A PHENOMENOLOGICAL STUDY OF PSYCHIATRIC ADVANCED PRACTICE NURSES' ROLE PERCEPTIONS IN THE CURRENT HEALTHCARE STRUCTURE

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A Phenomenological Study of Psychiatric Advanced Practice Nurses' Role Perceptions in the Current Healthcare Structure

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CERTIFICATE OF ORIGINALITY

I hereby declare that this thesis is my own work and that, to the best of my knowledge and belief, it reproduces no material previously published or written, nor material that has been accepted for the award of any other degree of diploma, except where due acknowledgement has been made in the text.

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(FUNG Yuen Ling)

Abstract

The implementation of the nursing grade reform in Hong Kong Hospital Authority has introduced the position of advanced practice nurse as the working title in 2003. Recent published studies suggested that the definition and the scopes of practice for nurses in advance practice were context-specific in both general and psychiatric streams. The changes in the healthcare contexts provide opportunity for psychiatric nurses to develop advanced practice skills to meet the mental healthcare needs to the global populations. Although, a few Western studies revealed significant results in psychiatric advanced practice nurses' psychosocial intervention in managing clients with depression and psychological stress, and improving in-patient services, none was conducted in Hong Kong. Unclear role definition and delineation of an advanced practice nurse found in both local and overseas' studies further added the need to explore the psychiatric advanced practice nurses' role perceptions in local context.

This study aimed to explore the lived experiences of existing psychiatric advanced practice nurses' role perceptions in the public hospitals using interpretative phenomenological research approach. Data were collected through individual interviews with thirteen out of around sixty psychiatric advanced practice nurses who were working in one of seven clusters of psychiatric hospitals under Hospital Authority, Hong Kong and were analyzed using the interpretative phenomenological analysis method. Three themes related to the experiences of psychiatric advanced practice nurses were discerned: (1) 'We are different' – the participants felt themselves to be different in many ways, which can be attributed to administrative policies in the psychiatric stream, (2) 'Who am I?' – the participants questioned their roles, which can be attributed to the unclear scope of their practice,

and (3) ‘I am who I am’ – the participants strove hard to meet their role obligations.

The findings of this study showed that the psychiatric advanced practice nurses’ perceptions on their roles, to a certain extent, were subjugated by the different administrative policy regarding the availability of clinical support given by nurse consultant between the general and psychiatric streams. Participants pointed out their needs for continuous development of psychiatric nursing skills and knowledge, and space for them to concentrate on clinical practice instead of spending time on managerial duties. In the current mental healthcare system, the impact of psychiatric advanced practice nurses needing to double their managerial duties which fall outside the prime clinical duties on professional patient care service should be further examined; and psychiatric advanced practice nurses’ concerns for role delineation and career prospects should be addressed by the administrators.

To meet the challenges that impact on psychiatric advanced practice nurses’ roles, this study offered some implications for both psychiatric nurses and the administrators to facilitate the psychiatric advanced practice nurses’ role enactment in mental health nursing practice, and has gained some insights into indigenous advanced nursing practice development of psychiatric nursing in Hong Kong. This study suggested that the success role enactment depends on the role-bearers’ commitment to advance their clinical knowledge via self-arranged studies and reflection on clinical practice. Some psychiatric advanced practice nurses needing to perform the dual roles of clinician and manager raises question about the impacts on the development in clinical practice. To facilitate their focus on clinical field, administrators should provide the psychiatric advanced practice nurses with clinical support and space via creating a nurse consultant post in each specialty and

assigning a managerial post in each unit. In addition, a clear pathway for career advancement for psychiatric nurses in public healthcare institutions should be developed.

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Definition of terms

The following definitions were used for the purpose of this study:

Role

A consistent behavior in a particular situation and is developed through an individual's interaction with others (Wright & Leahey, 2005).

Perceptions

The identification and interpretation of stimuli based on information received through the five senses (Moller, 2013). It may include a view of performance of self or others, past or present, in terms of some idealized norm (Chaska, 1978).

Role perception

A process by which individuals translate the sensory stimulus into significant information relating to the work situations (Colbert, Mount, Harter, Witt, & Barrick, 2004).

CHAPTER 1 - INTRODUCTION

The health care reform in Hong Kong Hospital Authority in 2003 has introduced the position of advanced practice nurse (APN) in the nursing career structure. As a new position in the healthcare team, recent published studies indicate that the definition and scope of practice for nurses in advance practice were context-specific in both general and psychiatric streams. The global changes in the political and economical contexts have also provided an impetus for psychiatric nurses to develop their advanced practice skills to meet the increasing needs and demands of the local mental healthcare services. Although studies in western countries have produced supporting evidence on the efficacy of interventions provided by advanced practice psychiatric nurses in a few settings, these findings are very preliminary and non-conclusive, and none were conducted in Hong Kong.

In this introductory chapter, the definitions of APN are examined. Historical development of APN roles globally and locally is then described. In addition, the evolution of mental health service in Hong Kong and its relation to the development of advanced nursing practice roles are fully described. Finally, the significance of the study is addressed.

Definitions of advanced practice nurse/nursing

The emergence of advanced nursing practices grew out of the perceived need to improve patient care (Reiter, 1966). There are different definitions of nurses in advanced practice: the terms APN, nurse practitioner (NP), and clinical nurse specialist (CNS) have been used interchangeably (Davies & Hughes, 1995; Rowell,

Forsythe, Avallone, & Kloos, 2008); and APN has functioned to blend the roles of CNS and NP (Skalla, 2006). A great deal of confusion has resulted as to which roles or practices constitute advanced nursing practices. In addition, each professional association has its own definition. For example, in the USA, the American Nurses Association (2010) defines an advanced practice registered nurse (APRN) as "a nurse who has completed an accredited graduate-level program preparing her or him for the role of certified nurse practitioner…; maintains continued competence as evidenced by recertification; and is licensed to practice as an APRN" (p.63). In Hong Kong, The Provisional Hong Kong Academy of Nursing (2012) defines an APN as "a Registered Nurse and/or Midwife who works both independently and in collaboration with other health care professionals to provide a wide range of advanced assessments and specialized interventions…." (p.3). To facilitate an understanding of the emerging roles of NP and APN globally, the International Council of Nurses has developed the following definition:

> "A nurse practitioner/advanced practice nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level" (International Council of Nurses, n.d., p.1).

The definition highlights that APNs are the elite group of nurses who possess clinical competence in complex healthcare needs, have achieved a master's degree or higher and, particularly, their practices are shaped by the specific healthcare context or culture in which they are practicing. However, this definition only provides a broad description of APN and it is still unclear the specific roles of an APN.

The proposed APNs' practice is particularly unclear in the psychiatric stream. There is neither agreement on the definition of the psychiatric APN, and little

information is available about the actual dimensions of psychiatric APN practice (Campbell, Musil, & Zauszniewski, 1998), nor is there a single set of core competencies to guide psychiatric APN practices (Wheeler & Haber, 2004). According to Psychiatric Mental Health Nursing Scope and Standards (2006), psychiatric nursing is a specialized area of nursing practice which provides comprehensive services along the continuum of identification of mental health issues, the prevention of mental health problems, and care and treatment for people with various mental health problems. With this wide scope and coverage of psychiatric or mental health nursing services, it is difficult for psychiatric nurses to specify their specific role(s) and specialized practices. The role performance of psychiatric APN remains uncertain, but their work position of advanced practice has existed for decades. This may result in wide varieties of demands for and expectations of psychiatric APNs, thus creating more role confusion in their practices.

An overview of development of advanced nursing practice

The emergence of APN became an international trend in the past decades (Sheer & Wong, 2008). The implementation of the nursing grade reform in Hong Kong Hospital Authority (HA) in 2003 has introduced the position of APN as the working title. Under the new career structure, the APN performs advanced-level roles and demonstrates advanced skills in their respective clinical settings. This reform has brought about opportunities for nurses who have specialized experience in a particular clinical field to expand their roles. However, the new position of APN, coupled with the existing nursing positions, not only makes the nursing grade structure complex but also unclear in terms of delineation of role and responsibilities when similar positions co-exist within the structure. Rapid changes

in mental healthcare service in Hong Kong calls for advanced nursing practice in the psychiatric stream. In order to have a better understanding of this emerging role in psychiatric APN, background knowledge regarding the definitions of APN, the historical development of APN roles globally and locally, and the impact of mental health system on the psychiatric APNs' role development were explored.

Historical development of APN roles globally

In the last few decades, APNs have been emerging globally. Sheer and Wong (2008) examined the development of APN practice in different countries across five continents, namely America, Africa, Asia, Australia, New Zealand, and Europe. They reviewed the countries' historical development, role titles, regulatory measures, and highest educational level for APNs. The pace of the APN development varies between the included countries and the United States (US), who has had the longest history of APN development. The experiences in these countries showed that APNs emerged as a result of the need to contain cost, improve access to care, reduce waiting time, serve the underprivileged, and maintain health among specific groups. In Sheer and Wong's study, they also discussed the challenges within each country since each place has its unique social, cultural, and economic context in which APNs exist. The challenges include: defining the APN role, providing education needed for advanced practice, and establishing the scope of practice and regulation. This study highlights that APN's role development is context-specific.

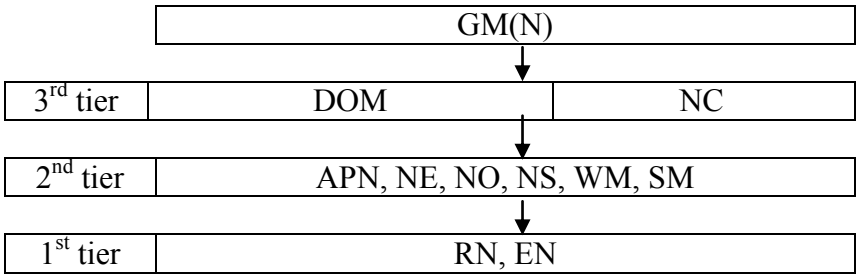
The APN development also varies in the other four continents. Most countries begin to develop the APN roles at the turn of the century. The highest education level for APNs in these continents is at the master's level. The regulatory measures

are available in some countries in Asia, Australia, New Zealand and the UK. Apart from Africa, which only uses NP as the role title, other continents use CNS, NP, and APN as the commonly used role titles.

In the US, the CNS movement grew out of a perceived need to improve patient care in the period following the World War II, with the development of NPs stems from a perceived shortage of physicians in the 1950s (Elder & Bullough, 1990). Currently, NP programs have entered the mainstream of graduate nursing education. In its 21 states, NPs can practice independently and have independence and authority to prescribe medication (Pulcini & Wagner, 2002). The evolution of NP roles in the US took several decades. In order to better fulfill roles and development of APNs in other countries, and in Hong Kong, there is clearly a need to review the past, present and future development of APNs under each local context.

Local development of APN roles

In Hong Kong, four experienced Registered Nurses (RNs) were trained in the late 1970's and 1980's to be Nurse Physician Assistants (NPA) in the United Christian Medical Service, which promoted the notion of advanced nursing practice (Lum, 2004). In late 1993, the Hong Kong Hospital Authority appointed its first group of NSs and piloted the role of senior NS position in 1996. In 2001, the HA set directions for nursing services development and depicted a three-level professional structure with second level nurses being described as APN. Proposed titles in the new nursing structure and their relation to the existing equivalent ranks are shown in Figure 1.



Note: APN-advanced practice nurse; DOM-department operations manager; EN-enrolled nurse; GM(N)-general manager (Nursing); NC-nurse consultant; NE-nurse educator; NO-nursing officer; NS-nurse specialist; RN-registered nurse; WM-ward manager; SM-service manager

Figure 1: Proposed titles in new structure and their equivalent ranks in existing nursing structure

In 2001, the HA explored the feasibility of introducing NP/APN role in general out-patient clinics and set out to explore the development of cost-effective nurse-led clinics (Hospital Authority, 2002). In 2003, 51 nurse-led clinics were established across 26 specialties. The consultation and examinations of Best Practice of HA Nurse Clinics conducted in 2003 revealed the important roles of the nurse clinics in contributing to clients' optimal health and continuity of care. The expert panel recommended that the nurse clinics should adopt a standardized definition of a nurse-led clinic (Wong, Chung, & Chan, 2003). Following the implementation of a new structure for doctors, the HA worked out plans to roll out a new staffing structure for nursing grades (Hospital Authority, 2002). In response to the plan, HA has implemented the strategies in respect to the structure, process, people, and culture for promoting the development of advanced practice nursing in HA (Lum, 2004). In order to differentiate the level of practice amongst enrolled nurse (EN), registered nurse (RN) and APN, Hospital Authority (2006) identified the scope and the focus of practice within each level of nurses. The core competencies of practice for APN embrace the EN and RNs' core competencies. Moreover, there are ten additional core competencies for nurses at advanced practice nursing level:

(1) therapeutic and caring relationship - support and facilitate the establishment of therapeutic and caring relationship among nurses and clients; (2) care management - manage complex clinical conditions and build up a care delivery system/model; (3) knowledge & skill application - master specialty knowledge and refine nursing practices; (4) quality and risk management - strive for effective care delivery systems and upkeep the standard of care through continuous monitoring and reengineering; (5) personal qualities - influence individuals and organisations using a variety of techniques and thinking broadly and outside traditional boundaries; (6) professional attribute - build credibility in clinical practice at advanced levels; (7) team work - lead the team and build the culture; (8) people development - be actively involved in staff development; (9) service development - facilitate changes and lead new projects; and (10) legal and ethical practice - establish the mechanism and maintain the system for ethical practice and client advocacy. According to the HA, advanced practice nursing generally refers to those areas of levels of nursing practice that go beyond the generic level. The identified scope provides a broad range of core competencies of APNs and is still unable to clearly specify their roles.

In 2003, the HA piloted the role of APN (entry level) for 2 years by introducing this new post to the existing nursing structure. In June 2005, there were 322 APNs and amongst them 31 were in the psychiatric stream. The pilot scheme aimed to examine the roles and responsibilities of APNs in the existing structure and was reviewed in 2005. The evaluation of the APN pilot scheme shows that APNs are generally satisfied in their work. Yet there are issues needing to be addressed. For example, the role delineation when the position of APN co-existed with other similar level positions such as nursing officer (NO) or NS; the salary payment and

benefit between Ward Manager and APN (Ward and Unit Management); and the issue of mandatory qualification for entry requirement of APN. In order to improve the development of APN, it is recommended that (a) APNs should be given more training and development in management and evidenced-based practice; (b) the entry requirement of master degree or graduate diploma for APNs should be mandatory with an initial grace period of 3 years; (c) the issue of management within the proposed nursing grade structure should be further considered before the implementation of the structure; and (d) following a revisit of the respective roles in the new nursing grade structure, an implementation plan would be drawn up for wider consultation with nurses.

There were a few changes after the evaluation. Firstly, the APN's entry requirement was changed to a minimum of a Bachelor's degree in nursing. Secondly, the pay scale of APN (Ward and Unit Management; W & UM) moved in line with that of the Ward Manager. Thirdly, the title APN (W&UM) changed to Ward Manager or Unit Manager. Lastly, the Nurse Consultant (NC) position was on trial after defining its scope and role. In 2009, there are six NCs with one in the psychiatric stream. However, the issue of role delineation when the position of APN co-exists with other positions in the similar level remains non-addressed. The evolution of APN development in Hong Kong is shown in Figure 2.

In general, when compared with APNs in Hong Kong and that of other countries in terms of its education requirement, regulations and role expectation, the education level for APNs in Hong Kong is bachelor's level, which is comparatively lower than most western countries. Also there is no regulation for nurses in Hong Kong to be licensed to practice as an APN. In addition, similar to other countries, APNs in Hong Kong are expected to perform expanded roles.

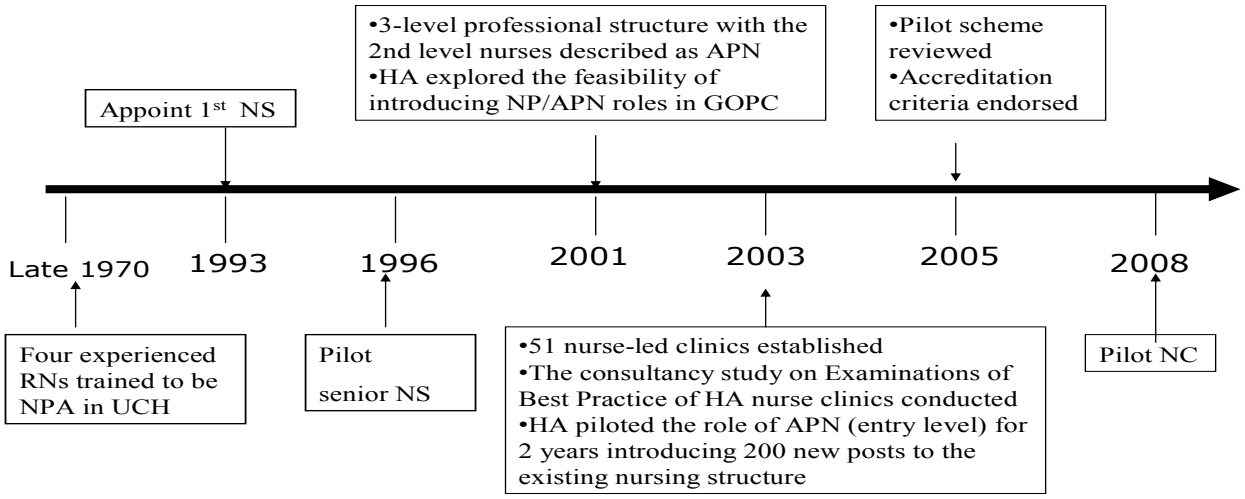


Figure 2: Evolution of APN development in Hong Kong

Nurses who are employed by the Hospital Authority are subjugated by the organization's prevailing policy. Generically, there are two different streams in nursing, the general and the psychiatric. Each stream has its own practice scopes and pace of development. Inclusion of both general and psychiatric nurses in this study may result in a disparity of findings. Thus combining the perceptions from the different streams would become difficult. With lack of any qualitative study on this topic in either general or psychiatric stream, the exploration on the role perceptions in the healthcare structure from the psychiatric setting would be included in the present study. Psychiatric APNs' practices were shaped by the local mental healthcare context. Therefore, it is necessary to understand the mental health services in Hong Kong.

