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How do emergency nurse practitioners experience managing acutely unwell patients in minor injury units? An Interpretative Phenomenological Analysis

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ABSTRACT

Introduction and aim: Emergency nurse practitioners (ENPs) working autonomously within minor injury units (MIUs) sometimes have to manage acutely unwell patients who self present. It is likely that whilst emergency departments remain under increasing pressure, this subsection of patients will continue to attend. There is little published research exploring ENPs' experiences during such incidents. This small qualitative study aims to explore emergency nurse practitioners' experiences of managing acutely unwell patients in MIU.

Method: Data were collected using semi-structured face-to-face interviews via a purposive sample of six ENPs from a countywide MIU service within one UK Trust. An Interpretative Phenomenological Analysis framework (IPA) was used to interpret data.

Findings: Three superordinate themes evolved: emotional resilience, ENP identity and external factors. These were explored further through six further subthemes; emotional responses, coping, clinical competence, who is the MIU ENP? environmental factors and 'why didn't you call 999?'

Discussion: ENPs regularly manage a diverse range of high acuity patients in MIUs, often with limited resources available. Such events are highly stressful, resulting in professional role disparity and leaving ENPs vulnerable to burnout and PTSD. Robust research is needed to determine how ENPs can prepare for such events, and the frequency of such incidents.

1. Introduction and aim

The scope of emergency nurse practitioners (ENPs) has expanded to meet progressive changes demanded from the challenging domain of urgent and emergency care [1,2]. ENPs work autonomously within the emergency department (ED) team or in smaller teams at nurse led minor injury units (MIUs), community walk-in-centres or urgent care centres (UCCs). MIUs were developed across the United Kingdom in response to rising ED attendances [3], and in contrast to large EDs, acutely unwell patients that present to MIUs are managed by a small group of nurses with limited resources available.

In the UK, ENPs are often experienced emergency nurses that have undertaken additional university accredited emergency practitioner training [4]; such courses address the autonomous management of minor injury and minor illness scenarios that typically present to EDs and MIUs. Although it can be argued that ENPs are practicing at an advanced level, unlike Advanced Nurse Practitioners, ENP training in the UK remains non standardised and is not registered by the Nursing and Midwifery Council [4]. Some ENPs may have the opportunity to undertake additional learning and progress to an Advanced Nurse Practitioner (ANP) or Advanced Clinical Practitioner (ACP); each are trained to autonomously manage patients presenting to minors, majors and resus within the ED [5]. The ANP/ACP training requires supervision from senior ED clinicians and study at Master's level, and once qualified gain organisational and professional accreditation [5,6].

Prolific media campaigns such as the Welsh Government's 'Choose Well' [7] were shown to be effective in signposting individuals to the correct service, yet inappropriate attendances to EDs persist and continue to be widely debated [8,9]. Similarly, individuals of all ages attend MIUs with acute conditions such as chest pain and breathing difficulties; the exact numbers of these attendances is not known. The Royal College of Emergency Medicine advises that staff at unscheduled care facilities should be competent in initially managing all acute patients and have appropriate supportive protocols [10]. In addition, it is recommended that both adult and paediatric Immediate Life Support courses should be completed by registered nurses [10].

Lack of professional clarity could partly explain the difference amongst the type of patients seen by MIUs across the UK; some units apply age and illness constraints, whilst other units see any presenting patient [3]. Despite such disparity, all MIUs will address the immediate

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needs of acutely unwell individuals attending the unit and facilitate timely transfer to appropriate services [10]. This small study aims to explore emergency nurse practitioners' experiences of managing acutely unwell patients in MIUs; an area which has received little attention in academic published research.

2. Literature review

A thorough systematic search of the literature is vital to contextualize what is already known [11]. It is also important to expose similar or existing studies of ENP's experiences of managing acutely unwell patients in MIUs, and if such a study would add to the current knowledge available [12]. Online databases CINAHL, BNI, Embase, EBSCO, Medline and The Cochrane Library were searched with relevant keywords.

