pressing concern for the RCN is that many nurses do not receive sufficient time or financial support from their employers to achieve this.

It is reasonable to ask how such capitalist intrusion into conventional wound care education disturbs 'novice to expert' progression, which relies heavily on pre-determined learning and teaching strategies at each stage

Safeguarding Professional Accountability

Being professionally accountable for one's own practice is a core value of nursing and involves nurses taking responsibility for their own actions, ensuring that they are competent to do activities they are asked to undertake and enabling them to always put patients'/clients' interests first. However, in light of the current education deficits affecting wound care nurses, significant regulatory implications exist.

The NMC revalidation process (Nursing and Midwifery Council, 2016) was one of the biggest changes to the regulation of nurses and midwives in the NMC's history and requires that the UK's almost 70,000 nurses and midwives demonstrate their ability to deliver care in a safe, effective and professional way. Registrants are required to give evidence of completion of 35 hours of CPD. However, across the board, there are no educational quality standards. Acceptable kinds of learning activities are diverse and range from accredited university-level education to simply reading and reviewing a few publications accompanied by review notes.

Despite this imprecision, the NMC still expects nurses who care for wounds to maintain the necessary up-to-date knowledge and skills and to participate in ***appropriate*** and ***regular*** learning and professional development activities that aim to maintain and develop their competence and improve their performance (Nursing and

Midwifery Council, 2015). Any failure to consistently meet NMC standards can result in the NMC investigating a nurse's fitness to practise to determine if they are still suitable to remain on the register.

Benner's theory needs to be re-considered to take account of these variations in education provision over time, as well as broader social and professional values.

Social Significance

Last year's policy, 'Future Nurse: Standards of Proficiency for Registered Nurses' (Nursing and Midwifery Council, 2019) was produced in response to the recent changes that have taken place in society and healthcare and sets the bar for the knowledge, skills and attributes necessary for all registered nurses when caring for people across the lifespan in a range of care settings. This policy also details what the public can expect nurses to know and be able to do in order to deliver safe, effective and compassionate care. In his framework, Meleis emphasises assessing a theory's social significance, because 'in our attempt to enhance nursing science and articulate the discipline of nursing, we must not neglect the significance of its practice to humanity and society' (Meleis, 1991, p. 237). In this respect, there are fundamental social ramifications for patients' quality of life, the wider economy and professional accountability in ineffective wound care education.

The NMC code (Nursing and Midwifery Council, 2015) presents the professional standards that nurses, midwives and nursing associates must uphold in order to be registered to practise in the UK, and is highly relevant to the social significance of Benner's theory. However, this policy has attracted criticism from a unique

perspective (Snelling, 2017). Snelling observed that the discourse contained within the document has changed over time when compared with its previous renditions. Instead of expectations and procedures being more black and white with clear steps and one way of doing things, Snelling believes that current discourse increasingly leaves these open to interpretation and argues the NMC has taken this position too far, asserting that consistency in practice is good for employees' individuality – that they know what they are responsible for, what is expected of them and what they can expect from their supervisors and co-workers, and, in doing so, are freed up to do their jobs confidently and with confidence. Unlike its counterparts such as the General Medical Council, Snelling believes that the NMC has changed its view on the value of detailed guidance, arguing that more detail helps nurses understand what their professional practice demands of them. Reducing the amount of guidance means that, 'nurses must make their own arrangements to interpret ambiguous clauses in the Code' (Snelling, 2017, p. 393).

Akin to the NMC position, Benner also supports a broad and vaguely outlined policy because it allows for greater interpretation and the capacity for nurses to adapt to changing complex situations. While the NMC and Benner might believe that more autonomy is necessary to translate policy and that drawing on individual professional judgement is beneficial, Snelling and the main nursing union, the RCN, as cited in Snelling (2017, p. 4) have expressed concern that such a 'poorly constructed code would overwhelm the NMC with fitness to practise cases'. The social significance of policy and professional regulation on professional accountability and on public

protection are emerging disruptive factors and are revealing when represented in existing theory.

Systematically applying Meleis's framework to Benner's theory has proved to be an effective device in the thesis, helping to expose a deficit of three distinct aspects of wound care education and practice from its inception, forming the basis of the research objectives: 'policy', 'practice' and 'student participation'.

What's the Hurry?

There is an urgency about getting wound care education right and for education to deliver specialist wound care expertise. The prevalence of acute, chronic and unspecified wounds is estimated to be growing at a rate of 9%, 12% and 13% per annum, so the current rate of wound healing must therefore increase by an average of at least 1% per annum across all wound types in order to slow down the increasing prevalence (Guest, Vowden, & Vowden, 2017). In 2017, the patient care cost of an unhealed wound was a mean 135% more than that of a wound that heals (ranging from £698 to £3998 per patient for a healed wound versus £1719 to £5976 per patient for an unhealed wound). However, as many as 30% of wounds still lack a differential diagnosis (Guest, Ayoub, et al., 2017) thought to be indicative of the 'practical difficulties experienced by non-specialist clinicians' (Guest et al., 2015, p. 5). If this burgeoning health service expenditure on wound care is to be curtailed, 'an effective education programme is needed, specifically, better diagnosis, treatment and effective prevention of wound complications' (Guest et al., 2015, p. 1). Guest believes that only through this is there potential for better patient management,

better wound care product selection, improving outcomes and increasing compliance with National Institute for Health and Care Excellence (NICE) and other best practice guidelines.

However, for this to succeed, the correct learning and teaching strategies must be in place, and it is thought that wound care should be viewed as a specialised segment of healthcare requiring clinicians with specialist training and detailed knowledge to diagnose and manage appropriately, as well as practise autonomously (Ennis, 2012; Funkesson, Anbäcken, & Ek, 2007; Gottrup, 2004a, 2004b; Holloway, 2014; Ousey et al., 2014; Ousey et al., 2015; Zulkowski et al., 2007). Reducing healthcare inequality and increasing patient quality of life are also NHS priorities and there are many variations in health and care outcomes, patient and staff experience and use of resources that cannot be justified by reasons of geography, demography or infrastructure. The 'NHS Atlas of Variation in Healthcare' (Public Health England, 2019) is currently being used as an instrument to identify opportunities to address unwarranted variations by revealing the possible over- and under-use of different aspects of healthcare. As part of this initiative, the Academic Health Science Network (AHSN) (Academic Health Services Network [AHSN], 2019) was commissioned to develop and deliver a National Wound Care Strategy Programme (NWCSP). The brief of the NWCSP is to scope the development of a strategy *for England* to focus on improving the quality of care for the most widespread chronic types of wounds such as pressure ulcers, lower limb ulcers and surgical wounds, through developing the following:

- national evidence-based recommendations to reduce unwarranted variation and to improve safety and optimise patient experience and outcomes
- a robust supply and distribution model that enables the right wound care products and intervention therapies to reach the right patients at the right time and in the right quantity
- access to education for healthcare practitioners, patients and carers
- robust ways to gather information to measure what is happening and direct efforts to improve care.

While only for England, this programme represents a major long-term commitment to improving patient care because care that is well organised and evidence informed can achieve better healing rates, better patient experience and better use of NHS resources.

Through a national dissemination strategy incorporating oral local and European conference presentations and publication in education policy and practice spheres, it is expected that the findings from this professional doctorate will make a positive practice-based contribution to resolving this real-world problem.

Conclusion

With increasing demand for wound care expertise to accelerate healing rates, there is still no imminent tangible solution on the horizon for effective higher education provision. Developing Benner's theory for the wound care context to reflect the external influences of policy, practice and student participation identified is

necessary to allow educationalists to more fully appreciate the complexity of wound care education and therefore inform curriculum development to meet the wound care needs of the future.

This chapter has outlined the practical nature of this EdD thesis, provided an overview of my current academic responsibilities in wound care, and highlighted national concerns over quality assurance in wound care education. The urgency behind resolving variations in education and practice because of their significant impact on the economy and patient quality of life has also been explained, and the chapter has detailed how this vaguely defined scope of practice compromises professional accountability. A critique of Benner's nursing 'novice to expert' theory, however, showed that, in its current format, it no longer characterises the nature of contemporary wound care, and policy, practice and student participation influence its assumptions. These three aspects form the basis of the research objectives and overall thesis aim of evaluating and adapting Benner's theory for contemporary higher education wound care curriculum development and implementation.

The following section outlines the research aim identified in the background literature review, alongside the research objectives and additional explanation of these.

RESEARCH AIM AND OBJECTIVES

Research Aim

To explore the relevance of Benner's 'novice to expert' nursing theory in contemporary wound care higher education provision.

Research Objectives

- **Explore the effect of policy on Benner's theory in higher education wound care curriculum development.**

    - Benner's theory does not account for the influences of healthcare policy and its effects on the assumptions made in progression from 'novice to expert' in contemporary wound care curriculum design and learning and teaching strategies.

- **Identify characteristics of contemporary wound care practice that affect Benner's theory in higher education curriculum development.**

    - Benner's existing assumptions do not currently consider how the everyday little understood experiences of wound care nurses might influence their progression from 'novice to expert'.

- **Understand the role of the student voice in modernising higher education wound care curriculum and development of theory.**

- Benner's theory does not incorporate the research participant's perspective of her findings or acknowlege their potential role in wound care curriculum design.

- **Adapt Benner's theory to represent the contemporary education needs of wound care practitioners.**

    - The nature of wound care education and practice is complex and Benner's current theory does not accommodate external factors specific to the discipline.

CHAPTER 3: THE RESEARCH PARADIGM: INTERCONNECTING MY WORLD VIEW WITH CHOICE OF RESEARCH METHODOLOGY AND RESEARCH METHODS

Chapter 3 explains my personal world view of the form and nature of the human world, or ontology, developed from my years of experience as a nurse and academic in which my priority has foremost been the welfare of my patients and students. This and my personal experience of evidence-based nurse education plays an important role in influencing the research methodology and research methods described. Strategies used to assure data access, research quality and ethical conduct are also addressed and the nuances between research ethics in nursing and in nursing education are briefly drawn out.

Personal World View – Viewing the Thesis through the Prism of Realism, Social Constructivism and Advocacy and Participatory Ontology

Making my own world view, or the general orientation I hold about the world and the nature of research, clear from the outset is important because it sets out my position to the reader as a researcher and also acts as the 'basic set of beliefs to guide action' (Guba, 1990, p. 19) that I used to direct the methodological decisions taken in the research design.

Since starting this thesis, I have experienced a significant degree of personal transformation in terms of this world view. During my 30 years as a registered nurse, I have always strived to provide the best possible outcomes for 'my' patients and, more recently as a lecturer in nursing, 'my' students, through evidence-based

practice (EBP). Nursing EBP is the objective process of locating, appraising and applying the best evidence from nursing and medical literature to improve the quality of clinical practice. Although I often consider these individuals as 'mine', and take responsibility for the outcomes. Only over the course of time did I come to appreciate that what I considered to be 'successful' patient or student outcomes did not necessarily represent what others thought of as successful. I now more readily accept that different perceptions exist because every individual's life experience is unique, resulting in people developing their own distinct sets of beliefs, values and expectations. Being 'successful' in my work as a nurse is not therefore necessarily always about being factually 'right' according to EBP and strictly following convention, but about appreciating and, more importantly, accepting the world from another person's perspective and understanding the meaning of their individual experiences. I also understand that, in nursing, knowledge and meaning can, at any particular point in time, be uniquely interpreted through quite different prisms.

At the beginning of the research, I firmly positioned myself somewhere along a realism-social constructivist world view, where I tried to interpret the world my students lived in and developed subjective meanings about their experiences, albeit grounded in EBP. However, as the research cycle evolved, my world view has also since evolved, purely as a consequence of participating in the research process itself, and my research goal at this time was to seek, as far as possible, students' views of situations. I now have a much greater appreciation of the existence of multiple realities and understand that subjective meanings are the products of our historical and cultural norms. This realisation has resulted in me moving from this traditional

realism-social constructivist position to one that also better represents the values of partnership and co-operation. The knowledge, confidence and assertiveness I have accrued as a consequence of engaging in the research process thus far has also moved me from an almost passive state, where I was inclined to accept inertia at work, to a much more active state, where I now readily question and challenge the norms of the organisation I work in and make concerted efforts to mobilise change to improve conditions for my students. The only way in which I can attempt to visualise this is as a slow but progressive accumulation along a time continuum from left to right, where I am in the process of 'muddling' my initial realism-social constructivism world view with one of advocacy and participation – a position that is political and change, power and justice orientated (Figure 4).

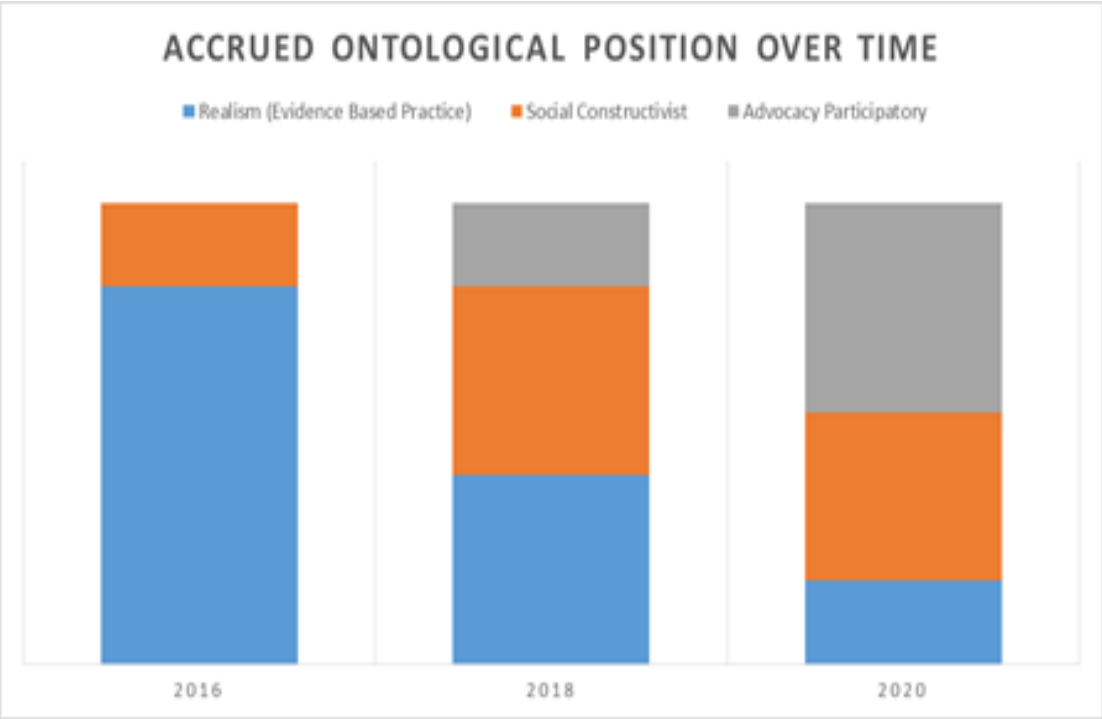


Figure 4. Graphic representation of my personal accumulation of realism- social constructivism – advocacy and participatory paradigms.

This movement resulted in a change in the way I originally interpreted the research problem and therefore in how I position myself within the thesis.

An advocacy and participatory framework holds that research inquiry needs to be intertwined with politics and a political agenda (Creswell, 2009) and has a specific research action agenda aiming to reform the lives of the research participants, their places of work and potentially my own circumstances. Issues such as empowerment, inequality, oppression, domination, suppression and alienation are often the focus of the research study, which offers a voice to research participants by giving them the opportunity to form an agenda for reform, holding true with my own world view. I therefore deemed this an alternative approach to carrying out this wound care research and believed this transformation to be the product of reflexivity, a process of ongoing mutual shaping between researcher and research (Attia & Edge, 2017).

Guba and Lincoln (1989) report that critical theorist Henry Giroux and neo-Marxist Brian Fay are advocates of participatory inquiry. Paulo Freire, a leading educator and philosopher and supporter of critical pedagogy, argued that this framework takes account of different value positions and that education cannot be divorced from politics – the acts of teaching and learning are considered political acts in themselves. Freire applies the oppressors–oppressed distinction to education campaigning, asserting that education should allow the oppressed to re-gain their sense of humanity and in turn overcome their condition. However, to do this, the oppressed individual must play a role in their liberation (Freire, 1968). I draw parallels between

Freire's oppressed individuals and those unheard voices of wound care nurses described in Chapter 2, whose education is being unfairly compromised, with their professional accountability unjustly exposed and their nursing care adversely affected because of unheeded economic, political, regulatory and commercial influences. Taking an advocacy participatory world view stance for this thesis ensures that oppressed views are accounted for.

The Advocacy/Participatory Framework

This shift along this continuum coincided with what I now identify as my adoption of a 'teacher activist' role, where I have an expectation of equality and take concrete actions in my work to stand up to oppression (Hytten, 2017). Kemmis and Wilkinson (1998) put forward four features of advocacy-participatory research and I use these to frame the research methodology.

- **Participatory actions are focused on bringing about change, and, at the end of this type of study, researchers create an action agenda for change.**

  The thesis findings will provide practical recommendations to improve wound care education provision and transform the status quo.

- **It is focused on freeing individuals from societal constraints, which is why the study begins with an important current social issue.**

  Inequitable standards of wound care and the compromised professional accountability that arises as a consequence are of professional and public

relevance to society.

- **It aims to create a political debate to enable change to occur.**

  The findings and recommendations of this thesis will be disseminated through conference presentations and journal publications to generate debate and progress change.

- **As advocacy-participatory researchers engage participants as active contributors in research, it is a collaborative experience.**

  My students are at the heart of the thesis. I will search for their perspectives, deliberate the findings and agree recommendations with them.

Research Methodology

Methodological Bricolage: On Becoming a Bricoleur

When deciding on the most suitable methodology to achieve the research aim and objectives, I found that the more established qualitative research methods had particular norms attached to them and tended to indicate the 'correct' way of how things are seen and what must be done to investigate them. This 'predictive quality' described by Yee and Bremner (2011) arguably contradicted the purpose of my thesis, which was to extend what is currently known about the research topic by generating new and innovative understanding. I was not confident that these conventional methods would represent the most effective way of meeting the

research aim and objectives and therefore examined the potential of using a fairly unusual methodology in nurse education research, known as 'bricolage' (Denzin & Lincoln, 1999; Kincheloe et al., 2001). This term refers to a 'handyman' who uses all tools and types of knowledge available to combine a variety of research tools. Denzin and Lincoln believe that the goal of a bricolage framework encourages researchers to become involved in inventive research that inspires unique knowledge development and challenges them to reach beyond standardised methods of inquiry and objectives, satisfying the overall research purpose.

Using this methodology, I combined three distinct research methods. This approach made it possible to examine the research problem from the different perspectives of policy, practice and research participants, alluded to in Chapter 2, and to consider the problem in a more sophisticated way. This self-reflexive choice allowed me to create new techniques to address the research aim, going beyond conventional wound care research. As 'bricoleur', I therefore actively constructed the research methods with the various tools available to me, which made the approach realistic and considered.

Building a Sequential Three-phase Multi-method Design – 'Brique-by-brique'

This bricolage consisted of a sequential three-phase qualitative multi-method methodology (Creswell, Clark, & Garrett, 2003; Creswell, Klassen, Plano Clark, & Smith, 2011; Morse, 2003).

A multi-method methodology is inductive and moves from specific observations to broader generalisations and theories, combining different methods of analysis of the same generic qualitative type. It is also suitable for explaining 'what is happening', using a series of related questions within the broad topic, and is specifically designed to solve the overall problem and therefore consistent with the research aim and objectives.

Systematically synthesising different research styles develops a fuller picture of relevant issues, expands the scope of the research, and informs its design and implementation (Brewer & Hunter, 1989; J. C. Greene, Caracelli, & Graham, 1989; M. J. Greene, 2014; Hammond & Wellington, 2012; Hunter & Brewer, 2015; Onwuegbuzie & Johnson, 2006). Moreover, this approach increases the possibility of my obtaining the varied and extensive results I wanted and presents more comprehensive explanations of complex situations than previously given (Gil-Garcia & Pardo, 2005). J. C. Greene et al. (1989) believes that this is often more significant than answering the research question. Each phase focuses on generating the respective policy, practice and research participant data and, when combined, will add an original new perspective to Benner's current theory.

The bricolage design depends on the results from each of the preceding phases. The sequential nature of the design provides a logical extension from the findings of the previous phase, with each phase deliberately created to integrate cohesively with and inform the next to answer each research objective. As in Table 2 below, this

integration process supports the multi-perspectival nature of the research by exploring the relationship between policy and everyday wound care education and practice, about which, as I have demonstrated through the literature, very little is understood, as well as how including student participation alters understandings of Benner's theory in wound care.

At this building stage of the research, I began to appreciate that it would have been more straightforward simply to use a single method of analysis. However, this would have produced results with a much more limited understanding of the research problem. Nevertheless, I was convinced this 'custom-made' multi-faceted design would ultimately reap the comprehensive multi-perspectival data I needed to develop existing understandings of this under-researched and increasingly significant healthcare topic. I also expected, as suggested by Denzin and Lincoln (1999) and supported by Santos, Ribeiro, Queiroga, Silva, and Ferreira (2020) that the articulation involved in bricolage would offer insight into new forms of rigour and add complexity to the context of wound care education research.

I wanted to avoid what Coxon (2005) and Pawson (1996) note – that what is considered 'complex' research can often be 'a bit of this and a bit of that to form a more complete picture' (Pawson, 1995, p. 9). Instead, I wanted to reflect on Pawson's ideology to find an approach fusing the domains of 'structure and agency, of individual and institutional, of the macro and the micro' to generate 'ontological synthesis' (Pawson, 1995, p. 9), and believed that the nature of the methodology

examined the research problem at the required organisational, economic, commercial, professional and individual levels.

Table 2 overleaf maps my world view against the choice of research method in each phase. The first phase, a CDA, finds problematic concepts in wound care policy. The second phase, DCA, finds themes and statements and develops the instrument and topic guide for the third and final phase, an adapted DD, to unitise and categorise the findings to inform the overall conclusions.

Table 2. Mapping of world view with choice of research method in each phase.

Phase	World view	Research method	Justification
1	An advocacy-participatory world view focuses on the needs of marginalised or disenfranchised groups and individuals in our society. Research is conducted though a critical theoretical lens.	CDA of wound care policy texts.	I integrated a critical theoretical perspective with this philosophical assumption to construct a picture of the issue examined, the students being studied and the changes needed.
2 & 3	Advocacy and participatory research assumes that the inquirer will proceed collaboratively so as to not further marginalise participants as a result of the inquiry.	DCA of secondary data from retrospective online asynchronous student discussion posts.	It was important that the research provided insight into the participants' working lives and that they contributed to the research process and ultimately reaped the benefits of the findings.
3	Advocacy research provides a voice for its participants, raising their consciousness and advancing an agenda for change to improve their lives. It becomes a united voice for reform and change and is practical and collaborative because it represents inquiry completed *with* others rather than *on* or *to* others.	Extractive summarisation of DD forum data.	This final phase engaged with the participants as active collaborators in their inquiry, in order to change wound care education to best meet student needs.

Creating 'Ontological Synthesis' – Integration Strategies Used Between Research Phases

I acknowledged that the epistemological nature of the data produced from different methods originated from diverse theoretical perspectives and that this had implications for the sequential relationship. To address this, I developed integrative processes to bring multiple methods and datasets together. In a research context, integration is the relationship between objects that are essentially different to each other when separate, but which comprise a coherent whole when brought together. I conceptualised this piecing together as interlocking cogwheels (Figure 5), where the cogs mesh with one another and provide 'torque', which then drives the next phase forward through to the final reporting of the research (Moran-Ellis et al., 2006).

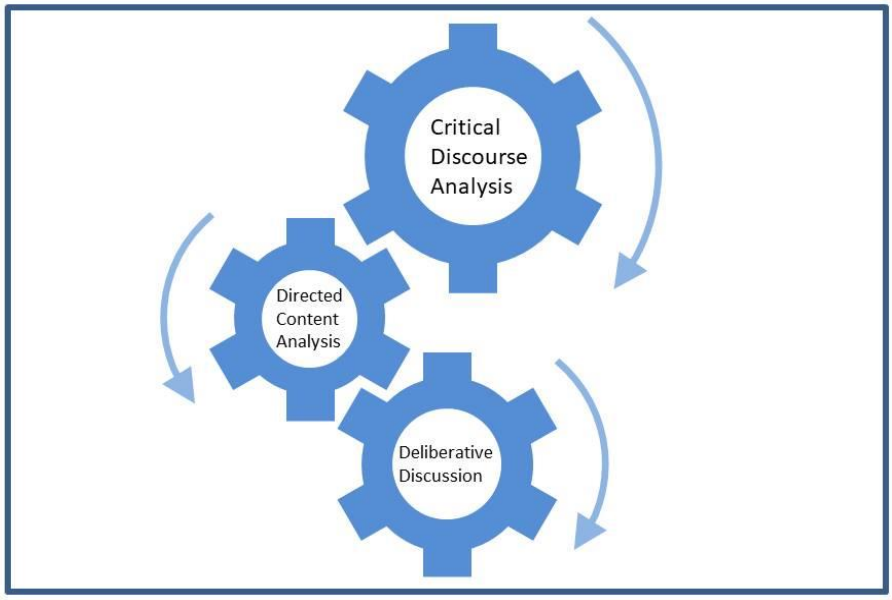


Figure 4. Illustration of sequential integration methodology of research phases from conceptualisation to reporting stage.

I did not want to generate more data about the research problem without addressing how the various datasets could be combined analytically, using integration as a way of bringing the research methods together (Cronin, Alexander, Fielding, Moran-Ellis, & Thomas, 2008). I was concerned about how this would work in the real world, as Maxwell describes the process of integration as a difficult goal to achieve (Maxwell, Chmiel, & Rogers, 2015; Maxwell, Chmiel, & Rogers, 2016). Integrating different methods successively retains their unique paradigmatic nature and is therefore useful in terms of 'knowing more' about a subject (Moran-Ellis et al., 2006). This approach would therefore be beneficial to understanding more about this under-researched problem. I gave the different methods equal weight and viewed the results from each phase through the different 'lenses' of CDA, DCA and ADD, examining the specific practical relationships between the different methods, sets of data, analytic findings and perspectives.

Between phases 1 and 2 and phases 2 and 3, I detail the 'mechanics of data collection and data analysis through which the methods are fused' (Pawson, 1996, p. 10). Integration can occur at different stages in the research process. For instance, data from different sources can be integrated in the analysis stage. The practicalities of integration in this thesis involved pre-planning, maintaining the modalities of the different types of data and, at the same time, dissolving barriers between them. As such, the methods were not 'transformed', with each phase interfacing and enmeshing with the next using, for example, a categorisation matrix to develop theories/themes evidenced by anchor text samples and audit.

My direct engagement with the three types of data facilitated integration, as did my systematic development and testing of the conclusions.

The phased data collection occurred sequentially within a pre-determined time, shown in the research timetable (Appendix A), between January and April, coinciding with the academic year 2018–2019. Each phase is interdependent and together the phases provide a more comprehensive picture than they would alone. As shown in Figure 6, the design of the study depends on the results of the previous phase. Each phase cohesively informs and integrates with the next, moving from an understanding of how the macro (policy) level informs the micro (practical) level, providing the information to make recommendations for wound care curriculum development.

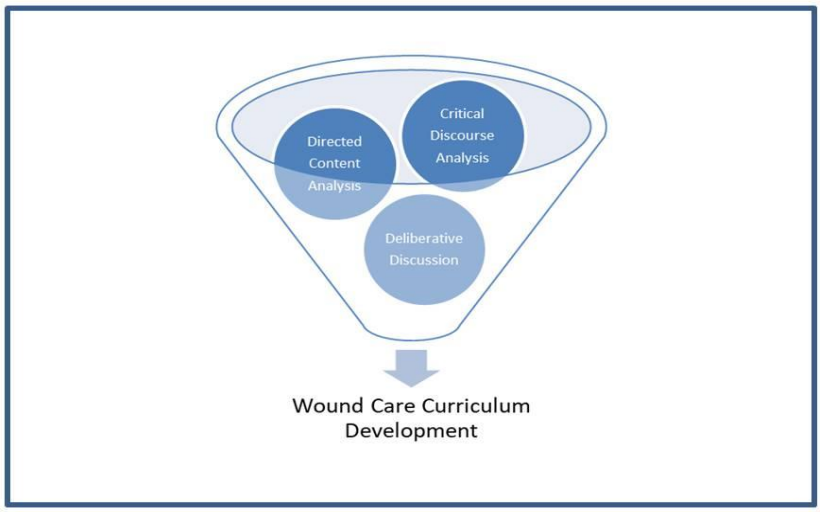


Figure 5. Sequential phased CDA, DCA and ADD research methods used to inform wound care curriculum development.

Quality Assurance Strategies

I combined these multiple research method activities and analytic techniques to add rigour, breadth, complexity, richness and depth (Denzin, 2012) to the research, before addressing each of Lincoln and Guba (1985) well-known mechanisms of credibility, transferability, dependability and confirmability to improve the research trustworthiness. These are discussed below. I also took account of 'authenticity', the least well-known of Lincoln and Guba's components. Authenticity is concerned with the potential of the study to benefit society and the social change that results from the process (James, 2008; Shannon & Hambacher, 2014). This complements the ethos and values of advocacy, participation and transformation detailed in the ontological position explained earlier. Verbatim quotes are used extensively throughout qualitative research. Sandelowski (1994), however, reminds researchers in pursuit of trustworthiness of a key and arguably somewhat overlooked principle in nursing research – that quoting is in fact a process that requires arriving at the right balance between the responsibilities of scientific reporting and taking artistic license. I therefore also provide justification for the selected verbatim quotations used to support my research claims.

Trustworthiness

Credibility

I established research credibility – the confidence that can be placed in the truth of the research findings (Korstjens & Moser, 2018) – using triangulation and respondent validation.

Methodological versus Theoretical Triangulation

Traditional methodological definitions of triangulation tend to relate to validating data through cross-verification from more than two sources. However, my preference was to use a wider theoretical interpretation suggested by Denzin (2009, p. 310), relating to 'multiple observers, theoretical perspectives, sources of data and methodologies'. By virtue of the multi-method design, the data therefore leads to the 'multi-perspective meta-interpretations' proposed by Cohen, Manion, and Morrison (2011) and therefore to a more comprehensive mapping out of the richness and complexities of human behaviour as a result of studying it from more than one standpoint.

Investigator Triangulation

I was also cognisant of the contribution that conventional investigator triangulation, where multiple observers/investigators are involved in a single study (Denzin, 2009), can make to enhancing study quality. As a result, I appointed a colleague who was independent to the study in advance of data collection to undertake this role.

Although investigator triangulation is typically limited to single-strand data analysis, Archibald (2016) also recommends its application in mixed-method research as a pragmatic way of managing the tensions that develop when mixing methods. There is no apparent reason why Archibald's reasoning could not also apply to multi-method research data. I also took the opportunity to address Archibald's criticisms

over lack of transparent and comprehensive reporting of investigator triangulation involvement and misaligned procedures in the research literature.

My primary rationale for using this independent observer was to reduce bias. The independent observer advised if the research plan appeared realistic and achievable, provided constructive criticism, reviewed the bibliography for completeness and adjudicated against potential researcher bias. The latter function was particularly important during the integration and in phase 3, where the DD topic guide was developed. The details of how we negotiated our degrees of convergence and/or divergence and how consensus was reached are explained throughout.

In order to highlight the diversity in our professional backgrounds and epistemological standpoints, I considered it important to provide the reader with a little 'thick description' (Geertz, 1973) of this person's attributes. While this observer was selected for the purposes of convenience as a result of an existing working relationship within the same organisation, we did not teach the same subject and our nursing backgrounds varied significantly. I have acute surgical nursing experience and an advocacy-participatory world view and the observer has a community medical nursing background and holds a critical epistemology. As a doctoral studies student with substantial academic, teaching and wound care nursing experience with the relevant knowledge and expertise, this brought credibility to the role.

Respondent Validation

Respondent validation, or member checking, involves submitting the research findings to the research participants to corroborate and to ensure that the investigator has correctly understood their social world. While many arguments for and against respondent validation in research exist, Torrance (2012), albeit in reference to mixed-method research, makes the valid point that it represents an important aspect of the development of democratic involvement and fits with the ethos and values of this study. I incorporated respondent validation into phases 2 and 3. However, because of the digital nature of the data, I was unable to use conventional approaches such as providing each participant with an account of what had been said.

Transferability

To increase transferability, the degree to which the results can be transferred to other contexts or settings, I included a thick description (Geertz, 1973) of the most obvious key features in the data collection process to give the reader a richer and fuller understanding of the research setting.

In phase 1, the CDA, I treat each of the policy documents in the sample by viewing each as a study participant, providing thick historical, political and contextual description. The remaining phases include detailed accounts of clinical situations, timescales, the nature of online learning, participant characteristics and how implicit

bias can affect participant responses to give contextual uniqueness and significance to the social world of wound care and help bring the reader to this world.

Dependability

To demonstrate the dependability, or stability, of my data over time and in different conditions, as suggested by Bryman (2016) and others (Carcary, 2009; Connelly, 2016), I maintained an audit trail of my problem formulation, rationale for selection of research participants, fieldwork notes, electronic interview transcripts and data analysis decisions. I kept records of unique and interesting topics during the data collection, as well as ideas about coding, rationales for why I merged certain codes, and the meanings of emerging themes.

At various points throughout the study, the independent observer undertook an external audit, examining the process of data collection and data analysis, confirming the accuracy of the findings and ensuring that the findings were supported by the data collection. Auditing to this extent, however, is not considered a popular approach for enhancing dependability (Bryman, 2016). Nevertheless, I found the effort worthwhile in safeguarding the research quality and formally extend my appreciation in the thesis acknowledgements section for the external observer's efforts.

Confirmability

In addition to showing an audit trail, reflexivity is a further technique available to researchers to demonstrate confirmability. This is the level of confidence that the study's findings are based on participants' narratives and words, rather than potential personal values introducing bias.

Lynch (2000) is sceptical about reflexivity, referring to it as 'slippery', and warns researchers to use it with caution because of its many interpretations. With this in mind, I used 'methodological reflexivity' as described by Raven (2006) to demonstrate my philosophical self-reflection, methodological self-consciousness and methodological self-criticism throughout the study. Engaging with reflexivity in the research process resulted in amending the proposed research method for phase 3 (and a subsequent ethics committee approval) to a more compatible method that complemented the ethos and values of advocacy and participatory research.

Authenticity

As explained earlier, authenticity is a less well-known aspect of research trustworthiness (Lincoln & Guba, 1986; Manning, 1997). Authenticity shifts the focus away from research quality to concerns about whether research is worthwhile and the impact of research on members of the community being researched.

Authenticity criteria relate to the wider set of issues concerning the broader political impact of research and emphasise its practical outcomes, thus resonating with the ethos and values of my advocacy and participatory ontology. The criteria for authenticity are addressed in the research methods in phases 2 and 3:

fairness: does the research fairly represent different viewpoints in social settings?

ontological authenticity: does the research help members to arrive at a better understanding of their social milieu?

educative authenticity: does the research help members to better appreciate the perspective of other members of their social settings?

catalytic authenticity: has the research acted as an impetus to members to engage in action to change their circumstances?

tactical authenticity: has the research empowered members to take the steps necessary for engaging in action?

Rationale for Inclusion and Exclusion Criteria of Verbatim Research Participant Quotations

A main feature running throughout the study involved enhancing research quality by creating a transparent audit trail to link the background literature with the research aim and objectives, data, interpretations and conclusions. As with my justification for my choice of policy extracts for the CDA, I also reflected carefully on the choices I

made about how I present research participants' quotations in phases 2 and 3. Cognisant of my advocacy-participatory positionality, I chose to ground these decisions specifically in Cordon's extensive body of work (Corden & Sainsbury, 2005a, 2005b, 2006a, 2006b, 2006c) on the impact of verbatim quote selection as expressed by research participants and users, many of whom had strong views on ethical issues associated with use of their spoken words. For this reason, I believed that it was important that I did not change the participants' 'spoken', or, in the context of the computer-generated research methods, written words, in any way by, for example, removing representations of language and expression. This was done in order to minimise the possibility of the words not being considered genuine, risking the possibility of the findings not being considered accurate.

I also wanted to make clear the purpose and basis for my selection. On the whole, these were chosen to illustrate the main arguments generated from the literature review. Others, however, particularly those in phase 2, were included to specifically illustrate how wound care nurses understand and experience the world and establish differences and similarities in their views and experiences. Examples of statements containing 'emojis' and expressive punctuation, including question and exclamation marks, also merited inclusion to illustrate their expression of strong views and explanations of feelings, bringing a new dimension to the findings through latent content analysis, as explained in Chapter 5.

Access and Ethical Considerations

As a registrant of the nursing professional body, the NMC, I carried out the study in accordance with its professional standards of practice and behaviour (Nursing and Midwifery Council, 2015). Despite this research not involving provision of direct care to individuals, groups or communities, I nevertheless adhered to the NMC's standards of conduct and behaviour in prioritising people, practising effectively, preserving safety and promoting professionalism and trust, bringing my professional knowledge to bear to produce an ethical education research design.

The decisions I took to ensure that I conducted safe and ethical educational research represented a natural extension of the ethical principles for professional nursing practice: autonomy, beneficence, non-maleficence, accountability, fidelity, veracity and justice. My decisions considered research ethics guidance published by the RCN, the UK's largest professional body and nursing union (Royal College of Nursing, 2009). The study satisfied the university's ethics committee requirements and I took steps to describe the objectives of the study in the Participant Information Sheet (PIS) to ensure that I did not deceive participants about the research and its purposes.

As the CDA in phase 1 was text based, only phase 2, the DCA, and phase 3, the online DD, raised potential ethical questions relating to informed consent, confidentiality, data protection and the right to withdraw. These are discussed below.

Informed Consent

Phase 3

Information about the study and consent form was contained in the PIS. Students studying on the module at the time of the research were invited to participate in phase 3 in the online DD. A timeframe was provided for them to consider whether to take part along with contact details of an independent contact to whom they could address any questions, so as to avoid coercion.

The PIS explained what the research was about, the purposes of the research, the nature of their involvement in the research, how long their participation would take, that their participation was voluntary and that they could withdraw at any time. Information was also provided about what would happen to the data and that their privacy would not be violated, particularly in connection with using online technology and how this might impact on anonymity.

Confidentiality

Phase 2

As a result of the retrospective nature of the DCA of the online discussion posts in phase 2, maintaining confidentiality called for a new way of thinking. Collecting non-reactive data without asking for it can raise serious ethical questions (Janetzko, 2008) and represents hidden data collection, which might be considered a breach of

privacy, but only if this links non-reactive data to reactive data (e.g. names) such that data becomes personally identifiable.

The online data collection tools available to me provided me with a unique opportunity to collect non-reactive data and a lens through which to investigate phenomena not usually accessible using other methods, while preserving the privacy of participants. In order for me to access this rarely obtained data, while preserving participant anonymity, I devised an anonymised coding system that was only available to me.

Phase 3

As a consequence of the overt nature of the discussions in phase 3, participants were asked to respect confidentiality in line with the NMC regulatory Code of Conduct (Nursing and Midwifery Council, 2015). Pseudonyms were used for mentioning patients, colleagues or their employers, and I then coded these further. Once the data was collected, I took steps to ensure that the names of the research participants and their organisations were not identifiable.

Data Protection

All data and analysis procedures, including the anonymising coding decisions, were held on the research institution's secure server, accessible only by me.

Phase 2

I sought advice from my institution's legal services team regarding recruiting students to the study online and on matters of online data protection. Recital 26 of the General Data Protection Regulation (GDPR) (Privazy Plan, 2018) states that as long as data is anonymised to the extent where no individual can be identified, GDPR does not apply. I was therefore confident that the mechanisms to anonymise the data, as described, complied with this requirement.

Phase 3

Although I would have preferred a more representative sample of the student population, to comply with GDPR (Information Commissioner's Office, 2018) in phase 3, recruitment to this phase of the study had to be limited to those students who were currently studying on the module and who could be invited to participate via their live university e-mail accounts.

The GDPR restrictions meant that I was unable to contact former students using their personal e-mail addresses as this could be challenged on the basis that it did not represent fair or lawful processing – i.e. students would not expect their personal e-mail addresses to be used for this purpose. While I could have relied on justifying a legitimate interest for doing this, this could also be challenged as I would have to show that interest in carrying out the research was not detrimental to the rights of students not to be contacted when they had not consented to this.

For the purposes of potential follow-up research, participants were given the option to consent to being contacted by the researcher to participate in future wound care-related studies. All participants agreed to do this.

Right to Withdraw

Phase 3

As I was the research participants' academic referee and assignment marker, I addressed the power imbalance in the researcher–researched relationship. The PIS therefore stated that students could decline to participate or withdraw at any time and this would not prejudice their current or future studies at UWS.

As a result of the advocacy-participatory nature of the study, it was important that I took steps that minimised the distance and separateness (Guba & Lincoln, 1988) of our relationship and that would create an anti-authoritarian atmosphere to help minimise any existing 'superior' and 'inferior' knowledge positions. In addition, I did not want to reduce my students to 'objects of research' (Tolbert, Schindel, & Rodriguez, 2018) and found that using critical researcher reflexivity, a practice that embraces subjective understandings of reality as a basis for thinking more critically about the impact of my assumptions, values and action on others (Cunliffe, 2004, 2016), developed a more collaborative and responsive relationship with the participants and encouraged a more thoughtful and analytic self-awareness of my own experiences, reasoning and overall impact throughout the study.

Potential Benefits and Potential Harm

Phase 3

Although participants were not expected to experience any harm or benefit from taking part in the study, to reduce any personal or professional inconvenience, it was made apparent to them that their involvement was expected to be over the course of several weeks. The PIS stated that, despite them not benefiting in any way, their participation would benefit future students.

Nursing Education Research Ethics versus Nursing Research Ethics – A Reflection

My experience is that ethical considerations when undertaking nursing ***education*** research are different from those involved in nursing research. Compared with how prepared I felt in my previous clinical experience, I was not prepared for how my familiarity with the different research methods would increase during the study. This changed my choice of data collection tool and meant going back to the research ethics committee for approval to amend my original idea of conducting one-to-one online interviews as part of a more collaborative approach using DD in phase 3. This was far more of an iterative process, which I was not used to, and, on reflection, I should have sought ethics approval in phases to accommodate for my improved understanding of research methods and thus better address the research problem.

This chapter explains that this research is positioned through a prism of social constructivism and an advocacy-participatory approach, and that a bricolage methodology was used to construct a sequential integrated multi-method three-

phase research design, with each phase addressing the respective research objectives of the role of policy, practice and research participants in how Benner's theory is currently understood. It details that each phase is interdependent with the findings from the previous phase and thus informs the next discovery phase. The first phase involves a CDA, the second a DCA, and the third a DD. How research quality issues were addressed is outlined, with particular reference to trustworthiness and authenticity, as well as access and ethical considerations.

Organisation of the Research Methodology

Each of the three research phases is now considered separately in Chapters 4 to 6 using the following approximate format:

introduction and justification for choice of research method

data handling

analysis

results

discussion

Chapter 7 concludes with a general discussion synthesising the main findings from each phase, considers the study limitations and concludes by setting out the implications of the study findings and making recommendations for future research.

CHAPTER 4: PHASE 1 – CDA

Research Objective 1: Explore the effect of policy on Benner's theory in higher education wound care curriculum development.

Introduction

The CDA explicitly addresses the first research objective, which is to explore the effect of policy on Benner's theory. This is because the evident influence of healthcare policy on progression from 'novice to expert' in contemporary wound care learning and teaching strategies and curriculum development is not represented. Contemporary wound care learning and teaching strategies, informed by Benner's model, assume that there is linear progression from 'novice to expert' throughout a wound care career, driven solely by the individual. Healthcare policy plays an increasingly powerful role in shaping the nature of wound care work and what it means to be a 'novice' or an 'expert' in this field. Benner's linear model does not account for this external force. Nor does it acknowledge the multiple ways in which policy can drive, restrict, distort or stall career progression.