Mental health services in Hong Kong

The emerging of APN roles is context-specific (Sheer & Wong, 2008). Therefore, an extricable link exists between the local healthcare system and the development

of APN roles. In order to clearly understand the role development of psychiatric APN, it is necessary to review historical and recent developments of mental health services in Hong Kong.

Past and current development of mental healthcare service in Hong Kong

According to Yip (1998), the development of mental health services in Hong Kong during the period 1841-1995 are roughly divided into five periods: the pre-asylum period (1841-1924); the asylum period (1925-1948); the organization period (1948-1965); the initial rehabilitation period (1966-1973); the centralized rehabilitation period (1974-1981); and the civic control versus community care period (1982-1995). The trends of development of mental health services across these periods involved gradual progress from a custodial model to a treatment model, and finally to a rehabilitation model.

In the past decade, Hong Kong mental health system kept on changing. With changes in the service model to generate savings, the number of hospital beds provided in mental hospitals has been undergoing a process of downsizing (Hospital Authority, 2003). Recognizing the increasing burden of mental illness and modernizing of mental health services, HA has been piloting various new programs in the early 2000s. The programs included: Extended Care Patients, Intensive Treatment, Early Diversion and Rehabilitation, Stepping Stone (EXITERS); Early Assessment Service for Young People with Psychosis (EASY); Elderly Suicide Prevention Program (ESPP); consultation liaison service in general hospitals; outreach service to private old aged homes; program for frequent re-admitters; recovery support program for discharged patients; and triage clinics. The roles of psychiatric APN in these programs are multi-faceted, similar to a gatekeeper in

consultation liaison services; a case manager in the services of EXITERS, EASY, ESPP, and caring for the frequent re-admitters; a therapist to provide psychosocial nursing interventions for recovery support program for discharged patients; a bridge agent to provide transitional care for pre-discharged patients; a co-ordinator for the outreach service to private old aged homes; and a clinician in nurse clinics.

Significance of the study

The Hong Kong mental health system is changing in order to provide high quality care in a financially restricted environment, resulting in restructuring of care-delivery models. In response to these changes, the demands for more efficient psychiatric care delivery have raised calls for psychiatric nurses to develop advanced practice skills to meet the increasing complexities and demands of nursing care. Hence, the role development of psychiatric APNs has to serve the complex needs of clients concerned in the broad ranges of care programs that exist within the mental health services. The implementation of new mental health services has given rise to both opportunities and challenges in the development of new roles in psychiatric advanced practice nursing. Psychiatric APNs' experiences in this emerging role will help in paving the way for further development of advanced psychiatric nursing practice in Hong Kong,

Research aim

The aim of the study was to explore the roles of psychiatric APNs in mental health nursing practices from their own lived experiences and perspectives.

Objectives of the study

Three objectives of this study included:

1. To understand the psychiatric APNs' perceived definition of their roles in their own work setting; and

2. To explore the role functions and responsibilities of psychiatric APNs in their role delineation in the new nursing structure of Hong Kong Hospital Authority; and

3. To explore the challenges that psychiatric APNs encountered in understanding and performing APN roles.

Research questions

In parallel, there were three main research questions of this study.

1. What were the psychiatric APNs' perceived definitions of their roles in their specialized psychiatric nursing care in daily practice?

2. What were the psychiatric APNs' perceptions of their role functions and responsibilities in current mental healthcare structure?

3. What were the challenges that the psychiatric APNs encountered in understanding and performing their roles?

CHAPTER 2 - LITERATURE REVIEW

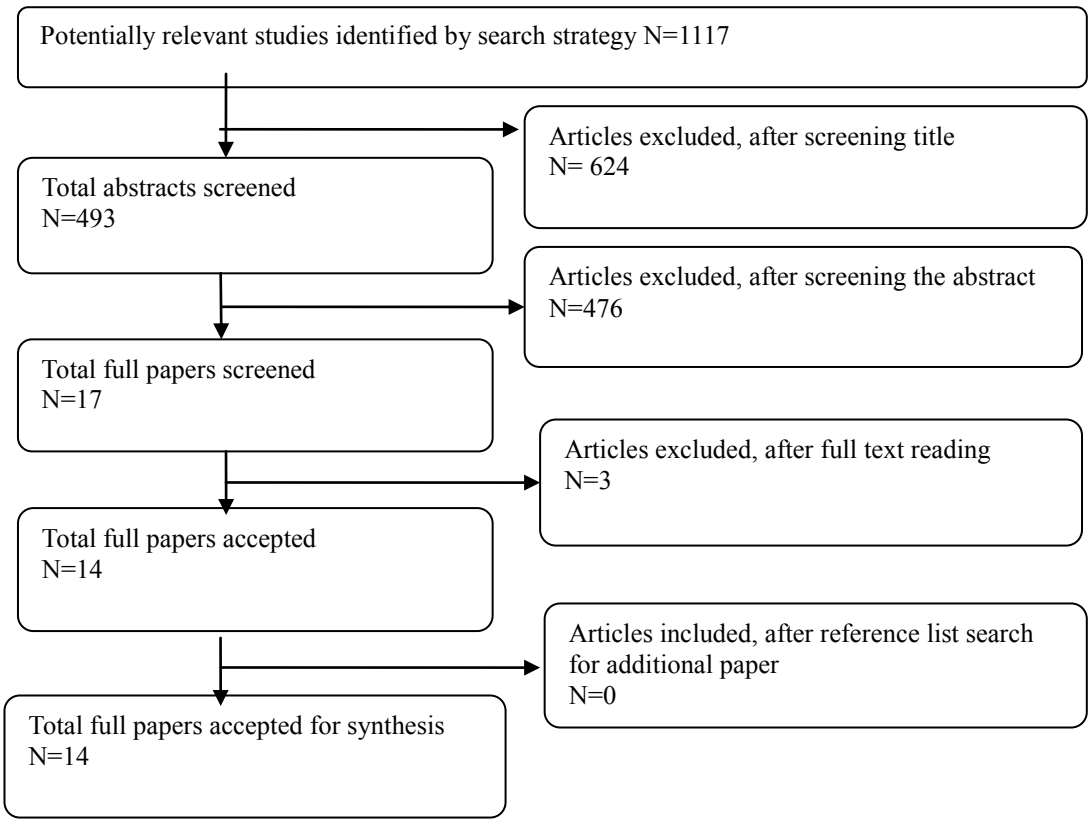
Within the psychiatric nursing profession, documenting the nature of each aspect of the performance of psychiatric APNs can help determine their impact on mental health care services. Understanding the psychiatric APN's role performance is particularly important to sensitize the researcher to the research area being investigated or under-investigated, thus facilitating the researcher to integrate or contrast the findings during the process of data interpretation.

Role performance of psychiatric nurses in advanced practice globally

In order to understand the role performance of psychiatric (mental health) nurses in advanced practice within a global context, a systematic review by searching through 11 electronic databases: AMED (Allied and Complimentary Medicine), the British Nursing Index, CINAHL, PsycINFO, EMBASE, Ovid MEDLINER(R), Journals @ Ovid, Medline, Cochrane (OvidSP), ERIC, and the Cochrane Library. Searches involve research studies published from 1997 to 2012 were conducted by combing the following keywords: "advanced practice nurse" or "clinical nurse specialist" or "nurse practitioner" or "nurse clinician" and "mental health or psychiatric" and "assessment" or "intervention or "evaluation" or "nurse-led" or "nurse-run" or "nurse-directed" or "service". Titles, abstracts, and manuscripts were included for initial screening if they were original articles and full research reports that met all of the following criteria: (1) dated no earlier than the year 1997; (2) a primary study (quantitative or mixed method); (3) involved psychiatric APNs in psychiatric service or psychosocial interventions; (4) reported intervention

outcomes or findings on psychiatric APNs; and (5) published in English. Fourteen out of 1,117 articles were selected based on a systematic review protocol (refer to Figure 3).

Figure 3 Flow diagram showing systematic review protocol



Of the fourteen articles identified, the studies were conducted in the U.S. (n=11), Australia (n=2), and the Republic of Ireland (n=1). Seven studies used nursing or health care models to guide the intervention: Peplau's Interpersonal Theory (Beeber & Charlie, 1998; Beeber et al., 2007), Orem's Self-Care Deficit Theory and Nurse-Directed Care Model (NDCM) (E-Morris et al., 2010), the care management model (Hanrahan, Wu, Kelly, Aiken, & Blank, 2011), the nurse-physician collaborative model (Knight & Houseman, 2008), the Interaction Model of Client Health Behavior (IMCHB) (Price, 2007), and an integration of

Caplan's model with a liaison model (Sharrock & Happell, 2002). The use of a theoretical model to guide the practice of APNs helped to guide the intervention strategies and to align appropriate outcome measures that were congruent with the theoretically predicted benefit of the intervention.

The 14 studies reviewed showed different aspects of the role and performance of psychiatric APNs. Their aims were mainly to test the feasibility of the assessment and the intervention model in diverse groups of patients with mental health problems, or to examine the effectiveness of the nurse-directed services in different health care contexts; or to examine the impact of the psychiatric nursing consultation service in various care contexts.

Among the 14 studies, only one directly examined the role of the psychiatric APN. This study was conducted by Sharrock and Happell (2002), who presented the model of practice of the psychiatric consultation-liaison nurse (PCLN) and a brief overview of the roles of the PCLN in case and administrative consultations, and in liaison in a general hospital. Other reported activities or interventions included: providing psychiatric nursing consultation service to medical teams in a general hospital (Johnston & Cowman, 2008), or to APNs for women after surgery for ovarian cancer (McCorkle et al., 2009; McCorkle, Jeon, Ercolano, & Schwartz, 2011); providing psychosocial interventions to women with depressive symptoms (Beeber & Charlie, 1998), to depressed low-income mothers (Beeber et al., 2007), to mental outpatients (Baradell & Bordeaux, 2001), to home-bound individuals with serious mental illness (SMI)/HIV (Hanrahan, Wu, Kelly, Aiken, & Blank, 2011), to adolescents exposed to catastrophic stress (Hardin et al., 2002), or to depressed homebound older adults (Knight & Houseman, 2008; McDougall, Blixen, & Suen, 1997); providing transitional care to pre-discharged mental patients (Price, 2007);

and implementing nurse-directed services in a psychiatric hospital (E-Morris et al., 2010) or emergency department (ED) (Wand, White, & Patching, 2011).

Although the outcomes of the 14 studies varied from study to study, the results captured three major areas that are relevant to the role performance of the psychiatric APNs, including the provision of psychosocial interventions, the provision of nurse-directed services in health care contexts, and the provision of psychiatric nursing consultation services.

Provision of psychosocial interventions

The majority of the studies examined the outcomes of the psychosocial interventions of psychiatric APNs. Four involved psychiatric APNs in managing clients with depression (Beeber & Charlie, 1998; Beeber et al., 2007; Knight & Houseman 2008; McDougall, Blixen, & Suen, 1997). Amongst these four studies, three reported significant positive results of interventions by psychiatric APNs on depressive symptoms in a primary care setting (Beeber & Charlie, 1998), or on homebound older adults (Knight & Houseman, 2008; McDougall, Blixen, & Suen, 1997). One study generated information about barriers to and strategies in engaging women with depression through an evaluation of an intervention provided by a psychiatric APN, but did not report any significant results on the outcomes (Beeber et al., 2007). Five studies involved psychiatric APNs in managing individuals with psychological stress: women with cancer (McCorkle et al., 2009; McCorkle, Jeon, Ercolano, & Schwartz, 2011), adolescent students who were under stress (Hardin et al., 2002), individuals with serious mental illness (SMI)/HIV (Hanrahan, Wu, Kelly, Aiken, & Blank, 2011), and mental outpatients (Baradell & Bordeaux, 2001). Significant positive results from interventions by psychiatric APNs were found in

all five studies. One study reported the feasibility of a transitional model of care in preparing inpatients with schizophrenia for discharge to the community (Price, 2007). This study did not report any significant outcome.

Beeber and Charlie (1998) tested the feasibility of screening women for depressive symptoms using the Beck Depression Inventory (BDI) and their intervention using Peplau's interpersonal theory. Although there was little change in the areas of social esteem and satisfaction with interpersonal relations, there was an increase in the mean efficacy self-esteem score post-intervention and a significant difference between the pre-and post-intervention BDI scores ($t=8.765$, $df=29$, $P=0.0005$) in a paired samples t-test. These findings showed that it is feasible and effective for a psychiatric APN to implement an intervention for depressive symptoms in a primary care setting, which can be considered part of her role in advanced psychiatric care. Beeber et al. (2007) identified the barriers to nurse-led psychotherapy for depressed low-income mothers, and the strategies used by the nurses to establish and maintain a therapeutic interpersonal relationship. This study found that initiating face-to-face contacts with the mothers, keeping appointments and retaining them in the psychotherapy, and attritions of some mothers were the three primary barriers to maintaining the mothers' engagement and continuous involvement. This study also identified personal contact, encouragement and empathy as the strategies most frequently used by nurses to engage mothers in the therapy.

In addition, psychiatric APNs also provided domiciliary nursing care for depressed older adults. McDougall, Blixen, and Suen (1997) examined the process and outcomes of life review therapy provided by a psychiatric APN to 80 homebound older adults; likewise, Knight and Houseman (2008) examined the

effectiveness of a psychiatric APN – primary care physician collaborative model to 36 homebound medically-ill/depressed older adults using a quasi-experimental, non-equivalent-groups design. In the study of McDougall, Blixen, and Suen (1997), there was a significant decrease ($p< 0.0001$) in total disempowerment themes which included anxiety, denial, despair, helplessness, isolation, loneliness, and loss in the early phases of treatment (M_1=13.073, SD=7.73) and as treatment progressed (M_2=9.14, SD=6.04). This study suggested that life review therapy conducted by a psychiatric APN could lead to a decrease in disempowerment themes and might be an effective therapy for the homebound elderly with depression. In the study of Knight and Houseman (2008), a significant decline in depression among the treatment group was noted using both the Hamilton Depression Scale (a decrease of 6.3, 95% c.i. 4.2-8.3) and Geriatric Depression Scale (a decline of 4.4, 95% c.i. 2.5-6.4). This study stated that partnering nurses with physicians is a creative strategy for improving the quality of care delivered to homebound elders with medical and mental health care needs. Similarly, psychiatric APNs also provided domiciliary services to individuals who were co-morbid with medical and mental problems. Hanrahan, Wu, Kelly, Aiken, and Blank (2011), in their randomized clinical trial study, evaluated the effectiveness of a home-based intervention for individuals with SMI/HIV. Over 12 months of the intervention by psychiatric APNs, the intervention group showed significant improvement in depression (P=.012) and in the physical component of health-related quality of life (QOL) (P=.03) from the baseline to 12 months. This study demonstrated that the intervention by psychiatric APNs may be a useful strategy for improving care and outcomes for high-need individuals with SMI/HIV.

Interventions by psychiatric APNs were also provided to depressed women with

cancer. McCorkle et al. (2009) and McCorkle, Jeon, Ercolano, and Schwartz (2011) in their experimental studies reported the effects of a nursing intervention in post-surgical women with gynecological cancers. Women in the intervention group received specialized care provided by an APN, and those women (sub-groups) in high distress were referred to a psychiatric consultation-liaison advanced practice nurse (PCLAPN). McCorkle et al. (2009) reported significant positive effects from the specialized nursing intervention program plus PCLAPN consultation with APN in oncology for 63 women on reducing uncertainty or ambiguity ($p=0.0181$) and symptom distress ($P<0.0001$), and improving both mental ($P=0.0001$) and physical ($P<0.0001$) aspects of QOL, when compared with 32 women in a placebo group at 6 months after surgery. The study showed that the nurse-tailored intervention provided by the APN + PCLAPN that targeted both physical and psychological aspects of QOL among women cancer patients with depression produced stronger outcomes than those targeted solely at a single aspect of QOL. Similarly, McCorkle, Jeon, Ercolano, and Schwartz (2011) evaluated the effects of the specialized nursing intervention provided by an APN + PCLAPN on health care utilization by post-surgical women with ovarian cancers. An oncology APN provided 17 contacts to women in the intervention group. Women in the intervention group found to have emotional distress after screening by APN received an evaluation by the PCLAPN. Based on the PCLAPN's evaluation, the APN developed a collaborative care plan targeting the women's specific emotional needs. The 59 women in the intervention group reported fewer primary care visits (β=-0.95±0.16, p=.0003) and more visits to the emergency room than those in the attention control group due to increased recognition of symptoms needing urgent care. These two studies highlighted the need for APNs coordinated and collaborated with other health care providers to care

for women cancer patients with depressive symptoms.

