Exploring the role of the Stroke Nurse Consultant in Scotland: a qualitative analysis

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Abstract

Exploring the role of the Stroke Nurse Consultant: a qualitative analysis

Background

‘The Coronary Heart Disease and Stroke Strategy for Scotland’ (Scottish Executive Health Department, 2002) sets out the future direction for stroke services in Scotland. Part of the role identified for Managed Clinical Networks for stroke is to consider the creation of consultant nursing posts. Currently no such posts exist in Scotland, so how would the role work in practice?

Aim

The research study aimed to explore the role of the Stroke Nurse Consultant from the perspectives of nurses caring for people affected by stroke, within health care settings in Scotland.

Method

This study used a qualitative approach based on the principles of grounded theory (Glaser and Strauss, 1967). An open style questionnaire was sent to a purposive sample of 156 members of the Scottish Stroke Nurses Forum. The questionnaire was designed to allow free flowing accounts of the respondents’ perspectives of the phenomenon to yield valuable insights and address the research question.

Findings

The overall response rate was 68%. A total of 112 completed questionnaires formed the data for analysis. The main findings showed nurses caring for people affected by stroke were in positive support of the creation of the Stroke Nurse Consultant role in Scotland. However, there was a need for clarity of the purpose and function of the role to ensure organisational ‘fit’ and synergy with existing nursing positions. The Stroke Nurse Consultant post was seen as adding value to the specialty of
stroke within the four domains of the role: expert practitioner, leadership, education, service development and research. The findings illustrate the Stroke Nurse Consultant role would provide recognition for the worth of stroke nursing, offer nurses career progression and the opportunity to retain a practice element at an advanced level. However, further evaluation of the efficacy of the Stroke Nurse Consultant role is required. The core category that linked the perceptions of the participants showed that they were patient focused. Thus the essence of what was most significant to participants was being ‘patient-centred’ and ‘the desire to improve patient care’.

Conclusion

The research study goes some way to begin to clarify key areas a Stroke Nurse Consultant may play in stroke services, the benefits the role may offer patient care and the opportunities for stroke nursing. The study provides new insights and direction to inform Managed Clinical Networks for stroke in the development of such posts.
1. Introduction

Stroke is the third most common cause of death in Scotland, and the most frequent cause of severe adult disability in Scotland. At any point in time 70,000 individuals are living with stroke and its consequences. Each year there will be approximately 15,000 new stroke events (Scottish Intercollegiate Guidelines Network (SIGN), 2002). Stroke generates a large clinical workload for nurses caring for people affected in hospital and community settings. The Minister for Health and Community Care launched ‘The Coronary Heart Disease (CHD) and Stroke Strategy for Scotland’ (Scottish Executive Health Department (SEHD), 2002) which sets out the future direction for stroke services in Scotland. Part of the role identified for Managed Clinical Networks (MCN) for stroke is:

“Considering the creation of consultant therapist and nursing posts, in line with service developments” (SEHD, 2002, page 15).

Currently, no Stroke Nurse Consultant posts exist in Scotland, so how would the role work in practice? There are a number of Stroke Nurse Consultants in England, but how would the role function in Scotland? The Scottish Stroke Nurses Forum (SSNF) has highlighted this specific issue in the document ‘Strategy for Stroke Nursing in Scotland’ (SSNF, 2003, Appendix B) stating the nurse consultant role in stroke requires clarity and definition.

The research study involved an exploration of the role of the Stroke Nurse Consultant in Scotland using a qualitative approach and the principles of grounded theory (Glaser and Strauss, 1967). An open-ended questionnaire was sent to nurses involved in the care of people affected by stroke to elicit perspectives on the role of the Stroke Nurse Consultant. The data were analysed to identify emerging categories and themes and yielded valuable insights into the issues relevant to the creation of such posts.

The NHS Executive (1999) has produced clear guidance on establishing nurse consultant posts and identified the key components of the role as; expert practice, leadership and consultancy, education, training and development, practice and service development, and research and evaluation. ‘The NHS Plan’ (Department of Health (DoH), 2000) set a target of 1000 nurse consultant posts by 2004. Among the
posts established in England there are currently eleven Stroke Nurse Consultants (Williams, 2004). The King’s Fund report (Guest et al, 2001) evaluated the experiences of nurse consultants to date and highlights the benefits for patients, improvements in services and career opportunities; but also showed the problems faced by the nurse consultants. Within Scotland in 1999, the Minister for Health and Community Care launched a pump priming exercise for one year to encourage health boards to create nurse consultant posts to provide better outcomes for patients by improving services and quality of care across NHS Scotland (NHS Scotland, 2003). Thirteen nurse consultant posts were created as a result, although none in stroke care.

**Aim of the Research Study**

The research study aimed to explore the role of the Stroke Nurse Consultant from the perspectives of nurses caring for people affected by stroke, within health care settings in Scotland.

**Objectives**

- To devise an open style questionnaire to explore the role of the Stroke Nurse Consultant in Scotland.
- To send the questionnaire to nurses caring for people affected by stroke in health care settings throughout Scotland.
- To discuss the findings in relation to the current literature, and critique and reflect on the research study.
- To consider the implications for clinical practice and future research studies.

The researcher currently works as a Director for the medical charity Chest, Heart & Stroke Scotland (CHSS) and is Secretary of the SSNF. For a summary of the researchers curriculum vitae see Appendix A.

To begin the literature review (Chapter 2) will critically evaluate relevant knowledge and theory in the area of the Stroke Nurse Consultant’s role. This will be followed in Chapters Three and Four by the research methodology and methods adopted in the study including: the research design, sampling approach, data collection and analysis. The findings will then be presented in Chapter Five,
followed by discussion and critique of the research design (Chapter 6). The conclusion will present the key themes in the final section. Full listings of abbreviations used throughout the text are contained in the glossary (p 65).
2. The Literature Review

The literature review will critically evaluate relevant knowledge and theory in the area of the Stroke Nurse Consultant’s role including; background, the nurse consultant’s role and other aspects. Undertaking this review of the literature concerning the nurse consultant within the context of nursing, stroke care and the NHS, has involved a series of literature searches including: the British Nursing Index, Blackwell-synergy, Ingenta, NHS and Health Department websites and manual reference searching.

Background

The Prime Minister, Tony Blair, in a speech at the Nursing Standard ‘Nurse 1998 Awards’ announced a government initiative to introduce nurse consultants. He drew on the results of a national consultation to inform a new strategy for nursing, in particular a broad consensus about the need to strengthen clinical leadership, to continue to develop new and innovative roles, and to improve career paths and opportunities. A commitment to establish the role was outlined in the national nursing strategy ‘Making a Difference’ (DoH, 1999) which acknowledged the need to retain senior nurses, midwives and health visitors in direct patient care. It was hoped that nurse consultants would enable organisations to implement the new vision for nursing, which in turn would facilitate the new modern National Health Service (NHS) in terms of evidence-based practice, clinical effectiveness, individual accountability and clinical governance. It also recognised the contribution of experienced nurses in relation to the development of innovative services (Da Costa, 2002). However, the announcement came suddenly and caught many organisations unprepared. As a result early focus was on the funding available from the government, rather than the role of the nurse consultant and the impact on patient care (Keighley, 2002).

Within Scotland in 1999, the Minister for Health and Community Care launched a pump priming exercise for one year to encourage health boards to create nurse consultant posts. Thirteen nurse consultant posts were created in Scotland as a result, although none in stroke care. The purpose of the nurse consultant posts was
to provide better outcomes for patients by improving services and quality of care across NHS Scotland (NHS Scotland, 2003).

The United Kingdom Central Council (UKCC), (1994) defined advanced nursing practice as:

‘Concerned with adjusting the boundaries for the development of future practice, pioneering and developing new roles responsive to changing needs, and with advancing clinical practice, research and education to enrich professional practice as a whole’

(UKCC, 1994, p 8).

This definition of higher level of practice forms a well-defined professional framework for the nurse consultant role. The role can be developed in any speciality where it can be shown that it will provide better outcomes. All nurse consultants must conform to a commitment to clinical practice involving working directly with patients, clients or communities for at least 50% of their time. The components of the role comprise of; expert practice, leadership and consultancy; education, training and development; practice and service development, research and evaluation (NHS Executive, 1999).

Three decades of development of senior clinical nurses have preceded the introduction of the nurse consultant. Following the increasing numbers of nurse consultant roles in the United States of America (USA) in the 1970’s, and the plethora of specialist nurses and advanced nurse practitioners in the United Kingdom (UK) in the 1980’s and 1990’s (Wright et al, 1991; Wilson-Barnett et al, 2000), experience and limited evaluations demonstrated clinical, professional and political advantages for establishing the consultant grade. Expansion of nursing functions to incorporate elements of clinical leadership, with expertise in applying evidence-based nursing, greater technical and medical skills and practice development abilities were seen to help the demands facing the NHS (Guest et al, 2001).

‘The NHS Plan’ (DoH, 2000) subsequently set a target of 1000 posts by 2004. Among the posts established in England there are currently eleven Stroke Nurse Consultants (Williams, 2004). Detailed literature on how the Stroke Nurse Consultant role works in practice is scant, and is comprised mainly of professional
narratives (Bryan, 2002; Williams 2004). However, among those already in post there is genuine optimism and a conviction that Stroke Nurse Consultants really can make a difference.

**The Nurse Consultant Role**

The NHS Executive (1999) has provided clear guidance on establishing and appointing nurse, midwife and health visitor consultant posts. The four components of the nurse consultant role are defined as:

- Expert practice
- Leadership and consultancy
- Education, training and development
- Practice and service development, research and evaluation.

This ambitious combination of functions was thought to provide the same status within nursing that medical consultants have within their profession. Da Costa (2003), states the risk of the nurse consultant post becoming just another nursing title is reduced through the tight guidance on the definition, creation and appointment of the positions. Manley (1997) highlights that the multi-dimensional role of the nurse consultant collapses a number of previous roles into one role. In Scotland, all new nurse consultant posts require approval by the SEHD.

The King’s Fund report for the DoH ‘A Preliminary Evaluation of the Establishment of the Nurse, Midwife and Health Visitor Consultants’ (Guest et al, 2001) is prominent in the research literature in its examination of the experiences of nurse consultants to date. Three main research methods were deployed, namely a questionnaire survey of all consultants in post in February 2001, 153 of which returned, a response rate of 95%; a series of repeated telephone interviews with a cross-section of 32 consultants as they started and subsequently developed in their roles, resulting in a total of 138 interviews; and ten network analyses built around interviews with the consultants and members of their role network, resulting in 26 interviews. Among the 153 who completed questionnaires; 54% were hospital based and 23% community based, the average length of service in the NHS was 21 years and the average age 41. The consultants reported that they engaged across all four
specifications identified by the NHS Executive (1999), with the highest involvement in leadership and the lowest in expert practice. The report highlights challenges and problems faced by the nurse consultants, although almost all thought that the concept of the consultant would benefit patients, improve service and quality, and improve career opportunities. Further relevant references are made to the report later in the literature review. A further evaluation of the establishment of nurse, midwife and health visitor consultants is under way, some of the aims include; conducting a fuller test of the job innovation model emerging from the first study, examining how consultants are ‘crafting’ their role to ensure that it remains manageable and they remain motivated, and exploring some of the wider implications for careers. The repeated use of the survey undertaken in first phase of the research will provide a useful longitudinal dimension. The publishing of findings is expected in 2004 (King’s College London, 2004; Crouch et al, 2003).

The research work of Ms Kim Manley, a senior fellow in practice development at the Royal College of Nursing (RCN) Institute (1997, 2000a, 2000b) has informed the health department and provides important insights into organisational culture and nurse consultant outcomes. Through action research, Manley (2000a) demonstrates how a nurse consultant in an Intensive Care Unit can create a positive culture of change in the unit, introduce evidence-based care and multidisciplinary collaboration, empower colleagues and develop practice. The findings strongly suggest that specific configurations of values, such as being people-centred, providing support, enabling development, active participation and devolving decision-making, were evident. The point is made that strong leadership sustained cultural change, and for this momentum to be fully beneficial, leaders of nursing practice need to provide strong clinical direction. The nurse consultant seems well placed in fulfilling such a role from both a practice and academic perspective. Manley’s (1997; 2000a; 2000b) work will be referred to further throughout the literature review.

