What Constitutes an Expert Registered Nurse in Labour & Delivery?:

A Phenomenological Inquiry

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Abstract

The purpose of this study was to explore what constitutes an expert registered nurse in a labour and delivery unit. A qualitative, phenomenological approach was used to guide and analyze the interviews of twelve participants recruited through purposeful sampling. Patricia Benner’s *From Novice to Expert* theory was used as both a theoretical definition of expert as well as a baseline for participants to self-identify with one of the levels of skill acquisition (novice, advanced beginner, competent, proficient or expert). Three themes emerged from data analysis including: 1) characteristics of expert nurses, 2) significance and impact of loss and 3) difficulty with the word “expert”. The study results showed that expert is a fluid concept that is both difficult to define and maintain throughout a nurse’s career. Factors such as education, technology, culture, environment and most notably autonomy, impact a nurse’s ability to achieve expert status as well as the ability to remain an expert of the same capacity throughout their careers. In addition, environmental and practice related changes resulted in feelings of loss that also significantly impacted the nurse’s perception of expert nursing. Ultimately, it was identified that Benner’s definition of expert is not complete and would require additional research with a focus on relational and psychosocial elements of nursing specifically in the area of labour and delivery setting in order to achieve a more comprehensive definition.

*Keywords:* Expert, Nursing, Labour and Delivery, Patricia Benner, From Novice to Expert
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Chapter One: Introduction

Nursing, in comparison to professions like medicine and law, entered late into the world of academia and is still debated in literature as to whether it is truly a scientific profession, or simply an art (Benner, Tanner & Chesla, 2009). Because of this tardiness to recognize nursing as a profession, formal education has become a high priority which is changing the landscape of the previously recognized hospital based apprenticeship model of nursing education. Education and practice have become distinctly separate, with education focusing on the understanding of and potential outcomes of formal abstract theories rather than the feasibility of their application in practice (Benner et al., 2009).

Formal abstract theory is important, especially to the new graduate nurse as it can act as a guide or practice foci in order to determine what type of typical responses to expect from patients, whether clinical or psychosocial (Benner et al., 2009). However, abstract theories fall short of two important characteristics critical in both clinical reasoning and practical knowledge. First, the formality of these theories limits the ability of practice situations to guide theoretical understanding (Benner et al., 2009). Second, it is difficult to incorporate change in patient condition over time making it impossible to individualize care (Benner et al., 2009). The formality of these theories does not take into account the qualitative distinctions important in holistic patient care. Unlike what the formal theory attempts to deliver, nursing practice often entails the management of undetermined and open ended patient situations where one cannot rely on the certainty that formal theory contributes, but nursing judgement is required (Benner et al., 2009).
Unfortunately, in today’s economic setting, the focus of health care institutions is largely related to cost and time saving measures. Nursing characteristics that cannot be quantified such as time spent building therapeutic relationships, time spent in silence with patients, caring techniques, communication with family or even moments spent listening to patients could be, to some, deemed nonessential or less important than those tasks that can be measured. While technical skill and task oriented procedures are essential to nursing practice, it is important to recognize the diversity of the nursing role and be able to recognize all contributions of care that nurses provide to accurately understand how professional nursing impacts patient care and wellbeing (Kostovich, 2012).

The purpose of this study is to explore what constitutes an expert registered nurse in labour and delivery. It was identified by the researcher that the best method to answer this question was through a qualitative methodological approach which will be explored further in chapter four. In setting the stage for this study, the researcher felt it was significant to introduce her personal reflection relative to the topic and site selection within the introduction in order to provide clarity for the reader in the remaining chapters.