Additional searches of grey literature via google and snowballing techniques were also executed. The studies reviewed supported the following themes pertinent to this study:

- ENPs provide a safe and effective service that is valued and recognized by colleagues and patients in an ED and MIU settings [4,13–16].
- As a profession ENPs continue to expand their role, extending knowledge and clinical competence to provide a range of advanced practice skills [4,17–19].
- The reason underpinning 'inappropriate attendance' to ED or MIU are multifactorial and hold different meanings to both patients and healthcare professionals [8,9,20,21].

The majority of qualitative papers exploring ENP perceptions were primarily related to ENPs in an ED setting. Roche et al. [13] investigated the effectiveness of ENPs managing patients with chest pain in a rural Australian setting; this quantitative study evaluated the service but did not explore ENP perceptions. No papers were retrieved that explored ENPs' experiences of managing acutely unwell patients in MIU.

3. Method

A qualitative phenomenological research design was identified as a methodology suitable for allowing a deep exploration of feelings and perceptions embedded within the ENP experience [22]. Interpretative Phenomenological Analysis (IPA) is theoretically influenced by phenomenology, idiography and hermeneutics, and is inspired by the philosophies of Heidegger and Husserl [23]. In IPA the researcher elucidates on how others interpret their own experiences, Smith describes this as a 'double hermeneutic' [24]. IPA offered the researcher an approach through which lived experience can be examined in its own terms, using an analytical framework that is rigorous and methodical but also allows freedom for creativity [24].

4. Sample

A non probability purposive sample of six ENPs was selected from seven MIUs from one county in England; each MIU will see and review any presenting patient and is part of a community hospital. Employed by a single NHS Trust, most ENPs participating in this study work in rotation across several units; each ENP was selected to ensure each MIU was represented, the first ENP to respond from each MIU was recruited, plus one additional ENP as a reserve. Recruitment commenced with presentations at two ENP mandatory teaching sessions, information posters were then dispatched to each MIU, followed by an invitation via Trust email which was sent to all eligible ENPs; a total of 45 ENPs were contacted. All initial responding ENPs collectively represented each of the seven MIUs, meaning the selection process did not have to be repeated until the sample was achieved. Developing ENPs and ENPs working less than one year for the Trust were excluded from the study, as it was felt they would not provide the range of experiences and depth of discussion required.

5. Data collection

A good initial response yielded eight potential participants for the study, six were interviewed for the study. The remaining two participants were not interviewed as the researcher felt data saturation was achieved, furthermore, the process of data collection was limited by time constraints and resources. The interviews were conducted solely by the researcher who is also an ENP employed at the same Trust and works regularly in clinical practice alongside three of the six participants. Individual semi structured face-to-face interviews enabled a focused approach, whilst still allowing flexibility and exploration throughout the dialogue [22]. Interviews were arranged at a venue of the participants choosing; five interviews were carried out in quiet rooms across several MIUs, one participant was interviewed at their own home. A Trust encrypted audio device was used to record all interviews, this was secured on NHS premises when not in use.

6. Data analysis: Interpretative Phenomenological Analysis (IPA)

Interviews were transcribed verbatim by the researcher. Transcripts were read and re-read, which allowed a deep familiarity with the data; this is considered as the initial part of the IPA process [23]. Initial exploratory notes were written as each transcript was intensely scrutinized and these grew into emergent themes. Connections evolved between emergent themes and transformed into subthemes; subsequent superordinate themes emerged. Numbering and colour-coding throughout the entire process allowed the researcher to trace each superordinate theme back to the original transcript, providing an audit trail and greater transparency [25]. The process was not linear but cyclical and reflexive, and although the themes are described independently they are also interrelated (see Fig. 1) [23].

In order to maintain the credibility of the research and ensure that interpretation of data remained true to the original transcripts, the researcher's academic supervisor checked the transcripts and agreed with the final themes.