The psychosocial intervention provided by psychiatric APNs was also found to be effective in distressed adolescents. Hardin et al. (2002) studied the effects of a long-term structured Catastrophic Stress Intervention (CSI) on 1,030 adolescents exposed to catastrophic stress for three years. Taking the first four time points (6-24 months) into consideration (N=810; 21% attrition), a significant intervention effect was noted from the CSI (p=0.006). When all six time points (6-36 months) were used (N=669; 17% attrition), a marginally significant intervention effect was seen (p=0.06). These findings reflected the CSI conducted by psychiatric APNs on the adolescents resulted in less mental distress over time when compared with routine care in the first two years, while improvements needed be sought to extend its effects to 36 months.

Mental health care can be provided by psychiatric CNSs in private practice. Baradell and Bordeaux (2001) evaluated 257 patients' clinical outcomes and level of satisfaction of psychotherapy whose psychotherapy was provided by 12 psychiatric CNSs. The patients' clinical symptoms were measured at the initial clinical evaluation, at termination, and 6 months after termination using the Profile of Mood States-Short form (POMS-SF) and QOL. The total POMS-SF scores were significantly reduced at termination (M, 30.97; SD, 14.05) compared with the scores at initiation (M, 51.93; SD, 17.46); and the total QOL scores were significantly higher at termination (M, 115.27; SD, 20.66) compared with the scores at initiation (M, 103.11; SD, 20.83). A patient satisfaction survey conducted 6 months after termination also reported a high level of satisfaction with the care provided by the CNSs. This study supported the view that mental health care provided by psychiatric CNSs can improve the quality of patient care and suggested

psychotherapy as an autonomous role for psychiatric CNSs.

In addition, Price (2007) reported on the feasibility of a transitional model of care involving preparing inpatients with schizophrenia for discharge to the community. Based on the IMCHB model, a psychiatric APN conducted a structured interview with pre-discharged patients, collaborated with the community case manager, and followed up with the patients after discharge. No significant improvement in the experimental group was found in either the results of the outpatient follow-up and medication compliance or in the mean difference in hospital readmission days. It is suggested that it is necessary to explore alternative intervention models to enhance transitional care.

Provision of nurse-directed services in health care contexts

Two studies involved testing the feasibility of implementing care models by integrating psychiatric APNs in the contexts of a psychiatric inpatient setting (E-Morris et al., 2010), and in an ED (Wand, White, & Patching, 2011). Overall, their results showed significant improvement in the care delivered to the patients.

E-Morris et al. (2010) described a quality improvement project focusing on the process of implementing the NDCM in one building of a psychiatric hospital to increase accountability in person-centered interventions. Significant differences were found in de-escalation: 50% in 2005 versus 90% in 2006. There were improvements in almost all environmental aspects of care from 2005 to 2006: significant differences were found for the number of showers, 37.5% in 2005 versus 77.4% in 2006; and adequate clothing, 22% in 2005 versus 80% in 2006. A comparison of incidences of seclusion and restraints between building A (full implementation of the NDCM) and building C (did not fully implement the model) revealed that building A had fewer episodes than building C in 2005 and 2006. This study indicated that the role of the psychiatric APN could have a positive influence on the recovery of clients in a psychiatric hospital.

Similarly, the integration of the practice of psychiatric APNs was introduced in the ED. Wand, White, and Patching (2011) adopted realistic evaluation for the implementation and evaluation of an ED-based mental health nurse practitioner (MHNP) outpatient service. The survey involving 101 outpatients showed that the mean score in K-10 measures decreased by two categories ($P<0.001$) at follow-up and the mean score in the General Self Efficacy Scale improved by one point at follow-up, and an improvement in perceived self-efficacy ($P=0.0137$). Client

satisfaction tool (n=51) showed strong agreement with the availability and accessibility of the service; therapeutic features: support and encouragement received; the feeling of being listened to and understood; useful information and health education; and overall standard of care provided. The interview with 20 ED staff showed that this service assists patients whose needs are not usually met. It also showed that the straightforward referral process was greatly appreciated, and that the outpatient service had improved and streamlined access to follow-up mental health care, raised mental health awareness, and enhanced the overall service provided by the ED. This study found that early consultation with key local stakeholders and ED ownership of the project was essential to the implementation process.

Provision of psychiatric nursing consultation services

Five studies reported positive client outcomes from the collaborative service developed by a psychiatric APN and non-mental health service providers. Three studies involved clients with depression who were referred to a psychiatric APN by primary care nurses, NPs, and physicians (Beeber & Charlie, 1998), or referred by an oncology APN for further psychiatric assessment and intervention (McCorkle et al., 2009; McCorkle, Jeon, Ercolano, & Schwartz, 2011). Two studies examined the psychiatric nursing consultation-liaison (PNCL) services in a general hospital (Johnston & Cowman, 2008; Sharrock & Happell, 2002). These two studies revealed that the majority of patients were admitted to hospital due to a medical issue and that the most common reason for a PCLN referral was deliberate self-harm.

In the study of Johnston and Cowman (2008), there was a significant difference

between the diagnosis provided by the PCLN and the reason for the referral (Pearson chi-square=36.885, df=16, p=.002). Four cases required the involvement of a psychiatrist; thus, 94% of the patients did not receive an assessment from a psychiatrist. This study showed that the PCLN operated as an autonomous practitioner and helped to meet the complex demands of the patients in a general hospital. In the study by Sharrock and Happell (2002), a survey of 117 staff using the PNCL services showed that >90% participants found these services to be timely, accessible, well-documented, and professional. This study highlighted the positive contribution of the PCLN as perceived by general hospital staff.

In summary, the 14 quantitative studies provided useful findings on the role performance of psychiatric APNs. However, only one study addressed the role of a psychiatric APN working in a general hospital (Sharrock & Happell, 2002). Also, the outcome measurements varied greatly among the included studies; thus, it was difficult to compare them directly. It is recommended that standardized outcome measures be used when the studies involve similar types or models of intervention. In addition, those studies with innovative and advanced psychosocial interventions lacked comparison with other treatment modalities, or benchmarks with generic practices. When new services or alternative health care options are provided, it is important to demonstrate their significance with evidence (Kirchhoff, 1999). Therefore, well-designed randomized controlled trials are needed to evaluate the role performances of psychiatric APNs.

To conclude, the existing literature supports the view that psychiatric APNs play multi-faceted roles and achieve significant results in managing clients with depression and psychological stress, and in improving inpatient services. Understanding the role performance of psychiatric APNs will help nurses to

develop contemporary mental healthcare services.

While the systematic review offered insights into the global view of psychiatric APNs' role performance, none was conducted in Hong Kong. It is possibly because it related to new roles emerged after the nursing grade reform in Hospital Authority Hong Kong. Since APNs' practice is shaped by the healthcare context in which they are practicing, the findings obtained in other countries sometimes may not be applicable to Hong Kong due to different social, cultural and economic contexts (Sheer & Wong, 2008). Therefore, it is necessary to explore the experiences and roles of psychiatric APNs in Hong Kong, especially since there is very limited local research evidence, and hence opening up the ability to compare these findings across countries.

Role performance of advanced nursing practice in Hong Kong

There are two publications discussing the role of Hong Kong nurses in advanced practice. These studies did not target on NS, CNS or APN. Wong (2002) examined 63 different grades of registered nurses' perceived competency in advanced practice in caring for critically ill patients at A & E Departments from five hospitals in Hong Kong. This study found that nurses perceived themselves to be less competent in the psychosocial domain of practice and expressed that continuing education was a means to professional and career advancement. This study implies a certain level of challenges that Hong Kong nurses will face when they are expected to assume the role of APN. Another publication discussed the findings on the six nurse-led clinics' evaluation study (Twinn, 2003). The findings of the evaluation study identified nursing practice focusing on four major activities in the general outpatient clinics, namely patient assessment, wound management, health

education and post medical consultation counseling. The findings revealed high levels of patient satisfaction with the nursing activities and the time to talk with patients. The findings also revealed that with the exception of the nursing activity in health education, other activities were generally undertaken by ENs and RNs. It is suggested that these activities do not necessarily provide examples of advanced nursing practice. This implies that further exploration on the distinctive role function and nursing activities of APN is required.

There is no published research involving APN in either general or psychiatric nursing stream in Hong Kong. As NS or CNS is considered to be having similar roles as APN, the findings related to these specialized nursing positions will serve as important references for the understanding of an APN. A literature review was conducted to identify studies involving the role performance of NS or CNS in Hong Kong. Five studies were identified.

The included studies mainly targeted to evaluate the NSs' role performance or compare the perceptions among different healthcare professionals on NSs' role performances. Two studies explored the NSs' or CNSs' role perceptions: among NSs, staff nurses and doctors in general settings (Chang & Wong, 2001), and among psychiatric CNSs and their nursing colleagues in psychiatric settings (Chien & Ip, 2001). Both studies found that there were different NS's role perceptions among nurses and doctors. In Chang and Wong's study, there were significant differences in the perceptions of importance of the administration, clinical practice, education and research roles, and the frequency of occurrence of the clinical practice research role. In Chien & Ip's study, there were a number of similarities of role perceptions in the clinical practice, organization, and education components, and differences in role perceptions in professional roles between the CNSs and their

colleagues regarding the time spent on clinical practice, research and quality improvement activities. The study also discussed the issues of role confusion, overlapping functions with frontline psychiatric nurses and concerns about inadequate knowledge and autonomy of CNS. They further suggested that a clear definition and description of role functions and areas of CNS practice is necessary to meet this challenge. These two studies showed that there was a gap between the actual NSs' or CNSs' role performance and the expected role performance as perceived by their colleagues. It implies that nurses in advanced practice may encounter challenges when they perform their roles in their work contexts.

Two studies focused on the role performance of the CNSs: the performance of senior CNSs who were commissioned in a consultancy project by Hong Kong Hospital Authority (Wong, 2001), and a randomized controlled trial on the effects of a diabetic NS follow-up model on early discharged diabetic patients (Wong, Mok, Chan, & Tsang, 2005). These two studies showed the CNSs' role competence on improving patient care. Wong (2001) evaluated the performance of three senior CNSs (diabetes, renal and psychiatric) pilot position in Hong Kong using non-participant observation and interviewing techniques with these three CNSs. The study explored the scope of service, role competence, and contribution to patient according to the projects proposed by the CNSs. The results showed that role components of CNS including clinical service, education and training, research, consultancy service, and administrative work were common across different countries; the value of CNSs to initiate cost-effective and quality care were confirmed. Wong, Mok, Chan, and Tsang (2005) compared the outcomes of diabetic patients undergoing an early discharge program that were followed up by the diabetes CNS in the intervention group and routine hospital care in the control

group. This study found that there was a saving of around US$1,510 for each patient who was discharged early from the hospital and was followed up by the CNS in the community. These two studies provided evidence to support that CNS can provide cost-effective patient care. It implies that nurses in advanced practice have opportunities to provide alternative healthcare options to patients.

Another study identified distinctive features of advanced nursing practice with references to the three local researches involving NSs (Wong, 2004). The features and the related studies are: goal-directed activities - using the experience of the senior CNS pilot scheme in the HA; holistic care - using the example from the nurse clinic study; and evidence-based practice - using an example of a diabetic NS who introduced an early discharge program for patients. Theoretically, these three features can be applicable to the APN when they are considered to assume the role of CNS. Yet the validity of these features on APNs' roles requires further examination.

To conclude, local studies demonstrated that both opportunities and challenges exist for nurses in advanced practice regarding their role performance and perceptions. The features of APN identified were based on the assumption that they are replacing the role of NS or CNS because they are considered to be of similar roles and ranks. The situation of unclear advanced nursing practice roles has been found in both general and psychiatric NS or CNS. Since the title of APN is evolved from NS, the definition and performance of APN roles have not been fully established or understood among nurses themselves, and other personnel within the healthcare system in Hong Kong as well. Similar to the experiences of NS or CNS found in the local studies, the role performance and perceptions of APN in Hong Kong should also be equally important and addressed.

The knowledge gaps

From the literature reviewed, there is no agreement on the definition of psychiatric APN locally and internationally. Previous studies identified only parts of psychiatric APNs' role function and performance, but the findings cannot provide comprehensive information and a complete picture for a full understanding of the topic. In addition, there is none studying psychiatric APN in local mental health care systems. Two local studies concluded that there are unclear role definitions and area of practice of NS in both general and psychiatric settings. Hence, there is a knowledge gap in clearly or fully understanding the role perception and performance of psychiatric APNs in mental healthcare systems both locally and internationally.

CHAPTER 3 - METHODOLOGY

This chapter discusses and justifies the use of qualitative, phenomenology as the method of inquiry for the present study. The characteristics and the philosophy of interpretative phenomenological analysis are also discussed. This chapter also presents the recruitment of participants, data collect methods, ethical considerations, procedures for data analysis, and the strategies to establish trustworthiness of the study.

Research design

In this study, qualitative, exploratory and interpretive approach was used to explore the lived experiences of psychiatric APNs about their perceived role functions and performance in mental health nursing practices. Qualitative approach captures participants' experiences and also offers better understanding of insider perspective when compared with quantitative method. Qualitative research explores the behaviors, feelings, and experiences of people and what lies at the core of their lives (Idvall, Bergqvist, Silverhjelm, & Unosson, 2008). An in-depth exploratory and qualitative study using interpretive phenomenological approach was employed to develop a better understanding of the lived experiences of psychiatric APNs.

While various approaches exist within the qualitative research paradigm, the topic under investigation in this research is suited to a phenomenological research approach. Phenomenology is the study of the individual's life-world as experienced and aims for a deeper understanding of the nature or meaning of everyday experiences (Munhall, 2007). This paradigm enables information processing that stresses the totality of the lived experience of each participant (Elliott, 2005); and can be used to analyze data in order to develop thick descriptions that may

illuminate human experience (Holloway & Wheeler, 2010). Interpretative phenomenological analysis (IPA) is one of the variants of phenomenology (Smith, Flowers, & Larkin, 2009). When considering IPA in relation to other forms of phenomenology, this approach is committed to the detailed examination of the case. Meanwhile the researcher wants details on what the experience for this person is like and how this person perceives what is happening to them.

Overview of interpretative phenomenological analysis

Interpretative phenomenological analysis is an approach that is committed to the examination of how people perceive an experience or what any particular experience means for them (Langdridge, 2007; Smith, Flowers, & Larkin, 2009). Unlike some other qualitative methods where the researcher's identity or perceptions are 'bracketed' or set aside, IPA specifically uses the researcher's perspectives to shape the analysis, using their conceptions to help make sense of the participant's experience (Smith & Osborn, 2003). IPA has been informed by three key areas of the philosophy of knowledge: phenomenology, hermeneutics and idiography (Smith, Flowers, & Larkin, 2009).

The major philosophy underpinning IPA is phenomenology. The phenomenological inquiry focuses on the study of experience. The second philosophy of knowledge in IPA is hermeneutics, which is the theory of interpretation. IPA involves a two-stage interpretation process as the researcher tries to make sense of participants' sense making. Smith, Flowers, and Larkin (2009) referred to this as a 'double hermeneutic', because it requires a two-stage approach to derive sense from data. IPA views that human beings are sense-making creatures and the information which participants provide will reflect their attempts to make

sense of their experience. The researcher needs to interpret that information from the participants in order to understand their experiences. The third philosophy in IPA is idiography. It concerns with the detailed examination of the particular and sought to capture the examples of convergence and divergence, rather than solely on commonalties. By taking an idiographic approach, the focus is on an individual's cognitive, linguistic, affective, and physical beings. Through a systematic and in-depth analysis on qualitative data obtained from a small-sized but more appropriate and purposively-selected sample, an IPA researcher is committed to the particular in his/her context by exploring his/her personal perspectives, and starting with a detailed examination of each case before moving to the next case.

In short, IPA is concerned with the detailed examination of lived experiences of human beings. This approach pursues an idiographic commitment and allows the researcher to take an active role during data analysis. Interpretative phenomenological analysis is also a method frequently used within health psychology. It has found helpful in the examination of a range of complex health care issues such as in identifying helpful support for women with chronic pelvic pain (Warwick, Joseph, Cordle, & Ashworth, 2004); exploring the HIV-positive women's experiences of partner relationships (Jarman, Walsh, & De Lacey, 2005); unraveling complexities involved in a woman's parenting a child with cystic fibrosis (Glasscoe & Smith, 2010); exploring the service users' experiences of treating the first episode psychosis (O'Toole et al., 2004); and investigating the attitudes to work among people diagnosed with clinical depression (Millward, Lutte, & Purvis, 2005).

An excursion into literature on using IPA has shown that this approach is an effective method that involved health care professionals or nurses as participants:

staff working in mental health care in the United Kingdom (Currid, 2009; Donnison, Thompson, & Turpin, 2009; Owens, Crone, Kilgour, & Ansari, 2010; Thompson, Powis, & Carradice, 2008); clinical nurse leaders in the US (Sherman, 2010); nurses who were involved the Miller Early Childhood Sustained Home-visiting trial in Australia (Kardamanidis, Kemp, & Schmied, 2009); and midwives (Kemp & Sandall, 2010). These studies highlighted the advantage of employing IPA for in-depth understanding of the lived experiences of health care professionals. The majority of these studies recruited 5-9 participants and employed audio-taped, face-to-face semi-structured interviews as the data collection methods.