Reflection. In March 2013, maternal child services (which includes labour and delivery, postpartum care, neonatal intensive care unit and paediatrics) within a health care system in Ontario, Canada amalgamated from three hospital sites into one centralized unit in a brand new hospital building. The staff from the three sites including registered nurses, practical nurses, physicians and support staff also amalgamated. In addition to being the researcher for this study, I am also a registered nurse currently working on the 40 bed labour and delivery unit chosen as the site selection for this study. I work closely with the 72 registered nursing staff who were eligible for inclusion as
participants in this study. What should be noted is that I am a co-worker; I do not hold a supervisor or managerial position on this unit, nor did I at any time during the duration of the study, nor do I anticipate this not being the case after the study is completed. That being said, my relationship with my fellow nurses is varied; the degree of personal attachment and level/extent of relationship I have with them varies greatly. As this unit has recently been amalgamated from three different sites into one, I worked for the past eight years with approximately one third of the staff currently working on the unit. The clinical unit we worked in during the three site model was staffed with only two nurses per shift. Working in pairs each shift caused us to form close bonds as we relied heavily on each other for clinical support and ultimately grew closer in friendship as well.

As an amalgamated unit, we were faced with many challenges, including an expanded practice role and loss of experienced nursing staff. Nurses in the new site were expected to be educated and trained in the operative roles for the implementation of a unit based operating room as well as an integrated labour and postpartum unit, often with interchangeable role expectations for the registered nurse. While the core nursing care remained the same, the physical setting and technology utilized for assessment and monitoring were updated or changed. Centralized monitoring for fetal surveillance was introduced, computerized charting replaced written documentation, epidural and intravenous infusion pumps were updated and digitalized medication access systems were introduced to name a few. Staff experienced higher patient volumes, an increased level of acuity, an enhanced focus on family centered care and a new nursing care delivery model which includes in-house physician services rather than on call which occurred in the three site model. These factors along with the system wide goals of decreasing
patient length of stay makes it a priority to retain experienced nurses, especially in specialized settings like labour and delivery (Benner, 1984).

Prior to the move to the new hospital site, I worked with many nurses that I would categorize as expert according to Benner’s theory. During the centralization of services, I witnessed a loss of almost all of the expert nurses from my site. After the move, the unit saw a loss of many additional expert staff due to retirement. This loss of expert staff and staff numbers in general allowed for an influx of new hires that consisted largely of novice staff. According to the manager of the unit being studied, 42 registered nurses were hired between April 2015 and March 2018, with only 13 of them coming into the role with previous experience in labour and delivery. While the immediate goal to fill the vacancies and need for staffing benefited from the influx of novice nursing staff, there was a growing need for both nursing staff and administration to understand the differences between the experience levels in nursing and how they impact both patient care and function of care settings (Benner, 1984).

In speaking with the unit manager, she stated that it had become evident that the large percentage of novice nursing staff presented a potential barrier to effective patient care and unit flow. Criteria needed to be initiated that limited the number of novice staff working per shift in relation to senior staff. In continued discussion with the unit manager, it was identified that an arbitrary classification of novice being three years of experience or less and a senior nurse being three or more years’ experience was determined. Seeing as the unit was participating in self-scheduling at the time of this reflection, this tactic was effective in limiting the number of novice nurses working per shift. However, it was identified by management that this approach was not guided by a
theoretical understanding but a means of providing a staffing matrix related to
generalized levels of experience, confidence, skill and judgement without needing to
identify limitations of individual staff. While this seemingly appeared to be an effective
means to managing the influx of novice staff, I often wonder if understanding the roles of
novice versus expert would have been more effective. If better understood, the loss of the
expert staff in the centralization process potentially could have been managed differently
or acknowledged differently for their rich experiential teaching potential.

I had considered the inclusion of myself as a participant in the study, however, I
chose to eliminate myself from the study in an attempt to better manage bias. While my
current thoughts related to nursing experts are heightened based on my connection
between the theoretical knowledge that I have of Benner’s theory through research and
the loss of expert staff during the centralization of services in the study site through
observation, I believed that I would provide answers that lend themselves heavily toward
Benner’s theoretical underpinnings rather than as they have appeared to me through
practice. I identified that I would need to utilize reflective practice at various points
throughout the research process and potentially as frequently as between each participant
interview.