In this chapter, I explain that CDA has no standard methodology. My CDA develops as an elaborate and detailed process, which I believe to be the legacy of my own formal and systematic experience of evidence-based nursing practice and clinical decision making. In addition to outlining the justification for my choice of CDA, I explain the data handling processes, including the rationale for document selection and the coding procedure used to develop a three-pillar framework, which distinguishes the various discourse macro- and micro-structures found in the documents. Four constructs and associated sub-constructs – 'Aspiration and

Resolution'; 'Ambiguity or Opportunity?'; 'Responsibility without Accountability'; 'The Public Face of the Regulator' – are then identified and analysed using Faircloughs' (1989) well-known 'description, interpretation, explanation' framework to identify the implications of policy for wound care nursing education and practice.

Justification for CDA

In this section, I explore the theoretical underpinnings of CDA to demonstrate its status as the most suitable choice of research method to address the research objective.

CDA is a 'problem-oriented interdisciplinary research movement, subsuming a variety of approaches, each with different theoretical models, research methods and agendas' (Fairclough, Mulderrig, & Wodak, 2011, p. 357). CDA is discipline- and context-specific (Weiss & Wodak, 2003) and emphasises the way in which language is drawn into matters such as power and ideology, which control how language is used, its effect, and how it reflects, serves and advances the interests, positions, views and values of those in power. From a CDA position, discourse preserves social patterns such as authority, discrimination, exploitation, dehumanisation, naturalisation (ideologically driven) 'common sense', unless its usually hidden effects are exposed so that awareness, resistance, emancipation and social action can bring about social change and social justice (Waugh, Catalano, Al Masaeed, Do, & Renigar, 2016).

It is important at this stage in the thesis to highlight that, unlike most research methods, CDA is not a single methodology or a fixed method. Instead, each methodological approach to CDA is grounded within a theoretical framework in relation to the nature of discourse and the relationships between discourse, knowledge and power (Potter & Wetherell, 1987; Wodak & Meyer, 2001). This freedom provided me with a degree of flexibility in its application, particularly suited to the bricolage approach.

Chapter 2 demonstrated that Benner's theory does not account for the difficulties and tensions that exist in wound care nursing policy or indeed for how the unseen motives of institutions during times of political and organisational change described by Lewis (2002) and Sokro (2012), for example, impact its application in higher education. As seen in Chapter 2, Flanagan (2005) offers a unique and mostly underrated perspective identifying that institutional and professional rivalry exists within the wound care fraternity and signposting this as a primary obstacle in delivering effective education. King (2014) recommends that, in order to understand and modify perceptions of competitive rivalry, it is important that the internal and external climate in an organisation is considered and I believe CDA allows for this.

A further incentive for adopting CDA incorporated Snelling's (2017) observations from his critical 'close reading' of the NMC Code of Conduct (Nursing and Midwifery Council, 2015), discussed in Chapter 2. Using extracts of policy discourse to demonstrate that its text is manipulated, thus making meaning more ambiguous,

Snelling concluded that this generates problems with interpretation and implementation in nursing practice. While uncertainty also arguably equips nurses with more autonomy, the preceding literature demonstrates that the scope of practice in wound care nursing is already very unclear. I was keen to develop Snelling's largely overlooked observations to explore how policy discourse processes might contribute to policy not being enacted as well as it ought to.

I consider Benner's theory through this CDA lens by crically examining the political, social and economic power relations that exist in key regulatory government and commercial and professional wound care-related discourses where text and visual communication methods are explored. As CDA is fundamentally a socially committed scientific paradigm addressing social problems that are problem oriented (Fairclough & Wodak, 1997), I chose this research method because it aligned with my own advocacy and participatory stance.

As a nurse whose professional education was founded on a systematic and structured evidence-based approach to scientific enquiry (A. Mackey & Bassendowski, 2017; Malloch & Porter-O'Grady, 2010; K. M. White, Dudley-Brown, & Terhaar, 2019), I felt particularly out of my depth using CDA as a research method because it is unfamiliar in nursing research (Evans-Agnew, Johnson, Liu, & Boutain, 2016). However, I was resigned to the idea that my own advocacy-participatory ontology, previously explained in Chapter 3, needed my research methods to be intertwined with a

political agenda and to contain an action agenda for reform that would potentially change the lives of students and the way in which I worked.

Strategies to Address Critics of CDA

CDA has attracted significant criticism over its inexact approach. Throughout the CDA design in this phase, I have therefore made a significant effort to mitigate this. Most of the criticism relates to the transparency of its methodological shortcomings, incorporating 'the level of how the data are actually obtained, and how they are subsequently interpreted' (Breeze, 2011, p. 503), which is particularly problematic. To re-dress these concerns, I constructed a bespoke three-pillar framework (Figure 8) to visibly demonstrate and justify the logic behind the decision-making steps I took throughout the analysis and included a detailed systematic account of the rationale behind the five policy documents included in the analysis (Table 3). In response to Breeze's further concerns over interpretation, I also detail the precise nature of how the coding system was created from a deconstruction of the discourse and how this data was then grouped conceptually into four underpinning constructs – 'Aspiration and Resolution'; 'Ambiguity or Opportunity?'; 'Responsibility without Accountability'; 'The Public Face of the Regulator' (Appendix C) – informing the final analysis.

In her in-depth analysis of the various critiques of CDA and its practitioners over the last 20 years, Breeze also criticises CDA for its lack of cohesion, as well as indiscriminately mixing incompatible concepts and applying random methods. For this reason, after sampling the policies and data collection, I provide a 'chain of evidence' using a process of 'chronicling' to help clarify to the reader how I move

from data to obtaining the results. As concepts do not just emerge from the data – 'they are created and imbued with meaning by researchers based on particular analytical processes and decisions' (Greckhamer & Cilesiz, 2014, p. 430) – I make these links between the data and results explicit.

The CDA findings from this phase subsequently inform and integrate with the practice focus of the research objective in phase 2 and move the reader from an understanding of how policy informs wound care practice. The findings and recommendations from phase 2 are then, in turn, subjected to student deliberation in phase 3 to understand the role of the student voice in wound care curriculum development. Lastly, Benner's model is adapted to represent the influences of policy, practice and student participation in each phase.

Data Handling Process

CDA is essentially an explanatory, interpretive and descriptive process of deconstructing reading and has no unitary theoretical framework or specific guidelines to follow. Despite my earlier reservations over this indistinctiveness, highlighted earlier in this chapter, I decided to capitalise on the flexibility it afforded and chose instead to adopt a variety of positions derived from my own advocacy and partcipatory ontology.

Similarly to the non-prescriptive 'little toolbox for constructing discourse analyses' described by Jäger (2001, p. 52), Chilton (2004), Fairclough (1992a), Manias and

Street (2000) and Rheindorf (2019), which can be adapted to researchers' own needs and tailored to fit their concerns (Schneider, 2013), I built a bespoke three-pillar analysis framework to specifically address the wound care nursing context. This format allowed me to take account of the key issues relating to professional regulation, institutional change, marketisation, power and society, with the design driven by the problem at the centre of the research objective and the discourses presented and analysed according to the power relations uncovered.

I focused first on creating a clear decision-making trail around my choice of policies for inclusion in the CDA. This is a critical component of CDA methodology because it provides underlying justification and significance of the insights offered by the analysis. From the outset of the policy selection and discourse sampling, in a similar way to more familiar nursing research methods that involve human participants, I approached the CDA process objectively, systematically treating, as Adams and Thompson (2011) suggest, each policy document and its contents as 'participants'.

As a novice CD analyst, I was pleasantly reassured to discover that, as the CDA advanced, I came across several recognised CDA nuances, the most notable being that the CDA data collection process often shares mutual characteristics with that of grounded theory research methodology described by Glaser and Strauss (2017). I found that, rather than the data handling component comprising one distinct phase, it became an iterative process, where 'new questions always arise which can be dealt with if new data are collected or earlier data re-examined' (Strauss, 1987, p. 56).

Similarly, I found myself 'zooming in' and 'panning out', as well as focusing, re-focusing, narrowing and refining the emphasis to address the research objective instead of it being a non-repetitive one-off process.

For the purposes of this thesis, I use wound care-related policy discourse as the central concept and view the policy process not simply as text but, as Bowe, Ball, and Gold (2017) suggest, as production, reification, implementation and interpretation.

Document Selection

Fairclough suggests that texts selected for CDA should demonstrate the existence of ideology and power relationships, meaning that not all texts are eligible for analysis. Ideology is generally considered as a set of ideas or beliefs. However, CD positions ideology as 'constructions of reality…which are built into various dimensions of the forms/meanings of discursive practices, and which contribute to the production, reproduction or transformation of relations of domination' (Fairclough, 1992a, p. 87). In CDA, language is considered as one way through which ideologies are constructed, maintained and challenged, and that 'meanings are produced through interpretation of texts' (Fairclough, 1992a, pp. 88-89). Meaning is therefore not always initially forthcoming and cannot simply be 'read off'.

Adopting Fairclough's interpretation of ideology, I first identified numerous nursing and wound care-related texts representing the wound care organisational 'order of discourse' – a 'particular combination of genres, discourses and styles which

constitutes the discoursal aspect of a network of social practices' (Fairclough, 2003, p. 220).

CDA Policy Document Inclusion Criteria

With a better appreciation of CDA ideology, I reduced the original 13 policy texts identified, including websites and non-UK documents, to five UK policy texts for inclusion in the analysis. I believed this sample to be representative of those policies that best aligned with the research objective in this first phase, which was to explore the effect of policy on Benner's theory in higher education wound care curriculum development.

The sample population of relevant education policy text from government and wound care nursing professional bodies was limited and resulted in the inclusion of only two texts (Policy 1 and 2, Table 3) in the analysis. Professional body policy was important to include because individual members in these organisations practise in particular disciplines, maintaining an oversight of the knowledge, skills, conduct and practice of their professions. Given their value, this low return concerned me and led me to question whether the systematic literature database search had been sufficiently comprehensive. I validated my results with the independent investigator, described in Chapter 3, who confirmed this to be the situation. In addition to the professional body policies, a further three regulatory NMC texts, published between 2012 and 2018, were included for analysis.

Machin (2013) recommends that CD analysts provide complete and accurate descriptions of each document because this permits a more complete and accurate analysis. As shown in Table 3 below, I therefore included the social and historical context in which each of these policy documents was produced alongside the source, place, authors, date, size, publisher and location of publication for each document.

Table 3. Policy documents included in the CDA.

Table 3 Policy documents included in the CDA								
Policy number	**Policy title**	**Institution responsible**	**Historical context**	**Location of publication**	**Number of pages**	**Author**	**Publisher**	**Notes and observations**
1	**Creating Viable Options: a tool for identifying key education content areas to support progressive development in tissue viability for healthcare staff (2009).**	The tool was developed by NHS Education for Scotland, in partnership with NHS Quality Improvement Scotland, at the request of the Scottish Government.	An initial draft of the tool developed at a special workshop of tissue viability clinicians and educators was refined and amended following a process of consultation with stakeholders.	Scotland	13	NHS Education for Scotland	NHS Education Scotland	Updated in 2016 with minor revisions to layout and electronic links to resources. PDF Available on-line only.
2	**Tissue Viability Leading Change (TVLC) (2015) Competency Framework.**	The framework was developed by a small group of TVSs and academics and peer reviewed by key opinion leaders in the UK.	Its main aim is to address gaps in training and education by providing clinical competencies for staff working within a tissue viability service. It is also hoped that this programme can foster strategies to	England	70	Clinical and Academic Tissue Viability Experts	URGO Partnership	Developed with an unrestricted educational grant from a commercial medical company 'URGO Medical'.

			measure patient and service outcomes to drive clinical effectiveness.					Available only in hard copy by mail order through company website after uploading personal details.
3	**The Code. Professional standards of practice and behaviour for nurses and midwives (2015) NMC.**	Contains the professional standards that registered nurses and midwives must uphold.	Replaces the previous NMC Code of Conduct (2008).	London	18	NMC	NMC	PDF available online only.
4	**Revalidation: how to revalidate with the NMC (2016) NMC.**	Gives an overview of the revalidation process that nurses and midwives registered with the NMC have to complete every three years in order to renew their registration.	Sets out recommendations for how to approach the revalidation process and collect the required information.	London	43	NMC	NMC	PDF available online only.
5	**Future Nurse: Standards of Proficiency for**	The proficiencies specify the knowledge and	Standards set out NMC expectations regarding delivery of	London	40	NMC	NMC	PDF available online only.

	Registered Nurses (2018) NMC.	skills that registered nurses must demonstrate and apply to all NMC registered nurses and midwives.	all pre- and post-registration NMC 'approved' nursing and midwifery education programmes.					

Again, as a CDA novice, I was reassured to discover that some of the decisions I took over text inclusion were consistent with established CDA theory, where it is typical for CDA only to involve a few texts – even just one or two. These should, however, be selectively chosen to draw out aspects in the text that are not normally obvious to the casual reader and where the ideology concealed within the text becomes clear.

After policy selection, I viewed each text as a 'link in a chain of texts, reacting to, drawing in and transforming other texts' (Fairclough & Wodak, 1997, p. 262), and examined the relationship that existed between them, or their 'intertextuality' (Fairclough, 1992b) because, as Grant and Hardy (2004) and Teun A van Dijk (1987) suggest, it is meaningless to analyse them in isolation and generate related understanding in separate texts.

Morgan (2010) argues that CDA only has a relevance and practical application at any given time, in any given place and for any given people, and is context specific. To help frame the document selection in this way, I first approached the text in an uncritical neutral manner, then again with a more critical analytical approach. During these subsequent readings, I re-visited the text at different levels, raising questions about them, imagining how they could have been constructed differently, and mentally comparing them to related texts, I became aware of something within the NMC texts akin to what Fairclough describes as a 'moment of crisis'. Such 'moments' constitute a key element of CDA theory because as Fairclough indicates, they 'make visible aspects of practices which might normally be naturalized, and therefore

difficult to notice; but they also show change in process, the actual ways in which people deal with the problematization of practices' (Fairclough, 1992a, p. 230). I was unsure at this early stage of the analysis what constituted this 'moment of crisis'. However, in light of Fairclough's seminal work, I believed this observation to be a discourse response to a kind of major event in which the NMC was involved.

I became aware of this 'moment of crisis' during the elimination process of reducing the original 13 policies to five when I had a sense that, compared with the previous decade or so, there had been a noticeable increase in frequency and number of NMC policies published within the comparatively relative short period of time between 2012 and 2018. I also noticed some obvious changes to the tone, content and style of the discourse between those published in the first decade and those in the second (Figure 7), with more use of the conditional mood, a decrease in the definition of a number of commonly used terms, the bizarre appearance of juvenile cartoon-like imagery, visible changes to the format, font and layout, and an increased emphasis on public and stakeholder involvement and their expectations of nursing standards and conduct. I considered this perceived shift in discourse to be a 'moment of crises' – a moment in the discourse where there is evidence that things are going wrong.

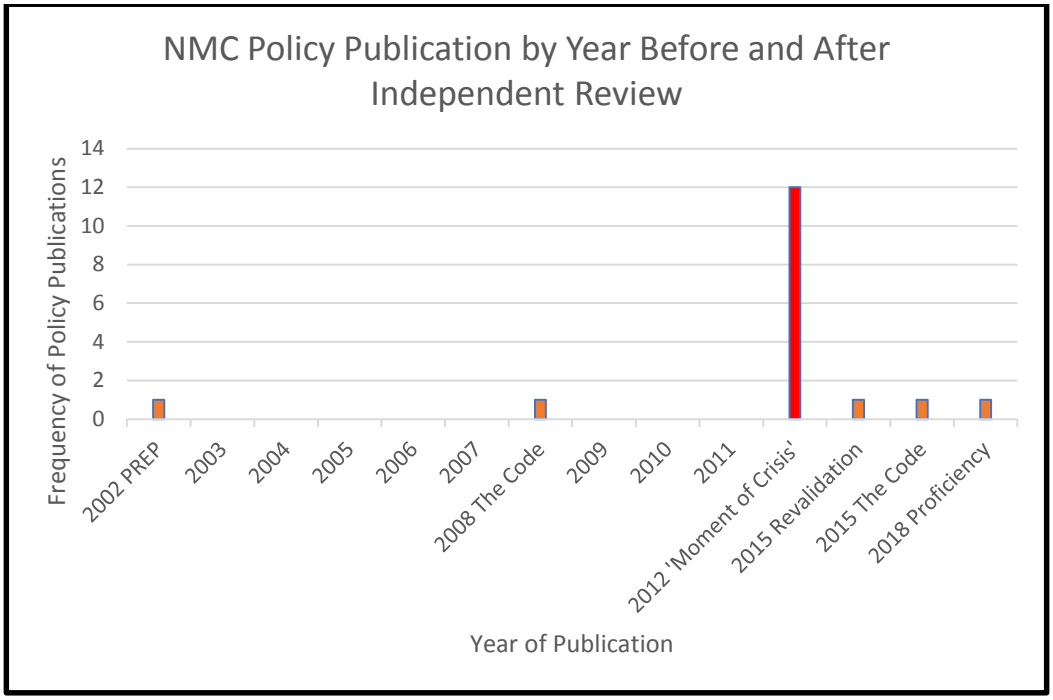


Figure 6. NMC publications before and after independent reviews.

This CDA takes place within this specific historical timeframe of political and organisational change in the NMC and is re-framed in a policy mode. Framing the research context in this way reinforces a key feature of CDA in that the 'historical context is always analysed and integrated into interpretation of discourses and texts' (Wodak & Meyer, 2001, p. 70).

The Three-Pillar Analysis Framework: Its Creation, Content, Coding and Constructs

Choice of Data Analysis Method

I explored 'NVIVO' as a software option to assist with the data analysis, but discounted this in favour of carrying out the analysis by hand because this freed me up to make decisions based on my own theoretical commitments and analytical thought processes. Although I realised that 'NVIVO' can also be used by entering codes and themes manually, it can also be restrictive because of the limited ways in which the codes and branches can be organised. On this basis, I did not believe that

the programme would be satisfactory to deal with the iterative and notoriously unpredictable nature of CDA and chose instead to develop a tabulated matrix using Word (Appendix C) to satisfy the unfolding nature of the method and various re-drafting. Strangely, I found that the hands-on and tactile nature of the analysis process, involving 'chopping and changing' notes of paper, somehow brought me closer to the data.

Building of Three-Pillar Data Analysis Framework – A Greckhammer's Hybrid

Greckhammer argues that, 'owing to its interpretative nature, discourse analyses may be challenged on the basis of how conclusions were reached based on specific data' (Greckhamer & Cilesiz, 2014, p. 431). These reservations resonated with me because, as explained earlier, my nursing practice has always been directed by evidence-based medicine, placing emphasis on the use of evidence from well-designed and well-conducted research, meaning that building a framework to make links between data, analysis and conclusions transparent by using a tabulated discourse analysis process (Appendix C), similar to that suggested by Greckhammer, appealed to me. This matrix format also shows how data 'anchors' (text excerpts) connect to data units (specific points of reasoning or concepts), then to constructs and supporting sub-constructs. This chronicling process involved multiple cycles and, although the framework appears to represent a linear process of moving from the data to the constructs, like any representation, it is an over-simplification of the analysis process. However, it shows enough to convey the logic of my interpretations and the analysis process.

Greckhammer's framework proved invaluable in helping to organise my thinking. Nonetheless, it is only configured for written text. During this iterative process, the format became restrictive because it did not satisfy the unexpected addition of visual imagery to the analysis. I modified the framework to accommodate this addition, and, in doing so, moved the analysis from a solely text-based analysis to a multi-modal CDA (Kress & Van Leeuwen, 1996; Machin, 2013; Machin & Mayr, 2012). Although I found incorporating this unexpected feature inconvenient, I was nevertheless intrigued to understand how, by turning data images into evidence (Denzin & Lincoln, 2008; Gershman & Thompson, 2018), these bizarre images affected policy, and how they worked to create meaning next to the accompanying policy text. I also thought that they showed promise, adding a novel perspective to the research context.

As explained, from the outset, I viewed each text as a 'link in a chain of texts' (Fairclough & Wodak, 1997, p. 262) that reacted to, drew upon and transformed other texts. I also considered intertextuality – the relationship that existed between the policies. During the reading cycles, the policy discourses contained within Policies 1 and 2 did not appear to gel naturally with the other NMC regulatory texts (Policies 3–5) in the way that intertextuality suggests. Instead, Policies 1 and 2 exhibited similarity in their overall large-scale macro-structures, relating to the processes through which each was produced. In contrast, Policies 3 to 5 steered me naturally towards a more detailed inspection of the text micro-structures (T. A van Dijk, 2019), prompting me to focus on local meaning through an analysis of different linguistic

and visual semiotic characteristics. This divergence is presented using the three-pillar framework in Figure 8 below.

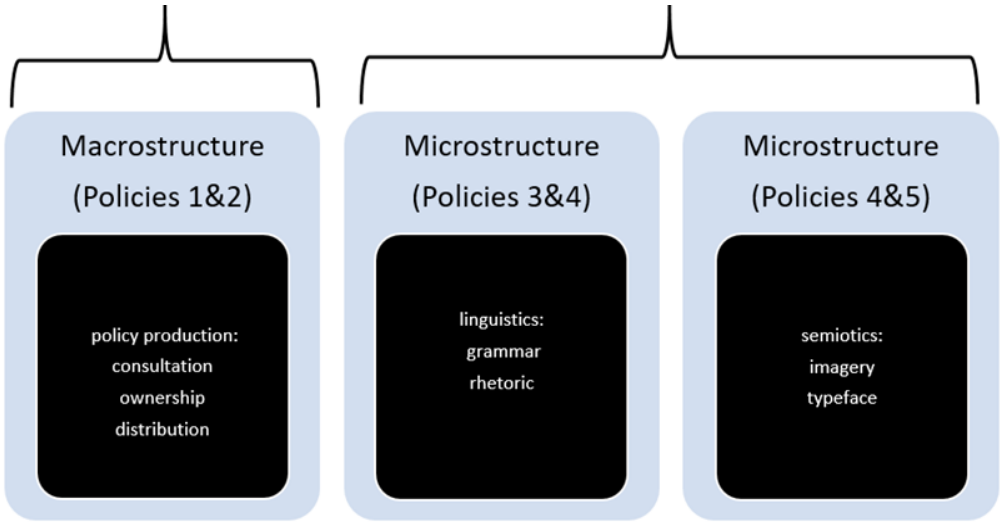


Figure 7. Three-pillar framework showing categorisation of policy to be included in CDA by the macrostructure and microstructure characteristics seen.

After critiquing numerous cycles of the policy's discourses and seeing concepts emerge, as in the approach taken by Greckhammer, I developed a rubric (Appendix C). The five rows were numbered according to the policies in Table 3 and the six columns labelled as follows:

- policy number
- policy name
- data unit in context
- data unit
- concept
- construct (including sub-constructs)

The cells were then populated with the associated data, and I identified the working concepts and generated constructs using the coding process outlined below (Appendix C).

Process of Coding Text Data

After categorising the policies according to their macro- or micro-structure, as shown in Figure 8, I started the coding process.

After several 'analysis revolutions', or cycles of independent analysis involving identifying, verifying and refining (by means of merging, splitting, changing and adding), I identified separate 'data units', which I then conceptualised. To help create congruence with the research background and research question, I included the original context from which the data units were extracted (Appendix C).

Table 4. Extract of CDA rubric (based on Greckhamer and Cilesiz (2014) framework).

No	Policy	Data Unit in Context	Data Unit	Concept	Construct (Sub construct)
1	**Creating Viable Options** **NHS Education for Scotland** **2009**	The tool aims to provide organisations and individuals with guidance on preparing education and development programmes on tissue viability or a wide range of healthcare staff and other such as volunteer workers and carers. It sets out key content areas for education to support progressive development in tissue viability expertise for healthcare staff as they progress through their careers	**It sets out key content areas for education to support progressive development in tissue viability expertise for healthcare staff as they progress through their careers**	Definitive wound care content and flexible progression framework proposed.	**ASPIRATION AND RESOLUTION** (addresses ambiguity, minimises personal interpretation, reduces vulnerability in professional decision making, supports progressive development, enhances expertise, improves accountability)

Creating Constructs from Discourse

Through the process of identifying the 'data units' and the general concepts they represented, I classified similarities before categorising these into four over-arching constructs: 'Aspiration and Resolution'; 'Ambiguity or Opportunity?'; Responsibility without Accountability'; 'The Public Face of the Regulator', and their sub-constructs (Table 5), which were subsequently used as the basis of the CDA discussion that follows and as a mechanism to direct the integration of phase 1 with the research method and data collection tool used in phase 2.

Table 5. Over-arching constructs identified from the policy discourse.

CONSTRUCT	SUB-CONSTRUCT
Aspiration and Resolution	recognition; ownership; intent; collaboration; consultation; distribution; sanctions; variation
Ambiguity or Opportunity?	variation and role ambiguity; inconsistency in implementation; personal interpretation; professional liability; professional vulnerability; ambiguous personal decision-making
Responsibility without Accountability	non-enforceable; hierarchical power relationship; professional exposure; dominance, power and control; quality control of education; no guarantees; professional liability; role ambiguity
The Public Face of the Regulator	burden of obligation; public image; regulator as ally; re-gain public confidence

CDA

Introduction

The analyses of the four constructs identified in the previous section – Aspiration and Resolution; Ambiguity or Opportunity?; Responsibility without Accountability; and The Public Face of the Regulator – are addressed in turn in this section. I used Fairclough's CDA framework (Fairclough, 1989), which consists of three inter-related processes of analysis, each tied to three inter-related dimensions of discourse as follows:

1. Object of analysis (including verbal, visual or verbal and visual texts)
2. Processes by means of which the object is produced and received (writing/speaking/designing and reading/listening/viewing) by human subjects
3. Socio-historical conditions which govern these processes

Each dimension requires a different kind of analysis: 1. text analysis (description); 2. processing analysis (interpretation); 3. social analysis (explanation). These different kinds of analysis are briefly outlined below.

<u>1. Text (Description)</u>

The descriptive stage is concerned with formal properties of text and is used to explore its linguistic features. With the exception of Pillar 1, the focus of which was primarily on policy macro-structures, in Pillars 2 and 3, I systematically analysed recognised linguistic features including pronoun use, modality, nominalisation, vocabulary, grammar and text structure, and the extent to which language used

appeared correct, clear or manipulative. This was the first step in which text became the object.

2. (Discursive Practice) Interpretation

In this stage, I examined the relationship between the discourse, its production and its consumption, and asked myself questions about the ways in which language was used – for example: 'what does this pronoun mean?'; 'what is it being used to achieve?'; 'is it being used in a positive or negative way?' This went beyond a simple reading of what was in the text, as my interpretation of discursive practice was informed by my personal interpretive procedures.

I also analysed policy 'intertextuality' to explore the inter-textual relations between the discourse, texts and settings, and considered how factors relating to how people produce and interpret discourse (Fairclough, 1995), including how text sources and reporting mechanisms might affect Benner's theory.

3. Social Practice (Explanation)

In this final stage, I asked why wound care nursing is represented in particular ways and what consequences this could have for the discipline and practitioners. This stage aims to represent the discourse 'as part of a social process, showing how it is determined by social structures and what reproductive effects discourses can cumulatively have on these structures, sustaining them or changing them'

(Fairclough, 1995, p. 163). At this stage, I considered factors such as ideology and power to explain the interaction between social and cultural context and the production and consumption of the texts.

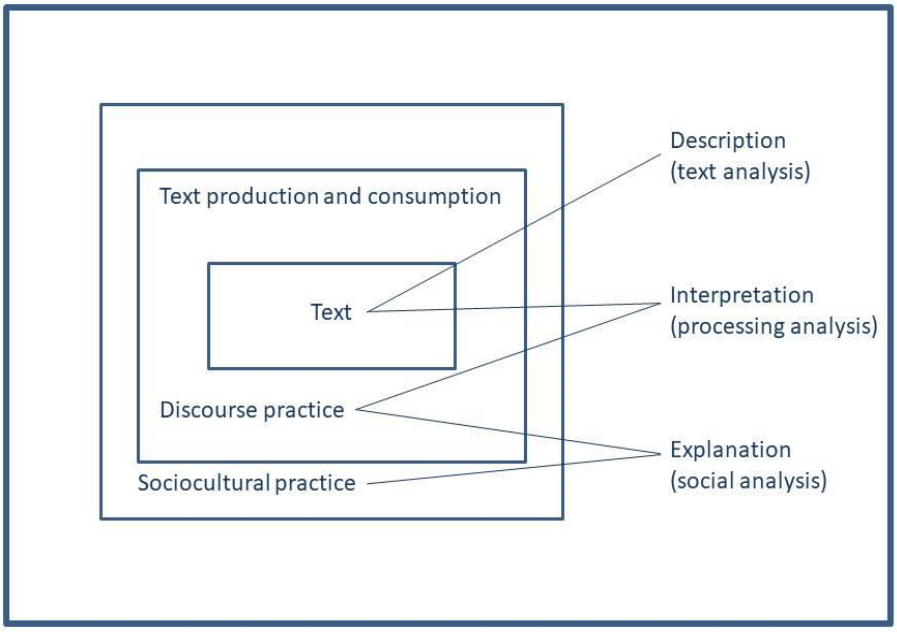


Figure 8. Fairclough's CDA framework (from Locke, 2004, p. 42).

I found Fairclough's approach useful because it provides multiple points of analytic entry and it makes no difference which kind of analysis the researcher begins with as long as all the dimensions are included and shown to be mutually explanatory. What is important is that the interconnections, patterns and disjointedness are described, interpreted and explained (Janks, 1997).

1. 'Aspiration and Resolution'

DESCRIPTION

This construct considers the consultation, ownership and distribution features of the policy production macro-structures – those processes involved in the creation of a text (Fairclough, 1989) – as seen in Figure 10.

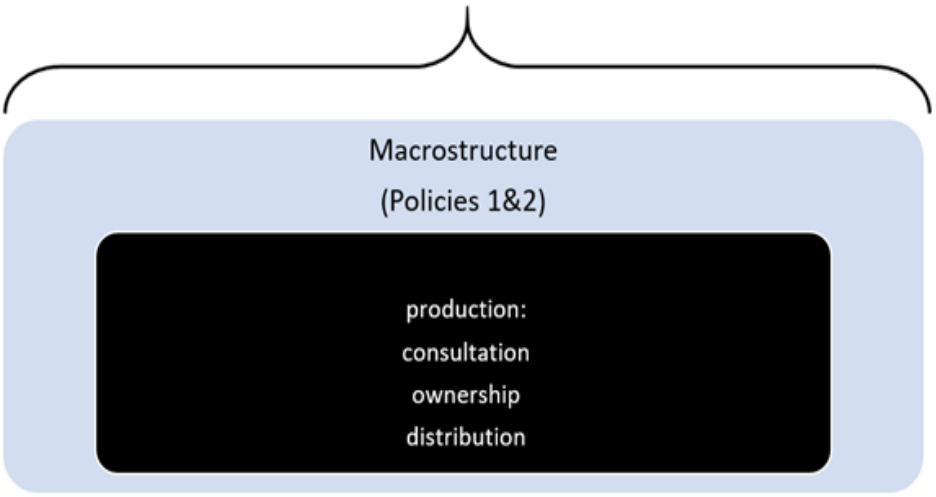


Figure 9. Pillar 1 – CDA of wound care policy production macro-structures.

I defined policy as 'courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system' (Buse et al., 2005, p. 6). In this context, policy can be made within government, by non-government actors and by organisations external to the health system (Walt & Gilson, 1994), and has an impact on health. My rationale for exploring policy production in particular was to understand how a policy's discursive practices – 'processes of text production, distribution and consumption' (Fairclough, 1992a, p. 78) – might be complicit in creating apparent power relations and inequity between policy producers and wound care educators and wound care nurses.

Controlling how these relationships are created asserts power through their use of language. Like Snelling's (2017) already outlined thoughts regarding the ways in which the NMC has used discourse to create ambiguity, thus altering accountability, this perspective also helps advance Flanagan's earlier unheeded suggestion that organisational and inter-professional rivalry are significant obstacles to reaching much-needed consensus in wound care education.

In CDA, discursive practices are thought of as 'social practices' – bodies of structured, usually institutionalised, activities that are mediated through language. I therefore considered the particular economic, political and institutional settings where wound care discourse is generated, such as government, professional bodies and regulatory social structures, alongside their conventions. To understand the meaning of actions as a whole, how parts related to one another and general models of textual development, I used the following macro-structures:

- Under what circumstances were the texts produced?
- Who produced them?
- For what purposes were they produced?
- What constraints were placed on text production?

1. Under what circumstances were the texts produced?

Only one government and one professional body policy text (Policies 1 and 2) were identified. At the time of selecting the Policy 1, Creating Viable Options – a tool for identifying key education content areas to support progressive development in tissue

viability for healthcare staff – was fairly outdated, but has, during the course of this research, since been revised with very minor amendments (NHS Education for Scotland [NES], Published July 2009. Updated October 2015). The low number of texts identified was peculiar because it was at odds with the escalating economic and public health concerns discussed in Chapter 2.

The origins and implementation of these policies were arguably determined by and dependent on the agenda priorities of their producers. In Policy 1, for example, tissue viability was identified as a priority. However, a closer inspection of the circumstances under which it was produced show that this emphasis was more of a 'one-off' event, with wound care only one component of a wider strategic government quality improvement initiative taking place at the time. Extant today, with only minor amendments in 2015, this policy remains the only credible 'go to' resource for wound care educators and practitioners in Scotland.

The presence of industry in wound care education in Policy 2 is worthwhile to note because it re-appears in phase 2. Production of Policy 2 – Tissue Viability Leading Change (TVLC) Competency Framework (URGO Partnership, 2015), – was only made possible as a result of private investment, because of 'an unrestricted commercial educational grant and other commercial sponsorship', (URGO Partnership, 2015, p. 7), and not through the allocation of public funding for wound care. This observation is reminiscent of the pharmaceutical industry some years ago, where nurses became a consumer target for a powerful industry and, arguably, wound care might be

entering a similar realm. The pharmaceutical industry was widely criticised for exploiting healthcare professionals by using a range of techniques, including sponsoring similar teaching materials and research funding.

Producers do not claim responsibility for implementation, enforcement or evaluation of their policies.

2. Who produced them?

The 'acknowledgements' section in policy documents are generally not read, let alone analysed, so adopting a CD perspective on these sections provided unique and unusual insights into policy ownership and the 'tribalism' that appears to exist, affecting policy production and enactment.

Since devolution in the late 1990s, the NHS is no longer one large body responsible for the whole of the UK – health and social care are now organised and funded by the devolved governments in Wales, Northern Ireland and Scotland. For example, in England, NHS England is the umbrella body that oversees healthcare and is an independent body, which means that the Department for Health cannot interfere directly with its decisions. Clinical Commissioning Groups (CCGs) are responsible for commissioning healthcare for their local areas. In Scotland, health services are devolved to the Scottish Government and cover 14 regional health boards across Scotland. Their role is roughly equivalent to that of CCGs in England in that they plan and deliver health services based on the needs of local communities.

A ‘top-down’ approach to instigating the wound care policy agenda in Scotland is apparent in Policy 1, as its production was instructed ‘at the request of the Scottish Government’, who then worked in partnership with NHS Quality Improvement Scotland over the production. However, the tissue viability clinicians, educators and stakeholders involved in its development are not credited anywhere for their contribution to the final document, and mention of their role is limited to the first draft. In contrast, in Policy 2 – ‘Tissue Viability Leading Change’ – acknowledgements and details of the authors and extensive list of peer reviewers are publicised, with those involved personally credited, with their job titles and employers noted.

A further interesting discrepancy can be found in the geographical representation of Policy 2. This policy commits to ‘promoting equity and transferability of expertise across the UK’ (URGO Partnership, 2015, p. 3), but the development team, with the exception of one representative from Wales, worked in England and there is no representation from Scotland or Northern Ireland. This is suggestive of the organisational and inter-professional rivalry previously witnessed by Flannagan and a tangible example of ‘tribalism’ within the wound care community. Given the extent of the unrestricted commercial educational grant made available, it is arguably remiss that this occasion was not viewed as an opportunity for much wider collaboration across the UK to enhance more widespread continuity. Similarly, in Policy 1, it is implicit that this policy was produced and promoted solely for Scottish practitioners and not considered as a UK-wide initiative.

Again, an interesting feature to note is that wound care policy was apparently developed through commercial investment.

3. For what purposes?

Both documents appear to be dependent on control over the wider nurse education agenda.

While tissue viability was high profile in Scotland in the 2008 to 2009 period, this was only as part of a wider initiative in which the tool 'was developed by NHS Education for Scotland, in partnership with NHS Quality Improvement Scotland, at the request of the Scottish Government'. Since this time, although the presentation has been updated, the content itself has not changed to any great extent.

Similarly, Policy 2 relied on the availability of the commercial interests of wound care product sponsorship at that time and it remains to be seen whether such a quality document, in terms of its content and appearance, would have occurred in the absence of these interests.

4. What constraints were placed on the production of the text?

The producers of Policies 1 and 2 do not claim to have a mandate for policy enactment or assign responsibility for its distribution and implementation to any

particular entity. The extent to which, for example, those with wound care education responsibilities working in higher education are familiar with their existence or indeed whether they have been implemented or evaluated remains unknown.

Follow-up research by Ousey, Stephenson, and Carter (2016) demonstrates a low uptake of the TVLC policy. This suggests this policy has not, for the moment at least, been adopted nationally. A growing dependence on commercial sponsorship to deliver a national wound care framework poses certain professional ethical problems, particularly when nurses are expected to trade their professional and personal data in exchange for access to vital knowledge.

INTERPRETATION

NHS Education Scotland and the 'URGO Partnership' have in common a 'shared knowledge' about the world they inhabit, allowing them to work together and minimise conflict or misunderstandings. Theoretically, this position should empower policy producers to join forces and collaborate, but wound care education remains fragmented.

A lack of control is evident over ability to prioritise wound care as an agenda item and there is an absence of accountability for policy enactment, both fundamental reasons for fragmented wound care education provision. Producers have arguably proliferated policy as and when it has suited them. However, access by practitioners to such vital learning resources and essential knowledge is lost because producers

cannot, or perhaps do not wish to, legislate for its enactment and implementation. They abdicate responsibility and leave the outcome to fate, hence, aspiration and resolution.

Nonetheless, there are several examples where semantic evidence supports the ambitious intentions of both policy producers. In Policy 2, for example, the subjunctive mood is used extensively throughout. This is a linguistic technique used to explore the conditional or imaginary using indicative verbs (Table 6) to convey a hypothetical situation and a mood of hope and aspiration, not one of action, accountability or attainment. In this instance, 'hoping' conjures up in the mood of those reading the policy a certain sense of abdication of any responsibility by the producers for its production so that the policy comes across as almost 'released', implemented at the mercy of current circumstances in education and practice.

Table 6. Examples of the subjunctive mood used in policy to convey hope and aspiration.

Subjunctive mood	'It is **hoped** that this framework can be used to identify and measure skills and knowledge' 'It is **hoped** that application of this framework will facilitate national benchmarking'

Furthermore, rather than policy supporting the preferred standardised approach evident in the background literature, this ambition is undermined because its content is described as 'non-prescriptive', 'subject to local variation' and for 'personal interpretation'.

This knowledge and practice gulf between policy production and its implementation generates significant confusion around wound care nurses' precise scope of practice, in turn compromising their professional accountability and fitness to practice. The power imbalance between policy producers, who arguably take no responsibility for enactment, and nurses, who are expected to access, interpret and implement policy, is unfair and unjust.

In CDA, an important factor for all discourse and communication is who controls, and changes, the topic, much the same as when editors decide which news topics are covered in the media. Considering discourse as a form of social action, the government (Policy 1) and commercial organisations (Policy 2), can permit (or refuse) topic primacy. Policy 2, for example, gives no explanation for why the pre-existing Scottish framework mentioned could not instead have been updated and rolled out across the UK, 'although the National Association of Tissue Viability Nurses in Scotland (NATVNS) has published core competencies for TV Nurses (2003), these are not used nationally across the UK' (URGO Partnership, 2015, p. 2) – or indeed why it was then necessary to initiate the commercially funded alternative.

This failure to reach national consensus on wound care education is further eroded because of the under-representation of contributors from across the country and it is worthwhile considering here Fairclough's (Fairclough, 1995, p. 1) idea of 'power', whereby people have different capacities to control how texts and thus discourses are produced, distributed and consumed. In contrast to public services, the wound

care industry, by virtue of funding, as shown in Policy 2, has demonstrated an innate capacity to own the means of production and power and is manifesting itself through the potentially insidious ownership of wound care education by bourgeois capitalist organisations (Marx, 2011). Additionally, Van Dijk (1995, p. 85) notes that 'social power and dominance are often organised and institutionalised, so as to allow more effective control and to enable routine forms of power reproduction', and suggests that the power of industry in wound care is successful because it is re-enacted in routine activities which are not questioned but instead regarded as normal.

In terms of acknowledgements, it is also worthwhile considering if there are ideological reasons why, unlike in Policy 2, the names and positions of those directly involved in the NHS policy consultation and production process are omitted in Policy 1. While some exclusions are 'innocent' in that they are details that readers are assumed to know already, like Van Leeuwen (1996), I suggest that exclusion in this way, where particular social actors do not appear in a text, helps to obscure or downplay responsibility for a policy, meaning that any individual or group involved in the production cannot be apportioned blame.

EXPLANATION

This final stage demonstrates how the wound care discourse is influenced by social structures and shows the reproductive effects of the discourse on perpetuating or changing such structures.

To summarise, four factors, explained below, relate to the production of wound care policy: agenda sovereignty, control over access to knowledge, enactment impotence and author accountability, and marketisation of wound care education. All of these have the effect of disrupting Benner's theory, as this applies to the context of wound care education.

1. Agenda Sovereignty

Dominance over the wound care education and practice agenda is top-down – policy production is regulated by government and commercial agenda interests.

2. Control Over Access to Knowledge

'Access' relating to CDA is concerned with who has access to certain types of discourse or role and thus control over the access of other people. Access is therefore strongly related to power and certain roles afford more access than others (Teun A van Dijk, 1995). For example, selection and representation of review members, timings of policy production and choice of corporate investors all concern control of access.

Access (or lack of it) therefore plays an important role in reinforcing existing power relations between recognised formal government and corporate organisations and wound care nurses. Lack of access to policies and their enactment is the greatest concern here and the situation is perpetuated where the dominated group (wound

care nurses), rather than resisting or condoning the situation, accept and comply with the status quo, legitimising the power and even finding it 'natural'.

'Trading' personal data in exchange for accessing valuable educational resources funded by commerce creates potential professional ethical issues. However, given the current restrictions of employer funding for CPD wound care education (Ousey, 2016), such commercial interest adds weight to the tripartite partnership model previously suggested by Fletcher and Ousey (2010a) and Watret (2005) of practice, education and industry, because it offers a potentially pragmatic solution to the current deficit in wound care education delivery and a model for the future.

3. Enactment Impotence and Author Accountability

Policy producers have no mandate to legislate for wound care policy enactment and can also avoid accountability through anonymity. The upshot of this impotence is a dilution of current efforts to standardise the wound care education curriculum. Policy content is often instead reduced to mere suggestion and recommendation and is thus non-prescriptive and subject to local interpretation, meaning that the existing structure of inequity and ambiguity is perpetuated.

