

The questioning of intuition; a post structural analysis of nurses' stories

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Faculty of Education, Health and Wellbeing.

Professional Doctorate in Health and Wellbeing.

Thesis.

The questioning of Intuition;

A post structural analysis of nurses' stories.

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A thesis submitted in partial fulfilment of the requirements of the University of Wolverhampton for the degree of Doctorate in Health and Wellbeing.

Abstract.

Aim.

The aim of this thesis is to question intuition, and analyse factors which influence Registered Nurses decision making, when recognising and responding to an acutely ill patient.

Background.

Two models of decision making are historically identified in the literature, the Hypothetical - Deductive reasoning and Intuitive-Humanist (Banning, 2008), with the Hypothetical - Deductive reasoning model initially adopted, to offer authority to nursing as a science (Dowding, 2008; Krishnan, 2018). The Intuitive-Humanist model came to the fore through the work of Benner (1984) and Benner and Tanner (1987), who stated that intuition is an essential part of clinical decision making, emphasising the importance of person-centred nursing care.

Intuition in nursing is afforded credibility as a legitimate form of knowledge (Benner, 1983; Green, 2012), particularly in relation to the 'expert' nurse, who is able to demonstrate an "intuitive grasp" of each situation, utilising a wealth of experience (Benner, 1983). But intuition is an abstract notion (Green, 2012), in order to study the role of 'intuition' in nursing practice, and the rhetoric that affords it legitimacy, means questioning how it is viewed in the current nursing paradigm, which I aim to do in my thesis.

Because much of the current data on expert intuition is based on nurses caring for acutely ill/deteriorating patients, this became a point of reference, to ensure a focus for the data collection, and the application of the findings from the data analysis to the discussion and conclusion.

Methodology.

Data was collected using a naturalistic focus group, with a group of experienced nurses on a Continuous Professional Development programme, with the University of Wolverhampton. The participants were asked to consider a time when they had cared for an acutely ill patient, they were then given one minute to write down ten words related to the scenario, this gave a focus for the subsequent paragraph they were asked to write, and stories they were asked to relate.

Analysis.

The data analysis was completed using the post structuralist philosophy of Roland Barthes, diachronic evidence from the literature review, was compared to the synchronic evidence from the data analysis, interrogating the text to potentially present an alternative perspective, from what is already 'known.'

Dissemination of findings.

Socratic questioning facilitated interrogation of the text, the data analysis was summarised into four themes, for the summary of findings,

What knowledge means to nursing and the impact this has on decision making.

Nursing feeling vulnerable and isolated, and the link between the two.

Emotion is associated with intuition, the manifestation of emotion and its meaning to nursing.

Patients or protocols?

The diachronic evidence of the literature review was compared to the synchronic evidence of the interrogation of the text to address the questions, whilst there is some agreement, mostly the synchronic evidence contradicted the diachronic evidence.

Conclusion.

Despite the drive to identify specific nursing knowledge, particularly when involved with an acutely ill patient knowledge, knowledge is an assumed and expected attribute of nursing. Knowledge is tied up, in the culture of nursing as a societal group, which as long as this is understood by the members of the societal group, the need to understand it, particularly with its link to intuition becomes irrelevant.

Personal agency and salience are tied up in being a member of the societal group, not just nursing, but also part of a recognised team. Judgement of others comes from not having the same cultural values, as nursing, despite being in a societal group, in a clinical placement area.

Knowledge, to nursing, is not related to evidence-based practise, but being up to date and informed about the patient. The relationship between the patient, the relatives, and the nurse is significant, with shared values and expectations, although the relationship is not one sided, with the nurse being the can giver, and the patient being dependent on the nurse. There is a sense of co-dependency which strengthens the relationship, but also leads to a sense of vulnerability for both the nurse and the patient. The sense of vulnerability, also occurs, not from being faced with a new situation, but being outside a societal group, with a sense of isolation. Nurses are not scared of 'getting it wrong', but being isolated, because of the humanistic element of their approach.

Actions and behaviour are what define nursing practise, knowledge is locked up in these, and are related to cultural norms and language. This is how nursing should be defined, by

what is done, the actions and behaviours which indicate what nursing is, and the knowledge and language that informed this.

Emotion is frequently linked to intuition, but again this is physical, a response, behaviour, and actions. Patient focused care is fundamental to nursing, most policies and procedures are valued, mainly as legal protection, the moral obligation to the patient, and to self, are fundamentally more important than the risk of not adhering to policies and procedures.

Gathering policies, understanding their use, is linked to the notion of an expert, but the linear trajectory of novice to expert, is challenged due to elements of uncertainty, mainly related to being outside the societal group and a loss of shared cultural values.

Glossary of terms.

Term	Meaning
<i>Brand</i>	For this thesis, “brand” meaning a service that has a distinctive identity, which helps to distinguish it from other professions in health care (Kenton 2023). Usually associated with attributes, such as packaging (uniform), title, value, and quality, and how the brand is viewed by others (ibid).
<i>Connotation</i>	Identifies the plurality of text, with more than one meaning (Barthes, 1991), reliant on the cultural focus of the person reading the text (Sonesson, 1998, Bouzida, 2014).
<i>Cultural group</i>	A group of people with shared identity, beliefs, and values (Anon 2023), for the purpose of this thesis it is the view nursing has of itself, rather than an outside perspective.
<i>Denotation</i>	Singular definition (Barthes, 1991), ‘common sense’ meaning, the obvious description of what is being read (Bouzida, 2014).
<i>Diachronic</i>	A historical perspective of the development of language, aligned with events which have modified the meaning of the language over time (Raclavsky, 2014).
<i>Intuition</i>	An abstract concept, a ‘sixth sense’, a cognitive ability that assists nursing assessment of patients (Robert, Tilley and Peterson, 2014). Frequently linked to judgements and decision making (Klein, 2017, Casullo and Thurow, 2013), an understanding without rationale (Benner and Tanner, 1987), the way thoughts are translated into actions (Klein, 2017).
<i>Lexia</i>	Units of reading which are arbitrary dependant on the reader but offer the best possible space to discern meanings (Barthes, 1991).
<i>Myth</i>	A type of speech, a system of communication, defined more by its intentions, it empties ‘reality’ to reveal alternative, multifaceted meanings (Barthes, 2009).
<i>Poststructuralism</i>	A theoretical movement regarding the world in which human beings exist and how meaning, particularly relating to language, is made and reproduced (Belsey, 2002), with the belief that there are multiple interpretations, dependant on cultural beliefs (Lundy, 2013).
<i>Paradigm</i>	The essential theories, language and ideas that are acknowledged by a specific scientific and cultural group (Armand, Larson and Mahoney, 2020).
<i>Readerly text</i>	The reader is a passive consumer, with consideration of the intentions of the author, rather than the readers own interpretation of the text (Barthes, 1991).
<i>Semiology</i>	Concerned with intentional acts of communication such as writing and speaking, as opposed to semiotics, which also explores unintentional and natural occurrences (Daylight, 2012).
<i>Signifier</i>	Sounds, images or objects, the physical form of a concept (de Saussure, 2005).
<i>Signified</i>	The mental image of the <i>Signifier</i> (de Saussure, 2005).

<i>Sign</i>	The associative link between the <i>Signifier</i> and <i>Signified</i> which is arbitrary; society or cultural means of expression is dependent on collective convention, or agreement of meaning and use, and is imposed on a community (de Saussure, 2005).
<i>Socratic method</i>	Using a series of questions to facilitate consideration of different issues (Overholser, 1995), supporting critical thinking, and challenging the status quo (Britton, 2021).
<i>Synchronic</i>	The study of language at a particular moment in time, as a fixed event (Raclavsky, 2014).
<i>Writerly text</i>	This necessitates active participation of the reader to establish meaning (Barthes, 1991).

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Chapter one – A background and introduction to the study.

In this chapter I will present a background of decision making and intuition, inclusive of areas for further investigation.

Nurses' ability to make effective clinical decisions has a significant impact on the quality of care for patients, with clinical decision making a fundamental principle of nursing care (Krishnan, 2018). Nursing roles are expanding, with a wider responsibility for making decisions (Dowding, 2008), meaning that the process of decision making becomes an everyday activity, as nurses make judgements about the care they provide to patients (Banning, 2008), in a more complex way.

Historically two models of decision making are identified from the literature (Banning, 2008); Hypothetical - Deductive reasoning and Intuitive-Humanist, it is these two models that I shall be focussing on for the purpose of this thesis, and will be expanding on in the literature review, and throughout.

In the 1970s and 1980s the Systematic Positivist model was adopted by nursing to offer authority to nursing as a science, this was based on the Hypothetico – Deductive reasoning model, which uses a positivist **approach (Krishnan, 2018)** and followed the medical model of care (Dowding, 2008).

Nursing has struggled with this however as the positivist stance of the Hypothetico – Deductive reasoning model, conflicted with the interpretivist ontology of nursing (Paley, 2002). In her seminal work, Benner (1984) advocated an alternative using the Intuitive – Humanist model with an interpretivist focus on holistic care involving the patient. The Intuitive-Humanist model of decision making puts an emphasis on intuition, and the knowledge gained from experience, which augments the decision-making process (Banning, 2008). This is problematic however as whilst there is respect for intuition, there is

limited explanation of what it is (Rolfe, 1997), and the theory is too simple to account for the complex pattern of phenomena, which is inclusive in the current narrative on intuition (Gobet and Chasse, 2008).

Despite this Intuition has proliferated throughout the nursing press through the work of McCutcheon and Pincombe (2001); King and Clark (2002); Lyneham, Parkinson, and Denholm (2008); Pretz and Folse (2011); Dalton *et al.* (2018), who all relate back to the work of Benner (1983) and Benner and Tanner (1987) to inform their research, but all of this accepts that intuition is genuine and essential, without questioning whether there is an alternative position for nursing decision making, and clinical judgement.

Clinical decision-making theories have traditionally been assigned to a specific discipline, Hypothetico – Deductive reasoning to doctors, and intuition through the Intuitive-Humanist model to nurses (Buckingham and Adams, 2000). Ramezani-Badr *et al* (2009) and Cappelletti, Engel, and Prentice (2014) argue however, that nurses adopt a variety of strategies to inform decision making, inclusive of hypothesis testing as well as intuition and pattern recognition. This suggests that nurses do not express a preference for either model of decision making, but adopt a comprehensive approach, dependant on the needs of the patient and other relevant factors.

Nursing knowledge, the environment and the patient-nurse relationship are all factors that could impact on nurses' decision making (Benner and Tanner, 1987 and Cappelletti, Engel, and Prentice, 2014). What influence these have and whether nurses prefer either the Intuitive-Humanist model or Hypothetico – Deductive reasoning, will be an area for further investigation within this thesis.

The aim of my thesis is to interrogate intuition and examine factors which influence Registered Nurses decision making, when recognising and responding to an acutely ill patient.

1.1 Introduction.

The purpose of this introduction is to present my thesis, the thoughts and reasoning behind the structure, and the justification for taking an alternative approach.

Intuition has been explored extensively in the nursing press, but much of the information available arises from qualitative approaches, this is supported by Price et al (2017), who also suggest that they are subject to error and bias. Consideration of the theoretical framework for my research, meant a step away from the previously used approaches, in an attempt to uncover what is not already “known”. I adopted a post structuralist approach, by evaluating what is ‘known’ about intuition, comparing this to an analysis of my collected primary data. I will make no claims to a new understanding of what intuition is, or how it is used, but to potentially offer an alternative view of some of the rhetoric that surrounds it and has been propagated to afford it credibility.

In the first chapter I will introduce the thesis and why I became interested in exploring expert intuition in nursing practice; in particular, the specific knowledge used by nurses, when recognising and responding to the signs and symptoms of an acutely ill patient, with claims to the use of intuition, to detect deterioration.

The literature view forms the second chapter and will provide a historical overview of how intuition has been presented, and the benefits and difficulties associated with this. The purpose of my literature review will be to present current evidence on intuition, and the impact the ongoing rhetoric has had on nursing and decision making. Taking a stroll through history meant evaluating the origins of intuition, relating back to Barbara Carper

(1978) and Patricia Benner (1984 and 1987). There is further consideration of how the narrative of intuition has endured, with the search for nursing identity, the link between intuition and indeterminate decision making, and the challenges faced by nursing with the continuation of rhetoric around intuition.

The methodology chapter introduces the structuralist theory of Ferdinand de Saussure (2005), and the poststructuralist theory of Roland Barthes, the data has been analysed following Barthes (1991 and 2009) notion of myth and a first order and second order Semiology. Following on from the presentation of the research approach is the data collection methodology.

The data was collected using a naturalistic focus group (Green and Thorogood, 2005) of five experienced nurses on an Advanced Practitioner course, at the University of Wolverhampton. The participants were asked to consider a time they had been involved in an episode involving an acutely ill patient. I gave them one minute to write down ten words associated with the incident; I anticipated that only giving them one minute would elicit a more authentic response. The participants were then asked to construct a paragraph using the ten words, this then became the basic construct of their stories.

The discussion chapter compares the diachronic evidence of the literature review, with the synchronic evidence of the data analysis, this adds to the existing body of knowledge, by creating an alternative narrative for nursing, particularly in relation to intuition and decision making.

Chapter two – Literature Review.

2.1. A Diachronic approach to the literature review.

Following on from the previous chapter, and the background on intuition and decision making in nursing practice, the aim of this literature review is to explore intuition, with consideration of issues that are linked to intuition and decision making.

Within this literature review I will present the diachronic perspective of intuition, the growth of meaning through history (Frog, 2018), and the development of language over time (Raclavsky, 2015), which aligns with the structuralist philosophy of a universal 'truth' (de Saussure, 2005). Each society has its establishment of 'truth', the dialogue that is acceptable, and the status of those who say what matters as 'truth' (Foucault 1980 in Bradbury-Jones, Sambrook, and Irvine, 2008). The universal 'truth', as accepted by nursing will be evaluated, to demonstrate how intuition, has become a fundamental part of the cultural dialogue associated with nursing decision making, and the benefits and difficulties associated with this.

2.2. Literature searching.

To search for the literature, I used databases for primary and secondary evidence, hard copies, reference lists and grey literature were also searched using the terms "Intuition and nursing practice", "Nursing intuition and expertise", "Nursing expert and expertise", "Intuition and escalation of concern about an acutely ill patient" and "Expert intuition". These themes were selected because of their inherent link with intuition, in the available nursing literature (McCutcheon and Pincombe, 2001, King and Clark, 2002, Lyneham, Parkinson, and Denholm, 2008, Pretz and Folse, 2011, Dalton *et al.* 2018), I therefore considered them to be relevant, to identify appropriate available literature, to inform my study.

A flow chart of the literature search process, inclusive of criteria, search engines and data bases used, and the inclusion and exclusion criteria are in appendix one.

I considered the longevity of some of the studies because, despite an extensive search, studies conducted more recently proved elusive, I therefore extended my search to include studies from the year 2000 which then generated relevant evidence.

I considered the concept proposed by Green and Thorogood (2005), who state that it is worth searching extensively and creatively to include definitive texts, as well as the most up to date studies. This was also significant in the adoption of the diachronic approach, to explore the historical context (Raclavsky, 2015), of intuition in nursing. Some texts may seem dated, but I considered that inclusion of these, was fundamental to undertake a comprehensive search of the literature (Green and Thorogood, 2005), and to understand how the meaning and significance of intuition in nursing has developed over time (Frog, 2018). Further searches also identified that research that was more current, relied on the seven studies in the first order semiology as seminal research. Therefore, no new data was generated, beyond the original seven identified, because of the extensive use in more current studies of the original seven studies in appendix two. I considered it appropriate that these be used in the literature review, although not exclusively, the first order semiology and to compare with the findings from my research.

Whilst my search yielded majority nursing texts, some non-nursing papers emerged, which will be used in the literature review to supplement the presentation of the evidence. The number of texts identified was 147, some of which are inclusive in the literature review, the others were not considered relevant, as they did not address the aim of my research.

2.3 Thematic analysis.

Reflexivity refers to the constant activity of “self-reflection” by the researcher, to make explicit their thoughts, reasoning, and insights (Anderson, 2008; Hughes, 2014) in Darawsheh (2014), acknowledging preconceptions and biases (Polit and Beck, 2012).

Through reflexivity, I needed to consider my motivation for identifying themes, and pre-empt any expectations and assumptions of the findings (Finlay, 1998; Lambert *et al.* 2010) in Darawsheh (2014), to address the potential for preconceptions and biases, which may influence the process (Darawsheh, 2014). Because my clinical background is in emergency care, the use of intuition, in relation to recognition of an acutely ill patient, has been focussed towards this area of nursing practice. By adopting a reflexive approach, I was able to recognise this as a possible bias, I therefore ensured that the studies used were from a variety of clinical settings, to ensure a distributive representation.

To conduct a thematic analysis, there needs to be a critique of all the papers (Aveyard, 2023), an example of this is in appendix two, this quality assured the appropriateness of the studies, to address the aim for my research.

To establish my motivation for identification of the themes, I ensured that findings from the studies were in context with the aim of my research (Aveyard, 2023), to maintain the focus of my study throughout.

My first step in identifying themes was to re-read the results and discussion section of each of the identified papers (Aveyard, 2023), I then transcribed highlighted areas, which I and the identified researcher and author of each study, had identified as significant. From these notes recurrent salient topics emerged, initially ten themes were identified, but by revisiting and narrowing these down, four predominant themes emerged, which intricately linked to my research aim. The themes have been organised to highlight the progression of intuition

in nursing, but there is no hierarchy of importance for any of the themes, I have presented these in what I believe to be a relevant order.

2.4. The themes I will be exploring for the literature review.

Taking a stroll through history; the origins of intuition,

Intuition and nursing identity,

The ontology of nursing,

What are the challenges related to decision-making and intuition?

2.5. Taking a stroll through history; the origins of intuition in nursing.

The aim of this section is to explore the historical context of intuition in the nursing press, evaluating the origins and ongoing rhetoric.

Benner and Tanner (1987) define intuition as “understanding without a rationale”, Valenzuela, and Marcos, (2019) also claiming that intuition is a legitimate type of knowledge, which is the catalyst for nursing decision making. But these lack any real explanation or definition of what intuition is, which becomes problematic, as intuition, as defined by nursing, remains an “unreliable, anti-scientific and unworthy” nursing practice (Michael *et al.* 2015). Hassani *et al* (2016) argue that despite the prominence of intuition in nursing research, it has become known as a contentious issue, but despite being controversial, nursing research frequently validates the use of intuition in decision making (Valenzuela, and Marcos, 2019).

Through her work on the *Fundamental Patterns of Knowing in Nursing*, it could be argued that Carper (1978), sparked the initial shift against the Hypothetical-Deductive reasoning model of decision making, raising the prominence of the intuitive humanist model.

Carper (1978) stated that the kind of nursing knowledge considered most valuable for the purpose of rationalising clinical practice, has patterns, forms and structures that form beliefs about the way nursing thinks about knowledge and behaviour. Epistemologically, Carper's patterns of knowing are meant to serve as the building blocks for practice (Henry, 2018), to inform nursing of where knowledge comes from and how it is used.

There is a great deal written about the dependence of nursing on scientific knowledge (Rolfe, 2009; Reed, 2021) but the other patterns of knowing proposed by Carper (1978) are of equal importance, to understand the rationale behind the clinical decisions made by nurses. Thorne (2020) proposes that the Empirics pattern of knowing, the science, now has a reduced acceptance, as the other patterns of knowing have gained a higher status, to privilege nursing knowledge. This implies that the patterns of knowing linked to the Intuitive - Humanist model, are now considered a more important influence on clinical judgement than evidence-based practice, and the scientific base of the Hypothetico – Deductive model.

The second component of the Intuitive-Humanist model of decision making is the humanist element, which, I would argue, sometimes gets blurred in the theoretical drive to rationalise and justify intuition.

In a reaction to the previous prominence of the positivist approach, Carper (1978) emphasised that the importance of attitude and actions, are as integral to nursing care as empirical knowledge (Holtlander 2008), meaning that the other patterns of knowing Carper (1978) identified are as important to decision making as science. The 'art' of nursing, as identified by Carper (1978), linked to the esthetics pattern generally is difficult to define however, as Paniagua (2004) and Henry (2018) argue, it is difficult to apply the term 'art' to nursing due to the multiple meanings of the term 'art', and the difficulty in defining nursing

knowledge and practice. But it does align to the definition of intuition by Benner and Tanner (1987), which is an understanding without rationale, although this vagueness is why intuition lacks recognition and value (Kenny, 1994; Lyneham, Parkinson, and Denholm, 2008).

Carper (1978) however aligns the 'art' of nursing with a definition by Wiedenbach (1963), who suggested that the 'art' of nursing is in evidence through the action and interaction between the patient and the nurse, and the behaviour that is being expressed.

English (1993) acknowledges that throughout her work, Benner (1984) and Benner and Tanner (1987) emphasise the importance of a holistic approach to patient care, and the impact of the nurse patient relationship on decision making, and clinical judgement. So, the humanist component is implicit, and the relationship between the nurse and the patient and relatives is significant. Whilst there is much written about the importance the patient -nurse relationship (Cappelletti, 2014; Adams, 2016; Allande-Cussó, Fernández-García, and Porcel-Gálvez, 2022), how the relationship manifests, and what impact this has on clinical judgement and decision making, lacks robust investigation. This implies that the link between intuition and the patient-nurse relationship as suggested by Lyneham, Parkinson, and Denholm (2008) and McCutcheon and Pincombe (2001) is questionable due to lack of evidence on what the relationship is, and how this supports intuition and decision making, but it has proliferated in nursing practice and the nursing press, to fulfil the caring ontology of nursing (Paley, 2002).

The relationship between the patient and the nurse is considered unique and deep-rooted, through this connection, the nurse can observe the patient beyond the range of a physical presentation of their presenting symptoms, and vital signs (Valenzuela, and Marcos, 2019). To detect to deterioration in a patient does require an appreciation of an holistic approach

to care (Pretz and Folse, 2011), so to have a physical appreciation of the patient's condition and what is normal for the individual (King and Clark, 2002) along with an emotional connection, is fundamental to decision making, as this strengthens intuitive feelings (Lyneham Parkinson and Denholm, 2008).

Continuity of care, and knowing the patient, were considered fundamental for the detection of changes in the patient, particularly if the changes were subtle (Olsen *et al*, 2019). Time spent with the patient enhances the relationship and increases intuitive thought (McCutcheon and Pincombe, 2001), through getting to know the individual and the relatives (Dalton *et al* 2018) the nurse becomes an expert in the normal, which concurrently develops the ability to recognise the abnormal (King and Clark, 2002).

This is possibly what is indicated by Benner and Tanner (1987) when they claimed the nurses needs to be part of the patient's world, with emotion which is frequently quoted as a significant factor when detecting deterioration in a patient (Dalton *et al*. 2018). There is a theoretical reliance on emotion needing to be present in order for intuition to be realised (Dalton *et al*. 2018), thus, to be able to justify intuition means it is necessary to understand what is meant by the term emotion, but there is no clear consensus in the literature, and the term is taken for granted, with no real agreement in the literature on a definition (Cabanac, 2002). With there being no consensus about whether emotion is a subjective, physiological, or behavioural response, and indeed, whether any of these phenomena are linked to the concept of intuition, it is difficult to discern the importance of emotion, the link to intuition, and how it manifests in clinical practice.

English (1993) questions why Benner (1984) introduces the concept of intuition in her work, asking whether it is a valid method of situation analysis, or whether it is employed simply to satisfy the adaptation of the model by Dreyfus (2004). Whatever the argument, this

conceptualisation of nursing intuition has captured the collective imagination and has become ubiquitous in subsequent publications. Enduring into the present day, the reasons how and why intuition has endured is explored in the next section.

2.6. Intuition and nursing identity.

The aim of this section is to present some rationale behind the endurance of intuition, and the difficulties experienced by nursing to identify a specific knowledge base, which will afford professional identity and credibility.

The strive for identity and professional status has become ubiquitous in the nursing literature, in 2017 Dame June Clark insisted that there should be a definition of nursing as a matter of urgency, due to the intricacy of the role, and the clinical judgement and expertise, that informs the decision making of the Registered Nurse (Hoeve, Jansen, and Roodbol, 2014, Middleton, 2017). Each group or profession has its own discourse, which creates an identity based on cultural societal structure, values and beliefs (Yazdannik, Yekta, and Soltani, 2012, Bell, 2021), attention has been given to the ongoing strive for nursing to find an identity and function (Bell, 2021), as nursing has an enduring battle to justify values, beliefs and actions, and the call for nursing to have a professional identity endures (Hoeve, Jansen, and Roodbol, 2014).

Based on a production of past substantial evidence, developed from relevant experiences, knowledge can be defined as automatic, instantaneous, and detached from one dimensional reasoning (Valenzuela and Marcos, 2019). Every profession must have a definable and distinctive knowledge (Hoeve, Jansen, and Roodbol, 2014), knowledge helps to define nursing as a profession and underpins the role of the nurse (Hall, 2005). But nurses describe having insider knowledge meaning that 'outsiders' were oblivious to what

seemed obvious to nurses” (Benner and Tanner, 1987). This potentially raises issues of concern, as the nursing claim to professionalism is thwarted, without definable knowledge.

A lack of a specific professional knowledge in nursing, challenges the dominance of the Intuitive-Humanist model of decision making, because of the inability to define intuition (English, 1993) with its claim to being a valid form of knowledge (Green, 2012), meaning that nursing is still unable to describe what it does (Bell, 2021). Therefore the emphasis on evidence based practice (Paley, 2006) and the biomedical paradigm, in the form of the Hypothetico – Deductive model, will potentially dominate decision making in nursing (Yazdannik, Yekta, and Soltani, 2012), due to the societal value of the medical model, and the claims to a definable knowledge base (Bell, 2021).

English (1993) disputes the claims of Benner (1984) and Dreyfus (2004), that intuition is ‘real’, by asserting that justification of decision-making that derives from anything other than robust clinical knowledge, and diligent observation, denigrates nursing. It is difficult to define, therefore, the ontological and epistemological position of nursing, because of the ongoing debate in the literature. Studies by King and Clark (2002) and Brier *et al.* (2014), identified that nurses value a comprehensive assessment of the patient, including visual cues, to detect deterioration. This suggests that nurses do not value one model of decision making over another but use both the Intuitive-Humanist and the Hypothetico – Deductive models in conjunction with each other, to inform decisions. This is supported by Banning (2008) who suggests that nurses use a combination of decision-making models to solve nurse related problems, but it is unclear whether this is practical, or what knowledge is important to nursing, particularly when detecting and reporting deterioration in a patient.

Nursing could potentially struggle further for identity, as nursing values are seldom recognised in health care, due to the dominance of medical values and the medical model

(Banning, 2008). However, as Porter and O'Halloran (2009) assert, it is not possible to judge traditional notions of knowledge, on the basis of epistemological compatibility with the practical obligations of nursing. The Hypothetico – Deductive model, and evidence-based practice, are not able to manage the sort of evidence that is needed, to understand care that is complex, and value based, or guide nurses in the authenticity of their connections (Porter and O'Halloran, 2009). Therefore, the intuitive-humanist model, and the use of intuition to justify clinical judgement, has proliferated because of its claims to specific, nursing knowledge (Benner and Tanner ,1987) which is subjective, and patient focused (Brier *et al.* 2014). To claim that nurses do not understand their contribution to healthcare is absurd (Bell 2020), but what nurses know and how they use knowledge is not really explored outside intuition, which has become one of the dominant narratives to justify nursing knowledge.

The search for professional identity continues, as the Nursing and Midwifery Council, issued new standards for pre-registration nurse education, to deal with the decision, that a bachelor's degree should be the minimum level for nursing (Nursing and Midwifery Council, 2018). This was to address the complex role of the nurse, changing health care needs of patients, and to promote nursing as a profession (Bhardwa, 2013). The Nursing and Midwifery Council standards, contribute to the specialist, and academic training requirements to meet the definition of a profession, but relate to tasks and attributes (Randall and McKeown, 2013), rather than what is perceived to be important to nursing (Benner and Tanner 1987; Traynor, Boland and Buus, 2010). Competence is now a fundamental aspect of nurse education, with the focus on what it is considered the nurse needs to know, to function in clinical practice, and nursing knowledge now focussing on technical skills, driven by guidelines and protocols (Foth and Holmes, 2017). This has enabled a new form of control over knowledge, transforming the role of professions, and

has become a measure to hold experts accountable (ibid), particularly as they more readily align to the Hypothetico - Deductive model, and can be assessed using a tick box approach (Randall and McKeown, 2013). Nursing is more complex than ticking a box however which may be classed as task focused (Bhardwa, 2013), rather than the patient focused expectations of the Nursing and Midwifery council in the code (Nursing and Midwifery, Council 2018), how much care is patient focussed and how much is task focused are further issues for debate and clarification.

Despite this alignment with a more Hypothetico - Deductive approach concerning identifying nursing knowledge, intuition has now become one of the dominant narratives, with claims that it affords credibility to nursing (Pretz and Folse, 2011; Green, 2012, Haegdorens, Wils and Franck, 2023), through the claims of the 'reality' of intuition in decision making (Benner and Tanner, 1987; Traynor, Boland and Buus, 2010; Lyneham Parkinson and Denholm, 2008; McCutcheon and Pincombe, 2001).

'Reality' is a social construct as people tend to favour products that match their values on a symbolic level (Baudrillard, 1981 and Mireanu, 2021), and attribute value to social symbols which form their beliefs (Kellner, 1989 and Mireanu, 2021). The sense of 'reality' is then created as intuition is exchanged for nursing practice, to develop social significance, offering nursing an identity, whilst nursing offers intuition credibility creating, a 'reality' of social status for both. The argument is not whether intuition exists, but it lacks a definition that substantiates it as a valid concept for scientific inquiry (Salas, Rosen and DiazGranados, 2010). These further questions the importance that has been placed upon it because of the perceived need to identify specific nursing knowledge, to afford nurses professional status.

Epistemology is the provision of a frame of reference to determine the quality and relevance of knowledge (Green and Thorogood, 2005), and how much trust is placed in the validity and truth of the knowledge (Johnson and Webber, 2015). The claims to the social capital of nursing, through intuition, which exists because of the value and truth afforded it through the work of Benner (1984), Benner and Tanner (1987) and Dreyfus (2004) is questionable, meaning that other aspects of the claims by Benner and Dreyfus also warrant further investigation, this will be the basis of the next section.

2.7. The ontology and epistemology of nursing.

The notion of intuition in nursing practise came to the fore through the work of Benner, and the idea that skill acquisition is developed through a framework first proposed by Dreyfus and Dreyfus in 1980 (Benner, 1984). The Dreyfus and Dreyfus model of skill acquisition is a five-stage model based on studying pilots and chess players (Dreyfus, 2004) which demonstrates how novices, adhering to rules initially, move through stages to become experts (Klein, 2017), with experts acting intuitively when making decisions (Dreyfus, 2004; Benner, 1984).

The validity of the taxonomy, relied on so heavily by Benner, is questionable due to the lack of the explanation of the five steps needed to advance from novice to expert (Gobet and Chassey, 2008) as well as little consideration or explanation of what constitutes expert practise, or expertise (Cash, 1995; English, 1993). The five-stage model of expertise has been very influential in many settings (Klein, 2017), and it is very persuasive, suggesting the expert ceases to rely on rules to make decisions. Klein (2017) suggests however it is just the reverse, too often the decision makers remind anchored in the belief, that expertise is all about mastering more procedures, therefore the ink of expert to intuition is questionable.

Benner (1984) claims that all nurses become experts, McCutcheon and Pincombe (2001), Lyneham, Parkinson and Denholm (2008), King and Clark (2002), Dalton *et al.* (2018) all refer to the term 'expert', with a presumption that nurses achieve this status, but it is unclear how the nurses in the studies relate to the term, outside the model by Dreyfus (2004).

There is little consideration of whether nurses believe themselves to be an expert, what this means, or the implications for decision making in clinical practice, and whether there is a continued reliance on rules as suggested by Klein (2017), or whether decision making is intuitive.

What constitutes an expert is not explained, neither is the claim by Benner (1984), that not all nurses who have worked in a clinical area for more than five years, will become experts (English, 1993), which is problematic if intuition, as Benner (1984) claims, is the exclusive domain of the expert. If, however, as Benner (1983) asserts, expertise develops through the testing and processing of thoughts and beliefs, in certain situations, then surely experience is an essential for this to develop. If intuition is also context specific, as claimed by Benner and Tanner (1987) and Thompson and Dowding (2001), then experience and subsequent 'expertise' may not be transferrable skills, suggesting that the 'heady heights' of 'expert' may not be achievable or permanent.

Constant changes in the clinical environment (Gobet and Chasse, 2008), and to nursing practice, with the implementation of new NMC standards (Bhardwa, 2013) mean that the context of nursing practice is fluid, and difficult to define. Cash (1995) asserts however that context must relate to the patient as an individual, as decision-making is reliant on the health status of the patient, and the clinical setting (Krishnan, 2018). There is little consensus of the meaning of context, despite the seeming importance placed on it through the work of Benner (1984) and Dreyfus (2004), and the subsequent rhetoric that has surrounded it (Cash, 1995). It may be the clinical environment or the situation, but it may

also be the patient or the nurse, or nursing, it is difficult to define which of these is more influential on decision making. Goodman (2004) suggests that decision making, autonomy, and interdisciplinary working all occur in a social context, this indicates therefore, that the status of the nurse in a social group determines how and what decisions are made. There is little consideration of this in the literature, whether a nurse considers themselves an expert is open to debate, but equally the position of expert may be dependent on status in a social group, questioning whether the status shifts dependant on the social group, and nursing's position within the group.

Caring became fundamental to nursing in the 1980s, with the terms caring and compassion used to legitimise the profession (Paley, 2002), and provide an ontological and epistemological stance. Caring is seen as person centred (Monteiro, 2016), the central element of nursing, and enables nurses to convey meaning to their role (Johnson and Webber, 2015). Nursing in the UK has now entered a fresh era, particularly with the implementation of new standards by the Nursing and Midwifery Council in 2018, with the ambition to present an image of a 21st century nurse, as having the skills and knowledge to provide care that is compassionate, evidence based, and person centred (Nursing and Midwifery Council, 2018).