I identify myself as a proficient nurse based on Benner’s classification, not an
expert. I believe that while I am working towards a level of experience that I could
identify as expert, I am not yet there. During the amalgamation of services in 2013, I
would have titled myself as competent, having five years of experience at the time. With
the expanded roles and expectations placed on me during the move also, I feel that the
requirement to learn new skills and simply understand the new flow of the unit slowed
my progression toward expert. Leading up to the amalgamation, I was able to recognize my potential struggle with feeling confident and comfortable in the new setting and opted to take a recognized position on the transitional team as the materials management coordinator. I immersed myself in understanding the new unit, most notably the materials and equipment that would be utilized there which was largely different than what was in the old sites. I deem my decision to be part of the transitional team as a key indicator in the success of my advancement towards proficiency. I feel that I became comfortable quicker, I was able to take on additional roles and responsibilities related to various unit based initiatives because I transitioned well. I can hypothesize that had we not amalgamated to the new site that I could at this point in my career call myself an expert, however, I believe that my continued involvement in new projects, initiatives and mentorship (to name a few) will continue to lead me in the direction of expert. With this study, I am interested in further understanding what my colleagues think it means to be an expert labour and delivery nurse.

This study is focusing on a labour and delivery unit within a hospital setting. Stemming from my identified connection and familiarity with the unit, the position I currently hold on the unit, the advantages to being immersed in the setting and the queries that have arisen from my own experience-based practices there, it is a natural fit for the study site. Through participant interviews with labour and delivery registered nurses, the research question, what constitutes an expert registered nurse in labour and delivery, will be explored.

The next chapter introduces the theoretical framework of Patricia Benner’s *From Novice to Expert* (2001) theory which serves to provide an explanation and importance of
understanding the various levels of skill acquisition that nurses pass through during their professional career as well as a rich explanation of how theory defines the role of expert in order to compare and contrast the findings of this study and to discuss implications for current practice and future research. Based on the underpinnings of Benner’s theory, my current interest in the area of labour and delivery nursing and the supporting literature presented, the purpose of this thesis is to understand what constitutes an expert registered nurse in labour and delivery.

Chapter three provides a description of the literature review beginning with the search strategy, inclusion/exclusion criteria and review of relevant research which revealed four major themes that support the significance of understanding the nurse expert including cue recognition, significance in identifying professional growth, understanding the expert in alternate clinical settings, and the gap in present literature.

Chapter four identifies and explains the chosen methodology used to guide the research study. The qualitative methodological process of transcendental phenomenology as understood by Clark Moustakas (1994) is described in addition to the details surrounding data collection and organization including site selection, participant recruitment, interview format and question, the process of data analysis and the three elements of trustworthiness that will be utilized to promote rigour.

Chapter five will highlight findings from the twelve interviews and chapter six presents a discussion of the findings from this research. In addition, how the findings enhance the body of knowledge related to what constitutes an expert registered nurse in labour and delivery and how this research advances Benner’s From Novice to Expert
theory will be addressed. Insights as to how this research impacts policy, education and research will also be discussed.
Chapter Two: Framing the Study

From Novice to Expert Theory

Patricia Benner is a nurse theorist whose development of the nursing theory *From Novice to Expert* in 1984 represented a critical shift in the theoretical understanding of skill development for nurses (Benner, 2001). Much of Benner’s written work illuminates her passion for research that began in the critical care practice setting where she worked as a nurse. She embarked on this research in an attempt to bridge the gap between nursing research and practice (Benner, 2001). Benner identified that there were significant gaps between excellent nursing practice and its relationship with existing nursing theories. She identified that nursing is multifaceted and much more complex than any previous theory could explain. Nursing narratives consist of the events and experiential accounts of meaningful patient situations that promote practical reasoning from the nurse (Benner et al., 2009). By collecting descriptive accounts of nursing experiences within the clinical setting, both the writer and those who read it are able to reflect and appraise the account. Benner’s research revealed that new knowledge and skill as well as barriers and areas of excellence in practice can be uncovered and explored through narratives (Benner, 2001).

Benner illuminated the idea that nursing narratives of patient encounters reflected an element of caring, instinct and intuition that had never been captured in existing formal theories. Benner identifies that while these narratives can enhance practice, they are not to be evaluated for performance. The goal of narratives is to foster change and learn from the experience of others (Benner et al., 2009).
Benner identified that her theory needed to be less rigid than other nursing theories based on the understanding that nursing practice in itself is not rigid; nursing practice requires flexibility in how one practices in response to the demands of each patient encounter (Benner et al., 2009). Also, nursing as a discipline is continuously changing in response to advances in medical science, evidence based research and political influence to name a few.