This study is concerned with seeking in-depth information regarding how the psychiatric APNs perceive their role performance in their specialized work context, a detailed picture of the experience of each participant would be required. IPA was a suitable method in this study. This is because the psychiatric APNs are practicing in different settings and wide ranges of service scope, their lived experiences are expected to be very different and unique. IPA is the only method that is concerned with the detailed examination of lived experience and emphasises the importance of individual accounts and pursues an idiographic commitment (Smith, Flowers, & Larkin, 2009). IPA will not be dependent on bracketing as one important principle of data analysis as in descriptive phenomenology. The emphasis on the active role of researcher in IPA would be a privilege in this research. The researcher is an experienced psychiatric APN and has been working at two of the hospitals within the study hospital cluster for 20 years. She is the peer of the informants. The researcher's foreknowledge on the research topic will influence the research outcomes. There were pros and cons of such a situation. For the pros, the background knowledge of the researcher facilitated the interpretation of

information from the participants because the researcher and the participants experience similitude (Fung, Chan, & Chien, 2013). For the cons, it would be humanly impossible to bracket the researcher's own perception during data analysis and this limited the use of other research paradigms. To tackle the potential bias from the researcher, active reflection on own preconceptions, feelings, and conflicts experienced has been done through journal reflection and has actively sought them out during the data collection and analysis process (Chan, Fung, & Chien, 2013). After reflecting on the aim of the study, the idiographic characteristic of the participants, and the common background between the researcher and the participants, IPA was selected as the research methodology.

Recruitment of participants

Participants were recruited from among the psychiatric APNs working in one of seven hospitals clustered within Hong Kong. The cluster comprised two psychiatric hospitals and two psychiatric units attached to a regional general hospital. This cluster is the largest geographical region in Hong Kong. It comprises the largest psychiatric hospital with about 1,100 beds providing general psychiatric admissions for the residents of the cluster. It also manages a network of psychiatric clinics and a day hospital, providing outpatient and daytime patient services. As at March 2011, the hospital had a staff force of 1,230, consisting of 526 nurses with 33 of them holding the title of APN. There are five specialties and a nursing services department in the study venue. Due to some promotions and staff relocation during the data collection period from September 2012 to October 2012, there were around 60 psychiatric APNs in the study hospitals. The numbers of psychiatric APNs in each department are different. The smallest has four psychiatric APNs in the department of old age psychiatry and the largest has over 20 psychiatric APNs in

the department of general adult psychiatry. This research targeted at data saturation. Based on the previous studies involving nurses as participants in IPA (Currid, 2009; Donnison, Thompson, & Turpin, 2009; Kardamanidis, Kemp, & Schmied, 2009; Kemp & Sandall, 2010; Owens, Crone, Kilgour, & Ansari, 2010; Thompson, Powis, & Carradice, 2008), thirteen psychiatric APNs were purposively sampled for this study. Purposive sampling is always used in phenomenological research (Corben, 1999). It means that the researcher deliberately selects the participants because of their characteristics (Morse & Richards, 2002). The participants were invited based on the inclusion criteria. The information on the specialty which the potential participant is affiliated with is available and can be accessed by the researcher through the Hong Kong Hospital Authority's intranet system. Participants were purposively selected from a variety of specialties and different years of service, thus maximum diversity of practices and clinical experiences have been included in the study. All the target participants were contacted via phone or e-mail by the researcher. A total of 13 colleagues were invited. They all agreed to participate in the study.

Inclusion and exclusion criteria of participants

Psychiatric APNs who were currently employed by the HA met the inclusion criteria. Nurses who were deputizing for the psychiatric APN were excluded because they would be reverted back to their original post after the deputizing period.

Data collection methods

This research used a variety of data collection methods. Apart from using interviews as the main source of data collection, field notes were also used. Field notes which comprise of description of observations, observer comments, sketchers of the environment, paraphrased documentation of interviews, and reflective notes and thoughts about emerging issues (Lambert, Glacken, & McCarron, 2008). In order not to interfere with the flow of the interview and the participants and the interviewer's attention that might be caused by note-taking, field notes were not usually taken during the interview unless the situation warranted it. Besides, when necessary, brief notes were jotted down during the interview and more detailed notes on the observations and reflection were made after the interview. In this study, a general description of the participant's working environment was included in the field notes if the interview was conducted at the participant's working area. The gathering of relevant materials and other information such as work records or diary from the participants were also used. The information from work records or diaries that indicated the participants' role function or performance were also taken, e.g. statistics reflecting the service rendered; the information reflecting the roles or responsibilities within the working group, and special duties or assignment. This information has been used to enrich the data and triangulate with the interview findings.

Data collection occurred between September 2012 and October 2012. Each participant was invited for a one-hour semi-structured interview and had at least one follow-up interview for clarification and exploration and validation of important issues identified from the data of the first interview. Each interview took one to two hours and was conducted by the researcher. Semi-structured

interview is a technique for generating qualitative data and is characterized by open-ended questions that are developed in advance, and by prepared probes (Morse & Richards, 2002). The aim of developing a schedule is to facilitate a comfortable interaction with the participant, which will in turn enable them to provide a detailed account of the experience under investigation. Interpretive phenomenological analysis researchers usually use an interview schedule to help them prepare for the possible or expected contents of the study topic for discussion in the interview (Smith, Flowers, & Larkin, 2009). Although the researcher conducting an in-depth interview is likely to have a co-determined interaction in its own, it is still important to produce an interview schedule in advance to guide and focus on the key areas of the study topic. The process of developing a schedule requires the researcher to think explicitly about what they expect the interview to cover and plan enables for any difficulties they may encounter. In the semi-structured interview, the interviewer has a set of broad and open-ended questions already listed in an interview schedule, but the interview was guided by the schedule rather than to be dictated by it; the interviewer is free to probe interesting areas that arise from the participants' responses, interests or concerns (Lindlof & Taylor, 2002; Smith & Osborn, 2003). Guiding questions were derived from the local studies (Chang & Wong, 2001; Chien & Ip, 2001; Wong, 2001; Wong, 2004; Wong, Mok, Chan, & Tsang, 2005), local mental health service development, and were based on the aim and the objectives of the study. The probing questions were also prepared in advance, in case the participants forgot or were not thinking of some important information. (refer to Appendix I for the interview guide in English version and Appendix II for the Chinese version).

Ethical considerations

Ethical approval for the research was granted by the University and the Clinical and Research Committee of the study hospitals, the principles of privacy, dignity, anonymity and confidentiality were adhered to throughout this study. Privacy and dignity were ensured by conducting the interview in a room without being seen and without interference from other people. To protect the anonymity of participants, any quotation that might compromise the identity of participants was not reported. The participants' transcriptions were coded to protect identity, and all information was locked up in the drawer inside the researcher's office. This drawer was accessed only by the researcher. To ensure confidentiality, the sharing of the information was limited to the researcher and the research supervisors. Data was stored and then destroyed after the study by the researcher. Prior to the interview, all of the participants gave their written formal consent to participate in this study. An information sheet (Appendix III) and the consent letter (Appendix IV) explaining the aims and the nature of the study were provided to the potential participants before obtaining their informed written consent. The researcher assured the participants that participation was voluntary and that they were free to withdraw from the study at any time. The venue and appointments for individual, face-to-face interviews were arranged at the participant's preference and convenience, such as at participant's office during their office hour or after duty. With their written consent obtained, the interviews of the participants were conducted. The researcher audiotaped the interview conversations and wrote field notes.

Pilot study

An expert panel has been set up to evaluate the content validity of the interview guide before a pilot study. The pilot study was conducted to test the feasibility of the interview procedures, participants' understanding of the questions, and data analysis procedures. A pilot study was carried out in September 2012 after the ethical approvals were obtained. Two psychiatric APNs consented to the pilot study. It was found that the participants could understand the questions stated in the interview guide and followed well throughout the interview. Thus, after discussion with the academic supervisors, the interview guide was adopted without amendment and the information provided in the pilot interviews was also utilized in the data analysis. The initial interview for the main study was carried out in October 2012.

Data analysis

Qualitative data were derived from narrative materials with the verbatim transcript from the in-depth interviews. The researcher individually analyzed the data before discussing with the supervisors afterwards. After conducting one interview, the data was processed in the following ways. Audio-taped information was transcribed initially into Cantonese and then into English. Checking of the translations was done by an expert, bilingual in English and Cantonese. Then, the data was analyzed using the analytic process in IPA as suggested by Smith, Flowers, and Larkin (2009). This analysis process provides a practical focus on process and strategies for analyzing data and for organizing and developing themes. The steps were applied flexibly during the analysis process. The six steps were outlined as follows:

1. reading and re-reading: each transcript was read at least three times to ensure

that the researcher was intimate with the account;

2. initial noting: one side of the margin was used to note down interesting or significant issues about what the participants were disclosing. The other margin was utilized to document emerging theme titles. The first level of analysis involved noting down interesting or significant issues and copied to a separate sheet for analysis. The researcher's thought and feelings during the interpretation process were documented on one side of the margin and the other margin documented the emerging theme titles (Table 1 shows an example of the interpretation process and the emergent theme);
3. developing emerging themes: the transcript was treated as potential data and no attempt was made to omit or select particular passages for special attention;
4. searching for connections across emergent themes: the emerging themes were listed and connections between them were explored. As clusters of themes emerged, they were checked back to the transcript to ensure the connections worked in relation to what the participant actually said. For each participant (transcript), a master list of themes was then created and sub-themes were identified and compiled. Master lists were then consolidated;
5. moving to the next case; and
6. looking for patterns across cases: master lists were then looked at together, compiling a consolidated list of themes. This was achieved by looking for similarities and connections between the participants.

Table 1 Example of the interpretation process and the emergent theme

Participant	Unit of analysis	Exploratory comments	Emergent theme
P1	Some referrers were of the opinion that we are not in a position to make decisions on the kind of treatment that a patient should receive, such as MA (medical advice). In fact, although we are not medical staff, we are permitted to give medical advice.	Experience of not being recognized. She sensed that others had a hard time accepting that psychiatric nurses can perform the role of a psychiatrist.	Role recognition by others

During the study, there were concurrent data collection and analysis to check data saturation and selection of purposive sample to enrich the understanding of the themes emerged. Data analysis was based on the information from the interviews. In order to make the description clearer and precise, the additional data from observation, diary and clinical records provided a broader and more holistic description of the phenomenon.

During the data analysis, follow-up contacts (by phone or interview) with participants were arranged to clarify any unclear findings or issues raised by individual participant. A second interview for each participant was arranged after all the data was analyzed. The themes and the sub-themes that were identified in the data were presented to the participants. The participants were asked to validate their perceptions and ideas from the findings. A final review on the themes and sub-themes was done.

Trustworthiness

To establish trustworthiness in qualitative research, procedural measures for demonstrating rigor are necessary within the methodology used in the study

(Denzin & Lincoln, 2000). This study used the Lincoln and Guba's methods (1985) for improving credibility, dependability, transferability, and confirmability. Credibility was enhanced by triangulating among the researcher and the academic supervisors, and checking the preliminary findings against the raw data. The researcher shared the transcripts and the interpretation with the academic supervisors every two weeks to discuss the progress of the study. Any discrepancies of interpretation were resolved by consensus. In addition, member checking was used by returning to the participants to elicit their views on the findings and to validate them. Each individual's list of master themes with exploratory notes was shown to the respective participant after all the data was analyzed. All of the participants indicated satisfaction with the results. They commented that the themes and subthemes were conclusive and the researcher interpreted their meaning correctly. Only a minor revision on one subtheme was needed. According to the results of the checking, the subtheme: 'similar title, different roles' had been modified to 'bench-marking of roles'. Dependability was enhanced by preserving the information from the transcription, which allowed for subsequent reviews. A reflective diary and field notes were used during the process of data collection and analysis. These helped the researcher to maintain a sense of self-awareness in relation to the meaning of the data and to triangulate with the findings of the interview. After starting the data collection process, a reflective diary was used to write down the thoughts, feelings, and perceptions about the study. The field notes were written during and soon after the interview. Appendix V showed a sample transcript and data analysis. The field notes and the reflective diary could be found in Appendix V, Step 1. In this study, the researcher highlighted each participant's descriptive experience. At this level of reflection, the researcher's exploratory

comments were written alongside the transcripts while interpreting the data meaning. Fitting the data into context provided an interpretation of the experience as being credible or not. The consistent results generated by triangulating the data from the interviews, field notes, and the reflective diary could further contribute to the validity. The reflective diary and the field notes could be found in Appendix V, Step 3. Transferability was enhanced by providing a rich and detailed description of the findings. This full and detailed description could be found in Appendix V and the excerpts incorporated in the results session. Finally, confirmability was enhanced by establishing audit trails of excerpts from the transcripts that allowed readers to follow with the course of the analysis and the development of the themes. These steps were taken as one of the procedural steps in the data analysis process. These steps could be found in Appendix V, Step 2, 3, and 4.

CHAPTER 4 - RESULTS OF THE STUDY

Characteristics of Participants

A total of 13 APNs participated in this study. Data saturation was detected in the fifth participant. According to Table 2, nine participants were female and four were male. The participants were drawn from three different hospitals and from all of the psychiatric departments within the cluster. Their mean number of years of experience as psychiatric APNs was 3.5.

Table 2 Characteristics of the participants

Gender	Female	(n=9)
	Male	(n=4)
Duration of experience as a	< 1 year	(n=3)
psychiatric APN	1-4 years	(n=5)
	4-7 years	(n=2)
	>7 years	(n=3)
Average years of experience as		
a psychiatric APN	3.5 years	
Hospital A	n=6	
Hospital B	n=5	
Hospital C	n=2	
Department	CAP	(n=2)
	FP	(n=1)
	GAP	(n=5)
	MHU	(n=2)
	NSD	(n=1)
	OAP	(n=2)

Note: CAP – Department of Child and Adolescent Psychiatry;
FP – Department of Forensic Psychiatry;
GAP – Department of General Adult Psychiatry;
MHU – Mental handicapped Unit;
NSD – Nursing Services Department;
OAP – Department of Old Age Psychiatry

Results

In this study, a total of three themes were developed with four subthemes grouped under each theme. Table 3 shows the master list of themes and subthemes. The major theme of 'We are different' emerged from data relating to administrative policies in the psychiatric stream. The other two themes: 'Who am I?' and 'I am who I am' related to aspects of those differences that gave rise to questions about their roles and experiences in coping with the challenges they faced.

Table 3 Summary of three main themes and twelve subthemes

Theme	Subtheme
We are different	1) Training and development
	2) The same title but different roles
	3) Career progression
	4) Peculiar nursing structure
Who am I?	1) Multiple roles
	2) Bench-marking of roles
	3) Unclear definition of roles
	4) Role recognition by others
I am who I am	1) Path building via self-reliance
	2) Continuous improvements in quality
	3) Professionalism
	4) Predecessor role

For each participant, the number of subthemes ranged from three to seven. All participants have at least one subtheme under the theme 'we are different'. The subtheme of 'training and development' was indicated by the largest number of participants (n=10). The subtheme of 'predecessor role' was reported by participants who were the first psychiatric APN in the service unit. Table 4 shows the master list of subthemes for the whole group.

Table 4 Master list of subthemes for the whole group

Participant	Subthemes
1	(1) The same title but different roles (2) Multiple roles (3) Unclear definition of roles (4) Role recognition by others
2	(1) Training and development (2) Peculiar nursing structure (3) Unclear definition of roles (4) Continuous improvements in quality (5) Professionalism
3	(1) Training and development (2) The same title but different roles (3) Career progression (4) Peculiar nursing structure (5) Role recognition from others (6) Path building via self-reliance (7) Predecessor role
4	(1) Peculiar nursing structure (2) Bench-marking of roles (3) Path building via self-reliance
5	(1) Training and development (2) Career progression (3) Peculiar nursing structure (4) Role recognition by others (5) Path building via self-reliance (6) Professionalism (7) Predecessor role
6	(1) Career progression (2)Multiple roles (3)Bench-marking of roles (4)Role recognition by others (5)Path building via self-reliance (6)Predecessor role
7	(1)Training and development (2) Multiple roles (3) Bench-marking of roles (4) Unclear definition of roles (5) Professionalism
8	(1) Training and development (2) The same title but different roles (3) Career progression
9	(1) Training and development (2) Career progression (3) Multiple roles (4) Bench-marking of roles (5) Continuous improvements in quality (6) Professionalism
10	(1) Training and development (2) Career progression (3) Multiple roles (4) Unclear definition of roles (5) Role recognition by others (6) Professionalism
11	(1) Training and development (2) The same title but different roles (3) Role recognition by others
12	(1) Training and development (2) The same title but different roles (3) Career progression (4) Continuous improvements in quality
13	(1) Training and development (2) Bench-marking of roles (3) Continuous improvements in quality

Theme 1 - 'We are different'

All of the participants stated that they were treated differently after they had been promoted to the position of a psychiatric APN. According to their descriptions, the differences were considered multi-dimensional in nature. They viewed the current nursing grade structure as unfavourable for the performance of their roles in clinical practice, and for career advancement. From their experiences, this theme was made up of four subthemes: 'training and development', 'the same title but different roles, 'peculiar nursing structure', and 'career progression'.