The Stroke Association (2002) undertook an overview of the range of opportunities available for nurses in stroke care. Job descriptions in stroke care for consultant nurse, specialist nurse, community nurse and lead/senior nurse were independently reviewed and categorised by researchers and clinical staff from University of Leeds and Leeds Teaching Hospitals NHS Trust. The review included a total of three job descriptions of nurse consultants in stroke, and a job template and personal
specification was produced (Appendix C). The job templates were intended as a
guide for clinicians considering developments in stroke nursing. How the Stroke
Nurse Consultant role works in practice varies on the size and nature of the stroke
service, the demographics of the patient population, and not least, the
multidisciplinary team involved (Bryan, 2002).

The literature contains many articles where nurse consultants describe their role,
and although these articles are not in the main research based they provide a rich
tapestry of professional experiences of nurses performing the role in practice.
Examples include: Tracey Williamson who carved herself a unique career
culminating in her appointment as a nurse consultant in research, development and
intermediate care, at the Pennine Acute Hospitals NHS Trust. Part of her role
involves supporting colleagues in their clinical or academic development. She
nurtures an inquiring attitude among nurses, and encourages examination of the
evidence and supports those who want to take part in research, as this will go on
to have an impact on the standard of care delivered (Smy, 2003). For Amanda
Jones, Stroke Nurse Consultant, the focus is on the patient’s journey and equity of
care, working across traditional boundaries to ensure continuity and integration of
acute care and rehabilitation which have been shown to save lives and reduce
disability (Bryan, 2002). Finally, for Lisa Maclean, Nurse Consultant in Accident and
Emergency (A&E) and prison nursing, the most important thing is she works with
nurses to change practice, not as a mini-doctor (Coombes, 2003). These personal
accounts provide interesting insights into how nurse consultants perceive their
role, wish others to perceive it, but are limited in their wider generalisation.

Performing the Role

As previously detailed the NHS Executive (1999) has provided guidance on nurse
consultant posts and the components of the role. However, experience has shown
the need for nurse consultants in new posts to undergo preliminary periods of
assessment and observation to explore the potential of their roles before
concentrating on selected aspects (Shuldharm, 2004). In the literature, authors
discuss the importance of ensuring a ‘fit’ of a nurse consultant post with the
organisation, developing networks and synergising with existing positions. This ‘fit’
is crucial for success of the role (Guest et al, 2001; Da Costa, 2003).
The specific components of the nurse consultant role are presented here as detailed by the NHS Executive (1999) to allow exploration in more detail, but in practice they demonstrate considerable overlap, each informing the other in terms of their respective knowledge bases and processes.

(i) Expert Practice

The NHS Executive (1999) state at least 50% of the nurse consultant’s time commitments are in direct patient contact, in a full range of clinical environments. In the event, Guest et al (2001) found nurse consultants spent an average of 44% of their time on expert practice although there was considerable variation around this average.

In stroke services, patient contact involves working directly in stroke care areas, alongside existing staff, taking referrals from both inpatient and outpatient services of individual patients and families often with more complex support needs (Williams, 2004). The importance of multidisciplinary teamwork within stroke care is well recognised (SIGN, 2002), and effectiveness of nurse consultants depends on their ability to work with other people, and on the willingness of members of the team to work with them and use their expertise to the benefit of patients and nursing (Ashworth, 2000; Bullock and Pottle, 2003). In the future, nurse consultants could play a key role in developing new treatments in stroke such as thrombolytic therapy for acute ischemic stroke. Research is showing some patients with severely disabling stroke recover quickly after early intervention of thrombolytic therapy, and are discharged home within days (National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group, 1995). Innes (2003) describes the nursing implications of introducing thrombolytic therapy in selected UK hospitals; acute stroke areas need to be developed, each shift should include at least one nurse who has been trained in stroke thrombolysis. Currently, the practical barriers to the introduction of thrombolysis include: the lack of nursing knowledge and necessary skill, the lack of organisation and the existence of nursing fears.

Manley (1997) states the work of expert practitioners encompasses both direct and indirect practice, in which direct practice involves caring for patients and their
families while indirect practice involves working with staff. Abley (2001) feels expert practice involves enabling nurses to develop from novice to expert within the speciality. She explains time spent within clinical practice gives nurses the opportunity to reflect on their practice and its rationale, highlights good practice and identifies potential for practice and service improvement. This is reinforced by Manley’s (2000b) study which found the post-holder affected individuals specifically; as a research and educational resource and as a motivator and supporter who was always there and helped them achieve their potential and recognise that there was a career pathway for them, a future in practice to stay and progress, using their expertise.

There is a range of examples of expert practice within the literature (Bryan, 2002; Clegg and Mansfield, 2003; Shuldham, 2004), those aspects related to stroke care include:

- Patient assessment, physical examination, investigation and diagnostics
- Prevention of unnecessary patient admission
- Nurse prescribing
- Support services for patient and families throughout hospital admission
- Improving co-ordination and communication between acute and community services, particularly in relation to discharges
- Nurse led outpatient clinics for follow-up and secondary prevention
- The development and management of multidisciplinary outreach teams and services.

Shuldham (2004) states the nurse consultant role in expert practice is developing and evolving all the time.

(ii) Leadership and Consultancy

Nursing is an increasingly complex and rapidly changing profession that is demanding of nurse leaders with advanced skills and knowledge. Manley’s (2000a) study showed sub-roles of the nurse consultant to be influential including transformational leadership. Transformational leadership has been described as being about change, innovation and entrepreneurship, encouraging personal growth
and empowerment of leaders and followers (Tichy and Devanna, 1990). Key to achieving a quality of care is developing a transformational culture. Such a culture will also facilitate staff empowerment and nursing practice development. Linked to transformational leadership processes are those of being a strategist and catalyst. Manley (2000a) says that being a strategist involves actively looking for and raising awareness of potential future issues, developments and opportunities. Acting as a catalyst encapsulates the activities needed to ‘get things going’. Moore (2001) feels nurse consultants are already proving themselves to be creative and innovative leaders who are shaping the NHS.

Manley (1997) suggests that the consultancy components are drawn from elements underpinning all four components of the nurse consultant role. Caplan’s model (1970) provides an appropriate framework for illustrating the types of consultancy undertaken by nurse consultants:

- Client centred
- Consultee centred
- Programme centred
- Organisation centred.

Carplan’s model offers a way of understanding the potential for different levels of consultancy, with the ability to operate within all four types being a fundamental function of the nurse consultant (Higgins, 2003).

(iii) Education, Training and Development

Within the literature, nurse consultants describe how they fulfill their educational remit of the role by; bedside teaching, often on day-to-day patient management issues, facilitating education for patient and carers and through local, national and international teaching and presentations at conferences and professional meetings (Shuldham, 2004). Many nurse consultants have honorary lecturer status with local universities and are involved in teaching and developing academic programmes, such as Masters courses (Clarke, 2001; Bryan, 2002; Cushen, 2002; Williams, 2004). In stroke care, education and training of health and social care staff is an important aspect (SIGN, 2002). Stroke services should ensure that resources are
allocated for continued professional development. Multidisciplinary education if service delivery is to be truly collaborative and integrated (Abley, 2001; Innes, 2003).

For nurse consultants themselves, prospective post holders are expected to have a portfolio of career-long learning, substantial senior experience and formal education, usually up to or beyond Master’s degree level (NHS Executive, 1999; Clarke, 2001). But it is apparent, as these requirements are translated into job specifications and advertisements, that there is no national consensus on the issues of academic and professional criteria for the role (Higgins, 2003). The evaluation undertaken by Guest et al.’s (2001) highlighted the impact of educational criteria as 65% of nurse consultants surveyed had either a PhD or Masters and 25% had a Bachelor’s degree.

(iv) Practice and Service Development, Research and Evaluation

In several areas the introduction of nurse consultant posts was part of the nursing strategy to empower and develop nurses (Shuldham, 2004). Nurse consultants are involved in both organisational and nursing strategy development and implementation to achieve strategic objectives (Abley, 2001; Da Costa, 2003; Williams, 2004). Da Costa (2003) describes how she acts as the trust lead for the implementation of national health policy and guidelines. Equally, in Scotland a nurse consultant could potentially act as a local lead for ‘the CHD & Stroke Strategy for Scotland’ (SEHD, 2002).

Nurse consultants play a role in both establishing, and participating in, forums and networks across health professions and health communities to move patient care forward strategically and collectively, and as a resource for mutual learning and support (Da Costa, 2003; Shuldham, 2004). In Scotland, this process is supported by the development of MCN’s for stroke (SEHD, 2002). Also part of a wider role, the nurse consultant works closely with the voluntary sector that funds medical research, offers advice and information, and provides community services (Shuldham, 2004; Williams, 2004).
According to Manley (2000a) practice and service development are linked to research and evaluation, and both need to be established by a research culture. This can be accomplished by:

- Utilising, interpreting, evaluating, communicating research and deriving implications
- Testing and applying, translating into protocols, acting as a research coordinator and research generator
- Replicating, generating original ideas, supervising research projects, undertaking collaborative research.

Undertaking such roles in practice requires a knowledge base that is founded firmly in the epistemology of nursing, related and appropriate methodologies and the assumptions underpinning of research paradigms; positivist and interpretive (Lucock, 1996).

Other Aspects of the Role

Several aspects of the nurse consultant role are referred to and discussed in the literature, including support, promotion, evaluation, recruitment and barriers, which are reviewed in more detail.

(i) Support

Although there was some national guidance as to the main functions of this aspect of the role, its practical application appears to depend on a number of factors, including the level of support for the nurse consultant (Cushen, 2002). Support is described as key to enabling nurse consultants to flourish and ensure that they succeed (Clarke, 2001; Bullock and Pottle, 2003). There is a potential for role isolation as the number of nurse consultant posts increases slowly and often with much variation in role and responsibilities. The mechanisms of clinical and peer supervision enable the nurse consultant as a reflective practitioner to establish strengths and weaknesses, informing future professional and academic progression. The experience of established nurse consultants has underlined the importance of
clinical supervision, and why both supervisor and supervisee felt that it was an essential provision (Bullock and Pottle, 2003). Guest et al (2001) reported those who had higher levels of support from their line manager, professional manager and senior management in general tended to report lower levels of role overload, conflict and ambiguity. However, only about a quarter of nurse consultants reported adequate management support and resources.

The NHS Executive (1999) highlighted the importance of local, regional and national networks to ensure practitioners are able to share, and hear about the latest developments. The RCN website (RCN, 2004a), in collaboration with the Foundation of Nursing Studies, offers a nurse consultant network. The purposes of the network are: to provide access to a virtual network, to map research in relation to consultant practitioners, to provide consultant practitioners (nursing and therapy) with a mechanism for influencing national policy, and to provide networking opportunities.

(ii) Promotion

The ‘supernurse’ image of the nurse consultant portrayed by the media has not been helpful (Williams, 2004). Raising awareness and promotion of the nurse consultant role is seen as important as there is a general lack of understanding and potential for misunderstanding of the new positions (Shuldham, 2004). Da Costa (2002) goes further stating nurse consultants need to market their impact on improving patient care and services. Telling people about the role are crucial to its inception and success, as well as having an impact upon nursing, leadership and organisational change across the health community. Raising awareness of what the nurse consultant post comprises of and its contribution to services may also provide information required on which to design evaluation.

(iii) Evaluation

There is much interest in nurse consultant posts including the inevitable question, will they work? It is felt important that the nurse consultant role is evaluated, as
this would help guide the future development of these roles (Bullock and Pottle, 2003). Evaluation needs to be done in a variety of ways both nationally and locally. There have already been national evaluation projects examining initial progress of these roles (Guest et al., 2001). Interestingly, less than a quarter of nurse consultants questioned in the project were clear about how their performance would be assessed and about the criteria for success in the job. Local evaluation may involve looking at patient outcomes and potentially cost analysis. In Manley’s (2000b) study outcomes of the post were measured on its ‘value-addedness’ to the trust. ‘Value-addedness’ was articulated as; lower sickness, turnover and incident rates compared with other areas, the absence of complaints, effective handling of infection outbreaks, and better retention and recruitment of staff. It would seem appropriate that evaluations also relate to the purpose of the post to trace the way in which the role evolves and to assess its impact on patient care as well as its contribution to services. However, nurse consultant roles are in the main extremely complex and may include broad functions (Guest et al., 2001). Clegg and Mansfield (2003) suggest the systematic introduction of patient and carer satisfaction measures, evidence of user experience, clinical outcomes measures and economic evaluation will help improve the evidence base, while the introduction of qualitative research methodologies will capture the essence of high quality care. Burton (2000) feels the ability of nursing to articulate its contribution to health care is paramount if health care is to achieve its aim.