Using narratives and storytelling as evidence was a ground breaking phenomenon and the start of a movement that identified the social element of nursing practice on learning, and the importance of experiential learning in high risk situations (Benner, 2001). A pillar of Benner’s (2001) *From Novice to Expert* theory was the need for reflective practice and narratives from nurses related to nursing culture and reflective experiences. As Benner states, nursing narratives, “…creates a self-study of clinical knowledge that identifies strength of practice, prevailing challenges, or silences…” (Benner, 2001, p.vii). Benner also identified that “collecting narratives and reflecting interpretively on these narratives uncovers new knowledge and skills, identifying impediments to good practice, as well as areas of excellence” (Benner, 2001, p.vii). In recognition of the importance of narratives in clinical practice, Benner promotes that not only do we learn and grow from the written experiences of our nursing colleagues, but the writer also learns from reflecting on and telling their story. One critical element of Benner’s theory is that nursing practice is “more than just a collection of techniques” (Benner, 2001, p.vii) and mastering a certain skill or aspect of a role does not always make a nurse an expert.
**Dreyfus Model of Skill Acquisition.** A pivotal tool in the development of Benner’s (2001) *From Novice to Expert* theory was the *Dreyfus Model of Skill Acquisition* developed by Stuart and Hubert Dreyfus, a mathematician and philosopher respectively. The Dreyfus model identifies that in any type of skill development there are five levels of skill that an individual can move through: novice, advanced beginner, competent, proficient and expert (Benner, 2001) (see Figure 1 below). The movement through these levels recognizes three changes in the aspect of skill. The first is a shift from relying on abstract principles to the utilization of past experiences to shape judgement. Second, the learner begins to shift from seeing the situation as a compilation of equally relevant parts, toward seeing the experience as a whole in which only certain parts are relevant. Third, the learner transitions from being a detached observer to an involved performer in which the learner is fully engaged in the experience (Benner, 2001, p.13). This model served as the starting point for Benner’s theory because it differentiated what could be taught through formal education while accentuating the need for experiential learning in practice in order for a nurse to achieve competency in practice, let alone a level of expert (Benner, 2001). Ultimately, the *Dreyfus Model* provided Benner with a tool to better understand and attempt to combat the tensions that existed between theory and practice (Benner, 2001).

![Figure 1. Stages of skill acquisition in Benner’s From Novice to Expert theory as adapted from the Dreyfus Model of Skill Acquisition. Adapted from From Novice to Expert. Excellence and Power in Clinical Nursing Practice. Commemorative Edition (p.13), by P. Benner, 2001, Toronto, ON: Prentice-Hall Canada Inc. Copyright 2001 by Prentice-Hall, Inc.](image-url)
According to Benner’s *From Novice to Expert* theory, a novice nurse has only been taught about the patient care situations they are expected to perform in. They have been educated on variables such as laboratory measurement, vital sign assessment, and how to identify deviations from normal. As novice nurses they lack experience in clinical understanding and judgement, they are governed by rules to guide their practice and cannot see beyond these rules. Typically, the novice nurse is the new graduate nurse entering practice. However, in some cases, the novice nurse is an experienced nurse moving from one clinical setting they have experience in; to one that is new (Benner, 2001).

The advanced beginner is a nurse who has gained some experience in the clinical setting and is now able to demonstrate some acceptable performance in the setting. The advanced beginner is able to recognize aspects of patient care. Aspects are elements of care that could only be recognized by nurses with some prior experience. These nurses are able to understand the overall condition of a patient and compare this patient to others they have cared for in the past in order to understand the current patient condition (Benner, 2001). While the advanced beginner is becoming more comfortable with the overall condition of the patient and expected outcomes, the clinical situation is often reported as being as demanding on the nurse as it is to the patient. Adverse reactions in patient care are often given equal emphasis by the nurse on herself as they are for the patient (Benner, Tanner & Chesla, 1992).