4. Marketisation of Wound Care Education

The growing 'consumption' of wound care education as a good or service is apparent. Collectively referred to as commodities, consumption is a key aspect of modern

capitalism, consistent with Fairclough's (1989) conditions relating to the rise of consumerism and including economic conditions such as the ability to produce large varieties of commodity in large quantities and technological conditions, as demonstrated, for example, in the plentiful availability of Policy 2 to wound care nurses across the UK. Advertising discourses are also essential to consumerism and these are apparent in the flyleaf of Policy 2 in the form of the company logos belonging to the main and lesser associated investors, pervading the context of education. For example, the charitable organisation, the Wound Care Alliance UK, is also supported by 'URGO Medical', the main funding sponsor.

While the creep of such capitalism, the system of economics that emphasises private ownership, might currently be regarded sceptically in nurse education as a whole, capitalism represents free markets, choice, competition and entrepreneurship to the wound care education market and could promote economic growth and freedom, as described by John Maynard Keynes (Keynes, Moggridge, & Johnson, 1971) and Adam Smith (A. Smith, 1987). However, it should be borne in mind that this can also serve to replace, create, maintain or even exaggerate current inequalities in wound care education and practice.

Agenda sovereignty, controlling access to knowledge, enactment impotence and author accountability, and wound care education as a marketable commodity are therefore powerful factors that influence the ways in which wound care policy is

produced and enacted, serving to disrupt many assumptions on which Benner's theory of progression from 'novice to expert' originates.

2. 'Ambiguity or Opportunity?'

The first pillar explored the effects of policy production macro-structures on Benner's theory. Pillar 2 (Figure 11) analyses Policies 3 and 4 to understand how particular linguistic micro-structures might also disturb Benner's assumptions.

DESCRIPTION

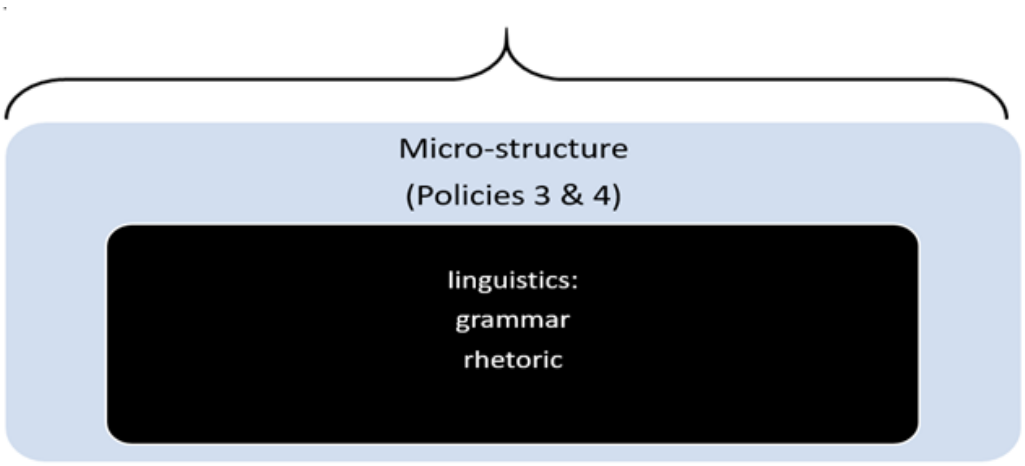


Figure 10. Pillar 2 – CDA of wound care policy linguistic micro-structures.

In this descriptive stage of Fairclough's model, the policy features of Policies 3 and 4, both NMC policies relating to the general principles of professional conduct, accountability and fitness to practice, are described without making value judgements.

The most obvious observation is the complete absence in these policies of descriptions of the meaning of numerous essential words on which professional nursing practice is based, with 'accountability', 'conduct', 'professionalism', 'standards', 'competence', 'proficiency' and 'scope of practice' particularly notable. Such lack of detail is consistent with Snelling's (2017) criticisms, described in Chapter 2, when, while acknowledging that complex professional practice cannot always be fully captured by a series of statements in professional codes, unlike other UK professional healthcare regulators and nursing regulators around the world, he criticises the regulator, the NMC, for an increased lack of detailed explanatory guidance in the Code (Nursing and Midwifery Council, 2015). In line with Snelling's observations, the NMC has chosen to significantly reduce the amount of guidance and advice that it provides, meaning that nurses must make their own arrangements to interpret ambiguous clauses.

'Appropriate' and 'reasonable' were two 'keywords' occurring with unusual frequency in the policies (Appendix C), supporting this idea of increased ambiguity. Keywords do not necessarily mean high frequency, but unusual frequency when compared with a reference corpus of some kind (Scott, 1997). These featured extensively throughout, and, similarly, were not defined. I intended to calculate the 'keyness' of these words, or the frequency with which they occurred in the text relative to a reference text, using a corpus linguistic statistical technique (Gabrielatos, 2018) in order to determine their statistical significance. However, time restrictions and a limited skillset made this impractical. However, Snelling does note that

'appropriate' and its cognates appears 16 times in the NMC Code (Nursing and Midwifery Council, 2015), in contrast to only five times in the much longer Good Medical Practice (General Medical Council, 2013), also stating that there is no comparable clause in the earlier 2008 version of the Code.

In linguistics, 'appropriate' and 'reasonable' are recognised as 'floating signifiers', not pointing to any actual object or agreed upon meaning (Lévi-Strauss, 1987). It follows that such extensive use in these documents can worsen the already unclear boundaries that exist in wound care nursing.

Significant intertextuality is also evident between the documents, with Policy 2, for example, referring to Policies 1 and 3 and the latter referring back to Policies 1 and to other NMC policies outside the scope of this CDA.

INTERPRETATION

Absence of Definitions

The absence of explanation of the meaning of fundamental words has the effect of increasing uncertainty because it makes consensus in wound care difficult. In CDA, 'absence' is something that could be present in discourse but is not, often for ideological reasons (Van Leeuwen, 1995, 1996), because it makes the meaning harder to express or even think of.

Such absence is problematic because Benner's theory is based on a shared understanding of what missing words, such as 'competence' and 'proficient', mean. However, in these key regulatory policies, the meaning is vague and relies on individual nurses' interpretations. Yet defining such cultural keywords is important because cultures can be understood through the use of particular keywords, which act as signposts for their discourse, ideology or argumentation (Wierzbicka, 1999). On reflection I found it interesting to note that, despite being invested in the analysis, even I had not initially been conscious of their absence, so I can imagine that most NMC registrants would also be oblivious to their omission and assume their interpretation to be consistent with that of the regulator and peers, whatever that might be.

The challenge of noticing 'absence' is hard because the text itself is unlikely to reveal what is absent (Baker & Ellece, 2011, p. 1) and, unfortunately, time constraints precluded me from asking various analysts to examine both documents to find a range of possible perspectives on further terms that could also have been present but were not. Nevertheless, I compared these documents with the draft versions and noticed numerous instances where the glossary contents had been significantly reduced and other keywords removed.

What is missing from a text is just as important as what is in a text (Fairclough, 2013). I concluded that this use of 'absence' as a linguistic technique was a form of suppression, where terms expected to be present are absent and where the producer

counts on, if it is not mentioned, the average reader not noticing their absence and therefore not scrutinising this. These absent terms are essentially statements that express the fundamental nature of nursing practice. When used, they should enhance communication by enabling a common understanding, and failure to use them correctly could therefore result in miscommunication and errors in reasoning in wound care practices.

Keyword meanings are determined by their usage, meaning that whichever way a word is typically used is what it means. Word meaning is consequently determined by agreement or consensus. Although surrounding words, sentences, paragraphs and chapters in both texts help to constrain their meaning, this context is not enough, and it is necessary to directly specify which definition is being used and thereby remove ambiguity. 'Precising' definitions – definitions used in technical disciplines, including medicine – are often used to clarify terms with a degree of ambiguity by adding an additional constraint in a specific context. This is problematic in wound care nursing because as Lisle (2017) warns, 'an individual may be wrong about the meaning of a word, and that can lead to countless errors'. Failure to define terms and use them consistently is a leading cause of erroneous, muddled thinking and bad argumentation, resulting in increased ambiguity and opening meaning to interpretation.

These absenting linguistic strategies have the effect of exacerbating the already present ambiguity that surrounds wound care roles and responsibilities and create difficulty in translating Benner's theory to the wound care context.

The Effect of 'Open Signifiers' in Wound Care Policy Discourse

The extensive use of the open signifier 'appropriate' (Table 7 and Appendix C) aggravates the ambiguity already created by absenting definitions. Similarly to other terms used in education and health, such as 'commissioning' and 'partnership', discussed by MacKillop (2018), these signifiers are intentionally emptied of meaning and represent, or signify an impossible fullness within the discourse. First coined by Lévi-Strauss (1987) and developed by, for example, Roland Barthes (1964) and others (Hall, 1996; E Laclau, 1996), as a concept to represent an undetermined quantity of signification, in itself void of meaning and therefore suitable for receiving any meaning, they absorb, rather than emit, meaning, do not point to any actual object, and have no agreed-upon meaning, therefore helping to make ideas 'disappear'.

Table 7. Example of 'appropriate ' used as an open signifier.

Open signifier	'Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field (s) of practice'.

In wound care policy, open signifiers appear loose enough to mean many things to many nurses, yet are specific enough to stimulate action in a particular direction. This emptiness, into which policy users can pour almost any meaning or desire, is a large part of the signifiers' power, meaning that 'finding the right floating signifier can

make or break a social movement or campaign' (Smucker, n.d.). By partially fixating meaning, empty signifiers are able to link together a vast array of demands, reducing differences and thus limiting possibilities for contestation (E Laclau, 1996, 2005). I questioned why 'appropriate' and 'reasonable' had been left undefined, and also wondered what effect this vagueness achieved and whether leaving these terms 'slippery' to quantify acted as a mechanism to apportion blame onto wound care nurses when their accountability is called into question. The onus on defining meaning in the event of malpractice appears to remain with the wound care nurse.

Policy discourse practices that generate ambiguity appear to have become naturalised in wound care – 'naturalization is the royal road to common sense…in the naturalization of discourse types and the creation of common sense, discourse types actually appear to lose their ideological character' (Fairclough, 1989, p. 75) – and been accepted by NMC registrants because they originate from the dominant group. The NMC is using discourse to sustain unequal power relations between their autonomy and registrants.

Validating the 'Moment of Crisis' in Wound Care Policy Discourse

On the understanding that historical context is always analysed and integrated into interpretation of discourses and texts in CDA, I carefully reflected on the NMC's possible organisational motives in creating such ambiguity within their discourse and observed a possible link between these open signifiers with the 'moment of crisis' that I sensed when first reviewing the sample texts. 'Moments of crisis' are moments

in the discourse where evidence emerges that things are going wrong – 'such moments of crises make visible aspects of practices which might normally be naturalized, and therefore difficult to notice; but they also show change in process, the actual ways in which people deal with the problematization of practices' (Fairclough, 1992a, p. 230). I believed that two events in the NMC's recent history involving independent scrutiny over its regulatory performance were linked to this detected 'moment of crisis'. This was made apparent through these changes to the policy discourse.

First, in 2012, the Parliamentary Under Secretary of State at the Department for Health commissioned the Council for Healthcare Regulatory Excellence (CHRE) to carry out a strategic review of the NMC. This review was in response to the NMC's 'troubled history' in which a succession of Chief Executives, Chairs and Council members had 'failed to create the modern, effective and efficient regulator that the public, nurses and midwives need and deserve' (Council for Healthcare Regulatory Excellence [CHRE], 2012, p. 1). This was especially problematic because the NMC, as the regulator, is charged with protecting the public and upholding public confidence in the practice of nurses and midwives. The NMC 'has not had its sights set correctly on its core regulatory functions but it has also reacted to external demands and expectations that are themselves based on a misunderstanding of its proper role and responsibilities' (Council for Healthcare Regulatory Excellence [CHRE], 2012, p. 1).

In 2018, the Professional Standards Authority for Health and Social Care (PSA) subsequently published a further report*: '*Lessons learned review into handling by the NMC of concerns about midwives' fitness to practise at the Furness General Hospital (FGH)' (Professional Standards Authority, 2018). Set up by parliament, the PSA oversees the work of all professional regulators of healthcare in the UK and social work in England, including the NMC, and each year reviews its overall performance, assessed against the PSA's Standards of Good Regulation, reporting on this to parliament. On this occasion, the PSA had been given the remit by the Secretary of State to examine the NMC's approach to managing the complaints, its administration of the cases and its relationship management with witnesses, registrants and other key stakeholders, and asked to identify lessons which the NMC and other regulators could learn from the handling of these cases. The report, commissioned by the Secretary of State for Health and Social Care and supported by the NMC, concluded that, although the NMC's performance as a regulator was improving, it continued to make some mistakes and must develop a more respectful and open culture, identifying two key areas as priorities: the NMC's approach to the value of evidence from communication with patients and its commitment in practice to transparency.

This critical analysis of NMC policy discourse linguistic strategies sheds light on the ways in which the regulator altered its discourse practices in response to its failure to meet its own statutory regulatory requirements and the loss of public confidence, triggering the discourse 'moment of crisis'.

EXPLANATION

The object of Fairclough's explanation stage is to demonstrate discourse as part of a social process, showing how it is determined by social structures and the potential cumulative reproductive effects of discourse on these structures, sustaining them or changing them.

Hegemony

These observations are consistent with the use of other open signifiers such as 'sustainable aviation', 'entrepreneurship' and 'governance' in other studies (Griggs & Howarth, 2000, 2016; C. Jones & Spicer, 2005; Norval & Howarth, 2016; Offe, 2009), described by (MacKillop, 2018), who argues that open signifiers are used to create ambiguity during particular times of crisis where organisational practices such as relations, identities and rules are being overtly re-negotiated. In this instance, the discourse, as part of the social process, was modified by the dominant group, the NMC, to retain its respected status in relation to its regulatory function. By emptying 'appropriate' of specific meaning, it becomes 'everything' in order to represent numerous demands (Griggs & Howarth, 2000) and 'helps to organize/stabilize a field of discourse and thus hegemonize it' (MacKillop, 2018, p. 4), with the effect of shifting the onus of defining regulatory accountability onto the registrant and facilitating the organisation's response to societal criticism of its inability to perform its core regulatory functions without appearing to be unhelpful. Ernesto Laclau and Mouffe (2014) contend that employing open signifiers as a linguistic strategy is key to mobilising consent and achieving hegemony by one social group over another.

Snelling (2017) has criticised the minimalist position on the provision of NMC guidance, claiming that this leaves registrants unable to ascertain action guiding meaning from its ambiguous clauses. Despite requests from its registrants to the NMC to help understand policies by asking for greater clarity of the structure of standards and the language used within them, and for a lead on certain professional matters and production of specialist areas of guidance, the NMC's response to the recommendations made following the above reviews has been to focus chiefly on its regulatory performance. However, 'since a core part of a regulator's role is to define the standards which its registrants must adhere to, and to help them understand how those standards apply in their daily practice (Council for Healthcare Regulatory Excellence [CHRE], 2012, pp. 10-11), a need exists for more guidance rather than less, and Snelling argues that, without such guidance, the regulator is not achieving its core role.

Maintaining control over and naturalising the discourse enables the regulator to save face by retaining its power while at the same time shifting the weight of accountability on to the registrants. This contrasts starkly with other healthcare regulators, including the UK General Medical Council, the American Nurses Association Code of Ethics and the Nursing and Midwifery Board of Ireland, all of which issue comprehensive guidance on a wide range of issues and interpretative statements. Using discourse in this way concurs with Fairclough's (1989) observations on how using creative combinations of discourse can re-produce, maintain or

transform change. Here, established conventions are re-produced and maintained as dominant discourses, achieving hegemonic status over a long period of time.

Exposure to Professional Vulnerability

The ambiguity generated as a result of these various linguistic strategies helps to perpetuate the existing wound care social structure in the UK, where there is a lack of consensus over an approved education framework. Consequently, nurses must continue to judge for themselves the extent of their scope of practice and accountability, and, in the event of malpractice, be prepared to defend this and produce evidence to support it, which can be readily found through the publicly available NMC fitness to practise hearings and sanctions.

In 2018, for example, two NMC hearings took place (Nursing & Midwifery Council Fitness to Practice Committee, 2018; Nursing & Midwifery Council Fitness to Practice Committee Substantive Hearing, 2018). In one instance, 'practice orders' were issued to a registrant to mark the importance of maintaining public confidence in the profession. These sent the public and the profession a clear message about the standards of practice required of a registered nurse. Following concerns over pressure ulcer prevention and care, this registrant was required to complete a 'recognised tissue viability training course' in the prevention and management of pressure ulcers and to provide 'evidence of learning and developing practice in tissue viability care, which *may be* assisted by shadowing or mentoring by a TVN specialist' in order to develop their 'knowledge and skills in tissue viability care', and

'demonstrate a full understanding of their accountability'. Alongside the failure of the NMC to provide the registrant with a precise definition of accountability in the key policy (Nursing and Midwifery Council, 2015), these sanctions are problematic because what is construed as a 'recognised' course and what constitutes a TVN 'specialist', detailed in Chapter 2, are ongoing, contentious and still far from established.

As seen from the extracts in Table 8, a further concern relates to the 'revalidation' process, previously outlined in Chapter 2 and included as Policy 4 in the CDA, because, despite registrants being legally required to meet its requirements to practise, this does not in any way claim to prove or guarantee their fitness to practise.

Table 8. Extracts from revalidation (Nursing and Midwifery Council, 2016) to illustrate ways in which discourse is used to place the onus of accountability on the registrant.

Policy discourse that compromises professional accountability	'revalidation is not an assessment of a nurse or midwife's fitness to practise' Therefore, 'it is ***for the individual to decide what is appropriate*** education, limits of competency, expertise and knowledge' '***but the level of expertise and knowledge required will vary depending on the chosen field***(s) or practice' 'Registered nurses must therefore be able to demonstrate the ability to ***undertake these procedures at an appropriate level*** for their intended field(s) of practice'

While Benner views a lack of policy definition and ambiguity as an opportunity for autonomous decision-making, 'broad, vaguely outlined policy allows for the greatest interpretation and adaptation to changing complex contingencies' (Benner, 1984, p. 192), when discourse is used in response to institutional crisis in this and other situations, it arguably has the opposite, and undesirable, effect of shifting blame onto its registrant, ultimately compromising their accountability.

3. 'Responsibility without Accountability'

DESCRIPTION

This stage of Fairclough's model also describes the features of the selected language in Policies 3 and 4 without making value judgements. Examples of naturalisation were evident in the textual modality and lexicon micro-linguistic structures.

> Textual modality – modal verbs are types of verbs used to indicate modality, or likelihood, ability, permission, request, capacity, suggestion, order, obligation or advice, including words such as can/could, may/might, must, will/would and shall/should. Through different use of modal verbs, Policy 3 generates the imperative mood, while Policy 4 generates the conditional subjunctive mood. The use of these verbs in these legislative policies evoke very different moods.

Lexicon – the use of nouns, pronouns and personal pronouns, including 'you', 'we' and 'they', varies throughout the discourse and has important ideological consequences on how ownership of accountability is construed.

The use of the noun 'the public is particularly noteworthy because it fails to define who they are and the ideological effects of anonymisation disguise responsibility and ownership.

In this section, it is useful to be aware that, in discourse analysis, it is thought to be typical that the 'content' of the medium often blinds the reader to its character (Federman, 2004), with readers focusing on obvious content and missing structural and non-obvious changes introduced subtly or over long periods of time that can affect the message set out. McLuhan (1994) suggests therefore the medium is the message.

INTERPRETATION

The ways in which modality and lexicon strategies are used here are instrumental to how the regulator adjusts the power differential over its registrants during this 'moment of crisis' and how they are used to help restore regulatory function following criticisms following independent scrutiny.

Textual Modality

The tone of a text can be set by using specific words to convey degrees of certainty and authority and a stark contrast is apparent between Policies 3 and 4 (Table 10).

Modal verbs often highlight power inequalities and ideology. 'High' and 'low' modality can be used to indicate judgement of probabilities and obligations and signal factuality, certainty and doubt, using words such as 'can', 'may', 'should', 'would' and 'must'.

High deontic modality is a linguistic intensifying strategy created through the repetition of 'must' in Policy 3, the Code (Nursing and Midwifery Council, 2015), emphasising and re-asserting the regulator's power and capacity to take remedial action against a registrant. When used in this way, it intentionally stops the NMC being involved in the action or connected with it. The command verbs in Table 9 also reinforce this imperative mood, giving authoritative instructions with little room for debate and serving to remind the registrant of the NMC's identity and the extent of the body's power and control of knowledge over them.

Table 9. High deontic modality.

High deontic modality	make sure; respect and uphold; work in partnership; recognise; respect; pay special attention; respond; act; balance the need; make sure; keep to all; tell; share; maintain; use; take; check; be able to; keep; work; be supportive; provide; gather and reflect; deal; support; attribute; collect, treat and store; confirm, accurately assess; ask; take account; complete; explain fully; document; arrange; raise; escalate; acknowledge; protect; keep; be aware; treat; stay; refuse; never use; cooperate; meet; keep; never allow; must; treat; make sure; avoid making assumptions

Consider the contrast between high deontic modality here, used to strengthen the regulator's position of authority with the modality created through the use of 'should'

in Policy 4, Revalidation (Nursing and Midwifery Council, 2016). Despite both policies being legislative, in the intervening period between the publication of Policies 3 and 4, the change in modality used in the discourse indicates that the NMC has opted to act in a more conciliatory, advisory, supportive and collaborative capacity though its use of suggestion, choice and recommendation (Table 10).

Table 10. Low deontic modality.

Low deontic modality	our recommended approach; how to demonstrate to us; is the process that allows you to; provide you with the opportunity; to encourage a culture of; to encourage you to engage; to encourage you to stay up to date; to provide you with; revalidation should lead to improved practice; you might like to; we recommend; you may choose; it is up to you; please refer; it is likely that

This shift in tone between policies is consistent with Brown and Levinson's Politeness theory (Brown & Levinson, 1987b), which relates to how people establish and maintain social cohesion and where speakers use particular strategies to achieve successful communication. The notion of 'face' is the basis of this theory and reflects two opposite needs of a human: on one hand, a desire to be approved of and appreciated by the speaker (positive face), and, on the other, to have an independent point of view and relative freedom of opinion (negative face). Politeness is therefore understood as the ability of people to use interactive strategies depending on the communicative situation.

I tested this idea of changing modality as the discourse response to the 'moment of crisis' by applying Brown and Levinson's three 'sociological variables' that speakers

use when choosing their degree of politeness (Table 11): the greater the social distance between the speakers and the hearer (e.g., if they know each other very little), the more politeness is generally expected, while the greater the (perceived) relative power of hearer over speaker, the more politeness is recommended and the heavier the imposition made on the hearer (the more of their time required, or the greater the favour requested), the more politeness will generally have to be used (Partington, 2006)

Table 11. Politeness theory – Brown and Levinson's three 'sociological variables'.

Politeness theory – Brown and Levinson's three 'sociological variables'	(i) the social 'distance' of the speaker and hearer (D) (ii) (ii) the relative 'power' of the hearer over the speaker (P) (iii) the absolute 'ranking' of impositions in the particular culture (R).

It appears that, following independent scrutiny, for the NMC to recover the confidence of their registrants, the discourse changed to move away from the domineering and authoritative modality to one of politeness and invitation. Yet, despite being more conciliatory, as seen from extracts of the discourse in Table 12, the registrant is left in no doubt that the NMC continues to be the dominant and authoritative figure holding the power to sanction removal of its registrants from the register.

Table 12. Extracts of NMC policy discourse indicating threat and consequence.

Dominance, control and power	'while you can interpret the values and principles…they are not negotiable or discretionary' 'we can take action' 'this can include removing them from the register' 'you will provide'

Lexicon

The 'you'

The use of 'you' in the discourse reinforces the power difference between the regulator and its registrants, the dominant and the subservient, and is a recognised linguistic technique used when the speaker wants to show contrast (Håkansson, 2012).

While 'we' acts to unite, 'you' separates the author from the audience and creates distance. As shown in the examples in Table 13, 'you' makes the writing appear as though it directly addresses the registrant, making it more personal and increasing the likelihood of the reader responding. Similarly to the first person inclusive personal plural pronoun 'we', discussed below, 'you' also serves to shift the responsibility of accountability onto the registrant – not about what the NMC is going to do, or what we are going to do, but specifically what they, the registrants, are going to do about it, making them think about their personal responsibility. Additionally, 'your', the possessive form of the personal pronoun, has the effect of further assigning ownership and creating more division.

Table 13 Use of pronouns to create power differences.

'revalidation will demonstrate your continued ability to practise safely and effectively'
'revalidation is the responsibility of nurses and midwives themselves. You are the owner of your own revalidation process'
'this includes the duty to recognise and work within the limits of your competence'
'keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance'

'You' is also the same word in the singular and the plural, making for a powerful effect because it appears as if the NMC is talking with each person individually and is thus extremely persuasive. In linguistics, persuasion is an integral part of argumentation and involves a speaker adopting strategies to convince the listener of the validity of what he/she is saying, again reinforcing that accountability is the registrant's responsibility.

In substituting pronouns for nouns, 'you' creates separation. This is another recognised linguistic technique used to create an 'us' and 'them' division, aligning the reader alongside or against particular ideas. Through the use of 'you' in reference to NMC stakeholders and members of the public, they are increasingly made to appear to side with the regulator and are thereby in opposition to the registrants and the burden of professional accountability is intensified.

The 'we'

The ambivalent way in which 'we', the first person inclusive personal plural pronoun, is employed is very persuasive and coercive. The use of 'we' in Table 15 evokes a sense of collectiveness and shared responsibility, as well as commonality and rapport between the regulator and registrants. Using personal pronouns in this way attempts to encourage the reader to agree with the authors, excluding other viewpoints with which authors do not want their audience to agree while persuading readers of their beliefs and ideas, basically bringing the reader to their side by creating a sense of togetherness, blurring the author–reader divide and creating a 'community' that promotes agreement. The use of 'we' instead of 'I' diminishes the responsibilities of the speaker, as they are portrayed as collaborating with the hearer (Fløttum, Dahl, & Kinn, 2006; Mühlhäusler & Harré, 1990).

Table 14. Personal plural pronouns to create persuasion and coercion.

we will use your personal data; we expect you; why we introduced revalidation; we recommend that you; we have produced; we strongly recommend; we do not prescribe; we know that many organisations; we want to encourage; we have provided; we will ask you; we will also; we will keep

This ambivalent use of 'we' is commonplace in political discourse (Fairclough, 2002). Here, constant ambivalence and slippage between exclusive and inclusive 'we' can be taken as reference to the NMC alone or to registrants or the public to which registrants are accountable. Such ambivalence is politically advantageous for an organisation looking to represent itself as speaking for the whole nursing community and not only for themselves. Although the impression is one of co-operation, accountability inevitably remains entirely with the registrant.

The 'they'

The CDA found increasing reference to 'the public' (Table 15), but it is not made apparent who this refers to. In discourse analysis, the ideological effects of such aggregation, where social actors are represented as groups, are that groups who are treated in this way are 'symbolically removed from the reader's world of immediate experience' (Van Leeuwen, 1996, p. 48) and treated as distant others rather than as people, that 'we' have to deal with in our everyday lives.

Table 15. Substituting pronoun for nouns to create separation.

'They are the standards that members of the public tell us <u>they</u> expect from healthcare professionals'

Passive agent deletion results in the agent of the process being omitted or backgrounded, making the perpetrators of an action appear discursively absolved from responsibility. Absolution can also be demonstrated through use of the nouns 'public' and 'stakeholders': who are the 'public'? Use of this linguistic technique, whereby participants in texts are anonymised, facilitates evasion of specification and development of detailed and coherent arguments (Machin & Mayr, 2012), in doing so allowing arguments to be conveniently summoned that are subsequently easy to dismiss. Registrants can then apportion the NMC's enhanced regulatory capacity to the public, not necessarily the NMC, who are required to enforce it.

The aggregation and anonymisation strategies found substantiate Fairclough's view that an important factor to consider in texts is where who acts and who has

responsibility has been obscured. 'The public tells us' endorses the NMC's increased emphasis on its regulatory responsibilities, ostensibly at the instruction of 'the public', rather than the NMC taking ownership for placing increased emphasis on accountability onto registrants – 'aggregation is often used to regulate practice and to manufacture consensus opinion even though it presents itself as merely recording facts' (Van Leeuwen, 1996, p. 49).

EXPLANATION

The explanation stage reveals the discourse to be part of a wider social process, determined by the social structures created between the NMC and its interface with registrants and the public. Its discourse has a cumulative and reproductive effect of self-preservation and of salvaging public confidence following the 'moment of crisis'.

Maintain Social Structures Between NMC and Registrants

Obvious dialectical tension exists. Dialectical theory assumes that all relationships, including organisations and their members, are interwoven with these kinds of multiple contradictions, which appear mutually exclusive but must be met simultaneously. On one hand, following independent enquiry, the NMC must focus on delivering its regulatory function, and, on the other, it must re-establish confidence and generate a positive trusting relationship with its registrants, stakeholders and the public – the NMC wishes to be accepted by others, its registrants and the public to achieve 'positive face', while its registrants prefer not be further imposed on by the NMC and maintain autonomy: 'negative face'.

Positive face is a concept in politeness theory which holds that every individual needs to feel appreciated, acknowledged, understood and accepted (Brown & Levinson, 1987a) and is related to issues of self-esteem, reputation and social standing. The NMC has moved to using positive politeness strategy here and changes to the discourse show that they recognise that the hearer has a desire to be respected, suggesting that the relationship is friendly, expressing reciprocity and placing emphasis on commonality and co-operation. However, 'politeness' is closely linked to power and power relations and the discourse strategies used here are a mechanism for strategic conflict management while meeting the organisational need for collaboration and improved social capital (Brown & Levinson, 1987b).

I gathered evidence to support the implementation of politeness strategies by contacting the NMC Corporate Communications Manager (A. Brown, personal communication, August 7, 2018). She confirmed that the NMC had indeed recently intentionally changed the language it had previously used on the basis that 'formal, distant, legal language can make us seem old-fashioned and out of touch. We're a modern regulator, so our language should be approachable and empathetic, concise and precise. It's a great way to show how we value people, fairness and transparency (these are our values)'.

The reply goes on to state that the change of tone I exposed as a consequence of the CDA was now one to be used by the NMC to 'write like a modern regulator'. The idea

is that everyone working at the NMC is trained in the style to enable them to use the tone themselves. This change in discourse was arguably the result of research conducted by the NMC that revealed that nurses and midwives found the institution distant and impersonal. Although the NMC did not know how much language had to do with that, they suspected it to be 'a fair bit' and was definitely a problem they believed language could help them with. Subsequent NMC circulars to its registrants further highlight this change to the discourse, demonstrating acceptance of blame, empathy, appreciation and consideration and support.

Interpretation of the various linguistic devices used in Policies 3 and 4 supports Fairclough's view that texts frequently use lexical choices to show levels of authority and, in doing so, attempt to influence their readers through claims of power over them through regulatory, legal and hierarchical means and of specialist knowledge through using specific terms to convey power. The NMC used discursive strategies to re-dress and sustain unequal power relations between registrant and regulator resulting from the 'moment of crisis'.

These findings support the insightful observation made by one nurse in K. Evans (2017, p. 20) opinion article that 'wound care is everyone's job, but no one's responsibility'.

4. 'The Public Face of the Regulator'

DESCRIPTION

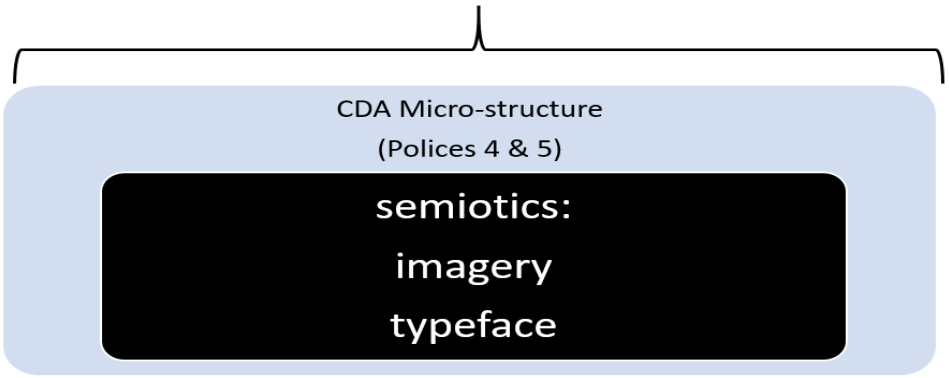


Figure 11. Pillar 3 – CDA of wound care policy semiotic micro-structures.

This stage of Fairclough's classic model describes the features of the selected language in Policies 4 and 5. This third and final pillar of the CDA framework (Figure 12) explores the use and interpretation of semiotics – the signs and symbols used.

In addition to production and linguistic features within the text, analysis of the images, layout and typography are also important because these features help to shape the meaning of the text, and, as previously suggested by (McLuhan, 1994), the medium is very often considered to be the message.

When contrasted with the rather austere layout of similar regulator policies published by the Health and Care Professional Council for dieticians and physiotherapists and the General Chiropractic Council (Figure 13), the most glaring feature of the analysis was the prominent and bizarre childlike cartoon caricatures that featured extensively through Policy 5 (Figure 13). I found this addition baffling

and wanted to understand how such images, alongside obvious changes to the typography and text, worked together to create meaning. The decision to incorporate semiotics into the analysis moved my CDA methodology to a multi-modal CDA (MCDA) to uncover the ideas, absences and taken-for-granted assumptions in the images and the kinds of power buried within them.

Figure 12. Image showing addition of cartoon-like images in NMC policy compared with other healthcare regulators.

Typography

In contrast to the typography used in the earlier version of Policy 4, 'Post-registration Education and Practice (PREP)' published in 2011 (Nursing and Midwifery Council, 2011), which mostly used more traditional and old-fashioned fonts such as the Times New Roman serif (Table 16), the most recent 2018 version of the same document mainly uses a Clarendon style typeface, characterised by thick, bold block-like slab serifs (Table 17). Although both font sizes are exactly the same, visually they both appear to the reader very differently and, when compared, convey very different emotions. A similar distinction is also found in the Policy 5.

Tables 16 and 17, showing contrast in typography between NMC policy published in 2011 and in 2018.

Traditional Times New Roman serif font	**The earlier 2011 post-registration education standards policy, PREP, used the more traditional Times New Roman serif, Arial Bold and Arial MF characterised by…**

Table 16. Typography of NMC policy published in 2011.

Clarendon style font slab serif	**…when compared with the 'Future Nurse' and 'Revalidation' policies that adopt a Clarendon typeface, a Slab Serif, characterised by thick, bold block-like serifs**

Table 17. Typography of NMC policy published in 2018.

INTERPRETATION

Visual Modality

I suggest that this these distinct changes to policy visual semiotics have mainly gone unnoticed by the nursing profession. This supports Barthes (1964) belief that readers tend to focus on obvious content, missing structural and non-obvious changes introduced over long periods of time, which can affect the message and have been naturalised and become difficult to notice. Naturalisation 'represents change in process, the actual ways in which people deal with the problematization of practices' (Fairclough, 1992a, p. 230), and these visual changes represent further evidence of discourse response to the NMC's 'moment of crisis' described earlier. I used Barthes' 'semiotic theory' of how images 'denote' and 'connote' meaning, aspects of sign theory, to help guide my interpretation of these changes.

A sign consists of a signifier, the representation of something, and what is signified, or the mental construct of what is being represented (Saussure, 1996). Signifiers do not have to be words but can involve other forms of representation, such as images, traffic lights or gestures. Language users agree on the overall relationship between signifiers and signifieds and these relationships can be denotative (literal) or connotative, whereby further (often non-literal) signifiers are ascribed to the signified. Such meanings require additional knowledge of social context in order to be correctly interpreted. Connotations often indicate positive or negative attitudes.

The NMC images contained within Policy 4, seen on the left-hand side of Table 12, denote, or represent, nurses working together and their interactions with patients. While they depict concrete notions to get general ideas across, they also connote, or imply, other ideas and values through what is represented and the way in which it is represented. Nursing is represented as a naïve, simplistic, unsophisticated, light-hearted and communication-based profession that is heavily reliant on technology and documentation as its interface with patients and with peers. Despite the frequent connotation of nursing as a communication-orientated practice, with nurses pictured here interacting with colleagues or patients, none of these cartoon-like characters have mouths, connoting that they do not have a voice or a say in the social process of engaging with the regulator or their profession.

Regarding image salience, where certain features in the composition are made to stand out to draw the reader's attention and foreground certain meanings, the scale of these cartoon-like images is disproportionately large when compared to the adjacent text, connoting that the policy content is not as important as the ideas and values that the images represent.

The low modality visuals combining brightness, pastel colours and reduced colour modulation build on this sense of simplicity, creating cheerfulness and almost romanticising the profession. Instead, full realisation modulation using photographs of real people, events and clinical locations would have made the images appear 'gritty' and real. This abstraction helps to conceal and deceive the significance of

professional accountability and the essence of the role. The messages behind the playful and light-hearted connotations in the images are incongruent with the officious and serious nature of the written text and create mixed messages as to who the audience is and its purpose.

Typography

As seen in Figure 14, fonts and typefaces can generate emotional connections and play a significant meaning–conveying role via their semantic association with other advertising elements. Although the psychology and importance of typeface is well established in design aspects, the impact of typeface on nursing policy specifically has not been explored.

Choi and Aizawa (2019) recent visual communication perspective research indicates that the suitability of typeface for a particular product, in conjunction with a congruent message, can generate positive responses among the advertising audience. Their conclusions represent an important factor to consider in the visual choices made by the NMC for inclusion in their policies as a form of deception about the nature of the profession. In this instance, the more traditional Times New Roman serif and Arial Bold and Arial MF sans serif fonts in the earlier PREP policy convey stability, maturity and conformity, instilling in the audience a sense of comfort that they are in the hands of someone reputable and stable. These fonts also have a firm, authoritative 'look and feel'.

Figure 13. Emotions elicited by different types of font. Retrieved from https://digitalsynopsis.com/design/font-psychology-emotions/

Instead, Policies 4 and 5 change to a contemporary Clarendon style typeface, which instils a sense of being 'hip', friendly and fun, is easy to read and has the effect of making an audience feel happy. These changes are symptomatic of my earlier personal communication with the NMC communications director, where it was noted that the NMC had indeed made a deliberate decision to change the language used because 'formal, distant, legal language can make us seem old-fashioned and out of touch above'.

The upshot of these visual strategies, however, serves to underplay, de-emphasise and detract from the seriousness of accountability, potentially misleading the public and stakeholders in suggesting that the role is somewhat simplistic, rather than the complex and multi-faceted reality.

EXPLANATION

Repression

In 1984 Allan Bell (Bell, 1984), put forward the theory of audience design. This theory suggests that speakers change style in response to their audience. Introducing visual modality into their discourse is how the NMC responded to independent scrutiny, specifically to the PSA's 'Lessons Learned' Review of Furness General Hospital from which one of the main recommendations was to improve engagement with patients and the public and act in a more transparent fashion: 'we consider that the NMC needs to look critically at its approach to providing information to the public in a way which goes beyond its published guidance and which actively attempts to be as open as it legitimately can without damaging its own or other people's rights' (Professional Standards Authority, 2018, p. 73).

However, when fun low visual modality and playful typeface are combined in this way in CDA, this can also be interpreted as a repressive discourse strategy. Repressive discourses are ways of showing power by being indirect, and tend to be regulatory. The effect is to prevent and attempt to remove from the consciousness any ideas, thoughts, memories or desires that are considered to be painful, unacceptable or otherwise unpleasant.

CONCLUSION

CDA assumes a study of the relations between discourse, power, dominance, social inequality, relations, rights and, importantly, vulnerability. Teun A van Dijk (1995, p. 85) notes that, 'social power and dominance are often organised and

institutionalised, so as to allow more effective control and enable routine forms of power reproduction'. This means that power is successful precisely because it is re-enacted in routine activities which are not questioned but instead considered as normal. Power is linked to discourse because discourses are ways of representing and constructing reality so that power relations are constructed, maintained and contested using discourses.

The first construct, 'Aspiration and Resolution', showed that power relations and dominance are re-produced in wound care policy production because of agenda sovereignty, control over access to knowledge, enactment impotence and creeping marketisation of wound care education. The constructed micro-textual linguistic strategies apparent in 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' were similar in that changes to the discourse stabilised the field of discourse and maintained hegemony during times of institutional crisis, with the effect of minimising guidance and further blurring the boundaries surrounding the scope of wound care practice. Visual changes to policy appeared to make the NMC more accessible but downplayed the true nature of the content and the role of the nurse.

The wound care 'nexus of practice' (Gramsci, 1985; Gramsci & Hoare, 1971) – groups who come together to engage in related social actions – have been persuaded that this uncertainty is a natural state of affairs. Ambiguity is created and maintained through manufacturing consent, whereby the dominant policy producers obtains the

consent of dominated practitioners to the point where they see the world from the point of view of the dominant, misrecognising power and recognise it as legitimate. Discourse has been used to control relationships, maintain social structures and re-gain the balance of power.

The marketisation of wound care education as a capital commodity was interesting. All types of capital relate to the concepts of advantage and power, and people who hold capital, or have access to it, are advantaged over those who do not. The wound care industry has the capital, wealth, labour and organisational capacity to produce, market and distribute required goods, as witnessed in Policy 2, while, I contend, simultaneously exploiting individuals in order for them to gain access to necessary knowledge. Control over cultural capital, which Bourdieu (1986) considers to be a collection of symbolic elements including skills, tastes, posture, clothing, mannerisms, material belongings and credentials that a person acquires through being part of a particular social class, has implications for governing the future quality of wound care education delivery.

Benner's theory does not address or visually demonstrate how these previously overlooked external wider forces have the propensity to disrupt the way in which her theory is currently construed.

Integration Strategy for Phases 1 and 2

The CDA identified that escalating ambiguity is the most pressing concern for wound care education and practice today. Very little is understood about what it is like from the practitioner's perspective to deliver care under such conditions and it remains unclear how, if at all, this manifests itself in Benner's theory.

The issues identified in the 'Aspiration & Resolution' and 'The Public Face of The Regulator' constructs were of interest but peripheral to the practice-based nature of this thesis. However, the mutual practice issues (Figure 15) contained within the 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' sub-constructs (Table 18) below were the most pertinent and were believed to be the most relevant to Benner's theory.

Figure 14. Venn diagram showing the shared practice constructs relevant to the thesis – 'Ambiguity or Opportunity?' and 'Responsibility without Accountability'.

Table 18. Shared wound care practice-based sub-constructs (highlighted).

CONSTRUCT	SUB-CONSTRUCT
Aspiration and Resolution	recognition; ownership; intent; collaboration; consultation; distribution; sanctions; variation
Ambiguity or Opportunity?	variation; inconsistency in implementation; flexibility; personal interpretation; professional liability; professional vulnerability; ambiguous personal decision-making; versatility versus variation; adaptability
Responsibility without Accountability	non-enforceable; hierarchical power relationship; professional exposure; dominance; power and control; fear, uncertainty and doubt; autonomy; role ambiguity; flexibility; trust; quality control of education; no guarantees; professional liability; lack of role definition
The Public Face of the Regulator	burden of obligation; public image; regulator as ally; re-gain public confidence

The overlapping issues of ambiguity, uncertainty and power relations contained within the sub-constructs shown in Table 18 are used as the conduits to integrate the main phase 1 CDA findings with phase 2, the DCA.

In this chapter, a three-pillar framework detected several macro- and micro-structures within the discourse of the five selected policies, which were, in turn, grouped into four constructs and sub-constructs. These were analysed using Fairclough's model. Of these constructs, 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' were identified as most relevant to the research context and selected as the pre-existing theory to be used to integrate with the DCA in phase 2.

CHAPTER 5: PHASE 2 – DCA

Research Objective 2: Identify characteristics of contemporary wound care practice that affect Benner's theory in higher education curriculum development.

Introduction

Justification for the Choice of DCA

This phase (Figure 16) addresses this research objective by validating and conceptually extending the pre-existing theories of 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' found in phase 1 and relating to wound care practices.