Subtheme 1: Training and development

The majority of the participants revealed that there were differences in training opportunities before and after their promotion. In their experience, they were offered limited training. Most participants coped with clinical operational needs on their own. As one participant revealed:

> It depends on what you are preparing for. If you target clinical service, merely clinical is not enough, you need to do more in service and to advance the knowledge. However, it seems there's no time to do this. Science and technology change with each new day. Today's APN needs to catch up with the technology. I have developed all the IT for this service and done it through exploration. Other colleagues can't help…. There is no more support or training for me now. (P5)

Although there was an induction programme for the newly promoted healthcare professionals, they found that training for clinical practice was scarce after their promotion. One participant reported:

> I joined a lot of educational activities when I was a RN. I'm responsible for several committees…. Two years before the promotion, I already took up multiple tasks…. After promotion, there is a management 101 program for newly promoted APN and medical staff. It's for newly promoted staff. This program teaches you how to write staff development review, how to coach staff, how to handle conflicts and so on. Clinically, you need to attend some related courses before the promotion, such as cognitive behavioral therapy. However, it seems none for clinical skills after promotion. (P9)

The participants perceived that their need for clinical training was inadequately addressed after their promotion to APN.

Subtheme 2: The same title but different roles

When there was more than one psychiatric APN in the same unit, the participants revealed that the senior and the junior psychiatric APNs were assigned different roles. This phenomenon was obvious when there was no nurse manager or nurse consultant in the unit. The most experienced psychiatric APN needed to take up the managerial and supervisory roles to offer support to other APN colleagues. When the interviews were conducted in the participants' work places, it was quite common to find that the junior colleagues either called-in or knocked the door for case consultation while the interviews were in progress. One experienced psychiatric APN reported:

> I squeeze some time from clinical duties to perform managerial duties, so my duties are different from them. Secondly, they will consult me on complicated cases. (P3)

A junior participant showed a report template that was prepared by a senior APN. He found that it was helpful for him to have some concrete advice when he asked the senior

APN for the proper ways of report writing. He echoed the need for supervision from the experienced APNs on the clinical aspect:

> Whenever I have a problem, I'm free to approach them and they can give me advice. (P11)

When there was no immediate nursing supervisor in the unit, the most experienced APN would automatically take up the additional roles of manager and clinical supervisor to fill the gap. Meanwhile, the junior APNs focused on their clinical duties.

Subtheme 3: Peculiar nursing structure

After the nursing grade reform, the nurse consultant (NC) is situated in the third tier and above the APN. According to the line of supervision, the NC is expected to provide clinical supervision to APN. As there is only one NC in the community psychiatric services, psychiatric APNs who worked in other departments are under manager's supervision. As a result, the majority of the psychiatric APNs were headed by a department operations manager (DOM). However, these APNs found the managers could not provide clinical support to them and instead they turned to medical staff for assistance, resulting in confusion in the line of supervision and ways of seeking help. This subtheme highlighted its impact on clinical support in the psychiatric stream. It is prestigious for a community psychiatric service to be headed by an NC. One participant reported:

> Our boss (NC) leads the routine morning meeting and discusses different issues, e.g., case sharing…. All of these things demonstrate good support. (P2)

When there was no NC in the units, some participants experienced confusion regarding

the line of supervision and ways of getting clinical support. One participant reported:

> According to our mechanism, colleagues will approach me for advice on the difficult clinical cases. Then, I will try my best to help. I never call my manager for clinical issues. When there are some issues that I can't handle, I will seek advice from Associate Consultant, but only one time for personal issue. (P5)

When there was no NC in the psychiatric department, the participants approached medical staff for advice on clinical issues instead of their nursing supervisor.

Subtheme 4: Career progression

Those in the general and psychiatric streams had different opportunities to progress in their careers. As there are only a limited number of senior posts in the psychiatric stream, most of the participants were pessimistic about their chance of promotion. Some participants perceived that they had reached a career dead end. One participant reported:

> Although the roles of APNs are important, in the future, I only perceive the trend that APNs' future will end up with APN. There are two pathways: One trend is ward manager, another trend is nurse consultant. However, the chance of development for both ward manager and nurse consultant is very limited. (P8)

Most participants thought that there should be NCs in other psychiatric services because they found that the number of NC posts was growing quickly in the general stream. In the experience of one participant, those in the general and psychiatric streams had different career prospects:

> For psychiatric, I think the future is gloomy. For general, I think the future is brighter. It is because our sector is too small, we have limited resource allocation. The management level cannot see our importance. Some (general) APNs promoted at the same time as me, they already got promoted to DOM (department operations manager). So it is because of different scopes. I have some classmates from the general stream, they promoted quickly to ward manager or DOM. Our mental health stream is comparatively small, making it hard to see our service expansion. (P10)

The careers of those in the psychiatric stream lagged behind those in the general stream. The participants viewed their future as gloomy. In summary, this theme highlighted that the key concerns of the participants was the lack of practical support from administrators and the lack of opportunities to advance in their career.

Theme 2 - 'Who am I?'

Although the participants were the role bearers, most of them had difficulties to describe their roles clearly. This theme included the subthemes of 'multiple roles', 'bench-marking of roles', 'unclear definition of roles', and 'role recognition by others'.

Subtheme 1: Multiple roles

When the roles of the psychiatric APNs were not clearly delineated, the participants performed their roles according to what they understood their own roles to be. For the participants in this study, a central concern was being overwhelmed by demands arising from undefined roles. One participant reported:

> The first role is nurse specialist. If we are working in specialty, like forensic psychiatry, then it would be specialist in forensic psychiatry. The second role is advanced nursing practice. We need to take up rather complicated cases because the junior nurses cannot

> handle it. Besides, we also play the role as shift I/C (in-charge), and need to take up the supervisory role for each shift, just like the NO's (nursing officer) role. On top of the NO's role, the expertise's role in APN highlighted the difference. In nurse specialist's role, APN involves more education or research practice. Besides, I think APN will focus more on developing the specialty, which means focusing on evidence-based practice or research…. It's a blended roles of NO and NS (nurse specialist). (P6)

One participant described psychiatric APNs performing multi-faceted roles and serving multiple functions in the daily nursing practice:

> The psychiatric APN is an all-rounder who is presentable – someone who can do things, write, and who needs to do research. I think I am more than psychiatric, it is a general post mixed with senior and junior posts. Then it's called APN -A、P、Night, three shifts. (P10)

The psychiatric APNs were involved in work of different kinds. They experienced the demands of managing complex and high-volume work in their daily practice.

Subtheme 2: Bench-marking of roles

Under the current nursing structure, APNs are in the same tier as other nurses holding similar ranks. As their roles were not clearly delineated, some of the participants enacted their roles by referring to those of other colleagues in the same tier. The participants from the specialty in mental health perceived their roles in clinical practice while the one from the nursing services department perceived her roles mainly from the perspective as a teaching one. One participant reported on the performance of her role by comparing it with the role of psychiatric nurse educators:

> They need to prepare exam papers, while I do not need to do that…. I do not need to comment on their assignments. (P4)

When there were psychiatric NOs and APNs in the same unit, role comparisons were obvious. One participant reported:

> Our team's NOs are comfortable. They are exempted from teaching and organising programmes. (P9)

Because the roles of those with similar nursing ranks have not been clearly delineated, the psychiatric APNs compared their duties with nurses who were in the same tier.

Subtheme 3: Unclear definition of roles

When there were no concrete definitions of roles, psychiatric APNs understood their roles differently. Some participants perceived that they had no distinctive roles and, thus, had difficulty in clearly describing their roles. One participant appeared puzzled and found that there were no role boundaries:

> The role of psychiatric APN is still unclear to me.... because the nature of the job ultimately requires us to go beyond the generic nursing roles. (P1)

Some participants hesitated to define their roles. One participant reported:

> It's vague. It's like what I have mentioned about the roles that I am performing. APN means everything, including administrator, educator, case manager, and clinician. (P2)

Although psychiatric APNs were key players in performing their roles, some participants felt uncertain about the scope of their service and the definition of their roles.

Subtheme 4: Role recognition by others

Psychiatric APNs practice at an advanced level. It is important for them to demonstrate their competence in carrying out their roles. The participants reported that it was hard to gain the recognition of others when they were involved in a programme that was new to the service. One participant reported that others had a hard time accepting that psychiatric nurses perform a medical role:

> Some referrers were of the opinion that we are not in a position to make decisions on the kind of treatment that a patient should receive such as MA (medical advice). In fact, although we are not medical staff, we are permitted to give MA. (P1)

Some participants evaluated their role performance through the gaining of recognition from others. In one participant's experience, this was a long process:

> Recognition developed over nine years. It cannot be achieved in one step, but only step-by-step. When the medical staff and the superior think that you can handle the cases independently, they can provide you the power to dispose the cases. When our experiences build up, our confidence and their confidences on us are rising, both recognition from others and our abilities will be developed eventually. (P3)

One participant was sorry to tell that some hospital staff expressed ill feelings towards their clients and deprived the patients' activity need. She was angry to know that the

professional staff stigmatized the mental patients via depriving their training needs as well as ignoring her roles:

> They perceived your role is not essential. They described that our role is just like a vase. If the patients don't go for training, its fine for them to stay in the ward. They (the ward staff) put patients' activities at a very low priority…. They think that it is not necessary to provide training for them. (P10)

The participants experienced the process of gaining the recognition of others as long and difficult, particularly when other healthcare colleagues were unfamiliar with the service. In general, this theme highlighted the concern that the psychiatric APNs' scope of practice was undefined and multi-faceted.

Theme 3 - 'I am who I am'

Psychiatric APNs encounter a variety of challenges while carrying out their roles. This theme highlighted the desire of psychiatric APNs to demonstrate their competence in performing their duties. It consists of four subthemes: 'path building via self-reliance', 'predecessor role', 'continuous improvements in quality', and 'professionalism'.

Subtheme 1: Path building via self-reliance

Some participants were involved in implementing new programs in the psychiatric service. Some services involved an expanded nursing role, such as making medical advice in psychiatric consultation-liaison nursing service. Although some participants worked closely with those in other disciplines during the process of developing the service, they were ultimately responsible for the service development. One participant stated:

> I was the only one to be appointed to develop this psychiatric consultation-liaison nursing service. It was a new service in 2003. (P3)

When there was no role model that the psychiatric APN could follow, some participants developed the service drawing upon their repertoire of knowledge and reflection through clinical learning. One participant reported:

> I'm the first APN in this cluster…. Until now, there has been no post-registration certificate course for this specialty in the local tertiary institute. After promotion, I've searched overseas. There are some post-graduate or even masters programs. But I don't have time to study. In 2010, our team's doctors, occupational therapists and I visited the UK's psychiatric services. As this service is unique in Hong Kong, I can't learn from other clusters.… I never attended any structured programs. I built up my knowledge through my clinical experience. (P6)

The participants demonstrated a pioneering spirit and used their repertoire of knowledge to explore and develop the new service.

Subtheme 2: Predecessor role

Most of the experienced psychiatric APNs reported experiencing a degree of hardship in carrying out their new roles. Instead of keeping their difficult experiences to themselves, they were eager to pass down their knowledge to the newly promoted psychiatric APNs. One experienced psychiatric APN reported:

> I was responsible for conducting a training course … for training potential colleagues to

be equipped with the relevant knowledge. (P3)

The participants predicted that the newly appointed psychiatric APNs would find it difficult to carry out their new roles and found that they could not help much in clinical duties. Some of the participants were prepared to coach them. Another experienced participant who worked in the forensic department conducted some self-arranged sharing sessions for the new comers and also reported:

> As they are newly promoted and are transferred from another (non-forensic) specialty, and they have less than one year experience here. I try my best to help them take up the tasks. It would be more effective if they can take up the tasks. Then I don't need to shoulder so many tasks. (P6)

Most experienced participants developed measures to help the newly promoted psychiatric APNs transition into their roles.

Subtheme 3: Continuous improvements in quality

Although there is no straightforward formula for measuring the quality of care in psychiatric nursing, the participants adopted various methods aimed at enhancing the service. One participant confided:

> At least, I have confident to dispose the case. After the case is discharged, I will self-audit to check whether the case will be referred back to our service within 28 days. I also ask the medical staff for their opinion during supervision …. (P12)

In order to enhance the service, some participants perceived that it was important for

them to ensure the quality of the care that they delivered. One participant reported:

> You need to monitor the progress while implementing care and to review whether there is room for improvement. (P13)

Although there was no concrete definition to measure the psychiatric APNs' role performance, the participants were themselves determined to strive to deliver quality care for the benefit of the patients.

Subtheme 4: Professionalism

Some participants demonstrated a desire to fulfil their roles well and had a positive attitude towards the nursing profession. One participant was satisfied with demonstrating fidelity to service:

> It's my responsibility to be accountable in many aspects: to patients, to the job, and to senior and junior colleagues. (P2)

For the best benefit of the users of the service, one participant perceived that it is important for APNs to explore and try new things, even at the expense of assuming some risk. It is because they need to shoulder the ultimate responsibility whenever things go wrong:

> We need vision and perspicacity. We need to take preventive measures before the mishaps. No matter whether it is nursing care or management, you need to try even though you cannot predict the outcome. (P13)

The participants put the interests of service users ahead of their own and demonstrated their commitment to the psychiatric nursing profession. This theme concluded that the participants had transformed their constraints into opportunities for clinical learning, and that they had also gone the extra mile to help newcomers perform their roles.

CHAPTER 5 - DISCUSSION

This study is the first to explore the roles of psychiatric APNs in mental health nursing practices from their own lived experiences and perspectives in Hong Kong. The impact of the current administrative policy on the psychiatric nursing service and the issues contributing to confusion over the role of psychiatric APNs are first described and discussed. Within such role confusion, ways of coping with the challenges of their role and the challenges of current developments in the psychiatric nursing service are critically discussed. Finally, the limitations of this study are also described.

An ivory tower

The policy-makers may stay in a place where they separated from the problems after the implementation of the nursing grade reform. They aimed at advancing the role of clinical nursing practice but they did not know that the psychiatric APNs were in lack of clinical support, clinical training opportunities, and career advancement in the psychiatric stream. The participants were generally frustrated with current administrative policies on the psychiatric nursing service when they compared the pace of development in the general and psychiatric streams of nursing. This difference in development, which may be the result of a disconnect between the administration's prime aim of advancing the role of clinical nursing and the real situation on the ground, underscores the practical concerns for the clinical development of APNs in the psychiatric stream. Psychiatric nurses saw themselves as being different from general nurses in many ways, including the difference in the nature of society's feelings towards their client populations and the structure of the psychiatric system (Humble & Cross, 2010). According to the participants, they found that the career prospects and clinical support between the general and the psychiatric streams were different after the nursing

grade reform. The existence of marked differences in the number of nurse consultant (NC) positions between the general and psychiatric streams as perceived by the participants in this study further added their views on the differences. In the view of the participants, psychiatric NCs play an important role in offering them clinical support because under the current career structure, the psychiatric NC is responsible for leading the clinical service and advancement in psychiatric nursing specialty.

In addition, the participants voiced a need for continuous clinical training. It is particularly important when the psychiatric APNs are posted to the new work settings that required specific nursing knowledge. The provision of quality care for specific clientele relies on nurses receiving the appropriate training has been highlighted by Bowen and Mason (2012). They concluded that the important differences with regard to the therapeutic actions between the forensic and non-forensic nursing for the psychopathic and personality disordered patients were related to the training that supports the development of therapeutic care and skills. Therefore, a well-designed training programme and clinical support are needed to enhance the competence of psychiatric APNs in performing their roles (Gilfedder, Barron, & Docherty, 2010).

Moreover, the participants were eager to know about pathways to job promotion or career advancement. This finding was consistent with that of Rowell, Forsythe, Avallone, and Kloos (2008), who found promotion as one of the critical components in a professional career. In the current nursing grade structure, there is a three-level professional structure with second level (2^{nd} tier) nurses being described as APN. In the third tier, both clinical and management career pathways co-exist for the nurses with different titles within the 2^{nd} tier. To achieve coherent and practical support for the development of advanced nursing practices, there should be a need for administrators to develop a clear clinical career pathway for psychiatric APNs, and to create a NC post in

each specialty.

A role without boundaries

Previous studies have described how psychiatric APNs perform multiple roles, such as case consultation role, liaison role, and therapist (Beeber & Charlie, 1998; Johnston & Cowman, 2008; McCorkle et al., 2009; McCorkle, Jeon, Ercolano, & Schwartz, 2011; Sharrock & Happell, 2002). Without a clear scope of practice, such nurses may experience more overlapping or overloading of roles when compared with other nurses. Therefore, it is necessary to delineate the roles of psychiatric APNs, as well as those of nurses with different job titles through re-visiting their respective roles in the nursing grade structure. For example, the specific role for a nurse educator is teaching, and the specific role for ward manager is management. In Ohio, a program for clinical advancement ladder for CNSs and NPs was established. It provided eligibility criteria for administrators to consider for APN's advancement to APNII or III (Rowell, Forsythe, Avallone, & Kloos, 2008). The successful implementation of the program is attributed to the effective communication and collaboration between the administrators and the APNs. Otherwise, a lack of understanding may cause confusion and even unnecessary conflicts amongst the nurses within the same tier. This, in turn, would adversely affect the optimal development of psychiatric advanced nursing practices. The participants in this study were concerned about recognition of their roles by others. This finding agrees with that of Bryant-Lukosius, DiCenso, Browne, and Pinelli (2004) and Wood (1998) that acceptance by stakeholders is one of the challenges associated with the introduction of APN roles. When the nurses' roles are unclear, this may lead to different expectations from other healthcare professionals on what roles the nurses should be performing (Chang & Wong, 2001; Chien & Ip, 2001). Therefore, it is important for both

policy-makers and the psychiatric APNs to work out the scope of practice of psychiatric APNs so that other healthcare professionals are well-versed in the roles of psychiatric APNs.