Competent, according to Benner, is a nurse who has been working in the same or similar setting for two to three years. These nurses are able to create long term goals and care plans for their patients with the knowledge of what typically lies ahead. The nurse is
able to prioritize and organize care based on importance however, the competent nurse is not as flexible and timely as the proficient nurse. Competent nurses begin to feel that they have an element of mastery and coping in their role and whatever the patient presents with. Efficiency and organization skills develop further to bring them closer to proficiency (Benner, 2001). Competent nurses constantly strive to limit the unknowns and unexpected by strategically organizing tasks in order to maintain a sense of status quo. Deviations from normal accentuate their need for continued education and experience (Benner et al., 1992).

The proficient nurse is characterized as one who is able to understand the patient as a whole, rather than in terms of aspects of care. Patient conditions present themselves to the proficient nurse based on knowledge and previous experience and does not require the nurse to think through the situation in order to get a perspective on the patient condition. Because the nurse is now able to recognize the patient situation as a whole and is guided by perspective, not conscious understanding, the nurse is capable of recognizing when the expected outcomes are not materializing (Benner, 2001). Proficient nurses no longer utilize aspects of care to understand the patient but start to use maxims. Maxims reflect nuances or subtle changes in the patient situation; they can also be cryptic instructions that are only logical to the nurse with a deep understanding of the experience. To the competent or novice nurse, maxims will seem unintelligible as their meaning can change depending on the situation (Benner, 2001). Proficient nurses are able to recognize and intervene based on contextual and situational changes in patient status rather than only acting on planned or anticipated interventions (Benner et al., 1992).
The expert level of skill acquisition is the focus of this research study. Benner identified the expert as one who “no longer relies on an analytic principle (rule or guideline) to connect her or his understanding of the situation to an appropriate action” (Benner, 2001, p.31). The expert nurse has extensive experience and now has an intuitive grasp on each patient situation with the ability to hone in on the most accurate and critical problem without wasting time considering alternate solutions. It is difficult to truly understand the expert nurses as they now function with a deeper understanding of the patient situation and make decisions based on perceptual certainty. While the expert is able to function beyond analytic tools, this is not to say they do not use them. Since health and illness are so individual, there will be situations that the nurse has had no previous experience with or patient events that are not as expected. In these cases, reliance on and the ability to use analytic tools available to the nurse is necessary (Benner, 2001). Benner identifies that experts are able to identify when they have a good grasp on a patient situation, they are able to act intuitively and are comfortable in situations; they are recognizably uncomfortable when they do not have a good grasp of a situation (Benner, et al., 1992). The expert’s attention to patient needs is one of the defining aspects of this level of care. The expert nurse manages many aspects of care that often goes unnoticed by the nurse of less experience including communication outside the medical team, advocacy of changes in treatment, and negotiation with team members to ensure elements of care are in order (Benner, et al., 1992). While Benner confidently describes the nursing transition from novice to proficient, she identifies that not all nurses will achieve expert level (Benner, 2001).
The Dreyfus Model of Skill Acquisition and ultimately, Benner’s (2001) *From Novice to Expert* theory is unique in the fact that it focuses on the strengths and practice capacities of individuals rather than their deficits. Benner identifies that individuals have the capacity to perform at their best regardless of which skill level they are at, recognizing that individuals may perform to their utmost capacity at their particular skill level but cannot be expected to perform beyond that level. To illustrate, novice nurses may be highly engaged and practice at a high functioning level, however, they will rely on the memorization of characteristics and features of a category of illnesses and treatments. Benner (2001) identifies that nurses can only learn how these characteristics and features manifest in clinical practice from experience.

As previously discussed, Benner identified that documentation in the form of narratives from expert nurses of their clinical performance, provides descriptions of patient experiences directly from practice that can demonstrate expert decision making process, breakdown in clinical performance or often elements of both (Benner, 2001; Benner, et.al, 2009). If expert nurses document their performance in the practice setting, clinical knowledge can be made available for further research and development of practice improvements (Benner, 2001). By understanding the clinical performance of proficient and expert nurses through narrative practice, patient outcomes are better understood (Benner, 2001).