7. Ethical considerations

Ethical approval for this study was granted by The University of the West of England and the researcher's NHS Trust. Throughout the study confidentiality and anonymity was maintained and participants were frequently reassured. Only the researcher and her supervisor had access to the securely stored and anonymised transcriptions. An identified risk of distress from discussion of traumatic events for both researcher and participants was addressed by signposting to the Trust's counselling service.

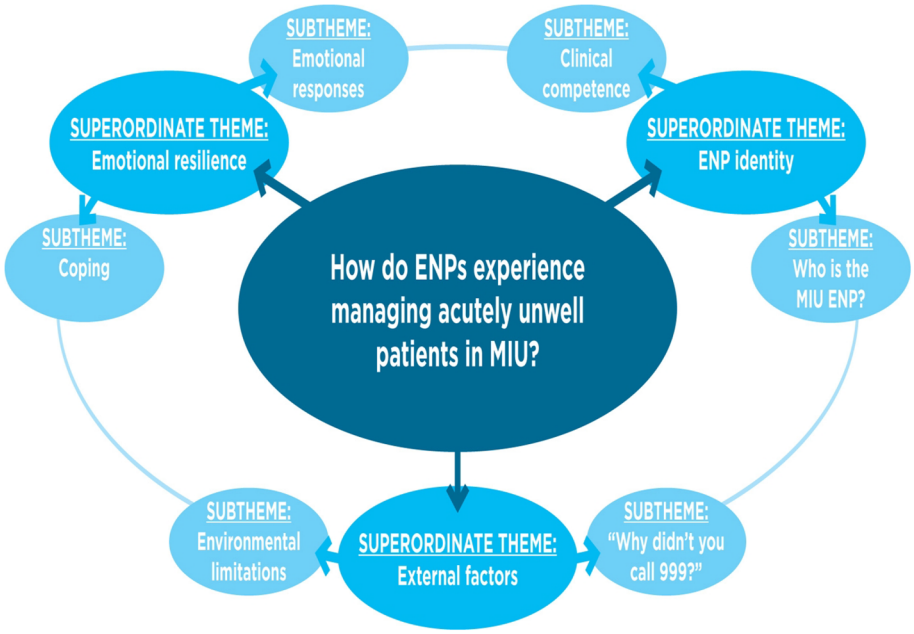

Fig. 1. The diagram above charts the emergent superordinate and subthemes.

8. Findings

Six ENPs were interviewed, four females and two males with between two and seventeen years' experience. Four ENPs had significant ED experience prior to working in MIU. All six had completed a formal ENP training programme at university and were non medical prescribers. All ENPs had up-to-date Advanced Life Support qualifications, one held an up-to-date Paediatric Immediate Life Support qualification.

'Acutely unwell' was not defined by the researcher and it was left to the ENP to interpret their own meaning. Every ENP discussed managing patients that had attended an MIU with chest pain. Interestingly, all ENPs felt that attendances by patients with increased acuity were becoming more frequent. Further examples of presenting complaints reflected upon were:

- Cardiac arrest – two separate events, one witnessed.
- Sepsis.
- Croup with respiratory distress.
- ST elevation myocardial infarction.
- Chest pain with significant bradycardia.
- Child with hypoxia and shortness of breath.
- Acute severe asthma.
- Tonic-clonic seizure.
- Children having seizures.
- Young child with suspected meningitis.
- Large post operative PR bleed and collapse.
- Massive pneumothorax.

8.1. Superordinate theme: Emotional resilience

Emotional resilience is used to describe how a person adapts to and manages stressful situations [26,27], when related to a phenomenon such as managing acutely unwell patients in MIU, this illustrates how ENPs cope emotionally in adverse situations. In this study, ENPs detail emotional responses to experiences and use impassioned language to describe emotional resilience.

8.1.1. Subtheme: Emotional responses

Powerful dialogue was used to articulate the stress and emotional impact in the moment and after the event. Emotive words highlighted the importance of each incident for the ENP and provided a snapshot of how they were feeling. ENPs were asked how they felt during each incident:

> "very scared –um and… I think, hopefully most people would feel, I felt then a little bit lost, because I didn't know where to go with him" and adds "that was quite traumatic" (ENP B).