Ways of coping in Chinese culture

The participants demonstrated their aspiration to succeed in performing the roles of psychiatric APNs when they encountered challenges within the healthcare system. This study revealed that the psychiatric APNs coped with carrying out their new roles by transforming the challenges that they faced into the opportunities for expanding their repertoire of knowledge. Some participants sought to manage their unmet clinical knowledge needs through continuous clinical learning and further education. In the end, they will equip themselves with more knowledge and skills that enable them to perform more proficient nursing roles in return. These findings are consistent with the Confucian value of appreciating that negative occurrences can foster personal growth (Cheng, Lo, & Chio, 2010). In addition, Harvey (1993) reported that taking up the post of APN when this position was new to the organisation was a daunting experience. To change this situation, the experienced participants developed strategies in helping their newly promoted colleagues to perform their roles. This value is reflected in the subtheme 'predecessor role' of this study. This reflected Chinese virtue that states: 'What you do not want done to yourself, do not do to others' – Confucius (551 BC – 479 BC). In this study, the Chinese virtues of the participants were demonstrated. Even in a healthcare context that is unfavourable to psychiatric APNs in the carrying out of their roles, the psychiatric APNs have roles to play that facilitate the growth of psychiatric nursing practices and ease the difficulties faced by other psychiatric APNs in adopting their new roles. Their experiences in role playing serve as role models and may have impacts on

the new psychiatric APNs' courage to face all the challenges when they try new roles.

The challenges of current development in psychiatric nursing service

One finding deserves particular attention. Psychiatric APNs need to take on managerial roles that fall outside clinical practices. The dilemmas between clinical and managerial roles could have several negative consequences. First, as conceptualised, psychiatric nurses who undertake the role of APNs should possess advanced knowledge and skills in a clinical specialty. This echoed the purpose of introducing the APN position into the nursing grade structure is to enhance professional accountability and autonomy of nurses and allows them to focus on the development of clinical practice competence as the basis for career advancement (Hospital Authority, 2006). If they perform managerial duties, their clinical skills are not being used effectively. This goes squarely against the prime aim of introducing the title of APN into the nursing structure. Second, the issue of role delineation between the psychiatric APNs and the manager may intensify. This point, supported by Chien and Ip (2001), suggests conflicts within an organization is one of the ward managers' concerns when there is overlapping administrative functions between them and the psychiatric CNSs. Third, psychiatric APNs are prepared to take up a specialised role in clinical practice and not a managerial role. Inadequate preparation for the managerial role could expose psychiatric APNs to vulnerable situations; thus, undesirable role performance may result. This gap in roles may put the newly promoted psychiatric APNs in a difficult position. Administrators should consider delineating the role of psychiatric APNs, as well as assigning a few specific staff with a managerial post in each unit.

Limitations

This study explored the lived experience of psychiatric APNs in one of the seven hospital clusters in Hong Kong; hence, the findings are not generalizable to other contexts. Regarding this account, participants were purposively selected from those in a variety of specialties and with different years of service; thus, allowing for a maximum diversity of practices and clinical experiences. This also allows fullest understanding of the topic and enables comparison of APN's lived experiences across settings. However, sample from diverse settings in different clusters should be obtained to compare and contrast the main themes identified and to ensure that data saturation would be achieved. Besides psychiatric APNs' role performance, the aspects of role preparation to become an APN, and the service users' expectation of an APN should be explored to facilitate their role development. This study only explored the perceptions from the role-bearers. Hence, this study is limited by the lack of other healthcare team members' and service users' views. This may affect the comprehensive understanding of the role performance of psychiatric APN.

Lastly, this research enhanced the understanding of the here-and-now situation of the topic, but it is difficult to predict the changes in the APN role functions and performance due to the current proposed re-structuring in mental health policies and services by the Hospital Authority and Food and Health Bureau of The Government of HKSAR. Therefore, based on the findings of this research, it is recommended that future research attempts should focus on the exploration of the development and changes in the APN structure and role functions.

CHAPTER 6 – IMPLICATIONS AND CONCLUSION

Lack of role clarity will influence the role development and performance of an APN (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004; Wong et al., 2009). The APN is part of the new nursing grade structure and was introduced by Hong Kong Hospital Authority in 2003. The post of APN is one of the most challenging for the nursing profession in Hong Kong, not only because of the creation of new job titles in the existing nursing structure, but also since APNs have great capability and capacity for contributing to delivery of quality care and leading effective change of practice (Christiansen, Vernon, & Jinks, 2013). However, their roles had not been elucidated clearly in both general and psychiatric nursing streams. Through this qualitative exploratory, identification of the key issues relating to psychiatric APNs' perceptions on their roles will help them tap into the newly developed nursing structure and enhance their role functions in mental healthcare services. Based on the results of the study, implications for advanced nursing practice and future research are discussed.

Implications for advanced nursing practice

This study revealed the perceptions of psychiatric APNs on their roles and provided relevant information for psychiatric nurses and administrators to more effectively facilitate role performance in clinical practices relating to psychiatric nursing. The findings of this study may provide the psychiatric APNs with insights for their role enactment through visiting colleagues' lived experiences. Although psychiatric APNs are expected to develop new service to suit the current healthcare needs, it is unlikely that the management will provide in-service training for them to advance their clinical

knowledge. Their unmet training needs are obvious when they are expected to perform the roles that are beyond the generic nursing duties, such as providing medical advice, or when they are posted to a specialty that they do not have training under. As they are in the forefront of the mental healthcare service, psychiatric APNs are expected to expand their nursing knowledge through self-arranged studies including both professional and technical knowledge, clinical reflections, and to extend the boundaries of their nursing practice via developing services to suit current mental healthcare needs. Furthermore, the findings may allow senior RNs to understand the actual dimension of psychiatric APNs' roles. Thus, nurses are able to better prepare themselves before taking up the advanced practice roles. Based on the literature review, it is concluded that psychiatric APN demonstrated significant results in managing clients with mental healthcare needs via psychosocial intervention. When compared with the findings of the present study, none is mentioned. Therefore, it is suggested that the role of psychiatric APN to provide psychosocial interventions and evidence-based practice should be further enhanced. To support psychiatric nursing service development, administrators should develop strategies that address the needs for psychiatric APNs and provide them with opportunities for continuous clinical training and the space to focus on clinical practice.

Implications for future research

This study already identified areas requiring further research, in particular the importance of seeking the views from other healthcare team members and service users on their expectations and demands for a psychiatric APN's role performance. Further research should also be allocated to expand the understanding of APNs' roles from those in all clusters and the preparation of being an APN from senior RNs. Role performance

of APNs revealed from the process of caring for their clients can be further studied to elicit the nurse-patient relationship and interaction, as well as the clients' expectation and perception of an APN role. The concrete suggestions for future research topics include: an exploration on the service users' views on psychiatric APNs' role functions, study on the role transition from psychiatric RN to psychiatric APN, and a multi-sites study on psychiatric APNs' role perceptions.

Conclusion

This study elicited psychiatric APNs voices on their perceptions of the roles and explored the challenges that psychiatric APNs encountered in understanding and performing APN roles. Participants' concern for a clear role delineation and career pathway, continuous clinical training and supervision needs, and in particular, the creation of adequate managerial and NC posts to meet the real situation for advanced nursing practice in the current mental healthcare system were identified. This study suggests that psychiatric APNs should be prepared to advance their clinical knowledge via self-arranged studies and to develop new mental healthcare services on their own. Meanwhile, administrators should provide the psychiatric APNs with the clinical support and space needed to focus on clinical practices. In addition, a clear pathway for career advancement for psychiatric APNs should be developed. Rowell, Forsythe, Avallone, and Kloos (2008) provided a model for the promotion of APNs and described how the competency performance criteria can be integrated into an approach for advancement in clinical practice. Finally, the findings of this study shed light on future studies in revealing the challenges that nurses encountered when serving these roles in advanced practice.

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APPENDIX I: INTERVIEW GUIDE (ENGLISH VERSION)

INTERVIEW GUIDE

Opening/Introduction

Hi! Welcome to participate in the research that aims at exploring the lived experience of psychiatric APNs in playing their roles in the new nursing structure in Hong Kong. The findings will provide essential information for the administrative levels of the Hospital Authority to understand the issues in nursing grade reform and pave ways for advanced psychiatric nursing development in Hong Kong.

You will be guided to answer some interview questions that may last about an hour. Please be assured that all the personal particulars and conversations will be kept strictly confidential and anonymous. Before starting the interview, I would like to ask for your permission for audio-recording and note-taking.

Background
● Can you tell me which unit /ward you are working now? Prompts: what kind of specialized service you are providing? ● How long have you been in your existing post? ● What are the experiences that involved in working out your present duties? Prompts: on-the-job training, specialty training, continuous education
Experiences of psychiatric APN
● What are your routine clinical duties? ● Then, describe how you do perform your daily work. ● Any special duties or work have you done recently assigned by your supervisor or manager? Describe the special assignment and your role in it. ● Do you have any experience in developing advanced psychiatric nursing program or service? If yes, would you share your experience of how to work out the program or service? ● Are you undertaking independent advanced practice roles in your work setting? If yes, can you share your experience? If no, then who are your colleagues? What are the experience when you are working with them?
Perception of role delineation
● What roles you are performing? Prompts: clinician, administrator, educator, researcher, gatekeeper, co-ordinator, case manager, therapist, bridge agent ● Then, can you describe these roles? ● Are there any colleagues with equivalent ranks (NO/NS/NE/WM) working with you? If yes, what is your perception of their roles as well as yours? Prompts: similarities and differences regarding the administration, clinical practice, education, research roles

Perception of role performance
● In daily practice, how do you demonstrate your competencies of APN and how to recognize and measure your role performance? Prompts: performance indicators such as evidence-based practice regarding patient's outcome or cost-effectiveness/achievement on the goal directed activities/provision of holistic care ● Then, how do you perceive your role performance?
Personal viewpoint
● In general, how do you understand the term 'psychiatric APN'? Prompts: what are the specific role and competencies of psychiatric nurses practicing at advanced level? ● What, in your opinion, is the ideal psychiatric APNs' development? Prompts: how would you describe the contribution of psychiatric APN role in mental health service? Autonomy/credential to practice/nurse-run service? ● Are there any other issues that you would like to share with me?

*** The above listed questions are suggested to guide the interview, in which they may not be asked in sequence and more questions can be added to clarify the interviewee's responses and seek further elaborations as needed.**

APPENDIX II: INTERVIEW GUIDE (CHINESE VERSION)

面談指引(中文版本)

引言

你好! 歡迎參與有關「探討精神科資深護師的經歷」的學術研究。研究結果將提供重要資料予行政階層了解護理職系改革及落實精神科臻深護理在香港的發展。

現希望邀請閣下參與大約一小時的面談, 對話只作研究之用途, 內容絕對保密, 謝謝!

閣下是否同意, 我在面談期間進行筆錄和錄音?

背景資料

- 請問你現時在那個部門或病房工作?

提示: 請問你正提供那一類型的專科服務?

- 請問你在現時的工作崗位工作了多久?
- 請問你過往有否任何經歷能令你有效地履行現時的職務?

提示: 例如在職訓練, 專科訓練, 持續進修

有關精神科資深護師的經歷

- 請問你有什麼常規工作的臨床職務?
- 可否分享一下你是如何實行此職務?
- 請問你最近有否被上司或經理指派一些特別職務?
  請描術一下那些特別職務及你所擔任的角色。
- 請問你有否任何關於發展臻深護理服務的經驗? 如有, 可否分享一下有關於如何實行此類服務的經驗?
- 請問你在現時的工作環境裏, 是否獨立擔任臻深護理的角色?
  如是, 可否分享一下你是如何獨立擔任有關職務的經驗?
  如否, 誰是你的同事? 請你分享一下有關你與他們一起工作的經驗?

有關角色描述的看法

- 你現時在工作上扮演什麼角色?

提示: 例如臨床、 行政人員 、 教育者 、 研究員 、 把關員 、個案經理 、 治療師、服務統籌者、 醫院及社區間的橋樑

- 可否描述一下你所提及的角色?
- 請問有否相等職級的同事(NO/NS/NE/WM)與你一起工作? 如有, 你對他們及你的角色有何看法?

提示: 你們彼此間在臨床、行政、教育、研究角色上的相同和分別

有關履行角色的看法
● 在現時的常規工作中,你是如何顯示你能勝任為資深護師及你是如何確認和衡量你已履行相關的角色? 提示:有什麼指標可以證明你的工作表現, 例如護理實證: 病人經護理介入後的效果或成本效益/達到預期目標/提供全人護理 ● 根據你所提及, 你對自己已履行的角色有何看法?
個人觀點
● 一般而言, 你如何理解 '精神科資深護師' 這個名詞? 提示: 資深護師有什麼獨特的角色及才能? ● 你對於理想的精神科資深護師發展有什麼個人意見? 提示: 你會如何形容精神科資深護師對精神科服務所作出的貢獻? 自主/執業認可/護士主導的服務 ● 除了以上的談話內容, 你還有什麼欲與我分享呢?

*** 上術問題只作面談指引, 在面談期間, 問題次序會因應被訪者所提供的資料而有所更改, 需要時亦會加插問題以作深入探討。**

APPENDIX III: INFORMATION SHEET

INFORMATION SHEET

A phenomenological study of psychiatric advanced practice nurses' role perceptions in the current healthcare structure

You are invited to participate in a study supervised by Dr. Zenobia Chan and conducted by Fung Yuen-ling, who are MPhil students of the School of Nursing in The Hong Kong Polytechnic University.

This research aims to explore the lived experiences of Psychiatric APNs in playing their roles in the new nursing structure in Hong Kong. The findings will provide essential information for the administrative level to understand the issues in nursing grade reform and pave ways for advanced psychiatric nursing development in Hong Kong. The whole investigation will be held within six months. You are invited for about one hour semi-structured interview and is expected to have at least one additional interview for clarification and further exploration of important issues identified in the interview data. All the interviews will be audio-taped. You will also be assured of anonymity, though some of the information that you provide will be published. The research data will be kept in locked cabinets and destroyed once the study has been completed. During the interview process, the researcher will ensure the privacy and confidentiality.

You have every right to withdraw from the study before or during the measurement without penalty of any kind. All information related to you will remain confidential, and will be identifiable by codes known only to the researcher.

If you would like more information about this study, please contact Fung Yuen-ling at telephone number 9805 or her supervisor Dr. Zenobia Chan at telephone number 27666426.

If you have any complaints about the conduct of this research study, please do not hesitate to contact Secretary of NTWC CREC.

Thank you for your interest in participating in this study.

Principal Investigator

_____

APPENDIX IV: CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

A phenomenological study of psychiatric advanced practice nurses' role perceptions the current healthcare structure

I _____ hereby consent to participate in the captioned research supervised by Dr. Zenobia Chan and conducted by Fung Yuen-ling, MPhil student.

I understand that information obtained from this research may be used in future research and published. However, my right to privacy will be retained, i.e., my personal details will not be revealed.

The procedure as set out in the attached information sheet has been fully explained. I understand the benefits and risks involved. My participation in the project is voluntary.

I acknowledge that I have the right to question any part of the procedure and can withdraw at any time without penalty of any kind.

I understand that NTWC Cluster REC as one of the authorized parties to access my records related to the study for ethics review purpose.

Name of participant _____

Signature of participant _____

Name of researcher _____

Signature of researcher _____

Date _____

APPENDIX V: A SAMPLE TRANSCRIPT AND DATA ANALYSIS

Step 1. Data collection (Audio-tape interview + field notes)

Field notes_P5 -Written during and soon after the interview

Date: 12 Oct 12
Time: 10:00 am – 12:00noon
Venue: Interview room at the out-patient clinic

- After phone contacted with P5 to confirm the interview, I was invited to visit her office. As she preferred to have the audio-recording at the interview room instead of her office, the interview was conducted at the adjacent interview room.

Environment of P5's office:

- Partitioned office occupied by seven nurses. The office was roughly divided into two equal half. One half occupied by the participant and her colleagues and another occupied by another service users. The room was about ~ 400 sq. ft.
- P5 occupied a partitioned corner. A set of computer and a telephone were solely used by P5. Other three sets of computers (CMS and IPAS installed) were shared use by the room occupiers. P5's desk was clean and tidy with not much file placed on the table top. The wall was posted with the clinics' contact numbers, staff's duty arrangement and some work schedule.
- There was no other staff in the office during that time because they all went out to do the nursing consultation in the hospital or in the clinic.

Observation:
-Bring along with a cup of tea and a cell phone.
-Relaxed and was ready to talk.
-Interview was interrupted by a call from her colleague asking for her advice.
-Before the re-start, she shared with her experiences in providing clinical guidance to her subordinates and was agreed to talk it again during audio- recording.
-Appeared helpless when shared her experiences in developing the service.
-Showed satisfaction when talked about the past hardship and returned with client's improvement, and this service helped to reduce unnecessary referrals to psychiatrist.
-Appeared contended when mentioned about the legitimacy of the nursing report and being the part of the team to work out the first psychiatric nurse clinic in Hong Kong.
-Just before leaving the interview room, she thanked me for choosing this topic and hoped their voices could be heard by the administrator.
-In general, P5 was very familiar with the evolution of the service establishment, the service scope, her roles involved in this service. The interview process was smooth and P5 could response to all the questions by elucidating the phenomenon clearly.