As nursing is one of the most highly regulated professions it should be known makes a good nurse (Randall and McKeown, 2013), but the role is changing as technology and innovation have grown "exponentially", so that having technical skills is seen as important to provide nursing care (Monteiro, 2016; Pepito and Locsin, 2019). There is concern that caring, as advocated by the nursing and midwifery council (2018), is no longer a central tenet of nursing, but has become habitual in an environment dominated by technology (Adams, 2016). There is now a "robotisation" of nursing responsibilities, such as recording vital signs (Monteiro, 2016), which have become task focused and ritualistic (Odell, Victor

and Oliver, 2009; Donohue and Endacott, 2010), potentially putting patients at risk, and compromising the individual focus of care, challenging the claimed professional legitimacy, through the ontological stance of caring.

Olsen *et al.* (2019) claim that due to workload pressures, vital signs are frequently recorded by students and health care assistants, who are the least qualified, potentially further distancing the nurse from the patients, and undermining the importance of recording vital signs. Standardised processes such as the National Early Warning Score create tension as this conflicts with the nurses own clinical judgement, and application of the scoring system is at the expense of other significant observations (Haegdorens, Wils and Franck, 2023). Whilst nurses report recording extra vital signs when concerned about a patient (Petersen, Rasmussen, and Rydahl-Hansen, 2017; Olsen *et al.* 2019), there is a preference for clinical judgement using intuition, as some observations such as patient reported distress, skin colour, altered breathing pattern and sweating are not included in the National Early Warning Score (Haegdorens, Wils and Franck, 2023), but may indicate early signs of patient deterioration.

As care is becoming more mechanized, and the role of the nurse reformed as a tick box, colour coded set of competences (Randall and McKeown, 2013), often to strive for “quality improvement” (Monteiro, 2016), it could be argued that nursing faces an ontological and epistemological transition, as the ‘reality’ becomes the machine, and the knowledge for care is derived from this, meaning that the machine becomes the focus for care, rather than the patient (Pepito and Locsin, 2019). Reliance on machines to inform decision making, supports the claim by Klein (2017) that experts learn to master more rules, as the information from the machines become the rules which inform decision making, conforming with the demands of the Hypothetico-Deductive reasoning model, and the mandate for scientific evidence. If however, as previously claimed, the Intuitive-Humanist model is now

more dominant, the relevance of machines to inform decision making is debatable, further questioning the ontological and epistemological stance of nursing

Defining the ontological stance of nursing is an ongoing challenge (Paley, 2002), further challenges related to intuition and decision making are discussed in the next section.

2.8. The challenges related to intuition and decision making.

Intuition in the nursing press is afforded an almost mystical quality with terms such as “gut feeling” “hunch” and “sixth sense” extensively used to rationalise some decisions made by nurses (Nyatanga and de Vocht, 2008; Melin-Johansson, Palmqvist and Rönnberg, 2017). In many situations where intuition informed significant decisions on patient care, there was difficulty in rationalising the thought process, other than an “inner voice,” meaning that conduct was difficult to define, and justify in these circumstances (Lyneham, Parkinson, and Denholm, 2008; Traynor, Boland and Buus, 2010). If the Intuitive-Humanist model dominates decision making, the nurse can be left feeling vulnerable, when escalating concerns about a deteriorating patient (Lyneham, Parkinson, and Denholm, 2008), because of the difficulty in verbalising and communicating their thoughts (Andrews and Waterman, 2005). This creates anxiety, and a sense of feeling stupid, due to lack of understanding of their feelings (Lyneham, Parkinson, and Denholm, 2008), which can potentially hinder their practice (Gobet and Chassey 2008).

The term vulnerability is usually applied to patients and their susceptibility to harm, but there is little recognition of the vulnerability of nurses (Heaslip and Board, 2012). The terminology associated with vulnerability changes but is often preceded by an additional description to give further meaning, such as “societal” or “personal” (Angel and Vatne, 2017). As discussed in the previous section the context of the social group impacts on decision making, the vulnerability identified by (Lyneham, Parkinson, and Denholm 2008),

may therefore correlate to the concept of societal vulnerability, which is associated with people who face social issues that are problematic (Kroner and Beedholm, 2019). The sense of vulnerability experienced by nursing is usually related to the patient-nurse relationship (Heaslip and Board, 2012; Angel and Vatne, 2017), which is important, but there is little consideration of the existence of societal vulnerability, and the impact this has on the nurse and decision making (Angel and Vatne, 2017).

Nurses fear of getting it wrong, a feeling of being vague leads to the sense of being “backed into a corner”, feeling the pressure to back down, and not be assertive (Benner and Tanner, 1987; McCutcheon and Pincombe, 2001, Dalton *et al.* 2018). Because of the difficulty in verbalising concerns, nurses considered ‘novices’ frequently relied on changes in the parameters of the vital signs to report deterioration, rather than rely on their feelings (King and Clark, 2002), Heaslip and Board (2012) also suggest that focussing on the technical aspects of care, may also address vulnerability by shutting off their feelings, which may not only apply to ‘novices’.

Predominant in the literature, is the suggestion that use of vital signs leaves nurses better equipped to escalate concerns, due to the objectivity of the data, and the requirement by medical staff for objectivity (McCutcheon and Pincombe, 2001; King and Clark, 2002). The medical model is highlighted again by Brier *et al.* (2014), as frequently nurses document communicating their findings to medical staff, but these were not acted on in the presence of normal vital signs. Nurses often rely on visual cues to detect deterioration, outside of the vital signs, with use of terms such as “worried” or “concerned” to escalate concerns about patients (Cioffi, 2000; Andrews and Waterman, 2005; Douw *et al.* 2017). Conversely medical staff find it difficult to treat a patient who was referred to them using the ‘worried’ criteria, stating that they cannot treat a patient who ‘does not look right’, and whose vital signs are normal (Andrews and Waterman, 2005; Douw *et al.* 2017).

Whilst there are many explanations for intuition; pattern recognition (Gobet and Chassey 2008, Bedke 2016), knowing the patient, and 'the development of unrecognised conceptual knowledge (English1993), because of the inadequacy of language to describe intuition, and the lack of immediate confirming empirical evidence of patient deterioration, in the form of abnormal vital signs, nurses, may struggle to articulate what they want to say (Kenny 1994).

Pivotal to patient care is the interpersonal relationship between the nursing and medical staff, a point of concern for nurses was disrupting the doctors without a necessary concern apart from the changes in the vital signs (Petersen, Rasmussen, and Rydahl-Hansen, 2017) This potentially could lead to confusion and a delay in patients accessing medical intervention, with a possible negative outcome for the patient

There is suggestion from this, of further conflict between the objectivity of Hypothetical-Deductive reasoning, and the Intuitive-Humanist model of decision making, which is reliant on subjectivity (Banning, 2008; Krishnan, 2018), and potentially a different language. Whilst nurses in specialist clinical areas have an 'elitist' language, there is also a language, common to all nurses, which delivers meaning and understanding for patient care delivery (Allen, *et al.* 2007; Douw *et al.* 2017). This relates to Benner and Tanners (1987) claim, that nursing knowledge is exclusive to nurses, so nursing language is exclusive to nursing, linked to context of the societal group. Whilst Allen, *et al.* (2007) claim that nursing language changes over time, the social construct of nursing language, the role of which is to act as a repository of meaning, significance and value through shared experiences (Mireanu, 2021), should not change, but whether nursing language does change over time, particularly in relation to an acutely ill patient, is contentious.

The use of specific nursing language, may help negate societal vulnerability, being able to communicate with peers with a shared understanding, but there may be a sense of

vulnerability when communicating outside the societal group, particularly with the use of terms like 'worried' and concerned' (Douw *et al.* 2017). The impact of a specific nursing language, whether it exists and what impact it has is worthy of further investigation.

A further challenge to intuition is the environment, if not supported then the de valuing of the use of intuition, could hinder the ability to use it (McCutcheon and Pincombe, 2001; Ede, *et al.* 2020). Workloads, and rigid rules and regulations ,could undermine vague decision making, when nurses lack time and motivation to follow their intuitive thought (Traynor, Boland and Buus, 2010; Ede, *et al.* 2020), particularly if intuition is not valued in a setting or situation, hindering intuitive capacity (Lyneham, Parkinson and Denholm, 2008; O'Neill *et al.* 2021). Situational factors such as bureaucracy, workload and being busy, could also undermine uncertain decisions, when nurses do not have the time to respond to intuitive thoughts (Traynor, Boland and Buus 2010). If there is an organisational culture focussed on blame, this also impacted on escalation of concerns about a deteriorating patient, when the concerns were based on intuition alone (Dalton *et al* 2018). A certain amount of error can be expected in decision making using intuition, however, within health care error is poorly tolerated, and is frequently used to reject intuition, as valid in decision making (Lyneham, Parkinson, and Denholm 2008). But rejecting intuition based on error remains unsupported (Lyneham, Parkinson, and Denholm 2008), so the cogency for dismissing intuition as valid, based on claims of error, is unsubstantiated. The importance of context was discussed in a previous section with Cash (1995) suggesting that the context should be the patient, but the importance of the social context in decision making was also advised by Goodman (2004). The clinical environment as context has a clear impact on the use of intuition, but the impact of the demands of the clinical environment, and the effect of blame culture is not fully explored in any of the literature.

I have presented an evaluation of the diachronic evidence as identified in the current literature, this will be compared to the synchronic evidence of the data analysis, the process of collecting the synchronic evidence is discussed in the following chapter.

Chapter three – Methodology.

3.1. An overview of the chapter.

In this chapter I will explain the research methodology I used for my study, and why I thought this to be the most suitable method to investigate previously travelled territory, from an alternative perspective to the methods of investigation, previously adopted.

The chapter is divided into two parts, the first part will be inclusive of a theoretical framework, and the philosophical approach I decided to adopt, with justification for the data collection and the data analysis, the second part will discuss sampling and participants, along with the data collection method.

3.2. Part one – theoretical framework.

This section, includes an evaluation of my ontological and epistemological positioning, with rationale for my decision to adopt a philosophical approach to the research process.

Inclusive will be an introduction to structuralism and post structuralism, along with the theories of Ferdinand De Saussure and Roland Barthes, and how these have influenced my thesis, particularly in the data analysis process.

3.3. My ontological and epistemological positioning.

Nursing has been caught up in the research culture (Rolfe, 2009), to provide a scientific explanation for the profession and practice, this has meant addressing the “power relationship” with medicine (Yazdannik, Yekta and Soltani, 2012), and adopting a positivist approach to research, with the requirements for objective data. The drawback to this is that research then focuses on what can be measured, rather than what is relevant to nursing practise, which tends to be subjectively focused, and related to the individual, with multiple versions of reality (Rolfe, 2006). The underlying assumption is that the positivist approach,

as practised in the laboratory, can no longer provide the only answers, so researchers have sought alternative paradigms (Tierney, 1988).

A researcher's orientation to a topic is formed by ontological and epistemological beliefs (Furlong and Marsh, 2002), the nature of reality and how and when knowledge is generated and communicated (Tierney, 1988). With my ontological belief in plurality, the nature of multiple realities (Furlong and Marsh, 2002), the interpretivist paradigm, allowed me to view the world through the perceptions and experience of the participants (ibid), so that research is no longer laboratory focused, but person centred (Tierney, 1988), meaning that it was possible for me to consider multiple realities, of the participants experiences.

Kuhn (2012) contends that when all the problems facing a particular profession, have been addressed under one paradigm, a new paradigm is generated to replace it.

Epistemologically, the nursing profession faces the dilemma of generating new knowledge, with existing processes that have proved problematic (Reed, 2021); a paradigm shift to challenge, and change the current traditions of research within nursing, will in turn change the foundations, by which the profession can advance knowledge and practise (Sochan, 2011). A Post structuralist approach supported the paradigm shift, by avoiding traditional foundations, and moving beyond the positivist approach from which nursing has struggled to distance itself (Holmes and Gagnon, 2018), but also challenging the current qualitative methodologies which are so problematic, because of the researchers inadequate understanding and application (Edwards, 2016). Adopting a more philosophical approach to my research, will also promote a shift, beyond a process driven approach to the quantity or quality of a phenomenon, with the pretence that this is infallible, to a more in depth examination of socially and culturally constructed reality (Williams and May, 1996), and an alternative interpretation of what is already 'known'.

3.4. Becoming philosophical.

This section will introduce the structuralist, linguistic theory of Ferdinand de Saussure initially, progressing to the influence this originally had on Roland Barthes, then Barthes shift to post structuralism. I will present both theories of structuralism and post structuralism and demonstrate how these have been used to inform this study, and were fundamental in enabling me to search, for a deeper meaning of the data I collected from the participants.

3.4.1 Structuralism.

Structuralism is a set of approaches, originating in France during the 1960s and 1970s, and adopted a more scientific approach, towards exploring the enigma of human culture, and existence (Lundy, 2013). Structuralism was revolutionised, by Ferdinand de Saussure in the 'Course in General Linguistics', where de Saussure (2005) criticised traditional linguistics, which, he claimed, reduced language to phonetics or simply words, with no consideration of the multifaceted structure of language. This was important for me as I wanted to consider not just the words used, but also the language adopted by the participants in my study, as well as the social and individual characteristics of their stories (de Saussure, 2005). These are fundamental to appreciate a deeper meaning of their understanding of an event, and what was important to them, when being involved in a situation, involving an acutely ill patient.

3.4.2. Structuralism explained – the linguistic *sign*.

To understand language in its entirety, means an appreciation of “linguistic structure”, in which when two people are talking to each other, there is the physical process of speech (*sound pattern*), which leads to the psychological process of interpretation (*concept*) (de Saussure, 2005). Language is a system of *signs*, the combination of the *concept* and the

sound pattern, which express ideas (de Saussure 2005), and present a mental image (Daylight, 2012).

In traditional linguistics, the *sign* represented the meaning behind the words, a single entity that existed outside speech (Belsey, 2002). De Saussure (2005) disputed this, claiming that the *sign* can only be found in speech, and that the linguistic *sign* is a two-sided unit, which is mentally constructed by the listener, to enhance understanding.

This can be visualised in the following diagram which illustrates how the sound pattern generates the concept, or the mental image. The two are inextricably linked, the combination of the two form the sign value, the meaning placed upon the combination of the two factors, which is arbitrary and usually culturally and socially constructed.

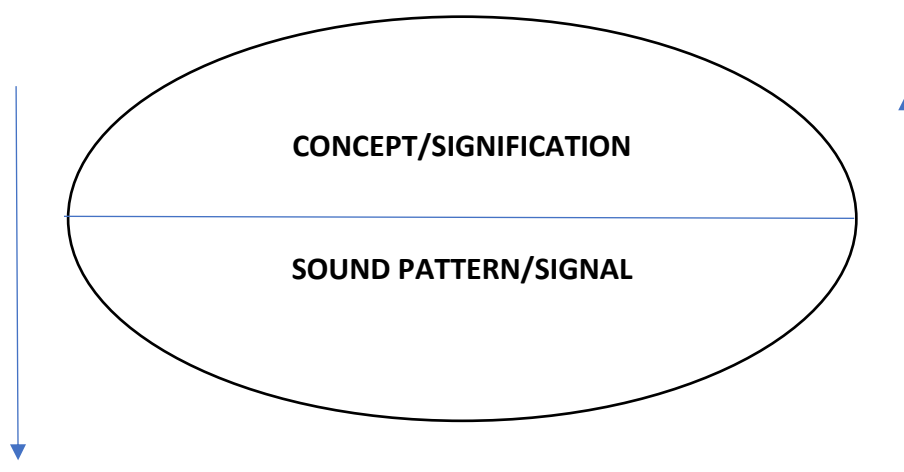


Figure one – *The linguistic sign, consisting of the concept and the sound pattern (de Saussure 2005)*

Both elements are deeply linked, and are sparked by each other (de Saussure, 2005), so they have a symbiotic relationship. The association between the *concept* and the *sound pattern* is arbitrary and exists as a cultural contract between members of a community, and

external to individuals (de Saussure, 2005). The members of the community have no influence over the meaning of the sign value, which is the conveyor of meaning, and is created from the link between the *concept* and the *sound pattern* (de Saussure, 2005), but may mean different things to different communities.

de Saussure (2005) uses images and sound to identify the *concept* and the *sound pattern* to create the *sign*, as in this recognised image from the 'Course in General Linguistics' in which de Saussure (2005) uses the term 'Arbor' as the sound and his definition of a picture of a tree to define the concept, the sign value, the link between the two, is arbitrary.

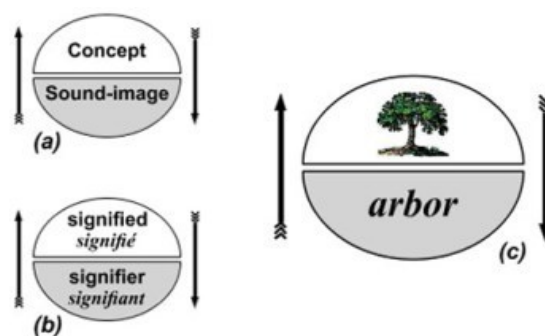


Figure two – *Diagram of the linguistic sign, as suggested by de Saussure (2005.)*

3.4.3. The cultural application of the *sign* value.

The sign value is the link between the *sound pattern* and the *concept*, which is arbitrary, but may have different meaning, dependant on cultural values and beliefs,

Speech is a social product, and differs from one community to another (Mireanu, 2021), the *sign* value is derived, through appreciation of the symbiotic relationship between the *concept*, and the *sound pattern*.

The *sign* value of diagram three may be different for nursing, compared to other cultural communities, as the sign value suggests a cultural sense of the values, and the speech and language, of a specific community (Mireanu, 2021).

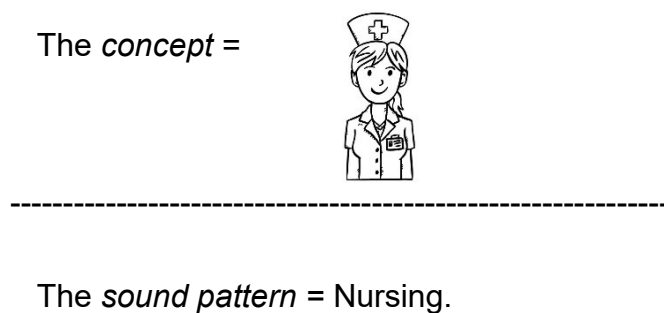


Figure three – contextualisation of the linguistic *sign*, (de Saussure 2005) the *concept* being an image, the sound pattern is the word associated with the image, the *sign* value being the meaning allocated to the symbiotic relationship between the two, which is culturally derived, and will have a different meaning to people outside of nursing, as a cultural group.

3.4.4. Moving on from the terms concept and sound pattern.

The terms *concept* and *sound pattern* were changed to signification (*Signifiant* Fr) and signal (*Signifié* Fr), to differentiate one from the other (de Saussure, 2005). The original French terms of '*Signifiant*' and '*Signifié*', as used by de Saussure (2005), are difficult to translate to English; there are two acknowledged translators of the French version of 'Course in General Linguistics' into English, the one I used, by Roy Harris, in the references as de Saussure (2015), was more appropriate for me, as it is generally more accurate (Joseph 2011). But it is the original translation by Wade Baskin, in 1969, in which '*Signifiant*' and '*Signifié*' were translated into *Signifier* and *Signified*, these terms are now

well established (Joseph, 2011), and will be used in future narrative, for the purpose of this thesis.

3.4.5. The past and the present.

De Saussure (2005) inspired the study of language, to move from a Diachronic approach (Lundy, 2013), where examining language, concerns the development overtime, meaning that language itself no longer becomes the focus, but, is the series of events, which modify it (Raclavsky, 2014). It could be argued that the language, associated with intuition, has become the victim of a Diachronic approach, as the use of historic beliefs, and the growth of meaning through history (Frog, 2018), has become the language associated with intuition. But this could potentially offer a distorted view, as language is never stable, and is subject to change overtime (de Saussure, 2005). To appreciate an understanding of intuition and associated concepts, in the current era of nursing, meant that I adopted a Synchronic approach to the data analysis, which requires examining language as a fixed phenomenon, at a given moment in time (Raclavsky, 2014). This was important to me because for the users of the language, how it is used at a fixed point in time is the only reality (de Saussure, 2005), I could therefore compare the past (Diachronic) narrative of intuition, to the present (Synchronic), the fixed point of the data collection.

The aspects of a Diachronic and Synchronic approach are detailed in diagram 4, this emphasises the differences between the two approaches, and how the Diachronic applies to the literature review, which will be compared to the Synchronic of the data analysis.

Figure four – *The difference between a Diachronic and a Synchronic approach to analysing language (De Sassure 2005).*

Diachronic.

Synchronic.

VS

An historical perspective of the study of language.

How the language of intuition, in relation to nursing practice and decision making, has developed over time, as evidenced in the literature review

The study of language at a fixed point in time.

How the language of intuition, in relation to nursing practice and decision making, applies to current practice, as evidenced in the data analysis of the participants stories

Provides a history of speech communities.

How nursing, over time, has adapted the language of intuition, and related ideas, to provide, justify and mark its own history related to decision making, and nursing practice. As evidenced in the literature review.

Analyses how language is used by a cultural group.

What is the language, currently used by nursing, to justify decision making and nursing practice, as evidenced in the data analysis of the participants stories.

Does not relate to a single language but a procession of facts.

The development of the language related to nursing intuition and decision making, multifaceted with many interpretations and ideas. As evidenced in the literature review

Aims to determine to what extent language exists, from the user's perspective.

What is the shared understanding of the participants, the cultural agreements of the language used and its meaning. As evidenced in the data analysis of the participants stories.

3.4.6. Poststructuralism.

The linguistic theory of de Saussure (2005) was significant in assisting me to start understanding the duality of language, and the possibility of exploring meaning, beyond the words. But the structuralist principle, of creating a stringent understanding of a phenomenon, with a claim to 'truth' (Holmes and Gagnon, 2018) was problematic, particularly, as this is how intuition is currently portrayed in the diachronic evidence. Structuralists emphasised the understanding of a single phenomenon as part of a wider pattern or system (Seymour, 2017), but this recognises only one 'reality', which conflicts with my interpretivist position, and ontological beliefs of multiple realities, and the importance of the individual.

I considered possibilities of an alternative theoretical framework for my study, discourse, and narrative analysis both analyse texts, which could have addressed the aim of my thesis. But both methodologies, whilst aiming to convey deeper meaning (Green and Thorogood, 2005), frequently explore the connection of one text to another (Franzosi, 1998). This aligns with the structuralist philosophy, which suggests that narrative is not merely a collection of ideas, but rather an intricate edifice (Herman, 2011), with a single claim to 'truth'.

Post structuralism challenges structuralisms claim to a single 'truth', by arguing that there are multiple versions of 'reality' (Holmes and Gagnon, 2018), concerning the connection between people, their world, and how meanings within their world are created, and reproduced (Belsey, 2002). Adopting a post structuralist approach therefore enabled me to consider the world of the participants, and the meanings they placed on matters they raised, acknowledging the potential for multiple interpretations and versions of 'reality'.

Post structuralism is founded on the philosophical thoughts, of many who share a critical viewpoint, and whose works originate, from a diverse range of fields (Holmes and Gagnon, 2018). Whilst most post structuralist research in nursing, focusses on the theories of Foucault and Deleuze and Guattari (Sochan, 2011: Holmes and Gagnon, 2018), for the purpose of this thesis I have chosen to use the theories of Roland Barthes. The reason for my choice of the theories of Roland Barthes is, because of Barthes structuralist link to de Saussure (2005), which enabled me to adopt a more in-depth consideration of the meaning of language, and Barthes post structuralist position, which enabled a look beyond initial interpretation, to uncover what is 'hidden'.

3.4.7. Roland Barthes.

The work of Barthes as an early advocate of structuralism, and application of the principles to everyday random subjects (Lundy, 2013), has received criticism for being unscientific, and his work being that of an 'essayist', with little regard for in depth analysis, of literary texts (de Man, 1990). The idea that Barthes is unreflective and unscientific, in a traditional way de Mann (1990), is perhaps undermining his theories, and the attraction they have for their artistic merit (Lundy, 2013). The essays and stories that Barthes (2009) presents, he justifies as interesting to him, and culturally and politically relevant, not just at the time they were published, but probably ongoing. It is the presentation of the argument through essays and stories which is what drew me to start reading Barthes, building my thesis around these principles, and the notion of myth, enabling me to identify deeper meaning to the speech of the participants.

Although he later came to question the structuralist approach, in his early work Barthes (2009), supported the assertions of de Saussure (2005), and adopted a structuralist approach to the study of *signs* in consumerism, and media culture (Kellner, 1989). In a

series of essays Barthes, aimed to regularly reflect on the myths of everyday life (Barthes, 2009), influenced by what was happening in the media, and guided by his own interests (ibid). Barthes (2009) questioned how naturally the media was presenting reality however, although representative of the here and now, Barthes (2009) claimed it was problematic because the beliefs and opinions of the of the individual, or groups which took precedent (ibid). Therefore, what was potentially hidden, or not told, was dependant on the ideologies of the presenters, with potential mis representation of the 'truth'.

In a seminal work by Barthes, 'The Death of the Author', the structuralist philosophy is further challenged, as Barthes (1986) claimed that many people read and use the information about the authors intentions to interpret texts. But the stories produced are not original, the author Barthes (1986) argues is a Shamen, a re- teller of narrative that has been told many times before, therefore the ideologies of the author should not be relevant to understanding what is being told. Not privileging the author, offers the reader the opportunity to look through the text, acknowledging that within the text is a multidimensional space, which may encompass several interpretations and meanings (Barthes, 1986).

This is particularly relevant in the diachronic representation of intuition, the evidence presented to support intuition and decision making (McCutcheon and Pincombe 2001; Traynor, Boland and Buus 2010; Pretz and Folse 2011; Dalton *et al.* 2018), cite the theories of Benner (1983), and Benner and Tanner (1987), as seminal to their research. Adopting the concerns of Barthes (2009), I believe this supports the misgivings about the representation of intuition in the press, and whether Benner (1993) and Benner and Tanner (1987) have become the Shamen, retelling of the same story, and in a world where their ideologies have taken precedent. Thus, meaning that the representation of intuition is not representative of 'reality', because of the reliance on the ideologies of the original story tellers. Although my thesis is presented as original work, I am also a Shamen, presenting a

collage of previous text and narrative, as did Benner (1993) and Benner and Tanner (1987), and subsequent studies which purport to present something new.

In a further move away from structuralism, in 'S/Z' Barthes (1991) claims that, attempting to see all the worlds stories in one structure is undesirable, because the text loses its difference (Barthes, 1991), this difference is infinite and dependant on languages, culture, and systems (ibid). To decipher text Barthes (1991) uses the term 'Readerly text', which relates to the intentions of the author, he claims that interpretation would be limited, because the 'Readerly text' supresses the possible plurality of the text, instead a novel approach is needed. The 'Writerly text' (Barthes, 1991) means that the reader is no longer a consumer but a producer of the text, with appreciation of the plurality of the text, without the constraints of representation of the author, and no claim of authenticity. I intend to take this approach to analysing the collected data, rather than consider the words used, which would mean contemplating the intentions of the author, the 'Readerly text', I will instead be taking a 'Writerly text' approach to understanding the plurality of the text. Rather than consider how these fits into a structure, it will be my interpretation of the *Signifier* and *Signified* to identify the *sign* value, with appreciation of the multiple interpretations and possible meanings, which will have no claim to the authenticity outside my interpretation.

3.4.8. Semiology.

Informed and influenced by de Saussure (2005), Barthes (2010) uses the term *Semiology*, to examine the relationship between *Signifier* and *Signified*, and their equivalence. Whereas de Saussure (2005) asserts linguistics is only a part of the semiological system, Barthes (2010) contends that in today's cultural and social climate, it is unlikely that any widespread classification of *signs* exists outside language, because to appreciate what elements something signifies, is the fall back on language (Barthes, 1986).

The term *Langue* (de Saussure, 2005), whilst frequently appropriated to mean language (Harris (translator) in de Saussure 2005), is the language system, which is dependent on the words and phrases (*Parole*) (de Saussure, 2005), to afford meaning. Whilst de Saussure (2005) maintains that the *Langue* is constituted of many fragments of *Parole*, the linguistic value, that is the capacity of a word, phrase, or utterance to represent an idea (ibid), the *sign* is dependent on the coexistence of all elements, as represented by the diagram below.

The linear process as identified by de Saussure (2005), suggests a reliance on what precedes each element and what goes after it, what de Saussure (2005) terms a “syntagmatic” relationship, the parts (*parole*) form a whole (*langue*), to supply meaning (*Sign*).

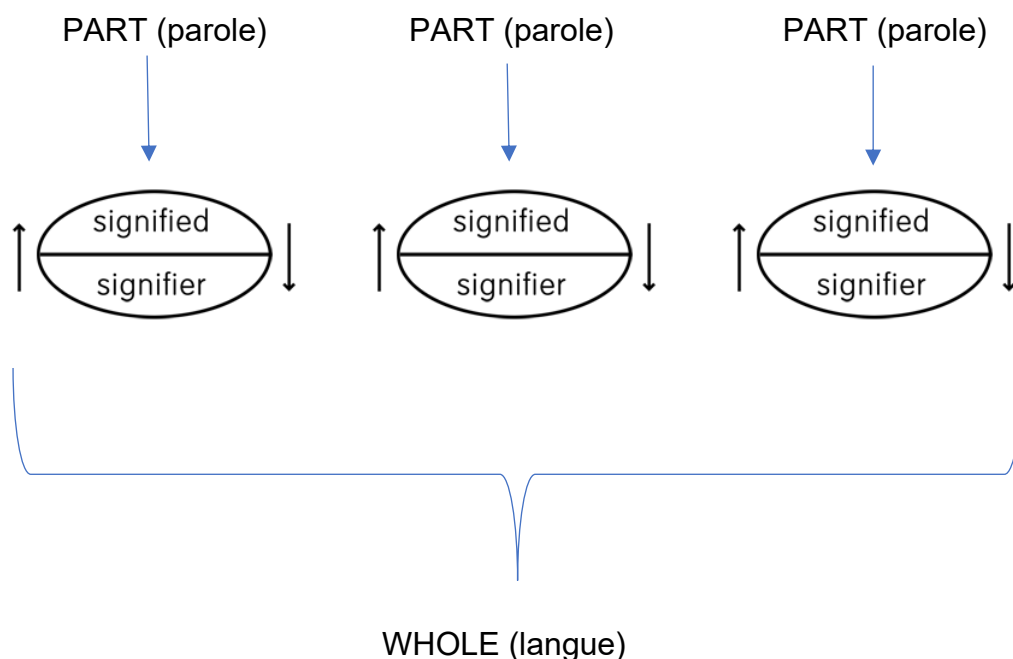


Figure five – *The coexistence of the elements of the sign* (de Saussure 2005).

3.4.9. The challenge to the linear process.

The linear process of the co-existence of the elements of the sign, as advocated by de Saussure (2005), is challenged by Barthes (2009), who argues that this limits interpretation as it reduces speech to only one meaning.

Barthes (2009) instead advocates a staggered system, the purpose of this is to uncover deeper meaning, which Barthes (2009) terms *Myth*, or the hidden meaning in language, Barthes (2009) designates this the first order and second order semiology. To differentiate these Barthes (2009) has termed them differently, the first order is called the language object, because it is language that *Myth* consumes to make its own classification, the second order then becomes the *Myth*. Barthes (2009) termed this the *Metalangue*, as this point moves beyond language, to appreciate the hidden meanings. The *sign* in the first order becomes the *Signifier* in the second, at this point it loses possibility of meaning, and is re named *Form*, the *Signified* in the second order is renamed concept.

I will use the staggered system, as advocated by Barthes (2009), as I believe this to be the most effective way to uncover *Myth* about intuition. To uncover what is hidden within the participants stories, offering an opportunity to move beyond language, and explore deeper and hidden meanings, and is inclusive in diagrams six and seven.

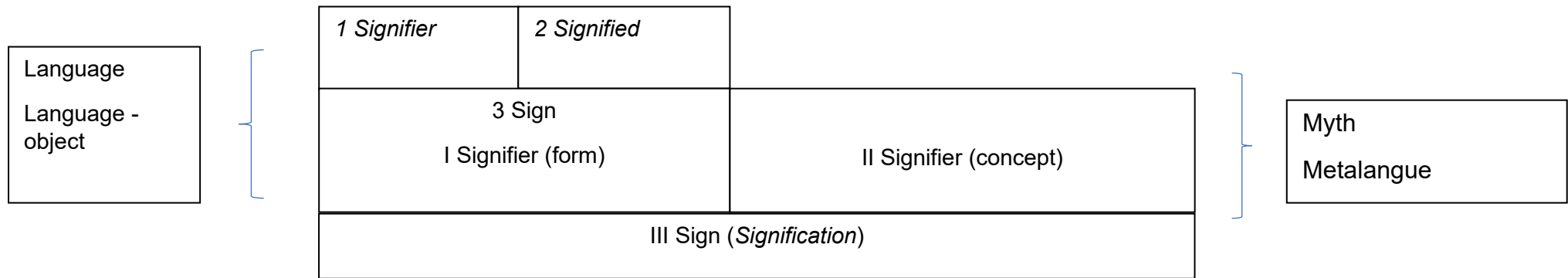


Figure six - *The First and Second order Semiology as identified by Barthes (2009).*

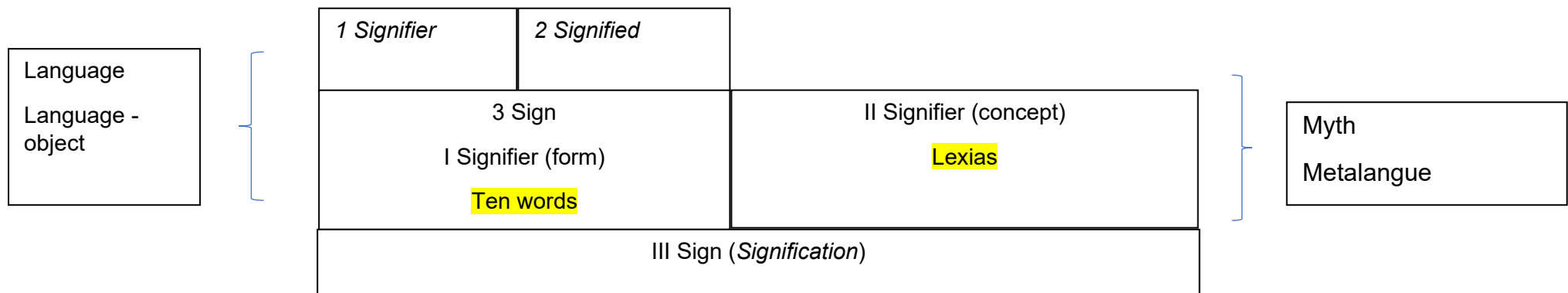


Figure seven – *Application of my study to the second order Semiology.*

The *Signifier* in the first order will be findings from the literature review, because of their relation to the *Signified*. Rather than include all the evidence from the literature review, seven primary studies were identified for this purpose, as these were primary research, and considered to be the most suitable and representative, for this purpose, critique of these studies is in appendix two.