> "you feel very vulnerable, and very alone" (ENP D).

Interestingly, not all ENPs were able to recall their emotions during the incident and described a feeling of detachment, compartmentalising the emotion:

> "I don't know, you don't think about it, or I don't tend to think about it at the time, I don't get anxious or, but you know you're kind of, I suppose you're busy ticking boxes making sure you've done everything" (ENP E).

After the event and depending on their own perceived gravity of the situation, ENPs responded in different ways. One ENP described how managing these patients led to feelings of anxiety, whilst another was able to emotionally release and move on from events:

> "when you stand back and you reflect and you look at the situation, I think that's then what makes you more nervous about unwell patients coming, because you realize what could happen, if it had gone wrong" (ENP B).

> "I'm quite good at just letting it go I think" (ENP C).

8.1.2. Subtheme: Coping

The discussion of emotions during and after the event, allowed the ENPs to describe different methods of coping with acutely unwell patients in MIU. There was a strong emphasis on using feedback to help ENPs make sense of a situation. Three ENPs discussed informal debriefing with colleagues after the event. Reponses were varied when

asked if the process of debriefing is a useful method of coping in stressful situations:

"absolutely I think, I think it's really important…that one went really well. I think it's really important when they don't go so well, to actually then have someone say, well right, this is what you did, this is what you could have done" (ENP D).

"I've been through a variety of different debriefy type things… it actually made me feel worse" (ENP A).

Two ENPs interviewed spoke about how a patient they had managed had been discharged home and died. Their practice was not at fault, yet the incidences were hugely significant and massively affected their lives; counselling and feedback assisted during a difficult period:

"From that point onwards, I just thought I can't do this job, that I'm not going to be able to do this job, but actually I overcame that, a very nice microbiologist rang up and debriefed me and a doctor from the ED rang up, and there was a meeting with the GP, the A&E consultant, myself and the nursing managers" (ENP D).
"I actually had some separate counselling, work sent me to well-being and things, you know because I was really devastated by it" (ENP F).

One ENP raised an interesting point about the preparedness of ENPs in dealing with the death of a patient:

"it actually knocked me backwards... I mean, you know doctors are taught that sometimes patients are not going to survive, but I don't think as a practitioner we're ever taught that, that sometimes they die" (ENP F).

8.2. Superordinate theme two: ENP identity

The participants interviewed frequently questioned their professional role and there was an overall feeling of unease at having to manage acutely unwell patients in MIU. Their level of clinical competence and ability to deal with complex scenarios demonstrates that ENPs are practicing beyond the scope of their expected role, although unsurprisingly they felt their ability to safely manage such patients was affected by staffing levels and skill mix.

8.2.1. Subtheme: Clinical competence

ENPs described clinical knowledge and decision making that can be seen aligned with advanced nurse practitioners when managing acutely unwell patients:

"we gave GTN, aspirin, oxygen, did a repeat ECG and it was obvious that the MI was progressing" (ENP D).

Feedback was very important to ENPs, they used it to evaluate their clinical decision making after the event, and as a significant method for furthering their clinical competence:

"I rung ED, spoke to the consultant and found out if there's anything more that I can do, I've done that previously, mostly with chest pains, things like that" (ENP D).

All ENPs described being aware of their perceived limitations of competency and managing risk:

"there's a limit you know, and what you don't know, you don't know" (ENP D).
"early intervention in serious situations is a good idea, so as soon as I actually think that something needs to go in, I will get an ambulance en route" (ENP A).

There was a feeling of frustration from learning new skills but not being able to implement them effectively:

"you have all this training but actually you haven't got the manpower to actually carry it out, you haven't got the bodies to be able to, to do most of it safely" (ENP E).

8.2.2. Subtheme: Who is the MIU ENP?

Several ENPs expressed disappointment at moving away from their perceived role as expert minor injuries nurses, they attributed this detachment with being required to learn increasingly complex clinical skills needed to manage patients with increased acuity. There was an underlying frustration at the affect that such attendances had on other MIU patients.