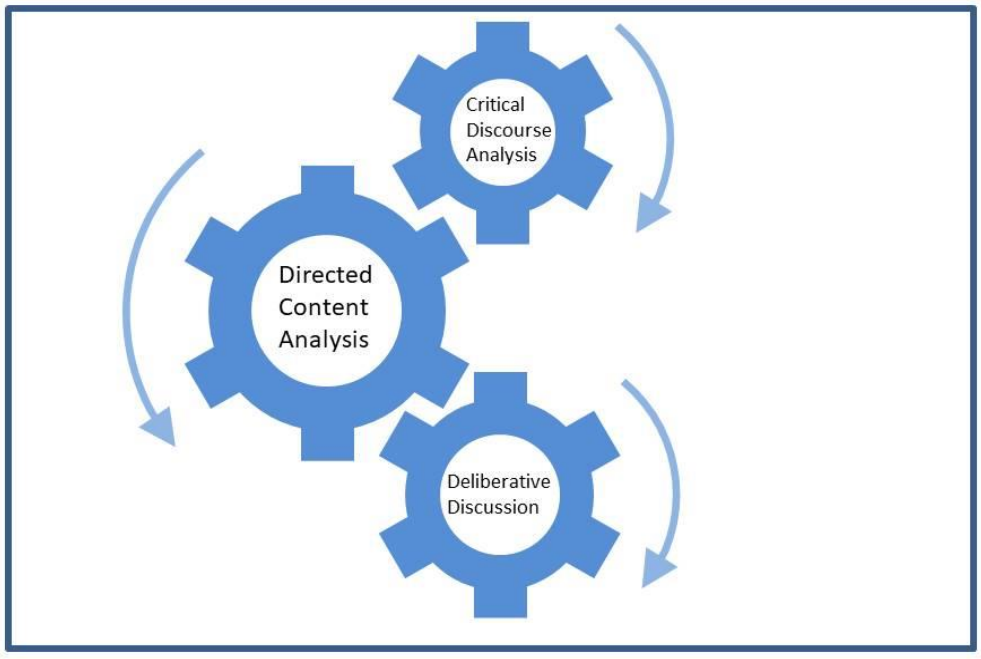


Figure 15. Integrated three-phase multi-method research design focusing on phase 2 – DCA.

DCA was used to analyse a sample of secondary data from comments students uploaded to discussion forums on the wound care module eLearning platform described in Chapter 2.

DCA

A directed approach is guided by a more structured process than a conventional content analysis. The main difference is that the researcher uses existing theory or prior research to provide predictions about the variables of interest or the relationships between variables. This process helps to identify key concepts or variables as initial coding categories and is known as deductive category application (Mayring, 2000).

The goal of the directed approach to analysing content is to validate or extend conceptually an existing theoretical framework or theory. Using existing theory or research in this way helps to focus the research question (Mayring, 2000), and involves application of pre-existing conceptual categories to a new context (Hsieh & Shannon, 2005) (Fig.17) . This approach can be particularly beneficial because these theories or research can sometimes be incomplete or benefit from further description, thus allowing the pre-existing theories identified in phase 1 to be progressed.

Benefits of Using Non-reactive Data for DCA

Characteristically, qualitative content analysis involves a close review of interview or observational content. For this thesis, I used non-reactive secondary data – data that has already been collected and is readily available from other sources – because it was readily accessible, on the understanding that it can be used alongside other qualitative or quantitative data analysis (Heaton, 2004), together with the phase 1 CDA. Additionally, Janetzko (2008) suggested that a productive development of research can be anticipated when non-reactive data collection is merged with existing work in the area being studied, meaning use of secondary data integrated with the pre-existing theory from phase 1.

On the understanding I have established the nature of wound care practice is an under-researched area, I believed seizing the opportunity to gain access to this rich, non-reactive source of data helped, as described by Irwin and Winterton (2012), give a voice, albeit not in the conventional way, to this rarely heard group of nurses.

Accessing secondary data also allowed me to reduce bias by avoiding a high-profile data collection procedure in a naturalistic setting.

Limitations of DCA

As the secondary data was previously collected for another purpose, and generated from discussion posts within the online wound care teaching module, the context was limited to where and when it was collected.

Data Collection and Analysis

The non-reactive secondary data was collected from the eLearning wound care module site described in Chapter 2. This sits on the secure 'Moodle' virtual learning environment (VLE) platform on the university server.

Non-reactive data collection is unobtrusive. The people under investigation are usually not aware that they are being studied, so their behaviour is not affected by the data collection procedure (Fritsche & Linneweber, 2006; Lee, 2000; E. Webb, Campbell, Schwartz, & Sechrest, 2000), helping to overcome response problems such as selective participation.

DCA Framework

I used Assarroudi's (2018) DCA framework of 'Preparation', 'Organisation' and 'Reporting' detailed below to organise the analysis. My rationale for choosing this particular framework was because it was designed to overcome the criticisms of DCA regarding insufficient analytical detail and its research trustworthiness.

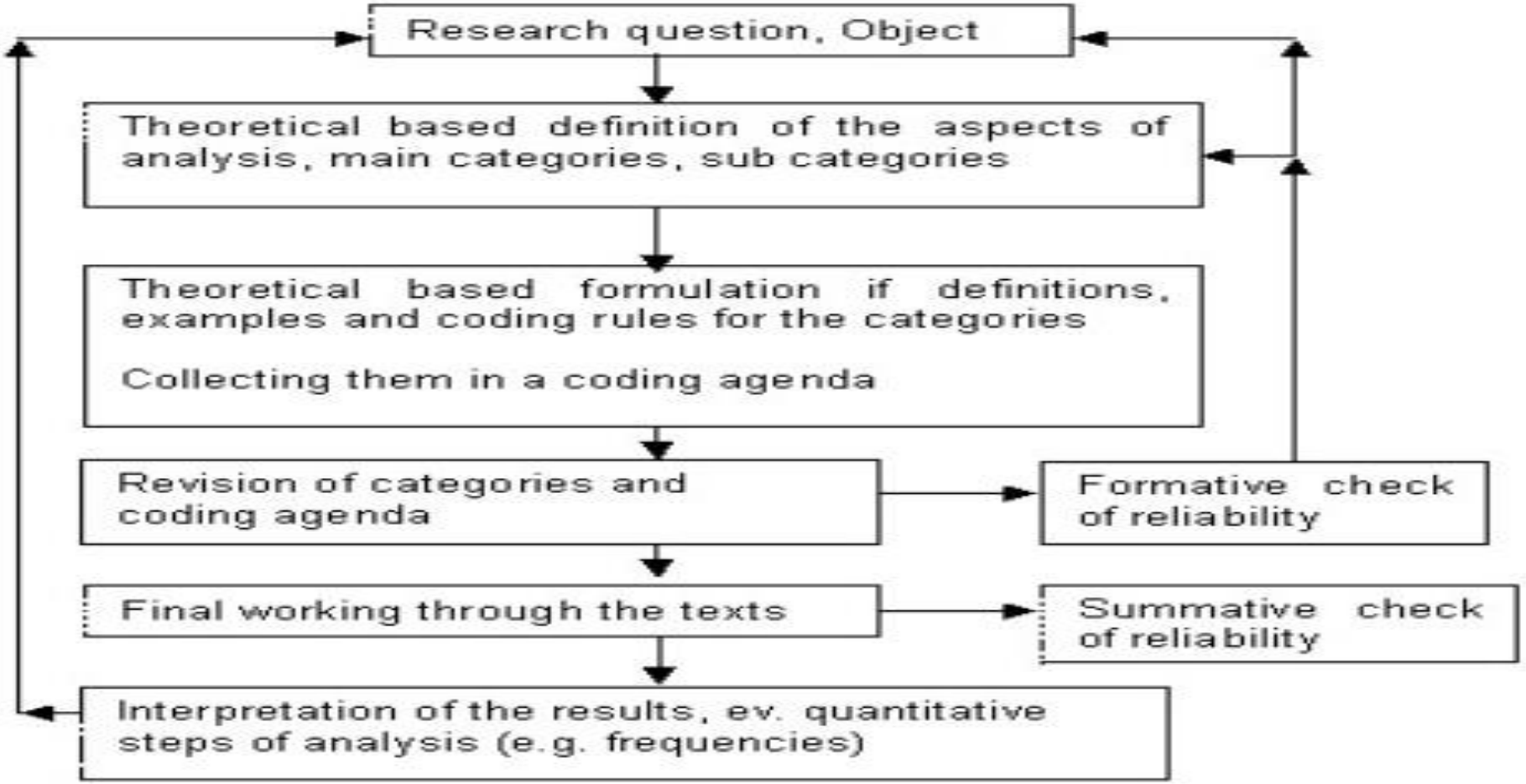


Figure 16. Step model of deductive category application (Mayring, 2004).

Assarroudi's framework relates to conventional interview data and not to secondary data, so I made some minor adjustments throughout the analysis to accommodate this.

Preparation Phase

Acquisition of General Skills

Neuendorf (2017) argues that training and coding experience are necessary for reliable DCA coding. To master the self-critical, analytical, data gathering and interpretive skills indicated as necessary by Elo et al. (2014), I practised different DCA approaches on test text sections. Different DCA approaches can be used depending on the research question. Coding can begin by first reading the transcript and highlighting the relevant text or, alternatively, it can start immediately using pre-determined codes from previous theory. I also used my research supervisors and independent observer as 'auditors' to help me develop these skills, asking them to challenge my decisions over the creation of the final categories, definitions, coding rules and the overall cohesion strategy to integrate the phases.

Sampling Strategy

From the entire wound care module content, I chose the forum discussion posts as the DCA datasets because, as explained in the inclusion and exclusion criteria section, their focus linked closely with the pre-existing theory and research objective.

As the module co-ordinator, I do not contribute to, monitor, judge or grade contributions to these discussions. The purpose of this virtual 'community of practice' (Dubé, Bourhis, & Jacob, 2005) is to facilitate collaboration, share best practice and encourage professional development and, because the content is non-assessed, the context and content provided impartial information about the nature of their work.

At the end of each academic year all discussion forum contributions are electronically archived and securely stored on the university server for five years.

A sample of the discussion posts made by the 22 students attending the module between 2017 and 2018 was used. As the discussion posts were not part of a summative assessment, the contributions from the students were not compulsory, introducing the possibility of contributor bias where the more vocal, confident and motivated views would be recorded. To mitigate the effect of this I extended the number of discussion posts from the original student population of 22 to 42 students by including posts from the preceding academic year (2016–2017) in the belief that this was more representative of the target population and to enhance the trustworthiness of the findings while also increasing their transferability.

Inclusion and Exclusion Criteria and Decisions

The discussion forum topics I selected for the DCA were those that related closely to the 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' pre-

existing theories from phase 1 and that tended to incite responses relating to the scope of their role, accountability and fitness to practise. I also chose those actively encouraging students to reflect on the nature and extent of their wound care knowledge and discuss mobilisers and barriers to their wound care practice.

Topics triggering descriptions, such as describing wound dressing procedures or stating facts or 'wikis' with links to research articles or web links, were excluded (Table 18).

Table 19. Wound care module discussion forum topics included in and excluded from the DCA.

Tissue viability module unit content discussion forums included	**Tissue viability module unit content discussion forums excluded**
Sharing Practice – Your Space Introduce Yourself and Why are You on the Module Wound Assessment and Factors affecting Healing Ethical and Legal Issues Patient-centred Care Organisational Culture and Communication Change Management	Describe How You Manage This Patient's Leg Ulcer Anatomy and Physiology of the Skin What Factors Influence Wound Healing? 'Wiki' – Upload Useful Research Publications Here

As a result of the retrospective nature of the secondary data, I was unable to obtain participants' demographic data such as age, role, nature and length of nursing experience or place of work, or establish whether their places of work were in rural or urban locations with the data from their discussion posts. However, I believe that this did not compromise the thesis because the purpose of the DCA was to identify categories and themes and not to generate a hypothesis.

Deciding on Manifest and/or Latent Content for Inclusion in Analysis

As DCA is more structured and deductive than conventional content analysis, I limited the data collection to manifest, or literal, content. This was because latent content – content that includes the researchers' interpretations of the text and participants' silences, pauses, sighs, laughter and posture (Elo & Kyngäs, 2008), which would normally be observed in face-to-face interviews – was not available to me using secondary data. However, during the course of the analysis, I became aware that some of the posts evoked the 'mind and feeling' of the participants through their use of emoticons and punctuation. For example, I found exclamation marks useful to capture because they helped to provide a deeper appreciation of some of the issues in which I was interested than the deductive data alone. Incorporating latent content in this way showed that, similar to the experiences of Daly (2007) and Mayring (2000), DCA analysis does not necessarily need to be constrained to manifest content and can be influenced by a combination of inductive, deductive and abductive reasoning.

Developing an Interview Guide

DCA interview guides are derived from the study's aims and existing theory and research (Hsieh & Shannon, 2005). Correspondingly, I used the phase 1 constructs of 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' and their sub-constructs (Figure 15 and Table 18), as pre-existing theories to identify key concepts as the initial coding categories. Using the findings from phase 1 and integrating these with phase 2 had as indicated by Maxwell et al. (2015), the overall beneficial effect of enhancing cohesion between the research phases.

Conducting and Transcribing Interviews

Debate exists over quality in content analysis transcribing. On one hand, Poland (1995) argues that interview content is meticulously transcribed verbatim. However, Loubere (2017) instead believes that verbatim transcription can often limit the kind of information thought valuable as data, and postpones the data reduction and analysis processes, thereby separating the investigator from the investigation. Fortunately, using secondary data meant that I did not need to concern myself about this decision because transcriptions already existed archived electronically on a secure server, which also avoided the need to back up data.

First, I copied and pasted all the sample discussion forum content into a Word document and assigned each line with a number to aid identification. Next, I used the 'underlining', 'highlighting' and review 'new comment' functions in 'Word 16' to

classify, then code, the associated text. As explained in Chapter 3, throughout this process, I systematically anonymised any reference to research participants' names and places of work.

Specifying the Unit of Analysis

The unit of analysis was the combined sample of chosen discussion forum post contributions made by 42 students who attended the Tissue Viability module in 2016–2017 (n=20) and 2017–2018 (n=22).

Immersion in Data

I wanted to validate and conceptually extend the theoretical constructs from phase 1. To do this, I immersed myself in the data by reading and re-reading all the posts in the sample, asking myself, 'who is telling?', 'where is this happening?', 'what is happening?', and 'why?'. From this, I was able to extract related meanings described by Elo et al. (2014) and Elo and Kyngäs (2008).

Organisation Phase

Developing a Formative Categorisation Matrix

Deductive category application works with previously formulated theoretical derived aspects of analysis to bring them into connection with the text (Mayring, 2000, 2004, 2014). This step in the analysis consisted of a methodological controlled assignment of the existing theoretical constructs 'Ambiguity or Opportunity?' and 'Responsibility

without Accountability' and their sub-constructs (Table 20) into nine main coding categories (Table 21).

Table 20. CDA constructs and sub-constructs from phase 1 for use as pre-existing theory to direct the content analysis in phase 2.

CONSTRUCT	SUB-CONSTRUCT
'Ambiguity or Opportunity?'	variation and role ambiguity; inconsistency in implementation; personal interpretation; professional liability; professional vulnerability; ambiguous personal decision-making
'Responsibility without Accountability'	non-enforceable; hierarchical power relationship; professional exposure; dominance, power and control; quality control of education; no guarantees; professional liability; role ambiguity

Table 21. Main categories derived from pre-existing theory 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' constructs and their sub-constructs.

1	**Variation in wound care nursing practices and role ambiguity**
2	**Ambiguous personal decision-making**
3	**Autonomy**
4	**Regulatory dominance power and control**
5	**Flexibility**
6	**Hierarchical power relationships**
7	**Revalidation is not a guarantee of fitness to practise wound care**
8	**Quality control of wound care education and skills framework is non-enforceable and inconsistency exists in knowledge and skills**
9	**Wound care nursing is subject to personal interpretation**
10	NEW CATEGORIES

Theoretically Defining the Main Categories and Sub-categories

I wanted the definitions of the nine main categories derived from pre-existing theory to be accurate and objective (Mayring, 2000, 2014), and therefore supported each of the main categories with examples from the policy text included in the CDA. I also gave explicit theoretical definitions for each of these nine main deductive categories determined by the sub-constructs and provided coding rules to determine in exactly which circumstances a text passage from the secondary data transcripts could be coded with a DCA category (Appendix D). As suggested by Hsieh and Shannon (2005), I used the theoretical definitions as operational definitions to increase the accuracy of the pre-determined categories before the analysis. An excerpt from the entire DCA categorisation matrix (Appendix D) can be found in Table 22 overleaf.

Table 22. Excerpt from the DCA categorisation matrix (Appendix D) to show link between main deductive categories generated from phase 1 CDA sub-constructs and DCA coding in phase 2.

Appendix D

DCA Categorisation Matrix

	MAIN CATEGORES DERIVED FROM SUBCONSTRUCTS	SUPPORTING TEXT FROM CRITICAL DISCOURSE ANALYSIS	DEFINITION	DIRECTED CONTENT ANALYSIS CODING RULES	DCA ANCHOR SAMPLE TEXT
1	**Variation in wound care nursing practices and role ambiguity**	'To date within tissue viability there are few tools with which to measure and benchmark expertise' 'There are no UK nationally agreed core competencies to which TVNs and their employers can match outcomes in ensuring interventions are of the same standard nationally' Extensive use of 'appropriate' throughout... policy - open signifiers 'Although the NATVs in Scotland has published core competencies for	Inconsistencies exist in role and in (1) wound assessment, prevention and management practices and (2) wound care experience and knowledge	Observation of variation in role across clinical disciplines and geographical areas Inconsistencies in wound care practice, knowledge and experience	'Colleagues of same team measure wounds differently. Some measure length left to right of body and some measure head to toe' (L4-6). 'I regularly measure wounds but have to say that I have never considered how my colleagues do it.....definitely something I'll have to research as if this isn't something that we are doing by the same method then its a fairly pointless exercise and the measurements are a bit useless!' (L26-29). 'Wound measurement is a problem I find as we do all measure differently and many times it is personal opinion of where the wound edge is and also everyone's

I became aware that I was approaching the data with an informed and strong bias and that it was possible that, during the DCA, I might look for evidence to support my earlier CDA findings rather than challenge them. To reduce this possibility of researcher bias, I asked the independent investigator to review the definitions I planned to use for the DCA.

Determining Coding Rules for Main Categories

To create distinction between each of the nine main categories, I developed DCA coding rules to explain them further. These rules described the properties of the main categories and were developed based on theoretical definitions suggested by Mayring (2014), to improve research trustworthiness (Appendix D).

Each of the nine categories was assigned a different colour (Table 21). As the analysis progressed, new categories also emerged and these were included, as suggested by Elo and Kyngäs (2008), under the 'new categories' heading in the matrix.

The feedback from my independent observer confirmed that the research objective was clear and that the text from phase 1 supported the main categories. The independent investigator was able to follow and understand the analysis process and stated that this was clear and well defined. However, more explanation was needed to help explain the terms 'appropriate' and 'no guarantees', and this was addressed by providing additional context. The conclusion was that the definition, coding rules

and categorisation matrix were cohesive and that the format successfully integrated with the pre-existing theory from phase 1.

Pre-testing the Categorisation Matrix

I improved the research trustworthiness by developing a transparent coding process and using inter-coder verification. As a result of the potential for misunderstandings over word meanings, main category definitions and coding procedures, the coherence and consistency of the coding practices were threatened which, in turn, compromised the credibility of the findings. To reduce the likelihood of this occurring, I tested the final coding scheme by undertaking a pilot study that asked the independent observer, as a first-time coder, to encode a sample of the text. This found noticeable consistency in the coding decisions made.

Choosing and Specifying the Anchor Samples for each Main Category

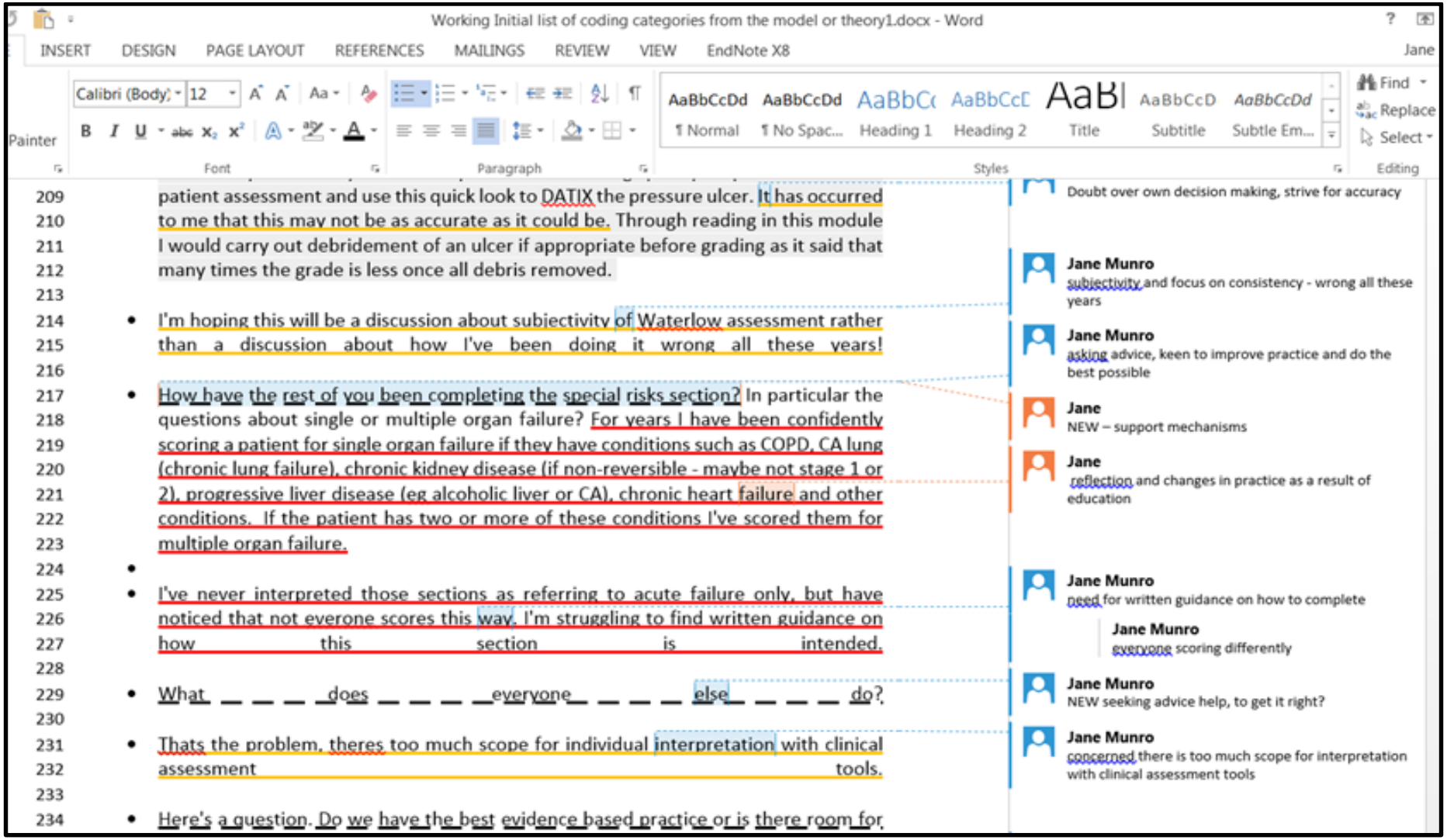
As suggested by Mayring (2014), I selected anchor samples from the DCA secondary data to give explicit and concise representative examples of the nine main categories.

Performing the Main Data Analysis

My intention was to carry out the DCA analysis using content analysis software to assist with the coding process. However, a drawback of this sequential methodology is that it was time critical, with only a limited amount of time available between each phase. I was unable to undertake the necessary training for this before commencing

phase 3. As a viable alternative, I used the 'scissor and cut approach' in 'Word 16' suggested by Kuckartz (2014). The contents of Table 22 show in the right column my identification and selection of 'meaning units' – those interesting or salient features from the transcript that related to the nine main categories. These units were underlined with corresponding colours for particular main categories.

Figure 17. DCA coding process and identification of 'meaning units'.



The analysis was grounded in the original main categories, so I considered how these 'meaning units' could be merged, grouped together or combined to form over-arching generic categories. Proposed by Graneheim and Lundman (2004), I then summarised these units and gave them preliminary codes (Mayring, 2000, 2014).

I kept the preliminary codes concise to move through the qualitative data analysis process. The majority of coding was completed at the manifest level by looking at the words in the transcript in front of me. For latent level coding, I used my own judgement and views, 'reading between the lines' of what was said within the data.

I continually went back and forth within the discussion forum post text looking for groups that stretched the diversity of data as far as possible (Saunders et al., 2018). During this process, new codes were developed and code names were changed, deleted or merged with others. I also used memos relating to various codes and coded segments to keep track of my emerging interpretations of the data. Occasionally, I identified multiple codes for the same segments of text. The themes and ideas that developed could therefore be linked directly back to the raw data to help demonstrate a level of trustworthiness in the way I conducted the data analysis.

Data that could not be coded was also identified and analysed to assess whether it represented a new category or sub-category of a preliminary code.

The sampling process of the discussion post texts ended when theoretical saturation, described by Cleary, Horsfall, and Hayter (2014), was reached, with no additional data found and each main category 'saturated' with all aspects of the pre-existing theory available.

Inductive Abstraction of Generic Categories from Preliminary Codes

I grouped together similar preliminary codes to create broader thematic categories before considering how these inter-related and the different levels of hierarchies and orders of categories. From these thematic categories, I identified the following four 'generic categories' (Elo & Kyngäs, 2008), which were grouped and categorised according to their meanings, similarities and differences:

1. 'It's all a bit 'hitty missy''
2. 'A question of judgement'
3. 'Too many coaches and not enough players'
4. 'Know your rights'

Linking the Main and Generic Categories

The iterative constant comparison technique (LaRossa, 2005; Zhang & Wildemuth, 2009) used for the original nine main categories and these new generic categories established conceptual and logical links between each whereby the generic categories could be thought of as 'nesting' into the nine original main categories.

The result of carrying out the DCA process meant that the original nine main categories were generated from the pre-existing theories of 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' in phase 1 (Table 21) and 'transformed' into four generic categories, which emerged inductively (Miles & Huberman, 1994).

I considered it important to include the following newly identified four 'main categories' in the findings because these look as if they offered alternative and contradictory views. I used these to help refine, extend and enrich pre-existing theory:

1. 'One of a kind'
2. 'Professional and human price of "push–pull" practice in wound care nursing'
3. 'A 'Safespace'
4. 'Access to wound care education – an invitation to industry'

The Reporting Phase

Results/Findings

DCA is used when 'existing theory or prior research about a phenomenon that is incomplete…would benefit from further description' (Hsieh & Shannon, 2005, p. 1281), with the goal to validate or extend conceptually a theoretical framework or theory. The goal of using DCA in this thesis was to validate and conceptually extend

the pre-existing theories of 'Ambiguity or Opportunity?' and 'Responsibility without Accountability' generated from phase 1.

The four generic categories and four new main categories found are discussed below:

Generic Categories

1. 'It's all a bit 'hitty missy''

Consistent with the CDA findings in phase 1, the DCA supported the widespread concept of ambiguity being present in wound care nursing. The findings indicate a generalised inconsistency in, for example, the availability of pressure-relieving equipment and access to professional advice in different health board areas and in hospitals and the community. Difficulties accessing wound dressings were also sometimes found to compromise the continuity of the wound healing process. There were also significant variations in wound assessment practices among wound care nurses as well as evident inequity in the availability of wound care education. Inconsistency was also apparent between the advice offered by different TVSs for the same patient's wound.

This unsatisfactory state of affairs was captured by one of the study participants who had, until attending the course, always made the assumption that every nurse assessed and treated wounds in exactly the same way. The revelation that wound care practices can in fact be quite random led to her to conclude that:

'Sometimes [wound care], I think it can be a bit hitty missy!'

Despite vague and variable working conditions, an almost primal instinct for these nurses to achieve perfection is also evident, where wounds can be assessed in the same way to achieve consistency and to ensure that the best wound dressing is provided to meet the individual healing requirements of every single wound. These diligent and ambitious professionals are thus placed in a difficult position and experience the uncomfortable tension between what they know to be theoretically possible compared with the harsh realities of what actually happens in their everyday wound care practice.

> **'I've never interpreted those sections [of the wound assessment chart] as referring to acute failure only, but have noticed that not everyone scores this way. I'm struggling to find written guidance on how this section is intended.'**

Further comments make evident differences in availability of support services for pressure ulcer prevention and treatment between health boards, acute and community settings and remote and city areas. This inequity influences nurses' ability to provide their desired fair and consistent approach to wound care practice.

> **'I've gone from working in an acute ward to working within an outpatients' clinic and I'm amazed that considering I still work within the same hospital how the resources available to me are so different!'**

> **'Despite the fact B and I work six miles apart, "Zetuvit" is all we use at Y hospital. It would be good to convert to "Kerramax" as it has the "lock" in feature and [is] less bulky, although we are trialling it on a patient!'**

The following discussion thread was taken directly from the forum and relate to the use of honey as a wound dressing product. The content serves to reify the theory of ambiguity already alluded to in the research and encapsulates the absurdities

experienced in wound care practice decision-making as well as the contradictions that exist even in acclaimed evidence-based wound care research to confuse practice.

> **'I work in 'V' health board and, as 'F' said, we don't use honey. The previous trust I worked in, we did.'**

> **'We don't use honey in 'Y' health board and haven't for many years, although when I worked in another practice a few years ago it was used.'**

> **'I used honey as a case study when I did my dissertation at uni two years ago on the use of specific types of honey used on wounds, mainly leg ulcers, and most of the studies I found supported the use of honey and found good results, especially in wounds colonised with MRSA and pseudomonas.'**

> **'The study included has suggested that there is no conclusive evidence that honey assists the healing of leg ulcers.'**

The implications of this inconsistency for professional accountability are significant because they clearly jar with the requirements laid out in the NMC's 'Future Nurse: Standards of Proficiency for Registered Nurses' (Nursing and Midwifery Council, 2019), Policy 5 in the CDA, which states that part of being an accountable professional requires its members to:

- 'demonstrate the ability to accurately undertake risk assessments in a range of care settings, using a range of contemporary assessment and improvement tools'

- ‘demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals’

- ‘demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence-informed decisions in all situations’

Wound care nurses are currently being forced into an impossible predicament. Without a consensus on the necessary education, competency framework and wound care treatment, the ambiguity that results, apparent in the literature and student discussion posts, makes it increasingly likely for nurses to be seen as not providing the best care possible. Nurses therefore become increasingly liable because each nurse interprets the vast array of national and local wound care guidelines, best practice statements and standards individually. This has inevitably resulted in the unacceptable variations observed by Guest (Guest et al., 2015; Guest, Ayoub, et al., 2017; Guest, Vowden, et al., 2017) in wound care that exist today. With this in mind, it should be remembered from Policy 3 in the CDA (Nursing and Midwifery Council, 2015), that, for any failure to consistently meet required NMC standards, the NMC can take action, which may include removal from the register.

2. 'It's all a question of judgement'

Nevertheless, one participant did hint at the presence of some inherent inconsistencies in wound care practice and conflicts with the overall desire to standardise the approach to wound care education and practice, as discussed in Chapter 2, in order to reduce the unwanted variations that currently exist.

> **'I do acknowledge, however, there is always going to be some slight individual discrepancy between different practitioners, but hopefully not too much.'**

Doubts and mistrust were also expressed over the reliability of frequently used wound assessment tools and the quality and credibility of respected research-based evidence guidelines and policies generally considered to be gold standard in directing best wound care practice.

> **'On reading the effectiveness of silver within this article it seems that there is no conclusive evidence on the benefits of silver use, apart from use it if you feel a wound needs it, if the wound improves then continue to use it, if not then don't. I'm not sure this is sufficient for the advocacy of silver use in practice, mainly due to the inconclusive nature of trials and conflicting evidence, and the fact that evidence-based practice is the corner stone of nursing.'**

> **'Randomised controlled trials seem to feature widely in nursing research and are the research tools that I'm most familiar with. I understand the concept of them and believe that, providing they carry no researcher bias and are, therefore, "pure", they do deserve the "good standard" label they've been given. However, I think this is the crux of the matter. If researchers are "tweaking" the questions, therefore directing the research in a particular way, can the findings be classed as pure?'**

Despite the difficulty such confusion means for decision-making in wound care practice, some of the discussion board contributions also indicate that care is based on the unique nature of individual wounds and cannot simply be reduced to a set of

rigid prescriptive protocols and standardised approaches. Instead, it was apparent that wound care nurses viewed their patients as people with unique personal and clinical circumstances, which was essentially a result of the nurses' skills. Drawing on previous experience of what works and their clinical judgement, they were able to make the best clinical decisions.

> **'The nurse's individual judgement definitely accounts for a lot. It would be interesting to analyse the differences between two nurses assessing the same wound to help identify differences in use of the wound chart and differences in individual wound assessment. I have used a decision-making tool to do this before for 'Waterlow' using 'Brunswick's' lens model. Long story short, you need to consider expertise and personal judgement and decision-making, and the tool is just a prompt for areas of consideration.'**

A further, until now, mostly over-looked challenge in standardising wound care education and practice is that patients themselves are acknowledged by wound care nurses as individuals and human beings but, by their very nature, they are also unpredictable and can respond to the wound care they receive and the advice and treatment provided however they choose.

> **'No single patient is interchangeable with another, even if, demographically, the similarities are apparent. Co-morbidities, polypharmacy, lifestyle factors etc. aside, a holistic approach to care must be adopted which is individualised for each patient. A blanket recommendation cannot, in my opinion, be applied and I believe that generalisation about wound management, amongst many other aspects of patient care, must be avoided.'**

Given this emphasis on individualised care and the resistance against standardised approaches, it is worthwhile for nurse educators to question how the suggestion discussed in Chapter 2 regarding an increasingly content-laden wound care curriculum might really develop a nurse's clinical judgement. The DCA found, rather,

that instead of conforming with evidence-based guidelines, policies and procedures, providing individualised care is frequently the over-riding factor for wound care nurses, even when this contradicts best practice.

> **'Clinical guidelines should inform and guide towards decision-making but nurses should also use their knowledge and experience likewise to make their final choices. It is crucial to be up to date and well informed about nursing interventions but I think we should caution against seeing patients with wounds as "categories" to be treated "as per guidelines". Instead, we should be fully aware of current guidelines and the rationale behind them whilst addressing each patient individually. I am sure we have all cared for patients whose needs differ from practice guidelines. I think, in situations like that, like so many other areas of nursing care, as long as our actions can be explained and justified, we can customise our care accordingly.'**

Strong feelings were also expressed in relation to the need for nurses to have some freedom when making clinical decisions and professional autonomy to allow them to make the right decisions to meet the individual demands of their patients in terms of their unique physical, psychological, social and economic circumstances.

3. 'Too many coaches and not enough players'

Hierarchical working relationships and the relative position of wound care in health service resource allocation when compared to other priorities were found to challenge the ability to provide effective and equitable wound care.

> **'The organisation is undergoing a transition from one company to another and some toxic organisational cultures are becoming evident. To be honest the blame culture was always evident, managers in areas actually believing that was the way to ensure good practice.'**

The views expressed regarding budgetary restrictions and negative management attitudes, expecting wound care nurses to 'make do' with resources at hand, were

noteworthy. For example, one nurse requesting a routinely available wound dressing she had judged to be the most effective choice for her patient's needs was told that her choice was 'financially unacceptable' and advised to work with what she had, and 'make do and mend'. Wolcott (2012) also found that availability and cost often dictate wound dressing choice and not that which is ultimately best for the patient. Similar instances of how limited access to educational resources and wound dressings impact on care are set out below.

> **'I don't know what the answer is to the training regarding ward staff, but they are limited to what is available for treating wounds and the most appropriate products are not always used.'**

> **'I feel that without formal training we are very poorly prepared for assessing wounds and even more poorly prepared for deciding the best course of treatment. The variety of dressings available to us sometimes hinders rather than helps in my experience, especially when there are often several dressings that can do very similar things, so sometimes deciding on the best treatment can be hard.'**

Further effects of reduced investment in wound care education for staff are apparent in one participant's comments that the last inspection report reported that, whilst there is no obligation for their or any other NHS board to employ TVSs, it 'strongly suggested' that 'all staff should have access to such advice even if that is remotely, through another health board'. The participant went on to admit that the 'board flatly stated that there is zero intention of allocating funding for TV services', noting that the inspectorate report recommendations were 'still being considered'. Further examples highlight geographical inequalities in accessing expert advice, and another participant commented that, in her health board, there was no tissue viability service, meaning 'no qualified, dedicated lead'.

Extensive differences between hospitals and community areas in prescribing wound dressing products were also found to compromise the continuity of wound care, giving rise to significant frustration. On one particular occasion, not having the right wound dressing available on the hospital formulary – the list of prescriptible products, – resulted in unacceptable and degrading care for a patient.

> **'Hospital doctors should be able to prescribe it rather than have nurses rummaging in the back of the cupboard for dressings. I have even seen incontinence pads put on heavy exudating leg ulcers!!!!!'**

Resentment and frustration are evident throughout the text but are most notable in relation to erratic discharge planning procedures where patients are often discharged too early from hospital wards and 'it is the community staff that have to sort out all the issues'. These feelings are compounded when 'staff receive phone calls from families expecting a nurse to visit when no discharge notification has been received' and patients are 'discharged from hospital with no packages of care or home assessments but need care'. One community-based staff nurse indicated her despair over this because she and her colleagues are left to 'pick up the pieces'.

Treatment decisions and the necessary knowledge for nurses to support these were also undermined by management. On one occasion, a study participant was asked to provide additional written justification to support her choice to apply a more expensive, but arguably more effective, wound dressing product instead of what was available.

> **'Silver dressings are scorned upon and we have to fill in a special rationale form if we want to use it.'**

> **'I feel in my area and the wide range of wounds we encounter more education and selection would be beneficial. It is so frustrating wound care is not thought of as a priority I feel it is an important aspect of my role.'**

Continuous health service reorganisation and increasing workloads are considered detrimental to organisational culture, arguably compromising wound care and resulting in sub-standard nursing practices. The introduction of 'corporate working' in the community, for example, has resulted in 'many more staff seeing the same patient and often continuity is compromised because of this'. In addition,

> **'when the ward is very busy staff nurses don't have the time to document on the wound chart after dressing the wound and leave the writing up towards the end of their shift. This can result in staff nurses guessing some of the information required as they have forgotten some of the vital information required.'**

> **'I think the culture in the hospital is not really focused on holistic care and there are so many other pressures with regard to delayed discharges and other targets that the time to care has gone out the window.'**

Despite attempts to introduce the relatively straightforward and effective use of photography to increase consistency in wound measurement, in some areas efforts were thwarted and plagued with difficulties because of the inability to source funding for the camera. For some, bureaucracy took its toll because meeting increasing legal requirements in relation to, for example, confidentiality, storage and access, were barriers – 'we rarely take photos due to the legal hoops you have to jump through' – and, for those who do actually use photography, the process remains frustrating.

'I've not been able to access them [the photographs of the wounds] on "Portal" in X Health Board, and the images taken for the purpose of district nurses to review, I never hear back if they are able to access them also.'

One participant likened the situation to 'too many coaches and not enough players' – an 'us versus them' mentality – that helped to characterise the power differentials between management and the nurses working at the interface with patients. This discrepancy was found to result in the use of unsuitable equipment and wound care products and in nurses having insufficient knowledge, compromising patient care.

'I don't know what we can do to change this as the coaches make the decisions and ultimately we are just the players.'

The image that is slowly emerging from the DCA is that it appears fairly commonplace for routine wound care to take place in the face of significant adversity originating from multiple and diverse sources. These difficult conditions are arguably par for the course and nurses have acquiesced, consequently making such conditions normal for wound care nursing.

4. 'Know your Rights'

Strong evidence now shows that, where individual patients are actively involved in their care, and share decision making, their health outcomes improve (Ahmad, Ellins, Krelle, & Lawrie, 2014; Coulter & Collins, 2011; Foot et al., 2014). This process requires empowering people to take charge of their own health, giving them greater choice and control over the services they use. An unexpected finding evident in the following DCA extract was the seemingly increased strain placed on nurses expected to deliver optimum wound care, which occurred as a result of the relatively recent

shift in power in the therapeutic patient–nurse relationship, away from traditional paternalistic care. Today, many people living with long-term health conditions such as chronic wounds are considered 'expert patients' (Tidy & Jackson, 2015), and can choose to take more control over their health by understanding and managing their conditions. These patients' 'voices' (Patient Voice, 2020), can also be used to express opinions and experiences to inform the nursing care they receive.

> **'Doppler test had been carried out and the patient was suitable for compression therapy, which she point-blank refused to consider. This was very frustrating for staff who tried to reason with the patient and explain that this was the best way forward to try and heal her wound.'**

This change in the balance of power has been challenging, not because nurses do not want to respect their patients' wishes – far from it. Indeed, the findings suggest, to the contrary, that patients occupy a central position in wound care nursing: 'the initial challenges were the patient herself, we had to respect her wishes but we also had a duty of care'. However, in the event that patients do not agree with the clinical decisions taken about their wounds, this hampered the nurses' 'raison d'etre' – to successfully heal wounds, jeopardising their professional duty of care.

> **'Patients are very informed now, they know their rights. Compliance is a big issue in my areas also. I provide equipment such as pressure-relieving cushions or mattresses then go back and find patients sitting on rubber rings.'**

Nurses providing wound care also encountered difficult legal and ethics dilemmas and these jeopardised professional accountability.

> **'If a patient will not comply/adhere to treatment, it can be detrimental to their care. For example, refusal of pressure-relieving equipment.'**

'Now the problems arose because he was completely unwilling to consent for any investigations of any type. We never even at any time managed to assess the wound fully. He was aggressive and one of my staff ended up with a black eye due to him punching her. He had fallen on the floor and was unable to stand up. We had no other choice but to use the hoist which was painful for him.'

'The upshot of it was the patient was discharged home with basically no resolution of his admitting problem. I have to say he was very challenging to look after and I did fear for the safety of my staff if he had remained in hospital.'

These extracts help to vividly develop the earlier idea that wound care is a nursing procedure usually provided under significant adverse conditions that jeopardise patient safety and professional accountability and where problem-solving, limited resources, decision-making with incomplete information, negotiation, and conflict resolution are essential characteristics required by a nurse in order to deliver the most effective wound care.

New Main Categories

a. 'One of a Kind'

The findings suggest that the process of wound healing per se cannot purely be reduced to treating the physical state of wounds. Each wound is unique to a patient and the set of circumstances in which they are being cared for: 'we need to care of the whole, not the hole.'

'I completely agree here, girls, with patients each one is unique and what might apply for one patient may not for another, although evidence-based practice is important, practice may be adapted to meet the individual's needs.'

In some instances, requirements to abide by strict wound care protocols and guidelines were felt to impede individualised care. On occasion, when a nurse opts out and chooses not to abide by these rules, certain personal qualities often came to the fore, such as creativity, confidence, flexibility and resourcefulness, with nurses simultaneously exhibiting wisdom and compassion with their patients.

> **'I too have had a patient who refused compression therapy and after long discussions it was found that it was because of her appearance, she liked wearing skirts. It can be something so simple that can prevent a patient complying with treatment.'**

> **'This chap appeared to be resisting care but he had in fact been unable to comply with our treatment plan or adhere to our schedule. Treatment had to centre on enabling this wound to heal whilst allowing him to continue to work…this partnership enabled wound healing in less than optimal conditions.'**

> **'Even a success of one product on one patient has the reverse effect on another…'**

> **'…we did use it with some success but not very often as patients didn't like the stinging pain and it was messy.'**

However, trying to always please the patient and respect their preferences generated some startlingly strong expressions of resentment and anger. This was particularly the case when patients did not follow nurses' advice and nurses then felt that their accountability was being jeopardised. When this occurred, the nurse's response was to place responsibility for healing the wound back to the patient.