As previously stated, the participants for this study were asked to reflect upon a time when they had been involved with an acutely ill patient, they were then given a minute to write down ten words associated with the situation. The ten words collected, see appendix three, were the culturally accepted understanding of the phenomenon. The words in red are the words selected as the *sign* value, in the first order semiology see appendix three, as these were identified as being representative of all the words. The rest of the words are included in the *sign* value, as synonyms, to ensure inclusive representation of all the participants words,

As these words, identified as the sign value in the first order semiology, see appendix two, enter the *Metalangue* however, they lose all meaning, because they are required to be empty, to be re appropriated by *Myth* (Barthes 2010). The *Signified* in the second order semiology, appendix three, will be the lexias, identified from the stories collected for this study, because of their relationship to the ten words, allocation of *Signified* and *Signifier* is arbitrary, dependent on my understanding, my beliefs, but also my role is data collector, and my presence at the data collection. The *sign* value, what Barthes (2010) terms *signification* in the second order semiology, arises from analysis of the lexias, the first order semiology is included in appendix three, the second order semiology is included in appendix four.

3.5. Data collection.

3.5.1. Sampling and Participants.

I will present the sampling strategy I adopted, and the pragmatic approach I took, to recruit participants for the study, inclusive of the requirement of the necessary experience, of the participants.

The criteria identified for participant selection, was Registered Nurses, with experience of caring for an acutely ill patient on a medical or surgical ward and could discuss the decisions they made in an identified situation. The sampling strategy, I adopted for the study, was purposive sampling, as I considered this to be the most suitable as It allowed for participants to be identified, on the basis that they had the necessary knowledge and experience of caring for an acutely ill patient (Green and Thorogood, 2005) . It was also important for the participants to have the capability to reflect and articulate (Flick, 2009), to provide information rich cases, for in depth study (Green and Thorogood, 2005).

It was essential to use Registered Nurses for my research because the studies used for the literature review, and the seminal research by Benner (1987), link intuition with experience as a registered nurse, and hence a level of expertise necessary for intuitive judgement (Benner, 1987). Expertise is related to the refinement of clinical and theoretical knowledge (Benner, 1984), and correlates to longevity of practice, with the 'expert' nurse spending at least 5 years in clinical practice (Benner, 1987), selection of participants therefore needed to include this criterion.

To access suitable participants, permission was granted by the ethics committee, to recruit Registered Nurses from one of the University of Wolverhampton post graduate courses, I approached two of the module leaders to ask if I could go and speak with one of their post graduate courses, to which they agreed, ethics approval is included in appendix five.

I spoke to two groups of students on a Nursing and Midwifery Council approved mentorship programme, as these were the groups currently being taught in the university, were experienced Registered Nurses, and potentially met the eligibility criteria. I spoke to the groups about the nature of my study, advised them about their role as participants, and what they would be asked to do, I also introduced some ethical principles, and reassured them that anonymity and confidentiality would be assured. Some members of the group did not meet the eligibility criteria as they worked in the community, other members of the group met the eligibility criteria but were reluctant to participate.

To expand my search to recruit suitable and willing participants, I gained agreement from the module leader of a master's degree in advanced nursing Practice, to speak to their current group of students. I explained the nature of my study to the group, inclusive of their role, ethical principles, and why they would be suitable as participants. From this introduction I recruited five participants, the participant statistics are included in appendix one.

Sample size is dependent on the aim of the study (Green and Thorogood, 2005), because of the richness of the data acquired and required through storytelling, and the naturalistic focus group. I set a sample size of between five and eight, because this is the number of participants suitable for a focus group interview, as identified by Clark, Maben and Jones, (1996); Green and Thorogood, (2005); Polit and Beck, (2012), to ensure a manageable group who can offer the richest source of data (Flick, 2009).

I initially had six volunteers, but one was not able to attend on the day, sometimes however there is a necessity to adopt an opportunistic approach to sample size, dependant on the number of people willing to participate (Green and Thorogood, 2005). I did consider whether there was a need to recruit further participants, but I decided that I would adopt a

pragmatic approach, conduct the data collection, and do the data transcription, and then consider whether the data I had collected, would give me sufficiently rich information to address the aim of the research, which it did, the demographics of the participants is included in appendix one.

3.5.2. Focus groups.

I decided to adopt a focus group approach, because much of the knowledge and understanding of nursing practice, is related through narrative and discourse (Wang and Geale, 2015), and traditionally data has been gathered through interviews (Price *et al.* 2016). This has progressed into being ritualistic, and highly structured (Kendall and Kendall, 2012), I wanted a much more unstructured approach to the data collection, to allow the participants the freedom fully express thoughts and beliefs, with the potential for shared meaning, and multiple realities (de Saussure, 2005).

Traditionally a focus group was used in market research (Clark, Maben and Jones, 1996), but more recently they have become a valuable research tool in health care, not just to evaluate health interventions, but also to understand behaviour change, and the generation of social knowledge about a particular topic (Green and Thorogood, 2005). A focus group involves around 5 – 10 people, to seek experiences and opinions from all participants, at the same time (Polit and Beck, 2012), this was important to appreciate the shared meanings between the group, and conforming with the post structuralist philosophy of understanding how people interpret their world (Belsey, 2002).

The focus group I organised had five participants, Kitzinger (1995) suggests that an optimum number for a focus group interview is between four and eight but found that the focus groups with fewest number of participants were the least interactive. I did not experience this however, as the members of the naturalistic focus group, which as previously stated were all

students on a master's degree in advanced nursing Practice, meaning that they were comfortable with each other, and they all participated equally.

Whilst five participants may seem limited, the process of transcribing the ten words, the paragraphs and the stories as a whole, took time, with consideration of the nuances and narrative between the stories, which offered further rich sources of data (Frank, 2010). I also needed to separate the ten words, paragraphs, and stories, to end these out to each of the participants. This was to ensure credibility of my transcription and interpretation of their words and verify confidence in the truth of the findings (Polit and Beck, 2012). To establish multiple meanings of a text, in accordance with the post structuralist philosophy (Barthes, 1986), necessitates multiple readings, to move the text beyond its sequence of events, which limits interpretation, as this is a traditional approach, which offers only one reality Barthes (1991). I read and re read the ten words, paragraphs and stories several times, to move them beyond the sequence in which they are presented, to establish the plurality of the text (Barthes, 1991). Research using focus groups, as a method of data collection, usually involves several groups, so that individual statements can be compared across all the groups, for a systematic coding of ideas (Flick, 2009). This indicates a structuralist position of a single version of reality (Seymour, 2017), which conflicts with my interpretivist ontology, and the post structuralist position of multiple versions of reality (Holmes and Gagnon, 2018). I therefore only used one focus group, to avoid comparison across groups.

Focus groups can be problematic to organise and predict the number of participants (Clark, Maben and Jones, 1996; Happell, 2007), but because focus groups have the potential to gather significant data fairly quickly (Green and Thorogood, 2005), I chose this method for my data collection, to ensure discussion between members of the group, but also to avoid inconveniencing the participants more than was necessary. It is important to organise focus groups, at a time and place that would cause the least possible disruption for the participants

(Happell, 2007), this was of particular importance, as the participants are senior nurses in clinical practice. I negotiated with the group a day when they were attending university, on the Advanced Nursing Practice course, as this would be more convenient than them being removed from practice. The focus group interview took place in their usual classroom, which I prebooked, as there was a need to ensure that the venue was accessible to all, and would accommodate the group (Clark, Maben and Jones, 1996), and would also be a familiar environment which made them feel more comfortable (Clark, Maben and Jones, 1996: Happell, 2007).

Focus groups organised for market research, traditionally involve participants who have not met before (Green and Thorogood, 2005), but because the aim of social research is to understand the generation of social knowledge (ibid), I adopted a naturalistic focus group approach. A naturalistic focus group involves a group of people who know each other, as this increases interaction between the participants (Green and Thorogood, 2005), which was important because of the post structuralist requirement of shared meaning (Belsey, 2002), and the access to shared group culture (Green and Thorogood, 2005). The participants met the criteria for a naturalistic focus group, as they all knew each other from the Advanced Nursing Practice course, but as Leask, Hawe, and Chapman (2001) state there was a risk of conformity, whereby participants want to fit into the group, so would be less likely to voice differing opinions. This was not the case however, the group all felt comfortable to agree and contradict, as necessary. There was also the risk of a protection ethos, in which participants try to protect others from anything that might be disturbing (Leask, Hawe, and Chapman, 2001), whilst the participants expressed concern for others in the group, which added to the rich data, there was no attempt to temper stories to protect others. The construct of a naturalistic focus group was important to ensure rich discussion between the participants (Polit and Beck, 2012).

Opening directions are important to ensure the validity of the data (Happell, 2007), whilst I did not ask the participants directly about intuition, I did ask the participants to identify a time, when they had been involved in looking after an acutely ill patient, as this is what much of the literature (Benner, 1983; McCutcheon and Pincombe, 2001; Lyneham Parkinson and Denholm, 2008; Pretz and Folse, 2011), identifies with the use of intuition. The first step in the process, was to ask the participants to write down ten words associated with the specific situation, they had identified. They were given a minute to do this activity, meaning that what they considered important, would be spontaneous and reflective of their genuine values. The ten words identified by the participants, see appendix three, are significant, and have been used as part of the data analysis, as will be discussed in the next Chapter. The participants were then asked to write a paragraph containing all ten words, this helped frame their story, the paragraphs were used alongside the stories for the data analysis, because this added rich data.

Happell (2007) claims that a disadvantage of adopting a focus group approach could be the dominance of one or a few of the participants, whilst I did not anticipate this because of the naturalistic focus group approach, adopting the strategy of a structured activity further mitigated against this, as they were concentrating on their own activity, but also interested in listening to others.

The participants were then asked to tell their story, using the ten words and the paragraph as guidance, the use of storytelling as a methodology is discussed in the following section

3.5.3. Storytelling.

Before embarking on storytelling as a method of data collection, I needed to consider whether this would encourage, and provide sufficiently powerful stories (Denning, 2021), and whether these would be rich enough for data analysis (Frank, 2014). This was particularly prevalent, as the participants were not asked specifically about intuition and decision making but were

asked to relate a story about an acutely ill patient, with the expectation that suitable data would emerge, because of their shared experiences, as a cultural group (Keeshig, Macfarlane, and Garnet Ruffo, 2015).

Storytelling as methodology is not as fully explored in research as narrative (Rooney, Lawlor, and Rohan, 2016), as frequently the story has been dismissed as of little importance, due to perceived time constraints of the data collection. The terms narrative and story are often interchangeably used, but people tell stories not narratives (Frank, 2000), to help make sense of the world (Rooney, Lawlor, and Rohan, 2016).

Stories are made up of *signs* (Frank, 2010) which supported a semiological analysis, and were powerful in facilitating reflection on personal attitudes and feelings (Keeshig, Macfarlane, and Garnet Ruffo, 2015). Stories often embody emotions and interactions (Frank, 2000), which was important as it was the harsh and emotive stories of practice, which offered the richest data, and made visible the behaviours of nursing, frequently only known to nurses themselves (Koch, 1998). This was strengthened through the naturalistic focus group, which facilitated co constructed meanings of the participants (Rooney, Lawlor, and Rohan, 2016), and shared experiences (Wang and Geale, 2015), offering a deeper insight into the meaning of nurses' behaviour and language,

Storytelling was used to supplement the narrative, which enabled deeper access to the participants thoughts, as they related their conduct in a more complex way (Rooney, Lawlor, and Rohan, 2016), as life is given through the story and the storyteller (Lewis, 2011).

The transcripts of the participants stories and subsequent discussion enabled me to look at the gaps, the silences and the nuances expressed by the participants, which as Frank (2010) states is important, as these spaces can offer more meaning to the story. For this

reason, it was important that I transcribed the focus group interviews, inclusive of all the discussion and comments between the stories, and the nuances of the dialogue. All the comments outside of the stories were incorporated in the transcript and in the data analysis, the nuances helped with application of signifier to signified, in the second order semiology, see appendix four.

Whilst transcribing the stories it was important for me to be reflexive, aware of my own biases and motivations for the data collection (Darawsheh, 2014), and ensure that the words, paragraphs, and stories were transcribed verbatim, and I kept an open mind whilst doing this, to avoid any early interpretation.

3.6. Ethical considerations.

Permission was gained from the ethics committee to conduct the research, See appendix five, the ethical standards I adopted to ensure protection of the participants, and ensure the quality of the study, are presented in this section.

Maintaining ethical principles is essential for good research practice, recognising there is always the possibility of harm, and planning to anticipate potential and actual risks (Polit and Beck, 2012). It was important, therefore, to consider the management of actual and potential ethical concerns, related to my study, how this was achieved is presented below.

Following the initial contact and positive reaction from the volunteer participants, to ensure consent was informed in accordance with the (Royal College of Nursing, 2009; Flick, 2009), who state that participants have the right to decide whether to participate or not, I contacted the participants individually by email. Each participant was sent an information sheet, with clear facts on the purpose of the study, what their involvement would be, and a consent form, which they all brought with them on the day. All participants were notified that they could withdraw from the study at any time without giving a reason, any data collected would

be destroyed and not used, and their progress on the Advanced Nursing Practice programme would not be compromised in any way. This is important as participants decisions should be respected throughout their contribution to the research process (Royal College of Nursing, 2009), with no fear of recriminations for withdrawing from the study (Green and Thorogood, 2005).

Once they had all responded, a date and venue were set for the meeting, time was given prior to the meeting for the participants to ask questions and express any concerns. Anonymity and confidentiality were assured in the information documentation, and each participant was assigned an identifying number, which was used for all research records, to ensure that readers of the thesis could not identify the participants (Flick, 2009).

I transcribed all the data from the digital recordings to further ensure confidentiality of the participants, and accurate recording of the data. Because the participants were comfortable with each other, they felt empowered to offer comments and support throughout the storytelling, capturing this was important to enhance and enrich the data.

Focus group interviews take longer to transcribe than an individual interview, because of the necessity to read the transcripts at least twice, to support familiarity and identify any nuances (Clark, Maben, and Jones, 1996). Therefore, the time taken to read, and transcribe the data was extensive, to consider not just the stories, but the way in which they were told, and the discussion that occurred between the participants, as this added to the richness of the data.

In line with NMC Code of Conduct (NMC, 2018), participants were be asked not to breach confidentiality, by not disclosing any identifying personal information about patients, there were no names of staff, patients or clinical areas included in any of the stories.

Consideration was given to non – maleficence and the prevention of harm to the participants (Flick, 2009), so it was important to consider available support, should distress be caused by recounting difficult/traumatic events. Because the group knew each other, much of the support came through the group members themselves, but support would also have been available through student advisers, at the university, which the participants were advised of

3.7. Evaluating the quality of research.

This has traditionally been concerned with reliability and validity, but their association with positivist research (Polit and Beck, 2012), means that they could be considered unsuitable for this research, which has an interpretivist focus. The rejection of the terms reliability and validity has meant a shift for “ensuring rigour” for interpretivist researchers Morse, *et al.* (2002), as without rigour taking a precise approach to the research, it could be considered a work of fiction (ibid), as the researcher struggles to justify the process and the findings.

3.7.1 - Trustworthiness - means ensuring that processes are transparent (Curtin and Fossey, 2007), and that the findings are accurately portrayed and reflect the opinions and experiences of the participants, not the researcher (Polit and Beck, 2012), and the practices are evident and auditable (Sandelowski, 1993 in Rolfe, 2006).

There is still an ongoing debate, about the appropriateness of a generic framework for evaluation of qualitative data, because of the variations in qualitative research approaches (Rolfe, 2006; Nowell *et al.* 2017). For purpose of my study, I will take a pragmatic approach to the framework suggested by Nowell *et al.* (2017), combined with alternative criteria suggested by Lincoln and Guba (1985), to demonstrate the trustworthiness of the research process within my study, and the findings are rigorous and robust.

3.7.2. - Credibility – is the strive to establish confidence in the truth of the findings, evaluating the integrity and quality of the study (Polit and Beck, 2012).

I achieved this by contacting the participants to ask for a follow up meeting from the interview, to verify the accuracy of the transcription. I had response from 2 of the participants, I sent them each their particular 10 words, paragraph and story, for confirmation that these represented the meaning of what they intended to convey, the feedback I received was positive, meaning the participants were in agreement with my representation of their 10 words, paragraph and story.

One of the participants had been inspired by participating in the process and had reflected on her role as a nurse, both participants confirmed that their story was represented accurately, assuring confidence in the truth of the presented data (Polit and Beck, 2012).

3.7.3. Confirmability - the concern that the researcher's interpretations and findings are clearly derived from the data (Polit and Beck, 2012).

This was achieved through the use of a reflexive journal, and maintaining field notes for a clear audit trail (Lincoln and Guba, 1985), for example I kept a track of and reflected on the activity around the data collection, to evidence the process that I took, there is inclusion of all of the stages of the process, from transcript to the first and second order semiology in appendices three and four. Reflexivity has also been included in each of the sections of this thesis with reflection on my thought process, and decision making, to demonstrate awareness my own preconceptions and biases (Darawsheh, 2014).

3.7.4. Transferability – evaluation of whether the findings can be generalised or transferred to other groups or settings (Polit and Beck, 2012), which is problematic for this study. Generalisation of findings suggests identification of a single reality, conflicting with the post structuralist philosophy of multiple realities (Barthes, 1991). Instead, Lincoln and Guba (1985) use Geertz (1973) term “thick description” which means providing in-depth background and

information, and the contextual details of the study, ensuring there is sufficient descriptive data, so that consumers can evaluate the application of the data to other contexts (Polit and Beck, 2012). Transferability, therefore, for the purpose of my thesis, will relate to methodology, and whether there are sufficient details for this to be transferrable to other studies.

3.7.5. Reflexivity - being aware of own biases, beliefs, and expectations (Cypress, 2017).

I strove to be conscious of any bias throughout the process, and to minimise the impact this may have on the participants, and the data collection and analysis, to ensure what emerged was true to the process of storytelling and Barthes semiological analysis (Barthes, 1991).

Inclusive of reflexivity is the ability to reflect on the data collection process and acknowledge any influence (Green and Thorogood, 2005), reflection following the data collection, suggested that it may have been beneficial to start with the story first, to give the participants a basis for the 10 words, but that may have introduced a different dynamic, or may not have made a difference. It was also important for me to consider what Denning (2021) terms “confirmation bias”, the search for information that confirmed my beliefs of values. I was very conscious to facilitate the participants in telling their own stories and what mattered to them, rather than directing them towards specific issues, which may have supported my initial ideas and values which is a common research issue (Denning, 2021). One participant decided to change her story from the original she had planned, and had done the ten words from, because she felt it was boring after hearing the other participants in the focus group stories. The participant was encouraged to stick to the original story, but ended up telling two stories, which have both been included in the data analysis, due to the value of the individual story, but also because of the interaction that occurred, between the participants.

Chapter four – Data analysis.

The aim of this chapter is to present the stages and rationale for the data analysis, adopting the theory of Barthes (1991 and 2009).

4.1. The data analysis process.

The themes for the data analysis have arisen as the ten words of the participants have transferred from being the sign in the first order semiology to the signified in the second order semiology in accordance with Barthes (2009). The participants stories have been broken into *lexias*, to become the signifier in the second order semiology.

4.1.1. Identification of *lexias*.

Historically the term *lexia* has been linked to a prefix such as *dys*, to form the term *Dyslexia*, the Greek term *dys* meaning difficulty, *lexia* meaning words, so a person with *Dyslexia* has difficulty with words (Berninger 2001).

Barthes (1991) however expands on the Greek meaning of words and defines *Lexias* as units of reading, which may be anything from a few words to a few sentences, an example of this taken from the first one of the participants stories.

“An emergency situation which meant life or death practitioner was performing CPR on arrival I ensured that we had enough equipment and skill mix to support and perform the operation, the timing was crucial. My thought was with his family, and I needed to ensure I did the best I could. There was a lot of blood loss, and we needed IV blood for.”

The *lexia*, using Barthes (1991) definition, may be the whole paragraph, individual words such as *practitioner or operation*, or a few words such as “my thought was with his family” or “I did the best I could”.

Lexias are the best place to look for meaning (Barthes 1991), the *lexias* from a text are identified for the propensity for multiple meanings, dependant on the readers cultural and social values and beliefs, *the age of foolishness* for example, may have many obvious as well as hidden meanings, dependant on individual interpretation.

The identification of *lexias* is therefore an arbitrary process (Barthes 1991), for the purpose of the data analysis for this thesis, the *lexias* have been identified from the transcript of the participants stories and will be selected at my discretion, based on my cultural and societal values as a nurse.

Some have been used more than once, under different *Signifieds*, because of the plurality of the text, and the potential for multiple interpretations (de Saussure, 2005).

When identifying the *lexias*, reflexively required me to be conscious of my biases (Polit and Beck, 2012) and ensure that the *lexias* were true to the signified, so they could become signifiers. This meant repeating the process of creating the second order semiology table many times and discussing this with my supervisors.

Green and Thorogood (2005) contend that, recruiting a partner when interpreting research findings is beneficial, to promote accuracy and an audit trail. Identification of the *lexias* was very dependent on my interpretation, keeping to the theory of Barthes (1991) therefore, I decided that the selection of the *lexias*, should be solely my choice, aware that others may have an alternative view.

4.1.2. Denotation and Connotation.

Barthes (1991, p94) argues for analysis of texts using five narrative codes which should be used exclusively to “group textual signifiers”. For a pragmatic approach I have chosen to focus on the connotation and the denotation, rather than use the narrative codes, because

of their relation to the first order and second order semiology (Barthes, 2009 and 2010) and because I considered this approach would offer a better opportunity to uncover hidden meanings.

The *denotation* of a word or phrase is its dictionary definition, the familiar or literal meaning; the *connotations* of a word or phrase are the meanings that it suggests, dependant on individual or group interpretation (Furniss 2012). However, because many dictionaries can include many denotations and connotations, the process of identifying one from the other, can be complicated (ibid).

Using the same passage taken from one of the participants stories,

“An emergency situation which meant life or death practitioner was performing CPR on arrival I ensured that we had enough equipment and skill mix to support and perform the operation, the timing was crucial. My thought was with his family, and I needed to ensure I did the best I could. There was a lot of blood loss, and we needed IV blood for.”

The word “family” taken from the passage, has a literal dictionary definition of ‘people related to each other’, the actual word or phrase, trapped in a single meaning, this is the denotation. Many dictionary definitions also include the terms ‘group’, ‘culture’ and ‘society’, these are the connotations, the understanding of the reader, based on cultural and societal values, and released from the words and phrases to individual interpretation and multiple meanings (Furniss 2012).

Denotation, the objectivity of depiction of a *Signifier* (Baudrillard, 1981) has a Diachronic referent, the historical context, and the accepted ‘truth’ (Barthes, 1991), and should have status alongside connotation, to support the analysis of meaning (Baudrillard, 1981). As

part of the data analysis, I have considered the principle of denotation, and applied it to the lexias, to present accepted orthodoxy, prior to presentation of the connotation. The denotation is derived from findings from the literature review, and the signifiers in the first order semiology (appendix three) as this is the diachronic referent.

Connotation acknowledges the plurality of the text, although no meaning shall take precedent over another, there is no search for 'truth', but the recognition of the very existence of multiple meanings (Barthes, 1991). Connotation will follow denotation, with recognition of the very existence of a plurality of the text (Barthes, 1991), and my interpretation of the potential of meanings, with no claim to 'truth'.

Once the *Signifieds* have been addressed and the *Signifiers* broken down into lexias, (Barthes, 1991), denotation and connotation applied, each will be allocated *signification*, which will be added to the second order semiology table (appendix four).

4.1.3. Socratic questioning.

Connotations are the space between the text, their meanings are neither in the syntax of the text nor the dictionary, they are the formulation of a voice interlaced within the text, which produces the plurality of meaning (Barthes 1991). By transcribing the collected stories, appendix four, I read and then re-read the text, Barthes (1991) argues this is fundamental to establish the text as expressive, and to scrutinise to find hidden meanings.

Whilst scrutinising the text for the Connotations, I found that I was asking questions, I therefore opted to adopt a Socratic questioning approach to deepen my understanding of the narrative (Britton, 2021). Jarvis (2006) argues that few of us ask questions, because the answers have been taken for granted, a perspective that I believe applies to the current rhetoric surrounding intuition, in nursing practice. There is trust in the view as it is presented (Luckmann, 1974 in Jarvis, 2006), the Denotation, a narrative well recognised (ibid). But the

world changes, so situations cannot be taken for granted, acceptance of ignorance, and the asking of questions promotes a learning process (Jarvis, 2006), potentially identifying and alternative perspective, the Connotation. Use of the lexias as a starting point and asking questions of the lexias, becomes part of the Connotation, an alternative and current viewpoint, acknowledging that memories of the past, the Denotation, may not always be in harmony with the present (Jarvis, 2006).

Traditionally used in psychotherapy, Socratic questioning helps gain a universal definition for clients (Overholser 1995), Socratic questioning can also support critical thinking, by asking questions to deepen understanding (Britton 2021). Rather than identifying a universal understanding, which would have conflicted with the post structuralist philosophy of multiple realities (de Saussure 2005), I used Socratic questioning to remain open minded and be systematic in examining alternatives (Overholser 1995), to the Denotative referent, adopting a reflexive approach to acknowledging my biases and pre suppositions (Darawsheh, 2014)

During the analysis of text, Barthes (1986), advocates distancing the author from the text, because the meaning of the text is dictated by the author and their intentions, which are homogenous (Barthes 1991). As this conflicts with the post structuralist tenet of plurality of the text, I adopted a “Writerly” approach, and interpreted the text, ensuring it was distinctive from its appearance, and its whole (Barthes 1991), ignoring the grammatical structure, logic and perceived intentions of the participants (Barthes 1986). Therefore, the purpose of the questions, included under each lexia, is to interrogate the text, and rhetoric around intuition and decision making, not my potential interpretation of meaning, by the participants.

4.2. The presentation of the data.

4.2.1. The *Signified* – these are the ten words which are the *sign* value in the first order semiology but have become the *Signified* in the second order semiology (appendix four), these have been used in this way for structure and direction of the data analysis.

4.2.2. The *lexias* – discretionary units of reading (Barthes 1991) from the stories of the participants, become further presentation of the data, and are included here because they form the *Signifiers* in the second order semiology, and because of their link to the *Signifieds*.

4.3. The analysis of the data.

4.3.1. The Denotation - the literal meaning of the lexia, the representation of the shared simplicity of language (Barthes 1991).

4.3.2. The Connotation and Socratic questioning – the delivery of the voice wound within the text (Barthes 1991), the use of questioning to seek out alternative meanings.

4.3.3. Answering the questions.

To complete the second order semiology (appendix four), and to suggest answers to the Socratic questions, I have included the *sign* value under each of the *Signifieds*. This is my interpretation of the correlation between the *Signified* and the *Signifiers*, but does not represent a complete image, and is open to further interpretation, to sustain the challenge to 'reality' (Barthes 1991), of intuition in nursing practice.

4.3.4. A summary of the findings.

Returning once more to Socratic questioning, themes have been identified and the findings from the data analysis, the Synchronic evidence, have been compared to findings from the literature review, the Diachronic evidence.

A glossary of the abbreviations, within the participants stories and the lexias, is in appendix four.

4.4. Presentation and analysis of the data.

Presentation of the data - *Signified* and *Signifier*, including the *lexias*.

Analysis of the data - the Denotation, Connotation and Socratic questions.

Answering the questions – the *sign* value.

1. Signified - Support.

(bearing the weight of something, have the backing of).

Presentation of the data.

Signifier - *Lexia* – “*I was emotional and showed compassion to the parents*”.

Analysis of the data.

Denotation - what could be seen as the role of the nurse, spending time with the relatives, hand holding, the ubiquitous image.

Connotation- a shared sense of being upset but also bearing the weight of the parents being upset, compassion meaning suffering together. The ‘truth’ of emotion, linked to the patient or self, but associated with behaviours.

What precipitates the emotion? what is the link between compassion and emotion, if this is essential to support the family?

Compassion as behaviour, is there a sense of vulnerability? Does it leave the nurse vulnerable because of the emotional response? Does the nurse bear the weight of the parents being upset, or is emotion as a sense of control?

What is the role of the family?

The role of the family is to be upset and share that with the nurse. Behaviour of the family, is it a shared responsibility?

Presentation of the data.

Signifier - Lexia – “Because I saved him”.

Analysis of the data.

Denotation - single handed act of heroism.

Connotation - This suggests that the role of the nurse is to save people, but what does save mean in this context?

Is this cultural narrative? As expert hero/saviour syndrome, and you alone saved the patient, does this connote that nurses feel alone in this situation?

There is no support, it may be different if there were other members of the societal group, or does it mean that you only see yourself in this situation? Or your role played a fundamental part. A sense of vulnerability, loss of support, lack of support but does this relate to feeling alone and unsupported. But from whom?

Presentation of the data.

Signifier - Lexia – “everyone looked to me as the senior nurse on shift to manage the situation”.

Analysis of the data.

Denotation - single handed act of heroism.

Connotation - nursing language, senior gives a sense of expertise, as does the responsibility of managing a situation, sense of authority, goes beyond competence and technical skills but what does it mean?

Does it suggest that there is no support despite other people being there, but what support were you looking for?

Who is 'everyone,' who matters, who is judging and by what rules?

What is the dominant narrative the social relation and hierarchy of the nurse?

But not compared to medicine, compared to itself, has senior been exchanged for expert?

But there is no mention of expert, so the nurse does not consider themselves as expert, just senior, is there a presumption of expert and does that necessitate supporting the situation?

Presentation of the data.

Signifier - *Lexia* – “*I nursed him*”.

Analysis of the data.

Denotation - the ubiquitous image.

Connotation - what does this mean?

Holistic, cultural language, is there an understanding of what nursed him means? Linked to making the patient presentable but again involves the family, very involved with the technical practicality, so is this what “nursed him” means?

But if this is the case, why did you feel the need to make him presentable for his parents?

The cultural language of “nursing” as a verb rather than a noun, it is an action, a way of being, a state rather than an action, a sense of cultural belonging?

“Nursing” as a brand, the *Sign* value of ‘nurse’ exchanged for behaviour, rather than a title.

Support is person centred, focus on the family, need for a relationship, is this important?

The values and beliefs of nursing as an epistemic community, does nursing already have a sense of who it is?

Nurses know what nurses know and are confident in that. The ontological belief in the Intuitive-Humanist model of decision making, the humanist approach, support being patient specific, suggests dominance over Hypothetico-Deductive reasoning.

Presentation of the data.

Signifier - Lexia – *“It was a sad day, but I was proud that we support the family”*.

Analysis of the data.

Denotation - that something sad had happened but the family were supported.

Connotation - nurses bear the weight of emotion, integration and relationship with emotion and compassion, what is the relationship with emotion?

There is no sense of vulnerability from the nurses but expressing sad day, does this connote vulnerability?

How much is compassion and emotion linked to vulnerability?

What is pride and how does it present, pride and support, pride important but why, pride as a professional, pride as in individual, proud self-respect sense of agency, indicates a sense of power and authority?

Sad as a reaction rather than an emotion.

Who is “we”, how much do nurses feel part of a team?

Person rather than context specific and which team is important?

Is context social, the notion of “we”, and the link to support, for the negative “sad day” and the positive “proud”?

Presentation of the data.

Signifier - Lexia – *“I was just on a break, and I could overhear the surgeon saying that there was something kicking off in ITU, and nobody told me about it”.*

Analysis of the data.

Denotation - serious event occurring, but kept a secret because on a break, or just not included in the conversation, because on a break?

Connotation - On a break so not switched off, is this the hero/saviour complex?

Kick off, difficult to find a slang or colloquial definition outside of the meaning above, the only one I could find was ‘to start trouble’ but this is far too narrow.

“Kicking off” as a colloquialism, nursing language, has a deeper meaning linked to culture but what does this indicate?

What will happen next?

How is this perceived by nursing?

A deeper meaning relating to a sense of responsibility, a need for action, relation to a patient, does this have an emotional connection, is this in relation to the situation or is there a person connection, cultural narrative?

Presentation of the data.

Signifier - Lexia – *“Nobody told me about it and on my own”.*

Analysis of the data.

Denotation - “Billy no mates”.

Connotation - gives a sense of isolation, lack of support but a sense of responsibility for bearing the weight of the situation, is there a sense of vulnerability?

But again, is this nursing language, what does this mean?