"it's up to you to give that peri-arrest, if you like, care and that's where I feel the gap in our knowledge and training is, I mean we're minor injuries and minor illness nurses" (ENP D).

Conversely, one ENP rationalised decision making in such situations through comparison with medical colleagues:

"you also compare yourself to you know, what a doctor would do" (ENP B).

Compassionate and caring values were evident as ENPs often spoke of the family during such incidences:

"we got his wife out of the room, now that's quite important I think because, as we don't do this very often, I didn't feel like we had any support for the wife to be in the room if he did arrest" (ENP D)

Several ENPs described managing such patients with ENP colleagues; the implied shared responsibility and accountability altered how the scenario was experienced:

"that situation felt very different when you've got another ENP the other side, you've got the child in between, you've got another ENP the other side of the bed, you're sort of stripping it off, one of you has got an oxygen mask, the other's drawing up Benpen, and it just feels – I don't know safer probably" (ENP E).

Despite the conflict in the boundaries of the role, ENPs conveyed a sense of professional pride:

"I do actually really love my job" (ENP D).

8.3. Superordinate theme: External factors

The physical environment and the reasons why acutely unwell patients attend MIU, were described by ENPs as important aspects in the phenomenon of managing acutely unwell patients. The following themes stood out as distinctly separate from the previous thematic concepts of self or emotional perceptions.

8.3.1. Subtheme: Environmental limitations

ENPs reflected on the environmental difficulties of managing acutely unwell patients in MIU, they reported feeling isolated and vulnerable in MIUs that were further away from larger acute hospitals; some older MIUs made situations physically difficult:

"we were in confined room because that was where she went first before she started to become really unwell, so again the unit doesn't identify or doesn't allow you to move patients very quickly – it's an old hospital" (ENP B).

ENPs working at smaller units attributed an increased clinical risk with remote geographical location. ENPs felt 'safer' working in larger teams, there was an added sense of isolation attached to more remote MIUs:

"I had a 24 year-old with asthma, deteriorating symptoms in the department, and the ambulance took an hour and a half to get here. So that period of time he's solely in your care, and it's up to you to keep him alive." (ENP D).

"sometimes you get somebody who's very sick in and you just don't know, you have to be prepared for that, and the ambulances take so long to come because they're miles away from anywhere" (ENP F).

8.3.2. Subtheme: "Why didn't you call 999?"

ENPs explored their own perceptions of why acutely unwell patients attended MIUs rather than the nearest ED or call 999:

"the general public will only take in what they want to take in if you see what I mean, so they will use us as a GP surgery, a fully blown accident and emergency department, a dermatology clinic, yeah everything, everything under the sun, which at times isn't particularly appropriate because we haven't got the skills to actually run all of the services that people seem to think we are running here" (ENP A).

"I think people don't know where to go, where the right place is, lack of education, 'I don't know what an MIU can do', patients' perceptions of where they should be and also the people, I always find the the people that need an ambulance never want to bother the ambulance service, so they won't call 999, they will appear" (ENP D).

Despite an implied lack of control over such attendances, ENPs felt that managing these patients was an inevitable part of their role:

"you can't completely filter what comes in because it's a self referral service isn't it? People do just turn up, when somebody turns up like that you've got to deal with it" (ENP C).

ENPs did not always confront acutely unwell patients about their choice to attend MIU rather than ED or ring 999. This decision was made based on the scenario; ENPs felt it was inappropriate if a patient's condition was life threatening. One ENP experienced hostility from relatives during one incident after raising this issue. Others connected with their role as health educator, particularly when it was felt the attendance may affect clinical outcome:

"I do tell them like the lady this morning, I said to her, 'cos she had chest pain as well, that she really shouldn't have been in a minor injuries unit and that she really should've phoned 999, because actually people don't understand it delays their treatment" (ENP F).