> **'I also think as nurses we often feel so responsible for the status of a wound that we forget how much responsibility the patient has.'**

'The initial challenges were the patient herself, we had to respect her wishes but we also had a duty of care, it was clear that this lady was unwell, her bloods were off and any attempt to explain the need for admission were met with decline, she was still capable of making her own decisions.'

These findings are consistent with Fletcher and Barrett (2018), who report an increasing expectation for wound care nurses to integrate patients' expectations, experience and self-care.

b. 'The Professional and Human Cost of 'Push–Pull' in Wound Care Practice'

The professional and personal repercussions of the opposing 'push–pull' forces that nurses experienced when striving to heal wounds under the adverse conditions described were arguably significant, particularly whilst using clinical judgement. While giving a cursory nod to evidence-based best practice guidance and going 'off formulary' was found to be second nature to some nurses, others were far more conformist and their preference was instead to strictly adhere to policy, with 'going off formulary' to request a non-formulary prescribed form of treatment was viewed as unacceptable practice, even when the only available dressing products in the formulary were not necessarily the most suitable for the type of wound or the patient's lifestyle.

One such participant was concerned that there was 'far too much scope for individual interpretation with clinical assessment tools'. In terms of the various prescribing formularies that recommend treatment for pressure ulcers and leg ulcers normally used to direct best practice, she stated that, 'I always try to follow the guidelines, but

my colleagues sometimes go off formulary'. Unlike the doubts expressed earlier regarding a lack of credibility in wound care research and the 'minefield' around evidence from wound care research that cautions nurses to 'always question and be sceptical' and to 'not take "evidence" at face value', for these conformists, guidelines, policies and formularies need to be kept to because:

> **'they have been fully assessed and every dressing has been scrutinised, trials have been carried out numerous times therefore I do not always see a reason to differ away from this.'**

It is apparent from the following extracts that there is a personal and professional cost of providing wound care within the realms of inconsistency and unpredictability. Through the latent analysis, several obvious emotional expressions of the feelings that nurses experienced, including inadequacy, failure, anger, sadness, unease, frustration and professional vulnerability, were palpable.

Personal

> **'Patients who refuse to comply with prescribed treatments and dressings and who are continually self-treating cause us much frustration and heartache.'**

> **'It is very frustrating because you know it's the best thing for the patient but you just have to try and convince them to go with compression therapy.'**

> **'Once he saw the deterioration in his wound, he was willing to work closely with us and this had a very favourable outcome. He admitted, at the end, that he wished he'd listened to us all along!!** 

Professional

> **'A few weeks ago I encountered a situation which left me feeling as though we had let the patient down and with that my own professional responsibility.'**

> **'…but I was not comfortable having him discharged home in the condition he was in.'**

A sense of nostalgia and frustration was also apparent with the increased say of patients in their care, with one participant stating that, instead of respecting the patient's choice, she,

> **'yearned for the days when patients just said "yes nurse" or you could say "this is what doctor wants", and that was enough to ensure compliance with little or no reasoning.'**

Another used the analogy of having to 'strike the balance', and this process proved to be difficult to accept,

> **'particularly when patients take offence or [are] defensive when they know that something about their lifestyle might be contributing to a wounds chronicity.'**

> **'Yes I have had to do that before too. Difficult as could have implications for breaching confidentiality which is more of a legal issue.'** 

Despite these professional and ethical encounters, nurses retain an obvious determination to practise wound care as professionally as possible, and this is apparent when one student posts a warning to the others on the discussion board to always 'remember "non-maleficence – do no harm"', and to

> **'do the best you can in any circumstance…use your initiative and be aware of your obligations as a nurse, in the patients' best interests.'**

Ultimately, wound care practice requires nurses to be resilient, confident and able to manage ambiguity and unpredictability, as well as take risks and be willing to walk a fine line between applying wound care practice in theory and dealing with the harsh reality of everyday practice.

> **'Hi 'G', I have similar views to you and agree with you but still don't know what the right answer is! I think the trick might be there is no right or wrong answer just valid opinions supported by evidence.'**

> **'You don't know what to do for the best. What is professional and practical are two different things.'**

Ambiguity and precariousness have been naturalised in wound care practice and endured as a matter of course. The often volatile circumstances in which wound care is practised suggest that ambiguity, not restraint, is not only the natural but necessary state in which wound care is provided.

c. 'A 'Safespace''

The latent analysis proved to be particularly valuable because it detected that participation in the discussion forums fulfilled a previously unrecognised purpose. Taking part in the discussions appeared to inadvertently provide a valued, although unbeknownst, social support mechanism, creating a virtual 'Safespace' where reciprocal contributions readily provided empathy and emotional support in the face of such adversity, confident in the knowledge of being able to admit errors in judgement, disclose deficits in knowledge, and ask for help.

> **'I've never come across a measurement template but it sounds like a great idea and something I would use.'**

'Interesting reading everyone's views on honey dressings!'

'I'm hoping this will be a discussion about subjectivity of [the] 'Waterlow' assessment rather than a discussion about how I've been doing it wrong all these years!'

'If I am wrong then please someone correct me so I can accurately measure wounds.'

'Thanks for the advice re. wound measurement J. I didn't know this!'

'I'm embarrassed to say that I don't think I have ever referred an overweight/obese person to the dietician, although I have known their diet would not be beneficial for wound healing  **but I'm certainly reviewing my practice now!!'**

There were also moving expressions of sheer despondency and despair, evoking a sense of the overwhelming futility of wound care nursing.

'I have shared similar experiences and it's soul destroying, "you did your best", about being unable to provide care as effectively as they would like.'

'I know myself that there are times when I feel that I've failed a patient by not finding the right dressing/topical application despite the fact that the patient's nutrition is poor (+/- other compromising factors).'

'I felt disappointed as the wound was progressively healing, but had to accept it was the patient's choice he has since failed to return for further appointments.'

'I think it's sad that wound management is not part of holistic care in hospitals and is not tackled by management.'

In my mind this conjures up the Royal Marines motto –'Improvise, Adapt, and Overcome' – a mindset that allows recruits to deal with any physical, mental or spiritual hardship, but without undergoing the necessary training.

The anguish can and does eventually lead to complete exhaustion, and, finally, disillusion.

'To be honest we were all at our wits end by this point in time.'

This demonstrates the necessity for wound care nurses to actively network and, while some online functions provide useful platforms to share learning materials, such features also represent a vital form of listening therapy. The discussion forums were used by nurses to vent their feelings of inadequacy, frustration and despondency over clinical dilemmas, providing them with a platform on which they could console and reassure one another: representing a 'Safespace' where morale was boosted and resolution agreed.

The new 'one of a kind' and 'Safespace' categories offer original insight into the human side of practising wound care, the professional and personal toll the role often takes on practitioners, the necessity for support mechanisms and the surprising capacity of wound care nurses to go above and beyond in order to deliver the best care possible.

d. 'Wound Care Education – An Invitation to Industry or Simply Marketisation?'

The findings illustrate that, very often, access to the necessary pre-requisite education to carry out the basics of wound assessment, measurement, care, documentation and dressing choice has been negatively affected as a result of budgetary restrictions. However, the wound care product industry has also been shown to be a useful ally in helping to rectify the shortfall.

> **'I would like reps (company reps) to come back like they used to as I felt this was informative and you got to see and feel the dressings.'**

> **'We have been getting reps in again, but same as 'F', just for those dressings in the formulary, which could be argued is really short-sighted as how can we expand, improve and develop the formulary if the doors are closed to new ways of thinking, it can't all be left to tissue viability teams to action.'**

> **'Lots (of reps) from the formulary list haven't made contact which is sad really as we are losing out on the information, case studies and been unable to trial products with support from the reps.'**

> **'At least now we are being allowed reps back in again, this way you can make your own mind up about dressings.'**

> **'There's a major assumption by saying that nurses just do what reps say. I think nurses are more critical than that and go by results we see. I do agree some nurses have favourite dressings. We all do. This is because we have seen results from the ones we have used. It's more of an experiential critique.'**

These tributes, alongside the recommendations made in the wound care literature (Fletcher, 2007; Fletcher & Ousey, 2010b), and commercially funded unrestricted education grant for the production of policy 2 reviewed in phase 1, Tissue Viability

Leading Change (URGO Partnership, 2015), suggest that there is now scope to formally progress official partnerships between higher education, industry and the health service, which could be aided by the standards included in the recently published Association of the British Pharmaceutical Industry Code of Practice (Association of the British Pharmaceutical Industry [ABPI], 2019). This code sets out the standards for the promotion of prescribed medicines to health professionals and other relevant decision-makers in the UK and determines the interactions between industry and health professionals, thus potentially ameliorating the ethical issues already identified.

Findings of the DCA

Figure 19 summarises the DCA findings. This shows that, despite the present drive to standardise wound care education and competency frameworks, in the context of the political, economic, professional and clinical environment in which wound care nursing takes place, wound care in nature is a much too dynamic, unstable and unpredictable phenomenon. A 'one size' approach to education is therefore unlikely to fit every need.

Instead, the evidence suggests that, rather than increasing the clinical content of the curriculum, education should include a skills 'toolkit' to develop processes and techniques. There should be a move towards a pedagogy aimed at developing processes and techniques that include a skills toolbox to enable problem-solving, approaches to managing ethical dilemmas, decision-making, change and conflict negotiation management they encounter in everyday practice. Education should also

equip nurses with the capacity to adapt and be resourceful in order to resolve inherent conflict and manage variations in evidence and ongoing inadequacies in resources, including equipment and dressings.

Additionally, formal networking learning environment ‘Safespaces’ enable practitioners to relieve themselves of the professional and personal strains they experience in an environment where they are not judged or criticised.

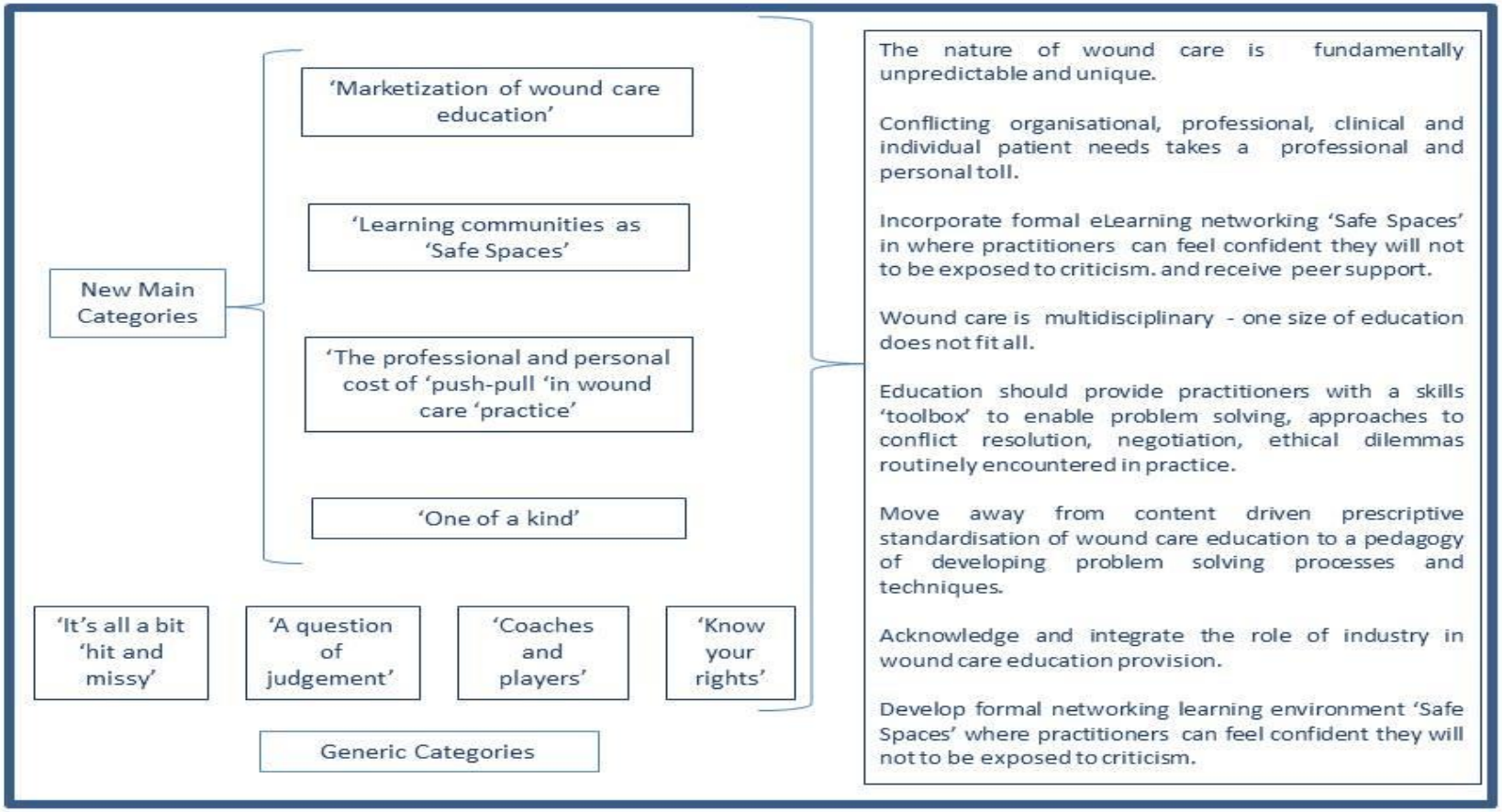


Figure 18. Summary of generic and new DCA categories and main findings.

Alongside an electronic platform on which practitioners can share and collaborate educational resources, incorporating online module 'Safespaces' was recommended in order to cultivate a community of practice found to be necessary for moral support and sharing experiences in a non-judgemental setting. Capacity in education should be extended to incorporate multi-disciplinary education for personnel other than nurses such as midwives, podiatrists, physiotherapists and moving and handling co-ordinators.

These results also provide a useful springboard to formally acknowledge the valuable contribution of industry in wound care education.

Process to Validate Phase 2 Findings

Consistent with my advocacy-participatory ontology and before proceeding to phase 3, I wanted to go back to the end users – the students – to validate my findings by establishing whether they resonated in any way. I therefore identified a convenience sample of two practising nurses, each with over 20 years' experience of wound care. I asked them if they could identify with the results in Figure 19 and to give their comments and ideas.

> **'I especially agree that wound measurement is subjective, especially if staff have had no training or explanation of this.'**

> **'Overall, yes, I think there are many issues with wound care in nursing today especially community vs. acute.'**

I found it reassuring that both agreed with the findings and that inconsistencies in wound measurement and dressings, product availability, restrictions on wound formularies, extensive differences in resource availability between acute and community services and patient co-concordance were the most pertinent.

Discussion of DCA Findings and Recommendations

The nature of wound care is unique and unpredictable and, as a result of inherent and conflicting organisational, professional, clinical and individual patient needs, the learning and teaching strategies within Benner's 'novice to expert' theory are arguably insufficient. The DCA identified that, as well as the need to ensure 'Safespaces', learning resource sharing functions such as 'wikis', built into online wound care courses, and wound care curriculums, should be designed to address the learning needs of the growing wider multi-disciplinary team (MDT) now involved in wound care and the increasing opportunities the wound care industry now appears to offer.

Reflecting on these findings and their relevance to Benner's theory at the end of this phase, I became aware that the learning and teaching strategies Benner associates with each of the five 'novice to expert' stages outlined in Chapter 2, while established in their own right, do not necessarily equip nurses and other healthcare professionals who are increasingly involved in wound care with the skills and attributes identified in phase 2, which were identified as essential in wound care. These include solving problems, negotiating, managing conflict and dealing with ambiguity and inconsistencies. I came to realise that working under such unsatisfactory conditions

is not a situation unique to wound care nursing and identified that, previously, Woods (Woods, 2000; Woods et al., 1997), also observed very identical conditions in which chemical engineering students were also required to solve new problems with limited resources and with incomplete or erroneous information.

Woods noticed that, despite his students engaging in problem-solving and using explicit suggestions to solve problems, including sample solutions, open-ended problems, worked problems and group projects, which are very similar learning and teaching strategies to those Benner advocates, and his expecting students to be skilled problem-solvers, his students still experienced unexpected difficulties.

Woods' longitudinal mixed-method study, conducted over 25 years (Woods et al., 1997), showed that just providing students with opportunities to solve interesting problems was ineffective in developing problem-solving skills and that even watching others solve problems was ineffective, with general problem-solving skills not developing over four years of undergraduate programme. Indeed, these strategies were found to be so ineffective that, when the wording or context changed, the students could not solve the problems. What happened instead was that they patched various parts of previous situations together to match the new problem situations, finding it difficult to bring together ideas from different courses to solve realistic problems from industry. Woods et al. (1997) observed that most of the mistakes that unsuccessful problem-solvers make tend to happen when they try to define problems, noting that the difference between unsuccessful (novice) and successful (expert) problem-solvers results from the latter using a broad range of

meta-cognitive and cognitive skills. Many similarities were found between these expert problem-solving skills in chemical engineering and those identified in phase 2 as essential to progress in wound care nursing curriculums, examples of which are shown in Table 23.

Table 23. Cognitive and attitudinal skills identified as being necessary to develop in wound care nursing education (adapted from Woods, 2000).

Cognitive and meta-cognitive skills	**Attitude**
keep the current problem in the perspective of the big picture	demonstrate perseverance
exhibit fairness and reason	motivated and willing to revise in the light of new evidence
monitor and adjust processes as they solve problems	cope with ambiguity and learn from failure
have an awareness and an ability to describe the processes used in problem-solving	willingness to take risks and to search for more alternatives
are decisive	respect evidence and show desire to use credible sources
seek reasons and clear goal statements	are willing to see objections and enter sympathetically into another point of view
seek as much precision as the subject/situation permits	independent thought and confidence in reason
have intellectual standards: clarity, accuracy, consistency, relevance, valid evidence, good reasons, depth, breadth, fairness	manage distress and stress
	defer judgement, overcome negative self-talk, build on other ideas
	willing to see objections and to enter sympathetically into another point of view

In response to his findings, Woods introduced the Build-Bridge-Extend (BBE) approach to curriculum design, whereby general problem-solving skills are ‘built’ (using content-independent activities), ‘bridged’ (to apply skill in a content-specific

domain) and then extended (to use the skill in other contexts and contents and in everyday life). Skills included developing focus, information gathering, remembering, organisation, analysis, integration, evaluation, flexibility, interpretation and description. He provided explicit activities that a) gave students a chance to see how to do a skill in a content-independent domain, b) allowed them to compare their behaviour with the target behaviour and c) helped them develop their behaviour through practice and immediate feedback. Tests and assessment of process skills that assess the degree to which students can apply the skills, such as self-assessment, were included.

The DCA findings exposed that, as a result of the ambiguous nature of wound care practice, education should correspond with the direction taken in chemical engineering. The BBE strategy helped Woods' students, the problem-solvers, to overcome the initial distress encountered naturally when beginning an ambiguous and challenging problem, gave them a common language to improve communication, and helped teams stay on task while improving their confidence and skills in problem-solving. Problem-solving workshops, the processes used to obtain a best answer to an unknown, or decisions subject to some constraints, enabled students to recognise that, for real-world problems, the perfect information is never available and the best possible answer must therefore be obtained with available resources – an answer that is 'a best answer' and 'subject to some constraints' (Woods et al., 1997, pp. 75-76).

Renewal and cross-pollination of this learning and teaching strategy between these professions would benefit wound care education because Benner's learning and teaching strategies do not address how nurses deal with apparent real-life difficulties in wound care. Developing the acquisition of the various cognitive and meta-cognitive skills shown in Table 23 should, to some extent, circumvent a content-loaded standardised curriculum and introduce necessary flexibility to accommodate the different needs of multi-disciplinary members. Furthermore, adopting the BBE approach could help 'dial down' the extremes in variation that exist in wound care practices and reduce the anxiety this appears to provoke while helping practitioners establish ways of documenting clear, logical and systematic decision-making trails to defend their professional accountability. Ultimately, BBE should benefit wound care nurses by obtaining best answers to unknown problems, or decisions subject to some constraints, where the problem situation is novel and one that the problem-solver has never encountered before, which was identified in Chapter 2 as the primary obstacle in applying Benner's theory to wound care practice.

However, with the advent of many other feasible innovative learning and teaching strategies in professional development nurse education such as flipped classrooms (Betihavas, Bridgman, Kornhaber, & Cross, 2016), problem-based learning (Gholami et al., 2016), simulation (Weeks et al., 2019), concept mapping (Al Johani & Al Nagshabandi, 2020), serious games (Maheu-Cadotte et al., 2020) and role play (Dorri, Ashghali Farahani, Maserat, & Haghani, 2020), which might be expected to yield similar outcomes in terms of professional development, it could be contended that,

by simply attempting to migrate Woods' BBE approach to problem-solving across to wound care education, this is merely a case of 'old wine in new bottles'. The reader should nevertheless exercise a degree of caution about readily arriving at this conclusion, as Sharma's (2017) analysis of emerging innovative teaching strategies in nursing alerts us to the idea that the efficacy of very few strategies, particularly those relying on technology, such as active learning classrooms (Owens, Barlow, & Smith-Walters, 2020) and simulation technology (Jeffries, 2020), are not in fact supported by particularly strong research evidence and have not been fully evaluated. The following systematic reviews validate Sharma's claims. Cant and Cooper's (2010) review of quantitative evidence for medium to high fidelity simulation-based learning in nurse education, for example, found some advantages over other teaching methods. However, results depend on the context, topic and method. Recommendations are made for further research to determine the effect of team size on learning and develop a common method of outcome measurement. Additionally, although many claims are made for case-based learning – education, learning activities based on patient cases – as an effective learning and teaching method, little evidence exists to support these claims. Although teachers enjoy case-based learning, Thistlewaite (2012) argues that the empirical data is inconclusive as to the effects on learning, compared with other types of activity.

Criticisms have also previously been raised regarding employing problem-solving as an approach in adult education generally. Sweller (1988), among others (C. E. Watson, 1976; T. L. Watson & Blanchard-Fields, 1998), has expressed concerns over

'problems with problem-solving'. Their concern centres on the basic tenet of general problem-solving approaches being heuristic – enabling a person to discover or learn something for themselves – and content independent. A vehement opponent, J. Carson (2007) for example argues instead that a knowledge base and transfer of knowledge, not a content-less heuristic, are the most essential components of problem-solving.

Having accepted such concerns, Woods' BBE is nevertheless exceptional in that the following two factors are key to setting it apart from its critics, thus validating its application to the wound care education context. In the first instance, unlike the limited availability of dubious evidence described above, a sound research evidence base exists over its efficacy. Sound positive results were gleaned from both Woods' original work and subsequent evaluation research into BBE (Woods, 1987, 2000; Woods et al., 1997), together with many fruitful examples of various cross-disciplinarity applications and successes over time (Gu, Chen, Zhu, & Lin, 2015; Hesse, Care, Buder, Sassenberg, & Griffin, 2015; Molnár & Csapó, 2018; Pusca & Northwood, 2018). Blanchard-Fields (Blanchard-Fields, 2007, 2009) also adopts an unusual perspective on solving problems. Blanchard-Fields' contribution is significant because unusually he believes that problem-solving can be considered from one of two quite dissimilar aspects. The first, and arguably more familiar, considers those problems that only have one solution – mathematical problems or fact-based questions for example – and which are grounded in psychometric intelligence. More relevant, however, the other is socio-emotional in nature and, similar to the main findings

emerging from this chapter regarding problem-solving in wound care, have answers that change constantly – in relation to, for example, someone's favourite food or what to get them for their birthday. Alignment is obvious as wound care decisions are, as I have clearly demonstrated, frequently emotional and subject to constant change.

I therefore suggest that adopting BBE will help develop those necessary, yet particularly under-developed, key cognitive and attitudinal skills which were identified as key findings. For example, it is envisaged that BBE will help work towards increasing wound care nurses' ability to manage ambiguity and learn from failure, see objections and enter sympathetically into another point of view, as well as have a willingness to take risks and search for more alternatives, manage distress and stress, and seek as much precision as the subject/situation permits (refer to Table 23 for a comprehensive list of Woods' cognitive and attitudinal skills).

In terms of its efficacy, Woods evaluated BBE and demonstrated several improvements: grades, a deeper approach to learning, an enhanced learning environment, enhanced skills in processing and problem-solving, a more positive attitude and skills for lifetime learning, improved self-assessment, skill development, and, crucially, in the context of wound care, confidence. As discussed in Chapter 2, Ousey and Blackburn (2019) emphasis on the importance of cultivating confidence in wound care nursing is echoed by one study participant, who also believes that wound care nurses,

‘need more knowledge and education to give us confidence to rationalise our decisions to our patient and management.’

Recommendations Following DCA

The learning and teaching strategies contained within Benner’s theory should be adapted to incorporate Woods’ BBE approach to wound care education curriculum design. ‘Safespaces’ and learning resource sharing functions should be incorporated into eLearning provision. Recognition of the wound care industry and MDT provision should also be incorporated into wound care curriculum design and development.

CHAPTER 6: PHASE 3 – DD

- **Research Objective 3: Understand the role of the student voice in modernising higher education wound care curriculum and development of theory.**

The DCA in phase 2 concluded with recommendations that Benner's theory should now be adapted in order to incorporate Woods' BBE approach into wound care curriculum design and that provision of 'Safespaces', online resource sharing functions, in the wound care industry and MDTs should also be incorporated. The most significant finding was that wound care practice is inevitably precarious and unpredictable. As an alternative to current thinking that seeks to standardise the curriculum (Guest et al., 2015; Pokorná et al., 2017; Probst et al., 2019), and as previously suggested by Dutton et al. (2014), Ousey (2010), Ousey et al. (2015), R White (2008) and (Richard White et al., 2016), increasingly fill it with content, and continue to apply Benner's learning and teaching strategies as they stand, it was recommended that Woods et al. (1997), BBE be integrated into Benner's learning and teaching strategies within the existing curriculum. It is anticipated that BBE will henceforth equip wound care nurses with the unique set of cognitive, meta-cognitive and attitudinal skills necessary to manage the difficult situations frequently encountered in routine practice.

Introduction

Consistent with my own transformative advocacy-participatory ontology outlined in Chapter 3, rather than now simply proceeding to make the changes to my wound care curriculum based on the main DCA findings set out in phase 2, it was important

that I consulted with my students about their views on these planned changes. This was an important step to undertake since, as highlighted in Chapter 2, there is no evidence to support the possibility that Benner took into account the views of her study participants in developing the theory. I wanted to explore how engaging with students at this policy implementation stage might affect the changes I planned to make and their possible role in developing wound care education theory.

In phase 3, I used the general principles of deliberative engagement research methods described by Chris Degeling, Carter, and Rychetnik (2015), Ercan, Hendriks, and Boswell (2017) and Curato, Dryzek, Ercan, Hendriks, and Niemeyer (2017), as my mechanism for data collection. This phase differs from the earlier phases in that it seeks to proactively and openly consult with and respond to wound care nurses and to involve them in a process of transformative change, a fundamental principle of deliberative approaches in policy research.

Consistent with Rogers (2012) and Kincheloe (2005) bricolage approach, outlined in Chapter 3, the methodology chapter, I used integration – 'a specific relationship between two or more methods where the different methods retain their paradigmatic nature' (Moran-Ellis et al., 2006, p. 51), to mesh this phase with the preceding phase in pursuit of 'knowing more' (Figure 20).

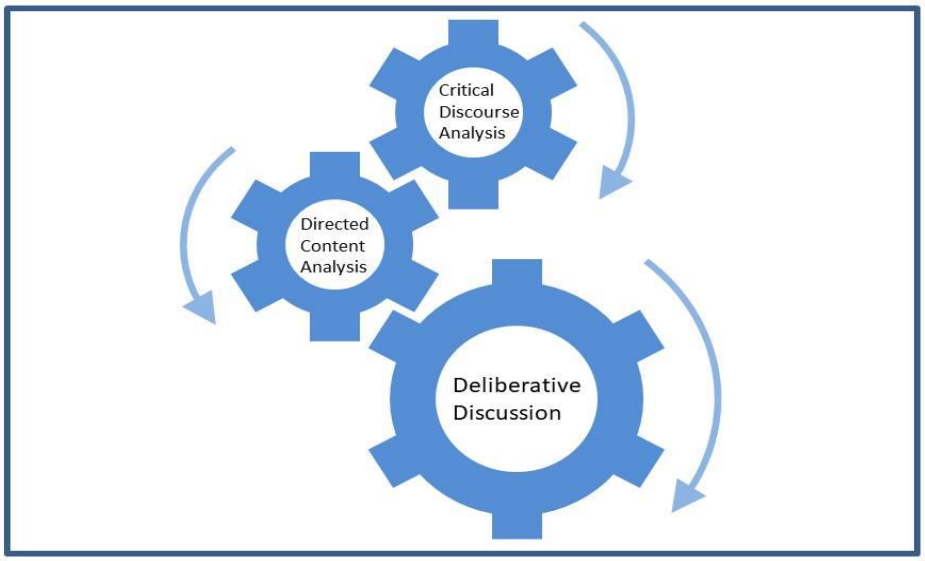


Figure 19. Inter-meshing of research methods between phases 2 and 3.

Justification for Choice of Deliberative Dialogue

Use of a deliberative approach was fundamental to the thesis, because, as far as I was aware, this enabled for the first time 'handing over control' of the curriculum to those practising wound care. I believed this would be advantageous because, ultimately, students know most about their learning needs and who will be most affected by change, rather than what I, policy-makers or key opinion leaders believed to be true.

Adopting a deliberative approach allowed me to seize a rare opportunity to give this mainly hard-to-reach and rarely heard group of nurses a voice, also enabling me to gauge the extent to which the thesis findings thus far aligned with their own views of what the wound care curriculum should look like in the future. I was nevertheless apprehensive, although resigned to accepting that the findings and recommendations made in phase 2 might not correspond with the views of the

students at all, which would, in turn, challenge and potentially jeopardise my thesis findings. However, I understood this outcome, although undesirable, to be an unavoidable consequence of adopting an advocacy-participatory ontological position. This realisation brought home to me the idea that, as a researcher, 'it is critical to pay attention to positionality, reflexivity, the production of knowledge and the power relations that are inherent in research processes in order to undertake ethical research (Sultana, 2007, p. 380), accepting the need to respond to unforeseen study findings.

Implications of Researcher Reflexivity – Amendment to Ethics Application

My principal objective in the final phase of the thesis was to capture the student voice. On this understanding, my original ethics approval was granted to carry out 12 individual semi-structured online interviews with students. However, by engaging in the process of reflexivity and to stay true to my own ontological transformative advocacy-participatory position, I decided to revise this to using an online focus group, believing that this would encourage more dialogue and interaction. However, over time, qualitative researchers, including Cobb (2011), Guttman (2007) and Kitzinger (1995), observed that the ability to capture the quality and depth of data I sought can be dependent on the knowledge of the participants on the topic of discussion. Interviews and focus groups are conventionally used to gather in-depth feedback on a topic. However, Rothwell, Anderson, and Botkin (2016) identify that little information is normally presented to participants prior to discussion. In the end, I decided to eliminate both these earlier methodological decisions. The ethics

application was amended to reflect this change and approved. My experience is consistent with Stevenson, Gibson, Pelletier, Chrysikou, and Park (2015) view that a 'one size fits all' standardisation of ethical procedures and approach to ethical appraisal acts against the production of knowledge about healthcare and restricts what can be understood about the social practices and conditions of healthcare.

Why Deliberate?

To ensure the most productive engagement possible, I finally settled on a relatively new approach in health research by applying the general principles of 'deliberative engagement' detailed by The Involve Foundation (2018). This is a qualitative research method, in which participants are supported to develop informed opinions about a topic through a process of learning, dialogue and public reasoning. I applied this to the online wound care education context. Deliberative engagement can take several forms and I chose to use 'deliberative dialogue'. This is an approach that builds on dialogue and consensus-building techniques, enabling participants to work together to develop an agreed view or set of recommendations. In terms of practical implementation of the thesis findings, I also believed that this approach would be beneficial because the participants themselves might also be involved in taking their recommendations forward to decision-makers, encouraging shared responsibility for implementation.

Deliberation is distinctive from more familiar forms of health service research methods in that it aims to uncover informed, considered, and collective public views

on a normative question within the wider social science context. As deliberation usually takes place in relation to research on aspects of inequality and 'where there is a need to define and justify the thresholds and concepts adopted on a deeper basis than convention alone can offer' (Burchardt, 2014, p. iii), it was relevant to my ontological position of advocacy and participation. As a minimum, the deliberation process involves encountering contrasting points of view and the requirement to justify opinions through arguments which make sense to others (Rawls, 1997). Its theoretical underpinnings also distinguish it from other types of qualitative research in that participants are active in the research process and operate, at least in part, through a collective forum, with an expectation that participants' views may be transformed by the research itself through new information and encounters with the arguments of others. This was an important aspect of the research because of the emancipatory effect of this empowering process on the participants, resonating with my positionality and the transformative nature of the research outlined in Chapter 3. One key anticipated benefit for using this approach was that, as a consequence of the intentional and direct input of new Information, the participants' views might change as a result of taking part.

I selected deliberation as the research method of choice because it is recognised as particularly suitable to use when the decision, policy or service in question involves complex issues, uncertainty or conflicting beliefs, values, understanding, experience and behaviours, all of which I observed in the background literature and in the findings of phases 1 and 2. Crucially, deliberation can be used at any point in the

policy cycle – for example, in policy determination or agenda setting, policy direction, policy design and policy delivery. The last two stages of the policy-making cycle were especially relevant to this thesis because I did not believe that I could, or indeed should, make and implement decisions that involved changing the curriculum by myself and wanted 'buy-in' from the end users – the wound care nurses.

Deliberation is a useful approach for policy consultations because it allows the public to be involved in decision-making that incorporates a wide range of viewpoints and ideas. Deliberative democrats emphasise that policies should be justified through the exchange of reasons and arguments relevant to all, rather than as a result of competition between private or personal interests where the most powerful lobby wins out (Kahane, Weinstock, Leydet, & Williams, 2010). From my ontological position, this was a useful feature because it moves away from the hegemonic approach to policy production and enactment found in phase 1 and in learning theory development in phase 2, where Benner does not take into account the views of the students, who ultimately stand to be most affected by policy outcomes but were not part of the policy decision-making process itself.

In terms of research quality, Carman et al. (2015) previously demonstrated trustworthiness of the deliberative process and confidence to extrapolate from the deliberative outputs and is increasingly used to seek scientific opinion and policy outputs of ongoing research (J. de Vries, Munung, & Tindana, 2016; R. De Vries, Stanczyk, Ryan, & Kim, 2011). Moreover, Michels (2011) and Searing, Solt, Conover,

and Crewe (2007) demonstrate this has strengthened citizens' power in decision-making, especially among disadvantaged sections of the population, symbolising open and transparent government and enhancing the legitimacy of the decisions reached, all of which were relevant to this unrepresented group of wound care nurses.

While deliberation is not a research method familiar to nursing education or practice, its promise warranted my taking a risk in order to secure a unique perspective to enhance wound care curriculum design.

Provision of Evidence and Integration Mechanism between Phases 2 and 3

DD is intended to have participants engage in discussion that moves through a structured process, facilitating higher levels of thinking and helping participants find common ground for action. In the participant briefing document I summarised the research aim and objectives then asked participants to consider the relevance of Benner's theory and each of the recommendations generated from phase 2 as separate deliberative items. The participant briefing document was key to obtaining an informed opinion, meaning that providing comprehensive information to participants ahead of the discussion was the key feature.

Data Handling Process

As a result of the novelty of using deliberation, several stages of the data handling processes were unfamiliar and amendments were made in places to adapt the approach to the research context. Deliberation is considered more of an 'approach'

to research, rather than a specific method, and this is reflected in the iterative nature of the data collection tool design process.

As expressed by Moran-Ellis et al. (2006), I wanted to 'know more' and needed the participants to give their views from an informed perspective. However, deliberators are expected to be capable of sophisticated reasoning and judgement and these qualities are not usually required of respondents when using more traditional research methods such as in-depth or survey interviews where activities generally involve encountering the views of others, occasionally incorporating prompts or aids for discussion of short duration and with minimal external input. Burchardt (2014) cautions that recommended participant numbers, recruitment procedures, duration of involvement, structure and content of process and types of analysis and interpretation vary widely within and between forms of deliberative research, ranging from workshops to focus groups, polls and consultations

Although opinions differ on the characteristics of DD, I used Fishkin's (2011), five requirements described below, for deliberation to underpin the design because these corresponded most closely with the open, fair, honest, balanced and participatory nature of the thesis.

- *Information*: The extent to which the participants are given access to reasonably accurate information that they believe to be relevant to the issue

- *Substantive balance*: The extent to which arguments offered by one side or from one perspective are answered by considerations offered by those who hold other perspectives

- *Diversity*: The extent to which major public positions are represented by participants in the discussion

- *Conscientiousness*: The extent to which participants sincerely weigh up the merits of the arguments

- *Equal consideration*: The extent to which arguments offered by all participants are considered on their merits regardless of which participants offer them

I wanted to ensure that the collaborative group deliberation was analytical, reflective and thorough, with purposeful and serious discourse that did not rush towards a decision, but as suggested by Bridges (1994), worked towards careful consideration of alternative points of views and choices. This process was operationalised, eventually using a protracted timescale of five weeks, within which the deliberation took place.

The deliberative dialogue took place using an asynchronous online text-based format. Despite the increase in synchronous communication over the internet and social

media, this has been shown to be less conducive for research participants in an online environment. Alongside dissociative anonymity, invisibility, solipsistic introjection, dissociative imagination and minimisation of authority, described by Suler (2004), conducting the study asynchronously would be useful because this is also thought to cause the online disinhibition effect whereby there is a loosening of social restrictions and inhibitions normally present in face-to-face interactions. With the DD not carried out in the same place or at the same time, this allowed the participants, and myself as moderator, time to think about answers, to be reflective and introspective and allow, as indicated by Poytner (2010), for views and reactions to develop, all essential characteristics of deliberation. The proposed research participants were all healthcare professionals, many of whom juggled shift work with study and busy personal lives, so this option offered a degree of convenience because they were able to log in to the study at a suitable time and place.

While deliberation may be considered as an 'approach', conventional research methods decisions still apply to the research design and implementation of the deliberative research. I therefore still needed to demonstrate transparency at all stages in the research process. To enhance methodological trustworthiness and rigour, I used Burchardt's (2012) four deliberative decision-making stages, which are normally used in face-to-face public policy consultation conditions as a guide – selection of participants; provision of evidence; nature of deliberation analysis and interpretation – and adapted these for the online data collection research purpose.

Selection of Participants and Sampling Strategy

Pragmatics

I discovered that, similar to that experienced by G. Smith and Wales (2000) and Michels (2011), with deliberative research, there is always a recognised trade-off between the quality of discussion that can be achieved in small groups and the representativeness or spread of opinion made possible by larger numbers. Papadopoulos and Warin (2007) characterise this as a tension between *'*participationists*'*, who emphasise inclusion and representativeness, and *'*deliberationists*'*, who emphasise the quality of the discussion.

The main challenge I experienced was that DD is generally intended to take place among participants in an open forum. I was unable to source any deliberative research that specifically related to online nursing education to direct best practice in participant sampling and selection. While consensus exists that transparent deliberative processes lead to more widely accepted policy choices, Friess and Eilders (2015) and Butteriss (2018) make known the design and quality of the communication process and expected results of deliberation remain largely contested. I therefore took a pragmatic approach to answering the research objective by applying some of the key principles of both deliberation and online focus groups to inform my design decisions.

Sampling

The parameters at which the quantity of participants are set in deliberative research are surprisingly diverse (Figure 21), ranging from 12 to 1000 people, and selection depends on the view of the participants – whether, for example, they are citizens, experts or self-interested individuals. Each view implies a distinct sampling strategy. I viewed my participants as experts able to bring their individual experiences as clinical practitioners and members of a hard-to-reach group. I selected a non-probability sample based on the research objective and the characteristics of the student population from the tissue viability module I was delivering at the time of data collection (2018-2019) to provide coverage and composition.

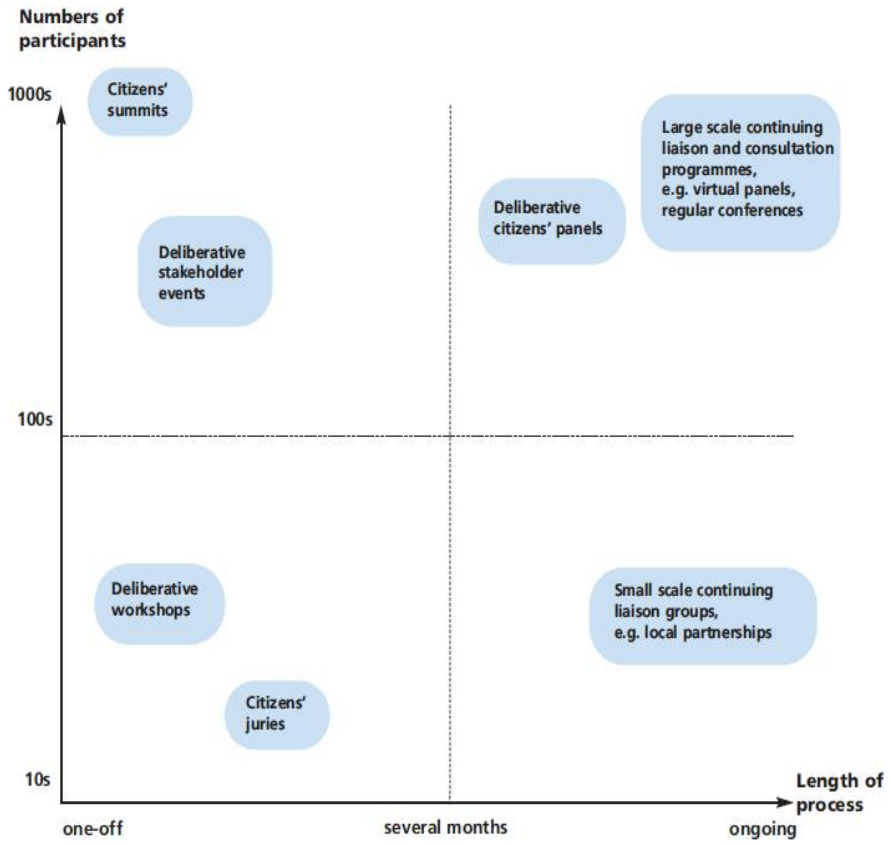


Figure 20. Deliberative engagement options plotted against length of deliberative engagement process and number of participants. https://www.involve.org.uk/resources/knowledge-base/what/deliberative-public-engagement.

Cognisant of the tension between 'participationists' and 'deliberationists' discussed above, the quality of the deliberation took precedence over representation and I therefore did not, as suggested by Fishkin and Luskin (2005), attempt to obtain a statistically representative sample to test statistical significance and produce generalisable results, instead favouring participant self-selection. This choice was informed by Wakefield et al. (2007) and G. Smith and Wales (2000) and the opinion that introducing statistical representativeness would create a microcosm of wider society because participants might see themselves as defined and divided by demographic characteristics. Instead, the participants were recruited because of the

particular roles they occupied as students and wound care practitioners because, as explained on page 42, Benner's theory does not consider how 'activist education' might also change its representation. This decision was key to the findings because, when compared to participatory research, Burchardt (2014), notes that deliberative research is especially useful where establishing a collective position is more important than understanding differences between sub-groups, and where the objective is to obtain considered, informed opinions on the subject at hand, rather than to extract information on attitudes, which will be useful as a guide to people's behaviour.

Recruitment

Findings remain largely inconclusive regarding recommended participant numbers to conduct DD online deliberation, which, as Silva (2017) observes, is still a field in its infancy. The sample population to be used was constrained by the number of students attending the wound care course and I took guidance from online focus group research methods literature for optimum recruitment numbers.