Benner (2001) clearly articulated the levels of skill acquisition from novice nursing to expert nursing. However, it was her unique understanding and articulation of the expert nurse that has motivated the intent of this study. Benner based her theory relevant to expert nursing practice on the basis that a “wealth of untapped knowledge is
embedded in the practices and the know-how of expert nurse clinicians” (Benner, 2001, p.11). Through her theory, she attempts to articulate the significant need for expert nurses to narrate their experiences with patients in order for both themselves and novice nurses to learn from the experiences of experts and attempt to facilitate the transition from novice to expert more effectively. Additionally, Benner (2001) identifies that narratives not only contribute to the recognition and knowledge of the nursing profession, but “is essential to the development and extension of nursing theory” (p.11).

As early as the 1930’s, progressive educator John Dewey (1933) has been a strong influence in nursing education by focusing on the importance of reflective thinking in the learning process. In 1933, he called for an education reformation in order to place greater importance on lifelong learning and learning through experience everyday rather than through isolated skills drills (Dewey, 1933). He also articulated that experiential learning does not occur in every clinical situation, but rather only in environments where there is opportunity for rich reflection and feedback (Benner, et.al, 2009; Dewey, 1987).

**Recognizing Skepticism**

Benner (2001) acknowledges and identifies areas of skepticism that could be identified within her theory. First, the clinical narratives used to establish the *From Novice to Expert* nursing theory are only those in which the nurse made a positive difference in the care of the patient and patient outcome. The narratives used to establish the theory are what Benner considered the most excellent nursing care examples. Second, she addresses those that may have skepticism that an expert level of nursing care is even possible at the beginning of her written theory. While she acknowledges that it may be hard to believe that this level of care is possible because the narratives exhibit an
exceptional level of care, if their skepticism comes from a place of generalized disbelief that hospital nurses can perform at a high level of compassionate, life altering care, then this theory and these narratives will provide a rebuttal to their impression of nurses (Benner, 2001). Third, Benner identifies that critics could misinterpret the theory as one based on “trial and error learning” (Benner, 2001, p. xxii). To clarify this potential misunderstanding, Benner explains that the purpose of her theory is not to encourage nurses to accept a trial and error attitude, but to recognize that skilled nursing care relies on a sound educational background and extensive experience level. In addition, Benner also acknowledges that the development and growth of clinical judgement is valuable and should be acknowledged (Benner, 2001). Benner clearly articulates that this theory is “…not a careless abandonment of rules. Instead, I am claiming that a more skilled, advanced understanding of the situation allows orderly behaviour without rigid rule following” (Benner, 2001, p. xxiii).

In the development of her theory, Benner introduced many new concepts to theory, most notably, intuition. Within the skill level of expert, intuition plays a significant role in distinguishing a nurse from proficient and is also an element of the theory that has been most criticized and discussed in the literature. The development (or lack of development) of intuition is also a defining factor in nurses not being able to achieve expert level skill (Benner, 2001).

While many skills within the practice of nursing are transferrable, each nursing setting is comprised of a unique set of skills and culture. While much of Benner’s work focused on her passion and service in critical care, the purpose of this study is to explore what constitutes an expert nurse in labour and delivery.
Chapter Three: Literature Review

The intent of this chapter is to understand the relevant literature that provides both rationale and significance to the purpose of this study with the focus on what constitutes an expert nurse in labour and delivery. When preparing to conduct research, professional and research literature pertaining to the topic of interest needs to be assessed by the researcher (Moustakas, 1994). In order to maintain methodological congruence, a literature review was conducted prior to data collection and a thematic approach was used to organize and present relevant themes that were illuminated from the literature and most pertinent to the current research question (Moustakas, 1994).

Three relevant themes emerged from the literature which include: 1) cue recognition, 2) significance in identifying professional growth and 3) understanding the expert in alternate nursing settings. Gaps in the literature related to Benner’s theory and the expert nurse in the labour and delivery setting will also be addressed.