9. Discussion

9.1. Emotional resilience

The unpredictable and dynamic environment of urgent and emergency care is synonymous with stress and highly emotive clinical incidences [28]. The ENPs interviewed had significant experience of managing a variety of acutely unwell patients in MIUs. Unsurprisingly, such moments brought feelings of increased stress and intense emotions; it is well documented that nurses exposed to repeated traumatic events are more likely to develop post-traumatic stress disorder (PTSD) and burnout [26,28]. As supported by this study, ENPs interpret resilience disparately; similarly, ways of coping are also individually unique [27]. All ENPs interviewed, described actively seeking feedback to make sense and learn from an incident in practice, but not all were positive about taking part in a formal debrief. Using debriefing techniques combined with clinical supervision can be effective in counteracting PTSD/burnout, but ENPs are required to be receptive to such methods [28].

How nurses cope with death in practice has been widely debated [26,27], yet coping as the responsible and accountable ENP in this unique situation has not. The impact of this experience on the ENP, was, in both cases profound, and consequential feelings of inadequacy and loss of confidence were significant. This generates additional questions to support future service evaluation/research: How frequently does this occur in MIU? And how can ENPs reasonably prepare for this? Answering these questions could help shape subsequent supportive services for MIU staff, and potentially lead to improved staff retention and performance [28]. It is also a recommendation of this study that open discussion around this phenomenon should be considered as part of ENP training programmes.

9.2. ENP identity

Practicing at an advanced level requires progressive critical thinking as well as complex reasoning and analysis to inform clinical practice [1]. This study's reflective experiences demonstrates that ENPs are working competently and managing risk within the sphere of advanced practice; ENPs had additional clinical training but felt limited resources were not allowing these skills to be realised. Interestingly, there were comparisons with medical colleagues and MIU nurses; the researcher noted correlations with the advanced nurse practitioner role [6], yet the ENPs in this study did not make this association. Each ENP held differing beliefs about their scope of practice, painting a perplexing picture. It follows that if ENPs are unsure about professional identity, patients and other healthcare professionals will be similarly confused.

Blurred boundaries in relation to the ENP role is longstanding, Melby et al. [17] and Lloyd-Rees [4] detailed widespread confusion amongst healthcare workers and patients about ENPs' responsibilities. Both studies called for ENP training to be registered and standardised, disappointingly this has not happened [4,17]. The recent introduction of the advanced emergency care practitioner (ACP) role in the UK within EDs offers a partial explanation [29]. ACPs follow a clear pathway to gain professional accreditation from the Royal College of Emergency Medicine [29]. However, this trainee role requires regular ED consultant supervision and support; for many ENPs working in remote community settings without strong links to secondary care, this is not feasible. Aimed at all ANPs as well as ACPs, the Royal college of Nursing (RCN), for a fee, now offers credentialing for nurses practicing at an advanced level [30], but the not all ENPs will meet the RCN criteria.

Despite the struggle to define their identity, in correlation with previous research, ENPs in this study expressed a strong sense of professional pride [4].

9.3. External factors

ENPs in this study considered that many patients were misinformed or unsure about services available at MIUs. This echoes findings from the Keogh Report published in 2013, which suggested the variety and ambiguity of urgent and emergency services led to patient confusion about when these should be accessed [31]. This issue could be addressed by recent proposed reforms in urgent and emergency care provision set out in NHS England's 'NHS five year forward view' [32]; a key aim is to direct people to the most appropriate service. The introduction by December 2018 of 150 Urgent Treatment Centres (UTCs) across England will provide a standardised and integrated approach to emergency care provision [33]. Offering triage and streaming at initial patient presentation and a variety of services to treat minor emergencies and illness, many UTCs will be at the sites of existing UCCs and walk-in centres. However, it is not clear whether UTCs will replace MIUs, and as detailed previously, the introduction of another emergency care provider may further confuse patients about the correct place to attend [31].

Paradoxically, Sturgeon [9] found that patients actively chose to attend MIUs for primary care rather than their GP surgery due to convenience and an expectation of 'choice', this may also be applicable to the subsection of acutely unwell patients attending MIU. The apparent dichotomy of 'patient choice' and 'inappropriate attendance' was evident through the ENPs' expressions of frustration and admonishment coupled with acceptance and management of acutely unwell patients.