(iv) Recruitment

The issue of recruitment of nurse consultants receives mixed commentary in the literature. ‘The NHS Plan’ (2000) envisaged 1000 nurse consultants being in post by 2004, however, Higgins (2003) indicates there are signs that Trusts are finding it hard to fill these posts. In contrast, Ashworth (2000) feels that the constant change in the NHS over many years and the removal of much of the hierarchy in nursing has allowed freedom for nurses to develop in more innovative ways, so that many more nurses have the clinical specialisation, clinical experience and advanced expertise knowledge required of the nurse consultant. Bullock and Pottle (2003) add that, prior to the nurse consultant, there was a distinct lack of clinical career structure potentially leading to dissatisfaction and frustration for people who want to remain ‘at the bedside’. The creation of the nurse consultant position was the
foundation for nursing undertaking changing roles with increased responsibility and autonomy. The nurse consultant concept can work in practice if the right people are appointed, having the right preparation, adequate freedom and flexibility, and support (Ashworth, 2000).

(v) Barriers

Historically research in the early days of clinical nurse specialists in the USA identified the main barriers encountered were:

- Difficulty in setting priorities
- Self expectations too high
- Too diversified expectations
- Loneliness and isolation (Aradine and Denyes, 1972).

Interestingly these main barriers are reflected in the literature on nurse consultants. When nurse consultant positions are established there is initially curiosity, suspicion and even contempt by some colleagues around the role, and what it has to offer (Guest et al, 2001; Cushen, 2002; Bullock and Pottle, 2003). Lack of clarity and organisational ‘fit’ is a problem and without a clear definition nurse consultants will try to be everything to all people, with the risk of failing. As Williams (2004) found achieving a balance within role is challenging, as well as managing your own and others expectations. Clarity can only be achieved by asking stakeholders directly in order to establish boundaries and realistic expectations (Da Costa, 2003). As Martin (2000) states, unless you ask people what they expect, you are dealing with speculation. Guest et al (2001) reported many of the nurse consultants found they were experiencing role ambiguity, role conflict, role overload and problems of role boundary management. In order to address any cynicism the role of the nurse consultant must be clearly defined from the outset and equal opportunity principles applied (Adkins, 2002). Moore and White (2002) calls for the Nursing and Midwifery Council (NMC) to define what determines each role and title, and what educational preparation and experience are required.

Shuldham (2004) has found through experience that the main members of a service network supported the introduction of the new posts. Most concerns were raised in
the early days of the initiative. The main exception was where the post replaced an old one and the workload had to be re-distributed or where there was cynicism that these roles are not new jobs, just old jobs repackaged (Moore and White, 2002). Shulham (2004) responds by stating that much of what takes place is a refinement of existing activities, so that nurse consultant roles build on the work done by others, such as nurse specialists. From her own experience Cushen (2002) found as a nurse specialist 80% of her time was taken up by clinical care, where as the nurse consultant post has more protected time for non-clinical tasks, which allows more scope for development. However, anecdotal suggestions have been made that the role itself was another government attempt to challenge the power of doctors (Walters, 2000). Guest et al (2001) states nurses can manage patient care adequately, particularly for chronic conditions, such as stroke. The question of what is nursing and what is doctoring remains key to the development and refinement of nurse consultant roles (Bullock and Pottle, 2003). Historically, there have been concerns even with the issue of title: whether or not nurses should be called consultants (Wright et al, 1991), and some have found a certain amount of antagonism from medical colleagues regarding this issue (Bullock and Pottle, 2003). However, Da Costa (2003) believes that the title was given to reflect the same status in nursing as consultant doctors in medicine: although sadly some nursing colleagues resent that too.

Political and social pressures have undoubtedly influenced practice development within health care. Shortages of general practitioners and the recent introduction of the European working time regulations, which impact upon junior doctor hours in hospitals, are driving forces for the current scrutiny of professional boundaries. This has lead to fears of inappropriate medical substitution from a number of health professions, including nurse consultants. Opportunities for development must be examined within the context of a liberalisation and support for the humanistic values of nursing and challenging the foundations of a paternalistic medical power base (Clegg and Mansfield, 2003).
Conclusion

The nurse consultant initiative provides undoubtedly one of the greatest career defining opportunities within the profession in modern times (Bullock and Pottle, 2003). Substantial evidence exists to support the policy initiative to introduce nurse consultants. The aim of the post is to provide an opportunity to develop nursing and help expand the roles of nurses into areas in which they have not perhaps traditionally worked, and lead in aspects they might not otherwise have done (Bullock and Pottle, 2003; Shuldham, 2004).

Existing roles have evolved and this provides freedom to those who have a clear vision based on assessment of need. However, problems have occurred because of professional rivalry or perceived threat and multiple and unrealistic expectations. Attention needs to be paid to how the challenges and problems identified within the literature are resolved and how far it is possible to ensure the demanding role of the consultant can at the same time make an effective contribution to patient care, contribute to the satisfaction and well-being of the nurse consultants.

Previous research shows certain professional, organisational and resource constraints have hampered the potential of some posts, while others provided examples of positive benefit to patients and services. It is too early to assess the full impact on patient care and services, but a large number of articles by nurse consultants have shown what has already been achieved.

The literature review summarised and critically evaluated relevant literature to determine the current body of knowledge. This involved identifying and synthesising the literature and writing the review to generate a picture of what is known and not known about the issue of the Stroke Nurse Consultant. The next chapter will present the research methodology of the study.
3. Methodology

Having reviewed the current literature around the issue of the Stroke Nurse Consultant’s role, this chapter will consider the research methodology adopted in the study including: the research design, approach to sampling, ethical considerations and timetable/work plan. The overall aim of nursing research is to validate and refine existing knowledge and generate new knowledge that both directly and indirectly influences nursing practice (Burns and Grove, 2003). This research study involved an exploration of the role of the Stroke Nurse Consultant in Scotland using a qualitative approach and the principles of grounded theory (Glaser and Strauss, 1967). The objective was to analyse the role and in doing so to facilitate the development of nursing for the purpose of providing better patient care.

The Research Design

Traditionally, the work of sociologists, psychologists and the medical professions has been based in the scientific positivist tradition. The positivist approach explains the natural and social worlds through the testing of hypotheses and the development of theories. However, nursing care, education and social work have seen a shift towards the interpretive perspective. The interpretative perspective acknowledges and recognises the subjective and naturalistic components of the world, and the different meanings to people. Therefore, positivist and interpretive approaches to research have their roots based in different assumptions about social reality (Holloway and Wheeler, 2002).

The selection between research approaches, while influenced by practical issues, must be based on the research question and the philosophical ideology on which the study was founded. The researcher was guided by the exploratory nature of the study in the choice of research approach. The basis of qualitative research lies in the interpretative perspective of social reality and in the description of the experiences of human beings (Holloway and Wheeler, 2002). A question that suggests an exploration of human experience of an area which little is formally known, such as the role of the Stroke Nurse Consultant, is best addressed through a
qualitative approach. Qualitative research allows an in-depth exploration of the way people interpret and make sense of the world in which they live (Holloway and Wheeler, 2002). Knowledge of these life experiences and processes increases understanding and provides a basis for development. A qualitative approach is often applied in health care when the focus is on a person-centred and holistic perspective. In the context of the study, the approach enabled a rich analysis that helps make sense of the realities of the Stroke Nurse Consultant role.

In contrast, a quantitative approach is a formal, objective, rigorous and systematic process for generating data about people, events or things that are numerical and can be statistically interpreted to establish the strength of the relationship between variables (Burns and Grove, 2003). Although clearly quantitative methods can address situations and events where there is evidence of causality, there is a danger of missing a wealth of rich data that allows interpretative understanding of the phenomenon. Some social scientists believe qualitative and quantitative approaches are merely different approaches to research to be used pragmatically, dependent on the research question (Bryman, 2001). Others have decided that they are incompatible and mutually exclusive on the basis of their different epistemologies (Denzin and Lincoln, 2000).

The qualitative approach collects data and pieces these together to build a picture of the human perspective and experience. This research study uses a questionnaire as a qualitative tool to collect data (Appendix D). The researcher acknowledges this method is normally associated with a more quantitative approach; however, the open style of the questionnaire allowed free flowing accounts of the respondents’ perspectives of the phenomenon to yield invaluable insights. The analysis focused on the written word in search of symbolic meaning and understanding. The advantages and disadvantages of this method are discussed further in the sub-section ‘Data Collection’ on page 28.

In their pioneering book ‘The Discovery of Grounded Theory’ (1967), Barney Glaser and Anselm Strauss first articulated their research strategies. Grounded theory derives its name from its method of grounding theory in data in order to contribute to closing the gap between theory and reality. Glaser and Strauss’s (1967) work was revolutionary as it led the way in providing guidelines for systematic qualitative data analysis with analytic and research strategies. The key principles
of grounded theory are: the need to reach out into the field, the importance of theory grounded in reality, the development of a discipline, the nature of the experience, the active role of persons in shaping the worlds they live in, an emphasis on the change process and the variability and complexity of life and the interrelationships among meanings and actions (Strauss and Corbin, 1998). The purpose of grounded theory differs from ethnography, which involves studying a cultural group within society. It also differs from phenomenology, which attempts to uncover how the person articulates the experience of what he or she is experiencing (Holloway and Wheeler, 2002).

Grounded theory has its origins in sociology, and is underpinned by the concept of symbolic interactionism. Symbolic interactionism focuses on the processes of interaction between people exploring human behaviour and social roles. It explains the meaning of events within people's natural setting, developing theory from data that has been methodically obtained from the real life setting. Mead (1934) was the main proponent of symbolic interactionism, and sees the self as a social rather than a psychological phenomenon. Members of society affect the development of a person's social self by their expectations and influence. People share their attitudes and responses to particular situations with members of their group. Hence members of a community analyse language, appearance and gestures of others and act in accordance with their interpretations. On this basis of these perceptions, they justify their conduct, and this conduct can only be understood in context. Grounded theory therefore stresses the importance of the context in which people function. Symbolic interactionism links to qualitative research methods where researchers must see the situation from the perspective of the participants rather than their own. Researchers use grounded theory to investigate these experiences as well as individual's perceptions, ideas and thoughts about them (Holloway and Wheeler, 2002). It has been described as suited to the needs of nurses who wish to investigate topics about which little is known (Benton, 2000), such as the role of the Stroke Nurse Consultant. In relation to this research study the context was health care, and in particular nurses caring for people affected by stroke, in an exploration from their perspective of the introduction of the role of Stroke Nurse Consultant and its future development.

The aim of the grounded theory approach is the generation of theory from the data. The researcher starts with an area of interest, collects the data and allows
the relevant ideas to develop, rather than commencing with preconceived theories and hypotheses to be tested for confirmation (Holloway and Wheeler, 2002). The researcher must be theoretically sensitive (Glaser, 1978). Theoretical sensitivity means the researcher can differentiate between significant and less important data and have insights into their meanings. Professional experience can be one source of awareness that can help make the researcher sensitive (Holloway and Wheeler, 2002). The professional experiences clinically and managerially of nursing and working with people affected by stroke makes the researcher in this study sensitive to the area and issues under exploration. However, this could also be a potential for bias as the researcher may have preconceived assumptions or ideas, and may miss something an external person would notice.

**Approach to Sampling**

The SSNF provided a purposive sample for the research study. Purposive sampling involves the conscious selection of certain participants to be included in a study. Many qualitative researchers employ purposive sampling methods and seek out groups, settings and individuals where the processes being studied are most likely to occur (Denzin and Lincoln, 2002). The SSNF consists of 156 qualified nurses with an interest in stroke, working in hospital and community settings throughout Scotland. All the members were included in the research study. The aims of the SSNF are:

- To promote the essential role of nurses in stroke.
- To share and develop knowledge, expertise and best practice.
- To incorporate research-based evidence into practice, and promote research to improve outcomes.
- To help develop core competencies, education and training initiatives for stroke nurses.
- To advise and influence the provision of stroke nursing services, which impinge on patient care and carers at local and national level (SSNF, 2004).

The chair of the SSNF was approached and supported approaching the forum’s members (Appendix E). The forum provided an extensive source of nurses caring
for people affected by stroke, therefore relevant to the subject being studied and in obtaining the essential data for the study. In qualitative research this purposive sampling method seems to be the best way to gain insight into a new area of study or to obtain an in-depth understanding of a complex issue (Burns and Grove, 2003).