Search Strategy

An initial search of the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), Proquest, and Ovid (Medline and HealthStar) was conducted using the search terms: Registered Nurse, Nurse; Obstetrics, Labour and Delivery, Maternal Child Nursing; Patricia Benner, Benner; From Novice to Expert, Benner’s Professional Advancement Model; Expert, Expert Nurses, Characteristics of Expert, Proficient versus Expert, Proficient or Expert. All search terms in the databases were restricted to English language and research articles only (CINAHL and Ovid). Date limits were not placed on the search due to the paucity of applicable studies. All terms were searched individually and in multiple combination of sequences to narrow the
search for all of the databases. All titles were searched to identify key terms and eliminate articles that did not correspond with the research question. Following the title search, relevant abstracts were reviewed using the inclusion criteria of: 1) research studies available in full text in the literature, 2) utilization of licensed and practicing nurses exclusively, 3) application of or reliability testing of Benner’s From Novice to Expert theory and 4) the significance of, or examples of expert nursing practice either independently or compared to other levels of skill acquisition described by Benner. In total, 22 articles were reviewed. Of the 22 articles, 15 qualitative, four quantitative and three mixed methods studies were determined to be most applicable to support the purpose and relevance of this study.

Significance of Understanding the Role of Expert

Cue Recognition. Several studies have explored the idea that patient deterioration can be identified prior to catastrophic events through recognition of patient cues and abnormalities preceding the event. However, in many studies patient deterioration is not well recognized or more seriously, not well acted on by hospital staff (McDonnell, Tod, Bray, Bainbridge, Adsetts & Walters, 2012). The following studies, identify the strength of expert nurses in cue recognition and how that affects patient care.

A study by Fuller and Conner (1996) identified not only cues related to various levels of pain in infants, but how varying skill levels of nursing staff prompted differences in how those cues were recognized. Significant differences in cue identification were made between level of nursing experience and levels of pain with the more experienced nurse identifying infant pain cues in those with mild or little to no pain. Novice nurses noticed cues like tears and facial expressions of pain while experts were
able to identify subtle characteristics like moaning and the success or failure of a parent’s ability to calm their child. Fuller and Conner (1996) noted that these study results were similar to several that came before it, noting the differences in nursing skill level on cue recognition. Understanding what type of cue was recognized at varying skill levels provided a teaching opportunity for novice nurses as well as recognizing the significance of experiential learning within the clinical setting from expert nurses (Fuller & Conner, 1996).

Hoffman, Aitken and Duffield (2009) studied the difference between novice and expert nurses’ identification of patient cues in an intensive care unit in an Australian hospital. Expert nurses were found to use a greater variety of cues, 89 compared to the 49 for the novice participants. This finding is comparable to other research conducted on the use of cues in novice versus expert nurses (Hoffman, et al., 2009). Hoffman and colleagues (2009) identified that expert nurses were able to identify a change in patient condition quicker because their cue collection was more generalized and not focused on the most obvious symptoms. The experts were able to gather cues from various aspects of care and cluster them together to form an accurate picture of the patient condition and utilize clinical judgement. Novice nurses were identified as being reactive to patient condition changes and intervening in care when necessary whereas the expert nurses were proactive and planned care prior to changes in patient condition. Furthermore, novice nurses were identified as being less accurate in the identification of patient cues than expert nurses (Hoffman et al., 2009).

McDonnell and colleagues (2012) researched the use and effectiveness of a track and trigger scoring tool (T & T) to monitor patients in an acute care setting in the United
Kingdom. The results of this study identified that while nursing staff scored themselves to be confident managing a deteriorating patient, they were less confident in identifying the deterioration. Junior staff identified that the tool was effective for them when providing care because it gave them a formula to recognize clinical deterioration. They felt a sense of security in having diagnostic criteria to identify changes in their patient. Alternatively, experienced nurses identified that they used the T & T scoring tool as part of their assessment and used the results differently by taking into account the patient as a whole. While the score may identify the need for intervention, the experienced nurses were able to take into account reasons for changes in the patient’s normal condition. For example, an increased respiratory rate in a patient with known chronic obstructive pulmonary disease (COPD) will increase the patient’s score and may alert junior staff as a deviation from normal respiratory rate, while the expert will be able to incorporate past medical history and utilize clinical judgement to determine whether to intervene (McDonnell et al., 2012). The experienced nurses also identified that they had concerns with patients who did not have a change in scores at all. The concept of intuition was identified in the experienced nurses when they “just knew” there was a concern before a change in any indicator. The importance of intuition that emerges in expert nursing practice and its addition to objective assessment and tools was acknowledged in addition to the importance of identifying patient cues (McDonnell et al., 2012).