Is this a sense of a hero complex?

Nobody told me but I knew something was going to happen, sense of autonomy and authority that although nobody said anything, knew about it and what to do.

'On my own' but not the only person there, the hero complex but is that a bad thing? Does the hero complex/syndrome or saviour complex give a sense of authority?

But does this also consider a sense of fear, can I do something, do I have autonomy and authority?

Answering the questions – the *sign* value.

Nurses see themselves as the support which is individual to them; the hero, the saviour, call to action, driven by the need to be in control, with an idea of autonomy. But there is a sense of isolation related to cultural language and the link to the social context, with identification of vulnerability related to this. There is also a feeling of isolation, not having support which is potentially linked to language and the societal context. Support for family and relatives is important and the need to support them, linked to emotion, support is also linked to emotion for other members of the team, but this is represented as behavioural, an action rather than a feeling.

2. Signified – Skill.

(Attitudes and ability appropriate for a specific job).

Presentation of the data.

Signifier - Lexia – “*The senior team appeared to be confused, and the defibrillator use/ALS skills were slow, and appeared to be not fluid enough*”.

Analysis of the data.

Denotation - incompetence and the patient at risk, unable to use the equipment.

Connotation - ‘senior’ suggests an element of authority, but this is dismissed by suggesting they were confused, and the skills were slow.

What skills did you think were important?

Were these practical skills in dealing with the cardiac arrest, or in relation to working together and understanding each other, speaking the same language?

There is a sense of superiority, connotes an element of judgement of the team.

Presentation of the data

Signifier - Lexia – “*My first role as a senior nurse*”.

Analysis of the data.

Denotation - experience and expertise.

Connotation - the role as a ‘senior nurse’, experience or does first role suggest an excuse or some sort of ‘get out clause’?

There seems an element of doubt of the skill, and the attitude is self-deprecating, as suggested by the first role, is this denial or non-recognition of the term “expert”?

'First role' also connotes inexperience, the self-doubt, scared of not knowing what they were doing, but senior nurse and skill, not just linked to tasks, contradicts the linear process of novice to expert.

Presentation of the data.

Signifier - Lexia – *"I could overhear the surgeon"*.

Analysis of the data.

Denotation - the surgeon was saying something, not directed at the listener, but loud enough it could be heard.

Connotation - overhearing suggests listening, having an element of control, the skill of control, connotes that this control is a skill and also a behaviour, what is the behaviour of control, how does this manifest?

Getting ready without being told connotes an ability to understand what you can do, of the skill needed to more than fulfil requirements, but what are the requirements?

What is the attitude that feels they must prepare without being told, sense of ownership, is this essential, ownership of the situation of a sense of agency?

Presentation of the data.

Signifier - Lexia – *"I remember feeling that I had managed it well, and I could control the situation"*.

Analysis of the data.

Denotation - positive outcome because of the input from nursing.

Connotation - the feeling that you managed the situation well, linked to emotion so management of a situation is linked to an emotion, and that is important because it meets the goals that nursing has set, but what are these goals?

The skill of being a nurse is having the attitude to take control, but in what sense, management of the situation is a skill, not the task but it is holistic the skill of nursing is being holistic?

'Managed' and 'control' connote an attitude to take control, the element of social standing, no question about whether as a nurse this was evident or in doubt.

Presentation of the data.

Signifier - Lexia – *“but the patient died”*.

Analysis of the data.

Denotation - that something happened that the patient died, an unfortunate event.

Connotation - failure that somehow despite being in control the ability to “save” a patient is how we are judged, and it is the nurses fault, or was it someone else’s fault, suggests failure, patients are not allowed to die.

nurses’ responsibility but what does ‘saved’ mean, cultural meaning, more than the patient lived?

Presentation of the data.

Signifier - Lexia - *“I had been a nurse for a long time”*.

Analysis of the data.

Denotation- longevity of practice.

Connotation - the sense of identity,

Is this a sense of belonging to a cultural society, a sense of pride but also an awareness of responsibility, and expected skills and ability to do the job?

Presentation of the data.

Signifier - Lexia - *"I hadn't been on this ward long"*.

Analysis of the data.

Denotation - being in an unfamiliar environment.

Connotation - a sense of vulnerability, but also with a sense of agency and control, to support a team because they were struggling, connotes confidence in own abilities.

But this also suggests being part of a team but what part, and which team do you feel part of?

The skill of the nurse is flexibility, suggests changing environment limits skills, the context of the environment potentially impacts of sense of salience.

Presentation of the data.

Signifier - Lexia - *"Lacked my own confidence"*.

Analysis of the data.

Denotation – uncertainty.

Connotation - lack of support but also taking some ownership for feelings, and consideration for the impact this may have had.

This also connotes a sense of vulnerability, particularly you did not feel good enough, but good enough for what?

What are the expectations of the profession or individuals?

What makes someone part of the societal group of nursing?

Why does someone not feel cultural identity and why is this linked to ability, what is ability, ability to do what, what are the expectations of nurses?

Answering the questions – the sign value.

Skill is not linked to experience or expertise but sense of self and self-worth, belief and identity, social context, not the exclusive right of what is deemed an expert because we are all experts if we understand the language of the societal group. We do not need to justify skill or knowledge, so intuition ceases to become relevant because we all understand the rationale for decision making, nursing judges itself against itself, not other professions. The environment can impact on self-worth, nurses feel comfortable in a familiar environment but feel doubtful of their skill and ability, if in a strange environment. Even nurses who consider themselves “senior”, whilst demonstrating some confidence in their abilities, clearly still have doubts, this questions the linear progression from novice to expert.

3. Signified – Panic.

(a sudden overwhelming fear that affects an individual or especially one that grips a crowd or population).

Presentation of the data.

Signifier - Lexia - “everyone was in a panic due to the environment”.

Analysis of the data.

Denotation - no control, no responsibility, nobody knew what to do because the environment was unfamiliar or had an impact on the loss of control.

Connotation - the environment can impact on perception of the situation, but this connotes not just the physical environment, but also the social and psychological environment, not just what is happening, but also other people and individual perception of self within that environment, crisis of identity may also lead to panic, How does the individual fit into the environment?

Was there also panic from the nurse, was the nurse part of “everyone”?

Was the “environment” linked to societal context, trying to work with people from different societal groups and different values and language?

Presentation of the data

Signifier - Lexia – *“I was worried how to manage the situation”*.

Analysis of the data.

Denotation - overall concern.

Connotation - an overall view of the situation and control maybe of self and others, manage is ‘big picture’ thinking about things at a higher level, but because of this the panic sets in, and the sense of responsibility, the fear of managing self or recognition by others who also will the ‘buy into’ your vision, as per the comments above about societal context. The “situation” suggests a move away from the Intuitive-Humanist model to more Hypothetico-Deductive reasoning, because of the objectivity of the “situation” rather than the subjectivity of an individual. Panic could then occur when moving outside of a person-centred approach to decision making, as this does not correlate with the values of nursing.

Presentation of the data.

Signifier -Lexia - *“it was not something I had ever seen”*.

Analysis of the data.

Denotation - a lack of experience, a sense of panic because this is something new.

Connotation - a lack of something to pin it on to, is this related to experience or perception, the sense of self and confusion about ideas and perception.

Never seen before maybe a colloquialism, nursing language, never seen before may be justification for feelings or sense of fear.

Presentation of the data.

Signifier - *Lexia* – “*there was a ridiculous amount of blood, and the smell was just like a? smell, so obviously it was something that just poured out*”.

Analysis of the data.

Denotation - a terrible sight.

Connotation - sights and smells so bodily fluids raise a sense of alarm, but also what is deemed too much raises a sense of panic. ‘Pouring out’ is a nursing term, the cultural language that connotes a sense of urgency, but also that there is a responsibility to the patient, the understanding of the implications but also the responsibility to keep calm and not panic. Understanding the role of self, the patient and others, the impact these things have and the panic that may ensue.

Is this the communication strategy nurses have as a cultural group?

Presentation of the data.

Signifier - *Lexia* – “*everyone is just working on this patient*”.

Analysis of the data.

Denotation - a team approach to physical labour, applied to the patient, there is something wrong with the patient that necessitates this.

Connotation - the cultural language of health care workers as a societal group.

But for nursing is this the outsider looking in but indicates a problem?

The term working on a patient is usually identified with an acutely ill patient, but what is the nursing language and the link to the patient?

This suggests a more humanist approach, the patient is identified as an individual, everyone else is clumped together.

Also connotes the nurse is not part of “everyone”, is there panic of being an outsider looking in?

Answering the questions – the *sign value*.

There is an awareness of nurses being outsiders, not being one of the “others” in the situation, but a focus on the humanist element of clinical judgement, which informs actions and behaviours, and potentially makes them different, or that is the way they perceive this? This seems to differentiate nurses from the “others”, there is no sense of panic from this but an acceptance. Panic ensues from being lost in the crowd and the perception of self and others in the crowd, with potential loss of control and identity. There is no perception of fearing situations not faced before, just non recognition of the cultural norms and standards, and the communication strategy that nurses use as a cultural group, not just by other professions but also by other nurses.

4. Signified – Control.

(The power to influence or direct people's behaviour, or the course of events).

Presentation of the data.

Signifier - Lexia – *“I also felt responsibility for the student nurse as she had raised the alarm and needed to be debriefed from the situation”.*

Analysis of the data.

Denotation - responsibility for others, concern for the student nurse as she had been with the patient, when the patient's condition deteriorated.

Connotation - a sense of guilt.

Is it possible to control the behaviour of others or even influence it?

Does the sense of responsibility relate to this?

Is this also related to the situation and lack of control but really suggests a sense of confidence?

Is responsibility linked to guilt?

Do nurses need control to assuage the guilt?

Does this link to nurses' sense of self-worth?

Control related to behaviour and actions, “debrief”, to “de brief” someone suggests a sense of control over self and others, but also the situation, action, behaviour related to control.

Presentation of the data.

Signifier - Lexia – *“just got as much as I could ready because I was listening, ear holing”.*

Analysis of the data.

Denotation - an understanding of what was happening and what the role of the nurse was.

Connotation- the power to influence own behaviour but needing to have control of others.

Are nurses control freaks?

Does having control of others mean nurses have control of themselves?

Preparing for a situation which “nobody had told me about” connotes that sense of control of self but not others, to have influence through own actions.

Why do nurses need to promote their own actions to example exerting control?

Does this again suggest vulnerability or is it because nurses have a sense of their own agency?

Do nurses understand how their actions influence others?

Is it because others outside the societal group do not understand, or do nurses just think they need to evidence control, through behaviour and action?

Presentation of the data.

Signifier - Lexia – “*and it just seemed that I controlled the staff, and I controlled the emergency on the ward.*”

Analysis of the data.

Denotation - the power to influence.

Connotation - the influence on others suggests a sense of agency and autonomy.

Understanding self and identity, having an identity but as what?

'I controlled' connotes a sense of competence, but again not skill related, competence in agency and trusting of self, if not of others. Control as in actions and behaviour.

Presentation of the data.

Signifier - Lexia- *"I felt I was not good enough, and not capable of dealing with things"*.

Analysis of the data.

Denotation - antithesis of control, denotes lack of competence and confidence.

Connotation - a lack of control, discussed through lack of confidence.

This links back to the sense of agency but also belief in self, but as what?

What is this being judged against?

Do nurses really care what others think of them, outside of the societal group?

This really questions the notion of subordination to medicine and is highlighted elsewhere, nurses do not consider themselves subservient to medicine, only to themselves, not good enough connotes not meeting the standards to join the societal group, rather than a lack of competence.

Answering the questions – the sign value.

There is a sense of guilt linked to a loss of control, the need to control to assuage the guilt.

The antithesis to control is the need to promote own actions because of loss or lack of control, which suggests a vulnerability due to lack of control and self-doubt, about how actions and behaviour impact on others.

5. Signified – Duty.

(moral or legal obligation to avoid acts or omissions, which may cause harm).

Presentation of the data.

Signifier - Lexia- *“All procedures went out of the window.”*

Analysis of the data.

Denotation - a sense of urgency, prioritised over duty to follow protocols.

Connotation - the suggestion that nurses always follow rules and to be an expert means the collection of more protocols is questioned here.

The legal obligation of the nurse is to comply to professional guidelines, but how do nurses interpret these?

Do they really matter?

What does procedure mean in this situation and what were the implications?

Why was this considered important, probably connotes the moral and professional obligation to not adhere to protocols, so the nurse is patient focussed not protocol focussed, acting in accordance with the Intuitive-Humanist model.

Presentation of the data.

Signifier - Lexia – *“he might still have a swab stuck in him”.*

Analysis of the data.

Denotation - medical mistake.

Connotation - nursing humour, but it moves beyond humour.

How does this relate to the duty of the nurse?

Sense of guilt?

Is there an obligation to take ownership of this?

Nursing humour, cultural language as a coping strategy, indicates a duty to self as well as the patient.

Presentation of the data.

Signifier - *Lexia* – “*luckily he survived*”.

Analysis of the data.

Denotation - despite everything.

Connotation - a sense of achievement.

But why luckily?

The moral implications of not surviving, and whether this could have impacted on the obligation of the nurse, are nurses obligated to enable patients to survive?

Does survival override everything else?

The hero/saviour complex, or humanist consideration, duty to the patient or duty to self?

Presentation of the data.

Signifier - *Lexia* – “*health workers do not want people to die*”.

Analysis of the data.

Denotation - wanting everyone to live.

Connotation - the mystery of wanting people to survive.

The morality of letting people die indicates failure, but what are nurses obligated to do?

What is the protocol of survival?

Is the obligation to the patient or self?

Death as a sense of failure because of the loss of autonomy and authority, is allowing a patient to die causing harm?

The culture of health care conflicting with the culture of nursing, suggesting that context is societal rather than anything else, is the patient part of the societal group, if only on the fringes, does everyone all have same values and goals, if not language?

Presentation of the data.

Signifier - Lexia – “we miss the opportunity to be honest sometimes”.

Analysis of the data.

Denotation – not telling the truth.

Connotation – the duty to be honest.

Honest to whom and is somebody being let down?

“The opportunity” suggests that there are times to be honest, fair and justified, the justification of telling the truth, but could this cause harm?

This necessitates communication skills, nurse’s role, also connotes being honest is in the best interests of the nurse and patient, duty related to the humanist ethos.

Presentation of the data.

Signifier - Lexia - “I stayed on his looking after him erm finished the shift”.

Analysis of the data.

Denotation - duty of care.

Connotation – duty to protect.

Moral obligation or professional obligation or is the duty an emotional one?

But why stay after the shift has finished?

What difference would that make?

Linked to relationship with parents, moral duty, is the obligation to the patient, parents or self?

Scared to let go, would nobody else do as good a job?

The importance of continuity of care, seeing things through to the end but do nurses also have a duty to let other people have a go?

The arrogance of you being the only one, indicates almost a sense of self-importance, but is that a terrible thing?

Knowing the patient and relatives is important but what is the duty in this?

Do nurses have a sense of duty to see it through to the end, so that we have control?

Duty linked to control.

Care linked to responsibility and professional obligation.

Presentation of the data.

Signifier - Lexia – “because that is the release from the good and the bad that I see in my day-to-day job, release is going home to my kids and just doing my job is irrelevant to them, I separate my role as a mom”.

Analysis of the data.

Denotation - split personality.

Connotation - that sense of being a nurse is different to sense of self.

Duty as a professional but does that stop, is it possible to separate identities?

Being a nurse is not being human?

Relatives may not be part of the societal group, so would not have shared values and understanding. The moral duty to protect.

Presentation of the data.

Signifier - Lexia – *“put myself in a situation, and it is bad what I do, cos I go this is what it will be like”*.

Analysis of the data.

Denotation - putting oneself in danger.

Connotation - no duty to self, potential harm caused to self and others by putting self in peril, but there is also knowledge and acceptance of this, because of the moral and legal duty, acceptance.

Antithesis suggests having control, aware of duty, “put myself” denotes having a choice, connote no choice, antithesis linked to duty.

Does duty lead to no choice?

Presentation of the data.

Signifier - Lexia – *“it is bad what I do”*.

Analysis of the data.

Denotation - doing something wrong.

Connotation - guilt for impact or control of others.

What do you do?

Why is it wrong?

Is there negativity linked to duty?

Duty or obligation?

Presentation of the data.

Signifier - Lexia – “I go into lifesaving mode, which is how I deal with it”.

Analysis of the data.

Denotation - a way of managing a situation and insight into the way this is done.

Connotation - robotisation or personal agency, notion of life saving, saving lives, hero, brave, duty, control, coping mechanism.

Lifesaving as a colloquialism, cultural language, narrative duty lifesaving, control over others or control of self?

Control of others is it the nurse’s duty to save others’ lives or their own.

Is there a need to package behaviour or way of thinking, cultural text packaging due to lack of explanation or is it because of a cultural understanding?

Loss of control means reliance on Hypothetico-Deductive reasoning, to address lack of cultural understanding of actions, behaviour and language, outside the societal context.

“That is how I deal with it”; innate knowledge tacit knowledge understanding of self, professional role, the duty to rationalise behaviour.

Packaging - the literature review talks about packaging findings, but that is not it packaging as in putting something into a neat bundle, such as the signs and symptoms of a

deteriorating patient, but more presentation of self in an advantageous way, a justification for behaviour and actions.

Presentation of the data.

Signifier - Lexia – *“the patient might die but I always think about the family”*.

Analysis of the data.

Denotation - antithesis to life saving mode, denotes lack of control, loss of duty to the patient, so focus on the family.

Connotation - acceptance nurses are more than themselves, control the situation through supporting the family, thinking about the family the humanist perspective, behaviour, family behaviour, patient, nurse in the middle.

Wrap around care but are nurses in the middle?

The duty to the family and consider harm to them, connotation, our own role and the link between the patient family and self.

Presentation of the data.

Signifier - Lexia - *“when you say about your manual handling I picked him up, I don't want to be in coroners court”*.

Analysis of the data.

Denotation - heard this before, “all procedures go out of the window”.

Connotation- if not doing something, responsible for death.

The notion of life saving again?

Hero complex, sense of fear and failed in duty. Connotation a wider fear, duty to the patient overridden by duty to the perception of the law.

Weighing up responsibilities, antithesis to patient focused?

This questions whether you were more worried about yourself than patient, does lack of control invoke fear in a wider context?

Presentation of the data.

Signifier - Lexia - *"you do what you have to do but it was scary"*.

Analysis of the data.

Denotation - a sense of control through knowledge and experience, but also understanding professional responsibility.

Connotation - a cultural understanding of the role of the nurse in particular situations not linked to experience or knowledge.

Why was it scary, what were you frightened of?

Because you say know what you have to do, so control to a point, maybe linked to ill equipped?

Connotation - a sense of responsibility, not meeting the duty requirement, not in control, going back to not letting patients die.

Frightened is the antithesis of control, but frightened of losing control?

Sense of duty, frightened, scary do not know what to do contradicts itself, what happens when we lose control?

What do nurses say is their duty?

What is the impact of death?

Presentation of the data.

Signifier - Lexia – “she needed to use the bed pan; everyone has their human rights”.

Analysis of the data.

Denotation - the action of helping to go to the toilet, moral code, ethical principles.

Connotation - respect the person as an individual, antithesis inconvenient interfering with tasks.

We've seen this before, the humanist, individual patient approach, but also moves beyond task focused and Hypothetico-Deductive reasoning.

Human rights in a nursing context, is it a human right to have a bed pan?

It is the antithesis to saving the patient, or is it, saving the patient linked to? what is meant by this?

Presentation of the data.

Signifier - Lexia – “think you were doing the right thing meet their ADLs and stuff”.

Analysis of the data.

Denotation - sense of obligation, justification, you are doing the right thing.

Connotation - sense of guilt-emotion, guilt, the feeling of failure. Guilt arises from others.

Is guilt an emotion, being judged against self not others?

and whether our expectations are met, more ADLs or something else? ADLs, nursing cultural language, related to Roper (1996), duty to justify approach.

Answering the questions – the sign value.

Duty is linked to autonomy rather than protocols, morality, and obligation to the patient and to self but self as a 'nurse', harm seems to come not from challenging conventional policies and procedures but from our own morality, the duty we have to the patient and ourselves. The belief of cultural identity seems to shield everyone important from harm, the use of humour and language, and the sense of professional agency, being in control ensures that cultural values and beliefs are adhered to, and we are all protected.

6. Signified– compassion.

(Feeling of sorrow and pity for someone in trouble, to suffer together).

Presentation of the data.

Signifier -Lexia – “*felt immense sadness*”.

Analysis of the data.

Denotation - more than normal sadness, the antithesis of sadness is not happy, but the absence of sadness. Sadness denotes negative, a sense of disappointment, someone at a disadvantage, a sense of helplessness.

Connotation - not the antithesis, but being part of ownership of the situation, the difficulties, the sense of suffering together, so the nurse and the patient were both in trouble, but where does the trouble stem?

Presentation of the data.

Signifier -Lexia – “*disabled son as the patient sadly lost her life*”.

Analysis of the data.

Denotation - feeling sorrow for those left behind, disabled son adds to the sorrow as denotes an inability of the son to manage alone.

Connotation - concern for son, disabled has influence?

Sense of not being able to manage, the loss of the carer, but are they alone?

A sense of helplessness from the son and the nurse.

“Sadly, lost her life”- sad for the patient denotation, lost her life does this suggest some responsibility by the patient?

Connotation - sorrow but who is in trouble? Is this the sense of suffering together? But what is the impact on the nurse and the perceived impact on the son?

Sorrow as a mental reaction rather than an emotion.

What motivates sadness?

What can nurses do?

Do nurses always feel that they must do something, take action?

How does sadness manifest and what are the actions associated with it?

Seen this before the sadness of death, again is this cultural language?

Compassion as behaviour and response.

Presentation of the data.

Signifier - Lexia – “*all my emotions flooding through as I could see the patient deteriorating*”.

Analysis of the data.

Denotation - being upset about a patient becoming unwell.

Connotation - strengths at one with the event and the patient.

But what is the motivation, and how and what is emotion?

All emotions, but there are more than one and there is a juxtaposition between emotions.

Which one dominates and how does this link to nursing language?

Emotion is linked to the positive, but is this positive?

There is a negative link with patient deterioration, negative emotions, could be anger and fear, but that is not right either unless emotion is considered a response rather than a feeling. Emotion is linked to intuition, but intuition is classed as a feeling rather than a response, maybe this needs to change, and the narrative linked to emotion becomes response and behaviour, rather than intuition.

Presentation of the data.

Signifier - *Lexia*- "*emotional and showed compassion to the parents*".

Analysis of the data.

Denotation - negative because emotion may not be professional.

Connotation – strength, but strength of what?

The understanding of others distress, shared responsibility between the nurse and the parents.

Emotion linked to behaviour, the behaviour of compassion because it is shown, but how do nurses show compassion?

Maybe it is how nurses respond to the relatives or themselves, professional expectation, or personal expectation maybe both?

Compassion and moral expectation, compassion linked to behaviour and response, reaction to a situation, links back to the 'art' of nursing?

Presentation of the data.

Signifier - *Lexia* – “*sad day but proud, really proud*”.

Analysis of the data.

Denotation - sense of pride denotes that something went well, a sense of happiness.

Connotation - a sense of pride may also connote arrogance, but also did the right thing, motivation linked to pride, driven by poor self-worth sense of shame.

But this is not the narrative nursing tells itself, denotation proud holding head up high but connotation proud, is power in the sense of control?

Link to arrogance or sense of self-worth, agency, belonging what achieved gives a sense of belonging, and part of the societal group.

The word emotion is not what participants mean, is it cultural narrative to be in the societal group, or used to justify self to give self-worth?

I was emotional so that makes me a nurse.

Is this what gives nursing an identity?

What motivates this and what do they mean?

Is this it, the notion of self-actualisation and esteem?

There are many negative links which is the denotation, but the positive link, the connotation, because 'emotion' means I understand and can manage a situation.

But it is just a word and seems to be a clear colloquialism, is 'emotion' a link to self-perception, self-awareness, compassion?

Suffering together but what does suffering mean?

Why is the nurse suffering?

Why is the patients suffering and what from?

'Emotion' Is more positive than negative, but does it also connote a lack of self-worth, emotion could be negative, linked to lack of control.

"According to the cognitive appraisal theory, emotions are judgments about the extent that the current situation meets your goals" (Thagard 2010).

Is this how nursing uses the term emotion?

Is it a judgement of others?

Related to the cultural language and values of nursing as a societal group?

Presentation of the data.

Signifier - *Lexia* – "*nobody prepared the patient or the family for the death*".

Analysis of the data.

Denotation - a lack of responsibility, a lack of ownership, somebody has let them down.

Connotation – blame, letting people down, a sense of guilt, self-blame, happens before I got there, a sense of disgust which is situation not patient centred. There was lack of liaison with the family, and no connection, preparing for death means communication, honesty.

Allowing to fail by letting the patient die, but this is not my fault, do you feel that you or other could do better?

Probably, actually if I had been involved, this would have been different. Is the situation emotive rather than emotional?

But what are the feelings and why does it matter?

The importance of a professional therapeutic relationship, nonsense rhetoric or barebones?

Does this just link back to the situation not meeting our goals, and the emotion linked to this?

But emotion as a response and behaviour, the response of being judgemental.

Presentation of the data.

Signifier - *Lexia* – “it was a really horrible death”.

Analysis of the data.

Denotation - something went wrong.

Connotation - anger a feeling that they have let the patient and relatives down, and also a lack of control from the nurse and the patient.

What is a nice death?

It just seems barbaric, cruel, and brutal, denotes doing harm, but how and why?

Is the patient being harmed?

Is a sense of duty to save the patient overriding the individual?

Barbaric is a strong word and is critical of the actions of others, all this has been seen before, emotion linked to judgement of others, if they have not met our cultural goals.

Presentation of the data.

Signifier -Lexia – “people working away on the patient trying to get access, mop up blood, trying to do CPR but he was already dead”.

Analysis of the data.

Denotation - trying everything to save a patient, despite the futility, and the refusal to give up.

Connotation - frustration why are we putting the patient through this?

It is a waste of time he is already dead. This was not the decision of the nurse but the suggestion that you were not part of the decision.

It does not feel there was the ability or opportunity to question?

The sense of frustration comes from others distress, the failures. why cannot the patient be allowed to die?

The hero/ saviour complex experienced by others, but absent in the nurse, because the patient was not protected, and neither was the nurse.

The hero complex in the nurse is about protecting the patient and themselves, not about making the patient live, emotion and behaviour, compassion manifests by protecting the patient from others who do not have the same cultural goals, because that is seen as having a negative impact.

Presentation of the data.

Signifier - Lexia – “it could have been very different had it been a planned death”.

Analysis of the data.

Denotation – prepared.

Connotation - what could have been different for the patient did they suffer?

Different for you, or different for the other people involved?

Why does it matter had it been a planned death?

I 'Googled' "planned death", it comes up with "assisted suicide". The patient makes the decision, so takes away medical control, nursing control advocates for the patient, involvement of the patient again. Patient autonomy, involved in the decision making. It is the hero complex of protecting the patient, cultural rhetoric with agreed goals.

What is the motivation for the relationship with the patient, are they part of the societal group?

Do they need to understand the rules?

Presentation of the data.

Signifier - *Lexia* – "sad side of nursing, and hard".

Analysis of the data.

Denotation - more than one side of nursing.

Connotation - but what does a side of nursing mean?

Aspect or feature of nursing?

Again, the cultural narrative of defining what or who is a nurse, what are the features of a nurse?

what does it mean to be a nurse or do nursing?

Nursing as a verb rather than a noun, nursing defined by tasks, but this does not define the behaviour of nurses or nursing, linked to compassion, it is the shared suffering, the sad side.

Connotes finding something difficult, but what is difficult why is it found difficult?

Are other aspects of nursing easier?

Why is it sad, is sad linked to finding something hard?

“Happiness is the evaluation that your goals are being satisfied” (Thagard 2010), so is sadness the antithesis to this? But according to Thagard (2010) sadness and happiness are not emotions, they are reactions and not as finely tuned as emotion, so behavioural response again, and the link to goals being met.

Presentation of the data.

Signifier - *Lexia*- “find situation harder now I have kids”.

Analysis of the data.

Denotation - having children impacts on ability to cope with certain situations.

Connotation - the nurturing role of being a mom, dichotomy with the role of the nurse. We have seen this before, the separate roles, but it is still difficult, is it still possible to empathise?

The narrative about empathy, bringing outside experiences, but not because they separated the roles.

Nursing identity what does it mean?

Is it related to interaction with patients or being part of the societal group, with distinguishing marks and features that allows us to recognise each other?

Presentation of the data.

Signifier - Lexia – “shocked by the story, it upsets me that (name) had to witness it”.

Analysis of the data.

Denotation - sorry for another.

Connotation - connection as a cultural group, what affects one affects all but why? What is the connection that nurses have?

If compassion means that suffering together, does that mean other societal group members?

Conscious of others distress but why get upset?

Why does it matter?

Why does it upset you, that another societal group member had to witness a distressing event?

Emphasis of shared language, cultural values and beliefs understanding each other and shared experiences.

Presentation of the data.

Signifier - Lexia – “I always think about the family, the patient might die but I always think about the family.”

Analysis of the data.

Denotation - that a patient is more than an individual, they are part of a family, and this is an important consideration, the holistic approach.

Connotation - consciousness of other, distress, the family are important and need to consider the impact this has on them.

What is the connection with the family?

Why are they important?

They are part of the patient or part of the context; the patient is the context. Is it also because they are part of the societal group?

How will the family react, and will it fit into our cultural, societal expectations?

What do we expect from the family?

Will the behaviour of the family fit into our cultural societal expectations?

Thinking about the family despite the patient dying or during the event connotes an understanding of others and some sort of connection, the nurse being in the world of the family, or the family being in the world of the nurse.

Presentation of the data.

Signifier - *Lexia* – “developed a heightened sense of awareness, of fear and danger going up and down an escalator, walking over a bridge, you see death, dying, disease and illness being a nurse.”

Analysis of the data.

Denotation - the link between ‘danger’ associated with death, dying, disease and illness – that is the working life of the nurse. The link of death and dying to using an escalator and going over a bridge is almost an antithesis, as going over a bridge and using an escalator, could almost be classed as mundane.

Connotation - fear as the emotional spectrum, the experience of reality, use of imagination, try to figure out what we do not know. Danger as a negative but also positive, the heightened sense of awareness linked to a challenging situation, a sense of self-awareness.

A developed sense of paranoia, creativity, conscious reasoning, informed judgement but informed by what?

Relates to the world outside nursing, but is linked to the world inside nursing, which contradicts previous research by Lyneham, Parkinson, and Denholm (2008), which suggested that intuition in personal life is different to intuition in nursing.

Death dying and illness could not be seen as mundane if it heightens the sense of awareness of danger, so how are they all linked?

What is real and reality, actually or physically?

Existing as a fact not an idea, but this is not imaginary heightened sense of awareness, it is not imaginary or paranoia. It is not what we do not know either or is it?

Is it related to unpredictability, fear of not knowing or fear of knowing?

The sense of danger, how is using an escalator the same as death and dying and illness, what is the danger perhaps not the fear of it happening to us but happening to others, the unpredictability (particularly since becoming a mom – we have seen this before)

The loss of control the loss of agency – identity by using the analogy is there a sense of suffering together, aware of others distress, does danger heighten self-awareness or sense of control do we feel that we must act?

Presentation of the data.

Signifier - Lexia – “I did get upset because I felt a big responsibility to the student nurse”.

Analysis of the data.

Denotation - that responsibility causes upset.

Connotation - the understanding of responsibility, but the duty of distress, felt as if someone was let down, is this what causes upset?

Shared experience, feel more important, does this connote a sense of importance?

Influence over other people and their experience.

Answering the questions – the sign value.

Compassion is related to a shared sense of suffering, not just with the patients and relatives but also with each other, there needs to be a sense of belonging and self-awareness because emotion is behavioural rather than a mystical feeling. Although the experience of nursing seems to heighten a sense of danger, emotion is evidenced not by an inner feeling but by the response by the nurse to situations and other people, is related to whether others meet nursing cultural norms, and the goals have are being met.

7. Signified - Knowledge/knowledgeable.

(Information gathered through learning or experience, well informed).

Presentation of the data.

Signifier - Lexia – “newly qualified nurse daunted by acute phase of illness”.

Analysis of the data.

Denotation - lack of experience.

Connotation - daunted – intimidated or overwhelming, not able to cope, not able to look after a patient as well as a nurse who is not newly qualified.

Does not connote lack of knowledge, just a sense of being intimidated or overwhelmed by the notion of an acutely ill patient.

But that is not exclusive to newly qualified, daunted and the novice, newly qualified could indicate novice but novice is not related to lack of knowledge, or longevity of practice.

Intimidation due to perception of self, a sense of agency and control.

Presentation of the data.

Signifier - Lexia – *“I became frightened and nervous, but I had the knowledge and power to treat the patient”.*

Analysis of the data.

Denotation - daunted as above, not linked to lack of knowledge or self-worth, but uncertainty.

Connotation - frightened and nervous is power, frightened, and nervous denotes out of control and unsure about something but this is contradicted by the link with knowledge.

Does having the knowledge cause being frightened and nervous?

Frightened denotes alarmed aware of danger, is this linked to the idea of being classed as an expert, and the fear of being found wanting?

But by whom?

Connotes anxiety for the situation, the patient, but knowledge and power connote a sense of self-worth, control.

What knowledge?

Why is this linked to power?

Is this power over self or others, does knowledge mean power?

Power comes next, because it is linked to treating the patient, is the knowledge of the patient?

But four of the stories related to a patient unknown to the participant, so knowledge of the patient means what?

Is it really knowledge of self, not as an individual, but the shared values of the societal group?

The knowledge not linked to context but to the patient, do nurses “treat” patients?

“Treat” denotes, in this situation, management of disease, but connotes the behaviour towards another in a specified manner (Robinson and Davidson 1999), so what is that behaviour and how does it link to knowledge?