Poytner (2010) argues that online focus groups use fewer participants than face-to-face groups, although recommendations vary depending on whether the group is conducted asynchronously (ten to 30 participants) or synchronously (three to eight participants), contradicting Murray's (1997) earlier recommendation of between six and eight participants for the former. Poytner does, however, caution that 'the offline (asynchronous) group size may not be appropriate in all circumstances and a larger

group may be needed to promote the level of discussion and interaction the researcher seeks' (p. 545), and Clark (2017) suggests that groups often have to include up to 30 participants or more.

Although the lengthy timeframe of five weeks might dissuade participation, asynchronicity has, when compared with synchronous groups, been shown by Abrams and Gaiser (2017), to be more effectual in that fewer participants were expected to drop out

As well as achieving the desired depth of data required using deliberation, the data collection process was relatively easy to co-ordinate, required minimal information technology support, and was inexpensive and the least resource-intensive option because the electronic transcript data was easily captured using the existing eLearning platform file, ready for analysis.

Using the Moodle 'groups' function within the existing eLearning module, I embedded a separate discussion forum for the DD (Figure 22) to take place. This was visible and access was restricted to the DD participants, maintaining confidentiality from the remainder of the class not selected to participate.

To reduce the possibility of coercion, the deliberative dialogue took place after the module assignments were submitted, leaving limited time before the end of the 15-week module.

Figure 21. Restricted DD link created in existing Moodle course for data collection.

Inclusion Criteria

Based on the characteristics of the population and study objective, I identified a non-probability purposive sample population from the target population of 16 students undertaking the 'Tissue Viability' wound care module, previously outlined in Chapter 2, from January to April 2019.

Trading-off, Risk-taking and Managing Uncertainty in Research in Pursuit of Student Participation

I predicted that this class size of 16 allowed for over-recruitment. However, recruitment was hampered by unusually high student attrition as a consequence of ill health, delayed employer funding and deferment that year, reducing the sample population to 11.

Immediately, this attrition jeopardised the feasibility of phase 3 and I recognised that I quickly needed to make a trade-off between my pursuit of deliberation and all the benefits I anticipated that it would bring to addressing the research objective and the possibility of too few participants, potentially invalidating the study.

Complying with GDPR regulations, invitations were sent to the 11 students to participate in the study along with participant information sheet, study background information and consent forms via their university and personal e-mail accounts, with a response requested within seven days. If no response was received, a further request was sent, with no further contact made after this if no response was still received. Of these 11 students, six consented to take part. While I appreciated that

this was at the lower threshold of that suggested in the literature, with further risk of drop-out, I decided to continue with the approach because alternative views existed that countered the predictions. First, Im & Chee's (Im & Chee, 2004, 2012) research found an unexpectedly high retention rate in a study involving patients with cancer who had characteristics that might reduce participation in the online forum. Second, Burkhalter, Gastil, and Kelshaw (2002) recognised that group members are likely to participate in deliberation if they are motivated to hear and process the contents of arguments. I believed, having got to know these enthusiastic and driven students over the previous months, that they were motivated in this way. While participation was not as high as I first predicted, I hoped, as witnessed by Mann and Stewart (2000), one further advantage of a small group would be that it engendered a more comfortable environment, encouraging participant self-disclosure.

DD e-Platform

Burchardt (2012) argues that the extent to which deliberative exercises succeed in producing considered views depends in part on the nature of deliberation, including, for example, the ways in which the discussion is structured and facilitated and, as seen later in this section, the length of time allowed. Elements of the deliberation included setting ground rules, introducing the topic and purpose of the event, discussion of initial positions, hearing/reading and considering evidence, debate, and reaching a conclusion. As there is no standardised DD framework and it can be structured in various ways, there were several iterations between the evidence and debate stages.

Adopting a deliberative approach had several implications for the research design. First, the research participants' participation in *debate* was essential. The data collection tool was therefore designed to help participants become better informed, enabling them to encounter contrasting points of view rather than simply expressing pre-determined opinions. Each topic for deliberation was created in the designated Moodle section as a separate discussion point, with participants then able to contribute their own views and respond to others in a clear discussion thread (Figure 23).

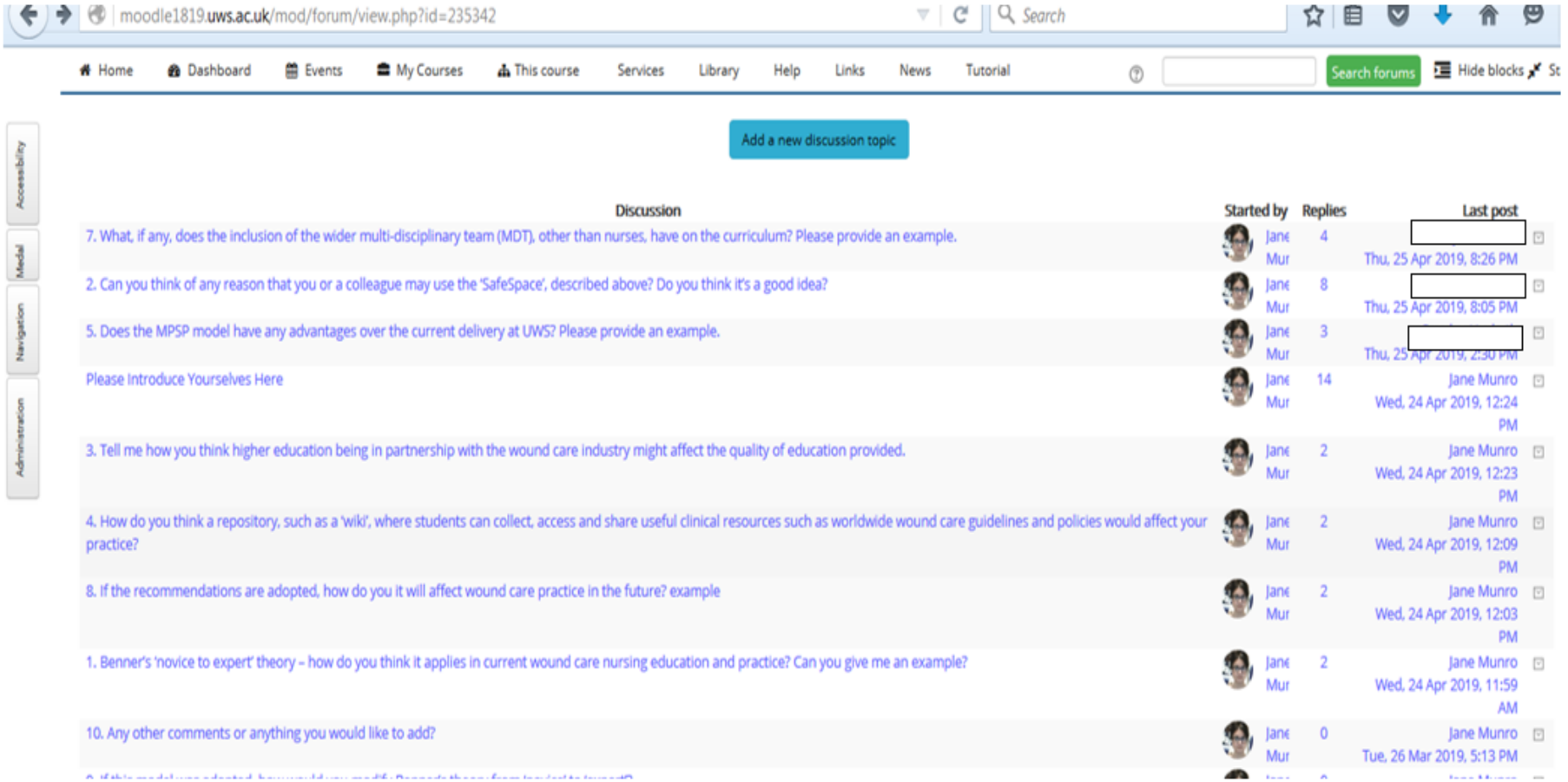


Figure 22. Topic guide of deliberative discussion forum created on Moodle platform.

Steps Taken to Mitigate Researcher Bias

Burchardt (2014) asks, if the research aims to generate *informed* views, one must ask informed by *whom* and *what*? Her thoughts on bias encouraged me to reflect on my role in the deliberation process, and I concluded that it was important that I informed the research participants' knowledge without manipulating them, and that, as suggested by Abelson et al. (2007), the pre-information provided was only used as a tool to encourage discussion.

To help mitigate bias, similar to that recommended by L. Carson (2006), I formed a 'steering group', inviting both research supervisors and my independent observer, whose role was outlined in Chapter 3, to comment on the briefing documents in advance. I also sought the independent adviser's involvement throughout the DD to observe for possible personal bias. I chose to explicitly position the participants, so that, rather than attempting to be neutral, I invited extreme views, as suggested by Davies, Wetherell, and Barnett (2006), encouraging debate that was honest, forthright and critical and asking for examples and alternative ideas. I was also cautious that the pre-information was, to an extent, incomplete and partial, thus giving the participants the opportunity to invite additional alternative viewpoints held by their peers and to ask me for any additional evidence or supporting information if required. This approach contrasted with most other qualitative research methods that facilitate discussion and stimulate participants' views because they limit the extent to which the researcher's presence and activity 'contaminates' the study.

The Nature of the DD

I used various strategies to create a safe and conducive atmosphere to encourage discussion, including an explanation about my role as moderator, providing a comprehensive brief, setting ground rules and introducing an icebreaker.

The Role of Moderator

I adopted the role of discussion moderator, a position that requires training and experience. While I felt competent in this role given my significant experience in regularly facilitating online discussions within the module, Gastil (2004) considers the moderator's behaviour, noting that modelling active listening and the democratic process can influence the behaviour of other group members. The moderator must therefore be skilled in actually conducting the DD format for an effective discussion to evolve. To address this, having not acted in this capacity before, I asked the independent observer to periodically review the content for possible bias – by, for example, detecting whether I had swayed the discussion or spent a disproportionate amount of time on any particular topic.

The independent observer reported that she had no concerns in terms of potential bias or my leading students with questions.

Briefing

The briefing document included the principle behind deliberation and the focus of the DD. I had to take cognisance that, despite being experienced clinical practitioners, the research participants were nevertheless 'non-experts', and that the conceptual nature of the research contained with the pre-information could be difficult for them to engage with.

Unlike Barnes (2008), I chose not to include anecdotes and personal experiences as an aid to communicate issues, concurring with Evans and Kotchetkova (2009) opinion, that they might act as an emotional veto over other perspectives and forms of reasoning, thus reducing the scope for effective deliberation.

Ground Rules

Ground rules are a common mechanism for outlining the role of participants and clarifying the purpose of the discussion. The forum began by establishing ground rules, including allowing everyone to participate, sticking to the research issues and 'attacking the problem, not the person'.

Icebreaker

The first activity invited participants to introduce themselves and say why they wished to take part. I tried to connect the issue to the participants' lives by inviting

them to take a personal stake and giving them opportunity to share personal experiences relating to the issue at hand to help make the issue tangible and relevant.

The Deliberative Process

Participants were first invited to read through the DD brief and then answer and respond to each other's opinions posted to each of the discussion questions, seen in Table 24.

Table 24. DD briefing document and discussion questions.

1. The DD background and participant joining instructions, including briefing, ground rules and icebreaker.
2. Benner's 'novice to expert' theory – how do you think it applies in current wound care nursing education and practice? Can you give me an example?
3. Can you think of any reason that you or a colleague may use the 'Safespace', described above? Do you think it's a good idea?
4. Tell me how you think higher education being in partnership with the wound care industry might affect the quality of education provided.
5. How do you think a repository, such as a 'wiki', where students can collect, access and share useful clinical resources such as worldwide wound care guidelines and policies, would affect your practice?
6. Does the BBE three-stage model have any advantages or disadvantages over the current wound care module delivery at UWS? Please provide an example.

7. What effect, if any, would the inclusion of members of the wider MDT, other than nurses, have on the wound care curriculum? Please provide an example.

8. If the various recommendations were adopted, how do you think it will affect wound care practice in the future? Please provide an example.

Participants were advised that they could contribute to each question as much or as little they wished over a five-week period and informed that I, as moderator, would respond to selected posts and that I might, on occasion, ask for more information or follow up with additional questions.

Of the initial six participants who consented to participate, five contributed to the icebreaker, providing details of their names, clinical backgrounds, wound care experience and reasons for undertaking the module. Of these five participants, only two, referred to as participants A and B, opted to engage further with the deliberative process.

'Salvaging' the DD

I was aware that recruitment numbers were much lower than normally acceptable and perhaps should have terminated this phase of the thesis at this point. However, I recognised that as detailed by Rawls (1997), the fundamental characteristic of deliberation is to encounter *contrasting points of view and the requirement to justify opinions through arguments* which make sense to others. On scrutinising the wound care roles and experience of participants A and B, it was clear that they still exhibited

the necessary diverse characteristics and the polarisation necessary to generate contrast, diversity and balanced DD (Fishkin, 2018).

Participant Profiles

Participant A

Participant A was a physiotherapist with significant experience, now working as a manual handling practitioner, usually advising staff on the management of patients with bariatric (obesity related) care needs and also often on problems with skin. Her decision to take the Tissue Viability module was because wound management and skin care had not been part of her physiotherapy training or career to date, but she needed to develop her knowledge.

Participant B

Participant B was a staff nurse in a busy general hospital who had been working on a combined assessment unit for nine years and manages a variety of mainly surgical, acute and non-healing chronic wounds. She finds looking after surgical and acute wounds typically straightforward but, in contrast, finds dealing with chronic wounds very challenging. Her experience echoes one of the phase 2 findings relating to the uniqueness of wounds and the complex challenges this brings to their management:

> **'since not one patient's case is the same as the other, therefore treatment and wound management is unique in each patient.'**

I remained neutral while guiding the participants through the deliberative process, encouraging them to consider all issue alternatives outlined. I asked participants to connect their choices with values, to illustrate their ideas with personal stories or examples, to consider hypothetical dilemmas and to explore the consequences of their actions for different people involved. I also encouraged both participants to think not only as individuals but also as members of their larger wound care communities. I provided opportunities for questions, gave examples of findings, and asked for examples. Incorporating deliberation into the design allowed both participants to explore the complexities of the subject, consider the implications for themselves and others, and for us to co-create an understanding of the issues. I also encouraged participants to speak to others and to bring their thoughts back to the discussion and, through questioning, to move from talking to critically thinking about solutions and how they might take action in their workplaces.

Modification to Proposed Study Length

The range of time recommended for DD to take place depends on the number of question topics covered and if, as I chose to ask, further questions as a result of ongoing discussions. Deliberations can last for as little an amount of time as a couple of hours or extend over several days with a mean length of four weeks (L. Carson, 2006; Coote & Lenaghan, 1997; C Degeling, 2019; Fishkin & Luskin, 2005). Following the initial icebreaker introductions, very little activity took place. I imagined this to be the result of my own oversight of the space between the participants' final module assignment submission date and the DD. To address this, I revised the length of time

for participation from three weeks to five weeks. I also hoped that this extension would offset the effects of the attrition, which, as previously explained, could impact the quality and quantity of data. I also aimed for the extension to encourage greater engagement between participants, permit issues and views to be explored in greater depth and introduce more flexibility to review the evidence.

Interpretation

I used a simple and widely used extractive text summarisation technique (Allahyari et al., 2017; Bonzanini, Martinez-Alvarez, & Roelleke, 2013) for creating synopses, abridgements and soundbites to present the deliberative opinion data. Extractive text summarisation preserves the overall meaning in a concise form, focusing on content that conveys pertinent facts and information while filtering out potentially 'noisy' data. I ranked the deliberative dialogue phrases by choosing only those most relevant to the meaning of the source, and organised the findings under the following topic headings: Benner, MDT, 'Safespace' and sharing resources, education–industry partnership and BBE. In addition, I inserted the participants' reflections on transforming their wound care practice.

On Benner

Only Participant A, the physiotherapist, chose to address Benner's 'novice to expert' principles during the discussion. She frequently applied these principles when assessing complex physical therapy problems and used the model as a device to help unqualified support worker staff to understand the principles of task delegation. She

also had reservations about her ability to confidently apply the same principles to wound care as she did to physiotherapy, suggesting,

> **'there may be some value [in Benner's model] in considering the skill level of the person who will undertake the treatment, as it relates to wound care.'**

Multi-disciplinary Wound Care Education

Both participants agreed that a multi-disciplinary approach to wound care education was more beneficial than each discipline working in isolation. Participant B, the nurse, also felt that wound care education should be available to a wider sphere of professionals than is conventionally acknowledged, including in old age psychiatry, drug and alcohol services and pain management, as well as more familiar disciplines such as dieticians.

After lengthy debate it became apparent that both participants were united that including additional members of the MDT would enhance the wound care curriculum. Participant B acknowledged that nursing would probably always have the lead in tissue viability. However, for a truly holistic approach to patient care, there needs to be,

> **'input from a range of specialities to ensure that the patient gets the very best treatment available.'**

Participant A explained that, as a result of studying on the module and seeing wound care management from the perspective of the nurses on the module, her practice had improved. Both participants agreed that a more inclusive curriculum would provide a greater appreciation of how team members contribute to wound healing

and pressure ulcer prevention, enabling better care planning and helping practitioners to,

> **'see the bigger picture, not just the wound.'**

eLearning 'Safespace' and Learning Resources Repository

After some productive discussion, the proposal to introduce an online 'Safespace' concept also met with joint approval. Participant B made an important point regarding the deficit in wound care education provision, believing that, because of an all-round deficit in knowledge, staff lacked confidence and struggled to make the correct decision, instead,

> **'rely[ing] on each other's knowledge and experience when assessing, treating and choosing dressing products.'**

A 'Safespace' would enable exchange of amassed knowledge.

The geographical inequalities in access to specialist wound care advice and wound care resources between acute and community settings identified in phase 2 were reinforced following debate as a concern, giving further weight to the idea of incorporating an eLearning functions that would enable shared access to educational resources:

> **'We often have to wait for quite some time for the nurse specialist.'**

Both were also united that this repository should be accessible to all disciplines, not solely nursing, in the form of, for example, a 'wiki', with access to an up-to-date, round-the-clock, one-stop shop of multi-disciplinary wound care information and

guidelines. This is believed to be a key component of any future wound care education provision.

Education–Industry Partnership

The proposal to enhance the role of industry in wound care education met with considerable deliberation. Participant A 'learned a lot' from commercially supported education and felt that this demonstrated that companies were able to invest in and provide a range of high-quality and engaging education packages, advocating that any commercial involvement in wound care education in the future 'would be very beneficial'. Participant B also viewed commercial provision of education as a beneficial way to promote cost-effective wound management by providing useful information on their products that is not always available as well as wider wound management-related topics. She also suggested more industry investment in online educational technology to advance simulated, dynamic, interactive and collaborative learning materials, preferably incorporating case study scenarios where students can become more involved by interactively grading wounds, developing management plans and choosing the most appropriate dressings.

Participant B, however, expressed concerns, fearing that any joint online education provision between higher education and industry did not negate the need for important personal networking opportunities on wound care study days. However, she did recognise the 'Safespace' concept as the modern-day digital substitute for this:

‘but I suppose this is where the ‘Safespace’ comes in.’

She felt that this would grow in usefulness, particularly as the cost pressures to run study days and release staff become increasingly prohibitive. Both participants were cautious about the possibility of introducing bias from commercial involvement in that information provided could be biased in favour of a company’s own products. Participant A, who regularly used companies to teach on specialist subjects, could, however, see no problem with it, on the provision that professional boundaries are well defined and industry best practice standards are followed.

BBE

The benefits of incorporating the BBE idea into wound care curriculum design primarily involved its application to problem-solving within the participants’ own areas of practice. Participant A was a particularly strong proponent of teaching the principles of problem-solving:

‘all good and successful treatment begins with understanding the problem rather than techniques, because you can never teach all the techniques that someone may require or anticipate all of the situations that they may be exposed to – in doing so, you give people the skills to address what they come across in practice.’

She believed this to be the foundation of clinical practice:

‘this [problem-solving] has been the cornerstone of physiotherapy for years.’

‘if you don’t understand the problem you can’t begin to form a treatment plan or discuss the case with colleagues.’

She takes this further, stating that not understanding the problem can even compromise the patient relationship:

> **'if you can't assess accurately, then I believe you cannot have a credible relationship with your patient.'**

Participant B was also enthusiastic about the proposal because it encourages nursing students to adopt skills to help them. BBE would help them to,

> **"'think outside the box", to analyse the problem instead of jumping from the problem to the "action"'.**

She suggested that, given the complex nature of wound care, the BBE approach would be invaluable as students would be taught not to skip certain steps in the process. She did, however, warn that one difficulty might be that nurses,

> **'learn that each problem has only one solution and I think that is particularly true to managing wounds. Its adoption, in principle, might therefore not be straightforward.'**

Participant B agreed with Participant A here that some pitfalls do exist where wound care practitioners learn a lot from one another:

> **'there is a risk of picking up bad habits if learning is only based on the exploration of techniques alone and consequently people might stop asking questions and doing the background research which would reflect on the result.'**

The BBE approach could arguably help in overcoming old learning and old habits. Participant A believed that it might also help practitioners analyse the causes of the wound and not to focus only on treatment in order to achieve better outcomes for patients and the economy:

'it is necessary to tackle the causes of the wound too.'

She then also considers how BBE might reduce the characteristic variations in wound care:

> **'we all have our own way of doing it, we are all different and multi-factorial just like wound care and that ranges from "systematic and logical" to "just react and don't plan ahead".'**

Consensus around this existence of indifference and idiosyncrasy was also apparent throughout the DCA narrative in Chapter 5 and background theory.

Transformative Wound Care Practice Through Deliberation

A key feature of DD is that, through informed opinion, participants should reflect on knowledge and transform their thinking, beliefs and practice: 'the action piece of the deliberative discussion is determined by the group and engages participants to assume civic responsibility' (Goodin & Stein, 2008, p. 273) . Attempting to mobilise transformation was an important intention in this thesis because it helped to realise the advocacy-participatory nature of the study.

Participant A believed that, if she could adopt the study's recommendation in her work environment, this could assist staff and students with better assessment and critical thinking skills. Participant B, however, considered that creative thinking resulting from using BBE might be problematic, and that the level of clinical skills possessed by nurses is often dependent on their own personal commitment to wound care and interest in the field:

> **'some nurses find wounds fascinating while others struggle to deal with them due to their smell and appearance and this in turn influences the outcome.'**

However, she remained optimistic, convinced that, regardless of this, with the BBE approach, staff would still have a much better understanding of the importance of assessment and that the recommendations in phase 2:

> **'may go some way to adopting standardising in some of the approaches to wound care.'**

No Data is Redundant

Despite choosing not to continue to participate in the full DD, I decided not to discard the data provided by three participants who only responded to the icebreaker (Participants C, D and E). My rationale was that a content analysis of their responses showed remarkable similarity to the generic and new main categories found in phase 2 (Table 25).

Table 25. Recovered data from participants choosing not to continue in the study and the connection with phase 2 results.

PHASE 2 GENERIC CATEGORY AND NEW MAIN CATEGORIES	PHASE 3 SUPPORTING NARRATIVE
'KNOW YOUR RIGHTS'	**'wound care depends more on patient compliance than on any other aspect'**
'PUSH–PULL – THE PERSONAL COST OF WOUND CARE'	**'I never hear how things finish or complete for the patients'**

	'when the sides match again and seeing the end results of patient satisfaction and wound closure is very rewarding'
'COACHES AND PLAYERS'	**'I have less control and impact in the community environment on wound healing than in an in-patient environment'**
'QUESTION OF JUDGEMENT'	**'specialist tissue viability nurses are vital and I have personally gained a lot of knowledge from them'** **'over time I noticed a change in leg ulcer management – initially, leg ulcers were very difficult to heal and once a patient with a chronic leg ulcer was admitted to a caseload it seemed very difficult to heal the wound and discharge [the] patient'**

I used this data, which I would have ignored had I used a more traditional research method, to help triangulate the phase 2 findings. The ability to do this demonstrates that, in bricolage research methodology, no data is redundant for a research problem where little is currently known.

Despite these students not continuing in the deliberative dialogue, their contributions and their reasons for studying on the course in the icebreaker activity indicated that even taking on the role of 'student' had in itself engendered an increased sense of empowerment to bring about change in their wound care practice:

‘passing on my newly acquired knowledge to less experienced staff junior members of the midwifery team get experience and knowledge in tissue viability which at present non-existent’

‘my plan is to mentor less experienced staff so they can obtain knowledge and skills to heal wounds efficiently and confidently’

Discussion and Conclusion

Deliberative dialogue was intended to give a voice to wound care nurses to express their personal views on the extent to which the research recommendations made in phase 2 matched their own ideas of what wound care education should be like in the future, not what I or policy-makers believed.

The extractive summary findings provide consensus in support of the findings from phase 2 although some consternation emerged around the ethics of the wound care industry’s involvement in wound care education provision.

Of the five topics offered for deliberation, the finding most likely to affect Benner’s theory and its respective learning and teaching strategies related to integrating Woods’ BBE into the wound care curriculum. This shifts the curriculum from a content-laden approach reliant on problem-based learning and critical reflection to prioritising a focus on practitioners acquiring fundamental baseline skills and attributes to solve difficult problems.

However, efforts to develop the wound care curriculum along these lines need to be cognisant of the way that the BBE process teaches students to ‘think outside the box’.

This is because BBE might conflict with the often-held belief in wound care relating to only one solution to each problem and mean that some students might need additional support to adapt to the possibility that one problem can have many solutions.

Deliberation proved to be a useful approach in which students, the end users, independently endorsed the recommendations for curriculum change and, through their participation in the deliberative process itself, felt empowered to transform change in their own practice. Ultimately, the final group size was determined more by the challenges of recruitment and retention than by the quality of discussion that arose. The total number of events available for deliberation was also affected by pragmatic considerations of opportunity and time.

The chance to deliberate extended a unique opportunity to research participants, giving them time to personally reflect on the topic, and the findings indicate that this facilitated a degree of transformative change for all participants. Examples of how they intend to make changes in their places of work demonstrate that deliberation encouraged shared responsibility for implementation.

In terms of my own advocacy-participatory world view outlined in Chapter 3, this act of deliberation was fundamental to the thesis because it helped re-dress the balance in wound care policy production and encouraged debate. Student participation here links with phases 1 and 2 because, as explained, from a critical pedagogy stance,

education cannot be divorced from politics and should allow the oppressed to re-gain their sense of humanity, in turn overcoming their condition. However, to do this, the oppressed individual must play a role in their liberation (Freire, 1968). Engaging with my students as active contributors represented a collaborative effort that helped to ensure that wound care practitioners most likely to be affected by educational and practice policy were handed power, giving them agency and a degree of control over what their own education should entail. In this regard, the 'voice' of wound care students makes an important contribution to modernising higher education wound care curriculum and development of theory.

The final chapter provides a summary of the separate findings from each phase, bringing the most significant and over-arching issues contained to bear on Benner's theory, which is then represented diagrammatically by visually changing the way in which the theory is currently construed. Directions for future research and study strengths and limitations are also addressed.

CHAPTER 7: GENERAL DISCUSSION AND CONCLUSIONS

> **'I am a community specialist podiatrist. I work mainly in domiciliary. The profession has greatly changed over the past few years and wound management is 90% of the workload. As well as profession development I wanted to do this module so I can give patient care the best of my knowledge.'**

Introduction

The aim of this thesis was to explore the relevance of Benner's 'novice to expert' nursing theory to wound care higher education curriculum design. The background literature identified policy, wound care practice and student participation as key influences on the research problem. These three concepts were used to guide the three research objectives and the overall research design. I use the introductory quote to this chapter to help galvanise the study findings: that wound care poses an ever-increasing financial cost to the health service and there is a growing need for effective wound care education, not only for nurses, as indicated by Benner, but for the increasingly diverse range of healthcare professionals.

The bricolage research methodology shaped an integrated, sequential, qualitative, three-phase multi-method study, and was used to address the respective research objectives of policy, practice and student participation. Synthesising three different research methods – phase 1 (CDA), phase 2 (DCA) and phase 3 (DD) – developed a more comprehensive picture of how Benner's existing theory applies to contemporary wound care nursing.

The CDA explored the influence of policy on the application of Benner's 1984 theory in higher education wound care curriculum design. The results suggest that Benner's theory does not

effectively consider the significant effect of the healthcare policy process on progression from 'novice to expert'. The policy-making process was found to have a particularly detrimental effect on wound care education, mainly as a result of professional and institutional rivalry and industry's increasing ownership and control over the wound care education agenda and consequent ambiguity and uncertainty. Lingusitic strategies in regulatory policy discourses also created ambiguity as a mechanism of maintaining existing hegemonic structures between the NMC and its members. This ambiguity was thought to jeopardise wound care nurses' professional accoutability. 'Aspiration and Resolution' and 'Ambiguity or Opportunity?' were identified as the main constucts from the CDA.

These constructs informed a DCA of wound care students' eLearning discussion forum posts in order to identify which, if any, features of routine wound care practice affected the application of Benner's theory to wound care education. It was found that Benner's assumptions do not take account of how everyday, and little understood, experiences of wound care nurses alter their projected progression from 'novice to expert'.

Analysis of everyday events identified the main issue involved as deep-seated and widespread feelings of inequality, inconsistency, contradiction and unpredictability in wound care knowledge, resources and education. The discontent caused by working under such conditions takes a previously overlooked toll on the personal and professional lives of those providing wound care – the product of inherent tension between strong professional ambition and drive to heal wounds and the unstable conditions encountered in practice. The presence of a wound care 'community of practice' created within the eLearning environment

was found to be a crucial factor in mitigating negative experiences and emotions through the ability to access non-judgemental emotional support and through sharing knowledge, experience and difficult-to-access learning resources.

The unstable conditions encountered in wound care provision exhibited a remarkable similarity to those observed by Woods et al. (1997), albeit in the entirely unrelated discipline of chemical engineering. As an alternative to adding even more content and standardising the wound care curriculum as is currently suggested, similarly to the approach taken by Woods, learning and teaching should be orientated towards nurses acquiring a selected set of cognitive and attitudinal skills that equips them to solve problems by helping them to systematically work with whatever resources and knowledge available at the time. Instead of wound care nurses fearing the inherent ambiguity present in wound care, with these skills, practitioners will be able to 'embrace' it. Ambiguity in wound care will not go away and cannot be curbed because it is not only intrinsic, but an essential feature of wound care.

Re-designing the wound care curriculum to incorporate Woods' BBE approach should help to 'dial down', or at least regulate, the extremes of variation and ambiguity experienced by wound care practitioners. This should also introduce a degree of flexibility in the curriculum to accommodate the increasing diverse educational demands of multi-disciplinary professionals while at the same time generating a systematic and credible way for practitioners to highlight their clinical decision-making processes and defend their accountability.

The DD in phase 3 then sought to understand the role of student participation in the process of modernising the higher education wound care curriculum. The findings from the rarely heard voices of wound care students demonstrated that Benner's current theory should be expanded to represent the potentially constructive contribution of the student perspective on validating and shaping changes in wound care curriculum development and theory.

Bringing the Study Findings to Bear on Benner's Theory

To my knowledge, this is the first research study to use a methodological bricolage to obtain an understanding of the research problem from multiple perspectives. This multi-method methodology facilitated a multi-perspective meta-interpretation between each of the three phases, allowing for a more comprehensive mapping out of the richness and complexities of wound care nursing and education by studying it from more than one standpoint.

I brought together the main findings contained with each of the three phases of CDA, DCA and DD to identify six over-arching themes most related to my teaching practice. This section now considers each of these in light of their influence on Benner's theory. Benner's linear theory (Figures 1, 2 and 3) is then re-drawn to more accurately represent its application to wound care education today.

- Wound Care Setting
- Student 'Voice'
- Policy Production & Enactment
- Wound Care Practices

- Inter-professional and Political Rivalry
- Marketisation of Wound Care Education

Wound Care Setting

Probably the most significant, and unexpected, finding, which had the greatest influence on Benner's theory, involved the distinct, often hostile, wide-ranging circumstances in which multi-disciplinary healthcare professionals, not only nurses, deliver their day-to-day care and the subsequent detrimental toll this took on them personally and professionally.

The extracts from the discussion forum posts in phase 2 show that practitioners with a vested interest in wound care are driven individuals motivated by, and reaping job satisfaction from, restoring their patients' skin integrity and returning it to its previous intact and undamaged state. However, it was discovered that the typical circumstances under which they provide wound care do not naturally lend themselves to this end, instead perpetually confounding it through inadequate and inequitable availability of essential resources such as the best wound dressings and essential pressure-relieving equipment. Guest et al. (2015) also found inconsistencies in wound care practice and in particular assessment, concluding that holistic assessment varied and assessment are suboptimal. Recurring contradictions in wound care research evidence, normally used to inform good practice, inconsistent experience of managing difficult complex wounds, differences in opinion on best practice among peers and reduced employer funding supporting CPD are some genuine obstacles standing in their way. Widespread confusion also exists over the correct level and amount of education required, and this finding builds on Flanagan's (2008) belief that lack of good-quality evidence in wound

care serves to perpetuate negative feelings among clinicians, in turn leading to feelings of apathy.

Noticeable differences were evident between rural and urban provision of community and acute care. While some practitioners are driven, others, perhaps with wound care tasks imposed upon them, are less so: 'some practitioners may find wounds fascinating, others struggle to deal with them due to their smell and appearance and this in turn influences the outcome'. These findings expose a significant discrepancy with Benner's study, where the research participants were limited to nursing staff in hospitals only – a 'representative sample of current clinical practice in hospitals' (Benner, 1984, p. 177). Furthermore, Benner's sample does not represent the increasingly important presence of the wider MDT in wound management apparent in both the findings and background literature, such as Hignett et al. (2015) valuable insight into the positive influence of manual handling professionals in pressure ulcer prevention.

Benner (1984, p. 178) claims that a nurse might only perform at 'expert' level on the proviso that she or he has innate ability and adequate educational preparation in a clinical situation. They must also be:

(1) highly experienced

(2) motivated to perform well

(3) in possession of the usual resources and constraints associated with that situation

However, the circumstances in which wound care has been shown to be provided in this thesis means that these conditions, on which Benner's theory is founded, can never be entirely satisfied, meaning that reaching and retaining 'expert' status is most unlikely. This is supported by Guest, Fuller, Vowden, and Vowden (2018), for example, who note that, in wound care, no direct correlation is evident between wound complexity, wound duration and senior involvement. In specialised disciplines such as wound care, where simply not enough is known about Benner's prerequisites, it is therefore wrong to make assumptions without more scrutiny. Reasons such as this might well be behind Benner making the rather outlandish and unqualified claim that, despite all that has been said, 'not all nurses will be able to become experts' (Benner, 1984, p. 35), thus absolving herself of any aspiration offered by the theory.

The probability of successfully healing wounds, particularly chronic ones, is widely regarded as challenging – 'although healing is not achievable in all wounds, it is the primary desirable outcome for all wound types' (Guest, Vowden, et al., 2017, p. 300) – and, as borne out by the phase 2 results, can often be unlikely. This argument is essential to keep in mind because negative clinical outcomes such as these further weaken the case of Benner's existing theory in the wound care context. Only if the reader seeks out the original out-of-print 1984 text is it made known that all of the interview data underpinning her theory relates exclusively to *positive encounters* – 'only patient care situations where the nurse made a positive difference in the patients' outcome are included' (Benner, 1984, p. xvii). This is in stark contrast to the often undesirable outcomes and adverse experiences of wound care practitioners brought to light in this thesis and is now, as a result of the study, understood to be the norm in day-to-

day wound care. I argue that the exemplars Benner used to inform her study do not display common events in wound care nursing practice. On this basis, in the context of wound care, an alternative view is that Benner's theory is skewed and incomplete. This is because it is not, but needs to be, adjusted to represent the real-world nature of frustration, disappointment, suffering, pain and loss the study found to be associated with wound care, as well those instances of successful wound healing and good clinical practice.

Benner also argues that achieving and maintaining expertise depends on the availability of certain employment opportunities to nurses in order that they can gain comparable experience and develop a shared language with clinical colleagues. Benner suggests that opportunities such as a clinical promotion ladder, CPD and staffing strategies are necessary to ensure that, 'nurses who are expert with the particular patient population area are available for consultation at all times' (p. 182). Benner also links provision and access to career structure, clinical expertise, educational opportunities and caseload constancy with attaining expertise. However, I have clearly shown that such ideal conditions are far from the norm in wound care practice, and correspondingly, this discrepancy jeopardises the likelihood of someone becoming an expert wound care practitioner, again challenging the theory's relevance to wound care.

Benner makes the logical argument that the same nurse might perform at various levels of skill in different conditions: 'one can reasonably expect a nurse to perform at the expert level for example in familiar situations and at the competent or even advanced beginner level in less familiar ones'(Benner, 1984, p. 179). However, this principle flounders when it is

generalised to delivering wound care to the enormously unpredictable and changeable patient caseload whose wound care needs vary in the extreme. Regrettably, the thesis shows that nurses with wound care responsibilities have no control over the frequency, volume or type of wounds in their caseload and that they often experience novel and unusual clinical situations in their everyday wound care practice. Under these circumstances, wound care nurses constantly deliver care in a persistent state of flux, perhaps even moving between each of the 'novice to expert' stages over relatively short periods of time or even pendulum swinging from one extreme to another. As things stand at present, the findings suggest that wound care practitioners are unlikely to ever satisfy the conditions Benner believes necessary to maintain expert status for any length of time. On this basis, by her own admission, the very weakly evidenced projected timescales necessary, given between each of the stages – 'this time period is an estimate at this point and awaits further documentation' (p. 31) – to reach competency, proficiency and expert status in two to three years, three to five years and ten years (Latham & Fahey, 2006) respectively, become immaterial in wound care and the theory needs to be revised to make this clear. Indeed, in wound care, Zarchi, Latif, Haugaard, Hjalager, and Jemec (2014) found that length of experience, adjusted for workplace and education, had no impact on nurses' knowledge.

Many concrete examples of the significant and undesirable personal and professional toll and the hostile conditions in which wound care nurses provide care emerged in the study. Although interest is growing towards this important yet under-researched aspect of wound care (Walsh, 2019), bringing this to light in this study helps build on Varga and Holloway (2016) descriptive interpretative study of the lived experience of five wound care nurses caring for

patients with pressure ulcers. Similarly, they found that the wound care role was demanding yet rewarding, but was influenced by the environment and the challenges experienced when caring for individual patients.

The research undertaken in this thesis independently identifies the urgent need for employers and education providers to raise awareness amongst practitioners of the importance of their own self-care and vulnerability. While Varga and Holloway rightly recommend changing wound care education to include more reflective practice and resilience strategies, this thesis points to the essential contribution of eLearning wound care 'communities of practice' – places where practitioners can support one another when studying online. 'Safespaces' should be incorporated as a networking mechanism within the eLearning environment for practitioners to share knowledge and resources and safely, without judgement, air worries over decisions of concern and express feelings of self-doubt and uncertainty. While this observation might not immediately appear to relate directly to Benner's theory, the personal and professional toll taken impacted on practitioner enthusiasm and job satisfaction. This could theoretically discourage the journey of a practitioner to expertise and should be considered as a threat when applying Benner's theory to attaining expertise in the context of wound care.

Student Participation and 'Voice'

In terms of factors now considered integral to quality in qualitative research, and as expected when conducting qualitative research today, there is no evidence of how Benner ensured trustworthiness and rigour in her study. As wound care nurses are an under-represented voice, research participants validating the study findings in phase 2, and phase 3 in particular,

was a key factor in research trustworthiness, and I believed it necessary to include this. It is not apparent whether Benner subjected her data to any form independent analysis or indeed if the interview transcriptions or themes decided upon were returned to study participants for respondent validation. As explained in Chapter 3, respondent validation, or member checking, is now a popular quality control process and is generally believed to give back power to research participants in order to correct errors and allow them to challenge perceived wrong interpretations, thus representing an important technique to employ in research validation (Birt, Scott, Cavers, Campbell, & Walter, 2016; Skeggs, 1994). This aspect was particularly important because advocacy and participation were intrinsic to my ontological position and student participation was shown to positively contribute to enhancing the quality of wound care education research and wound care education theory development. This should now be included as part of re-imagining Benner's theory in the wound care context.

Policy Production & Enactment

A further surprising and perhaps contentious finding of this thesis came from the CDA in phase 1. As with the findings in the Wound Care Setting section, ambiguity, variation and uncertainty were created in wound care policy because of how it is produced and enacted. This has ongoing implications for education provision and professional accountability.

As asserted by Snelling (2017), the RCN as cited in Snelling (2017, p. 394) and others (Ousey et al., 2011; Pokorná et al., 2017; Probst et al., 2019), in Chapter 2, and I have to admit that to some extent this applied on my own part at the outset of this research, general opinion

currently leans towards a desire for more detailed wound care guidance, standardised policies and frameworks. However, the overall traits of wound care found in the study often clashed with this. Instead, the findings supported Benner's strongly held preference for less rigidity in practice, believing that more broad, vaguely outlined policy 'allows for the greatest interpretation and adaptation to changing complex contingencies' (Benner, 1984, p. 192), and recommends that organisations 'legitimise for increased discretionary decision-making for the expert' (p 179), as well as for limits to be placed on what can be made explicit.

Both CDA and DCA results inferred that, by its very nature, wound care practice cannot be constrained in this way because it ***is*** ambiguous and ***is*** uncertain, it ***is*** inherently irrepressible, it ***is*** unpredictable and it ***is*** intrinsically variable. This suggests that Benner's conflicting position of 'loosening' policy might better represent wound care policy education requirements than current beliefs and corroborates Guest, Vowden, et al. (2017) findings of inconsistencies in wound care, staff involvement and dressing choices alongside an apparent lack of a patient-specific treatment plan in many instances.

The intrinsic and adverse conditions in which wound care is provided therefore do not appear to lend themselves easily to the recommended rigid 'one-size-fits-all' policy position. In some instances, the very existence of ambiguity was found to be essential for some practitioners – deviating from local practice guidelines and going 'off formulary', rather than being bound to strict policy, was fundamental in meeting their individual patients' needs. The long-standing question of using honey as a wound care product, different clinical practices and conflicting research evidence regarding silver dressings found in phase 2 were found to be good

illustrations of this. However, at the same time, this engendered feelings of confusion and loss of confidence in evidence-based research and personal practice, ultimately leaving nurses to draw their own conclusions, usually based on personal experience or custom and practice, over the best course of action. This unsatisfactory state of affairs is regrettably not isolated to wound care nursing. Blazeby (2016) also reports that the choice of wound dressing often comes down to a surgeon's best knowledge, practice and overall preference because of the limitations of high-quality clinical cost effectiveness evidence.

These examples certainly point towards a need to 'loosen the reins' in wound care policy to free up professional creativity and flexibility and support Benner's position that norms and policies be kept broad and functionally vague. However, the difficulty here is, when we fast-forward to 2020, Benner's theory does not factor in the radical shift that has taken place in professional healthcare regulation and accountability since its publication in 1984. In the intervening period, policy has shone a spotlight on healthcare professional regulation, public protection, patient safety, professional conduct and malpractice (NHS Improvement, 2020; Professional Standards Authority for Health and Social Care, 2020a, 2020b) have heightened practitioners' awareness of their scope of practice and the potential litigious consequences of practising outside this. As we move towards this more legislative approach, where Ovens (2020) raises awareness of the role of the expert witness in failures of wound care prevention and management, Ousey et al. (2011) have gone so far as to suggest that wound care is introduced as part of a mandatory training programme. Arguably, these are impediments to an unhindered journey from 'novice to expert' and this needs to be made clear and represented in current theory on the wound care context.