**Ethical Considerations**

The research study involved sending out a questionnaire to members of the SSNF throughout Scotland. As previously stated, the chair of the SSNF gave permission for members to be approached regarding participation in the research study (Appendix E). The research study was dependent on the willingness, expression and conscientiousness of the participants. Therefore, it was imperative that participants had adequate information on which to base their choices (RCN, 2004b). A covering letter was sent out with the questionnaire (Appendix F) that clearly explained the research, the precise nature of participation, the assurance of confidentiality, and gave the participant the opportunity to discuss any questions or concerns with the researcher. Non-return of the questionnaire after one reminder was assumed to be non-consent. The members of the forum were not considered to be a vulnerable group as they had the freedom to choose to respond or not to respond to the request. There were no perceived risks or associated trauma by participating and the subject matter was not thought to be sensitive, therefore no protective or support measures were required to be in place. To be able to act in a truly autonomous manner a participant must have no untoward pressure or coercion applied to them (RCN, 2004b). The researcher (Appendix A) is known to a number of the members of SSNF and it could be perceived some may have felt under some coercion to respond; however, a significant number chose not to respond and a few respondents made critical remarks about the research study (see sub-section ‘The Research Study: Strengths and Limitations’ p 60). Confidential information acquired in the course of data collection was stored securely in compliance with the Data Protection Act (HMSO, 1998). Data will also not be divulged outside the sphere in which it was collected except with the express permission of the respondent. The confidentiality of the respondents was assured within the presentation of the research findings, although each questionnaire was coded to allow the researcher to identify and follow up non-responders. Care was taken by the researcher in the presentation of the findings to
ensure respondents could not be identified through quotations, particularly those who work in smaller health board areas or more rural settings where the numbers of members are less. Throughout the research study the researcher followed the institutional policy of Napier University, and was guided and monitored by a research supervisor as recommended by the RCN (2004b).

Timetable/ Work Plan

In accordance with the regulations of a dissertation within the Masters programme at Napier University, the research study was planned over a one-year period. The timetable of activity over the twelve months is detailed in Appendix G. The researcher planned activity in accordance with the timetable and the various components were carried out as detailed. However, the interpretation and analysis of the findings did take longer to complete than expected due to the good response rate (see sub-section ‘The Research Study: Strengths and Limitations’ p 60).

Having considered the methodology of the research study, the next chapter will go onto examine research methods used for data collection and analysis.
4. Methods

Following on from the research methodology, this chapter will consider research methods including: data collection, initial phase, main phase and data analysis. The researcher devised an open-ended questionnaire to elicit a broad range of perspectives on the role of the Stroke Nurse Consultant. Nurses involved in the care of people affected by stroke completed the questionnaires. The data were then analysed to identify emerging categories and themes that were grounded in reality.

Data Collection

Questionnaires are a common form of tool for data collection and are used within a wide range of different research designs (Murphy-Black, 2000). The aim of a questionnaire is to collect written responses to specific questions. The most common type is self-administered postal questionnaires, which provide a very flexible and versatile method of collecting data.

The questionnaire used in the research study (Appendix D) formed the qualitative tool to gain an insight and understanding into human experiences, knowledge and respondent’s perspectives of the phenomenon under study to address the research question. The questionnaire investigated the issues surrounding the Stroke Nurse Consultant, including exploration of the components of the role: expert practice, leadership and consultancy, education, training and development, practice and service development, research and evaluation (NHS Executive, 1999). The questionnaire consisted of questions related to demographic data selected to allow comparisons between respondents followed by a series of questions. The questions were designed to be open ended and aimed to highlight participants’ perspectives in relation to; the creation of the role, advantages and disadvantages, examination of the components of the role, potential barriers, supporting others and finally whether they would consider applying for a Stroke Nurse Consultant post. The main benefits of a postal questionnaire were; it covered a large, geographically dispersed population relatively quickly and economically, reduced the direct influence bias of the researcher, and was viable within the time and financial constraints of the study. The main limitations of a postal questionnaire were
potentially a low response rate, the inability to clarify or rephrase a question, the inability to ask participants to elaborate or use probing strategies, and the lack of personal contact with the researcher (Murphy-Black, 2000). The researcher acknowledges alternative approaches could have been adopted, for example one-to-one interviews, but a questionnaire was determined as the best option to allow the study to be as inclusive as possible.

Initial Phase

The most important stage of the study using a questionnaire is the preparation and design of the questionnaire itself (Murphy-Black, 2000). The purpose of the initial phase was to ensure the questionnaire design was clear, comprehensive and relevant to the people concerned. The sample comprised of one general nursing colleague and six specialist stroke nurses (members of the SSNF). The general nursing colleague was included to ensure the questionnaire was understandable to someone outwith a specialist stroke background. Verbal contact was made with the participants by the researcher. An explanation of the aim of the study was given and any questions were answered. Verbal agreement to participate was obtained at this stage. Participants were sent a summary of the research study, the letter that would be sent to participants and the questionnaire. Participants were asked to complete the questionnaire and comment on the following issues: length of time to complete, any ambiguity, any amendments or changes, and finally any suggestions for additional questions. Materials were sent electronically to speed up the process, and participants were given two weeks to return the completed questionnaire and comments. Reminders were sent to three participants at the end of two weeks. Following the reminder all seven participants returned the completed questionnaire, and four out of the seven returned comments.

The feedback from the initial phase indicated no major problems with the questionnaire. The general nursing colleague indicated it had taken her one-hour to complete the questionnaire, which she felt was about right as she was not entirely familiar with the subject matter. Three other participants indicated the length of time to complete was 30 minutes. One participant suggested that the main health board area of the respondent should be included in the demographics. This was incorporated although the researcher exercised care throughout the study.
to respect the anonymity of respondents from smaller health board areas, by avoiding using direct quotations that could potentially identify an individual or area (see sub-section ‘Ethical Considerations’ p 26). Other comments received were carefully considered and incorporated, although one or two comments, after due consideration, were not taken on board. The following examples demonstrate an item acted upon and one unchanged. One comment taken on board was the order of the first three questions; one participant indicated that by agreeing with the creation of the Stroke Nurse Consultant role in Scotland (Question 1) implied that the advantages (Question 2) outweighed the disadvantages (Question 3). Therefore the questions about the advantages and disadvantages of the role were placed before asking about agreement on the creation of the Stroke Nurse Consultant role. One item not acted upon was the suggestion for an additional question on how the nurse consultant would relate to other professional groups and the Managed Clinical Networks for stroke. This was not included because the questions were designed to be open in style to allow respondents to provide a response to what they see as important; the researcher did not want to lead the respondent.

Following the principles of grounded theory methodology, data from the initial phase were analysed to form part of the main study. As Holloway and Wheeler (2002) suggest, data collected from the initial phases of a study give indications of the first ideas and concepts to emerge.

Main Phase

Following the satisfactory initial phase the questionnaire was distributed to members of the SSNF. The questionnaire was posted to the member’s work address, to be completed and return in a stamped addressed envelope marked ‘private and confidential’. Participants were assured their confidentiality would be respected. The researcher used an identifiable code for participants for follow-up purposes. Postal surveys can have a lower response rate (25-30%) than researcher administered tools, but a reminder can enhance response rates (Health Education Board for Scotland, 2003). If a response rate is lower than 50% the representativeness of the sample is in question (Burns and Grove, 2003). Based on this evidence the researcher aimed for a 50% response rate as a positive target. Techniques were adopted by the researcher to try and improve the response rate
on the advice of an experienced researcher (Dennis, 2004) as follows; keep the layout of the questionnaire to one A3 size piece of folded paper as opposed to several A4 pages, use white envelopes instead of brown envelopes, use first class stamps as opposed to pre-paid envelopes, enclose a small gift as an incentive (the researcher enclosed a CHSS pen), use headed paper, and finally personalise the letter by using the participant’s first name and sign each letter by hand. A letter addressed personally to each individual is far more effective than ‘Dear Colleague’ (Murphy-Black, 2000). A follow-up reminder and second copy of the questionnaire was sent to non-respondents after four weeks. Questionnaires were sent out to the 156 members of the SSNF. This generated an initial response of 60 (38%) completed questionnaires. A subsequent reminder generated a further 45 responses (29%). This resulted in a total of 105 (68%) completed questionnaires returned. This well exceeded the target of a 50% return rate set by the researcher (see ‘Findings’ p 36).

Data Analysis

Following the principles of grounded theory, the data were analysed using a comparative method. This involves using codes to develop categories and subsequently comparing categories to identify concepts and bring out dimensions (Strauss and Corbin, 1998). The researcher explored the qualitative software package NVivo (Morse and Richards, 2002) for the purposes of data management. However, the researcher felt the package was complex in nature, and no means were available to access the software without purchasing it directly. The researcher also wanted to retain a personal feel and immerse himself into the analysis of the data. An ‘Excel’ spreadsheet was used to assist with the analysis of demographic data only. For all other data the researcher compared each section of the data throughout the study for similarities, differences and connections. As codes were identified and categories were developed, the researcher checked the literature for confirmation or refutation of these categories (Strauss and Corbin, 1998; Holloway and Wheeler, 2002). All the data coded and categorised formed the major concepts and constructs. The researcher searched for major themes that linked ideas of the study (Holloway and Wheeler, 2002).
The process of analysis in grounded theory has been described by Benton (2000) as consisting of the following stages:

1. **Substantive codes**

   Individual words or short phrases, which contribute to the comprehension of the underlying processes, are highlighted in the questionnaire and codes are written in the margin. Each sentence is coded into as many substantive codes as possible to ensure detailed theoretical coverage. Codes are based directly on the data, and therefore the researcher avoids preconceived ideas. An example of one substantive code created in this study was in response to the question about the advantages of the introduction of the Stroke Nurse Consultant role. One respondent replied that it “allows a nurse to be as important in the stroke organisation as other professionals”; therefore one code was ‘professional equity’.

2. **Categories**

   Categories are produced when a number of substantive codes are clustered into a higher level of abstraction. They are used to describe a class of individuals, events, situations, phenomena that have certain characteristics in common, aiming to highlight where there is unity, uncertainty and conflict. Following on from the example given above a number of substantive codes were clustered to produce a category around “the recognition of stroke nursing”.

3. **Theoretical constructs**

   Theoretical constructs involve linking various major categories and interweaving the component parts into a coherent entity. These constructs contain developing theoretical ideas and themes. Developing the example from above a large number of respondents, across a number of issues led to the creation of a theoretical construct around “nurses feeling undervalued and the need for acknowledgement and recognition among professional peers”.

4. **Developing theory**

   The developing theory describes the underlying basic social and psychological processes, which account for the majority of the variation in the data gathered. Within the research study undertaken a single developing theory was not identified, however, a number of clear emerging themes developed. Continuing the
example from above one key theme identified was “promoting awareness of the condition of stroke and the worth of stroke nursing”.

In grounded theory, the major category that links all others is called the core category. The core category underpins the whole of a research study. The linking of all categories around the core is called selective coding. This means the researcher uncovers the essence of the study that integrates all elements of the emergent themes. The core category is the basic social-psychological process involved in the research. The basic social-psychological process represents the idea that is most significant to the participants and explains the variations in the data (Holloway and Wheeler, 2002). Benton (2000) summarises the criteria for a core category as:

- Central to the theory
- Capable of explaining much of the variation in the data
- Occurs frequently in the data and develops as a pattern
- Is clearly related to the majority of other categories
- It takes longer to define the precise nature of the core category
- A core category has clear implications for more general theory.

The core category of the research study that linked the perceptions of the participants showed that they were patient focused. Thus the essence being ‘patient-centred’ is the core category. The basic social-psychological process most significant to participants is ‘the desire to improve patient care’ (see sub-section ‘Core Category’ p 59).

(i) Saturation

Grounded theory involves activities of data collection, organisation and analysis. The process continues until a theory or themes are developed of sufficient detail and at a sufficient level of abstraction to explain any differences in the data gathered. Saturation is achieved by the quality of the theory or themes that have been developed. Saturation occurs at a different stage in each research project, cannot always be predicated at the outset and is not feasible in all cases due to the length of the study or the level of response (Holloway and Wheeler, 2002).
During the end stages of the data analysis for the research study the researcher reached a point when no new major themes were developing and the quality of the themes were fully developed.

(ii) Participant ‘Validation’

The purpose of the study is to create an account of participants’ perspectives, using synthesis and abstract conceptualisation. This includes many direct quotes from respondents that highlight the findings of the study, to capture the human experience and present it so that others can understand it (Streubert, 1998). The result is a product of all participants’ accounts that is subjective and will therefore vary slightly from the substantive account from any one participant. It is therefore inappropriate to use participant confirmation as an indication of the rigor, or validity, of the study (Morse, 1998). However, the theories evolved from nurses’ perspectives in clinical practice and this means as the researcher uncovered the essence of the study and integrated all the elements of the emergent theories it is likely that it is directly relevant (Holloway and Wheeler, 2002), thus offering greater understanding of stroke care.