Links to behaviour and actions, knowledge is behaviour.

Presentation of the data.

Signifier - Lexia – “as my adrenaline kicked in, I felt proud of myself, and with this I felt upset with joy”.

Analysis of the data.

Denotation - an emergency that was managed well and triggered a negative and positive response.

Connotation - nursing traits, pride as an emotion, linked to goals being met, or is it a reaction rather than an emotion?

A sense of achievement, but what are nursing goals?

Does “proud of myself” connote arrogance or relief?

Is this linked to knowledge, because being well informed helped to manage the situation?

Well informed about what?

Presentation of the data.

Signifier - *Lexia* – “we were open and honest regards the situation.”

Analysis of the data.

Denotation - knowledge and understanding and being able to communicate, not hiding anything and telling the truth.

This links to NMC and duty of candour (2018), and being the patients advocate, but also means being open and honest, not just with patients, but also other members of staff, and acknowledging limitations.

Connotation - mutual respect, having a good line of communication, “we” connotes a team approach, and this may work both ways. It also connotes being well informed to be able to be open and honest.

Is this the role of the patient/relative, not just a passive role but an active part of the relationship and mutual respect?

Is it therefore important if we don't “know” the patient, probably not, there just needs to be the mutual line of communication, what do they see when they see the uniform?

Knowledge is not just about what do nurses know but being well informed, which is something different, being knowledgeable does not necessarily mean being current or up to date, having a better understanding of the situation. When nurses use the term knowledge, they mean being up to date meaning the patient and their situation, so this is what informs decision making and relies on the Intuitive-Humanist model.

Presentation of the data.

Signifier - Lexia – *“I had never worked on a gastro ward before, so it was a new speciality for me, so as I say I was still learning”.*

Analysis of the data.

Denotation - a new experience, inexperience.

Connotation - a sense of uncertainty, anxiety a new speciality requires different knowledge and learning was ongoing and perhaps infinite. This is someone who has been a nurse for a long time, so longevity does not mean the nurse is an expert necessarily, the novice to expert trajectory is fluid, as uncertainty arises from being in a different environment.

Uncertainty could also arise because, for nurses, knowledge relates to being up to date about the patient and their situation, a ‘new speciality’, the unfamiliar environment, also unfamiliarity with the social context of the ward, is this also knowledge that informs decision making?

May also connote lack of ability, the anxiety arises from the situation, but also acknowledges that nurses cannot always know everything. This contradicts previous assertions that intuition is person centred, but the learning could still relate to the staff and patients rather than the context, the patient and nurse, the individual, as the context, but also the societal context of the clinical placement.

Presentation of the data.

Signifier - Lexia – *“having worked on there for 4 years, after that I think I would have made that decision, or that call a lot sooner”.*

Analysis of the data.

Denotation - longevity of practice leads to more assertive decision making.

Connotation - being in the same environment empowers being the patient advocate, agency develops with confidence, which comes with acceptance and respect, being part of the societal group with shared values, language and goals.

Presentation of the data.

Signifier - Lexia – *“the consultants did not know how to sit, so obviously because you are the nurse looking after that patient, you have to go and sit and have those conversations with the parents.”*

Analysis of the data.

Denotation - responsibility to talk to the parents, the role of the nurse because the doctor lacks competence.

Connotation - taking over, nursing knowledge of knowing not just what to say but also how to say it, the relationship with the patient and the relatives is important and informs the conversation. This is what the nurse has, because they are the ones spending time with the patients, and relatives. The knowledge is also about other staff, but also being up to date with the patient and their family, and the relationship with the family, the impact this has on behaviour and actions.

Presentation of the data.

Signifier - Lexia – *“I think it is because you know how to do it and you are shocked at first because you don’t expect to walk into a situation like that.”*

Analysis of the data.

Denotation - confidence with knowledge but can still be surprised at the unpredictability.

Connotation - unpredictability can impact on knowledge, but there is still an expectation of having the knowledge to manage the situation.

If there is knowledge what is shocking about the situation?

What is unexpected?

This comes down to unexpected, as in not culturally acceptable, it does not meet nursing goals.

Presentation of the data.

Signifier - Lexia – *“but still you are wet behind the ears, you still don’t have that exposure that nurses who have been in the job ten or twenty years have got.”*

Analysis of the data.

Denotation - longevity and experience mean knowledge.

Connotation - inexperience in judgement, lack of confidence the consideration that nurses with longevity of practice means that there is exposure to certain situations. This leads to increased confidence in judgement, but what is the knowledge that informs these decisions?

What knowledge is gained through experience and longevity?

The knowledge of self as a nurse, confidence in own judgement or understanding the rules.

Presentation of the data.

Signifier - Lexia – *“as far as I am concerned erm, I don’t think whether it was a junior nurse or a senior nurse, that I think the outcome would still have been the same.”*

Analysis of the data.

Denotation - experience does not impact on the outcome of the situation.

Connotation - antithesis to previous lexia, it is not the longevity of practice or experience that impacts on the outcome of the situation, the outcome is influenced by the nurse as an individual, and their sense of agency.

Answering the questions – the sign value.

The concept of novice is not related to a lack of knowledge but to a lack of self-worth, knowledge is related not to what is known, but shared values and behaviour. Being overwhelmed and a lack of self-worth relates to not understanding these, being part of the cultural group. Knowledge also comes from being informed, mostly about patients and self but also about the shortcomings of others, if they do not meet cultural expectations.

Decision making is not linked directly to knowledge as this seems to be expected and assumed but relates to the individual’s confidence in their own judgement and the sense of agency to communicate this.

8. Signified – power.

(Control and influences exercised over others, skills, opportunity, or authority to do something).

Presentation of the data.

Signifier - Lexia – *“they came through the doors, I was half scrubbed and still nobody had said to me that he was coming, I had just got as much as I could ready because I was listening ear holing”.*

Analysis of the data.

Denotation - preparation, listening but not being told.

Connotation - control of self, the power to have control over self but not over importance of self by others, individual not important because it was not deemed necessary to tell them what was going on. Lack of power, lack of importance but the authority over self to get things ready, which suggests power over the situation, afforded by own sense of agency and autonomy.

Presentation of the data.

Signifier - Lexia – *“because I saved him, and if I hadn’t listened, I felt I was responsible for the whole, not me on my own, but I managed”.*

Analysis of the data.

Denotation - power over life and death, but sense that may have missed something.

Connotation - power to save lives, but what was your role?

The role is to listen but to what?

What gives you the power to manage and for what were you responsible? “not me on my own” is an afterthought, trying to claim the hero stance.

What was managed?

What does it mean?

Suggestive of overall control, so the power of the nurse is to control the “whole”, but what does that mean?

What is the role of the nurse outside of the hero?

The power to protect the patient, but also a sense of protecting self. The opportunity afforded to self because others did not afford that opportunity, lack of respect.

Not part of the societal group, alternatively opportunity afforded because of expectations of others.

Presentation of the data.

Signifier - *Lexia* – “everyone looked to me as the senior nurse on shift, to manage the situation”.

Analysis of the data.

Denotation - the power to control, respect as a senior nurse, the role of the senior nurse is to have power.

Connotation - the sense of responsibility, the expectation of power to manage, not just self-expectation, what defines a senior nurse?

Is it attitude, self-agency gives autonomy, authority and power?

The respect afforded by others, perception of self as a ‘senior nurse’, does this provide authority and power, given by self or others.

Who is 'everyone'?

Was there an expectation of the patient or relatives?

The expectation of power or the opportunity for power, the authority to take control? The use of nursing language and cultural values, the self-expectation of being able to cope and be in control, transferred on to 'everyone'. Presentation as a senior nurse, projection of authority and autonomy, behaviour and actions.

Presentation of the data.

Signifier - Lexia – *"I remember feeling that I had managed it well and I could control the situation, but the patient died."*

Analysis of the data.

Denotation - negativity of the patient dying despite control and power, negativity overrides positivity, the role of the senior nurse is to have power.

Connotation - patient dying is a failure, so despite control and power not able to have power over life and death, but still the hero complex. Sense of failure, letting someone down, evidence of reflection and again a sense of agency.

The positivity of the hero complex, but what are they trying to achieve?

Linked to agency, sense of worth.

"I had managed it well and I could control the situation" connotes a feeling of self-expectation, not related to others but to self, manage and control related to self, power over own autonomy and opportunity to take control.

Presentation of the data.

Signifier - Lexia – *“and it just seemed that I controlled the staff, and I controlled the emergency on the ward, and we had done everything that we were meant to be doing, and that was all fine”.*

Analysis of the data.

Denotation - overall control and power, managed the situation and the people involved, the nurse as leader.

Connotation - working as a team, changing of “I” too “we” so “I” dominates “we,” “I” has power over “we”. The power to control, to affect people and the environment, strong sense of self-worth, but only part of the staff when doing, on your own when controlling, authority and power come from the individual, with a strong sense of agency.

“Everything we were meant to be doing” connotes the power to influence other to meet cultural goals, “that was all fine” connotes they were being met, the opportunity to share values.

Presentation of the data.

Signifier - Lexia – *“I think it is because you know how to do it, and you are shocked at first, because you don’t expect to walk into a situation like that.”*

Analysis of the data.

Denotation – unexpected.

Connotation - loss of power, unexpected situation, shock connotes an emotional response, a sense of outrage perhaps because it should not have happened.

The sense of why has this happened.

Should have been in control, loss of power.

What does “a situation’ relate to?

There is clear emphasis on the ability of the nurse, but does shock arise from others not having the ability and the nurse not having the power to change that?

Does unpredictability mean a loss of power?

If the nurse knows how to do it, then there should be an opportunity to exercise power?

Presentation of the data.

Signifier - Lexia – *“I felt a big responsibility to the student nurse, and also to the son.”*

Analysis of the data.

Denotation - responsibility linked to being in charge, having control over others seemingly outside of the main team.

Connotation - consideration of direct and indirect impact on others, outside the lifesaving, sense of sorrow, sympathy linked to power, but power exerted over self. Authority over self and others, power over emotions, own and others.

Student nurse and son suggests lower status, is that why there is a sense of power? Big responsibility, more than normal responsibility, but what does that mean?

More than control, a higher power.

Presentation of the data.

Signifier - Lexia – *“I had been a nurse for a long time, and I had managed other areas, I hadn’t been on this ward long, I had gone to a ward that was in special measures, the team was really struggling”.*

Analysis of the data.

Denotation - power to take control, sense of authority despite lack of longevity.

Connotation - also the hero complex, going in to save the day, but on a different scale to saving an individual patient's life, much wider sense of power, strong sense of agency linked to longevity, expertise through experience but not situation related.

Answering the questions – the sign value.

There is a strong sense of agency and self-worth, power over emotions, own and others and a confidence to have power and control, although the reflection was negative if the patient died. There was not the sense of not being able to do anything, or having autonomy or authority, not context related due to personal agency and being part of the societal group, whether it be in the context of nursing or the context of the clinical placement area. This offers protection, but not always being part of the wider team impacts on autonomy and authority, but that does not seem to matter because the nurse has power over self and a sense of agency.

9. Signified - Ill equipped.

(not having the necessary resources or qualities for a particular role or task.)

Presentation of the data.

Signifier - Lexia – “I felt the team was maybe ill equipped to deal with the cardiac arrest.

Analysis of the data.

Denotation- personal opinion”.

Connotation - sense of frustration, ill equipped in the sense of knowledge rather than lack of equipment, but that does not apply to the nurse who has the knowledge to make the judgement about everyone else, the sense of self-worth.

Ill equipped could also relate to qualities, what was the role of the other members in the team, did the reliance on Hypothetico-Deductive reasoning, and machines to inform decision making in relation to the management of the cardiac arrest, mean that “the team” did not have the necessary qualities?

The nurse did not consider themselves to be part of “the team” because of a lack of shared values.

Presentation of the data.

Signifier - Lexia – *“I was the assistant at the table in the only theatre that was working, I had only got some students, which was all we had got, just me and some students”.*

Analysis of the data.

Denotation - limited resources.

Connotation - managed with limited resources, sense of isolation, ill equipped in the sense of having control, but having control of the situation and others. Ill equipped in the sense of lack of support, non-recognition of the nurse as important, but antithesis if left to run theatre with just some students.

Presentation of the data.

Signifier - Lexia – *“I think a lot of health care workers want to save people from dying, nobody wants patients to die, but death is a part of life.”*

Analysis of the data.

Denotation - reality check.

Connotation - the hero complex, death seen as failure, who are the “health care workers”?

Does this include the nurse?

Almost as if not part of this, it is somebody else, judgement and blame, ill equipped as the hero complex related to whether patients live, not accepting that they die.

Is the judgement related to the nurses’ use of the Intuitive-humanist model of decision-making, and consideration of the person-centred approach?

Presentation of the data.

Signifier - *Lexia* – “it is more that you are isolated, and I have worked on community wards where we had to phone 999 if anything happened, and you had to cope on your own, with what went on, not having doctors on site”.

Analysis of the data.

Denotation – isolation.

Connotation - cope on your own more than isolation, but a sense of not being part of a team which made it worse, but were doctors’ part of the team?

Being ill equipped means lack of staff and support, so support is important even from doctors, although they are included separately so not part of the Societal group. Nurses value the Intuitive-Humanist model because of the humanist approach but having to rely on this alone could give a sense of isolation, the Hypothetico-deductive reasoning of the medical model, used by medical staff may mitigate against isolation and vulnerability.

Presentation of the data.

Signifier - Lexia – *“I had been a nurse for a long time, and I had managed other areas, I hadn’t been on this ward long, I had gone to a ward that was in special measures, the team was really struggling”.*

Analysis of the data.

Denotation - saving the day.

Connotation - confidence, sense of agency antithesis to ill equipped from the individual but the team was obviously ill equipped if struggling.

How is ill equipped mitigated against being a nurse for a long time?

Ill equipped is situational and not specific to the nurse as an individual, there is a sense that the nurse is not ill equipped to manage the situation, being a nurse for a long time contributes to this.

Presentation of the data.

Signifier - Lexia – *“I don’t think the advanced life support offered was the best quality, I really don’t at all, I can remember staff, particular staff members on the day.”*

Analysis of the data.

Denotation- poor care.

Connotation - opinion on the abilities of others, judgemental perhaps lacking equipment but more related to knowledge on how to use it.

Elevated role of the nurse, outside the situation, not involved, not my fault, absolving blame but what was your role?

Patients advocate if the team was ill equipped what did you do?

Presentation of the data.

Signifier - Lexia – “it sticks in my head because I just lacked my own confidence at the time, I felt I was not good enough, and not capable of dealing with things.”

Analysis of the data.

Denotation – failure, self-deprecation.

Connotation - ability to reflect feeling of failure, being judged by self and others but what were you measured by? This would not be just your own standards, but those of others. Not good enough for what? Dealing with what? Enigma – was this lack of experience or knowledge or was it being able to understand the rules of the game, being part of the societal group?

Answering the questions – the sign value.

Judgement and blame, others not good enough and do not meet the standards of the nurse, something gave the candidates the right to judge others, is it because they are not in the societal group? But they are also good at judging themselves, there is an antithesis with the sense of lack of confidence, the enigma here is what was done about the failings of others? Whilst there is judgement of others for not having expected qualities, potentially through the use of Hypothetico-Deductive reasoning, there is also a perception of vulnerability and isolation through the use of the Intuitive-Humanist model of decision making, potentially use of either leaves nurses ill-equipped.

10. Signified– Responsibility.

(The state or fact of having a duty to deal with something or of having control over someone. The opportunity or ability to act independently and take decisions without authorization).

Presentation of the data.

Signifier - Lexia – *“I also felt responsibility for the student nurse as she had raised the alarm and needed to be debriefed from the situation”.*

Analysis of the data.

Denotation - accountability and justifying actions.

Connotation - failing because left the student to raise the alarm, sense of guilt for what was done wrong, but responsibility to put it right.

Why did you feel the need to take the blame for leaving the student and then rectify the situation through taking the blame?

Does taking the blame give a sense of responsibility?

Presentation of the data.

Signifier - Lexia – *“we would support the family, to explain, the consultants did not know how to sit, so obviously because you are the nurse looking after that patient, you have to go and sit and have those conversations with the parents.”*

Analysis of the data.

Denotation - importance of the nurse, responsibility to others.

Connotation - taking responsibility due the failings of medical staff, the moral obligation, does being the nurse looking after the patient engender trust which increases the moral obligation and therefore the responsibility?

Apologising for others is there a sense of blame of others and self?

Relationship with parents and patient, being in their world but more the parents and patient are in the world of the nurse, spending time together, shared cultural values and beliefs, shared language.

The language of the patient and the parents, is this why the medical staff struggles, because they are not part of that societal group?

Presentation of the data.

Signifier - Lexia – *“I stayed on his looking after him erm finished the shift, and then the next day they asked me to go back being his named nurse, because of the relationship I had built up with the parents.”*

Analysis of the data.

Denotation – obligation.

Connotation - moral conduct, the hero staying after the shift what sense of responsibility did you have?

Was there trust in others?

The moral obligation to the parents, sense of guilt?

But again, part of the societal group, shared values, language, and goals, not acting independently but independent of others outside the group.

Presentation of the data.

Signifier - Lexia – *“they came through the doors, I was half scrubbed and still nobody had said to me that he was coming, I had just got as much as I could ready because I was listening, ear holing.”*

Analysis of the data.

Denotation – preparedness, forward planning.

Connotation - sense of blame of others, not able to control others actions- antitheses to responsibility.

Responsibility to prepare and be aware, moral obligation to be ahead of the game because if you were not ready, what would have happened?

Responsibility linked to self-importance. The opportunity to act independently without authorisation, ultimate responsibility, but for what, and to what?

Connotes a sense of self-importance, only you are in control, linked to behaviour and action, responsibility linked to behaviour, and self-importance as positive behaviour because of the act of being prepared.

Presentation of the data.

Signifier - Lexia – *“thinking back now I did get upset because I felt a big responsibility to the student nurse, and also to the son, he was only in his 40s”*.

Analysis of the data.

Denotation – duty of care.

Connotation – upset as an emotion or reaction, expressed in behaviour, feeling obligated to support the student nurse and the son, responsibility can mean acting without authorisation.

There is a sense of independence in clinical judgement but does the “responsibility” also relate to involvement of the student nurse and the son, if so responsibility is a shared duty?

Answering the questions – the *sign* value.

Nurses have a strong sense of what they deem to be responsibility, but this also seems to be linked to the blame culture, and nurses blaming themselves for circumstances outside of their control, and within their control. Societal context may have a significant impact on a sense of responsibility particularly the societal group of the nurse, patient and relatives.

There are shared cultural values, as the patient and nurse share worlds, neither of which is dominant, which increases the nurse's sense of duty as well as potentially the patients and relatives.

Chapter 5 - A summary and dissemination of the findings, including a comparison of the Diachronic and the Synchronic data,

5.1. Identification of themes for the summary of the findings.

As previously discussed in the literature review, reflexivity refers to the constant activity of “self-reflection” by the researcher, to make explicit their thoughts, reasoning, and insights (Anderson, 2008; Hughes, 2014) in Darawsheh (2014), acknowledging preconceptions and biases (Polit and Beck, 2012).

Through reflexivity, I needed to consider my motivation for identifying themes, and pre-empt any expectations and assumptions of the findings (Finlay, 1998; Lambert *et al.* 2010) in Darawsheh (2014), to address the potential for preconceptions and biases, which may influence the process (Darawsheh, 2014), to ensure I was presenting themes that emerged from the data, not what I thought I should find.

To quality assure the appropriateness of the identified themes I read and re read the presentation of the findings (Aveyard, 2023), I identified several recurrent salient themes that emerged, but in order to give the lexias a ‘voice’, and ensure that I had addressed the aim of my research (Aveyard, 2023), I narrowed these down to four themes, based on the frequency of their occurrence, under each of the *Signifieds*. There is no hierarchy of importance for any of the themes, I have opted for a pragmatic presentation, in what I believe to be a relevant order, in the sense they emerged from the data.

5.1.1 - Theme one - what knowledge means to nursing and the impact this has on decision making.

Nursing knowledge, according to the diachronic evidence of the literature review, is firmly linked to intuition, as the patterns of knowing by Carper (1978), linked to the Intuitive-Humanist model of decision making, which now has a higher status than evidence-based practice (Thorne, 2020). The interrogation of the text in the data analysis, the synchronic evidence, suggests however that none of this is relevant, because decision making is not linked directly to knowledge, as this seems to be expected and assumed. But relates to the individual's confidence in their own judgement, and the sense of agency to communicate this. Whilst the diachronic evidence, emphasises the importance of defining nursing knowledge, to afford nursing professional status, Luntley (2010), argues that nurses do not need to be able to articulate what they know, or how it impacts on practice, but to be able to justify behaviour. The synchronic evidence did not yield any insight into what nursing knowledge is, because it was an expected attribute of a nurse.

As suggested in the diachronic evidence, nurses have an insider knowledge which is not obvious to outsiders (Benner and Tanner, 1987). The synchronic evidence supports the concept of specific nursing knowledge, that only nurses know, which comes from shared values and behaviour. Being able to define nursing knowledge therefore becomes unnecessary, and possibly unachievable, because it is locked in the culture, and is relevant if nursing understands it. Thorne (2020) argues that nursing is distinguished by a robust and lasting set of staple principles, the shared values of a cultural group, which the synchronic evidence suggests offers a layer of protection. The power related to knowledge comes from the cultural understanding, if nursing understands it, there should be no need to define it, so intuition ceases to become relevant.

The diachronic evidence suggests that a discernible knowledge base will offer nursing an identity, and potentially a sense of self-worth (Hall 2005, Hoeve, Jansen, and Roodbol, 2013). The synchronic evidence suggest however that knowledge is related not to what is known, but shared values and behaviour, being overwhelmed and a lack of self-worth relates to not understanding these, being part of the cultural group. Interrogation of the data did not suggest a lack of self-worth, but a strong sense of agency and being in control.

There was not the sense of not being able to do anything, or having autonomy or authority, not context related, but due to personal agency and being part of the societal group, whether it be in the context of nursing or the context of the clinical placement area.

The diachronic evidence emphasises the importance of context in relation to decision making and the use of intuition. But there is limited agreement on what context means, in this context, despite the narrative that has enveloped it (Cash, 1995), and the significance it has been given through the work of Benner (1984) and Dreyfus (2004). The synchronic evidence suggests that context relates to personal agency, and being part of the societal group, whether it be in the context of nursing or the context of the clinical placement area.

The synchronic evidence suggests that the environment can impact on self-worth, nurses feel comfortable in a familiar environment, but feel doubtful of their skill and ability, if in a strange environment. This is supported by the diachronic evidence, which suggests that pressures of work, and a potential blame culture, could undermine decision making (McCutcheon and Pincombe, 2001, Lyneham, Parkinson, and Denholm, 2008).

The synchronic evidence suggests that nursing knowledge does not relate to evidence-based practice, as suggested in the diachronic evidence (English, 1993; Paley, 2006). Nursing knowledge is tied up with being up to date about the patient, the relationship between the patient and the nurse is included in sections two and three.

5.1.2. - Theme two - nursing feeling vulnerable and isolated, and the link between the two.

Vulnerability is a key concept in nursing (Morse, 1997, in Angel and Vatne, 2017), and is often only significant, when a person has an illness, which requires nursing intervention (Angel and Vatne, 2016). As stated in the diachronic evidence of the literature review, the term vulnerability is usually applied to patients and their susceptibility to harm, but there is little recognition of the vulnerability of nurses (Heaslip and Board, 2012). Daniel (1998) in Angel and Vatne (2017), states however that nurses must be aware of their own vulnerability and be willing to enter a shared relationship. The synchronic evidence, from interrogation of the text in the data analysis, suggests that nurses and patients are connected by shared goals and values, which strengthens the relationship, but this potentially leaves everyone feeling vulnerable, although this does not impact on the connection between the nurse and the patient.

The diachronic evidence states that vulnerability arises due to lack of status, feeling stupid, and difficulty escalating concerns (Benner and Tanner, 1987, McCutcheon and Pincombe 2001, Dalton *et al* 2018), the synchronic evidence further explores this but dismisses some of the previous theories. There is no fear of lack of status, but loss of agency and being 'lost in the crowd', there is no sense of vulnerability in facing new situations, but an absence of shared values, non-recognition of the cultural norms, and the communication strategy used by nursing.

The diachronic evidence states that nurses fear getting it wrong, a feeling of being vague leads to the sense of being "backed into a corner", feeling the pressure to back down, and not be assertive (Benner and Tanner, 1987, McCutcheon and Pincombe, 2001, Dalton *et al* 2018). The synchronic evidence suggest however that anxiety arises from being 'lost in the

crowd', and the perception of self and others in the crowd, with potential loss of control and identity.

Further evidence from the synchronic data suggests being overwhelmed and a lack of self-worth relates to not being part of the cultural group. Nurses see themselves as the support which is individual to them; the hero, the saviour, call to action, driven by the need to be in control, with an idea of autonomy. But there is a sense of isolation, related to cultural language and the link to the social context, with identification of vulnerability related to this.

Goodman (2004), in the diachronic evidence, suggests that decision making, autonomy, and interdisciplinary working all occur in a social context, this indicates therefore, that the status of the nurse in a social group determines how and what decisions are made. The synchronic evidence suggests an awareness of nurses being outsiders, not being one of the "others" in the situation, with a focus on the humanist element of clinical judgement which informs actions and behaviours, and potentially makes them different, or that is the way they perceive this.

The synchronic evidence proposes there is also a feeling of isolation, not having support, which is potentially linked to language, and the societal context. Whilst nurses in specialist clinical areas have an 'elitist' language, there is also a language, common to all nurses, which delivers meaning and understanding for patient care delivery (Allen *et al* 2007). knowledge is locked into the culture of a societal group, as evidenced in the synchronic data, so language is locked into the culture of a societal group, however, the synchronic evidence suggests, that isolation occurs through not being part of a societal group, whether the group be nursing, or a collective of staff, involved in managing an acutely ill patient.

In the instances of being part of a cultural group, outside of nursing, rather than, as the diachronic evidence suggests, nurses need to act discreetly because of being scared of

getting it wrong (Benner and Tanner, 1987; McCutcheon and Pincombe 2001, Dalton *et al* 2018), the synchronic evidence suggests that nurses have a strong sense of agency and salience. Nurses are very good at judging themselves, but also others, particularly if they do not meet the cultural expectations, of nursing as a societal group. Whilst there is judgement of others for not having expected values, potentially using Hypothetico-Deductive reasoning, there is also a perception of vulnerability and isolation, using the Intuitive-Humanist model of decision making, possibly identification of the use of either, leaves nurses isolated and vulnerable.

The synchronic evidence questions nursing as a brand, and the viability of defining nursing by what is done, rather than who they are. There is synchronic evidence to suggest, that nursing as a group, has a sense of control not linked to expert or intuition, but a sense of self-worth, linked to a sense of belonging, being in the societal group. The cultural identity acts as a force field, the use of humour, cultural language, and a sense of professional agency, ensures that cultural and values and beliefs are adhered to, and we are all protected, like Penguins in a huddle.

Whilst there is little consideration of the existence of societal vulnerability, and the impact this has on the nurse and decision making (Angel and Vatne 2017), the sense of vulnerability experienced by nursing is usually related to the patient-nurse relationship (Heaslip and Board, 2012; Angel and Vatne, 2017). The synchronic evidence supports this assertion, support for family and relatives is important, and the need to support them, linked to emotion, what emotion means is explored in the next section.

5.1.3 - Theme 3. - emotion is associated with intuition, the manifestation of emotion and its meaning to nursing.

Whilst the use of the Intuitive-Humanist model of decision making, may leave nurses feeling isolated and vulnerable, the humanist element is significant, as emphasised by Benner (1984) and Benner and Tanner (1987) in the diachronic evidence of the literature review. There is much written about the importance of the patient -nurse relationship (Cappelletti, 2014; Adams, 2016; Cusso, Fernandez-Garcia and Porcel-Garcia, 2022), but little follow up on how the relationship manifests, and what impact this has on nurses' clinical judgement and decision making. The synchronic evidence suggests that there are shared cultural values, as the patient and nurse share worlds, neither of which is dominant, which increases the nurses' sense of duty, as well as potentially the patients and relatives. As previously discussed, context relates to a societal group, the synchronic evidence suggests that societal context may have a significant impact on a sense of responsibility, particularly the societal group of the nurse, patient and relatives. In the diachronic evidence Benner and Tanner (1987) suggest that, to support decision making, nurses become part of the patient's world, the synchronic evidence however, shares the onus between the patient, and the nurse. There is a mutual appreciation of cultural values and language, as the patient and nurse share worlds, neither of which is dominant, which increases the nurses' sense of duty, as well as potentially the patients and relatives.

As suggested by the diachronic evidence, time spent with the patient enhances the relationship (McCutcheon and Pincombe, 2001), through getting to know the individual and the relatives (Dalton *et al* 2018). Interrogation of the data in the synchronic evidence, contradicts this however, whilst there was evidence of patient nurse relationships, there was no indication that any considerable time had been spent with the patient or relatives.

The diachronic evidence states, to detect to deterioration in a patient does require an appreciation of a holistic approach to care (Pretz and Folse, 2011), with emotion frequently quoted as a significant factor when detecting deterioration in a patient (Dalton *et al* 2018). To have a physical appreciation of the patient's condition and what is normal for the individual (King and Clark, 2002) along with an emotional connection, is fundamental to decision making (Lyneham Parkinson and Denholm, 2008). The synchronic evidence suggests that, although the experience of nursing seems to heighten a sense of danger, emotion is evidenced not by an inner feeling, but by nursing's response to situations and other people. To describe emotion in nursing practice, means moving away from undefinable intuition, to explore the link with behaviour and action. Emotion in nursing practice is physical, nursing needs to be defined by behaviour and actions, which is tangible evidence, rather than intuition, because this questions the legitimacy of nursing due to its mystical quality.

As nursing needs to be defined by behaviour and action, the question arises how much of this behaviour, particularly in relation to decision making, is determined by an individual, or by policies and protocols, this will be discussed in the following section.

5.1.4 - Theme four - Patients or protocols?

As stated, in the diachronic evidence of the literature review, care is becoming more mechanized, and the role of the nurse reformed as a tick box, colour coded set of competences (Randall and McKeown, 2013), often to strive for "quality improvement" (Monteiro, 2016). it could be argued that nursing faces an ontological and epistemological transition, as the 'reality' becomes the machine, and the knowledge for care is derived from this, meaning that the machine becomes the focus for care, rather than the patient (Pepito and Locsin, 2019). Interrogation of the text for the data analysis, the synchronic evidence,

questions this assertion, there is no mention of machines, vital signs or any objectivity in the assessment and treatment of the patients, who were all acutely ill, the narrative is emotive, and person centred.

The diachronic evidence states that nursing relies on policies for decision making, particularly novices, who are not fluent in intuitive thought (Traynor, Boland and Buus, 2010; Brier *et al* 2014), although there are also claims that the expert is a gatherer and Master of Policies and procedures (Klein, 2017). The synchronic evidence suggests that nurses understand policies and their benefits and use, but moral obligation to the patient, and a personal sense of autonomy, outweigh the risks of not using policies, which are mainly seen, as legally protecting nursing, from harm.

What constitutes an expert is not explained, as suggested in the diachronic evidence, neither is the claim by Benner (1984), that not all nurses who have worked in a clinical area for more than five years, will become experts (English, 1993). If intuition is also context specific, as claimed by Benner and Tanner (1987) and Thompson and Dowding (2001), then experience and subsequent 'expertise' may not be transferrable skills, suggesting that the 'heady heights' of 'expert' may not be achievable or permanent.

The synchronic evidence disputes any claim to the concept of expert or novice, nurses do not recognise being assigned to a criterion, but manage each situation on an individual basis. Being a nurse for a long time does not mean that nurses do not question themselves, or others, there is just an initial uncertainty, which applies to all, but no claim of being an expert, despite longevity of practice. The synchronic evidence highlights that, uncertainty is not related to novice, expert, or anything in between, but to a sense of belonging in a societal group, with shared values, culture, and language. Social context, not the exclusive

right of what is deemed an expert, because we are all experts if we understand the language of the societal group.

Duty is linked to autonomy rather than protocols, morality, and obligation to the patient and to self but self as a 'nurse'. Harm seems to come not from challenging conventional policies and procedures, but from our own morality, the duty we have to the patient, relatives, and ourselves.

Table one is a summary of what is already known and what is not known, my contribution to knowledge.

Table one. A summary of this section to include what is known, and how the findings from this study can contribute to knowledge.