Continuing with this notion of risking professional accountability, Benner also believes that, for expert status to be fully realised, the formalisation of their [the patients'] treatment that is imposed by rules, policies and procedures should be reduced. However, the CDA results described how the terms 'appropriate' and 'reasonable' were used by the NMC, similarly to other institutions noted by MacKillop (2018), as linguistic strategies, which are mostly unfamiliar within the policy discourse of nursing (Evans-Agnew et al., 2016; J. L. Smith, 2007).

The effect of using such open signifiers, a 'moment of crisis' in the NMC, had the effect of increasing ambiguity in accountability. This is similar to the observations of MacKillop (2018), who used Laclauian discourse theory and critical explanation to examine their effects in local government during instances of crisis where organisational practices such as relations and identities are obviously established. Here, I viewed certain demands as open signifiers, giving me the opportunity to critically explain how and why relations between the NMC and its members were modified by concentrating on the power plays and the beliefs surrounding the definition of these signifiers.

Creating ambiguity in policy using signifiers in this way might, as Benner and several research participants found useful for broad interpretation, also represent numerous demands, help stabilise the field of discourse, and hegemonise it. In this instance, the effect of the ambiguity created was to shift the burden of proof of clinical decision-making relating to what is 'appropriate' or 'reasonable' in wound care practice to the practitioner. This explains why other research participants vehemently preferred to adhere strictly to policy, which, as

Benner rightly suggests, is more likely to constrain, rather than encourage, the path to expert status.

The aspects of wound care policy production and enactment revealed by the CDA are important to acknowledge. This is because, without recognising how individuals within organisations receive, adopt and adapt evidence or organisational factors that constrain or facilitate adoption or implementation of policy and the interests and values at play within organisations influencing responses to policy issues, and if organisations choose not to 'adopt, adapt and act', policy will, as Greer, Goodwin, Freeman, and Wu (2002) point out, remain idle. Disregarding the processes involved in policy issues, particularly implementation and interpretation, and the ways in which these can be part of what forms and re-forms policy, fails to explore the whole picture surrounding policy. Furthermore, ignoring the interpretation component of the policy process, the whole picture remains unknown and 'the values within policies can be critiqued, refined and even resisted' (T. Jones, 2013, p. 7). How policy is experienced by users themselves also remains undiscovered. The findings suggest that wound care educationalists would benefit from becoming more familiar with policy processes and their effect on education provision.

Wound care policy-makers must now adopt an active (Bowen & Zwi, 2005), not passive approach to policy-making. An active position, compared to the inertia that appears to currently exist, would take into consideration the capacity to implement policy and not merely increase awareness or disseminate, as found in the CDA. As argued by Dodson, Brownson, and Weiss (2012), wound care policy-making agencies need to make decisions on

how to disseminate and implement policy. Active policy-making would also adopt target audiences' decisions to implement policy, instigate activities to improve knowledge and skills, facilitate change and ensure continued use of policy as part of organisational operations.

Wound Care Practices

Asking that ambiguity, as described above, be accepted as a core concept of wound care, rather than uniformity and standardisation, is a risky strategy because it conflicts with current curriculum development theory. To date, the very thought of ambiguity unnerves educators, academics and practitioners alike (Ousey et al., 2011; Pokorná et al., 2017; Probst et al., 2019): 'standardisation in education [is] fundamental for the establishment of a healthcare structure within wound management' (Gottrup, 2012, p. 133). This conflicts, for example, with Welsh (2018, p. 53) recent recommendation that 'more structured wound care education programmes, both at pre-registration/undergraduate and professional development levels', be established.

However, adopting Woods' effective BBE approach, as endorsed in phase 3, offers a fundamentally new solution to the wound care education problem. Rather than striving for standardisation and further loading the curriculum with set topics such as those described in Chapter 2, the idea instead is to develop a curriculum where practitioners acquire a particular set of cognitive, meta-cognitive and attitudinal skills to help them work with the knowledge, resources and skills available to them at the time. In effect, the BBE process is used to obtain a best answer to an unknown problem or a decision that is subject to some constraints where the problem situation is one that the problem-solver has never encountered before, helping

to overcome a main condition of Benner's theory:

> **'since nurses do not control the patients in their caseload, and since novel and unusual clinical situations will always occur in clinical practice, one can reasonably expect a nurse to perform at the expert level, for example, in familiar situations and at the competent or even advanced beginner level in less familiar ones.'** (Benner, 1984, p. 179)

With BBE, the inherent ambiguous conditions causing practitioners to fluctuate extensively between the extremes of 'novice to expert', described earlier, can be 'dialled down' or regulated, whereby terms such as 'best answer" and 'subject to constraints' are introduced in order to emphasise that, when solving real-world problems, the perfect information is never to hand. In much the same vein as Woods argues, eLearning workshops could be designed to develop a prescribed set of cognitive and attitudinal skills to solve problems, where each skill is 'built' (using content-independent activities), 'bridged' (to apply the skill in the content-specific domain of wound care nursing) and 'extended' (to use the skill in other contexts and contents and in everyday life). Tests and assessment of process skills that assess the degree to which students can apply their skills, including self-assessment, could also be included. BBE would therefore be introduced as an addition to the well-established learning and teaching strategies associated with Benner's 'novice to expert' stages, flexible to suit the learning needs of multi-disciplinary healthcare professionals' students and representing a credible and systematic approach to rationalise and document decisions, protecting accountability.

Woods found that acquisition of these cognitive and attitudinal skills develops particular attributes necessary for problem-solving and encourages practitioners to become more confident, but, crucially for wound care, also:

- Places emphasis on accuracy (rather than speed)
- Enables practitioners to be organised and systematic yet flexible (keeping options open, seeing situations from many different perspectives and points of view)
- Leads to monitoring of and reflection on the processes used
- Draws on pertinent subject knowledge and objectively assesses the quality, accuracy and pertinence of knowledge and data
- Results in willingness to accept risk and cope with ambiguity, as well as welcome change and manage distress
- Produces willingness to spend time reading, gathering information and defining the problem (rather than equating problem-solving with 'doing something' despite its pertinence
- Involves an overall approach that uses fundamentals rather than trying to combine various memorised sample solutions

A curriculum intentionally designed to acquire these attributes provides practitioners with many of the tools needed to handle the hostile conditions in which they are often expected to work. The degree to which variation is so entrenched and widespread is evidenced though results of a survey (Ousey, Gilchrist, & James, 2018) of wound care specialists attending the European Wound Management Association (EWMA) in 2018. Despite their clinical status and being aware of frameworks for wound bed assessment, 40% of respondents did not use them, and those who used them did so in very variable forms. Results showed variability about beliefs and unbalanced implementation of therapeutic decisions. Variation in wound size and

in the characteristics of the wound bed were considered the main factors for the assessment of wound progression. Unfortunately, this thesis findings are a 'spoke in the wheel' of the respondents' requests that assessment tools should be unambiguous, easy to teach, easy to implement by a large base of health care practitioners and carers, and should guide the practitioner consistently through assessment and reassessment processes towards the best therapeutic decision. In effect, instead of giving wound care practitioners more and more fish in the form of curriculum content and standardisation, BBE learning teaches them how to fish, so that, regardless of discipline, expertise or knowledge, the practitioner can always find the best answer even with limited resources available. This recommendation helps support Poole's view, as cited in Ousey et al. (2011), that, in relation to wound care, higher education institutions have a responsibility to not only develop clinicians' underpinning knowledge and analytical skills but also deliver education that equips nurses to meet the needs of today's patients.

Woods also demonstrated that BBE increases student confidence. This is an important by-product for wound care. Ousey and Blackburn (2019) have asserted that any learning and teaching strategy that boosts confidence is particularly valuable in wound care because confidence is considered to be one of the most influential aspects in performance.

BBE is also beneficial because, although Guest, Ayoub, et al. (2017) suggests that nurses take the lead in treating wounds across the lifespan continuum, and that tailoring education to their specific requirements is the priority, this is short-sighted because of the wider educational needs of the growing MDT responsibilities and CPD requirements. In their pre-

post-test research design, Goudy-Egger and Dunn (2018) prove that continuing education is a key factor to making changes in wound care management, thus adoption of BBE would promote flexible education provision.

Inter-professional Rivalry

For the policy production and enactment findings in phase 1, the organisational and inter-professional rivalry within the wound care community previously commented on by Flanagan (2005) was seen in relation to control of the wound care agenda and absence of a mandate for policy implementation. However, the most crucial and unfortunate fall-out of this was arguably the wasted opportunity to arrive at a UK-wide consensus on wound care education strategy as a result of different health service arrangements across the UK.

As detailed in the current National Wound Care Strategy Programme (NWCSP) (Academic Health Services Network [AHSN], 2019), the initiative is a major development because, unless new models of care are introduced and unwarranted variations are addressed, the changing needs of the population and individual patients will not be met, people will be harmed who should have been cared for and unnecessary disparities will continue, resulting in the waste of valuable healthcare resources. The NWCSP's ambitious aims are to improve the quality of wound care provision by reducing unwarranted variation, improving safety and optimising patient experience and outcomes through developing several evidence-based recommendations. These aims also incorporate workforce issues and the educational needs of all those involved in care delivery, including patients, carers and non-clinical staff. Of its four clinical workstreams, 'Education and Workforce' is, at present, reviewing what is needed

and what is already available. However, its title is deceptive because, at present, the initiative relates only to the NHS in England.

This disparity between nations re-produces Holloway's (2014, p. 3) view of general disharmony as a much wider international problem, where, 'there are many examples of wound care curricula both nationally and internationally'. Finding an agreement on a required skillset is essential to provide an adequate level of education, and it is recognised that this effort, 'poses challenges'.

Political and organisational differences must be truthfully represented as a factor influencing Benner's current model. Biggs (1997) suggested that strong identity of professional groups has led to rigid distinctions between them and their frequent rivalry has been described as 'a form of social Darwinism of occupations', where the power struggles within society become barriers to inter-professional working. Of the nine most common organisational, cultural and inter-personal barriers to collaboration described by Gabriel-Petit (2017), the CDA suggests that wound care decision-makers are 'on the same page' and the internal competitiveness relating to decentralisation of government is problematic:

1. A lack of respect and trust
2. Different mindsets
3. Poor listening skills
4. Knowledge deficits
5. A lack of alignment around goals

6. Internal competitiveness
7. Information hoarding
8. Organisational silos
9. Physical separation

As G. Daly (2004) suggests, removing the NHS from the political agenda and decentralising management is arguably a potential way forward to better collaboration in wound care management.

Marketisation of Wound Care Education

The 'Education and Workforce' workstream of the NWCSP is, as previously stated, presently reviewing current wound care education provision and the focus is understood to be on free-to-access, online, bite-sized learning opportunities. Although no detail is available at the moment, the focus on a 'free-to-access' direction for future wound care education provision is intriguing, raising interesting questions over potential sources of funding. The TVLC resource (URGO Partnership, 2015), the second of the five policy documents selected for the CDA, might indicate a possible way forward. Access to this high-quality, well-researched and practical resource, from which the NWCSP is taking direction, was only made possible through an unrestricted commercially funded grant but is only available to those practitioners willing to exchange their personal details, including job title, place of work and, presumably for marketing purposes, areas of wound care interest. Similar examples of exchanging personal data for access to online education are becoming routine. The literature in Chapter 2 also identified weakness in many commercially available online wound care education products

mainly related to quality control, assessment strategies and certificates awarded via 'take until you pass' accreditation, with necessary cohesion of learning and teaching strategies as wound care experience increases lacking.

Having said this, the participants were found to regard the contribution of commerce to wound care education highly enthusiastically, welcoming the re-appearance of company representatives in clinical areas, probably as a result of the ABPI best practice guidelines (Association of the British Pharmaceutical Industry [ABPI], 2019), and appear to be filling the vacuum created by employer reductions in investment experience in education. Additionally, private investments in pioneering wound management products such as dressings with in-built indicators designed to reduce unnecessary dressing changes (S. Milne et al., 2015) have been shown to improve practice efficiency by reducing nursing time, however Dowsett, Bielby, and Searle (2014) highlight such innovations are only successful when accompanied by education and training on correct use.

Caution on the proposed NWCSP strategy is, however, advised, as Fletcher (2007) has already vocalised the logical view that *ad hoc* delivery of education does not offer any type of quality assurance and has no strategic direction, arguing that quality assurance should encompass:

- Equality of opportunity
- Quality of information provided
- Quality of educational experience

- Relevance to clinical practice, drawing on occupational standards and meeting core knowledge and skill requirements that prepare practitioners for practice.

Thesis Findings Represented as a Remodelling of Benner's Theory – Before and After

These findings are important because, to my knowledge, this is the first study to appraise Benner's general nursing theory and adapt it for use in a specialised discipline. This contributes new knowledge to the field of wound care education in the form of learning and teaching and theory development. The thesis findings can now be used to complement and re-model Benner's current theory (Figure 24).

Figure 23. Familiar depiction of Benner's 'novice to expert' nursing theory.

Super-imposing the thesis findings on Benner's existing theory alters the way in which the theory is traditionally construed and visualised (Figure 25). Making this adjustment addresses the fourth and final research objective of adapting the theory to better represent the contemporary education needs of wound care practitioners.

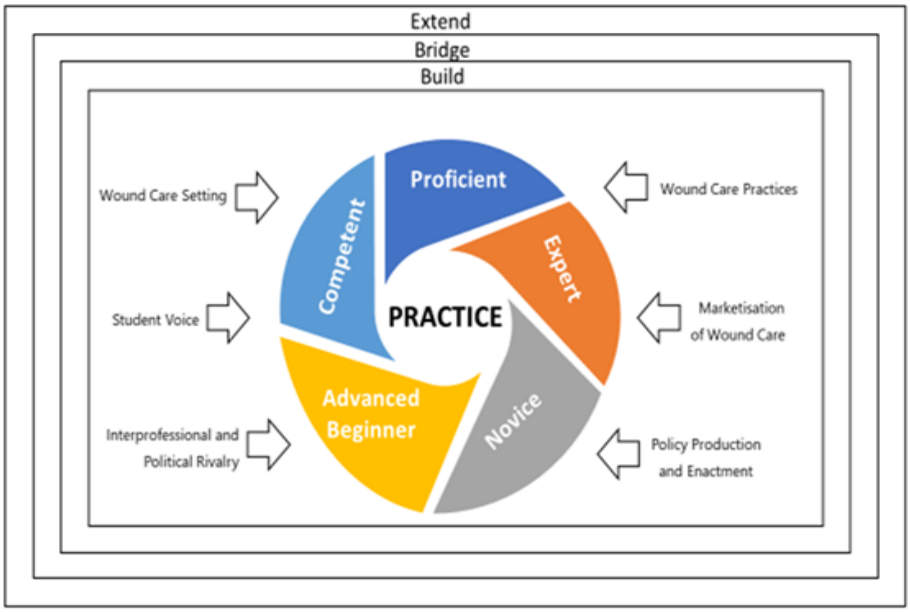


Figure 24. Depiction of Benner's 'novice to expert' theory remodelled for the wound care education context.

The rotating image central to Figure 25 depicts that wound care is dynamic, inconsistent and *ad hoc*. These conditions stymie wound care practitioners who provide everyday wound care from ever being able to accrue enough of the necessary kind of clinical experience to achieve expert status, meaning that the familiar, linear, one-dimensional hierarchical progression represented (Figure 24) becomes more or less irrelevant. Instead, this cyclic feature in Figure 25 shows that, at any one time, a practitioner's wound care knowledge and experience pendulum swings – proficient one month and novice the next; competent one month, advanced beginner the next; then novice a few months afterwards, and so on. Acknowledging that the nature of wound care is uncontrollable in this way means that each of Benner's 'novice to expert' stages attracts equal status and wound care practitioners fully take on board and accept that knowledge and experience can often be transient. This then begs the question – what is, and can one ever truly be, a wound care 'expert?'.

The three perimeter boxes around Figure 25 also show that Woods' BBE approach expands Benner's learning and teaching strategies, previously outlined in Chapter 2. This will allow all wound care practitioners, not exclusively nurses, to acquire the necessary cognitive, meta-cognitive and attitudinal skills to get 'the best possible answer' in wound care practice decision-making. This proposal supports Flanagan's (Flanagan, 2005) recommendation that, for educational programmes to be effective, they need to use a model of learning and teaching based around theory- and practice- based knowledge. BBE helps to integrate practice-based wisdom in clinical decision-making in the absence of strong evidence.

The six arrows represent the tensions imposed by wider external factors on the wound care education setting: student voice, inter-professional and political rivalry, wound care practices, marketisation, policy production and enactment. These all have an impact on Benner's theory in the wound care context.

Future Research Directions

Although the thesis offers important insight into the research problem, several pressing questions remain unanswered, mainly linked to the limitations of the study.

The findings of this thesis relate only to one higher education institute. The vision is to secure a research grant to set up a prospective multi-centre cohort study of higher education institutions offering online wound care education to implement then evaluate Woods' BBE model on practitioner confidence, which was found to be important in effective wound care. However, Woods recommends introducing curriculum changes by starting small. In the first

instance, the current local curriculum should therefore be re-designed using BBE and evaluated, potentially by working in partnership with, and securing funding from, wound care companies. It should be acknowledged that, in Woods' experience, in the early years, evaluations tend to first decline, then improve. Designing the study to involve collecting demographic data relating to, for example, whether practitioners work in urban or rural areas, length of wound care experience, accreditation and age, which was inaccessible for this research, would be valuable in order to better understand how such factors influence learning and practice.

The critical issue relating to the personal and professional toll of wound care practice on practitioners found in this thesis uncovered a new and revealing aspect of wound care not anticipated at the start of the study. The thesis suggests that obtaining a greater appreciation of the challenges experienced could direct further curriculum development. Seeking out research opportunities to collaborate with Welsh (2018) and Varga and Holloway (2016) and seek joint funding would involve further qualitative studies to obtain rich data on clinician experiences in wound management.

The thesis findings echo Fletcher (2007), Fletcher and Ousey (2010b), Ousey et al. (2016) and Watret (2005), thoughts regarding a potential future role for tripartite wound care provision, involving forging partnerships to collaborate across industry, academia, the health service and government to identify joint working project opportunities, with the aim of designing and evaluating practitioners' education and driving innovation.

Study Strengths and Limitations

Strengths

The strength of this study lies in its bricolage research design, enabling a comprehensive three-dimensional exploration of the little researched and poorly understood area of wound care education. The most valuable contribution of the research design was its capacity to provide original data in the form of pre-existing theories from the CDA, which then directed and supplemented the little understood nature of routine day-to-day wound care practice through the under-represented voices of wound care practitioners. This was significant to the overall thesis findings.

Bricolage design and the unfamiliar approaches of CDA, DCA and DD in nursing should be promoted as useful research methods to be used in wider nursing and wound care education and practice studies.

The DCA proved to be innovative in identifying rich secondary data for this purpose, which, in turn, generated original data to inform curriculum development as part of which BBE and 'Safespaces' were identified as fundamental modifications to be made to Benner's existing ideas on curriculum design.

Considerable restrictive effects of Covid-19 are now resulting in reduced opportunity for researchers to undertake face-to-face investigation with their study participants. Exploring new ways in which secondary data can be used to help mitigate these challenges introduces

new and exciting means of data collection. Researchers should avail themselves of the opportunities secondary data affords, similar to those experienced in phase 2.

Despite the general use of CDA in education and sociology, nursing policy research employing CDA methodology is sparse but nonetheless, as suggested by Evans-Agnew et al. (2016), represents a promising methodology for policy research in nursing education. Although I was initially uneasy about its unfamiliar practices and worried about going outside my comfort zone, CDA did prove to be an extremely valuable research method with which to examine how policy promotes and impedes social transformation in wound care, offering new insight into examining health policy formation, enactment and implementation. Supplementing the analysis to include the recent appearance of images and changes in typeface to produce a multi-modal perspective demonstrated its flexibility and confirmed its potential for conducting grounded policy research.

Preparedness to look beyond nurse education and identify ways in which similar problems are resolved across different disciplines, thus migrating these ideas, proved productive and insightful.

Limitations

The generalisability of the study findings from phase 2 could have been improved had I, in phase 2, been able to retrieve the research participants' personal data, including details of

their age, place of work, rural or urban location, nursing experience, extent of wound care experience and time in the profession. However, I was unable to do so because of GDPR. I traded this off in favour of using powerful and previously under-utilised secondary data analysis, which proved beneficial in capturing rare, impartial and rich data from this already under-represented group, enabling much greater insight into the everyday lives and education needs of wound care practitioners than currently exists. It is therefore anticipated that the findings will be relevant beyond the sample and the context of this research and of use to other comparable specialist practices including infection control and continence.

I learned an important lesson when conducting research online. Attrition of research participants from the DD in phase 3 jeopardised the study findings. Despite the research literature indicating the sample to be adequate, I did not account for the extent of attrition that took place. This could have compromised the trustworthiness and generalisability of the study and might have been avoided through significant over-recruitment. The DD component was, however, integral to the study's epistemology and the pragmatic decision to proceed with it was grounded in the knowledge that both participant contributions represented extreme positions of wound care practice required of DD and the participants actively engaged in the deliberation process. The consequences of the unforeseen attrition were mitigated by an extension of the period of time given to encourage richer in-depth discussion and incorporating earlier discarded data from those leaving the study early.

Research as Transformation and Transformation as Research

The thesis began with an entrenched, structured and systematic evidence-based medicine approach. In retrospect, I recognise this to be a product of my own professional training as a

nurse, driven to demonstrate robust formal mechanisms of research trustworthiness and rigour. Throughout the research, however, I offer examples of where engaging in the process has resulted in, as expected by Vahed (2018), a transformation of my thinking, identity and agency as an educator. I have also experienced professional growth through exploring new and unfamiliar research methods in nursing. This experience has increased my confidence in experimenting with new approaches to framing and addressing research problems in my own teaching practice. Experiencing CDA, for example, has provided me with new skills and a unique perspective, relatively unfamiliar to nurse education. As a consequence, I have a greater global appreciation of the policy process and feel able to engage in or even instigate the process and challenge any weakness to enhance implementation and ultimately improve my students' learning experience. I now resolutely consider myself as an agent of change and these policy analysis skills have already opened up exciting career opportunities within nursing professional bodies for me to help bring about justice and equality for students in education.

Dissemination Strategy

Younas and Porr (2019) suggest that knowledge translation (KT) emphasises a shift in researchers' practice. This is defined by the Canadian Institute of Health Research (2016) as 'a dynamic and iterative process that includes synthesis, dissemination, exchange, and ethically sound application of knowledge to improve the health of Canadians (individuals), provide more effective health services and products and strengthen the healthcare system' (para. 2). In addition to submitting to journals for publication, presenting at wound care conferences and depositing the thesis in the university library, my intent is for research uptake and actual application for the improvement of nursing education and patient

outcomes. KT is therefore consistent with the practical nature of an EdD, explained in Chapter 2. My dissemination and implementation strategy are therefore tailored for implementation settings, including my own place of work, as well as my lobbying wound care organisations, higher education institutions and regulatory bodies associations for policy and practice change.

With little agreement over a way forward for wound care education provision efforts, collaboration with peers in education and practice is key. Thus far, my networking has promoted the research protocol to contemporaries at an influential UK wound care conference, and an oral presentation of the thesis findings at a high-profile European conference is imminent. I anticipate that publicising the findings will provoke debate and contribute to the current body of knowledge because they mostly contradict the current view generally held of standardising the wound care curriculum, thus offering innovative direction to curriculum development.

The research findings and methodology used were innovative in nursing education research and, as such, I also intend to promote their use in the discipline by publishing in peer-reviewed qualitative research methods and nurse education journals and non-peer-reviewed dissemination strategies including WhatsApp and Twitter in simple summaries. As the CDA findings demonstrated that healthcare policy enactment contributes to wound care management dissemination in health service research and policy, I have submitted my conclusions to a refereed healthcare quality periodical to promote awareness and generate dialogue.

A three-minute thesis (3MT) presentation at the University of Strathclyde will be used to encourage new EdD students, develop my own public presentation and synopsis skills, and raise awareness of this health issue, which affects us all, regardless of sector.

Conclusion

The aim of this thesis was to explore the relevance of Benner's 'novice to expert' nursing theory in contemporary wound care higher education provision. The findings confirmed that, as it stands, Benner's theory is significantly limited in its application to wound care. The theory must now be developed and adapted to integrate the key nuances found to be exceptional to the new context of wound care. Above all, this conclusion is fitting in that, in 1984 – the inception of Benner's theory – Benner herself pleaded to expand ways of describing and thinking about nursing expertise and nursing practice itself. The outcomes are not only a recognition of the theory's seminal contribution to nursing but also a 'call to arms' to educators to seriously examine how Benner's work might now also be applied to other contexts over and above wound care.

No doubt Benner, working at the University of California in the United States of America, did not know that this, her formative work, would withstand the test of time and still be respected now as a foundation for nursing education and practice worldwide. Neither do I believe that she envisaged that, almost 40 years later, it would serve as the blueprint for this multi-method research undertaken at the University of Strathclyde, Scotland, almost 5,000 miles away, and be remodelled as a tool to advance conventional wound care education, a discipline only in its infancy in the 1980s, or indeed that, for a second time, it would be used to enrich the nursing profession in 2020 and beyond.

The judicious choice of Meleis's theory evaluation framework proved to be inspired in critically evaluating Benner's theory. Its application to Benner's theory in the context of wound care higher education has revealed sizeable idiosyncrasies in many of its beliefs. As well as endorsing its many indisputable strengths, this approach also uncovered several noteworthy and previously unidentified limitations. These weaknesses will sound alarm bells for wound care education particularly when, as often happens, the theory is casually applied to other contexts such as this without interrogation. Original and exciting insights were identified and this was particularly the case when analysis took place through the prism of advocacy-participation and teacher activism ontological positioning. The findings from this unconventional position have undoubtedly advanced the present-day philosophy of wound care education in the UK, reframing the research problem under the wide-ranging and topical umbrella of social justice – a position intended to uphold fairness and equity for educators, students and, in particular, patient care.

Social justice ideology is central to this thesis. Striving for social justice seeks redistribution of power to enhance the well-being of individuals through equal access to healthcare, justice and economic opportunity. In education, social justice is about ensuring distributing resources fairly and treating all students equitably, enabling equal access, diversity and participation, while simultaneously respecting their human rights. It is disappointing to discover that current higher education wound care provision is sadly wanting.

Throughout, emotive data has exposed numerous disturbing examples of social injustice. A combination of professional and regulatory policy processes, mostly those constructing

ambiguity and the inequitable unfair distribution of and access to knowledge, have far-reaching implications that undoubtedly impact on wound care nurses' accountability, and patient safety. One such example is the problem of diminishing, and often non-existent, employer funding essential to support CPD activities. Engagement in wound care CPD is indisputable in order to ensure robust and effective clinical decision-making, often in hostile circumstances. As a reducing entity, it follows that an individual's professional accountability, and, ultimately, patient care, will be unfairly jeopardised.

Taking away CPD funding is counterintuitive. Ousey (2016) has already advised health service management that any reduction of employer funding used to support post-registration HE provision, through local Service Level Agreements, for example, compromises the ability to develop and deliver courses to satisfy the needs of local employees and reduces recognition of the ever-changing needs of wound care. Consequently, the workforce is no longer able to access the necessary education to develop or enhance new skills and knowledge that can be integrated into patient care, potentially increasing patient morbidity and mortality. This is incomprehensible. Given that the purpose of HE provision is to develop students' ability to critically analyse research and evidence and use this to support interventions that enhance patient care, the findings confirm that these are precisely the skills wound care nurses require. Given the evident ongoing struggles for social justice occurring in the 21st century, Benner's theory does not give due consideration as to how the need for right and proper education is correctly resourced. Accordingly, this must be reflected in how theory is interpreted and represented.

Not only is diminishing funding for CPD a major concern, but access to the right knowledge is also problematic. While essential CPD education is erratic and contingent on employers' and individuals' willingness or ability to pay (reproducing present geographical and patient inequity), there is also a slow and insidious widespread creep of dependency on the wound care product industry's generosity. At first glance this is ostensibly magnanimous. Commercial funding of wound care education is being normalised, and thus governs and regulates wound care nurses' access to knowledge in a way that is essential. More and more, the established, unchallenged and routine practice of nurses, desperately seeking to plug their wound care knowledge deficit, is to exchange personal and professional data in order to be granted select admission to seemingly 'free' and undeniably often extremely high-quality privately sponsored learning resources and excellent educational opportunities. Unfortunately, this arrangement brings about significant social, moral and ethical dilemmas for wound care education, many of which are going unnoticed in the fervent and urgent hunger to fulfil knowledge gaps. That said, in a concerted effort to right potential concerns, developments in the field, notably by the Association of the British Pharmaceutical Industry (2019), have set out the commitment of industry to healthcare to operate in a professional, ethical and transparent manner, to ensure appropriate marketing and support health professionals in the provision of high-quality healthcare.

Although controversial, the data validates the contribution of industry in the education of wound care nurses. This revelation cannot be snubbed or marginalised purely out of principle. Indeed, industry is opportunistic – it has detected, and is exploiting, the education deficit by picking up the slack. Yet, like so many others in the quest for knowledge, from personal experience, this is difficult without the generous commercially funded scholarships awarded

to me to disseminate the findings of this thesis at national and European conferences, thus encouraging debate and knowledge exchange to drive up wound care standards. Any employer responsibility for CPD funding will be relinquished and the very real possibility of implosion exists.

At present, the AHSN's (2019) solution to fill this gap is apparently by means of ad hoc bite size online provision. It remains unclear how this ambition will be governed, quality controlled or financially resourced. Nevertheless, given the current economic situation and the events described, I anticipate significant commercial expenditure. While the AHSN answer is by no means perfect, in practical terms, it does still improve the current erratic and insufficient provision by guaranteeing at least some overseen provision and, crucially, one which is accessible to all, regardless of ability to pay.

Although this is all well and good, on the flipside, wound care educators in higher education need to regroup and take stock over the AHSN position. We must interrogate and reflect on NMC registrants regarding whether accepting the AHSN position is short-sighted and miscalculated – the product of wound care policy mishandling and breakdown and a disservice involving selling short our own HE students by accepting a provision less than the thesis findings warrant. We also do ourselves an injustice by misjudging our own professional accountability while also jeopardising higher education institutions' expectations of having 'a responsibility to develop clinicians' underpinning knowledge and analytical skills and to offer education that equips nurses to meet the needs of today's patients' (Ousey et al., 2011, p. 146).

Conceding to the AHSN solution will be the result of impotent and passive, not active, wound care policy-making on behalf of all those who hold a stake in wound care education. Failing to challenge how things stand undermines and plays down the urgency around the need for effective implementation of wound care education policy as a priority for government and regulatory responsibility. Falling into line falls far short of Guest's (Guest et al., 2015; Guest, Ayoub, et al., 2017; Guest, Vowden, et al., 2017) pressing call for prerequisite specialist wound care education to deliver the necessary problem-solving and critical thinking skills. Another consequence will be the effect of mounting private enterprise in wound care education on social justice. In 'Why Socialism', Albert Einstein (1949) stated that the worst evil of capitalism is the crippling effect on individuals. Believing that our entire educational system suffers from the evil of capitalism and its crippling effect on the individual, Einstein argued that the only way to eliminate the 'grave evil' is to establish an educational system orientated towards social goals. With the words of this great theorist in mind, there is a real risk of engendering 'profit over patient care' in wound care education and of this becoming even further entrenched.

Call to mind that Benner's theory is grounded in the acquisition of knowledge through practice, not through education. The outlined education social justice problems therefore hold special significance when evaluating what exactly the theory offers to wound care education today. To all intents and purposes, the ASHN position mirrors, promotes and, troublingly, risks the re-emergence of anti-intellectualism – opposition to intellectuals and the modern academic where intellect and reason are less important than actions and emotions in solving practical problems and understanding reality. This is witnessed in nursing today. Only last year, the RCN president, Professor Anne Marie Rafferty, was extremely

critical of government cuts to nurse education, warning, 'we must never lose sight of how lucky we are to study at university, and how a university degree affords us the opportunity to critique our practice and to investigate issues such as leadership and politics' (as cited in Mitchell, 2019). Choosing to support the ASHN path only risks reproducing perpetual core tensions between theory and practice in nursing education, which were particularly evident in polarised unresolved debates among education, industry and practice stakeholders, set out in this thesis.

A further neglected concern for education social justice is that, whatever curriculum is finally settled on, it must not be the sole product of educators working in academic silos. Non-recognition of key stakeholders is constricting. Going forward, unlike Benner's research, the thesis findings dictate that educators must now be aware of the invaluable contribution of 'voice' emanating from its largely ignored stakeholders – students and patients – in a co-created curriculum, and tailored learning opportunities made with them and not on their behalf. Determining the knowledge and understanding of treating wounds must now be a non-negotiable core quality indicator of wound care curriculum design. Persisting in doing otherwise risks further prising apart the perpetual gulf between wound care theory and the very hands-on business of everyday clinical practice. Judicious and infrequent use of secondary data analysis presents the reader with a rare, privileged, and, until now, inaccessible glimpse into what it is truly like to deliver routine wound care. This vital new data has put me in an extremely fortunate position and enabled me to re-evaluate the degree to which contemporary educational theory matches clinical practice. Equipped with valuable new insights, I can conclude that the most effective solution is no longer to accept Benner's learning and teaching strategies as these stand but to complement them with Woods'

content-independent principle of BBE. In my view, this is the best mechanism to enable students to acquire the essential problem-solving cognitive and attitudinal skills found lacking in conventional wound care education today.

Tolerating the status quo is a risky strategy indeed and comes at an unavoidably high price. Although perhaps not immediately obvious to unsuspecting nurses hellbent on doing their best to deliver exceptional wound care, regardless of the frequently challenging care settings they find themselves in, they increasingly expose themselves to greater allegations of malpractice and negligence, and therefore more professional liability. Generally, the NMC, the regulatory body, and employers are not particularly sympathetic to their plight and examples of this can be found throughout NMC policy discourse. As well as numerous other linguistic strategies, omission of basic working professional definitions and extensive use of open signifiers engender extreme ambiguity and ease the way in which blame is shifted to its registrants. In using these routine linguistic strategies, the regulator thus abdicates its responsibility, and, in turn, generates the accepted paradox of relaxing policy constraints to enhance patient care while at the same time exposing nurses professionally – a hardly just state of affairs. This contradiction is particularly important because one major premise of Benner's theory depends on, and assumes, a shared understanding of underpinning terms, including 'proficient', 'competent' and 'expert', and yet, among countless others, regulatory policy neglects to define its fundamental terms.

I want to return now to a further key consideration of Meleis's framework that holds particular relevance for social justice. Meleis places considerable weight on the role of values

in nursing theory and uses his methods to critique theory and scrutinise its values from several perspectives. In a profession, values are standards for actions that are favoured by experts and professional groups, and create frameworks for evaluating behaviour. Poorchangizi (2019; 2017) argues that nursing is a profession rooted in professional ethics and ethical values, and nursing performance is based on such values. While Benner pays heed to many caring qualities inherent in nursing, what really stands out about wound care is a particular kind of values found to be integral to bringing about positive change in wound care and patient experience. Regardless of the often complex challenges encountered, including managing a multiplicity of resources, patient demographics and the struggle to reduce inequality, compassion, trust, humility, responsibility, self-sacrifice, autonomy, respect for human dignity, integrity and a strong drive for social justice are present. However, staying true to these values, while also delivering effective wound care under difficult circumstances, manufactures tension that generates personal emotional cost and compromises liability. Unfortunately, Benner's theory portrays idealistic expectations for wound care nurses – the expectancy of 'expertise'. This is problematic because it serves to aggravate personal angst and feelings of failure. It is misleading to have wound care nurses believe, as Benner's theory always represents pictorially, that, when more structured learning is combined with experience, this equates to better wound care practice, which in turn precipitates 'expert' status, a rank which is currently urgently sought after. Nonetheless, existing wound care education and practice exhibits no such predictable trajectory and is, without doubt, far more complex. Fulfilling all the conditions Benner deems necessary for 'expertise' is by and large sporadic and inaccessible to the majority. Instead, wound care nurses can dynamically swing between any stages of the given 'novice to expert' extremes. This unfairly knocks professional confidence, a feature that is unquestionably vital to good wound care, while also undermining

self-belief. Education in social justice expects educators holding responsibility for their students' emotional and educational needs to do this safely and without judgement. Regardless of delivery mode – face-to-face or online – wound care education provision must therefore no longer exploit these inherent values and should rectify the societal shortfall. Provision of support network mechanisms, such as incorporating formal 'Safespaces', will help mitigate angst experienced by enabling emotional and shared learning needs to be met safely and, crucially, without judgement.

From the macro perspective, focusing on the structure of society and seeing society as a unified whole, Benner's theory fails to truly represent the significant influence of external forces and identify influencers in effective nursing care. In wound care nursing education, many tensions exist, including tension between different healthcare professionals, tension and power imbalances between policy producers and nurses, tension between nurses and line managers, tension between clinicians and academics as nurses gain experience via practice rather than through education and theories and tension between industry and government. Undoubtedly, this culminates in the idea of wound care being everyone's problem, but no one's responsibility. This thesis addresses and resolves the 'elephant in the room' – the problem that everyone knows about but no one mentions or wants to discuss because it is provocative, controversial and politically embarrassing – 'who leads in wound care education?'. To realise wound care education standards that are fit beyond 2020, it is important that this awkward and arguably professionally sensitive question is tackled head on and Covid 19 has been instrumental in bringing this to a head. The pandemic has exposed dramatic inequalities that exist in all aspects of social justice – wealth, opportunity and

privilege – among the Black, Asian and minority ethnic (BAME) community. Reframing current wound care theory through this lens confirms that the disparity previously identified by Lyder (2009) also exists in wound care and has particular relevance to the UK's growing elderly population. Similarly, Bliss (2017; 2015) found that a significantly smaller proportion of BAME older adult admissions had their pressure ulcer heal than might have been expected had they been white, concluding that reducing disparities in pressure ulcer development offers a strategy to improve the quality of nursing home care.

These findings neatly lend themselves to the sort of problem-solving BBE offers – it has the capability of freeing wound care from the constraints of pigeonholing education by subject topic, instead encouraging nurses to address new challenges in far more sophisticated and complex ways. Dermatologists, Venkatesh, Maymone, and Vashi (2019) and Mukwende, Tamony, and Turner (in press) also warn that, as the population becomes more diverse, ethnic skin is emerging as the norm. Tailored diagnostics, prevention and treatment are therefore essential to achieving successful outcomes for this population, certainly justifying embedding the subject within the wound care education curriculum.

Together with active, rather than the current passive, policy-making, and pooling the strengths of the various agencies who hold a stake in advancing wound care, the change required demands strong leadership, ownership and accountability. While identifying and making any one agency accountable for wound care deliverables appears to be the preferred solution, it must be remembered that delivering wound care is also frustrating. It is intangible, nebulous, unpredictable, variable and complex and fails to stand still. As such, it requires

equal invested buy-in, collaboration, co-operation and commitment on the part of all its stakeholders – formal non-negotiable provision for active engagement with those nurses who are actually working on the front line and the patients themselves. These are essential to reaching consensus on the way forward. This stance represents my personal values of partnership, co-operation, advocacy and participation in nurse education, made clear from the outset.

Staying true to this position requires me to generate an action agenda for change. On the understanding that education is a political act and cannot be divorced from politics, change needs to be intertwined with politics and have a political agenda. In practical terms, a joint working agreement must be drawn up and management arrangements conducted with participants from all parties to create a curriculum fit for multi-disciplinary use in an open and transparent manner. Prevailing recommendations for a tripartite arrangement between education, industry and the NHS therefore do not go far enough. All future joint working goals must also involve government and regulatory and professional bodies in the interests of patients and be shared throughout the policy process. While the excellent work of AHSN in reducing inequality is admirable, forthcoming policy applies to England only – devolved government education bodies must be obligated to dissolve, as far as wound care education is concerned, the current imaginary, unnecessary and fractious national boundaries between England and the other nations to work together to deliver excellent wound care education and thus improve care. In keeping with the practical nature of a professional doctorate, the responsibility to mobilise change now lies firmly at my feet.

CHAPTER 8: APPENDICES

Appendix A

Research Timetable

	2017-18				
	April	May	June	July	August
Literature Review					
Research Proposal Prep & Submission					
Proposal Feedback					
Critical Discourse Analysis					

	2018-19											
	Sept	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July	Aug
(Tissue Viability Module in Trimester 3)												
Literature Review												
Critical Discourse Analysis												
Ethics Application												
Secondary Data Analysis												

Convenience Sampling & Interview Recruitment												
Deliberative Discussion												
Deliberative Discussion Analysis												

	2019-20											
	Sept	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July	Aug
Update Literature Review & Write Up												

	2020-21											
	Sept	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July	Aug
Submission												

Appendix B

Participant Information Sheet

Participant Information Sheet

Research Project

A multi-method qualitative study to explore the wider effects of policy on Benner's nursing 'novice to expert' theory on wound care education.

Would you like to take part in a research study to understand how wound care education currently prepares nurses to meet the Nursing and Midwifery Council's regulatory requirements and have your say in the design of a new curriculum?

Why Have I Been Sent This?

You have been sent this information sheet because you are being invited to take part in a research study. This information sheet describes the study and explains what will be involved should you decide to take part.

What is the purpose of this study?

In this study I want to explore the views of nurses with a specialist interest in wound care about how education provision prepares them to meet the Nursing and Midwifery Council's (NMC) regulatory requirements. The findings will inform the redesign of the current curriculum at UWS to meet the needs of contemporary wound care nursing.

Who is conducting the study?

My name is Jane Munro.

I am a registered nurse and lecturer in adult health at the University of the West of Scotland. One of my responsibilities is to design, co-ordinate and deliver the Tissue Viability module that you have recently undertaken at the University of the West of Scotland. This research will contribute towards a Doctorate in Education (EdD) I am studying for at the University of Strathclyde and is intended to ensure wound care nursing education meets the demands of current wound care nursing practice.

What will participating in this project involve?

If you agree to participate, you will be invited to take part in an on-line asynchronous semi-structured interview using your existing UWS on-line learning platform (Moodle) account.

I would like your views on the design and content of a new wound care nursing curriculum I am proposing to be delivered at UWS and to what extent you feel its prepares nurses for their role in wound care and in meeting the NMC's regulatory requirements. I would also like any new ideas or suggestions you have that could be incorporated into the new design.

The interview will use a typed 'discussion forum' format, similar to that used throughout your Tissue Viability module and will allow your responses to be automatically transcribed. It is asynchronous, meaning that you can contribute and respond to other students and my posts at any time during the 3 week period between **28th March and 18th April 2019**. I imagine your total contribution should last no longer than one hour over this period.

To reduce the possibility of interviewer bias, another UWS nurse lecturer, Lynn Welsh, who is independent of the study, will occasionally go on-line to observe and mediate if necessary.

Do I have to take part?

No, it's completely up to you whether or not you take part in the study. If you agree to take part, you are free to change your mind at any time without giving me a reason.

If you chose not to take part, this will not compromise any current or future studies or opportunities at the University of the West of Scotland.

What will happen to any information I give?

In accordance with the General Data Protection Regulations (2018), any information I have about you and everything you say during the discussion will be kept confidential. Your name and contact details will be kept separately from the transcript and any details that could be used to identify you will be removed from the

transcript. Any extracts from what you say that are quoted in written work will be entirely anonymous.

All electronic data will be stored on a password protected computer and help on the UWS secure server. Any paper copies will be kept in a locked filing cabinet in my office. All digital recordings will be destroyed after completion of the project.

Confidentiality

Your contribution to the project will be treated in confidence. It will not be used other than for the purposes described above and third parties will not be allowed access to them (except as may be required by the law).

The online forum will only be open to participants in the forum. Only researchers involved in the project will have access to the website after that date. If you request it, you will be supplied with a copy of your contribution so that you have a record of the discussion.

Your data will be held in accordance with the General Data Protection Regulations (2018). You will not be personally identifiable in any of the output posted on this site.

Anonymity

Your data will be held and used on an anonymous basis with no mention of your name, place of work etc.