Defining an 'appropriate' attendance is contentious; historically healthcare organisations have considered the appropriateness of a presentation based on acuity or urgency [20]. However, this definition has been challenged and now includes the patient's perceived view of their own acuity [8,20,21]. This would support ENPs' perceptions that patients did not understand the severity of their problem or possible life altering consequences by delaying their treatment. The ENPs interviewed expressed concerns about managing these patients more frequently and for longer periods; successive increases in yearly ED attendances and continued pressure on emergency services [34], indicates that unless service provision changes, acutely unwell patients are likely to continue to attend MIUs.

As well as the proposed reforms to emergency and urgent care provision, another simple recognisable solution would be to increase public awareness about the services offered at MIUs; previous research identified that a widespread media and advertising campaign reduced inappropriate ED attendances by 11% [7].

10. Recommendations

It is a recommendation that robust research/audit is needed to determine the frequency of acutely unwell patients attending MIU and if, as the ENPs in this study felt, these incidents are occurring more regularly. The resulting data could provide an insight on how this may impact existing services, as well as underlining areas required for further training and additional support; keeping expert nurses within the NHS is vital for continuation of a quality service [1].

This study has reiterated proposals of previous papers calling for ENPs across the UK to have a standardised training programme [4,17], this could clearly define the ENP role leading to greater professional clarity for ENPs, healthcare professionals and the public.

Furthermore, it is recommendation of this paper that ENP training should include open discussion around the phenomenon patient death and what to expect in such circumstances.

11. Strengths and limitations

The small scale of this research and uniqueness of individual experience offers limited transferability, yet it hoped that some of themes discussed in this article will resonate with other ENPs/nurse practitioners. The researcher accepts that this study could have been strengthened by interviewing a larger group of ENPs from a variety of clinical settings such as UCCs and UTCs. However, under the supervision of an academic supervisor, this research was completed and funded solely by one researcher as part of a Master's dissertation; ultimately this study was restricted by limited resources which prevented a larger sample group.

Qualitative researchers are often closely involved with their research area and participants [35]; the author/researcher is an ENP and works alongside the participants in this study. This could be seen as a limitation, as the researcher will have preconceived beliefs within the ENP subculture which may bias data collection and interpretation [35]. Conversely this can also be viewed as a strength, as being an ENP and having an insider's view, or emic perspective, was felt to be crucial for data collection [35]; an understanding of ENP culture enabled the researcher to elicit meaningful responses from participants. A reflective diary used throughout the process assisted the researcher in being mindful of prejudices and opinions that could impose additional partiality [36]. Credibility of data analysis could have been strengthened by additional methods such as triangulation and respondent validation [25], but again this was prevented due to limitation of time and resources.

12. Conclusion

ENPs working in MIUs sometimes have to manage a variety of self presenting acutely unwell patients with limited resources. Such events are described as stressful, increasing vulnerability to PTSD and burnout, yet they are viewed as an inevitable part of the ENP role. After managing acutely patients, ENPs use informal feedback techniques as a method of coping and to improve practice.

There was agreement amongst the ENPs interviewed, that acutely unwell patients attending MIU do so because of a lack of understanding about what services an MIU offers. It was also felt that such incidents are becoming more frequent, and at the more remote MIUs, ENPs reported managing these patients for longer. ENPs expressed concern that the clinical outcome of a patient could be affected by the patient's choice of attending MIU, instead of calling 999 or presenting to ED; there was frustration at the affect that such attendances had on the overall MIU service.

ENPs continue to hold differing opinions about their scope of practice, reinforcing confusion about professional role boundaries, despite this, there was a widely held sense.

Conflict of interest

The author declares there is no conflict of interest for this paper.

Ethical statement

Ethical approval for this study was granted by The University of the West of England and the NHS Trust in which this study took place. Confidentiality and anonymity was maintained throughout the study.

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