What is already known	What this study adds/My contribution to knowledge
<p>There is an identified struggle and need to contextualise nursing knowledge, which is linked to intuition, in an attempt to rationalise decision making in nursing practice. Nursing knowledge is specific to nursing, only nurses know what nurses know.</p>	<p>Decision making in nursing practice is not related to knowledge, because this is expected and assumed, but relates to the individual's confidence in their own judgement, so nursing does not need to convey what it knows but be able to justify its actions and behaviour.</p> <p>Nursing knowledge is tied in with culture and being part of a societal group, with shared values and behaviour, defining nursing knowledge is therefore possibly unachievable, as it is locked in the nursing culture.</p>
<p>Nurses tend to act covertly, particularly when responding to an acutely ill patient, for fear of "getting it wrong," with a lack of a sense of agency and autonomy. There is a sense of feeling isolated, caught in the knowledge and language that is specific to nursing, particularly when using the Intuitive-Humanist model of decision making.</p>	<p>Throughout the diachronic evidence, there is very little consideration of the existence of societal vulnerability, a sense of belonging to a societal group which is empowering and offers a layer of protection. However, there is a perceived threat from others, without the shared values and behaviour, but also a judgement by nursing of others, who are not in the societal group.</p> <p>This is particularly important as language, knowledge, and values are tied up within the societal group, and are only known to those who belong, offering a sense of agency and autonomy, if those conditions exist.</p>
<p>There is much documented about the importance of person-centred care and the importance of the nurse-patient relationship, which is highly valued by nursing and is part of their professional conduct. The nurse in the relationship is dominant with the role of nursing seen as helping the patient to manage their ill health issues.</p>	<p>Despite the emphasis on person centred care, much of the evidence discussed the nurse – patient relationship, suggesting the importance of the nurse is paramount.</p> <p>I have decided to put the patient at the forefront to identify the patient – nurse relationship, however this is a shared relationship, with the patient and the nurse connected through shared goals and values.</p>

<p>Time spent with the patient is significant, in facilitating the relationship, and the nurse in understanding the patient, and being able to recognise deterioration in their condition.</p>	<p>Time spent with the patient is beneficial but is not the overriding factor in recognising deterioration or acting on concerns about the patient's condition. None of the participants in my study had spent any significant time with the patient(s), but this did not impact on their response to the situation, connection with the patient and the relatives.</p>
<p>Intuition is an undefinable feeling that the condition of the patient is deteriorating, and is linked to emotion which is related to personal feelings and is also undefined outside of a "feeling".</p>	<p>Emotion in nursing practice is not defined by feelings but a physical response to the deterioration of the patient, Intuition should not be the entity that defines nursing knowledge but instead the behaviour and actions taken by the nurse in response to patient deterioration is what should define nursing knowledge and nursing practice.</p>
<p>Nursing faces an ontological and epistemological challenge with the predominance of the NEWS, and nursing observations and care now focussed on machines rather than the patient. Nursing relies heavily on policies and protocols, such as the NEWS, to guide practice, particularly to avoid litigation issues, the "expert" nurse has been in clinical practice for more than five years, and is the Master of Policies and procedures.</p>	<p>Nurses do not recognise being assigned to any criterion such as "novice" or "expert" but manage situations on an individual basis. Longevity of practice does not mean that nurses do not question themselves, or display uncertainty, but this is related predominately to being part of a societal group, with shared language and values. Duty is linked to autonomy rather than protocols, morality, the sense of responsibility nurses have to the patient and themselves.</p>

5.2 Implications for professional practice.

The professional group for whom this work is intended is Nursing, particularly Registered Nurses, but also, entering a new era, Registered Nursing Associates, to help with an understanding of who they are, and what they do. The findings from this study may also be useful to doctors and AHPs, to promote and support team working across professions.

The implications of the summary of findings are that nursing knowledge is difficult to define, due to the cultural understanding of what nursing knows, and the language used, which is my first contribution to knowledge, and a potential for future research

Intuition in nursing practice should no longer be considered an undefinable entity that is linked to expertise, instead decision making in nursing practice should be defined by actions and reactions, to the interaction with the patients, and other health care professionals, with recognition of professional and cultural identity, for nurses as individuals and nursing as a group.

Nurses as individuals have a strong sense of autonomy and agency, and what motivates nursing staff is being able to carry out the nursing care to the highest standard (Royal College of Nursing, 2020), there is no evidence as to how this transfers to nursing as a group, and the capacity to be autonomous as a professional group, outside of the Nursing and Midwifery Council regulations.

5.2.1 - Based upon the analysis of the findings from this study, I make 4 recommendations:

1 – Further research to explore societal context in nursing, and the behaviour and actions taken by nurses in response to patient deterioration.

As knowledge is tied up in behaviour and language, exploration of these may provide a deeper insight into what nurses know and do, this may better inform nursing and offer a stronger sense of identity as a profession.

2 – Nursing to work with the Royal College of Physicians to review the current National Early Warning Score (NEWS).

This study has its roots in recognition and response to patient deterioration, which is what the NEWS is designed to support, the current NEWS is measurement driven with reliance on vital signs to detect deterioration. The sense of autonomy valued by nurses is potentially undermined by the objectivity of the NEWS and the current lack of nursing input. The findings from this study suggests, that the NEWS conflicts with patient focussed approach that is the shared value of nursing, this needs to be included in the NEWS scoring system, to make it meaningful to nursing.

5 – Consider the impact of increasing reliance on technology in nursing practice

Whilst nursing practice is becoming more technology focussed, with computer systems to plan and manage patient care, is there a risk of nursing losing its caring ontology, and person-centred approach, has the computer become the patient? Is nursing at risk of losing a sense of job satisfaction, if, as the data in this study suggests, nursing identity comes from behaviour and interaction with the patient, relatives, and other members of staff. The reliance of nursing on technology to inform actions and behaviour, and the impact of this on job satisfaction is worthy of further investigation.

4 – Nursing research to enter a new era.

The findings from the study suggest that using a philosophical approach to a theoretical framework for research, rather than a process driven approach, means being able to examine what is already 'known', from a different perspective. A strong theoretical base may also give more credibility to nursing research.

Chapter six - Discussion

The purpose of this chapter is to present an overview and evaluation of the research process for my study, and to present a discussion around the findings with the introduction of further supporting evidence.

6.1. A review of the research process.

The aim of my research was to question intuition, and analyse factors which influence Registered Nurses decision making, when recognising and responding to an acutely ill patient. The data was collected using ten words and storytelling of a situation involving an acutely ill patient. The participants were experienced registered nurses, who all knew each other as they were all on the same programme of study together, a transcript of the data collected is in appendix four.

The data was analysed using the theory of Roland Barthes (2009) identifying myth and deeper meanings, using a second order *Semiology*. In the second order *Semiology* the ten words of the participants were summarised to become the *Signifieds*, and the stories were broken down into Lexias to become the *Signifiers*. The Lexias were interrogated using Socratic questioning, the answers were presented at the end of each *Signified* as the *Sign* value. From this I identified recurrent themes, to summarise the findings.

6.2. An evaluation of the research process.

The first challenge for this study was the recruitment of participants, a purposive sample was needed, but I also needed to use a convenience sample due to lack of initial response. The positive aspect of this was the enthusiasm the participants had for the process, the evidence of reflection by the participants following the data collection and the contribution being a participant had made to their MSc studies.

The use of storytelling was appropriate to capture important information, which may have been lost through more formal interviewing. This was helped through the natural focus group approach, as the participants knew each other, were supportive of each other, and were comfortable sharing thoughts and feelings, which created rich data. The use of the 10 words to start with followed by a paragraph and then the stories was beneficial, not just because it gave the participants a beginning, but also because of the significance of the 10 words in the Semiological tables, without those, 50 words overall, created by the participants, I would have struggled with this element, and I would advocate this approach, in any future studies.

Adopting a post structuralist methodology was challenging, the work of Ferdinand de Saussure and Roland Barthes facilitated adopting a reasonably structured approach, but for this thesis. I have been pragmatic in my approach to interpreting their work, opting to identify solely the Denotation and Connotation in the data analysis, rather than the five narrative codes as selected by Barthes (1991), which the Denotation and Connotation are part of. This was a less complicated approach, still offered an in-depth exploration of the data, but also potentially would present the reader with data that was easier to relate to.

I chose to use the linguistic theory of de Saussure because this was a good starting point and related to the early structuralist theories of Barthes. Progression to Barthes post structuralist theories however, with inclusion of the first and second order semiological tables, better enabled an exploration into a deeper meaning of the text. These tables have been included in the appendices of the thesis, to evidence the process taken, and to present an audit trail of the research approach. Whilst breaking down the evidence from the data collection was time consuming necessitating several attempts at the first order Semiology, it was fundamental to ensuring that the rest of the process, and the second order Semiology reflected the narrative of participants but also could be converted to *Myth*.

Implementing Barthes concept of a second order Semiology was important, in enabling an exploration of a deeper meaning, being able to interrogate the text, using Socratic questioning, offering a new insight into intuition and the rhetoric that surrounds it.

6.3. Discussion

Despite being explored in a variety of ways, the role of the nurse is still not very well understood by the public, and others, due to its complexity and being difficult to articulate (Royal College of Nursing, 2023). But, the role of the nurse is diverse, as evidenced by the participants in my study, see appendix one, nursing knowledge is therefore dependent on the specificity of the type of healthcare setting, so nurses develop specific knowledge and skills, according to their work environment (Karlsson and Pennbrant 2020; Bell, 2021), which is an important consideration in the strive to 'brand' nursing knowledge.

The search to 'brand' nursing knowledge, is the strive for professional status for nursing (Hoeve, Jansen, and Roodbol, 2014; Bell 2021), however a universal definition, to offer nursing identity, denies the specificity and uniqueness of nursing knowledge and influence on patient care and the health care environment (Bell 2021), because of the diversity of the role, and the clinical environment.

The knowledge required by nursing is very varied, nursing knowledge, whilst identified in the findings of my study, as an assumed and expected attribute of nursing, it is argued, is also firmly embedded in the concept of 'caring', so the work of the nurse is to be 'caring' (Jackson, *et al* 2021, in Royal College of Nursing, 2023), a rhetoric which has become almost habitual (Paley 2002).

Caring implies a focus, by nurses, on the relationship with the person by seeing, understanding, and taking responsibility, for the patient as a human being (Karlsson and Pennbrant 2020). The findings from my study emphasise the importance of this to nursing,

with knowledge being intrinsically linked to being up to date about the patient, and the relationship between the nurse, the patient, and the relatives.

Nurses rather than focussing on a particular symptom, will concentrate on the patient, with consideration on presentation of the person and how the symptoms are affecting them as an individual (University of East Anglia 2023). Royal College of Nursing (2023), define person centred care as “compassionate, personalise, dignified care”, related to the professional therapeutic relationship between the patient and the nurse, but this implies a traditional one-sided relationship, in which the nurse is the giver of care, and the patient is the receiver (Benner and Tanner 1987). The findings from my study suggest, however, that the relationship between the patient and the nurse is a mutual one, further supported by Albinsson, Carlsson-Blomster, and Lindqvist (2021), who state that the relationship must be based on shared trust, communication and understanding.

This relationship supports clinical judgement, which, The University of East Anglia (2023) state, is as accurate as other forms of assessment in identifying how unwell the individual is, as it is based on experience and knowledge, with nurses relying on “intuition” to inform their decision making.

Nursing is still difficult to define (Royal College of Nursing, 2023), but if, as the findings from my study suggest, actions and behaviour are what define nursing practice and decision making, linked to intuition, and knowledge is locked up in these, nursing and intuition should be defined, by what is done, the actions and behaviours which indicate what nursing is, and the knowledge and language that informs this.

Behavioural science is becoming extensively considered as important, to understand the behaviour of patients and health care staff (Sleet and Dellinger, 2020). For a person to perform competently they must have the opportunity to do this with appropriate resources,

motivation, and a favourable working environment, as a positive physical and social environment authenticates behaviour and motivation to act (West and Gould 2022). Therefore, analysis of the behaviour of nurses could potentially better inform specific knowledge about nursing and its relationship to the behaviour of the patient (Sleet and Dellinger, 2020), to better understand the role of the nurse and nursing.

Autonomy is a widely recognised distinguishing trait of a profession (Friedson 1970, in Royal College of Nursing 2023), with the ability of nursing to practice autonomously, widely featuring in nursing literature and policies (Skår, 2010). However, the ability of practitioners to truly work autonomously is debatable, due to the many controls, such as policies and budgets, which prevent true freedom of working (Royal College of Nursing 2023).

Whilst nurses identify as having a sense of agency, in accordance with the findings from my study, the positive social environment (West and Gould 2022), as identified in my study arises from being a member of the societal group, not just nursing, but also part of a recognised team. Judgement of others comes from not having the same cultural values, as nursing, despite being in a societal group, in a clinical placement area.

Judgement from others is also significant, as nurses perceived as 'not coping', could trigger negative emotions, and impact on the decision to escalate concerns, about an acutely ill patient (Donahue and Endacott, 2010). This is supported by Ede *et al* (2020), who suggest that the contextual factors may act to facilitate or be a barrier to escalation, organisational factors such as the culture of the clinical environment and communication may also impact on decision making by nurses (Mackintosh, Rainey, and Sandall, 2011; Sleet and Dellinger, 2020).

Language and communication are a symbolic representation of a culture (Jiang, 2000), nursing as a cultural/societal group, has its own language, as identified from the findings in

my study. Language plays an especially important role in the connections between health care staff (Atkin 2021), but if staff in a team speak a different language, this could potentially function as a barrier to communication, and may be considered as incivility, and rudeness (Riskin *et al* 2019).

Rudeness and incivility have a direct correlation with negative patient outcomes, because there is frequent interruption of safe care for the patient, leading to adverse events and near misses (Freedman *et al* 2024). Therefore, it may be important to identify the relationship between cultural language and rudeness and incivility, to further explore the links between these factors, and safe patient care (ibid).

Information sharing is crucial to the performance of a team (ibid), but team working may be adversely affected by “negative interpersonal relations”, risk factors may include impoliteness and lack of respect (Schilpzand, De Pater and Erez, 2016), leading to poor working relationships, compliance with protocols, affecting the safety of the patient (Riskin *et al* 2019). Witnesses are also affected by any adverse communication, so any incivility and rudeness, has the potential to impact the whole team, not just those involved directly (Schilpzand, De Pater and Erez, 2016).

Conformity with protocols may be impacted by rudeness and incivility (Riskin *et al* 2019), but compliance, by nurses, with the use of the National Early Warning Score may also have its roots, in the societal values of nursing.

There is increasing concern, expressed by James *et al* (2010) and Douglas *et al* (2014) in Grant (2019), that recording and documenting patient vital signs, is frequently considered a menial, ritualistic task, often delegated to students, or clinical support workers. But clinical observation, and escalation of concern, is complicated, involving an understanding of pathophysiology, and the uniqueness of the individual patient, (Haegdorens, Wils, and

Franck, 2023). Vital signs are only part of the process, but currently they are the main component of the National Early Warning Score (ibid), and nurses feel a conflict between the standardisation of the National Early Warning Score and their own clinical judgement (Haegdorens *et al* 2020).

There is disquiet that nursing has not advanced with the new technological age (Booth *et al* 2021), evidence from my study however demonstrates the nurse's moral obligation to the patient, not protocols or technology. It could be argued that nursing is in an ontological and epistemological flux, as technology and protocols becomes the focus for care (Pepito and Locsin 2019), rather than the patient. With technology being considered an unwanted distraction from hands on patient care, and the therapeutic relationships nurses have, with patients and relatives (Booth *et al* 2021), which is of priority importance, and should be recognised and valued.

Chapter seven – Conclusion.

7.1. Conclusion.

The purpose of this study was to question the current narrative around intuition in nursing practice, and its link to decision making. The adoption of a post structuralist approach to the data analysis facilitated a deeper exploration of the data collected.

Being reflexive throughout facilitated me being able to acknowledge any potential biases or pre assumptions I may have had about the data collection, and the data analysis, which was important to be transparent to the reader.

Evidence from this study shows that, intuition is not the mystical entity that cannot be described, but is linked to nurses' behaviour, actions and interactions with patients, other nurses and the wider multidisciplinary team. Communication is vital for good team working, but nurses have strong cultural values and beliefs, which is tied up in the language they use, not always understood by others, and can sometimes be perceived as being rude uncivil.

The focus for nursing is the patient, and the individuality of their needs as nursing is entering a new era with more acutely ill patients and more technology there is a need to be ready but not ignore core values.

7.2. Limitations.

Whilst de Saussure (2005) has become synonymous with semiology, the use of his work is problematic; the course in general linguistics, which is often quoted by scholars, and I have also used, was not written by de Saussure himself, but constructed by his publishers from student lecture notes, and notes he had written. It is therefore debatable whether the book is a true reflection of his original theory, nevertheless the theories in the book, have been

adopted into popular culture, and the terms he used, have now become nomenclature in themselves.

As a small-scale study, it could be argued that view of the participants, do not necessarily reflect the view of the general population, I could have recruited more participants, and considered this, but it would have generated data that would have been unwieldy.

All the participants were female, data from male participants may have generated different ideas, also the participants represented 2 of the 4 fields of nursing, data from nursing in Learning Disabilities and Mental Health may have also generated different ideas.

7.3. Areas for further study.

1 - A wider scale study, using the ideas created through the data analysis, and a more positivist approach, would assess the text on a wider scale, and potentially reflect the view of the wider population of nursing.

2 - Using the same approach, collection of data from male nurses may generate an alternative view, or it may be the same. It may also address any criticism or concerns about men in nursing, and whether they are part of the societal group, with the same values and behaviours.

3 - Using the same approach again, collection of data from nursing in the other 2 fields of nursing may also generate further data, it would be important to consider the attributes of nursing as a collective, and whether this is altered in nursing for a different client group, are they part of the societal group, or do they have their own shared values and behaviours.

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Appendices

Appendix one. – Searching for the literature.

A flow chart of the literature search process, inclusive of criteria, search engines and data bases used and the inclusion and exclusion criteria.

The literature search process

Primary Search
Included in the following table
Search hits
CINAHL, Medline, SCOPUS, Google Scholar and Science Direct n= 32,415
Supplementary search
Scrutiny of reference lists in other articles n=76
Data cleaning
studies remaining after removal of duplicates n=1,213
Filter
Studies discarded for not meeting the selection criteria n=31,020
Selection
182 papers left, 7 included in the first order semiology

Demography of the participants.

Gender	Field of nursing	Current area of work	Qualified more than 5 years
female	Adult	GP practice	yes
female	Adult	Acute medical ward	yes
female	Adult	HMP	yes
female	Adult	ITU	yes
female	Adult	Operating theatre	yes

The outcome of the Literature search.

Database search including key words.	Cumulative Index to Nursing and Allied Health Literature (CINAHL)	Medline plus full text	Scopus	Science direct	total	Accepted overall, once inclusion criteria had been applied
Intuition and nursing practice.	462	325	322	3,222	4,331	3
Nursing intuition and expertise.	63	129	4	1,207	1,403	2
Nursing expert and expertise.	56	159	0	22,195	22,410	1
Intuition and escalation of concern about an acutely ill patient.	496	413	0	151	1,060	1
Expert intuition.	222	249	1,323	1,417	3,211	0

Inclusion criteria, as exclusion is antonym to inclusion, only the inclusion criteria has been included.

Inclusion criteria	rationale
Key words	As previously identified, these were an important part of the inclusion criteria to ensure that retrieved literature addressed the topic. These are included in the first column of the table on the next page.
Primary research	Primary research is the most robust and reliable evidence to underpin practice (Aveyard 2014) therefore only primary research was identified as an inclusion criterion, although secondary research was used to support the discussion.
Date of publication	The study by Benner and Tanner (1987) and Benners From Novice to expert; excellence and power in clinical nursing practice Addison (1984) were frequently quoted in studies, therefore these were considered the seminal research. I considered whether 1984 was too far for studies used in my literature review to be relevant and therefore amended the date of publication to anything beyond the year 2000
Research where registered nurses caring for adult patients, are the identified sample group	Narrowing down the focus of the population may achieve more defined results, only studies which investigated registered nurses were selected but the practice area was extended beyond general ward areas as relevant studies in emergency departments and ITUs may be relevant
UK and NI	Initially only literature published in the UK and Northern Ireland was included however it was identified that the Netherlands and America are proactive in addressing the topic, the terminology and key words were explicit therefore the inclusion criteria was extended.
Peer reviewed	Peer review identifies that research findings have been evaluated by experts, this should offer reassurance on credibility (Gardenier 2012); although an inclusion criterion, this was approached with caution as a large number of poor quality studies are still published (Roseberg and Donald 1995).

Appendix 2 – A critique of studies used in the literature review to quality assure appropriateness for inclusion.

Reference.	Aim.	Design and sampling strategy.	Characteristics and number of respondents.	Findings.	Critique.
Benner, P. and Tanner, C. (1987) Clinical Judgement: How expert nurses use intuition, <i>American journal of nursing</i> , volume 87, issue 1.	This is a pilot study, as a follow on from a previous study, to “identify the nature and role of intuition in expert clinical judgement.	Interviews were conducted on 3 or more occasions, and participants were observed in practice, on at least one occasion.	Twenty-one nurses, with at least 5 years’ experience in a single clinical area and were identified as experts by their peers.	The findings were mapped against the six key characteristics of intuitive judgement by Dreyfus and Dreyfus. Findings included the importance of the nurse patient relationship, and the nurse having knowledge of the patient’s world.	There is no real identification of the format of the interviews, or the observations, so it is difficult for the reader to ascertain the viability, of the data collection. The six headings by Dreyfus’ are used, another heading has been added to respond to some of the findings, that intuition is devalued by other health care professionals. Overall, the findings support the headings, but it is questionable whether anything new was discovered.
Dalton, M. Harrison, J. Malin, A. and Leavey, C. (2018) Factors that influence nurses’ assessment of patient acuity and response to acute deterioration, <i>British Journal of Nursing</i> , volume 27, issue 4.	“To discover what factors, influence how nurses assess patient acuity and their response to acute deterioration”.	A qualitative approach, using semi structured interviews.	10 nurses working in either acute medicine or acute surgery. within one NHS Trust.	Several themes and sub themes were identified, findings included the reliance by nurses on a numerical system, to identify and escalate deterioration. Difficulties arose when the score was low, and nurses needed to rely on their own	Presentation of findings is scant, although it is claimed that several themes were identified, only three were in the presentation of findings, it is presumed that this was because of the criteria for publication. The discussion is more comprehensive with findings being supported by evidence and greater exploration of the importance of the nurse patient relationship, the impact of the culture of the doctor/nurse association and the use of numerical scoring to escalate deterioration. The value of knowledge is also explored but this is linked to intuition, Experiential and theoretical knowledge, with

				judgement. The relationship with medical staff influenced the nurses assessment, accepting the judgement of the medical staff, rather than their own.	the presumption that intuition is a real phenomenon, but no real justification for this. Although the authors state that the participants work in acute medicine or acute surgery, there is no further explanation or justification for this.
King, L. and Clark, J. (2002) Intuition and the development of expertise in surgical ward and intensive care nurses, <i>Journal of Advanced Nursing</i> , volume 37, issue 4	The aim of this study was to explore and identify nurses' clinical expertise, in surgical ward and intensive care settings in England. One of the objectives of the study and, the focus of this paper, was the exploration of these nurses' understanding, and use of intuition, in the context of their practice.	This was a qualitative study, based on a constructivist approach conducted with the aim of exploring and identifying the levels of nursing expertise and the understanding of use of intuition in practise. 61 registered nurses were purposively sampled 30 working in four speciality surgical wards and 31 in two intensive care units across three hospitals in England but could only be involved if post operative patient was	Researcher participant observer took fieldnotes of the 61 nurses post-operative assessments of patients returning from surgery the episode was followed as soon as possible by a semi structured interview average length of 45 minutes based on the nurses reflexive retrospective accounts of the episode the interview progressed to consider the nurses perceptions of	Findings demonstrated that intuitive, and analytical elements, were apparent in nurse clinical decision making, from advanced beginner to expert. Intuitive awareness, appeared to become an increasingly powerful aspect, of some of these nurses' clinical decision making, and acted as a trigger, to spoken analytical process, that involved the nurse, in a conscious search	The authors state they're going to use a constructivist approach, but there is limited identification of what that means, or how it has been applied it to the study. The non-participant observer was the researcher of the study, and author of the paper, the issue of bias is therefore questionable. There is no inclusion of the format of the semi structured interview, what questions were asked, or how these were focused. The data includes feedback from participants, but not the field notes taken by the researcher.

		<p>allocated to their care all of the nurses approached were able to participate</p>	<p>how their expertise had been developed and the nature of their decision-making process in the current and similar past situations</p>	<p>to acquire data, which would confirm their sense of change in the patient. Status, the difference between experts and non-experts' decision-making, appeared to lie not in the presence or absence of intuition, but rather in the experts ability to use intuition more skilfully, and effectively. Non experts, identified how more experienced staff, helped them to consider their intuitive feelings of concern, analyse the basis of them, and interpret their importance into the relation with the patients' clinical signs, and react in an appropriate, and effective fashion.</p>	
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<p>Lyneham, J. Parkinson, C. and Denholm, C. (2008) Explicating Benner's concept of expert practice: intuition in emergency nursing, <i>Journal of Advanced Nursing</i>, volume 64, issue 4.</p>	<p>To report the study exploring the experience of intuition in emergency nursing, in relation to Benner's fifth stage of practice development; 'the expert practitioner'.</p>	<p>An Hermeneutic phenomenological study was conducted, using Van Manens approach, and a Gadamerian analysis. Self-selecting recruitment process, advert placed in nursing journals.</p>	<p>14 RNs with between 4 1/2- and 30-years' experience, with experience in the emergency department. It is unclear whether there was a non-structured interview, with an opening statement.</p>	<p>3 phases of expert practice are proposed, Cognitive intuition, Transitional intuition, and Embodied intuition.</p>	<p>There is a vague mention of Gadamer's fusion of horizons, but the results are presented as a thematic analysis. There is a reasonable sample, and an opening statement of the proposed interview identified. The interviews were conducted in 5 Australian states and lasted between 45 and 125 minutes. The themes were validated. There was no real definition of intuition, other than what the participants say, there is no definition of expert, other than longevity, overall, the study is very reliant on the theories of Benner.</p>
<p>McCutcheon, H.H.I. and Pincombe, J. (2001) Intuition: an important tool in the practice of nursing, <i>Journal of Advanced Nursing</i>, volume 35, issue 5.</p>	<p>The aim of the study was to evaluate the role of intuition, to examine nurses' understanding of intuition, and their perceptions of their use of intuition, and to assess the impact of intuition on nursing practice.</p>	<p>A Grounded Theory approach, using the original work of Glaser and Strauss. The use of Grounded Theory would reveal nurses' perceptions, of the use of intuition in nursing practice, and facilitate the emergence of a coherent theory, on nurses, understanding of intuition. With a mixed method approach, using focus group interviews and the</p>	<p>262 nurses volunteered to participate, 29 were involved, in four focus group interviews.</p>	<p>Intuition is not something that just happens, it is the result of complex interaction of attributes, including experience, expertise, and knowledge along with personality and the environment. Acceptance of intuition as a valid behaviour, and the presence or absence of a nurse-client relationship, the theory of intuition</p>	<p>Data collection was undertaken using triangulation of methods. Whilst there is information on the survey, which was facilitated by a Likert scale, and consisted of statements about intuition, knowledge, experience, and expertise, there is no inclusion of the final questions, so it is difficult to analyse whether the questions were appropriate, or how they differed from the focus group interviews. There was an appropriate discussion, on the use of the grounded theory approach to develop the analysis from the start of the data collection, and the researchers discuss codes and categories for analysis of the data, but the themes that emerged, are not included in the paper. 262 nurses volunteered to participate, 29 were involved in four focus group interviews, information from which is provided as qualitative data. This was analysed using the technique of constant comparative analysis,</p>

		<p>Delphi survey technique.</p> <p>Glasser and Strauss suggests that all qualitative all quantitative or a combination of both may be used, as all three approaches can generate theory.</p>		<p>that emerged, was that knowledge expertise and experience are mutually dependent. The data also revealed that the environment in which the nurse was working, could either support the use of intuition, or suppress it.</p>	<p>but also used to assist, in developing the first questionnaire for the Delphi survey.</p>
<p>Pretz, J. E. and Folse, V.N. (2011) Nursing experience and preference for intuition in decision making, <i>Journal of Clinical Nursing</i>, volume 20, issue 19 – 20.</p>	<p>To examine the relationship between domain specific, and domain general intuition amongst practising nurses and student nurses, to determine the role of intuition in decision making.</p>	<p>A correlation design was used, to examine the factor structures, and the interrelationships of self-reported measures of intuition, as well as their relationship to experience.</p> <p>Two hypothesis was set,</p> <p>1 given that intuition is based on experience, it was predicted the preference of the use of intuition in nursing, would be independent and relatively unrelated</p>	<p>175 practising nurses and student nurses RNs n=145 Student nurses n=30</p> <p>10 first year 6 second year 4 third year 12 fourth year RNs medical surgical nursing n = 38 critical care n= 14 maternal/newborn n= 13</p>	<p>nursing intuition itself is not a unitary construct, testing intuition was found to have two dimensions, a sense of being skilled being able to read patients cues, and a sense for affinity for innovation in practise.</p>	<p>There is a lot of discussion on different types of intuition scales, but no real identification of how they have been used, or the questions set.</p> <p>Strength is that they have participants, with varying levels of experience, which addresses the hypothesis that they have set.</p> <p>More experienced nurses may also have increased confidence in their intuitive judgement, experience was coded as number of self-reported years' experience, as a registered nurse, students were coded as zero years of RN experience.</p> <p>Nurses with up to four years' experience scored lower than nurses with 12 to 25 years experience.</p>

		to the general trusting of intuition. 2 the relationship between experience and trust in nursing intuition, was expected to be positive, nurses would trust their intuition in nursing more, as their level of experience in the field increased.			
Traynor, M. Boland, M. and Buus, N. (2010) Autonomy, evidence and intuition: nurses and decision making, <i>Journal of Advanced nursing</i> , volume 66, issue 7.	To report a study conducted, to examine how nurses represent professional clinical decision-making processes	This was a qualitative study, using focus groups for data collection, and elements of discourse analysis. Ethnomethodology was used to inform the analysis	The participants were registered nurses and were recruited from 3 post qualification courses for specialist nurses. The groups were run in lunch breaks, there were three groups of eight, 8 and 10 participants.	The nurses described technical instruments for decision-making as impossible to adhere to fully and introduced person experience as a rational way of utilising them in everyday practise. The nurses found talk of indeterminate decision-making processes awkward, and attempted to	The topic guide for the focus groups is included in the paper, and the possible prompts for the participants. There is rationale given for the use of a focus group, and the size of the participant numbers. The focus groups were moderated by the 1st and 2nd authors which questions an element of bias or coercion, they also serve the food but I'm not sure whether there was potential bribery involved. The focus groups focussed on how groups represented instances of decision making, in the light of indeterminacy technicality ratio, which is defined. Michael Traynor has written previous papers on the indeterminacy technicality ratio so clearly has an understanding of it, it feels as a presumption that the reader will also understand this, as what he means isn't clear, he states, talk of

				<p>normalise such talk, by aligning it with personal experiences. The nurses distanced themselves for competing calls to identify their professionalism, as wholly with intuitive practise. There was the possibility of being disempowered through following of procedures. Having recourse to experience, allowed them to maintain a sense of professional autonomy</p>	<p>intuition is understood as an example of a claim for indeterminacy, but what indeterminacy means, in the context of what he's talking about isn't clear. The analysis consisted of coding, and re coding, the question asked was "how is this spoken interaction, being used to present or challenge a particular account of professionalism", but I don't understand what the relevance of that is.</p>
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Appendix three – the first order semiology

A table of the 10 words of the participants, these are in a table with fifty words, ten for each of the five participants, the words highlighted in red were the ones selected for the first order semiology.

The first order semiology table, intuition is the signified, the data from the seven identified studies has been analysed and applied to become the signifier and the ten words of the participants have become the sign.

The ten words of the participants, fifty words in total, the red words were used primarily as the sign value in the first order semiology

Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Emergency.	Emergency.	Sad.	Worried how am I going to manage this.	Commode/bedpan.
Life.	Control.	Emotional.	Frightened.	Disabled son.
Death.	Fear.	Sympathy.	Nervous.	Student nurse.
Family.	Blood.	Duty.	Emotional.	Panic.
Support.	Family.	Compassion.	Upset.	Confusion.
Skill.	Staff.	Scared.	Honesty.	Ill equipped.
Equipment.	Noise.	Honest.	Knowledge.	Defib/ALS skills poor.
Blood.	Smell.	Open.	Power.	Sadness.
Time.	Busy.	Knowledgeable.	Proud.	Responsibility.
CPR.	Fail.	Proud.	Adrenalin.	Debrief.