Reflective diary_P5 (written soon after the interview and during the data analysis):

P5 worked out the present duty since she was a RN. According to her description, her nursing supervisor was unable to offer her any clinical guidance throughout the process in developing the service. On top of her past experience, she gained the clinical knowledge through the informal clinical supervision and coaching from the medical staff. She treasured the support from medical staff and she found it was helpful for her

to develop the new service. From her experience, she found the nursing supervisor was not helpful or unable to help regarding the clinical matters. That's why she never called her nursing supervisor and would turn to medical staff for advice instead.

Since she was the pioneer in developing the service, she needed to develop and perform the advanced nursing practice role independently. I was impressed by her positive and optimistic attitude throughout the process in developing the new service and as well as playing her roles in the current work setting. She was initiative to participate in developing this brand new service ever since she heard about it. However, in the time of science and technological advancement, she experienced the tension from the time constraint to further advance the related knowledge by self. Although we work in different units, we were declined to attend the relevant specialty course conducted by IANS. And we were told by the manager that APN had the lowest priority. She implied that continuous job-related training should be arranged by the administrator.

During the interview, she mentioned multi-faceted roles. Being the service in-charge, she had to deal with the challenges whenever it comes. The roles she mentioned mainly related to the day-to-day clinical operations, and some ad hoc issues. All these are important to assure the service quality to care receivers, and to smooth other colleagues to perform their duties.

Although she joined the nursing service for over 20 years, she was confused with the career pathway after the nursing grade reform. According to her understanding, advanced practice nurses are expected to perform clinical duties. Taking up both administrative and clinical duties seemed to be her routine duties. That's why she was confused with her career pathway. Hence, her need to perform the additional managerial duty in real practice was unexpected to her.

Step 2. Raw data with initial noting (highlighted)
(To protect the anonymity of the participant, only some of the raw data will be shown)

Interview 5

R: 咁我想問吓你而家喺邊個部門或病房工作㗎？

P5: 我而家响呢間醫院個 XX team。零五年 Pilot，零七年我哋個 cluster 開始發展，我由零六年開始做。個 service 有幾個 component 嘅响 HA 裡面。我哋跨部門同一啲唔係 HA 嘅人合作緊。Non-HA 除咗 SWO，NGO 都有。

R: Which department or ward are you working?

P5: I am working in XX team. The service piloted in 2005. In 2007, our cluster started to develop this service. I started this service in 2006. In this service, there are some components inside HA. We also collaborate with non-HA staff including SWO and NGO.

R: NGO 點同你合作㗎?

P5: 因為我哋都會 refer 一啲 case 畀社工啦，因為佢哋可能有一啲 psychosocial 嘅問題呀、stress，我哋會 refer 返畀社工去處理。例如如 marital 嘅問題，family relationship、financial、housing，或者 child care 嘅問題咁樣。我哋都好靠佢哋喺 community 度幫到個 case 囉。

R: How do you collaborate with NGO?

P5: We will refer some cases to social workers and they also refer some cases with psychosocial problems or with stress to us. We will refer cases with problems of marital, family relationship, financial, housing or childcare to social workers. We rely on them to help the cases in the community.

R: 06 年開始呢個 service?

P5: 正式 implement 喇，之前其實都要一啲準備工夫啦

R Is this service commenced in 2006?

P5: We need to do some preparation work and it implemented in 2006.

R: 你 APN 個 title 幾時 in post㗎?

P5: 07 年。

R: When is your APN tile in post?

P5: In 2007.

R: 你 06 年做 RN 嘅時候已經著手 develop 呢樣嘢嘅喇?

P5: 係呀。

R: Is that mean when you as a RN in 2006, you already helped in developing this service?

P5: Yes.

R: 可唔可以 share 返你 05、06 年 develop 呢個 service 嘅嘢?

P5: 05 年我都係响 ward 嘅。係一個 informal ward 嘅 admission 咁樣。知道有呢一樣嘢嘅時候，都係 call 返啲同事有冇興趣去做啦。當時我諗咗一段時間，因為都係好新呀，都未知係啲乜嘢。但係與此同時，我 02 年都係參與緊一啲 CL 嘅 service。當時唔話好認識咁，有個 consultant 嘅醫生帶住我哋去 general ward 做 CL service 咁樣。所以出去睇 case 呢，我覺得唔係咁困難嘅。所以我就毅然舉手啦，以示自

己嘅興趣。當時 (2006 年)都有另一個同事參與呢個服務開展、準備服務。
R: Can you share your experiences in developing this service in 2005 and 2006?
P5: In 2005, I worked in in-patient service. It is an informal admission ward. Since knowing this service, the management invited those interested staff to develop this service. After thinking for some time – because this was new – I knew nothing about it. In 2002, I participated CL service. At that time, it was new to me, I followed a psychiatrist to general wards to do the consultation-liaison service. So I don't find it difficult to consult cases. I showed interest. In 2006, there is another staff who also helped to develop and prepare this service.

R: 另外嗰位同事係 RN 呢?
P5: 係，當時係。
R: Is that colleague also a RN?
P5: Yes, at that time.

R: 仲有冇其它嘢幫到你 develop 而家呢個 service㗎?
P5: 其實當時都好 brand new 嘅。因為一來要同出便啲人 liaise 點樣配合返自己個服務，所以要同出面嘅同事呀，去講返我哋會服務啲咩、畀啲咩 client、開會講 logistics。好關注就係話我哋個服務好 front line 嘅，同醫生個 concern 就唔同囉。因為我哋有醫生幫手，但係佢哋睇嘅呢就係我開嗰個服務，我哋護士呢全部都落手落腳去做，個服務嘅細節全部都係護士自己去諗，好多嘢都係自己 plan 嘅，以自己經驗睇返咁樣 o 唔 ok。另外都要認識個服務啦，我哋都有同佢地嗰邊介紹返自己將要做呢個服務囉。例如 OPD 有個最大嘅 NO，同佢哋一齊開會，等佢哋認識我哋，大家容易啲溝通。呢個其實好重要，因為做外展服務、或者一啲 senior 嘅 level 呢，你個 relationship with other departments 係一定唔可以缺失嘅。要保障返服務啦，畀佢哋知道我哋個 professionalism 喺邊度，同埋你可以幫到佢啲咩。我覺得呢個係必需。我哋都好多謝當年帶住我哋嗰位醫生啦。响我哋開始 plan 呢個服務嘅時候呢，佢一路都喺 clinical 方面都 sharpen 我哋嘅。我哋冇好 formal 嘅 training 但係佢一路帶住我哋去做 CL，畀我哋深化一啲去睇，好確實 diagnose 到一啲 case，跟住有啲 criteria 咁樣。跟住我哋睇一啲 case 呢，都好重要囉。但係知道同 apply 係兩回事呢嘅。你一定要親力親為去 gain 到一啲 experience。喺個案身上，佢出現咗啲咩 symptom、有咩變化，都需要經驗上掌握嘅。
R: Is there anything that can facilitate you to develop this service?
P5: Actually, the service was brand new. Since I'm the one who needs to liaise with the partners, I need to communicate with them concerning our service scope, our clients' needs, and the logistics. Although we have support from the doctor, they focus primarily on the service, while nurses are responsible for implementation. I planned every detail by myself and then check if it is OK or not based on my past experience. Besides, I need to understand the service. For example, the most senior NO in the OPD will have meeting with us. So, we know each other. This will ease the communication between us. It is important. The relationship with other departments should be close because we are doing outreach service or working with senior personnel. To assure our service quality, we need to let them know our professionalism and in what ways we can help them. I think it is necessary. I am thankful for the doctors who coached us in the past years. They sharpened our clinical knowledge ever since we planned this service. We don't have formal training. Our psychiatrists brought us to do the consultation-liaison, to deepen our knowledge and to confirm the diagnosis according to the criteria. It is

important for us to see the cases and gain some experiences. Knowing and application are two different things. You need to do in order to gain the experience. We need experience to grasp the symptoms, or the change of conditions from the cases.

R: 同事間有冇分工?係一個人負責幾間?

P5: 喺初初 pilot 嗰陣，我哋都要試個 demand 有幾大，所以初時我哋係坐定嘅。坐定有好有唔好。好處係個同事一定喺度，有咩事，都可以即刻搵返佢。個唔好處係，如果有同事要放假，唔可以話因為你放假，人哋冇晒服務，就講唔通喇。所以我哋諗，同事都要坐唔同嘅地方都做到同一樣嘅嘢，都覺得冇 reservation、冇問題嘅，咁會好啲啦。所以當有同事 in and out 嘅時候，新嘅同事嚟，我哋帶都容易囉。

R: How do you arrange the work amongst colleagues? Is each staff responsible for the designated clinics?

P5: In the pilot phase, we need to test the demand. So each staff is assigned to some designated clinics. There are pros and cons. For the pros, when there are some problems, the partners can contact our designated staff direct; for the cons, there is no one on duty in the clinic when the designated staff is on leave. I think it is unreasonable that the service suspends whenever the staff is on leave. Later, I arranged staff to work in different clinics. So, there will be no reservation and no problem whenever there is staff movement. It would be easier for us to coach the new comers.

R: 有冇一啲困難嘅經驗要人 support 你?

P5: 我哋個機制係，如果同事覺得 clinical 上有啲比較 difficult 去 handle 嘅嘢，佢哋會 call 我囉 advice 啦，我會盡我嘅能力睇吓點處理。一般我哋未曾試過再 call IC、我哋嘅醫生囉。如果我都解決唔到，就會 seek AC consultant，或者 associate consultant。實際上 clinical 就冇試過，因為 clinical 上 manage 得都 ok 嘅。但係反而有一次試過 personnel 嘅問題啦。

R: Is there any experience that you need others' support?

P5: According to our mechanism, colleagues will approach me for advice on the difficult clinical cases. Then I will try my best to help. Yet, I never call my in-charge or our medical staff for clinical issues. When there are some issues that I can't handle, I will seek advice from Associate Consultant, but only one time for personal issues.

R: 你覺得喺呢啲工作單位度扮演緊啲咩角色?

P5: 我自己扮演緊好多角色啦。如果個服務冇，我要開展佢，service developer 咁樣。Develop 得嚟，你又要 coordinate，即係唔係話呢樣嘢要做，跟住擺畀人做啦，所有都要落手落腳嘅。你要 relate with 其它部門啦，logistics 點行呀，咁所以你要 plan 好多嘢，跟住要 coordinate。跟住實踐方面啦，甚至你要 negotiate 一啲 resource 啦。好似我哋要 negotiate 一間房，一間 decent 啲嘅房，要擺一啲櫃呀、一啲 forms。本簿點樣擺、排版點樣開其實都係一個問題，好多細節嘢都要做嘅。你問佢哋攞啲 resources，佢哋覺得好緊絀呀，但係緊絀裡便點樣負責埋呢啲嘢呢?

R: What roles are you performing?

P5: I am performing multiple roles. When there is no service, I need to develop, i.e service developer. During the service development, you need to co-ordinate. That means, I need to do it on my own because you can't just ask someone to do it. You also need to relate with other departments to work out the logistics, so you need to plan and coordinate. During implementation, you also need to negotiate some resources. Like, I

need to negotiate a decent room, some furniture to place the forms and documents. I need to work out all the details such as the place to keep appointment book, and how to open a new case file. It is really difficult to ask them when there is resources constraint.

R: 咁啲係咪可以顯示到你係做緊 advanced nursing practice 嘅嘢？
P5: 係呀。喺 basic training 裡面未必預計得到有呢樣嘢啦。因為 case，一來，我哋係一手一腳去做，睇到佢個 improvement 好大，亦都可以改善到佢個 coping 啦，所以我覺得我哋幫咗成個 community 同個家庭。呢個絕對係 advanced nursing 嘅 skill 呢嘅，喺 psychia 嗰方面。
R: Are all these demonstrating your advanced nursing practice?
P5: Yes. The basic training cannot predict these. For the cases, I manage them by self. We can see the big improvement and we can enhance their coping skills. So, I think we can help the family in the community. It is absolutely advanced nursing skills in the psychiatric aspect.

R: 另外一個 APN 嘅同事……
P5: 佢早兩年都係 upgrade 出嚟嘅。你知而家 HA 有啲 upgrade 嘅 post 啦，你做多啲嘢……
R: How about the other APN colleague…?
P5: She is upgraded from a RN two years ago. You know in HA you need to do more in order to upgrade the post….

R: 你哋點分工?
P5: 個同事都係啱啱再返過嘅，都係啱啱 pick up 返個 service。當我放假嘅時候，佢會跟返我嘅嘢啦。Parallel 咁互相 relieve，唔可以一齊放假。
R: How do you work with her?
P5: This colleague is just returned from another unit. She just picked up the service. She will relief my duty in my absence. We are parallel and cannot take leave at the same time.

R: 你點睇 APN 呢個 term?
P5: understanding 我就唔知係咪好清晰啦。APN 呢個 post 都係早幾年 nursing reform 先出，以前係 NO，而家個 rank 都係 NO，只不過個 title 改咗，都係換湯不換藥。Nursing reform 裡便似乎就分咗兩條龍啦，一邊係 management、一邊係 clinical 吖嘛。喺 nursing reform 裡面 APN 都係跟 clinical service 嗰條，再上就係 NC㗎喇──nursing consultant，吓。我而家 clinical skill 都係一個 major part㗎喇，但唔等於一切。因為 RN 都係做緊 clinical skill 嘅嘢，take 緊同一樣 number 嘅 section，但係我所謂 advanced 咗呢，我 perceive 到就係畀到佢哋 clinical 嘅 support，點睇 clinical 覺得 difficult 嘅 case 啦、點畀 advice 佢哋啦。另外我要 plan 所有 relief 啦，呢啲佢哋未必幫到我做。我都要 support 佢，喺 service 嘅 logistics 裡便遇到問題、甚至 relationship 上便嘅問題，例如面對唔係 HA department 嘅人、點將自己 difficulty 話畀人聽，因為佢哋未必 comfortable 做呢樣嘢:「你可唔可以幫我出聲呀?」除咗 client 嘅 advocate，亦係同事嘅 advocate，有啲咩方面係可以中庸一啲去睇。因為我呢個 post 唔可以即時將同事嘅 expression 同一個 volume 表現返畀人睇，我一定要分析返件事。Somehow 我哋做咗咁多年，都會明──唔一定係個服務本身有問題，可能同事個內心、psychological，或者個 family 出現問題，返工嘅時候個 emotion 都 stir

up 到嘅，跟住 perceive 嘅嘢唔會係正確㗎喇。我哋就要分析返，係咪樣樣嘢都要 reflect?點去 reflect 啱?當然，如果個同事真係好 stress、confront 到一啲好大嘅問題，例如出便嘅 counter part、我哋嘅同工覺得大家做嘢嘅手法唔同，咁樣唔得，咁我哋就要中介返喇，因為我要 protect 返我嘅同事，以中庸嘅態度話返咁係唔㗎喎。我 stand in 佢哋個 position，講返樣中肯嘅嘢，咁係重要。有時都要同同事傾吓、counsel 吓。你話一個 APN 唔須要處理 admin 嘅嘢就假嘅，但 percentage 就冇 ward manager、service manager 咁多囉，所以唔係一定 clinical，所以同 nursing reform 個 grade 唔銜接呀。有時個會懷疑，佢哋 prepare 個 APN 係 for 啲咩呢?去兩樣嘢──management way 或者 nursing consultant 個 way?呢樣嘢未必係 communicate 得咁清晰囉。淨係你落嚟，咁我哋就要做，ok 做到梗係好啦，做唔到……「唉?點解你做唔到?APN 呢㗎喎!」咁樣。唔係淨係我哋 cluster 會咁，有時同唔同 cluster 嘅同事傾 APN 個 grade 呀，佢哋都 experience 同一樣嘢。有時諗嘅，management 方面，個 communication skill 應該係最好，係咪就係 lack of time 去 communicate 呢?

R: How do you perceive the term APN?

Actually, I don't quite understand. The post of APN evolved from Nursing Officer. It's just a title change. In nursing reform, it seems to have two pathways: one is management and one is clinical. Within nursing reform, APN follows the clinical path, followed by nurse consultant when move upward. Clinical skill is the major part but not equal to the total. Since RN also taking up duty that requires clinical skill and takes up equal number of sessions. What I mean advanced is that I can offer them clinical support, advice them how to assess difficult cases. In addition, I plan all the relief. All these, the RN can't help. When they have problems concerning the service logistics or relationship with other partners, I shall support them. For example, they may feel uncomfortable to disclose their difficulties to other staff who work in the HA department. Then, they may ask me to 'voice out for them'. Apart from being the client's advocate, I also serve as colleague's advocate. I can take a neutral stand to understand the issue and analysis the incident. In my position, I can't copy colleagues' expression or volume when I reflect the issue to others. Somehow, after having a few years' experiences, I understand that there may not be necessarily something wrong with the service. May be there are some problems in the colleague's herself or her family. Her emotion was stirred up when they are on duty. Then, their perceptions may not be correct. We need to analyze and to decide whether it is really a matter and need to reflect. If yes, how to reflect? Of course, when the colleague is under stress and encountered some big problems e.g. our partners found that there are discrepancies in doing things, then I will mediate. It is because I need to protect our colleagues by adopting a neutral stand. It is important for me to stand in their position and to talk with them or counsel them. However, in reality, APN also need to handle the administrative duties despite when compared with ward managers or service managers. So, it would not be necessarily clinical. This does not fit with the nursing grade reform. Sometimes I wonder if nursing reform is preparing APN as management or nurse consultant? This is not clearly communicated yet. We need to do that when it comes. It would be OK if we can do it. If not, then…'As an APN, why you can't do that?' Not only our cluster, but also the APNs in other clusters experienced the same. Sometimes I think, the communication skills in management should be good. May be they are in lack of time to communicate.