(iii) Strengths and Limitations of Method

All research methods consist of a number of strengths and limitations. The key strengths of the research study undertaken included; the appropriateness of the sample of participants who have a wide range of expertise and interest in the subject under exploration, the wide geographical inclusion achieved which included every health board in Scotland (Appendix I), the opportunity for participants to provide extended responses without time constraints, the unbiased approach as participants were not directly influenced or led by the researcher, and the good response rate (see ‘Findings’ p 36). Some of the limitations of the research identified included: the data not being independently analysed, the inability of the researcher to personally engage with participants, the inability to seek clarity or expansion of any of the issues raised by participants, and the inability to analyse and develop the data as it evolved. The strengths and
limitations of the research study are further expanded in sub-section ‘The Research Study: Strengths and Limitations’ page 60.

The final research report was written in a way that allowed the researcher to convey the depth and richness of the data. The report will be disseminated to key stakeholders within the NHS, such as senior nurses and lead clinicians for stroke MCN’s. The researcher plans to develop an article for publication and a poster for display at forthcoming conferences. Participants from the study will have access to the report via the SSNF website (SSNF, 2004).

Having discussed the methodology underpinning the study and the methods of data collection and analysis, the next chapter will present the findings.
5. Findings

Having considered the methods adopted to collect and analyse the data, this chapter now details the findings from the questionnaires returned by participants. The findings are presented in the same sequence as questions on the questionnaire (Appendix D). The participants’ quotes used throughout the chapter aim to reflect the findings, and focus on the written word, in order to capture the human experience in the search for symbolic meaning and understanding. The quotes featured were not selected to be ‘the best’ but were those that encapsulate the general tenor of the comments made about that issue. The researcher can track any quote to the original participants’ comments; however, questionnaire codes were not used in the text to prevent participants perceiving confidentiality had been compromised and to avoid fragmenting the flow of the passage. The full data from the study is available from the researcher for future reference.

Questionnaires were sent out to the members of the SSNF, a total of 156. Of the 156 members 143 (92%) were female and 13 (8%) male. Initial distribution generated a response of 60 (38%) completed questionnaires. A subsequent reminder generated a further 45 responses (29%). This resulted in a total of 105 (68%) completed questionnaires returned. This well exceeded the target of a 50% return rate set by the researcher. With the seven questionnaires from the initial phase this resulted in a total of 112 completed questionnaires that formed the data for analysis.

Background Information

The first question asked the respondent about demographic information. Of the 112 questionnaires analysed the largest proportion were female 103 (92%) compared to male 9 (8%). The largest proportion of participants - 49 (44%) fell between 11-20 years since first registering as a nurse, with 32 (29%) in the 21-30 year grouping, 17 (15%) in the 30+ years and 13 (12%) in the 0-10 year grouping (one respondent left the answer blank). The respondents covered a wide range of professional roles, with the largest grouping being Charge Nurse/Sister 39 (35%), followed by ‘others’ 20 (18%), then staff nurses 17 (15%) and Stroke Liaison Nurses making up 15 (14%)
of respondents (for the full breakdown of categories see Appendix H). The respondents covered the fifteen health boards of Scotland; including the three island health boards. The health board area with the most participants was Greater Glasgow 23 (21%), followed by Grampian 12 (11%) and Lothian 11 (10%) (for the full breakdown see Appendix I). The main area of current practice of the respondents was a hospital setting 69 (62%) with only 8 (7%) working in a community setting and 25 (23%) working across both hospital and community settings.

Advantages of the Stroke Nurse Consultant

Participants were asked their views regarding the advantages of the introduction of the Stroke Nurse Consultant. This generated a large amount of rich data. The majority of respondents saw the introduction as advantageous, both from a local and national perspective.

The greatest perceived advantage was related to stroke nursing and care delivery. There was a general view the role would bring recognition, leadership and career development for stroke nurses. It was felt the role would “raise the profile of stroke nursing, both in status and recognition” and awareness of “the important role nurses have to play in stroke care”. It was believed the post holder “could be a champion” and the “clinical, educational and research roles add credibility and value to stroke nursing”. The role would “provide a clinical lead for stroke nursing” and bring “strategic vision”. The introduction of the post was seen as an advantage for career development as it “would give a more structured career pathway in this field” and “marks the pinnacle of the clinical career ladder in stroke nursing”. There was also a suggestion of beneficial effects on standards of care, with particular mention to providing holistic care and ensuring continuity. It was felt there would be “a direct benefit to stroke patients and families” with “improved standards of care” and “innovative practice”. It was perceived the role would facilitate “continuity of specialised stroke care” and a “holistic approach to individuals”.

Another significant advantage was the coordination, collaborative working and strategic development of stroke services both locally and nationally. Coordination
was described by one respondent as “creating partnerships across organisational and professional boundaries to provide seamless care” and collaboration by another as “developing and delivering care within a multidisciplinary framework”. The Stroke Nurse Consultant was seen as “a key person to be involved at a strategic level in the design of stroke services” and this was felt to “allow a structure to evolve where information is easily filtered both upward to a strategic level and downward to nurses directly involved in stroke care”. The Stroke Nurse Consultant was perceived as a “facilitator of structural, cultural and practice change” and able to “develop and deliver efficient, cost effective, outcome driven care”.

A further advantage was the benefit of advanced knowledge and expert practice. The Stroke Nurse Consultant was perceived to possess “advanced skills, knowledge and experience”. This expertise and competency could be “maintained through direct contact with stroke patients” and “could be shared with others working in stroke”. This would help to “facilitate practice development and practice change”.

A recurring perceived advantage was the Stroke Nurse Consultant as a resource person for advice, information and support. It was felt this could lead to “better communication and sharing of information” and provide a helpful “contact for information and assistance”. It was also perceived as advantageous for patients and families who “would receive information regarding all aspects of the patient’s pathway from a knowledgeable source and someone who would have more time than a medical consultant”.

The final main advantage to emerge was the enhancement of education, training, development and research. The Stroke Nurse Consultant was seen to “help create a learning culture” and encourage “local training initiatives for staff, patients and relatives”. One respondent felt it was important to “establish formal University links to provide academic and research support locally”. The theme was encapsulated by a respondent as “empowering, educating and developing staff in response to the changing needs of stroke patients”.

Disadvantages of the Stroke Nurse Consultant
Participants were asked about potential disadvantages of the introduction of the Stroke Nurse Consultant role. The most significant response to the question was that most participants perceived there were no disadvantages. One participant replied, “If executed properly there should not be any disadvantages, as the overall impact should lead to better patient and carer experiences”. Another respondent reinforced this by stating “I don’t see any barriers that the right individual couldn’t address and turn around”. The general lack of perceived disadvantages was encapsulated by one participant’s response “any disadvantages I feel would be quickly dispelled, the mood is generally Stroke Nurse Consultant posts are beneficial and a huge step forward”.

However, several disadvantages were clearly expressed by some participants, which were thought to have both local and national application. The strongest of these was that the Stroke Nurse Consultant role would overlap with posts already in existence as this could lead to “potential conflict of roles and responsibilities” and it may “nullify some of the work presently being done by specialist nurses”. However, one respondent also felt “there is a bit of not wanting to see others progress”. The general underlying feeling was expressed clearly by the following comment: “they would have to have clear remit to avoid duplication of roles with existing ones”.

Another emerging disadvantage related to role boundaries with the possible lack of understanding and clarity about the Stroke Nurse Consultant’s role from nursing colleagues and other health professionals. One respondent’s reply captured the mood by stating “an unclear definition of role may lead to resentment and confusion”. It was felt therefore “a clear definition of the role” was needed.

A further strongly perceived disadvantage was that the Stroke Nurse Consultant would take away from the remit of others in a variety of ways. The main themes were firstly in relation to skills and knowledge, expressed by the following respondents: “it may lead to nurses working within stroke units being deskill1” and “reduce thinking for yourself”. Secondly, in relation to existing nurses the post would “undermine nurses who already do a lot of work with stroke patients” and perhaps may create a dependency as nurses “may rely on them too much”.

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Participants saw problems around how the Stroke Nurse Consultant would be perceived and accepted by patients and professional colleagues. One respondent felt there could be “a lack of cooperation from the team” and another had concerns of “the public and professionals perception of the role of ‘supernurse’”. This was even more strongly expressed by others with the post being seen as taking over or interfering with our domain” or causing conflict within existing services resulting in “mistrust or hostility from other colleagues”.

Another frequently expressed disadvantage was around the issue of finance. This was expressed in different respects for example; how the post would be funded, the variance in salary grading or more frequently negativity around the expense of the post. One participant encapsulated the view of several stating the argument is around “quantity versus quality, would the budget be more wisely used on two staff at a lower grade?”.

Lesser issues expressed under disadvantages were concerns around availability and access to the post to ensure “equity of services around Scotland” and the issue of meeting the needs of a large geographical area leading to the role “being too diluted to be effective”. Finally, there was concern regarding the wide remit of the role, which could cause a tendency “to lose sight of the problems at a local level”.

Creation of the Role

When participants were asked if they agreed with the creation of the Stroke Nurse Consultant role in Scotland the overwhelming majority responded positively. The overall responses were generally supportive of the development. A small number were unsure or expressed concerns surrounding the creation of the role, and a minority gave negative or opposing statements.

One of the main themes to emerge around the creation of the post was the benefit for stroke nursing. One respondent encapsulated the collective view stating, “To have a strategic nurse consultant post which encompasses a clinical role along with other functions is a great opportunity for nursing development within stroke”. Creating the position was felt to “give a career pathway for specialists
working in the field of stroke” and at the same time “provide an important role model for future nurses”. Generally it was felt to be “the way forward for stroke nursing in Scotland”.

One of the recurring perceived benefits was the increased awareness of stroke illness. Several respondents emphasised the “importance of stroke as a condition” and the creation of the role would help “gain acceptance that stroke was a speciality within its own right”. The development was perceived to address “the inequality of stroke care throughout Scotland”. It was felt vital “that Scotland’s health service moves with the times” and the creation of the post was seen as a way of doing this as “the Stroke Nurse Consultant will have the knowledge, leadership and drive to improve stroke services in Scotland”.

Another of the key issues was the benefit to patient care. The collective perspective was expressed by one respondent as “a great impact on the quality of care given to patients with stroke” this was even taken further by the view that the post would “promote excellence in care”. One respondent placed the development in context as “a positive step towards an excellent package for the patient and their families”. The clinical component of the role was another reason to support the post as they could “present the patient and carers voice as they will have worked closely with them” and raise “awareness of stroke in the community and issues affecting people”.

The final main benefit of the creation of the role was based around the components of the role in relation to the development of stroke services. It was felt elements of the role would provide “professional leadership and consultancy” and “increase educational and research activity”. The Stroke Nurse Consultant could be seen as “an identifiable expert, accessible to all involved in stroke management”. Within stroke services, the role could “cross boundaries of disciplines and agencies” and “dedicate time to improving the quality of services”.

The last smaller grouping to emerge expressed mixed views and caution about the creation of the role. This was particularly in relation to the relationship with stroke nurse specialists. One respondent agreed with creation “only if the role is interpreted, and the person appointed, is more than a nurse specialist” another felt “stroke nursing as a speciality is a relatively new concept, many nurse
specialists have emerged and it may be too much too soon”. To make a better judgement a few thought “it would be useful to have a greater evaluation available as to their efficacy”.

Clinical Activity

Participants were questioned on their views regarding what clinical activities the Stroke Nurse Consultant might undertake.

The largest theme to emerge was being involved directly with nursing care of stroke patients and their families; carrying out the “assessment, planning, implementing and evaluating of nursing care, goal setting and rehabilitation”. Several respondents expressed a view that the Stroke Nurse Consultant should be involved at an early stage of stroke care with “acute assessment and management, including acute treatments i.e. thrombolysis, swallow assessment and feeding regimes”. One respondent felt the role could provide “specialist aspects of care” while others saw a role in supporting “complex cases with multiple needs”. Finally the Stroke Nurse Consultant was seen by some respondents as someone to progress standards and “develop evidence based protocols”.