Signified	Signifier	Sign
<p>1 intuition</p>	<p>Nurses have learnt to understand the patients illness, to support the patient, to cope with the illness therefore personal histories, the circumstances of the patients illness are as important as the signs and symptoms (Benner and Tanner 1987). This suggests that nurses bear the ‘weight’ of the patient, their illness, and the response to their illness, which informs intuitive decision making.</p> <p>Intuition is a result of many things, including the environment, and acceptance of intuition as a legitimate action (McCutcheon and Pincombe 2001). So nurses need support to acknowledge intuition, which is related to expertise, and frequently reported validating their findings with others (McCutcheon and Pincombe 2001).</p> <p>The environment could support the use of intuition or repress it, if not supported in an environment, then the de valuing of the use of intuition could hinder the ability to use it (McCutcheon and Pincombe 2001). Situational factors such as bureaucracy and workload, and being busy, could also undermine uncertain decisions, when nurses do not have the time to respond to intuitive thoughts (Traynor, Boland and Buus2010). If there is an organisational culture focussed on blame, this also impacted on escalation of concerns about a deteriorating patient, when the concerns were based on intuition alone (Dalton et al 2018). So institutional blame culture, suggests a lack of support, particularly when not using approved numerical mechanisms, for escalating concerns about a deteriorating patient. Fear of being considered ‘silly or ‘stupid’, led to nurses feeling anxious, and reluctant to share their feelings</p>	<p>Support (bearing the weight of something, have the backing of).</p> <p>Synonyms, <i>Family,</i> <i>Disabled son,</i> <i>Student nurse,</i> <i>Honesty,</i> <i>Busy.</i></p>

	<p>with others (King and Clark 2002). So a lack of support, may potentially influence response to intuitive thought, and honesty about feelings.</p>	
<p>2 intuition</p>	<p>One of the 2 dimensions of intuition is a “sense of being skilled”, and being able to read the patients signs, with an understanding of the importance of practice innovation (Pretz and Folse 2011). Patients present patterns of responses, that expert nurses learn to recognise (Benner and Tanner 1987), so the skill of the nurse is the relationship, and emotional response to the patient, emotion which is linked to intuition. Criteria or lists that are context free, are never sufficient to describe either the fundamental relationships, or any slight variations in the presenting patterns (Benner and Tanner 1987). The use of policies and protocols was dependant on the personal agency of the nurse, and their experience in using the manuals (Traynor, Boland and Buus2010). Whilst participants acknowledged policies and protocols are something they had to adhere to, there was agreement, that they were sometimes too theoretical, and of little practical use (Traynor, Boland and Buus2010), perhaps being process, rather than context driven.</p> <p>Intuition sparks an analytical process, which informs nurses decision making, this leads to a quest for data, that would substantiate their claim of a change in the condition of the patient (King and Clark 2002). There is a heroic, and autonomous focus on saving lives, with a constant battle against the bad decisions of other professionals, driven by a hazy, sense but firm belief, that there is something wrong, and action needs to be taken (Traynor, Boland and Buus2010), taking a sense</p>	<p>Skill (attitudes and abilities appropriate for a specific job).</p> <p>Synonyms, <i>Control,</i> <i>Equipment,</i> <i>Honesty,</i> <i>Open,</i> <i>Emotional,</i> <i>Upset,</i> <i>Time,</i> <i>Sympathy.</i></p>

	<p>of control. Regardless of the medical response therefore, nurses would follow “their intuitive feelings of concern”, and prepare staff and equipment to intervene, should the condition of the patient deteriorate (King and Clark 2002), but because of the covert nature of the behaviour, the opportunity to be honest and open about intuitive thoughts is missed. “The nurses description of insider knowledge included a discussion of outsiders who were oblivious to what seemed obvious to nurses” (Benner and Tanner 1987). So the skills of the nurse are culturally exclusive, and different to those of the medical staff, which were viewed as task orientated (Dalton et al 2018). There is a willingness to trust others intuitive thoughts rather than own, with implicit acceptance of the concern raised about a patient, with limited ability to explain why (Lyneham, Parkinson, and Denholm 2008), questioning the skill of the nurse when linked to intuition.</p>	
<p>3 intuition</p>	<p>The expert nurse holds a tentative judgement about the patient’s condition, because of the undetermined nature of the situation (Benner and Tanner 1987). This suggests fear or uncertainty about how the situation will be managed, or whether they will be believed. Participants described the fuzziness of their physical feelings, which only alerted that something was wrong, rather identify a specific cause (Lyneham, Parkinson, and Denholm 2008). Nurses were uneasy about reporting their feelings, particularly if there were no changes in the vital signs, with the overriding fear of being considered ‘silly’ or ‘stupid’ (King and Clark 2002). This means that here is a desire not to rationalise the intuitive thoughts, but continue with a</p>	<p>Panic (a sudden overwhelming fear that affects an individual or especially one that grips a crowd or population).</p> <p>Synonyms, <i>Emergency,</i> <i>Worried how am I going to manage this,</i> <i>Frightened,</i> <i>Fear,</i> <i>Nervous,</i> <i>Blood,</i> <i>Confusion,</i> <i>Scared,</i> <i>Smell,</i></p>

	<p>conventional paradigm (Lyneham, Parkinson, and Denholm 2008). The reliance on a conventional paradigm, suggests a sense of panic due to previously reported dislike of policies and protocols, but the fear relates to not being believed, which suggests that fear inhibits intuition and impacts on expertise.</p>	<p><i>Time,</i> <i>CPR,</i> <i>Adrenaline.</i></p>
<p>4 intuition</p>	<p>Fear of not being believed could be related to the cultural status of nursing, “Nurses are so brutalised by the pecking order of the system, that you have to have a lot of security, the kind that comes with experience, to make the call” (Benner and Tanner 1987). More experience, affords the opportunity, to develop a better understanding between “physical signs and specific patient outcomes” (Lyneham, Parkinson, and Denholm 2008). But control is still potentially inhibited, if nurses see themselves as subservient and waiting for the doctor to tell them what to do (Traynor, Boland and Buus2010). Some nurses consider the doctor in authority, and would not be happy to contradict them, even if they disagreed (Dalton et al 2018) the power to control therefore, relates not only to other people, but also the individuals own behaviour.</p> <p>King and Clark (2002) argue however that regardless of the medical response, some nurses would follow “their intuitive feelings of concern”, and prepare staff and equipment to intervene, should the condition of the patient deteriorate, but this is done tacitly, presumably so as not to upset the doctor.</p> <p>More experience affords the opportunity, to develop a better understanding between “physical signs, and specific patient outcomes” (Lyneham, Parkinson, and Denholm 2008).</p>	<p>Control (the power to influence or direct people’s behaviour or the course of events).</p> <p>Synonyms, <i>Life,</i> <i>Death,</i> <i>Confusion,</i> <i>Staff,</i> <i>Noise,</i> <i>Time,</i> <i>Busy,</i> <i>Fail,</i> <i>Debrief.</i></p>

	<p>The use of intuition has an effect on patient outcomes, by either averting a disaster, or prompting the nurse to take action, which had a positive impact on the outcome of care (McCutcheon and Pincombe 2001). With experience, there are more opportunities, to gather data about the correlation between vital signs, and patient outcome, with growing confidence in intuitive reasoning (Pretz and Folse 2011).</p>	
<p>5 intuition</p>	<p>There is an appreciation, of the importance of using protocols and manuals, and their role in decision making, particularly in relation to covering oneself legally, should something go wrong (Traynor, Boland and Buus2010). To attempt to protect themselves, nurses will insist that the doctors document their conversation, around escalation of a deteriorating patient, thus transferring responsibility for action or non-action (Dalton et al 2018). This implies the perception that there is no implication for the nurse, but no real consideration of the implication for the patient. A certain amount of error can be expected in decision making using intuition, however, within health care error is poorly tolerated and is frequently used to reject intuition as valid in decision making (Lyneham, Parkinson, and Denholm 2008). But rejecting intuition based on error remains unsupported (ibid). A blame culture within an organisation, further impacts on decision making, and willingness to escalate concerns in the absence of a change in vital signs (Dalton et al 2018).</p> <p>There is a heroic and autonomous focus on saving lives, with a constant battle against the bad decisions of other professionals, driven by a hazy sense but firm belief that there is something wrong, and action needs</p>	<p>Duty (moral or legal obligation avoid acts or admissions that may cause harm).</p> <p>Synonyms, <i>Life,</i> <i>Death,</i> <i>Staff,</i> <i>Honesty,</i> <i>Open,</i> <i>Time,</i> <i>Busy.</i></p>

	<p>to be taken (Traynor, Boland and Buus2010). But the fuzziness of the decisions, and difficulty in conveying meaning to medical staff, means that nurses frequently struggle to escalate concerns solely based on intuition (Dalton et al 2018).</p> <p>Workload and bureaucracy, which inhibit nurses willingness to act on intuitive thoughts, being weighed down with the day to day activity of the clinical area, portrays nurses with no professional agency (Traynor, Boland and Buus2010). The duty to themselves and others. is impacted on therefore. in the balance between bureaucracy and ethical principles, such as Non-maleficence and Beneficence (Beauchamp and Childress 2008).</p>	
<p>6 intuition</p>	<p>“The language of illness is a human language, with emotions and lived experience, which nurses learn to recognise, the language of disease is a language of pathophysiology and tests”, which is more aligned to the medical model (Benner and Tanner 1987). This suggests that nurses adopt a naturalistic approach to patient care (Dalton et al 2018), with utilisation of the Intuitive-Humanist model (Banning 2008).</p> <p>The more time spent with the patient, the more likely the nurse is to have intuitive feelings about the patient’s condition, and what is ‘normal’ for the patient (King and Clark 2002). Whilst this does not necessarily mean a feeling of sorrow, there is a link to emotion, and connection to the patient. Consideration of the risks for each patient, also relies on skilled judgement (Benner and Tanner 1987), but intuition is</p>	<p>Compassion (feeling of sorrow and pity for someone in trouble).</p> <p>Synonyms, <i>Sad,</i> <i>Commode/bedpan,</i> <i>Frightened,</i> <i>Sympathy,</i> <i>Emotional,</i> <i>Upset,</i> <i>Honest,</i> <i>Open,</i> <i>Sadness,</i> <i>Proud.</i></p>

	<p>also reliant on a physical appreciation of non-clinical signs, and a spiritual connection with the patient (Pretz and Folse 2011), which feasibly involve compassion and emotion.</p> <p>There was debate, about whether or not a relationship with a patient was necessary, for intuition about the individual and their condition (McCutcheon and Pincombe 2001), but knowledge of the patient, and the “human world”, provides a basis for clinical judgement about the vulnerability of the patient (Benner and Tanner 1987), and the potential for deterioration. Because the situation with some patients is indeterminate, and subject to change, expert nurses make their judgements tentatively (Benner and Tanner 1987), to accommodate changes in the patient, and the environment. Intuition therefore is context and patient dependent, but also nurse dependant, and the connection with emotional connection to the patient (Pretz and Folse 2011).</p>	
<p>7 intuition</p>	<p>Intuition is a result of a “complex interaction of attributes”, that include expertise, knowledge and experience, and these are mutually dependant (McCutcheon and Pincombe 2001).</p> <p>Whilst the relationship between knowledge and experience is not new, in their study, Lyneham, Parkinson, and Denholm (2008), suggest that themes emerged, which are an alternative view on their position and value; “feeling, syncretism and connection” (Lyneham, Parkinson, and Denholm 2008), as there are times when the nurse struggles with their feelings, so intuition becomes an unconscious process (ibid), leading to confusion.</p>	<p>Knowledge/knowledgeable (information acquired through learning or experience/well informed)</p> <p>Synonyms, <i>Confusion,</i> <i>Honest,</i> <i>Defib/ALS skills poor,</i> <i>Open,</i> <i>Proud.</i></p>

	<p>Experience was found to have a direct correlation with the willingness, by nurses to act on intuition, alongside perception of self as a skilled practitioner (Pretz and Folse 2011).</p> <p>More experience, affords the opportunity, to develop a better understanding between “physical signs, and specific patient outcomes” (Lyneham, Parkinson, and Denholm 2008), with growing confidence in intuitive reasoning (Pretz and Folse 2011).</p> <p>Nurses also learn to recognise their intuitive feelings, and use the findings more skilfully, facilitated by the extent of their experiential learning, and knowledge base (King and Clark 2002). But intuition is reliant, on looking after patients in specific circumstances (King and Clark 2002), so as intuition is context specific, it may be argued that knowledge is also context specific, but the context could be self, patient or environment. It may even be knowledge, the context may be what the nurse knows.</p> <p>The nurses description of insider knowledge, included discussion of outsiders, who seemed oblivious to what seemed obvious to nurses (Benner and Tanner 1987). But there is very little explanation about nursing knowledge, that does not include intuition, and that is a problem, because rationale and explanation about intuition remain elusive, so the same could be said about the knowledge, that is frequently applied to intuition and decision making, in all of the studies.</p> <p>Nurses considered ‘novices’, frequently relied on changes in the parameters of the vital signs, to report deterioration, rather than rely on their feelings (King and Clark 2002). However in the study by Dalton et al (2018), findings suggested that all nurses relied on the objective findings of the vital signs, to validate</p>	
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	<p>subjective findings. Participants suggested that their knowledge base and academic achievement, is inferior to that of medicine, so subjective knowledge is not validated by doctors, nor by nurses, particularly if they lack self confidence in their own clinical ability (Dalton et al 2018).</p>	
8 intuition	<p>In the study by Benner and Tanner (1987), a recurrent theme was the devaluation of intuitive judgements by other nurses, physicians, and the 'experts' themselves, suggesting that the power to respond to intuitive thoughts, is diminished.</p> <p>In some instances however, nurses gain power covertly, because regardless of the medical response, nurses would follow "their intuitive feelings of concern", and prepare staff and equipment to intervene, should the condition of the patient deteriorate (King and Clark 2002).</p> <p>The difficulty in escalating concerns about a patient's condition (Pretz and Folse 2011), diminishes the power some nurse have, and the perceived authority over the situation. This is heightened by the concerns around feeling stupid, and wasting peoples time Dalton et al (2018), and the potential subservience to medicine, as nurses frequently followed the decision of the medical staff, regardless of whether they agreed with it or not (Dalton et al 2018), which further diminishes power and authority.</p>	<p>Power (control and influence exercised over others, skills opportunity or authority to do something)</p> <p>Synonyms, <i>Life,</i> <i>Death,</i> <i>Staff,</i> <i>Honesty,</i> <i>Fail.</i></p>
9 intuition	<p>Scared of getting it wrong, a feeling of being vague leads to the sense of being "backed into a corner", feeling the pressure to back down and not be assertive (Benner and Tanner 1987), suggesting a sense of fear,</p>	<p>Ill equipped (not having the necessary resources or qualities for a particular role or task.)</p> <p>Synonyms,</p>

	<p>being ill equipped, because of the difficulty in verbalising concerns.</p> <p>Whilst trust is important to facilitate intuitive thoughts, it is precarious and complex (Lyneham, Parkinson, and Denholm 2008), so intuitive thoughts are not always acted on, because the resource of trust is developmental (ibid) linked to what could be classed as an 'expert'.</p> <p>Nurses considered 'novices', frequently relied on changes in the parameters of the vital signs to report deterioration, rather than rely on their feelings (King and Clark 2002), but this leaves them better equipped to escalate concerns, due to the objectivity of the data. In relation to knowledge and the potential subservience to medicine, nurses feel ill equipped to make decisions, which leads to uncertainty (Dalton et al 2018). whilst some nurses rely solely on their intuitive observations, they struggled to defend their assessment, and convey meaning to the medical staff (Dalton et al 2018). Therefore, the subjectivity with which nurses make judgements and decisions, currently described as intuition, potentially leaves nurses lacking some resources, to escalate concerns effectively.</p>	<p><i>Worried how am I going to manage this, Frightened, Nervous, Scared' Fail.</i></p>
<p>10 intuition</p>	<p>Whilst there is evidence that nurses trust the judgement of others above their own, particularly medical staff (Dalton et al 2018), validating findings with others, is an important part of recognition of a deteriorating patient (King and Clark 2002), suggesting that there is a need for authorisation to take action, or make a decision.</p> <p>There is a constant battle to trust intuition, with a craving to rationalise the intuitive thoughts, and "continue within a conventional paradigm" (Lyneham,</p>	<p>Responsibility (he state or fact of having a duty to deal with something or of having control over someone. the opportunity or ability to act independently and take decisions without authorization.</p> <p>Synonyms, <i>Disabled son, Student nurse, Family,</i></p>

	<p>Parkinson, and Denholm 2008), with appreciation of the importance of protocols and manuals, to cover the individual legally, should something go wrong (Traynor, Boland and Buus2010). The use of manuals and protocols seemingly takes the responsibility, and gives authority for decision making, but there is still a need for a level of individual thought, because of the relationship with the patient (Benner and Tanner 1987) and the constant strive for person centred care (Traynor, Boland and Buus2010).</p>	<p><i>Staff, Honesty.</i></p>
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Appendix four - A transcript of the focus group interview and the second order semiology, I have also included a glossary of terms to explain some of the abbreviations and nursing terminology used by the participants.

Transcript of the focus group interview

I. *Right thank you for your time, erm all I am going to ask you to do is to think about a patient you have looked after who was unwell, acutely unwell ok, it can be any situation it doesn't matter, it can be in your current role previous role whenever but it is something that is significant to you, it may be one patient it may have been more than one patient it may have been a situation, and the first thing I am going to ask you to do is so think about a time when you have looked after an acutely ill patient and in ten words I want you to describe the event and its significance for you ok so think about what happened how you felt about it then and now.*

P. **In ten words?**

I. *In ten words that's a start so I am going to give this out bear with me a minute because I am going to give you a minute to do it.*

P. **A minute**

I. *A minute*

P. **How generous**

P. **Oh my gosh**

I. *I know but you see if I give you a minute it actually stops you thinking, it's what comes out instinctively, are you all happy with what you have got to do?*

P. **You put each word**

I. *On one, yes ten words*

P. **So just thinking about a scenario and then the words that pop into your head**

I. *Yes that is all I am asking you to do*

P. **Not words about the scenario**

I. *It's anything that comes into your head OK so ten words and I am going to give you a minute to do it*

SILENCE

P. **Do you want the words that feel good about it**

I. *It's whatever is important to you*

SILENCE

I. *OK are we done?*

P. **yep**

I. *Right underneath I want you to write a paragraph about the event that incorporates all of those ten words*

SILENCE

I. I bet you never thought that you would be asked to do so much work, did you?

SILENCE

P. So you have to make lots of sentences?

I. Yes, it is a paragraph.

SILENCE

P. how long have I got, I haven't used any of my words yet?

P. I think I have done this wrong

I. There is no right or wrong (name), it is just

P. Did you want more clinical stuff or experience?

I. It is entirely what you think is important to you, when you do this you think am I doing it right but there is no right or wrong it is just

SILENCE

I. Whilst (name) is finishing, shall we form a circle and just may be sit around here and then we can start, you can start talking about what you've put because (name) is about to go over the other page now.

LAUGHING

P. Sorry

I. What are you sorry for?

P. You know I can talk

I. Now just to sat I will be making notes it's just really for my benefit, if there is anything I think is significant or any clues that I pick up because at the moment I am going to get this data collection, what I am going to do with it, the analysis I am not sure about so that is really exciting because I don't know what I am going to find and what I am going to do with it so (name), would you like to go first because I will then call you participant 1

P1. OK

I. So would you like to tell us, read your paragraph out

P1. An emergency situation which meant life or death practitioner was performing CPR on arrival I ensured that we had enough equipment and skill mix to support and perform the operation, the timing was crucial. My thought was with his family and I needed to ensure I did the best I could. There was a lot of blood loss and we needed IV blood for

I. Right Ok wow do you want to tell us a little bit more about that?

P1. Erm we erm didn't have a lot of staff

I. Right, where were you?

P1. In an emergency theatre erm we didn't have a lot of staff we only had one operating theatre working erm and I was just on a break and I could overhear the surgeon saying that there was something kicking off in ITU, it was a man who had been brought to theatre earlier that day, and they thought that potentially a clip had come off and he was bleeding and nobody told me about it and I was the assistant at the table

in the only theatre that was working. I had only got some students that was all we had got just me and some students, so I went into another theatre and set it up without being told, and set the theatre up with a big laparotomy set and everything else and still nobody had said that anything was coming and it was just three of us me and 2 students working late and at that they came through the doors I was half scrubbed and still nobody had said to me that he was coming I had just got as much as I could ready because I was listening ear holing and erm the patient came through the doors they were guided in and they just came in and one of the practitioners was doing CPR on the patient, quickly they put the patient to sleep and then they did the laparotomy and we used to count on the board, all procedures went out of the window we were literally swabbing and scooping blood and throwing it onto the floor basically to get rid of the blood so we could see the bleed and suctioning as much as we could see we managed to get a clip on the bleed and save the patient he went home 2 weeks later.

I. Excellent

P1. Well I hope so he might still have a swab stuck in him.

LAUGHTER

P2. Do you know it was just one of them situations, luckily the man survived, I don't know if he is still alive now he left went to ITU for 2 weeks well 1 week and then he got moved?

I. So how does it make you feel?

P1. Proud, just really proud.

I. Why?

P1. Because I saved him, and if I hadn't listened I felt I was responsible for the whole, not me on my own but I managed, I only had 2 students just to and they were fantastic you they just we organised it really well and I was proud to be part of the team that day.

I. (name) your turn.

P2. So erm my first role as a senior nurse and I had a patient who had a huge GI bleed, everyone looked to me as the senior nurse on shift to manage the situation and I remember feeling that I had managed it well and I could control the situation, but the patient died and the death was probably expected but not planned for, which always sat really uncomfortable with me that you know you had a patient that had got alcoholic liver disease, and was going to die but nobody had prepared the patient or the family for the death so it wasn't a nice death it was a really horrible death and it was the first situation I had ever been in where I needed to council a team after a death so I had been a nurse for a long time and I had managed other areas I hadn't been on this ward long I had gone to a ward that was in special measures the team was really struggling so it was a really difficult death for everyone to deal with so I remember everyone having to be counselled afterwards .

I. So do you want to just run me through what happened?

P2. Patient ? next thing you know someone shouted the patients arrested, there was just I have never seen so much blood, I have not worked on a gastro ward before and it was not something I had ever seen it was like something out of a horror movie, there was a ridiculous amount of blood and the smell was just like a ? smell so obviously it was something that just poured out the emergency medical team came out and everyone is just working on this patient and it just seemed that I controlled the staff and I controlled the emergency on the ward and we had done everything that we were meant to be doing and that was all fine but it was just it just seemed barbaric it was just a horrible death there were people working away on

this patient trying to get access trying to mop up blood like you say trying to do CPR but he was probably already dead this patient is already dead and it could have been very different had it have been a planned death.

I. So because it was an emergency death like a non-planned death and he has just suddenly got this hematemesis I presume was there any warning signs that he was going to have this event

P2 I think probably in retrospect yes for me that is something we could have all done better but as I say I had never worked on a gastro ward before so it was a new speciality for me so as I say I was still learning the speciality the medics could have made that decision you know they look after gastro patients all the time you know with alcoholic liver disease this man was really poorly having worked on there for 4 years after that I think I would have made that decision or that call a lot sooner in that man's care

I. What do you think could have been done differently

P2. More meaningful conversations preparing the patient's family preparing the staff not having to put the call out keeping the patient comfortable palliative cares

I. So was it not considered that he was going to die

P2. I think it should have been I think if they had had meaningful conversations or put some reasoning around the fact that this was end stage liver disease that could have been planned for properly and an appropriate plan of care put in place and I still think to this day that happened as I say working on there for 4 years after and seeing how other patients were treated and how the conversation were had I just think they missed an opportunity and he hadn't been there long so maybe those conversations may have happened in a few days I don't know but I just feel it was not a nice death it was a horrible death

I. it might have been a horrible death anyway?

P2. It probably would have been, but I, just even in health care there are missed opportunities to have meaningful conversations not that everyone has to be on a supportive care plan or anything but I think we miss the opportunity to be honest sometimes.

I. With patients, with relatives?

P2. You know this may happen, it may not happen but at least especially

I. Why do you think that does not happen though?

P2. I think a lot of health care workers want to save people from dying nobody wants patients to die but death is a part of life.

P3. As an ITU nurse I was scared due to the devastation that this situation had whilst I was on duty I was emotional and showed compassion to the parents we were open and honest regards the situation and show sympathy it was a sad day but I was proud that we support the family and I am more knowledgeable now of processes.

I. Do you want to tell us about the situation?

P3. It was a 15-year-old boy who had a severe asthma attack, his parents had brought him into A+E and he had had an attack in the car and he was really bad. A+Es process was that they would not come out to the car to get him his dad had to bring him into A+E it was a 6-foot child so by the time he got to A+E he was coded or resused brought to us on ITU.

I. When you say coded what do you mean by that?

P3. He was not breathing they (?) full arrest some security men had gone and helped the dad to get him out of the car and bring him and put him on the trolley but policy would not allow them to go out to the car so they brought him up to us on ITU and we spent 2 hours doing chest decompression bag him to get the air into him bag him decompress his chest just to be able to get him onto a ventilator the reason we did it for so long is because he was a 15-year-old child I mean we do it for everybody but his mom and dad, he was their only child so we did that then the consultants came up we managed to get him on the ventilator then the consultants came up the surgical team came up but there was no signs of life so, over the next few hours they decided that they would have to do brain stem tests erm we would support the family to explain the consultants did not know how to sit so obviously because you are the nurse looking after that patient you have to go and sit and have those conversations with the parents.

I. So it was your role as the nurse to talk to the parents?

P3. No it was the consultant's role but the consultant did not know how to broach it was a bit of a stigma the problem was the dad was mixed heritage but I can't remember his I want to say American Indian but I can't quite remember he was a very big 6ft 5in man, he was very quiet everybody took the assumption that because he was quiet he was going to be (?) but mom wasn't she was a white lady and she was quite small and but actually she was the same (?) that the dad wasn't the consultant found it quite intimidating the size of the dad but the dad he was really inoffensive but I think they were more concerned that they knew that nobody had gone out to help the dad bring the son in to A+E because basically that was already being investigated all we did in the end we went in and had a conversation because the first thing on the agenda would be organ donation because of how young he is and his organs so I had to sit through that conversation about organ donation erm the mom was definitely against it dad was in agreement he wanted his son to live on in that it took a few hours to get the mom to come round which she did and then the process after when you do organ donation is quite erm it was a learning curve for me because the (?) came to talk about harvesting and he was just trying to explain to this family that their beautiful boy who was just now he had to go through the brain stem death tests and what not and she said well he is still warm he is still pink he is you know he is breathing it is really hard then to explain to somebody yes but they are clinically dead and I stayed on his looking after him erm finished the shift and then the next day they asked me to go back being his named nurse because of the relationship I had built up with the parents erm and nursed him until he went down for donation and took him down to theatre for harvesting and erm made sure that with the theatre nurse that he looked well for his parents to go down and say their good byes and I think that is the sad side of nursing sad and hard especially when the people who are working with you have got kids and now that I have got children I don't know that I would have I think I would find that situation a lot harder than I did at the time

I. It is interesting to watch your reactions to this because some of you are going, so what sort of shocked you about it?

P. The fact that they can't go out to get the boy out of the car because I thought we had all got a duty of care you know what I mean if that happened out there you would stop and jump on the ? you know you would as a nurse you are told by the NMC to stop your car if there is an accident

P. I am shocked by asthma attacks anyway, like I say because I have children then I am not a nurse, I am putting myself, I am a mom and my children haven't got asthma but when there is a situation like that I immediately go to mom I don't go to dad I going into mom and I am thinking oh my god this is terrible this is someone's child it could be my child that is why I am shocked because of the story not because I am a nurse but because of the reflection and because (name) had to witness it, that upsets me for (name) you know because I haven't ever you know touch wood I have been fortunate that in ten years I have never

had to go through that situation and I am thankful for it but I am upset for (name) that is why I am shocked

I. That is interesting

P. I think with children it always is when it is children who are severely unwell, life threatening that is when it is but I don't know why because it is equally the same with adults but it is children

P. It is desperate because people still don't realise that asthma kills erm we lost one of our nurses 5 years ago from an asthma attack she was 22

P. It does because in like September my (?) died of an asthma attack just a general asthma attack

P. And some of my children's friends and that is the worst knowing that I have worked on a respiratory ward and a nurse has died from an asthma attack

I. What do you think is the difference between your role as a mom and your role as a nurse because you are actually breaking the 2 up you are actually giving them 2 identities?

P. I separate my role as a mom the things I see in the day to day in my nursing I don't take home because that is my release from the good or the bad that I see in my day to day job my release is going home to my kids and just doing my job is irrelevant to them they don't see mommy the nurse they just see mom

P. But you are still that kind caring compassionate person

P. Yeah you are but it is different isn't it because they can jump off the slide and jump off walls and you can separate it

P. I am different I put myself in a situation and it is bad what I do cause I go this is what I will be like, you know like I go into saving mode that is how I deal with it, it is important to me about family, everyone has got a mom, everyone has got a brother everyone has got a sister everyone has got a friend and I always think about the family the patient might die but I always think about the family

P. I do think being a nurse changes you as a person

I., Do you?

P. I absolutely do

I. In what way?

P. I mean these guys will know and I am not ashamed to say that I have had counselling for 18 months not only my nurse dying but I didn't realise it was a catalyst to a post traumatic distress and I developed a heightened sense of awareness of fear and danger so even going up and down an escalator I would see the danger with that walking over a bridge I would see the danger in that and I think a lot of that is because I have been a nurse because you see death dying illness disease since being a nurse and becoming a mom as well I think it just changes you as a person

P4. I have changed mine

I. God love you, why have you changed it, no no don't change it actually we will have the 2 because I want to know why you changed it because that is really interesting.

P4. Because when you are listening to other people's stories you think oh god yeah and something else pops in my mind I mean this is just it came to mind first thing when you asked me but now it seems boring so erm a patient was under the influence of NPS and due to the environment I was worried as to how to

manage the situation all my emotions came flooding through as I could see the patient deteriorating in front of my eyes I became frightened and nervous but I had the knowledge and power to treat the patient as my adrenaline kicked in I felt proud of myself and with this I was upset erm I responded to this guy erm the whole wing was out so I had got 400 cons around me I had to get through these prisoners and he was in his cell

I. Is this one of these legal highs?

P4. It is yeah erm and it was just he was just deteriorating in front of my eyes, he was seizing he was going blue I was like oh god what am I going to do?

I. And this is the boring one?

P4. It seems boring to me yeah, I was on my own and didn't know what to do obviously paramedics were coming any way because he came over as a code blue so the paramedics were already on their way I never stood it down he went into obviously cardiac arrest and I did what I could on my own and the officers assisted me the officers did the chest compressions and I bagged him

I. And did he survive?

P4. He did but I don't know he still does it again I see him do it again and it is just frustrating

I. You say you had the knowledge and the power what do you mean by that do you all feel that in your scenarios that?

P4. I think it is because you know how to do it and you are shocked at first because you don't expect to walk into a situation like that and obviously being in a cell it is small it is tight you've got a patient on the floor who is unresponsive what could I do you know rectal diazepam that is all I could give him while he was fitting and I am obviously limited to the equipment I've got I've got to rely on my colleagues which was officers because I was the only night nurse on duty

P. I don't think that is boring at all there is a big risk, walking through and not being able to just put an emergency call out and there is not a load of doctors turn up with equipment, there is no one there to help

P4. I was petrified obviously because you are walking through and you don't know what these guys are in for, because my fear is, I had one who was hanging that went out of the window and you know when they say about your manual handling, I picked him up I don't want to be in coroner's court I picked that guy up with his pad mate you do what you've gotta do but it was scary

TALKING

I. Was that your second one?

P4. Yeah I remember it like it was yesterday I was on a night shift this is what I was going to change it to I was on a night shift and I got 2 overdoses 1 paracetamol and he had been staying on (?) for four hours that was my decision I got 3 (?) out so that was 6 staff, 6 officers that was on a night shift so you are obviously down to skeleton staff I am the only night nurse I got a heroin overdose bearing in mind I work in a jail so they shouldn't be having heroin anyway so he'd got to go out, he went out I said to the officer who was in charge of the jail I said what happens if there is anything else, at that we were discussing it and it came over the radio I got a swinger Charlie 4 Charlie 4 her was petrified she was absolutely petrified this girl was and I got the blue emergency response bag and obviously (name) walked up the stairs he tripped up the stairs I remember it really well he tripped up the stairs and fell I fell I was like this I was like a turtle on my back because the blue bag was really heavy he picked me up he went up there and he

unlocked the cell door and I saw him swinging from the light he had tied the noose through the light so I lifted him up me and his pad made lifted him up (name) was hacking him down got him on the bed checked a pulse got a pulse and it was like oh god but yeah

P. I thought I was quite tough and not able to be shocked

I. Why are you shocked? I am curious.

P. Not shocked because you are in a prison and I know that sort of thing goes on in a prison it is more that you are isolated and I have worked on community wards where we had to phone 999 if anything happened and you had to cope on your own with what went on not having doctors on site but to be in a prison on your own

P4. You know when you are doing CPR on your own like I said to you before I had a death on that Sunday and you are doing CPR and I aint joking it feels like for ever for the paramedics to get there because they have got to get through the gates they have got to get through the sterile field then the y have got to get to wherever you am and don't forget the prison regime is still going on you know they are still out on exercise or they are still getting their dinner so it is mind-blowing and it is not effective I will hold my hands up it is not effective you can't be doing CPR for 50 minutes no way even with a rotation it is tiring I had to have erm a massage because of my shoulder and you are in awkward positions like I say manual handling goes out the window

I. So we have got 2 nice ones there.

P4. I thought the first one was quite boring but

P. No not at all

P. My boring is people telling me it took 10 minutes to park like we can have a 10-minute consultation and spend 5 minutes talking about the car park

I. Right participant 5

P5. As a newly qualified nurse in EAU receiving a patient from A+E can be quite daunting as they were in the acute phase of their illness. The patient in question arrived and promptly asked to use the bedpan I was required to assist a catheterisation in another bay and left a student nurse to monitor and wait for the patient to finish the emergency alarm sounded and we all ran to the bed space where the patient was her disabled son with learning difficulties was ushered out the bay and everyone was in a panic especially the student nurse the senior team my seniors that attended bearing in mind I only had my PIN number a matter of months they bought the defib and started advanced life support however they didn't seem fully equipped to deal with that even though they had advanced life support they weren't sure on how the defib was working or how to utilise it effectively they were all certificated as well it wasn't fluid the arrest the management of the arrest but by which time the crash team had come afterwards honestly I felt exceptionally sad for the disabled son as he did not seem to comprehend what was going on very well I had to break the news I had the skills of breaking bad news but didn't feel I was well equipped to as the patient sadly lost her life. I also felt responsibility to the student nurse as she had raised the alarm and needed to be debriefed from the situation that is my story.

I. Was there anything leading up to that that might have suggested that patient was acutely unwell?

P5. Erm she come from A+E and she was a chest pain admission she had been stable her ECG we was waiting tropins and everything she came she was a good colour she was chatty she was positive but she wanted to use a bedpan it was literally she was off the trolley can I use the bedpan please before I had

even had chance to get a set of admitting obs or anything there so A+E were quite happy to bring her down the corridor so I assumed she would be fine but she needed to use the bedpan you know everyone has human rights to use the loo when they want erm that's it you think you are doing the right thing meet their ADLs and stuff yeah you couldn't have predicted it I couldn't have predicted it the fact that I had left my student she was fine it was an acute assessment unit so its they were senior student nurses she wasn't on her own but still you are wet behind the ears you still don't have that exposure that nurses who have been in the job 10 20 years have got

I. What difference might it have made if somebody with more experience had been looking after her though?

P5. I don't think it would have made anything because she would have still needed to use the toilet and who are we to say well no you have got to hold it whilst we are doing your obs and your admission paperwork you know we can read the obs from before she left A+E perfectly fine so you know carry on as far as I am concerned erm I don't think whether it was a junior nurse or a senior nurse that I think the outcome would still have been the same I don't think the advanced life support offered was the best quality I really don't at all I can remember staff particular staff members on the day

I. Medical staff or nursing staff?

P5. Nursing staff and medical staff it happened quite early on in my career and it is just something that has stuck with me I was doing male catheterisation training I was catheterising a male under the supervision of a particular doctor and I can remember all the names in the next bay and I mean when the emergency alarm went off I mean we all run we know that alarm and god it was my bay erm but yeah and I can remember who was messing with the defib who was sticking the pads on the chest I don't remember a lot of things so I am quite surprised I remember stuff like that

I. Why do you think you remember it though?

P. Because it has affected you that bad probably

TALKING

P5. I didn't think it did at the time but thinking back now I did get upset because I felt a big responsibility to the student nurse and also to the son he was only in his 40s erm it may have been my first arrest as a qualified nurse as well but at that time I wasn't having a good time on the ward where I was working I had been subjected to some bullying I just think the whole confidence thing that was a bad time and may be that is why it sticks in my head I just lacked my own confidence at the time and may be that had an influence on how I felt maybe I was made to feel I wasn't good enough and I wasn't capable of dealing with things like that maybe I doubted my own abilities I shouldn't have in retrospect but great we develop we are reflective practitioners at the end of the day we look back on these experiences and see how things change for us at that time I couldn't have said well that is because I am being spoken to everyday by senior members of staff only a couple of them that sort of thing it will make you feel like that if someone is getting at you and screaming at you on a daily basis

FINISHED

Glossary of abbreviations and terminology.