R: 你而家 management 同 clinical 個 percentage 係幾多呀?

P5: 要計呀……因為 clinical 其實好容易計嘅。每個禮拜 at least 都有 50%出咗去

clinical㗎喇 at least，甚至要 relieve 呀，at least 80%都係 clinical 方面。因為就算唔係出去 session，都有 offsite 嘅嘢要做，例如 with 社工。有啲嘢真係唔可以喺 session 度做得到，例如同 carer 傾電話，唔係個個都帶住個電話等你㗎嘛，仲有 recommendation 咁、answer 同事嘅 inquiry、clinical difficulty、同其它 cluster 啲服務呀轉介呀，admin 嘢就 suppose 20%。但好多時就話我哋拎住個 call 機嘅，NGO、social work、診所同事 call 我，好多時好難抽返出嚟 count。如果你話好 clear cut，20%就一定係，因為我都要搞返個 statistics、成個 team 嘅嘢、ward man 畀我嘅服務、工作。

R: What is the percentage of management and clinical?

P5: When calculate…, it is easy to calculate in clinical. I have at least 50% to work in clinical, sometimes I need to relief others, so at least 80% in clinical. Even in office, we have something to do offsite e.g. communicate with social worker. There are something that we can't do during the session e.g. phone contact with the caregivers because they are not waiting for your call. Others include making recommendations, answering colleagues' inquiry concerning the clinical difficult cases, handling referrals from other clusters. It is supposed 20% in administrative. However, we always bring along with a pager. The partners will call me. All these are difficult to count. If you have to clear cut, it should be 20%. Ward manager also ask me to do the statistics for the team.

R: 你對上有 ward man 嘅?

P5: 有嘅。

R: Is there a ward manager in your unit?

P: Yes.

R: 你覺得理想嘅 APN 應唔應該 80% clinical、20% management?

P5: 睇吓你 prepare for 邊樣嘢啦。首先你個 target 如果係 clinical service 嘅時候，你要畀多啲服務，就唔係淨係 clinical 嘅，仲要 advance 返你嘅 knowledge，而家就似乎冇乜時間做呢啲嘢啦。科技日新月異，APN 要兼顧追得到個 technology 囉。已經唔係追得貼㗎喇，但係一定要識用、apply，比起你同工、RN、唔係直接幫手嘅，所以所有 service 嘅 IT 都係我自己 develop 嘅，我都係摸住條樹過河嘅，未必其他同事幫到。啲 RN 點會識 IT 嘅啫?但你又真係要用 IT 去做啲數喎，因為你要交數，唔可以就咁 fax。呢啲要時間去做，因為 IT 嘢唔係你望一望、教一堂就識，你要 apply，有問題你問邊個?HA 用好多錢喺 IT 度，有個 IT 嘅 department，你見到好多 clinical service 唔止一部電腦，但同時電腦嘅 knowledge 係咪 advance 得到呢?可能你見都唔係好識用。極其量就係攞住個 iPhone send WhatsApp、send email，其它嘢呢?好多同事都好驚郁到個掣會全部冇晒。我都試過打 notes，我冇撳 save，唔知 high 到邊個掣，全部冇晒要重新打過。

R: What are your views on the ideal APN development when there is 80% clinical and 20% management?

P5: It depends on what you are preparing for. If you target clinical service, merely clinical is not enough, you need to do more on service and to advance the knowledge. However, it seems there's no time to do this. Science and technology change with each new day. Today's APN needs to catch up with the technology. I have developed all the IT for this service and done it through exploration. Other colleagues can't help. The RNs do not know IT. However, you need to use IT because you need to work out the figures. You can't fax the document. It requires some time to learn and cannot be

acquired after attending one class or just have a glance. You need to apply but no one you can ask. HA spent a lot in IT. It consists of an IT department. There is more than one computer in most clinical services. Why can't the computer knowledge be advanced at the same pace? Most probably you don't know how to apply. We merely use iPhone to send WhatsApp, send email, and what else? Some colleagues are panic about things will lost when they press the wrong button. In clinical, I have experience in losing data while I am typing notes using the CMS. Because I did not save the document, all things disappeared after I touched the wrong button. I needed to type it again.

R: IT knowledge 你係點學返嚟㗎?

P5: 我 RN 嗰陣 HA 有啲好 prelim 嘅，老細都唔係畀你睇好 advance 嘅，都係 Introduction to Word、Excel、中文輸入法咁樣。但好多嘢就你 apply 嗰陣，你摸一個掣，你先至 competent 去用囉。上咗堂唔丟等於一切，因為唔用到就唔記得。做咗 APN 後再學多啲就好啦但而家冇 support 或 training 畀我哋。如果 IT 有咩問題，都係問一啲識嘅人囉。你 connect 到啲同事，例如佢都有用開 Excel 嘅，可以問佢啲 icon，其實都係靠 sharing。但係冇 IT 部門，呢個係 deficit.。

R: How do you learn the IT knowledge?

P5: As a RN in HA, I've learnt some preliminary knowledge e.g. introduction to Word, Excel, Chinese word processing. Our boss won't let you learn something advance. You become competent only when you press the button and apply. You will forget if you won't apply even you have attended the class**.** It would be better if I could learn more after promoted to APN. There is no more support or training for me now. When there is an IT problem, I will ask someone who know about the IT. You can connect with the colleagues who used Excel. You can ask him/her about the icon and share the knowledge with me. It is a deficit that we don't have IT department to ask.

R: 仲有冇嘢想分享返?

P5: 之前講緊話我哋個 role 係點樣。除咗頭先所講，我哋亦都有 documentation 嘅 role，因為 assess 嘅嘢、risk、improvement 都要 well documented 啦，等對方都知道個 assessment 係點樣。有啲 case 都想攞返自己個報告……佢都想 identify 返自己個情況，有啲 case 都會攞 nursing report 囉，所以個 documentation 要好 formal。佢哋要 apply PRO 啦，咁 PRO 就將個 Record 拎返出嚟，highlight 咗，我哋就寫返個 report 啦。

R: Is there anything else you wish to share?

P5: Have just talked about our role. Apart from what I have said, I also have documentation role. We need to document what we have assessed the case's risk and the improvement. So that others will know about the assessment. Some cases may need to obtain their own report…. They want to identify their own situation. Some cases may ask for nursing report. So, it requires formal documentation. If they make the application to patients' relation officer (PRO), the PRO will pick up the record and highlight it, then we will prepare the report.

R: 個 nursing report 點用?

P5: 好似 medical report 咁囉。例如個 case 睇咗醫生之後，都想知一啲 legal 嘅嘢、access 一啲 formal institution，佢都想 by 呢個 report，facilitate 到 proceeding 嘅，佢就會 apply medical record。呢個係 legal 嘅 document。個 report 做咗、修改咗，都會畀 AC counter sign 嘅，跟住就出。喺 advanced nursing practice 都需要有咁嘅

readiness involve with 呢啲嘢。雖然唔係 daily，但喺 advanced 方面都要有咁嘅 nursing judgment。因為有 70% case 都無需睇醫生，呢啲 case 如果要 justify 返自己個情況，就只可以攞到個 nursing report㗎啫。如果我冇錯嘅話，我同其它 nursing clinic 講返嘅時候，佢哋未必有咁大 population of clients 係唔須要睇醫生。

R: What is the purpose of the nursing report?

P5: Something like medical report e.g. after medical consultation, the case may want to know some legal things, to access some formal institution. If they can make use this report to facilitate the proceedings, they will apply the medical record. It is a legal document. After the report is ready, I will send it for Associate Consultant's signature. It is necessary for advanced nursing practice to be ready to be involve with this. Although it is not a daily practice, nursing judgment is one area that should be advanced. There is 70% cases not seeing psychiatrist, when they need to justify their own situation, they can only access the nursing report. As far as I know, other nurse clinics do not have such great population of clients that do not need to consult psychiatrist.

R: 我見你都好有滿足感……

P5: develop 個 service、做開荒牛係辛苦嘅，我唔反對自己做咗隻牛嘅，但係你睇到 clinically 個 return、啲 client 真係好 treasure 呢個服務。你用心咁解釋佢個 presentation、symptom、究竟 related to 啲咩，佢好用心聽、仔細講。當中有情緒變化，例如佢喊得好犀利，某程度上係 suppress 得太耐嘅情緒，所以好 treasure 呢個服務。暫時响 HA 其它 clinical service 個 workload 裡便係畀唔到嘅。雖然頭先話要開數，我覺得唔同意嘅，因為你開大咗，究竟有幾多 man-time 畀呢個 client，呢樣係最重要。新症好 stress，我哋一定要個半鐘頭，因為唔知……你係要 ice-breaking。你諗吓一個普通人:「點解我要見精神科護士呢?」有啲會好抗拒。我哋 service 已經將呢個 stigma 減低好多，但有人見到我「精神科護士」以為自己有精神病。但係你一路响 interview 時就要融化佢呢個 point，跟住佢要將唔開心嘅嘢講返畀你聽，呢個係 advanced practice 嘢 interview skill，跟住佢哋好開心咁離開。

R: I sensed that you are satisfied….

P5: It is really hard to develop the service, but I don't mind, anyway. When you see the return clinically, the clients really treasure this service. When you see them explaining wholeheartedly a presentation, symptom or anything that's related, they will listen to you carefully. Sometimes they have emotional changes. They will cry bitterly because their emotions have been suppressed too long, so they treasure this service. So far, there is no other clinical service in HA that can offer this service. Although I have mentioned the number (target), I do not agree that it is good to exceed the target. It raises the questions of the man-time to the client. It is important. If the new case is under stress, we need to spend half an hour to break the ice. People may think 'why I need to see the psychiatric nurse?' Some people are resistive. Our service already put down the stigma a lot. However, some people when come to see us 'psychiatric nurse', they will found themselves have mental illness. Throughout the interview process, we need to dissolve this point. Then, they will leave the room happily.

Step 3: Noting down interesting or significant issues, then copied them on a separate sheet for analysis. The thoughts and feelings during the process of interpretation were documented on the left margin of the paper, and emerging theme titles were noted on the right margin.

	Significant statement:	
Preliminary Theme	Original transcript	Exploratory comments
	R: How do you work out the present duties? P5: '當時唔話好認識咁，有個 consultant 嘅醫生帶住我哋去 general ward 做 CL service 咁樣…..' '我哋冇好 formal 嘅 training 但係佢一路帶住我哋去做 CL，畀我哋深化一啲去睇，好確實 diagnose 到一啲 case，跟住有啲 criteria 咁樣。' ' …..其實當時都好 brand new 嘅。…..因為我哋有醫生幫手，但係佢哋睇嘅呢就係我開嗰個服務，我哋護士呢全部都落手落腳去做，個服務嘅細節全部都係護士自己去諗，好多嘢都係自己 plan 嘅，以自己經驗睇返咁樣 O 唔 OK.'	
Path building via self-reliance	P5: 'At that time, it was new to me, I followed a psychiatrist consultant to general ward to do the consultation-liaison service….' 'We don't have formal training and he brought us to do the consultation-liaison, to deepen our knowledge, to confirm the diagnosis according to the criteria….'	She found the hand on experiences from the medical colleagues were helpful in developing the new service.
	'Actually, it was very brand new…. Although we have support from the doctor, they focused on the service, nurses need to implement. I planned every details by myself and then to check if it is OK or not based on my past experience.'	Experiences of developing a pioneer service
	R: Is there any experience that you need others' support? P5: '我哋個機制係，如果同事覺得 clinical 上有啲比較 difficult 去 handle 嘅嘢，佢哋會 call 我囉 advice 啦，我會盡我嘅能力睇吓點處理。一般我哋未曾試過再 call IC、我哋嘅	

	醫生囉。如果我都解決唔到，就會 seek AC consultant，或者 associate consultant。實際上 clinical 就冇試過，因為 clinical 上 manage 得都 ok 嘅。但係反而有一次試過 personnel 嘅問題啦。’	
Predecessor role Peculiar nursing structure	P5: ‘According to our mechanism, colleagues will approach me for advice on the difficult clinical cases. Then, I will try my best to help. Yet, I never call my in-charge or our medical staff for clinical issues. When there are some issues that I can’t handle, I will seek advice from Associate Consultant, but only one time for personnel issue.’	Field notes: ‘Colleagues called-in for case consultation during the interview.’ Experiences of taking up the roles as advisor to the juniors nurse and seeking support from medical staff instead of senior nurse.
	R: How do you perceive the term APN? P5: understanding 我就唔知係咪好清晰啦。APN 呢個 post 都係早幾年 nursing reform 先出，以前係 NO，而家個 rank 都係 NO，只不過個 title 改咗，都係換湯不換藥。Nursing reform 裡便似乎就分咗兩條龍啦，一邊係 management、一邊係 clinical 吖嘛。喺 nursing reform 裡面 APN 都係跟 clinical service 嗰條，再上就係 NC 喫喇──nursing consultant。….. 你話一個 APN 唔須要處理 admin 嘅嘢就假嘅，但 percentage 就冇 ward manager、service manager 咁多囉，所以唔係一定 clinical，所以同 nursing reform 個 grade 唔銜接呀。有時個會懷疑，佢哋 prepare 個 APN 係 for 啲咩呢？去兩樣嘢──management way 或者 nursing consultant 個 way?呢樣嘢未必係 communicate 得咁清晰囉。	
Career progression	P5: ‘Actually, I not quite understand. The post of APN is evolved from Nursing Officer. It’s just a title change. In nursing reform, it seems to have two pathways: one is management and one is clinical. Within nursing reform, APN follows the clinical path, followed by nurse consultant when move upward…. However, in reality, APN also need to handle the administrative duties despite with lower percentage when compared with ward manager or service manager. So it would not be necessarily clinical, this is not fit with the	Field notes: ‘The monthly duty is prepared by the participant’ Reflective diary: ‘Taking up both administrative and clinical duties seems to be her routine duties. That’s why she was confused with her

	nursing grade reform. Sometimes, I wonder if the nursing reform prepares APN for management way or nurse consultant? This is not clearly communicated yet.'	career pathway.' Experiences of confusion in career pathway
	R: What are your views on the ideal APN development?	
Training and development	P5: '睇吓你 prepare for 邊樣嘢啦。首先你個 target 如果係 clinical service 嘅時候，你要畀多啲服務，就唔係淨係 clinical 嘅，仲要 advance 返你嘅 knowledge，而家就似乎冇乜時間做呢啲嘢啦。科技日新月異，APN 要兼顧追得到個 technology….. 所以所有 service 嘅 IT 都係我自己 develop 嘅，我都係摸住石頭過河嘅，未必其他同事幫到。' '做咗 APN 後再學多啲就好啦但而家冇 support 或 training 畀我哋。'	
	P5: ' It depends on what you are preparing for. If you target on clinical service, merely clinical is not enough, you need to do more on service and to advance the knowledge. However, it seems no time to do this. Science and technology change with each new day. Today's APN needs to catch up with the technology….I have developed all the IT in this service and done it through exploration. Other colleagues can't help.' 'It would be better if I can learn more after promoted to APN, there is no more support or training for me now'.	Experiences of the need to meet the increasing demand. As there is no further training support, she coped all the challenges by self. <u>Reflective diary:</u> 'Although we work in different units, we were declined to attend the relevant specialty training course organized by IANS. And we were told by the managers that APN had the lowest priority.'
	R: You have just mentioned nursing report, can you elaborate more? P5: '…..呢個係 legal 嘅 document。個 report 做咗、修改咗，都會畀 AC counter sign 嘅，跟住就出。喺 advanced nursing practice 都需要有咁嘅 readiness involve with 呢啲嘢。雖然唔係 daily，但喺 advanced 方面都要有咁嘅 nursing judgment'	

	'…..develop 個 service、做開荒牛係辛苦嘅，我唔反對自己做咗隻牛嘅，但係你睇到 clinically 個 return、啲 client 真係好 treasure 呢個服務。你用心咁解釋佢個 presentation、symptom、究竟 related to 啲咩，佢好用心聽、仔細講。當中有情緒變化，例如佢喊得好犀利，某程度上係 suppress 得太耐嘅情緒，所以好 treasure 呢個服務。'	
Role recognition by others	P5: '… this is a legal document. After the report is ready, I will send it for Associate Consultant's signature. It's necessary for advanced nursing practice to be ready to involve with this. Although it is not a daily practice, nursing judgment is one area that should be advanced….we can contain and handle our cases are the most important parts of nurse clinic.'	Experiences of demonstrating the advanced nursing practice role, as the nursing consultation report can be used as a legal document.
Professionalism	'…it is really hard to develop the service, but I don't mind anyway. When you see the return clinically, the clients really treasure this service. When you wholeheartedly explain to them the presentation, symptom or anything that are related to, they will listen to you carefully. Sometimes they have emotional changes, like, they will cry bitterly because their emotions have suppressed too long, so they treasure this service'.	Experiences of devoted work and returned with job satisfaction.

Step 4: These notes were classified to develop emerging themes and their connections were explored