Another main view expressed was the Stroke Nurse Consultant could be involved in setting up and running of stroke clinics. A number of types of clinics were proposed including “transient ischaemic attack (TIA) and stroke clinics” where people can be seen who have not been admitted to hospital, but referred by their General Practitioner. Secondly, “stroke follow-up clinics to monitor patients and carers progress” following discharge from hospital, or one respondent felt the Stroke Nurse Consultant could address “more complex psychological issues”. Finally, the third type of clinic suggested was a “secondary prevention clinic” where a number of checks could be undertaken such as “blood pressure, medication review and blood analysis” including “a cholesterol check”. Several respondents felt the clinic should be “nurse led” by the Stroke Nurse Consultant. One respondent went so far as to propose the clinic provide “nurse led diagnosis and diagnostic investigation”. Currently, many community-based clinics operate and a participant felt the Stroke Nurse Consultant would be well placed to “manage primary care clinics”.

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Education of patients, carers and health professionals was a further recurring theme when asked about clinical activities the Stroke Nurse Consultant might undertake. Education was referred to by many participants but not often elaborated upon. One participant stated the role would involve “educating patients and communities about stroke and stroke prevention”. Another felt the Stroke Nurse Consultant should “act as a role model and mentor to other staff” this was expanded by another who felt the role should “be an educator of excellent nursing and rehabilitative practice”. Finally, one respondent captured the essence by writing the role would be involved in “teaching in practice at ward and community level, addressing the theory practice gap”.

A further recurring issue was the Stroke Nurse Consultant’s role in supporting patient, carer and health professionals. Several respondents felt support could be provided to “patient and carer groups” in the local community. A few respondents also felt “psychological input would be beneficial” others felt this should be as “a counselling role for both clients and significant others”.

The final area highlighted by respondents was “coordinating the patient’s journey with the multidisciplinary team” to improve the pathway of care. This role was felt to include “partnership working across professional boundaries” to “link primary and secondary care ensuring a seamless service”.

Other Activities

After focusing on clinical activity, participants were asked to comment on activities the Stroke Nurse Consultant might undertake to fulfil the professional leadership and consultancy, education and training, practice and service development, research and evaluation functions.

By far the strongest focus of response related to the education and training function of the Stroke Nurse Consultant. One respondent captured the view of many with their comment “to be central to developing and delivering education and training programmes for all levels of staff”. This was required to be done in partnership with “Universities and training departments” and be part of an “ongoing professional development plan”. One respondent felt training should
focus on “nurses in A&E and receiving wards in carrying out assessments and screening following admission i.e. swallow screening and catheterisation”. However, the general perspectives was that the role of the Stroke Nurse Consultant should involve the “development of training programmes for nurses working within stroke care to ensure each nurse has core competences”.

The next main perspective was round the research and evaluation function of the Stroke Nurse Consultant. One respondent felt the Stroke Nurse Consultant should “foster an environment where care is questioned and evaluated, to keep practice informed and up to date”. Others suggested this could be achieved by “helping implement new research based practices at ward level” and “developing audit tools for use in clinical practice to gauge effectiveness”. Many participants felt the role should entail “identifying gaps in research and conducting research or supporting others involvement in research, especially at a local level”. Several respondents particularly felt research should be conducted by the Stroke Nurse Consultant into “patient and carer perspectives of the services”.

Another main theme to emerge was around the function of practice and service development. Many respondents saw the Stroke Nurse Consultant as “a key member of the MCN to help promote service developments” and “provide representation of ‘the shop floor’ issues”. The role would be “a strategic voice within the local area” although some felt the Stroke Nurse Consultant must also “be involved at a national level, with awareness of what is happening at ground level”. Several respondents referred to practice development and change, particularly around the areas of “developing local guidelines, policies and protocols for stroke patients” and “creating, promoting and monitoring standards, in conjunction with SIGN guidelines and NHS Quality Improvement Scotland”. One respondent looked forward and perceived the Stroke Nurse Consultant “being involved in planning for future stroke services and looking at the nursing provision for these”.

Some participants raised the issue of leadership and consultancy as an important activity of the Stroke Nurse Consultant. Informal consultancy was frequently expressed by respondents as “providing advice and support” to junior and senior nursing colleagues by visiting stroke units. One respondent felt the role could “provide clinical supervision for nurse specialists”. In respect of the leadership
function the Stroke Nurse Consultant could “influence and lead changes in practice, services and strategy” and “become involved in leading initiatives forward for the whole service”.

The last theme raised by fewer participants was around the issue of service coordination and networking. The Stroke Nurse Consultant was seen as “playing a pivotal role within the multidisciplinary team and nurturing good relationships” and ensuring “communication must be top of the agenda”. They also had a function in networking and “setting up links between centres within the health board area”.

Barriers

After considering activities, participants were asked their views on potential barriers a new Stroke Nurse Consultant could face.

(i) Inter-professional barriers

Respondents perceived the greatest barrier a new Stroke Nurse Consultant could face was from medical staff. The general view was that doctors would feel “threatened and insecure”. There was a number of potential reasons suggested for these feelings including; doctors feeling “their role was being eroded”, and the threat of “a nurse with such a highly specialised knowledge”, particularly if the Stroke Nurse Consultant was “able to challenge and change practice”. Respondents also felt medical staff would have a lack of appreciation of both “nurses in this kind of role” and of “the post holder’s knowledge, skills and competency”. This could potentially lead to “medical staff not seeing the value of such roles” or the Stroke Nurse Consultant “not having their full support”.

(ii) Intra-professional barriers
Nurses themselves were another perceived barrier the Stroke Nurse Consultant would face. One respondent felt for the Stroke Nurse Consultant to “achieve credibility with nursing staff would need a strong clinical background”. Other participants perceived “tension from existing stroke nurse specialists, due to the threat and insecurity felt within their own role”. A few respondents stated “I do what a new Stroke Nurse Consultant would do everyday without the recognition”. One respondent stated, “I think that resistance may be felt from other nurses, which I find particularly sad”.

Respondents perceived a wide grouping of general and professional barriers. These perceived barriers or threats encompassed a range of reactions including; “a lack of recognition, acceptance and cooperation”. Acceptance from professional colleagues was felt by one participant to be based on “the need for such a role”. Other reactions suggested by respondents included: “professional jealousy” “resentment” and even “hostility and opposition”. Some respondents indicated this would be felt by “those already working at an advanced level”. While others felt it might make others feel they are being “deskilled”. Respondents felt there is an “inflexibility of professionals” and a general “resistance to change” as one respondent put it “nobody likes change”.

The remit of the role and expectations of the Stroke Nurse Consultant was another perceived barrier. One respondent described the barrier as “the enormity of the task”, resulting in “being pulled in all directions”. Many respondents referred to the number of “demands on time” and the importance of “good time management”. Some felt the “expectations of the post or other professionals maybe unrealistic”. One respondent felt the Stroke Nurse Consultant might become a “jack of all trades”.

The final perceived barriers were around role clarity and lack of understanding of the post. It was felt the post “may not be understood by fellow professionals” in relation to “the role, its focus and aims”. One respondent felt “there needs to be clarity about the purpose and functions of post to minimise barriers”.

Help for the Respondent
The next issue explored was whether respondents considered that a Stroke Nurse Consultant could help them in their current role. The overwhelming majority agreed that the Stroke Nurse Consultant would be of help to them.

The greatest area in which the Stroke Nurse Consultant was seen as helpful to the respondents was as a resource person, someone who could offer advice and information. One respondent reflected the mood of many in their response; “a point of contact for advice and information”. The post was also seen as helpful in “keeping up to date with research” and “sharing experiences of good practice in stroke care”. A few saw the role as “a resource for advice on the management of individual patient cases” one respondent felt this would be particularly helpful for “a difficult patient case”. Some generally saw the Stroke Nurse Consultant as helpful for liaison and communication with different professionals and agencies, allowing the “dissemination of information in a structured way”.

The next main way respondents perceived the Stroke Nurse Consultant could be of help was with service development. The Stroke Nurse Consultant was seen as “a real advantage in supporting and developing stroke services”. One respondent described this as “a valuable resource to service redesign, providing innovative thinking, knowledgeable enquiry and active participation in shaping and delivering improved services”. The help was also seen as directly influencing patient care through “promoting best clinical practice and influencing change”. One respondent expressed the Stroke Nurse Consultant could provide them support in service development so they “would not be a ‘lone voice’ in attempting to improve stroke care”. Another shared this sentiment “I am relatively new to the field of stroke, working in a rural environment with very little support; we need someone with stroke expertise to develop the service”. Overall, the Stroke Nurse Consultant was seen as helpful in “acting as a catalyst”, “exploring new ideas” and “facilitating sustainable improvements by expanding the traditional boundaries of practice”.

Another way the Stroke Nurse Consultant was perceived to be able to help respondents was with education and training. One respondent expressed “a desperate need for education for nurses”. Another respondent described the help as “developing strategies with professional colleagues to implement training, education and development”. The general feeling was expressed by one
respondent as “close involvement in training, supporting my role and encouraging staff to continue further education”. This help would “take some of the pressure off educating and training colleagues”.

The last main theme expressed was based around support from the Stroke Nurse Consultant. This support was for a variety of individuals including; patients, relatives, colleagues and the respondent themselves. One respondent stated “I feel it would be a support to me as a manager treating stroke patients”, another explained “it would enhance my role by providing support”. The Stroke Nurse Consultant was perceived as helping through “supporting and inspiring colleagues”.

Would you apply for the Post?

The last part of the questionnaire explored whether participants would consider applying for the post of Stroke Nurse Consultant. In response the majority stated they would not consider applying for a Stroke Nurse Consultant position.

The two main reasons given for not applying for a Stroke Nurse Consultant position were; a lack of experience and knowledge, and respondents enjoyed their current position. One respondent captured the concept of a lack of experience and knowledge “I do not have a degree or adequate stroke experience”. Other stated they would “require further professional development”. A respondent expressed the sentiment “I do not have enough experience or qualifications, possibly in the future it would be a good challenge”. The other reason given for not applying was the respondents enjoyed their current position. This was expressed by one respondent as “happy where I am”. Another respondent stated, “I am extremely happy in my job, but wish I could do more to change attitudes in the hospital setting”. Some expressed satisfaction with their roles “I am enjoying my role as Ward Manager of the Acute Stroke Unit” and “I am already in a senior position within a proactive setting”.

The participants who did respond positively stating they would consider applying for a Stroke Nurse Consultant position, expressed the main benefit would be the
challenge of developing services and making a difference. One respondent felt “the development of the role in other areas has proved one of the most successful aspects of the government’s strategy to empower and develop to the changing needs of patients” another stated “this challenging role could really make a difference to stroke patients and their families”. Finally, one respondent’s stated “I would love to have the opportunity to have more influence in how stroke care is delivered”.

Any Other Comments

The final section gave respondents the opportunity to make any other comments. The majority made no additional remarks, however, a number made positive statements regarding the post of Stroke Nurse Consultant. One respondent encapsulated the general essence of these comments “I think the post would be a positive benefit for stroke services in Scotland”. Another respondent stated “I feel the post of the Stroke Nurse Consultant has been a long time coming for Scotland and will be delighted to see these posts in the very near future”. Finally, one respondent’s sentiments expressed the mood “stroke nursing needs this kind of role, every health board should have one!”.

Having presented the findings from the questionnaires; the next chapter will discuss the findings in relation to the literature, and critique and reflect on the research study.
6. Discussion

Having presented the findings from the participants this chapter will; discuss these findings and their implications in relation to the literature, critique and reflect on the research design, and consider the strengths and limitations of the study. Whilst some of the themes overlapped one another and were not always clearly discrete entities, they are presented separately in this chapter, to aid analytic comment. The participants’ quotes used throughout this chapter aim to reflect the findings and capture the human experience in the search for symbolic meaning and understanding. The quotes featured were not selected to be ‘the best’ but were those that encapsulate the general tenor of the comments made about that issue. The researcher can track any quote to the original participants’ comments; however, questionnaire codes were not used in the text (see ‘Findings’ p 36). The full data from the study is available from the researcher for future reference.

An overall theme running throughout the research study and consistent within the findings is that the role of the Stroke Nurse Consultant has been seen as advantageous, with positive expressions of agreement for its introduction. Examples of supportive responses include: “This sort of post can only improve patient care” and “It would be a privilege to be able to work with a Stroke Nurse Consultant”. Therefore, nurses who formed the purposive sample are in positive support of the creation of the Stroke Nurse Consultant role in Scotland.