ALS	Advanced Life Support, moves beyond cardiac compressions and mouth to mouth resuscitation to include drug treatment and defibrillation, usually involving the cardiac arrest team.
ITU	Intensive Therapy Unit, or Intensive care but usually abbreviated to ITU.
IV blood	IV stands for intravenous, blood administered through a small plastic tube, inserted into a vein, straight into the blood stream.
CPR	Cardio Pulmonary Resuscitation
A+E	Accident and Emergency, more commonly known now as ED or the Emergency Department, but still frequently referred to as A+E.
NMC	The Nursing and Midwifery Council, nursing's governing body.
"bagged him"	Use of a device to support breathing, the trade name is an Ambubag, the generic name is a bag, valve and mask, use of this device is colloquially known as 'bagging'.
EAU	The Emergency Assessment Unit, mostly medical patients will be admitted to EAU from A+E for assessment and management, but should be transferred to a ward soon after.
defib	Defibrillator, a device used to correct any electric anomalies in the heart, which are a threat to life.
ADLs	Activities of daily living.

	<u>Second order semiology</u>	
Signified	Signifier	Signification
<p>1. Support (bearing the weight of something, have the backing of).</p> <p>Synonyms, <i>Family,</i> <i>Disabled son,</i> <i>Student nurse,</i> <i>Honesty,</i> <i>Busy.</i></p>	<p>I was emotional and showed compassion to the parents. (p2). It was a sad day, but I was proud that we support the family. (p2). I was just on a break and I could overhear the surgeon saying that there was something kicking off in ITU, and nobody told me about it.(p1). because I saved him and if I hadn't listened, I felt I was responsible for the whole, not me on my own, but I managed, I only had 2 students, just two and they were fantastic, they just, we organised it really well, and I was proud to be part of the team that day.(p1). Everyone looked to me as the senior nurse on shift to manage the situation.(p3). it was the consultant's role, but the consultant did not know how to broach it, it was a bit of a stigma. We went in and had a conversation, because the first thing on the agenda would be organ donation, because of how young he is and his organs, so I had to sit through that conversation about organ donation. I stayed on his looking after him erm finished the shift, and then the next day they asked me to go back being his named nurse, because of the relationship I had built up with the parents, erm and nursed him until he went down for donation.(p2). And took him down to theatre for harvesting, and erm made sure that, with the theatre nurse that he looked</p>	<p>Nurses see themselves as the support which is individual to them; the hero, the saviour, call to action, driven by the need to be in control, with an idea of autonomy. But there is a sense of isolation, related to cultural language and the link to the social context, with identification of vulnerability related to this.</p> <p>There is also a feeling of isolation, not having support, which is potentially linked to language, and the societal context. Support for family and relatives is important, and the need to support them, linked to emotion, support is also linked to emotion for other members of the team, but this is represented as behavioural, an action rather than a feeling.</p>

	<p>well for his parents to go down and say their good byes. (p20 I was on my own and didn't know what to do. I said to the officer who was in charge of the jail, I said what happens if there is anything else, at that we were discussing it and it came over the radio I got a swinger.(p4).</p>	
<p>2. Skill (attitudes and ability appropriate for a specific job).</p> <p>Synonyms, <i>Control,</i> <i>Equipment,</i> <i>Honesty,</i> <i>Open,</i> <i>Emotional,</i> <i>Upset,</i> <i>Time,</i> <i>Sympathy</i></p>	<p>The senior team appeared to be confused, and the defibrillator use/ALS (Advanced Life Support) skills were slow, and appeared to be not fluid enough. I felt the team was maybe ill equipped to deal with the cardiac arrest.(p5). My first role as a senior nurse and a patient had a GI bleed.(p4) I was just on a break and I could overhear the surgeon saying that there was something kicking off in ITU, and nobody told me about it.(p1) They came through the doors I was half scrubbed, and still nobody had said to me that he was coming, I had just got as much as I could ready because I was listening ear holing.(p1). I remember feeling that I had managed it well, and I could control the situation, but the patient died, and the death was probably expected, but not planned.(p3). So, I had been a nurse for a long time, and I had managed other areas, I hadn't been on this ward long, I had gone to a ward that was in special measures, the team was really struggling. (p3). I lifted him up, me and his pad made lifted him up, (name) was hacking him down, got him on the bed</p>	<p>Skill is not linked to experience or expertise, but sense of self and self-worth, belief and identity. Social context, not the exclusive right of what is deemed an expert, because we are all experts if we understand the language of the societal group. Nurses do not need to justify skill or knowledge, so intuition ceases to become relevant, because nurses all understand the rationale for decision making. Nursing judges itself against itself, not other professions. The environment can impact on self-worth, nurses feel comfortable in a familiar environment, but feel doubtful of their skill and ability, if in a strange environment. Even nurses who consider themselves "senior", whilst demonstrating some confidence in their abilities, clearly still have doubts, this questions the linear progression from novice to expert</p>

	<p>checked a pulse, got a pulse and it was like oh god but yeah. (p4).</p> <p>I just lacked my own confidence at the time, and may be that had an influence on how I felt, maybe I was made to feel I wasn't good enough, and I wasn't capable of dealing with things like that, maybe I doubted my own abilities, I shouldn't have in retrospect. (p5)</p> <p>But great we develop, we are reflective practitioners at the end of the day, we look back on these experiences and see how things change for us at that time.(p5).</p>	
<p>3. Panic (a sudden overwhelming fear that affects an individual or especially one that grips a crowd or population).</p> <p>Synonyms, <i>Emergency,</i> <i>Worried how am I going to manage this,</i> <i>Frightened,</i> <i>Fear,</i> <i>Nervous,</i> <i>Blood,</i> <i>Confusion,</i> <i>Scared,</i> <i>Smell,</i> <i>Time,</i> <i>CPR,</i> <i>Adrenaline.</i></p>	<p>The emergency alarm sounded, and we all ran to the bed space where the patient was. Her disabled son was ushered out the bay, and everyone was in a panic. (p5)</p> <p>Due to the environment, I was worried how to manage the situation.(p1).</p> <p>As an ITU nurse I was scared due to the devastation this situation had whilst I was on duty.(p2).</p> <p>It was a man who had been brought to theatre earlier that day, and they thought that potentially a clip had come off, and he was bleeding. (p1).</p> <p>It was not something I had ever seen, it was like something out of a horror movie, there was a ridiculous amount of blood and the smell was just like a ? smell so obviously it was something that just poured out. (p3).</p> <p>The emergency medical team came out, and everyone is just working on this patient. (p5).</p>	<p>There is an awareness of nurses being outsiders, not being one of the "others" in the situation, but a focus on the humanist element of clinical judgement which informs actions and behaviours, which potentially makes them different, or that is the way they perceive this.</p> <p>This seems to differentiate nurses from the "others", there is no sense of panic from this, but an acceptance.</p> <p>Panic ensues from being lost in the crowd, and the perception of self and others in the crowd, with potential loss of control and identity.</p> <p>There is no perception of being scared of situations not faced before, just non recognition of the cultural norms and standards, and the communication strategy that nurses use as a cultural</p>

	I was petrified obviously because you are walking through, and you don't know what these guys are in for. (p4).	group, not just by other professions but also by other nurses.
<p>4. Control (the power to influence or direct people's behaviour or the course of events).</p> <p>Synonyms, <i>Life,</i> <i>Death,</i> <i>Confusion,</i> <i>Staff,</i> <i>Noise,</i> <i>Time,</i> <i>Busy,</i> <i>Fail,</i> <i>Debrief.</i></p>	<p>I also felt responsibility for the student nurse as she had raised the alarm, and needed to be debriefed from the situation. (p5).</p> <p>They came through the doors, I was half scrubbed and still nobody had said to me that he was coming, I had just got as much as I could ready because I was listening ear holing.(p1).</p> <p>Everyone looked to me as the senior nurse on shift to manage the situation. (p3).</p> <p>And it just seemed that I controlled the staff, and I controlled the emergency on the ward, and we had done everything that we were meant to be doing and that was all fine. (p3).</p>	<p>There is a sense of guilt linked to a loss of control, the need to control to assuage the guilt.</p> <p>The antithesis to control is the need to promote own actions because of loss or lack of control, which suggests a vulnerability due to lack of control and self-doubt about how actions and behaviour impact on others.</p>
<p>5. Duty (moral or legal obligation avoid acts or admissions that may cause harm)</p> <p>Synonyms, <i>Life,</i> <i>Death,</i> <i>Staff,</i> <i>Honesty,</i> <i>Open,</i> <i>Time,</i> <i>Busy.</i></p>	<p>All procedures went out of the window, we were literally swabbing and scooping blood and throwing it onto the floor.(p1)</p> <p>Well I hope so, he might still have a swab stuck in him.</p> <p>Do you know it was just one of them situations, luckily the man survived, I don't know if he is still alive now he left, went to ITU for 2 weeks well 1 week and then he got moved. (p1)</p> <p>I think we miss the opportunity to be honest sometimes, I think a lot of health care workers want to save people from dying, nobody wants patients to die, but death is a part of life. (p3).</p> <p>I stayed on his looking after him erm finished the shift, and then the next day they asked me to go</p>	<p>Duty is linked to autonomy rather than protocols, morality and obligation to the patient and to self but self as a 'nurse'.</p> <p>Harm seems to come not from challenging conventional policies and procedures, but from our own morality, the duty we have to the patient and ourselves.</p> <p>The belief of cultural identity seems to shield everyone important from harm, the use of humour and language, and the sense of professional agency, being in control ensures that cultural values and beliefs are adhered to, and we are all protected.</p>

back being his named nurse, because of the relationship I had built up with the parents erm, and nursed him until he went down for donation. (p2)

The fact that they can't go out to get the boy out of the car, because I thought we had all got a duty of care, you know what I mean, if that happened out there you would stop and jump on the ? you know, you would as a nurse, you are told by the NMC to stop your car if there is a an accident.(p2).

I separate my role as a mom, the things I see in the day to day in my nursing I don't take home, because that is my release from the good or the bad that I see, in my day to day job my release is going home to my kids, and just doing my job is irrelevant to them, they don't see mommy the nurse they just see mom.

I am different, I put myself in a situation and it is bad what I do, cause I go this is what I will be like, you know like I go into saving mode that is how I deal with it. (p2)

It is important to me about family, everyone has got a mom, everyone has got a brother, everyone has got a sister, everyone has got a friend, and I always think about the family, the patient might die, but I always think about the family.(p5)

I had one who was hanging, that went out of the window, and you know when they say about your manual handling, I picked him up I don't want to be in coroner's court, I picked that guy up with his pad mate, you do what you've gotta do but it was scary, I lifted him up me and his pad made lifted him up (name) was hacking him down got him on the bed checked a pulse got a pulse and it was like oh god but yeah. (p4).

	<p>You know when you are doing CPR on your own, like I said to you before, I had a death on that Sunday and you are doing CPR, and I aint joking it feels like for ever for the paramedics to get there.(p4). But she needed to use the bedpan, you know everyone has human rights to use the loo when they want erm, that's it, you think you are doing the right thing, meet their ADLs and stuff.(p5).</p>	
<p>6. Compassion (feeling of sorrow and pity for someone in trouble).</p> <p>Synonyms, <i>Sad,</i> <i>Commode/bedpan,</i> <i>Frightened,</i> <i>Sympathy,</i> <i>Emotional,</i> <i>Upset,</i> <i>Honest,</i> <i>Open,</i> <i>Sadness,</i> <i>Proud.</i></p>	<p>It is important to me about family, everyone has got a mom, everyone has got a brother, everyone has got a sister, everyone has got a friend and I always think about the family, the patient might die but I always think about the family. (p5). I felt immense sadness for the disabled son as the patient sadly lost her life. (p5) All my emotions came flooding through as I could see the patient deteriorating in front of my eyes.(p3). I was emotional and showed compassion to the parents.(p2). It was a sad day, but I was proud that we support the family.(p2) Proud, just really proud. (p1) You had a patient that had got alcoholic liver disease and was going to die, but nobody had prepared the patient or the family for the death, so it wasn't a nice death it was a really horrible death. But it was just it just seemed barbaric, it was just a horrible death, there were people working away on this patient trying to get access, trying to mop up blood. Like you say trying to do CPR, but he was probably already dead, this patient is already dead, and it</p>	<p>Compassion is related to a shared sense of suffering, not just with the patients and relatives but also with each other. There needs to be a sense of belonging and self-awareness, because emotion is behavioural rather than a mystical feeling. Although the experience of nursing seems to heighten a sense of danger, emotion is evidenced not by an inner feeling, but by the response by the nurse to situations and other people, is related to whether others meet our cultural norms, and the goals we have are being met.</p>

	<p>could have been very different had it have been a planned death. (p3).</p> <p>And I still think to this day that happened, as I say working on there for 4 years, after and seeing how other patients were treated, and how the conversation were had, I just think they missed an opportunity.</p> <p>I think that is the sad side of nursing, sad and hard, especially when the people who are working with you have got kids, and now that I have got children I don't know that I would have I think I would find that situation a lot harder than I did at the time. (p2).</p> <p>I am shocked by asthma attacks anyway, like I say because I have children then I am not a nurse, I am putting myself, I am a mom and my children haven't got asthma but when there is a situation like that I immediately go to mom I don't go to dad I going into mom and I am thinking oh my god this is terrible this is someone's child it could be my child that is why I am shocked because of the story not because I am a nurse but because of the reflection and because (name) had to witness it, that upsets me for (name). (p1).</p> <p>You know because I haven't ever, you know, touch wood, I have been fortunate that in ten years I have never had to go through that situation, and I am thankful for it, but I am upset for (name) that is why I am shocked. (p2).</p> <p>I am different, I put myself in a situation, and it is bad what I do, cause I go this is what I will be like, you know like I go into saving mode that is how I deal with it. (p2).</p>	
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	<p>I developed a heightened sense of awareness, of fear and danger, so even going up and down an escalator I would see the danger with that, walking over a bridge I would see the danger in that, and I think a lot of that is because I have been a nurse, because you see death dying illness disease, since being a nurse, and becoming a mom as well I think, it just changes you as a person. (p2).</p> <p>Thinking back now I did get upset, because I felt a big responsibility to the student nurse, and also to the son he was only in his 40s.(p5).</p>	
<p>7.Knowledge/knowledgeable (information acquired through learning or experience/well informed).</p> <p>Synonyms, <i>Confusion,</i> <i>Honest,</i> <i>Defib/ALS skills poor,</i> <i>Open,</i> <i>Proud.</i></p>	<p>As a newly qualified nurse on the ward, receiving a patient from A+E could be quite daunting, as they were in the acute phase of their illness. (p5).</p> <p>I became frightened and nervous, but I had the knowledge and power to treat the patient as my adrenaline kicked in I felt proud of myself and with this I felt upset with joy.(p3).</p> <p>We were open and honest regards the situation, and show sympathy.(p2).</p> <p>I had never worked on a gastro ward before, so it was a new speciality for me, so as I say I was still learning the speciality.(p3).</p> <p>The medics could have made that decision you know, they look after gastro patients all the time, you know with alcoholic liver disease, this man was really poorly. Having worked on there for 4 years after that I think I would have made that decision or that call a lot sooner in that man's care.(p3).</p> <p>But there was no signs of life, so over the next few hours they decided that they would have to do brain stem tests erm, we would support the family to</p>	<p>The concept of novice is not related to a lack of knowledge, but to a lack of self-worth, knowledge is related not to what is known, but shared values and behaviour. Being overwhelmed and a lack of self-worth relates to not understanding these, being part of the cultural group. Knowledge also comes from being informed, mostly about patients and self but also about the shortcomings of others, if they do not meet cultural expectations.</p> <p>Decision making is not linked directly to knowledge, as this seems to be expected and assumed, but relates to the individuals confidence in their own judgement, and the sense of agency to communicate this.</p>

	<p>explain. The consultants did not know how to sit, so obviously because you are the nurse looking after that patient you have to go and sit and have those conversations with the parents.</p> <p>Organ donation is quite erm, it was a learning curve for me.(p2).</p> <p>I think it is because you know how to do it, and you are shocked at first, because you don't expect to walk into a situation like that.(p4).</p> <p>You couldn't have predicted it, I couldn't have predicted it, the fact that I had left my student, she was fine, it was an acute assessment unit, they were senior student nurses she wasn't on her own but still you are wet behind the ears, you still don't have that exposure that nurses who have been in the job 10 20 years have got. (p5)</p> <p>As far as I am concerned erm, I don't think whether it was a junior nurse or a senior nurse, that I think the outcome would still have been the same. (p5).</p>	
<p>8. Power (control and influence exercised over others, skills opportunity or authority to do something).</p> <p><i>Synonyms</i> <i>Life</i> <i>Death</i> <i>Staff</i> <i>Honesty</i> <i>fail</i></p>	<p>They came through the doors, I was half scrubbed and still nobody had said to me that he was coming, I had just got as much as I could ready, because I was listening ear holing. (p1).</p> <p>Because I saved him, and if I hadn't listened, I felt I was responsible for the whole, not me on my own but I managed, I only had 2 students just two, and they were fantastic, you they just we organised it really well, and I was proud to be part of the team that day. (p1).</p> <p>Everyone looked to me as the senior nurse on shift to manage the situation. (p3).</p> <p>I remember feeling that I had managed it well, and I could control the situation, but the patient died, and</p>	<p>There is a strong sense of agency and self-worth, power over emotions, own and others and a confidence to have power and control, although the reflection was negative if the patient died.</p> <p>There was not the sense of not being able to do anything, or having autonomy or authority, not context related, but due to personal agency and being part of the societal group, whether it be in the context of nursing or the context of the clinical placement area.</p>

	<p>the death was probably expected but not planned.(p3) It was the first situation I had ever been in where I needed to council a team after a death.(p3). And it just seemed that I controlled the staff, and I controlled the emergency on the ward, and we had done everything that we were meant to be doing, and that was all fine.(p5). I did what I could on my own, and the officers assisted me, the officers did the chest compressions and I “bagged” him. (p4). I think it is because you know how to do it, and you are shocked at first because you don’t expect to walk into a situation like that.(p4). What could I do you know, rectal diazepam, that is all I could give him while he was fitting, and I am obviously limited to the equipment I’ve got, I’ve got to rely on my colleagues which was officers because I was the only night nurse on duty. I’d got 2 overdoses, 1 paracetamol and he had been staying on (?) for four hours that was my decision. (p4).</p>	<p>This offers protection, but not always being part of the wider team impacts on autonomy and authority, but that does not seem to matter because the nurse has power over self and a sense of agency.</p>
<p>9. Ill equipped (not having the necessary resources or qualities for a particular role or task).</p> <p>Synonyms, <i>Worried how am I going to manage this,</i> <i>Frightened,</i> <i>Nervous,</i></p>	<p>I felt the team was maybe ill equipped to deal with the cardiac arrest. (p5). In an emergency theatre erm, we didn’t have a lot of staff we only had one operating theatre working.(p1) I was the assistant at the table in the only theatre that was working, I had only got some students that was all we had got just me and some students . (p1). I think a lot of health care workers want to save people from dying, nobody wants patients to die, but death is a part of life. (p2).</p>	<p>Judgement and blame, others not good enough and do not meet the standards of the nurse, something gave the candidates the right to judge others, is it because they are not in the societal group? But they are also good at judging themselves, there is an antithesis with the sense of lack of confidence, the</p>

<p><i>Scared'</i> <i>Fail.</i></p>	<p>It is more that you are isolated, and I have worked on community wards where we had to phone 999 if anything happened, and you had to cope on your own with what went on not having doctors on site.(p4).</p> <p>I had been a nurse for a long time, and I had managed other areas, I hadn't been on this ward long, I had gone to a ward that was in special measures, the team was really struggling.(p3).</p> <p>I was on my own and didn't know what to do. What could I do, you know rectal diazepam that is all I could give him while he was fitting, and I am obviously limited to the equipment I've got, I've got to rely on my colleagues which was officers because I was the only night nurse on duty.(p4).</p> <p>It is not effective, I will hold my hands, up it is not effective, you can't be doing CPR for 50 minutes, no way even with a rotation, it is tiring I had to have erm a massage because of my shoulder, and you are in awkward positions, like I say manual handling goes out the window.(p5).</p> <p>I don't think the advanced life support offered was the best quality I really don't at all, I can remember staff particular staff members on the day.(p5).</p>	<p>enigma here is what was done about the failings of others?</p> <p>Whilst there is judgement of others for not having expected qualities, potentially through the use of Hypothetico-Deductive reasoning, there is also a perception of vulnerability and isolation through the use of the Intuitive-Humanist model of decision making, potentially use of either leads nurses ill-equipped.</p>
<p>10. Responsibility (The state or fact of having a duty to deal with something or of having control over someone. The opportunity or ability to act independently and take decisions without, authorization).</p>	<p>I also felt responsibility for the student nurse as she had raised the alarm, and needed to be debriefed from the situation.(p5).</p> <p>We were open and honest regards the situation and show sympathy.(p2).</p> <p>I went into another theatre and set it up without being told, and set the theatre up with a big laparotomy set and everything else, and still nobody had said that anything was coming.(p1).</p>	<p>Nurses have a strong sense of what they deem to be responsibility but this also seems to be linked to the blame culture, and nurses blaming themselves for circumstances outside of their control, and within their control.</p> <p>Societal context may have a significant impact on a sense of responsibility,</p>

<p>Synonyms, <i>Disabled son,</i> <i>Student nurse,</i> <i>Family,</i> <i>Staff,</i> <i>Honesty.</i></p>	<p>They came through the doors, I was half scrubbed and still nobody had said to me that he was coming, I had just got as much as I could ready, because I was listening ear holing.(p1). But there was no signs of life, so over the next few hours they decided that they would have to do brain stem tests erm, we would support the family to explain, the consultants did not know how to sit, so obviously because you are the nurse looking after that patient you have to go and sit, and have those conversations with the parents.(p2). I stayed on his looking after him erm finished the shift, and then the next day they asked me to go back being his named nurse, because of the relationship I had built up with the parents erm, and nursed him until he went down for donation.(p2). It is more that you are isolated, and I have worked on community wards where we had to phone 999 if anything happened, and you had to cope on your own with what went on not having doctors on site.(p4). Thinking back now I did get upset, because I felt a big responsibility to the student nurse and also to the son, he was only in his 40s.(p5).</p>	<p>particularly the societal group of the nurse, patient and relatives. There are shared cultural values, as the patient and nurse share worlds, neither of which is dominant, which increases the nurses sense of duty, as well as potentially the patients and relatives.</p>
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Appendix five – ethical approval.

Interview guide

Introductions

- Thank the participant for agreeing to be interviewed
- Remind the participant about the focus of the study and potential benefits
- Read out consent and check that the participant is happy to proceed with interview and that interview will be taped.
- Reassure the participant she/he can withdraw any time from the study and that anonymity will be guaranteed.
- Remind the participant to maintain confidentiality in relation to patients, member of staff and/or clinical areas.
- Inform the participant about the process of the interview - what to expect.
- Reassure the participant that any information they give will be in strict confidence, no judgements or actions will be taken on anything that they disclose. In the event of dangerous practice being identified, the participant would be encouraged to escalate concerns, following the agreed protocol within their Trust.

Ice breaker / warming up questions

- Can you tell me how long you have been a registered nurse?
- What do you enjoy most about your job?

Key Question

Can you tell me about a particular event that stands out for you when you had serious concerns about a patient's condition?

Describe what happened.

Probe questions

Who else was involved?

Can you tell me a little more about.....

How did you feel about that..?

What do you think were the consequences of what you did?

Do you think anything else could have been done and by whom?

Winding down questions

Your stories have provided an interesting insight. Is there anything else I should have asked you or that you want to add?

Please feel free to email me if you have any comments or questions following the interview.

Thank participant for her/his time and contribution

TO BE PRESENTED ON FACULTY LETTERHEAD

Letter to Manager



Dear

Project title: Recognising and responding to an acutely ill patient; revisiting nursing intuition post Benner

As part of my Professional Doctorate in Health and Wellbeing at the University of Wolverhampton, I am undertaking a research project, which aims to explore the concept of intuition and how this is represented in contemporary nursing practice, including the impact this has on inter-professional relationships.

I anticipate that the potential contribution of the study will be:-

- A contribution to the evidence, research base and current discussion on knowledge specific to nursing, and whether traditional notions of “instinct” and “intuition” are relevant for contemporary nursing practice
- A contribution to the current pre-registration nursing curriculum and assessment of nursing knowledge, moving beyond task-focused to a more holistic approach.
- At a practice level offering nurses a voice, in current discourse about knowledge and language, how this is represented in actions, and inter - professional relationships.

The study is being conducted within The University of Wolverhampton and I would like to interview 6-10 registered nurses individually, from your organisation, currently enrolled as a student on a Continuous Professional Development course. The interviews will be conducted in a setting that is most convenient to the participant.

Please be reassured that strict confidentiality and anonymity of staff, patients and clinical locations will be ensured at all stages of the project, in accordance with established research governance guidelines.

I hope you will feel able to give your support for this study. I have enclosed a copy of the participant information and informed consent documents for your information. If you have any queries or would like to discuss this further please do not hesitate to contact me (details above) and I would be very happy to answer any questions you may have. Thank you for your time.

I look forward to hearing from you.

Yours sincerely,

Letter to participants.

TO BE PRESENTED ON FACULTY LETTERHEAD

Dear

Project title: Recognising and responding to an acutely ill patient; revisiting nursing intuition post Benner

I would like to invite you to participate in a research project, which I am conducting as part of a Professional Doctorate in Health and Wellbeing at the University of Wolverhampton. I have enclosed an information sheet, which explains the project.

If you are agreeable to being interviewed, the interview would take approximately 60 minutes, and will be arranged at a mutually convenient location, date and time. As indicated in the attached project information, strict confidentiality and anonymity of staff, patients and clinical locations will be ensured at all stages of the project, in accordance with established research governance guidelines.

A summary report of the findings will be available to you upon completion of the project.

Please take time to read the attached information and consider whether you would like to be take part in the project. If you are willing to be interviewed please return the attached informed consent form to me by e-mail, only those who return the form will be considered as willing to participate in the project.

Feel free to contact me for any further information, or if there any questions that you have about being a participant in the project

Yours sincerely,

Andrea Mason, Senior Lecturer, Institute of Health Professionals.

Telephone [redacted] e-mail [redacted]

Participant information sheet.

Project title: Recognising and responding to an acutely ill patient; revisiting nursing intuition post Benner

You are being invited to take part in a research study, please take time to read the following information carefully to ensure that you make an informed decision on whether you wish to be a participant and feel free to discuss it with anyone with whom you feel appropriate. Please feel free to contact me for any further information or if there any questions

Thank you for reading this.

What is the purpose of the study?

Recognising and responding to the acutely ill patient, and recommendations for accurate and timely monitoring of vital signs, and escalation of concerns using agreed protocols, are dominant imperatives in contemporary nursing practice. Research literature suggests that nurses take a different approach to medical professionals in recognising the signs and symptoms of an acutely ill patient, and escalating concerns, with prevalent use of terms such as “worried” and “knowing something is not right” (Massey, Aitken and Chaboyer 2008).

Historically, nursing practice has been informed by ‘nursing knowledge’ exemplified by Benner’s (1984) staged model of nursing expertise, ‘From Novice to Expert’. In recent times such models have been criticised on the basis that their value is not in the staged process, but in the insights they provide about the nature of nursing practice, which are achieved despite rather than through the stages (Dall’Alba and Sandberg 2006). To this extent, ‘Intuition’ is a concept embedded in Benner’s model as fundamental to nursing knowledge. However while some suggest that Benner (1984) provides good evidence that intuition, as a phenomenon is real, others argue that the legitimacy of intuition, when applied to nursing knowledge, lacks robust reasoning and explanation (Gobet and Chassy 2006; Paniagua 2004). Hence it may be denigrated as a mere magical process of knowing. This is an original study, which aims to explore and understand more about intuition, its contribution to nursing knowledge, and how it influences contemporary nursing practice and inter - professional relationships, particularly with medical staff.

Potential contribution of the study to nursing practice

It is anticipated that the potential contribution of the study will be:-

- A contribution to the evidence, research base and current discussion on knowledge specific to nursing, and whether traditional notions of ‘instinct’ and ‘intuition’ are important in contemporary nursing practice
- A contribution to the current pre-registration nursing curriculum and assessment of nursing knowledge, moving beyond a task-focussed to a more holistic approach.

- At a practice level offering nurses a voice, in current discourse about knowledge and language, how this is represented in actions, and inter - professional relationships.

Why have I been chosen?

You have been selected to participate in study because you have relevant knowledge and experience of working with adult patients in an acute clinical area, and are involved in the care and management of an acutely ill patient/deteriorating patient

Do I have to take part?

It is entirely your decision on whether or not to take part. If you do decide to participate you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw from the project at any time and without giving a reason. All data will be anonymised meaning that there is no possibility of either you or the clinical area where you work being identified. Direct anonymised quotes from your interview may be used in the presentation of the findings and in the final report. These will be identified by a code or pseudonym.

What will happen to me if I take part?

If you agree you will be asked to take part in an individual interview with me at a mutually agreed time and venue. I anticipate that the interview will last between 30- 60 minutes, which will be digitally recorded. During the interview you will be invited to describe your experiences of recognising and responding to an acutely ill/deteriorating patient. It is possible that a follow up interview might be requested at a later date to clarify or expand on any issues you raise.

What do I have to do?

In order to be involved in this study, you need to return the enclosed consent form either by post or email to me, as the researcher. My contact details are enclosed. I will then contact you to arrange the interview at a mutually agreed date, time and venue. You will be given an information sheet and a copy of the signed consent form for you to keep.

What are the possible benefits of taking part?

By taking part in the study you will be contributing to the evidence base and discussion around nursing knowledge, how this influences patient care and inter-professional relationships and how notions of 'intuition' and 'instinct' may or may not make a contribution in contemporary nursing practice. The findings of the study will be available to managers, academics, commissioners, service users, decision makers and will inform their thinking about current nursing practice.

What will happen to the results of the research study?

The final research report will be available electronically from the researcher at the end of the study period. It is anticipated that the results of the study will be widely disseminated within the national nursing community via conferences and peer-reviewed journals such as the Journal of Advanced Nursing.

Who has reviewed the study?

This study has been approved by the University of Wolverhampton School of Health and Wellbeing Research Ethics Committee.

What if I have a problem or concern?

If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions. Alternatively, you can contact one of my supervisors- Dr. Vinette Cross: [e-mail address redacted] or Dr. Dean-David Holyoake: [e-mail address redacted].

Contact for further information

You can contact me for further information by email: [e-mail address redacted]

Thank you for reading this information.

Debriefing Form

During the interview (if participant becomes upset/distressed):

Would you like a short break before we continue?

Would you like a drink of water?

Is it alright to continue?

Would you like me to stop the interview?

At the end of the interview

Before we finish the interview, I just need to ask you a few questions:

- Do you have any questions or comments about anything that we haven't already discussed?
- Does anything strike you as particularly interesting?
- Is there anything else you would like to add?

After the interview:

The interview is over now, but before you go, I have a written information sheet for you to take away with you in case you are worried or upset by anything we have discussed.

Thank you for agreeing to participate in this study.

If you feel especially upset about anything you have discussed with me please feel free to contact me about options for counselling:

[number redacted] e-mail [e-mail address redacted]

Alternatively, you could also contact a member of my supervisory team:

Dr. Vinette Cross: [e-mail address redacted] or Dr. Dean-David Holyoake: [e-mail address redacted] with whom you may discuss any problems.

Appendix 6 – excerpts from my reflexive diary.

Data collection;

“Introduced the topic to a group of SLAIP students using a powerpoint, included recognising and responding to acutely ill patient. The reaction from the group was underwhelming, had seven people offer, three I knew,? coercion ?motive”.

“Why the reluctance? Did I explain it well enough how persuasive was I?”.

“E - mailed all of the students only one response, why? I felt a little lost! What do I do now realise we'll need to find other groups, how much time will this take?”

“Approached some students of advanced practitioner course, seemed very keen now trying to sort suitable time for data collection”.

“Recruited all six for next Wednesday before class, lots of enthusiasm about being part of doctoral study I'm very keen stupid faction for their portfolio”.

“I gave them the activity and they all seemed to understand if I was to do it again I would start with scenario first as this would give the words and paragraph more meaning or would I? On reflection that is probably the link to be made on an individual basis”.

“I could have explained my role within the process better, I found it difficult not to interject comment and ask questions, but on reflection this was appropriate because it enabled the participants to do it for themselves”.

“The participants seemed to understand or at least see me as the data collector what this means I'm still struggling, with I may need to do some reflection on my role within the group and maybe including in the following interviews