What will happen to the results of the project?

Findings from the discussion will be summarised and returned to forum members to comment on their accuracy.

The results of this study will be used to inform future wound education curriculum developments at the University of the West of Scotland. They will also be used in academic papers for publication and in presentations. I would be happy to send you a summary of the research study on request.

What are the possible benefits of taking part?

There will be no immediate benefits for you, but by taking in part in this study you can help us better understand how nurses view the current education provision and how this prepares them to meet NMC regulations.

Are there any risks?

No. There is no known risk if you take part in this study.

Contact details

I am the main contact for the study. If you have any questions about the project, please don't hesitate to ask. My contact details are:

Jane Munro, Lecturer in Adult Health
Email: jane.munro@uws.ac.uk
Tel: 0141 848 3000

School of Health and Life Sciences, Paisley Campus, University of the West of Scotland, Main Street, Paisley PA1 2BE

Should you wish to ask independent advice on participating, please contact:

Lynn Welsh, Lecturer in Adult Health
Email: lynn.welsh@uws.ac.uk
Tel; 0141 849 4320
School of Health and Life Sciences, Paisley Campus, University of the West of Scotland, Main Street, Paisley PA1

If you wish to contact a senior member of the University of Strathclyde about the research or make a complaint please contact:

Professor Ian Rivers (1st Research Supervisor)
Email: Ian.Rivers@strath.ac.uk
Faculty of Humanities and Social Sciences, University of Strathclyde, Lord Hope Building, 141 St James Road, GLASGOW G4 0LT.

Dr Eugenie A. Samier
Chair of the School of Education Ethics Committee
Email: Eugenie.samier@strath.ac.uk
Lord Hope Building
141 St. James Road
Glasgow
G4 0LT

Project team: Jane Munro, University of the West of Scotland, University of Strathclyde

Dr Anna Beck, Lecturer in Education, University of Strathclyde (2nd Research Supervisor) anna.beck@strath.ac.uk

Thank you for considering taking part in this study and taking the time to read this information.

If you are willing take part in the semi-structured interviews for this research project, please complete the consent form on the next page by Thursday 21st March 2019 and return by email to me.

Jane Munro, 14th March 2019.

Lecturer in Adult Health, University of the West of Scotland.

Consent Form

<u>Project title</u>: A multi-method qualitative study to explore the wider effects of policy on Benner's nursing 'novice to expert' theory in wound care education.

Consent

I voluntarily agree to participate and to the use of my data for the purposes specified above. I am aware that I can withdraw consent at any time by contacting the researcher.

- I confirm that I have read and understand the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason. ☐
- I understand that the on-line semi-structured interview will be digitally recorded and transcribed. ☐
- I understand that information given in this interview may be used by the research team in future publications, reports or presentations. ☐
- I understand that any personal data that could be used to identify me will be removed from the transcript and that I will not be identified in any publications, reports or presentations. ☐
- I give permission to be contacted regarding wound care related research conducted by the researcher in the future. ☐

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

14th March 2019

Appendix C

CDA rubric (based on Greckhamer and Cilesiz (2014) Framework)

No	Policy	Data Unit in Context	Data Unit	Concept	Construct (Sub construct)
1	**Creating Viable Options** **NHS Education for Scotland** **2009**	The tool aims to provide organisations and individuals with guidance on preparing education and development programmes on tissue viability or a wide range of healthcare staff and other such as volunteer workers and carers. It sets out key content areas for education to support progressive development in tissue viability expertise for healthcare staff as they progress through their careers	**It sets out key content areas for education to support progressive development in tissue viability expertise for healthcare staff as they progress through their careers**	Definitive wound care content and flexible progression framework proposed.	**ASPIRATION AND RESOLUTION** (addresses ambiguity, minimises personal interpretation, reduces vulnerability in professional decision making, supports progressive development, enhances expertise, improves accountability)
		Users of the tool can therefore cross-match key education content appropriate to the needs of different grades of staff in developing a range of education and development activities, from single-session orientation and refresher initiatives to academically accredited programmes of study	**Users of the tool can therefore cross-match key education content appropriate to the needs of different grades of staff in developing a range of education and development activities, from single-session orientation and**	Tool is adaptable and versatile	**ASPIRATION AND RESOLUTION** (resolves education provision for skill-mix, flexibility for

			refresher initiatives to academically accredited programmes of study		professional development, solution offered for academic education provision, supports 'novice to expert' progression)
		It must be emphasised that the tool is presented for guidance only and is not intended to be prescriptive (in bold). The education and development needs of all grades of staff will often be determined by the kinds of service they provide, rather than the grade of post: staff at levels 2 and 3 of the NHS Career Framework devised by Skills for Health (adapted to reflect generally recognised terms in Scotland) who are working in a unit that cares for ill older people, for instance, may require greater knowledge of tissue viability issues than those operating at Level 6 within services such as child and adolescent mental health	**It must be emphasised that the tool is presented for guidance only and is not intended to be prescriptive (in bold). The education and development needs of all grades of staff will often be determined by the kinds of service they provide, rather than the grade of post**	Non enforceable Open to personal and local interpretation Flexibility	**AMBIGUITY OR OPPORTUNITY** (offers variation in provision, weakens initial intention, compromises 'novice to expert' model)
		The tool can nevertheless be used as a template from which educators, managers, and clinicians can devise programmes to meet the needs of individuals and teams across a range of clinical and service settings. They can review the key content areas within the tool to piece together educational activity that will meet identified needs and enable individuals	**The tool can <u>nevertheless</u> be used as a template from which educators, managers, and clinicians can devise programmes to meet the needs of individuals and teams across a range of clinical and service settings**.	Relies on self-assessment of education needs	**AMBIGUITY OR OPPORTUNITY** (Introduces inconsistency,

		and teams to build their knowledge and skills in relation to tissue viability scientific underpinning, prevention and therapeutic management.	**'piece together'**	Meets need for progressive acquisition of knowledge and skills	variation and flexibility)
		It is also important to note that the tool assumes a progressive accumulation of knowledge spreading from 'left to right' – in other words it would be expected that anyone undertaking the education content suggested at levels 4 and 5 of the staff graded axis would have already accumulated the knowledge defined in levels 1, 2 and 3.	**the tool assumes a progressive accumulation of knowledge spreading from 'left to right' – in other words it would be expected that anyone undertaking the education content suggested at levels 4 and 5 of the staff graded axis would have already**	Assumptions made that do not reflect current practice – 'would deals with unlikely and impossible'	**ASPIRATION AND RESOLUTION** (supports novice to expert progression, assumption regarding progress)
2.	TV Competency Framework 2015	Practitioners are expected to possess specialist knowledge and skills to expertly manage a range of skin issues and to identify, appraise, analyse and implement up-to-date evidence-based findings into clinical practice	**Practitioners are expected to possess specialist knowledge and skills to expertly manage a range of skin issues**	Gap in provision with no justification	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** (Ambiguity, personal interpretation, professional liability, vulnerability in professional decision, making, defence on fitness to practice
		Evidence based safe practice is integral to the delivery of care. To date within tissue viability there are a few tools with which to measure and benchmark expertise.	**To date within tissue viability there are few tools with which to measure and benchmark expertise**	Acknowledgement no framework exists to measure expertise Unexplained why existing resources are not used across the UK	

		Although the National association of Tissue Viability Nurses (NATVNS) in Scotland has published core competencies for Tissue Viability Nurses (TVN) these are not used nationally across the UK	**Although the National association of Tissue Viability Nurses (NATVNS) in Scotland has published core competencies for Tissue Viability Nurses (TVN) these are not used nationally across the UK**	Acknowledgement of existing competencies yet no rationale given for lack of national framework/competencies	**ASPIRATION AND RESOLUTION** (Ownership, collaboration, consultation, distribution, purpose/intention of policy)
		There are no UK nationally agreed core competencies to which TVNs and their employers can match outcomes in ensuring interventions are of the same standard nationally	**There are no UK nationally agreed core competencies to which TVNs and their employers can match outcomes in ensuring interventions are of the same standard nationally**		**RESPONSIBILITY WITHOUT ACCOUNTABILITY** (Professional Vulnerability)
		The NMC (2015) identified that as from January 2106 all nurses registered with the NMC must undertake revalidation. This will include providing evidence of up to date skills and knowledge evidenced via an online portfolio. The NMC paragraph 22 clearly states registered nurses must:	**The NMC paragraph 22 clearly states registered nurses must:** **22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to develop your competence and improve your performance**	Professional body recognition that regulators require registrants to demonstrate knowledge and skills in wound care yet these remain aspirational	**AMBIGUITY OR OPPORTUNITY?** (Professional vulnerability) (Personal decision making) (Ambiguous accountability)

		22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to develop our competence and improve your performance		Personal judgement of what educational activity is 'appropriate' and 'regular'	
		This framework offers those working in tissue viability services a vehicle to evidence this criteria providing a minimum standard of measure knowledge and skills It should be noted that this framework is not prescriptive but serves as a guide that can be used as a baseline to build and shape services and support personal development	**It should be noted that this framework is not prescriptive**		
		It is hoped that application of this framework will facilitate national benchmarking of knowledge and skills within the field, in addition that its use will promote equity and transferability of expertise across the UK thereby helping to develop the workforce in this area. **This framework is designed to be personalised to your development needs** and may be used to provide evidence for your skills passport.	**It is hoped that application of this framework will facilitate national benchmarking of knowledge and skills. This framework is designed to be personalised to your development needs**	Non-existence of national competency framework on which to base education	**ASPIRATION AND RESOLUTION** (Non enforceable)

		There is no prescribed timeframe for progressing through the levels however it would be expected that senior staff within services to complete the core competencies within 18 months.	**There is no prescribed timeframe for progressing through the levels however it would be expected that senior staff within services to complete the core competencies within 18 months.**	Adoption is voluntary and not regulated	**ASPIRATION AND RESOLUTION** (Ownership for strategic implementation) (Resource dependent) (Variation in knowledge and skill framework) (Local interpretation) (Non-committal) (Versatility vs Variation)
		It is hoped that this framework can be used to identify and measure skills and knowledge required of those practitioners working in tissue viability (	**It is hoped that this framework can be used to identify and measure skills and knowledge**		

		Practitioners who complete the framework will need to self-assess themselves and identify an assessor who will be able to assess your knowledge and skills independently. **The assessor should be a registered practitioners who is recognised for their expert knowledge and skills in TV.**	**Practitioners who complete the framework will need to self-assess themselves and identify an assessor. Practitioners who complete the framework will need to self-assess themselves and identify an assessor**	Optimism and aspiration the framework will meet the need	**ASPIRATION AND RESOLUTION** (Ownership)
		Following completion of the self-assessment you will need to discuss the statements with your assessor to ensure you have assessed yourself at the correct level. This should be in keeping with the service specification and your job description. Evidence can be provided in a range of ways: self assessment, peer review; observation of practice; reflection on prior knowledge and skills; reflections following an educational event.	**Following completion of the self-assessment you will need to discuss the statements with your assessor to ensure you have assessed yourself at the correct level. Following completion of the self-assessment you will need to discuss the statements with your assessor to ensure you have assessed yourself at the correct level.**	Development needs vary due to existing inconsistencies and variation in roles and responsibilities	**AMBIGUITY OR OPPORTUNITY** (Local Interpretation, implementation)

		The authors have presented a continuum of knowledge ranging from basic through to advanced: **it is anticipated that the boundaries for each will be agreed locally.**	**It is anticipated that the boundaries for each will be agreed locally.**	Lack of timeframe is inconsistent with Benner's 'novice to expert' theory Aspirational Framework is yet not proven to be efficacious	**AMBIGUITY OR OPPORTUNITY** (Dilutes necessity for national enforceable framework) (Personal and local variation)
		Please note the competencies are not presented as a hierarchy nor are they progressive**. To ensure you are assessed on the appropriate competencies it is important that you and your assessor decide which are appropriate to your area and job role** and action plans developed to meet the outcomes	**To ensure you are assessed on the appropriate competencies it is important that you and your assessor decide which are appropriate to your area and job role** **This framework offers those working in tissue viability services a vehicle to evidence this criteria** **It should be noted that this framework is not prescriptive**	Reliance on self-assessment and identifying own assessor Current variation in job role, description and responsibilities - potential for conflict with proposed framework levels Aspirational, not enforceable	**AMBIGUITY OR OPPORTUNITY** **(Inconsistency)** **(Non-enforceable)** **(Adaptable)**

				Dilution of national benchmarking by over reliance on self-assessment and local variation Interpretation of 'appropriate' challenging as no nationally consistency	
3.	**The Code** **Professional standards of practice and behaviour for nurses and midwives (2015)**	UK nurses and midwives must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education or research. **While you can interpret the values and principles set out in the Code in a range of different practice settings, they are not negotiable or discretionary.**	**While you can interpret the values and principles set out in the Code in a range of different practice settings, they are not negotiable or discretionary.**	Incumbent on registrants to interpret values and principles within own practice that are non-negotiable nor discretionary	**AMBIGUITY OR OPPORTUNITY** **RESPONSIBILITY WITHOUT ACCOUNTABILITY** **(Hierarchical power relationship)** (**Professional vulnerability/exposure)** Ambiguity (of interpretation and in implementation)

					Hierarchical power relationship (power differential/control) Vulnerability (defencelessness/ futility/inevitability)
		Our role is to set the standards in the Code, but these are not just our standards. **They are the standards that patients and members of the public tell us they expect from healthcare professionals.** They are the standards shown every day by good nurses and midwives across the UK.	**..These are not just our standards…..They are the standards that patients and members of the public tell us they expect from healthcare professionals.**	Widens and reinforces net of accountability. Stakeholders, not the NMC, are credited with increased emphasis on adherence	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** (Diffusion to those answerable to) (Changes modulation of policy ownership and perceived burden of obligation)
		When joining our register, and then renewing their registration, nurses and midwives commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. **We can take action if registered nurses or midwives fail to uphold the Code. In serious cases, this can include removing them from the register.** The Code should be useful for	**We can take action if registered nurses or midwives fail to uphold the Code. In serious cases, this can include removing them from the register.**	Punitive action is omnipresent	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** **(Dominance)**

		everyone who cares about good nursing and midwifery:			(intention of hostile action, absolute power and control)
		For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing their professionalism.	**For the many committed and expert practitioners on our register**	By implication of 'for the many', a few therefore exist who are neither committed or expert Assumes consensus of what is 'expert'	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** **(Fear, Uncertainty and Doubt (FUD) strategy)** **AMBIGUITY OR OPPORTUNITY** (Vague terms)
		Through revalidation, you will provide fuller, richer evidence of your continued ability to practise safely and effectively when you renew your registration. Extensive use of **MUST**	**Through revalidation, you will provide fuller, richer evidence of your continued ability to practise safely and effectively** **Must**	Use of modal verbs 'will' and 'must' - registrants obliged to fulfil regulators requirements	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** (Power relationship) (Legal duty and personal accountability)

					(Deontic modality) Undefined meaning assumed without question Deontic modality (reinforces legal duty and personal accountability) according to regulator expectations
4.	**Revalidation (2017)**	38. Practice hours should reflect your current scope of practice. Practice hours do not have to be related to your original field of practice when you first joined the register. Irrespective of your role, you must comply with The Code: professional standards of practice and behaviour for nurses and midwives. **This includes the duty to recognise and work within the limits of your competence.** The Code (paragraph 22) requires you to fulfil all registration requirements. To achieve this you must: • meet any reasonable requests so we can oversee the registration process (22.1); • keep to our prescribed hours of	**This includes the duty to recognise and work within the limits of your competence.** **keep your knowledge and skills up to date, taking part in appropriate and**	Currently no competence framework available Individual decision making re. education and at what level necessary	**AMBIGUITY OR OPPORTUNITY** (Adaptability, flexibility) (Flexibility)

		practice and carry out continuing professional development activities (22.2), and • **keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance (22.3).**	**regular learning and professional development activities that aim to maintain and develop your competence and improve your performance (22.3)**	Encouraging and supportive approach to revalidation yet NMC confirm that by participating in the revalidation process itself still does not guarantee a registrants fitness to practice	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** (Revalidation processes do not guarantee fitness to practice)
		What Is Revalidation (p3) Revalidation is the process that allows you to maintain your registration with the NMC; • **demonstrates your continued ability to practise safely and effectively,** and is a continuous process that you will engage with throughout your career. **Revalidation is the responsibility of nurses and midwives themselves. You are the owner of your own revalidation process.** **Revalidation is not (p4)** **an assessment of a nurse or midwife's fitness to practise;** a new way to raise fitness to practise concerns (any concerns about a nurse or midwife's practice will continue to be raised through the existing fitness to practise process), or an assessment against the requirements of your current/former employment.	**Revalidation demonstrates your continued ability to practise safely and effectively** **Revalidation is the responsibility of nurses and midwives themselves. You are the owner of your own revalidation process.** **Revalidation is not an assessment of a nurse or midwife's fitness to practise;**	The process demonstrates a registrants ability to practice safely and effectively yet is not an assessment of their fitness to practice	**AMBIGUITY OR OPPORTUNITY** (Personal Liability and Accountability) (Imprecise) (Professional Vulnerability)

		Why we introduced revalidation (p4) To raise awareness of the Code and professional standards expected of nurses and midwives To provide you with the opportunity to reflect on the role of the Code in your practice as a nurse or midwife and demonstrate you are 'living' these standards To encourage you to stay upto date in your professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals To encourage a culture of sharing , reflection and improvement To encourage you to engage in professional networks and discussions about your practice, and To strengthen public confidence in the nursing and midwifery professions	**To provide you with the opportunity to reflect** **To encourage you** **To encourage you** **To encourage you** **To strengthen public confidence**	Process in place partly as need reassure public	**THE PUBLIC FACE OF THE REGULATOR** (Regulator as Nurturer) (Moves to regain public confidence in NMC as regulator)
		Revalidation and the Code One of the main strengths of revalidation is that it reinforces the Code by asking nurses and midwives to use it as the reference point for all the requirements, including their	**This should highlight the Code's central role** **should lead to improved practice and therefore public protection benefits**	Conditional mood Encouragement Supportive	**THE PUBLIC FACE OF THE REGULATOR** Expressions of unexpectedness in the

		written reflective accounts and reflective discussion. **This should highlight the Code's central role** in the nursing and midwifery professions and encourage nurses and midwives to consider how it applies to their everyday practice Overall, revalidation **should lead to improved practice and therefore public protection benefits** **Keep a portfolio (p9)** **We strongly recommend** that you keep evidence that you have met the revalidation requirements in a portfolio **We recommend** that you keep your portfolio until after your next revalidation. **You need to be mindful** about any personal or commercial relationship between you, your confirmer and your reflective discussion partner	**We strongly recommend** **We recommend** **You need to be mindful** **You might find it helpful** **You may choose**		situation referred to (fake tense) Katrin Shulz **AMBIGUITY OR OPPORTUNITY** **Uncertainty of process** (no guarantees) Regulator as ally

		You might find it helpful to have a discussion with your confirmer every year as part of an annual appraisal, so you can keep them updates on your revalidation. **Storing Your Reflective Account (p13)** **You may choose** to store your completed reflective discussion and confirmation forms in either paper or electronic format. **You should still** respect the fact that these forms contain personal data about your reflective discussion partner and confirmer. **How To Meet The Requirements (p19)** **We do not prescribe any particular type of CPD. We think you are better placed to decide what learning activity would be most suitable** and beneficial to your individual scope of practice.	**You should still** **We think you are best placed to decide what learning activity** **We do not prescribe any particular type of CPD. We think you are better placed to decide what learning activity would be most suitable**	Uncontrolled education provision	Opportunity Variation Flexibility

5.	**Future Nurse: Standards of proficiency for registered nurses (2018)**	The proficiencies in this document therefore specify the knowledge and skills that registered nurses must demonstrate when caring for people of all ages and across all care settings. **They reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care.**	**They reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care.**	Widening expectations and accountability. Attempts to regain public confidence through their involvement and stakeholders expectations of accountability - burden of accountability	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** (Increasing burden of responsibility) (Distancing decision from increasing accountability by - use of 'the public') (Regain public confidence)
		Registered nurses play a vital role in providing, leading and coordinating care that is compassionate, evidence-based, and person-centred. **They are accountable for their own actions and must be able to work autonomously,** or as an equal partner with a range of other professionals, and in interdisciplinary teams. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed. **They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation, and rapidly evolving technologies.**	**They are accountable for their own actions and must be able to work autonomously** **They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation, and rapidly evolving technologies. Increasing integration of health and**	No guidance for wound care available Function is insurmountable and unattainable The knowledge and skills required for wound care nursing remains undefined	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** Reinforcing personal accountability Futility of nursing

		Increasing integration of health and social care services will require registered nurses to negotiate boundaries and play a proactive role in interdisciplinary teams. **The confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care therefore lies at the centre of all registered nursing practice.** Those procedures outlined in Annexe B, Part I: Procedures for assessing needs for person-centred care, CHAPTERs 1 and 2 also apply to all registered nurses, **but the level of expertise and knowledge required will vary depending on the chosen field(s) of practice. Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field(s) of practice.**	**social care services will require registered nurses to negotiate boundaries and play a proactive role….** **The confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care therefore lies at the centre of all registered nursing practice.** **but the level of expertise and knowledge required will vary depending on the chosen field(s) of practice. Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field(s) of practice.**	The knowledge and skills required for wound care nursing remains undefined. What is 'appropriate' for wound care	Ambiguity Lack of role definition in wound care **AMBIGUITY OR OPPORTUNITY** (Lack of role definition) (Professionally vulnerable)

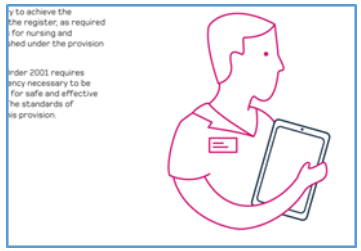
		1.2 understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks, including any mandatory reporting duties, to all areas of practice, **differentiating where appropriate between the devolved legislatures of the United Kingdom** **take responsibility for** continuous self-reflection, seeking and responding to support and feedback to develop their professional knowledge and skills	**differentiating where appropriate between the devolved legislatures of the United Kingdom** **take responsibility for**	Confirms acceptance of variation despite demands for standardisation	**RESPONSIBILITY WITHOUT ACCOUNTABILITY** **AMBIGUITY OR OPPORTUNITY** (Sanctions variation in wound care practices, responsibilities and role) (Personal interpretation and responsibility)
		2.4 identify and **use all appropriate opportunities**, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances	**use all 'appropriate' opportunities** **use appropriate**	Failure to provide definitions for routinely used terms: Appropriate Accountable Proficiency	**AMBIGUITY OR OPPORTUNITY** Vague fuzzy Understanding and interpretation of appropriate contestable

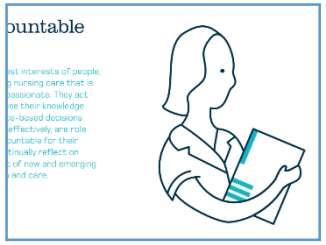
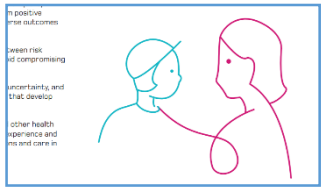
				Standards	
		2.9 use appropriate communication skills and strength based approaches to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability **Annexe A 1.3** **use appropriate** non-verbal communication including touch, eye contact and personal space 1.4 **make appropriate** use of open and closed questioning **2.2** use clear language **and appropriate**, written materials, making reasonable adjustments where appropriate in order to optimise people's understanding of what has caused their health condition and the implications of their care and treatment	**use appropriate** **make appropriate** **and appropriate**		Polysemous (Words that have multiple meanings Word sense disambiguation and schemas Polysems Words that can be interpreted differently – open of media texts to multiple interpretations – advantages/disadvantages)

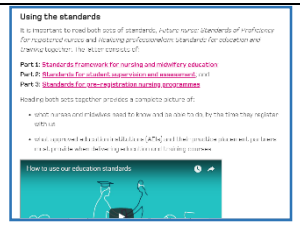
		4.2.4 **appropriate** and effective confrontation strategies 4.2.6 effective co-ordination and navigation skills through: 4.2.6.1 **appropriate** negotiation strategies 4.2.6.2 **appropriate** escalation procedures 4.2.6.3 **appropriate** approaches to advocacy	**Appropriate** **Appropriate** **Appropriate** **Appropriate**		
		3.2 use **appropriate** bed-making techniques including those required for people who are unconscious or who have limited mobility 3.3 use **appropriate** positioning and pressure-relieving techniques 3.4 take **appropriate** action to ensure privacy and dignity at all times 3.5 take **appropriate** action to reduce or minimise pain or discomfort	**Appropriate** **Appropriate** **Appropriate**		

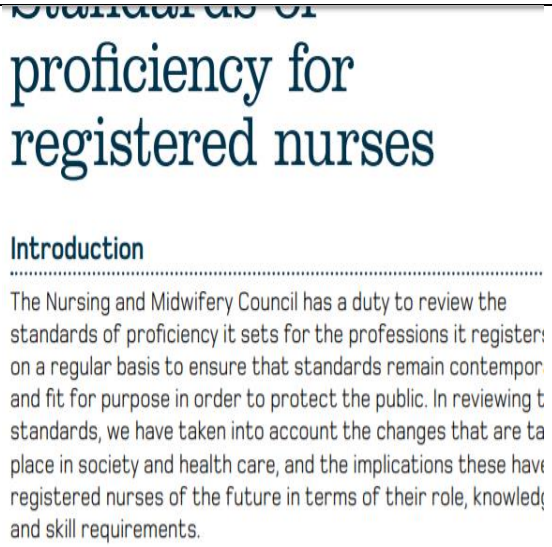
		3.6 take **appropriate** action to reduce fatigue, minimise insomnia and support improved rest and sleep hygiene.	**Appropriate**		
		4.2 use contemporary approaches to the assessment of skin integrity and use **appropriate** products to prevent or manage skin breakdown 4.3 assess needs for and provide **appropriate** assistance with washing, bathing, shaving and dressing 4.5 assess needs for and provide **appropriate** oral, dental, eye and nail care and decide when an onward referral is needed	**Appropriate** **Appropriate** **Appropriate**		
		5.3 assist with feeding and drinking and use **appropriate** feeding and drinking aids	**Appropriate**		
		6.2 select and use **appropriate** continence products; insert, manage and remove catheters for all genders; and assist with self-catheterisation when required	**Appropriate**		
		6.6 undertake stoma care identifying and using **appropriate** products and approaches.	**Appropriate**		
		7.3 use **appropriate** moving and handling equipment to support people with impaired mobility 7.4 use **appropriate** safety techniques and devices			

			Appropriate **Appropriate**		
		8.1 observe and assess the need for intervention and respond to restlessness, agitation and breathlessness using **appropriate** interventions 9.4 use **appropriate** personal protection equipment Key components of the roles, responsibilities and **accountabilities** of registered nurses are described under each of the seven platforms. The outcomes set out below reflect the **proficiencies for accountable professional practice that must be applied across the standards of proficiency** for registered nurses, as described in platforms 2-7, in all care settings and areas of practice	**Appropriate** **Appropriate** **Appropriate** **Accountabilities** **proficiencies for accountable professional practice that must be applied across the standards of proficiency**		

			Clash of graphics with content – disaccord Discordant incompatible incongruent	Graphics designed to appeal to public through use of images not professional nurses Modalities Degrees of articulation of detail Degrees of articulation of the background Degrees of depth articulation Degrees of articulation of light and shadow Modalities	**THE PUBLIC FACE OF THE REGULATOR** (Policy designed to appease appeal to stakeholders not nurses) (Who are the documents for – degree of guidance contained within and images more in keeping with appealing to public not registrants)
					(Inconsistency Saying one thing but

		  			fulfilling another function) Meeting needs to stakeholders and regaining public confidence with limited information provided to registrants through use of polysemes Treating registrant s like children

					
				By uploading a jpg of the font onto the internet based font analysis programme 'fontsquirrel.com' the typeface, I was able to identify the font.	

			Consider text as another image – what type face used – using analyser Using the PDF document upload it into the https://www.fontsinpdf.com/Clarendon-BT-Heavy.font What It is Saying - CONFIRMED		

Appendix D

DCA Categorisation Matrix

	MAIN CATEGORES DERIVED FROM SUBCONSTRUCTS	SUPPORTING TEXT FROM CRITICAL DISCOURSE ANALYSIS	DEFINITION	DIRECTED CONTENT ANALYSIS CODING RULES	DCA ANCHOR SAMPLE TEXT
1	**Variation in wound care nursing practices and role ambiguity**	'To date within tissue viability there are few tools with which to measure and benchmark expertise' 'There are no UK nationally agreed core competencies to which TVNs and their employers can match outcomes in ensuring interventions are of the same standard nationally' Extensive use of 'appropriate' throughout… policy - open signifiers 'Although the NATVs in Scotland has published core competencies for	Inconsistencies exist in role and in (1) wound assessment, prevention and management practices and (2) wound care experience and knowledge	Observation of variation in role across clinical disciplines and geographical areas Inconsistencies in wound care practice, knowledge and experience	'Colleagues of same team measure wounds differently. Some measure length left to right of body and some measure head to toe' (L4-6). 'I regularly measure wounds but have to say that I have never considered how my colleagues do it.....definitely something I'll have to research as if this isn't something that we are doing by the same method then its a fairly pointless exercise and the measurements are a bit useless!' (L26-29). 'Wound measurement is a problem I find as we do all measure differently and many times it is personal opinion of where the wound edge is and also everyone's

		TVNs these are not used nationally across the UK' 'It should be noted this framework is not prescriptive'			take on the % of slough etc is different' (L44-46). 'A non-uniform approach to wound care is a real issue in NHS Y. I've worked in areas that do have dedicated tissue viablity nurses and the guidelines, advice and consistency of practice across the organisation was something I had taken for granted'(L86-89). 'I have to agree X, it is quite frustrating not having a specialist nurse to deal with problematic wounds' (L92-93). 'the problem is the assessment of such is very subjective (what I think is 50% slough my colleague may feel is 60% etc)'. 'We don't use honey in the Y Health Board and haven't for many years, although when I worked in another practice a few years ago it was used'

					'One thing I find frustrating is that I have been advised by a Tissue Viability nurse at a cutimed academy training day and by another rep for coban 2 compression, that bulky padding like Zetuvit is recommended for use under compression. This is despite my understanding that the lowest suitable profile primary layer should be used in order not to alter the compression values at the point of increased circumference'.
2	**Ambiguous personal decision making**	'.but the level of expertise and knowledge required will vary depending on the chosen field (s) of practice. Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field of practice'	Lack of self-confidence, doubt or uncertainty over clinical decision making in wound care practice	Statements of concern over clinical decision making Requests sought for peer advice.	'If I am wrong then please someone correct me so I can accurately measure wounds' 'Thanks for the advice re wound measurement X. I didn't know this!' 'We often pull back a dressing quickly as part of the initial patient assessment and use this quick look to DATIX the pressure ulcer. It has

		Extensive use of 'appropriate' throughout… policy			occurred to me that this may not be as accurate as it could be'. 'I'm hoping this will be a discussion about subjectivity of Waterlow assessment rather than a discussion about how I've been doing it wrong all these years!' 'That's the problem, there's too much scope for individual interpretation with clinical assessment tools'. 'I'm embarrassed to say that I don't think I have ever referred an overweight/ obese person to the dietician'. 'You don't know what to do for the best……what is professional and practical are two different things'. 'Hi X I have similar views to you and agree with you but still don't know what the right answer is! I think the trick might be there is no right or

					wrong answer just valid opinions supported by evidence' 'I've seen a few Waterlows recently completed by folks who don't seem to interpret it the same way and beginning to wonder if I'd been misinterpreting it. Can you remember if this is because you were taught or learned it this way at some point or is it just that you interpret the questions in the same way I do?' 'It was how I practiced until a couple of years ago until I learned otherwise at a tissue viability study day. I passed this information on to my colleagues with variable uptake!! '
3	**Autonomy**	'They are accountable for their own actions and must be able to work autonomously'	Independent thinking in clinical decision making and identification of contributing factors	Independent wound care practices discussed with reference to application and relevance of policies and guidelines	'I prefer 'Kerramax' (or other superabsorbent lik or eclipse)'.

		'The confidence and ability to think critically, apply knowledge and skills and provide expert, evidence based direct nursing care therefore lies at the centre of all registered nurses practice'			'There's a major assumption by saying that nurses just do what reps say. I think nurses are more critical than that and go by results we see. I do agree some nurses have favourite dressings. We all do. This is as we have seen results from the ones we have used. More of an experiential critique'. 'I always try to follow the guidelines but my colleagues have gone off formulary as sometimes not all dressings are appropriate for certain wounds and also to suit patient lifestyle and conditions.' 'I agree with questioning the research and evidence in NICE, SIGN and local policies and guidelines, but it is stipulated that these are what we must use therefore we are legally and professionally bound, and any deviation from these is regarded as a deflection from accepted practice'

4	**Regulatory dominance power and control**	'We can take action if registered nurses or midwives fail to uphold the Code. In serious cases, this can include removing them from the register'	Professional liability and potential fitness to practice consequences	Awareness of NMC role in misconduct if practising outside scope of practice. Evidence of practising outwith/within boundaries of professional practice	
5	**Flexibility**	'They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation and rapidly evolving technologies. Increasing integration of health and social care will require registered nurses to negotiate boundaries and play a proactive role' Extensive use of 'appropriate' throughout… policy	Knowledge and competence to adapt wound care practices to changing environments	Indications of requirement to adapt and modify practice to meet individual patients' needs	
6	**Hierarchical power relationships**	'Proficiencies for accountable professional practice that must be	Personal accountability to be proficient in wound care practices and role of employer and managers	Confident in own practice to meet regulatory requirements.	'That brings up the whole accountability versus blame argument which I could go on about for hours'.

		applied across the standards of proficiency' Extensive use of 'appropriate' throughout… policy		Employer and line management influence on wound care practice	'I was at a recent wound formulary meeting where it is acknowledged that nursing staff on the wards have little knowledge on what to apply to wounds. One of the factors cited was that there was so little time that nurses grabbed the first thing that "looked appropriate" and "hoped for the best". This was said by a senior nurse in the hospital. I said that there was an obvious need for some wound education but I was told that nurses were not able to get away from wards and putting on wound study days was costly in view of poor attendance'….. I was disgusted that "senior management" thought this would be a solution. You read everywhere about the cost to the NHS of pressure damage and management and yet this was the solution? Our trust does not have a TVN and this is where the education and access to research that they would provide would have an effect'.
7	**Revalidation is not a guarantee of fitness to practice wound care**	'Revalidation demonstrates your continued ability to practice safely and effectively'	Understanding that acquisition of what are considered to be relevant knowledge and skills is one of personal responsibility	Appreciation of personal responsibility for wound care practice and need to keep own skills current	Is that not more of a cultural consideration? Would legal and ethical be practices we would undertake with regard to NMC code, including our accountability

		'Revalidation is the responsibility of nurses and midwives themselves' 'You are the owner of your own revalidation process' **'Revalidation is not an assessment of a nurse or midwives fitness to practice'**		Apprehension over inconsistencies and its effect on registration	and how we are required to stay up to date, for example statutory mandatory training, CPD and revalidation?
8	**Quality control of wound care education and skills framework is non-enforceable and inconsistency exists in knowledge and skills**	'It is anticipated that the boundaries for each will be agreed locally' 'The NMC paragraph 22 clearly states registered nurses must: 22.3 keep your knowledge and skills up-to-date, taking part in appropriate and regular learning and professional development activities that aim to develop your competence	Awareness of variation and inconsistencies in wound care education and its effects on knowledge and skills and personal decision making	Wound care education is inconsistent in wound care practice Consequences of inconsistencies in wound care education Access to and accreditation of knowledge and skills for wound care provision Appreciation of the need for associated knowledge and competence for role.	'Wound measurements can be difficult if everyone has not received the same training on how to carry this out' (L16-18). 'I know, in the ward I work in the wound assessments charts are mainly a guesstimate, due to lack of teaching when all these assessments tools are brought into use. It is so frustrating as it an essential tool in wound management' (L105-107). 'Most of my colleagues were not aware of this therefore

		and improve your performance'			communicating with them about any new knowledge is important'. 'Nurses need to be trained in taking photos to ensure quality of photos and adequate documentation must accompany them' 'I have realised that there is a real lack of knowledge surrounding wound assessment and dressing choice. Due to the wide variety of dressings available I think some nurses play it safe and stick to what they know rather than risk doing harm by trying something new'. 'I think more education should be provided at ward level and time allocated for study, this would allow wound care to be more uniform across the organisation and stress importance of evidence based care'. 'Being fairly new to nursing with just two years' experience, I have been guided by more experienced nurses and learning gained on placements'. 'I agree regards the inconsistencies of measurement of wounds but in my place of work we tried to

					overcome this with staff training and consensus as to what constitutes as length and width and boundaries from where measurements are taken so hopefully producing more accurate readings'. 'There is a lack of knowledge regarding wounds and the treatment they need but it's difficult to get time away from the wards for mandatory training never mind the training offered over and above it.'
9	**Wound care nursing is subject to personal interpretation**	'Practitioners are expected to possess specialist knowledge and skills to expertly manage a range of skin issues' 'To date within tissue viability there are few tools with which to measure and benchmark expertise' 'Practitioners who complete the framework will need to self-assess	Personal interpretation of desired knowledge and skills and of wound care policy has implications for accountability	Evidence of individual interpretation of knowledge and skills and implementation of wound care policy Expression of consequences of individual interpretation	'I feel the guidelines and formularies have been fully assessed and every dressing has been scrutinised, trials have been carried out numerous times therefore I do not always see a reason to differ away from this'.

		themselves and identify an assessor' Following completion of the self-assessment you will need to discuss the statements with your assessor to ensure you have assessed yourself at the correct level' 'To ensure you are assessed on the appropriate competencies it is important that you and your assessor decide which are appropriate to your area and job role' Extensive use of 'appropriate' throughout… policy 'Through revalidation you will provide fuller, richer evidence of your continued ability to			

		practise safely and effectively'			
10	**Professional exposure, vulnerability and liability**	'While you can interpret the values and principles set out in the Code in a range of different practice settings, they are non-negotiable or discretionary' 'Differentiating where appropriate between the devolved legislatures of the UK' Use of 'appropriate' throughout … policy	There is professional vulnerability in the absence of standardised education and competence framework	Recognition that boundaries of practice are unclear Professional repercussions over personal clinical decision making and indistinct professional practice boundaries are evident Notions of concerns over wound care decision making, associated levels of competence and support mechanisms and repercussions	'A few weeks I encountered a situation which left me feeling as though we had let the patient down and with that my own professional responsibility'. 'Maleficence - do no harm. You do the best you can in any circumstance'. 'Yes I have had to do that before too. Difficult as could have implications for breaching confidentiality which is more of a legal issue' 'We don't have tissue viability services here, so there will be no qualified, dedicated lead. The board have flatly stated that there is zero intention of allocating funding for TV services. The last inspection report stated that whilst there is no obligation for NHS ? Board to employ TV specialists, they strongly suggest that all staff should have access to such advice even if that is

					remotely, through another health board (the last I hear they were thinking about possibly? Health Board). In these circumstances I am worried about what is going to be expected of the new wound care group and I am anxious and cross about the position we may be put in professionally. I am also concerned about the amount of time that will be involved in this - not just meetings but, dependent upon what is expected, research etc'. The NMC states in section 10 of The Code that nurses must 'keep clear and accurate records relevant to (their) practice and outlines the importance of completing records at the time or as soon as possible after the event, identifying any risks, problems etc that have arisen and steps taken to deal with them. This allows colleagues who use the records to have access to all the relevant information that they need to provide continuity of care and to effectively continue assessing, planning, implementing and evaluating the best care for each patient that they can achieve. I do think, however, that we often fall short of this ideal. I have witnessed on occasion, for example,

					colleagues forgetting to measure a wound at the time of dressing change and subsequently 'guesstimating' the wound's dimension at a later stage. I have also witnessed wound bed appearance being documented retrospectively after the wound has been covered. Apart from potentially falsifying records, examples like these can lead to inaccuracies in wound documentation and at a later stage, at next dressing change, for example, when the appearance and size of the wound possibly differ significantly from that stated in the documentation. 'Wound care can be complex and for nurses to treat wound effectively I agree they must have a good knowledge of the anatomy and physiology of skin. Nurses have a responsibility to keep their knowledge and skills updated'.
NEW EMERGING CATEGORIES					

				DIRECTED CONTENT ANALYSIS CODING RULES	DCA ANCHOR SAMPLE TEXT
11	**Professional Judgement and Implementation of Guidelines and Research EBP**			Disputes or supports the need for experience, professional judgement. Does or does not adhere adheres to guidelines and policies	'I don't feel wound care is generalisable due to the uniqueness of each wound and individualised/holistic management of same'. Choosing research evidence I find a minefield of information. This module has taught me to always question and be sceptical and not take "evidence" at face value. I agree. I think it is a matter of opinion when it comes to choosing a research method. 'I feel that ultimately that any HCP that ventures into the research arena must have adequate appraisal skills and we should not take research at face value as being good just because its an RCT'. 'I do believe however that in the mainstream many nurses follow current EBP guidelines but have no idea of research behind them other than that its "evidence based"). I

					believe it is my responsibility to understand the research behind my interventions alongside my own clinical judgement to be able to defend actions and inform patients carers why I am choosing this course of action over another'. 'I feel that due to the amount of evidence and research out there that there isn't a write or wrong answer just a different approach to the understanding'. 'Wound care and appropriate dressings is very much about making do with the best that you have, management and at the end of the day are trying to balance the books and will only give the most cost effective ones that are available'.
12	**Moral Dilemma Conflict and Tension – Patients Rights**				'Whilst we try to "non-maleficence/beneficence", patients with pressure ulcers are the hardest challenge, not only to try to tactful

	Compromising Decision Making				convince pressure relieving equipment is to allow comfort etc. Knowing we cannot heal wounds without corroborated/mutual agreement'. 'Sometimes the biggest challenges with wound care are the families some who refuse the education and continue to use quilt covers on top of airwave mattresses .They also would rather use old fashioned barrier creams as opposed to 'sorbaderm'
13	**Emotions of Wound Care Nursing**			Displays emotions associated with the challenges of wound care	
14	**Wound Care Education in the Wider Arena MDT and Drs Carers**				'Our doctors never take anything to do with the wounds apart from reviewing them and I have never once met a doctor - FY1, registrar, consultant or GP that actually measures a wound, even in theatre! '

					'The District nurse is responsible for the care of patients on the caseload, but wound management is very much a team effort with input from all staff members who have loads of individual experience'.
15	**Access to Resources – barriers cameras, equipment, miscommunication hospital/community, documentation inadequate**				'I feel that medical imaging of wounds could probably be the way forward in alleviating miscommunication between hospital and community settings, however a confidential universal or easy to access software/ system would need to be developed. If there is such a thing already widely available, please let me know as I would love to look into it!' 'Because of the way the wound chart is worded, you have to contradict yourself!'

					‘In previous work in remote locations I have been very appreciative of being able to send images to onshore doctors and it worked very well; indeed very reassuring for clients’. ‘Cloud technology is currently being advertised/promoted on TV as an international approach to healthcare all over the world; and yet I am not able to record a wound digitally’
					‘Agree with you both really interesting topic and somewhat an insulting implication that the reason for stopping reps was we as registered professionals could be swayed in our judgement by a free pen or 2! ‘ Agree reps are starting to come back, however as they weren't for so long there are lots from the formulary list haven't made contact which is sad really as we are losing out on the information, case studies, been able to trial products with support from reps.

					I have to agree with this X we are told the dressings on the formulae and left to make choice. At least now we are being allowed reps back in again, this way you can make your own mind up about dressings
16	**Contribution of an Online Safespace to Practice**			Uses the discussion opportunity to indicate compassion, support, share knowledge, confess and non-judgemental	

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