The Role

A major theme to emerge from the findings was the relationship of the Stroke Nurse Consultant role to other existing posts. As one respondent stated, a potential disadvantage was “the overlap of roles, currently there is a large diversity of posts and job descriptions”. Participants’ concerns were around the “need for clarity about purpose and function”. In the literature, authors discuss the importance of ensuring a ‘fit’ of a nurse consultant post with the organisation, and synergising with existing positions. This ‘fit’ is crucial for success of the role (Guest et al, 2001; Da Costa, 2003). The launch of the CHD and Stroke Strategy for Scotland (SEHD, 2002) requested MCN’s for stroke to consider the creation of
consultant nursing posts. Recent guidelines have also encouraged Trusts to consider the appointment of a Stroke Liaison Nurse/Coordinator; although these guidelines state further work is required to define the optimum role and service characteristics of such posts, and to demonstrate their effectiveness (SIGN, 2002). The Strategy for Stroke Nursing in Scotland (SSNF, 2003, Appendix B) states the role of Stroke Nurse Consultant, Stroke Specialist Nurse and Stroke Coordinator have developed differently and calls for clarity and definition of these roles. This message is reiterated in the letter to the researcher from the SSNF chairperson (Appendix E). Shuldham (2004) states much of what nurse consultants undertake is a refinement of existing activities, so the role builds on the work done by others, such as nurse specialists. The new pay system ‘Agenda for Change’ for health care staff is currently being piloted by the Scottish Pay Reference and Implementation Group, who as part of the pilot are looking at roles different to traditional existing health service jobs (Scottish Nurse, 2004), such as nurse consultants. Health and Community Care Minister Malcolm Chisholm said:

“Agenda for Change will ensure fair pay and clearer system for career progression for NHS staff across Scotland” (Scottish Nurse, 2004, p 6).

It has been felt a pay system based on roles will result in clearer definitions of posts; ensuring staff are rewarded fairly for what they do. This research study aimed to explore the role of the Stroke Nurse Consultant, and may go some way to helping inform these developments.

**Promotion and Awareness**

A key theme to come out from the analysis of the data was the value of promotion and awareness. This was in two main areas: firstly of stroke as a condition and secondly of stroke nursing. In relation to stroke, quotes which reflect what participants saw as an advantage of the Stroke Nurse Consultant role included: “raising the profile of stroke which is often viewed generally as one of the ‘Cinderella’ services of the NHS” and “bringing stroke in line with other specialities”. The Improving Stroke Services: patients’ and carers’ views (Scottish Association of Health Councils (SAHC) and CHSS, 2001) study supported this finding calling for awareness-raising campaigns aimed at a range of professionals and the
general public. The stronger theme in the promotion and awareness dimension was in relation to stroke nursing. Several respondents, who are representative, described it as “raising the profile of stroke nursing”. This links closely to the constitutional aim of the SSNF, who formed the purposive sample, to promote the essential role of nurses in stroke care. However, one respondent stated, “there are still issues around what stroke nursing is”. In a review of the literature, Nolan and Nolan (1998a; 1998b; 1998c) found the role of the stroke nurse was not clearly defined and state that whilst physical activities are clearly defined, the psychological, emotionally and ‘family’ orientated aspects are not recognised as clearly. Conversely, the ‘Strategy for Stroke Nursing in Scotland’ (SSNF, 2003, Appendix B) appears to go someway to address this issue. Analysis of the data led the researcher to identify an underlying theme of stroke nurses feeling undervalued, and needing acknowledgement and recognition among professional peers. This theme was generated from responses such as “promoting an understanding of the nurses’ role in stroke management” and “raising awareness of the important role nurses have to play in stroke care”. Fabricius (1999) describes in the literature how nurses feel badly used and held in low esteem. This has resulted in poor self esteem in the profession, and is part of the low morale; although, she believes the cure rests in the capacity to hold onto the belief that real nursing is worthwhile and therefore worthy of standing up for.

The theme of nurses feeling undervalued and needing acknowledgement and recognition among professional peers seemed particularly in relation to the medical profession. One respondent described the challenges from medical staff, and questioned, “How supportive are they of these posts?” Others felt “medical staff are not used to seeing nurses in this kind of role” or “the value of such roles”. In the literature, some have also reported a certain amount of antagonism from medical colleagues (Bullock and Pottle, 2003). Fabricius (1999) describes how nursing has somehow lost faith in itself; the proper business of nursing that is complementary to medicine, but completely different from it, has been seen as second-class and menial. But she sees nursing has its place, a place different from medicine, and does not have to be denied. Historically, there have been concerns with the issue of title: whether or not nurses should be called consultants (Wright et al, 1991). This issue remains evident in the current press, in a letter to the editor of ‘The Times’ following an article on the issue, Dr. Nina Essex wrote:
“Medically qualified hospital consultants have sound reasons for objecting to the hijacking of their title ... the specialism of other professionals is relatively narrow compared to that of senior doctors, and this is what makes their designation as consultant inappropriate” (Essex, 2004, p13).

However, Da Costa (2003) believes that the title of nurse consultant was given to professionalise nursing and reflect the same status in nursing as consultant doctors in medicine.

In parallel to the above themes is the concept that the Stroke Nurse Consultant will “give a career pathway for specialists working in field of stroke”. As mentioned previously ‘Agenda for Change’ will ensure a clearer system for career progression for NHS staff. Bullock and Pottle (2003) describe that, prior to the nurse consultant, there was a distinct lack of clinical career structure; potentially leading to dissatisfaction and frustration for people who want to remain ‘at the bedside’. The Strategy for Stroke Nursing in Scotland (SSNF, 2003, Appendix B) highlights the issue of career development indicating it will be achieved through the implementation of national guidelines for stroke and the development of nurses in leadership skills and roles. The role of the nurse consultant is regarded to offer a career pathway, and a future in practice to stay and progress (Manley, 2000b). The role of the Stroke Nurse Consultant is perceived to go some way in addressing career progression within stroke nursing.

**Expert Practice**

A key theme from the findings focused on the rewards achievable from the expert practice of the Stroke Nurse Consultant operating at an advanced level. As previously indicated, at least 50% of the nurse consultant’s time commitments are working directly with patients, clients or communities (NHS Executive, 1999). Respondents, representative of the theme, felt the role would directly benefit patients and families who would “receive the best possible care cascaded down for the Stroke Nurse Consultant” with “better management leading to improved outcomes”. As previously mentioned there was previously a distinct lack of opportunity for people who want to remain ‘at the bedside’ (Bullock and Pottle, 2003). Some current senior positions within stroke nursing have seen the expert
practice element disappear from their roles, as one respondent stated “I would see the Stroke Nurse Consultant as a key nursing post, which would be within the remit of a nursing role which my current post is not”.

The UKCC (1994) has previously defined part of advanced nursing practice as pioneering and developing new roles responsive to changing needs. In the literature, Moore and White (2002) call for the NMC to define what determines each role and title, and what educational preparation and experience are required. Subsequently, the NMC recently held focus groups on the subject of nurses working at advanced levels of practice (NMC, 2004). The focus groups were to address a major concern of the NMC (as the regulator of the profession) and of the public regarding the existence of nurses who hold job titles which imply an advanced level of knowledge and competence but who do not possess such knowledge and competence. Therefore, the public is potentially at risk when being cared for and treated by such nurses. The NMC believes that all practitioners working at an advanced level of practice should meet a common standard and register that competence. The NMC are working to identify competences required of a nurse working at an advanced level. In the future, nurse consultants will have to meet the common standard in undertaking the role. Ashworth (2000) feels many more nurses now have the clinical specialisation, clinical experience and the knowledge for the advanced expertise required of the nurse consultant.

Respondents expressed a view that the Stroke Nurse Consultant should be involved at the early stage of stroke management including acute interventions such as: thrombolysis and assessment of swallowing ability. The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group (1995) has shown some patients with severely disabling stroke recover quickly following thrombolysis treatment. Innes (2003) goes on to describe the nursing implications of thrombolysis treatment, which requires to be administered early after stroke onset; As one respondent remarks “sometimes valuable time is lost due to a lack of knowledge”. The fourth national stroke nursing conference ‘Stroke Care: into the Future’ (Stroke Association, 2004) gave delegates the opportunity to discuss, exchange views and develop collective ideas on thrombolysis. In relation to the assessment of swallowing ability, one respondent stated the Stroke Nurse Consultant should be “involved in expanded roles such as dysphagia screening, assessment and treatment”. Undertaking swallowing screening has been
highlighted as a key element of good nursing care in a stroke unit (SIGN, 2002). Subsequently, a more recently published guideline recommends all stroke patients should be screened for dysphagia before being given food or drink, and a standardised clinical bedside assessment should be used by a professional skilled in the management of dysphagia (SIGN, 2004). Traditionally, assessment of dysphagia was undertaken by a Speech and Language Therapist; however in more recent times, due to a number of factors, nurses have also carried out this function in order to improve the patient’s pathway of care. Another concept respondents perceived in relation to expert practice was the Stroke Nurse Consultant undertaking a supporting role with more complex cases. Complex cases often have multiple problems after stroke and a number of interplaying factors. Williams (2004) describes how she takes referrals from both inpatient and outpatient services of individual patients and families, often with more complex support needs.

A multidisciplinary context was a recurrent underlying theme that emerged from the findings with recommendation that the Stroke Nurse Consultant should work collaboratively with professional groups. Aspects involved partnership working and coordination of the patient’s journey of care across boundaries. The SIGN (2002) highlights the general rehabilitation principle of multidisciplinary teamwork and communication. Within the literature, the effectiveness of nurse consultants is reflected in their ability to work with other professionals across traditional boundaries to ensure continuity and integration of care (Ashworth, 2000; Bryan, 2002; Bullock and Pottle, 2003).

Leadership

A theme to evolve from the data was the leadership qualities and functions of the Stroke Nurse Consultant. Participants saw this aspect as an advantage to the introduction of the role. Examples that represent this theme from the findings include: “a clearly defined person who can contribute as a leader” and “would provide a clinical lead for stroke nursing”. The introduction of nurse, midwife and health visitor consultants was proposed in the national nursing strategy ‘Making a Difference’ (DoH, 1999). The strategy provided new opportunities for a stronger focus for clinical leadership, to help improve quality and shape services to make
them more responsive. It also gave a commitment to work to equip individuals with these skills to boost leadership across the NHS. Clinical leadership programmes, such as the scheme run by the RCN (2004c), have shown how development programmes involving action learning can have very positive results. Since 2001, the Scottish Executive has provided funding for Trusts to join the programme and a Head of Clinical Leadership has been appointed by RCN Scotland (RCN, 2004c).

From the literature, Moore (2001) and Manley (2000b) feel nurse consultants are already proving themselves to be creative and innovative leaders and seem well placed in fulfilling such a role from both a practice and academic perspective.

Consultancy

Within the study another theme to develop was the perceived role of the Stroke Nurse Consultant as a resource person offering informal consultancy at an advanced level of practice. This was seen both as an advantage and as a support to respondents. The following quotes from participants are representative of this concept: “a good resource for patients and staff” and “someone with advanced specialist knowledge that is there for advice”. This concept of the Stroke Nurse Consultant as a resource person operating at an advanced level of practice reinforces the suggestion by Manley (1997) that the work of expert practitioners encompasses both direct and indirect practice, in which direct practice involves caring for patients and their families while indirect practice involves working with staff.

Education, Training and Development

Education, Training and Development emerged as a recurring theme through the research study. Participants perceived the Stroke Nurse Consultant’s role as developing and delivering training for stroke nurses and others, plus supporting others providing education. Analysis of the data led the researcher to identify an underlying theme of a current lack of provision of education for stroke nurses, in relation to training opportunities available or accessible. The following quotes act as representative of the many within the findings; an advantage of the introduction of the Stroke Nurse Consultant role is “the provision of ongoing education
programmes and personal development in stroke care” and “to provide help and support in continuing training and development”. The Improving Stroke Services: patients’ and carers’ views (SAHC and CHSS, 2001) study recommended all staff involved in stroke care should be provided with specialist training in the physical and emotional needs of stroke patients. Subsequently, guidelines recommended members of the multidisciplinary stroke team should undertake a continuing programme of specialist training and education (SIGN, 2002). ‘The CHD and Stroke Strategy for Scotland’ (SEHD, 2002) identified the need to establish core competences for all professions dealing with stroke. It highlights that current opportunities in postgraduate training in stroke are limited, and development of local training programmes would support basic stroke care skills as well as specialist’s skills. It also adds:

“The development of nurse and therapy consultant posts would support local initiatives and ... could be pivotal in developing the non-medical contribution to stroke service developments”


The SSNF (2003, Appendix B) have also supported the development of stroke education programmes. It states that these provide major benefits to all nursing staff by providing an increased knowledge of clinical skills, evidence based care and an understanding of the advantages of integrated stroke services. The literature highlighted many nurse consultants have honorary lecturer status with local universities and are involved in teaching and developing academic programmes, such as Masters courses (Clarke, 2001; Bryan, 2002; Cushen, 2002; Williams, 2004). In recent years, a number of academic modules in stroke have developed in universities throughout Scotland (CHSS, 2004).

Practice and Service Development

Another main dimension to emerge from the findings is the strategic role of the Stroke Nurse Consultant. Strategic involvement encompassed the design and development of stroke services, and the involvement in MCN’s for stroke. One respondent’s comment encapsulates the essence of the theme; the Stroke Nurse Consultant will “improve stroke service developments and be “a strategic voice within the local area and member of the MCN for stroke”. From the literature,
Manley (2000a) says that being a strategist involves actively looking for and raising awareness of potential future issues, developments and opportunities. ‘The CHD and Stroke Strategy for Scotland’ (SEHD, 2002) laid out the recommendations for stroke services in Scotland. Along with this the Scottish Executive provided substantial additional investment (an additional £40 million pounds funding over 3 years) to support renewed commitment to tackling coronary heart disease and stroke. The investment targeted priorities, including the establishment of MCN’s for stroke, with outcomes being monitored through a national advisory body for stroke. The term of ‘Managed Clinical Network’ is used to refer to a way of working which comprises clinicians from different backgrounds and sectors working across traditional boundaries of care, and which actively involves patients in service design and focus. MCN’s for stroke have now been established in every health board area in Scotland and work to identify local stroke priorities for investment and development. This includes considering the creation of consultant therapist and nursing posts. Interestingly, one respondent remarked that the post of Stroke Nurse Consultant “should have been considered at the launch of the stroke strategy given that a lot of work is now going on, one would question that their input could have been an asset to recent stroke developments and policy”.

**Evaluation**

The issue of evaluation of the Stroke Nurse Consultant role was a concept to surface from the data. It was felt important for the introduction of the role to be based on evidence of effectiveness, and once established be carefully evaluated to monitor outcomes. One respondent saw a disadvantage as “there is not enough research or time since introduction to evaluate the impact and value of the position” and another “it would be useful to have a greater evaluation made available as to their efficacy”. The concept is in agreement with the literature, Bullock and Pottle (2003) state it is important that the nurse consultant role is evaluated, as this would help guide the future development of these roles.
Core Category

Towards the end of the research study, during the process of identifying, describing and conceptualising that data the core category emerged. The core category consists of all the elements of analysis condensed into a few words that seems to explain what ‘this research is all about’ and forms an explanatory whole (Strauss and Corbin, 1998). The core category of the research study linked the perceptions of the participants that showed that they were patient focused. Thus the essence being ‘patient-centred’ is the core category. The basic social-psychological process most significant to participants is ‘the desire to improve patient care’. The core category occurred frequently at all stages and developed an underpinning pattern. Examples from participants are evident throughout the data and the following are representative of the ‘patient-centred’ core and ‘the desire to improve patient care’: “a direct benefit to stroke patients and families”, “a great impact on the quality of care given to patients with stroke” and “the post of Stroke Nurse Consultant can only improve patient care”.

The Scottish Executive

The Scottish Executive (SEHD, 2004, Appendix J) has recognised the importance of guidance regarding the creation of therapy and nurse consultant posts. In May 2004, a workshop was held to consider the development of Allied Health Professional (AHP) and nurse consultants in stroke care following requests from stakeholders. It emphasised that the priority and focus of the development of these new posts needs to be seen in the context of local strategic thinking and priorities. Some of the key issues around the development of consultant posts from the workshop included:

- Clarity about purpose and function, in relation to prevention, risk management and outcomes
- Development of some existing posts to consultant level as a result of ‘Agenda for Change’
- Opportunity for clinical advancement and advanced practice
- Development in partnership with the team and other key stakeholders
• Clinical leadership, clinical effectiveness and enhancement of the patient pathway
• Professional autonomy at a strategic level
• Added value of posts i.e. patient focused change, gaps in service, service and practice development.

Some of the key issues from the workshop link to the findings of this research study including: clarity about purpose and function, the opportunity for clinical advancement, clinical leadership and the added value of posts.

The Research Study: Strengths and Limitations

The research study raises aspects that require further exploration and discussion. All research has strengths and limitations; some related to this study have been previously highlighted (see sub-section ‘Data Analysis’ p 30).

The study achieved a high response rate of 68%, which exceeded the target set by the researcher of 50%. As previously discussed (see sub-section ‘Main Phase’ p 30), techniques were adopted by the researcher to try to improve the response rate on the advice of an experienced researcher (Dennis, 2004). However, the researcher feels additional factors may have played a factor in the good response rate obtained. The purposive sample was made up of members of the SSNF. SSNF members join voluntarily and comprise registered nurses with an interest in the care of patients who have had a stroke. The phenomenon under exploration, the role of the Stroke Nurse Consultant, is of direct relevance both from a nursing and career perspective; therefore, participants probably felt motivated to respond. SSNF members comprise of many nurses in senior positions (see Appendix H) who probably have knowledge, skills and expertise in the field of stroke care thus felt capable of responding. As Murphy-Black (2000) states, willingness to respond is enhanced when questions do not expose ignorance. Finally, although no personal contact was made with participants, the researcher (Appendix A) is known to many of the respondents as an experienced stroke nurse and this may have added a personal context and emphasis to the study and improved the response rate.
The reasoning behind the selection of a questionnaire for data collection purposes, and the strengths and limitations of the tool were previously discussed in the subsection ‘Data Collection’ page 28; however, some issues require further exploration. The good response rate provided a large quantity of data for analysis. This resulted in the analysis of data taking far longer than anticipated at the outset of the study. It was also more challenging for the researcher to manage the data, and compare and contrast findings due to the volume of questionnaires. The nature of responses within the questionnaires varied greater from one participant to another. Responses varied in detail and length, and anecdotally the researcher noticed that many questionnaires went from ‘thick to thin’ in the richness of the quality of responses i.e. more detailed responses being given to the early questions as opposed to the latter. Some responses to questions referred back to previous responses with comments such as “see answer to question 2” and “as above”. Some questions were also left blank. As Burns and Grove (2003) comment, respondents commonly fail to mark responses to all the questions, especially on long questionnaires.

There are currently eleven Stroke Nurse Consultants in England (Williams, 2004). However, the researcher made the decision not to involve English post holders in the study. The reason for this was to avoid super imposing existing ideas and concepts but to take a fresh approach to explore how the role could function in Scotland. The Scottish health care system operates differently from that of England and has its own strategy in relation to stroke services (SEHD, 2002). The population distribution is also different in Scotland to that of England, and presents challenging of caring for people affected by stroke in urban, rural and island communities. Some respondents referred to this issue as, “the geographical barriers of a predominantly rural area”. The study sought to obtain the perspective of nurses caring for people affected by stroke who are working in Scotland, to gain insights to potentially inform the development of such posts.

‘The CHD and Stroke Strategy for Scotland’ (SEHD, 2002) identifies for MCN’s for stroke to consider the creation of consultant therapy posts, as well as nursing posts. Consultant therapy posts were not explored as part of the research study, as the researcher wanted to focus on the discipline of nursing. Some respondents grouped AHP’s with other professionals who may be resistant to the introduction of the Stroke Nurse Consultant (see ‘Barriers’ p 46). It is currently unclear whether
therapy and nursing consultant posts are going to be created simultaneously or at the expense of one another. This could potentially generate conflict among multidisciplinary stroke teams. One respondent commented, “nurses tend to have a more holistic viewpoint, however, AHP’s have different skills to bring”. The Scottish Executive (SEHD, 2004, Appendix J) emphasised that the priority and focus of the development of these new posts needs to be seen in the context of local strategic thinking and priorities.

Analysis of data followed the principles of grounded theory, which requires the researcher to be theoretically sensitive (Glaser, 1978). This means the researcher, in relation to addressing the research question, was required to differentiate between significant and less important data, and have insights into their meanings. One could debate why one quotation was used to illustrate an emerging theme as opposed to another one. The researcher aimed to select quotes that reflected the emerging concept and captured the essence of the meaning. A limitation of the study was that the data were not analysed or verified by an independent researcher due to time constraints. However, the full data set is available from the researcher to support the findings including linking quotations used to specific respondents, or for future reference.

A few participants made direct comment regarding the research in their responses. One respondent stated, “I think it’s a good thing you are doing this research”. However, a couple of respondents made more negative remarks “I found the questionnaire very difficult to answer as there was no definition of exactly what was meant by a Stroke Nurse Consultant” and “I would have probably answered the questions differently if I had known the exact job description”. The researcher made the decision not to include detailed information such as a job description of the Stroke Nurse Consultant with the questionnaire. This was to ensure responses elicited were from the participant’s perspective, and not influenced by the preconceived beliefs and ideas of the researcher and others. However, due to the purposive sample some of the participants would have some prior concept of the Stroke Nurse Consultant. The researcher did offer the participants the opportunity to ask the researcher any questions about the questionnaire in the covering letter (see Appendix F), which no one took up.

The conclusion will now present the key themes from the analysis.
7. Conclusions

‘The CHD and Stroke Strategy for Scotland’ (SEHD, 2002) indicates the Stroke Nurse Consultant role may be part of the future development of stroke services. This research study explored the role of the Stroke Nurse Consultant in Scotland using a qualitative approach and the principles of grounded theory (Glaser and Strauss, 1967). The aim was to analyse the role from the perspectives of nurses caring for people affected by stroke, within the context of health care in Scotland.

The main conclusions from the analysis of the key themes are as follows:

- Nurses caring for people affected by stroke are in positive support of the creation of the Stroke Nurse Consultant role in Scotland.
- Clear clarity of the purpose and function of the Stroke Nurse Consultant role is necessary to ensure organisational ‘fit’ and synergy with existing nursing positions.
- The Stroke Nurse Consultant role is seen as adding value to the specialty of stroke by:
  - promoting awareness of stroke illness
  - providing evidence-based nursing care at an advanced level
  - advancing collaborative multidisciplinary working
  - offering consultancy and support to patients, families and professionals
  - strengthening clinical leadership
  - developing, delivering and supporting education and training in stroke
  - playing a strategic role in service design and development within the MCN for stroke.
- The Stroke Nurse Consultant role would provide recognition for the worth of stroke nursing, offer nurses career progression and the opportunity to retain a practice element at an advanced level.
- Further evaluation of the efficacy of the Stroke Nurse Consultant role is required.

The core category that emerged from the research uncovered the essence of the study and underpinned all of the emergent themes. The analysis linked the
perceptions of the participants that showed that they were patient focused. Thus the essence of being ‘patient-centred’ was the core category. The basic social-psychological process that was most significant to the participants was ‘the desire to improve patient care’.

The research study achieved its aim and objectives in clarifying key areas Stroke Nurse Consultants may play in stroke services in Scotland, and provides new insights and direction to inform MCN’s for stroke in the development of such posts. The study design did have limitations particularly in relation to the data collection method that did not allow the researcher to clarify or seek expansion, or allow data to be analysed on a continuum. The report will be disseminated to key stakeholders within the NHS; such as senior nurses and lead clinicians for stroke MCN’s. The researcher plans to develop an article for publication and a poster for display at forthcoming conferences. Participants from the study will have access to the report via the SSNF website (SSNF, 2004). Further research in this field could; evaluate Stroke Nurse Consultants as appointments begin, consider comparisons between the roles in England and Scotland, compare and contrast how therapy and nursing consultant posts develop, further clarify the essential elements of advanced practice, and explore the views of patients’ and families’ receiving care.

Currently there are no Stroke Nurse Consultant posts in Scotland; the aim of the study was to explore the role from the perspectives of nurses caring for people affected by stroke. The research goes some way to facilitate the development of stroke nursing and more importantly the purpose of providing better patient care. Finally, to end in the words of one respondent “I feel the post of Stroke Nurse Consultant could really make a difference to stroke patients and their families”.
### Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>AHP</td>
<td>Allied Health Professional</td>
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<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
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<tr>
<td>CHSS</td>
<td>Chest, Heart &amp; Stroke Scotland</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>MCN</td>
<td>Managed Clinical Network</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
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<tr>
<td>SAHC</td>
<td>Scottish Association of Health Councils</td>
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<td>SSNF</td>
<td>Scottish Stroke Nurses Forum</td>
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<td>SEHD</td>
<td>Scottish Executive Health Department</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UKCC</td>
<td>United Kingdom Central Council</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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