The literature reviewed identified that there is conflicting evidence in the teaching-learning element of cue recognition implying that cue recognition is an inborn trait and others identifying that accurate and heightened cue recognition is gained through meaningful experience (Fuller & Conner, 1996; Hoffman et al., 2009; McDonnell et al.,
Regardless of how cue recognition develops, the general consensus is that cue recognition and confidence of critical thinking in advocating or acting in the form of intervention needs to be a strength of nursing practice. Understanding how the expert accurately identifies patient cues whether through mentorship or reflective practice can provide novice nurses with increased knowledge (Fuller & Conner, 1996; Hoffman et al., 2009; McDonnell et al., 2012).

**Significance in Identifying Professional Growth.** Benner (2001) noted that not all nurses will become experts. However, descriptions of excellence in practice from expert nurses is a way of facilitating movement of nurses who are at a competent level as they move towards proficient. The level of knowledge is not what distinctly separates the competent nurses from the proficient or expert nurse, but the vision of what is possible in the patient care experience is more definitive (Benner, 2001).

The current and impending nursing shortage in Canada is well documented in the literature and felt strongly in practice settings. The Registered Nurses Association of Ontario (RNAO) identified, that in 2017, Ontario had the lowest RN to population ratio in all of Canada (Zych, 2017). For the first time in two decades, Canada saw more regulated nurses (which includes registered nurses) leave the profession than enter it (Australian Nursing and Midwifery Foundation, 2015). While the recognition of all aspects of nursing practice is critical in truly understanding the complex role of the nurse, reality of the current economy has identified the importance of utilizing resources effectively in order to provide safe and high quality care to patients. Identifying varying levels of competence in practice is one way to ensure safe and effective care by providing an appropriate staffing mix for each shift (Meretoja & Koponen, 2011).
Hughes (2012) reinforces the importance of understanding the skill level of nurses when identifying that lower mortality rates and fewer adverse events have been identified when a higher proportion of experienced nurses staff nursing units. Experienced nurses have the ability to identify early signs of clinical deterioration and provide closer patient surveillance to avoid negative patient outcomes (Hughes, 2012). Hughes (2012) suggests that experienced nurses not only minimize negative outcomes by close surveillance and early intervention, but they are able to reduce the time between clinical identification of issues and treatment, including reporting time. Hughes (2012) reported that nurses within her study verbalized that bridging the gap between recognition of clinical condition and treatment was highly related to running interference. Experienced nurses described the concept of running interference as the process of offering advice and guidance to novice nurses on how to work effectively with the health care team, particularly physicians; receiving physician orders for patients of novice nurses because they are more confident dealing with experienced medical staff and resolving obstacles within the health care system that they were more familiar with (Hughes, 2012). This act of running interference with experienced nurses is directly related to daily staffing ratios on units. When staffing ratios include novice nurses or nurses who are not as proactive as necessary to expedite the time between patient assessment and intervention, experienced nurses were left to bridge the gap from clinical recognition to intervention by running interference (Hughes, 2012).

Richards and Hubbert’s (2007) research was significant in understanding how expert nurses care for patients with post-operative pain. Within the literature review of the study, the researchers state that this is the first study to understand the role of expert
nurses in the care of post-operative patients. While the concept of pain management is highly researched, the ability of expert nurses to care for these patients had not been researched as of 2007. Additionally, this was the first study within the scope of understanding post-operative pain management, to utilize nursing narratives and subjective data through a qualitative research methodology. This is significant, as research utilizing narratives from front line staff can provide a higher level of understanding directly from the expert nurses in this practice setting who are personally dealing with patients in post-operative pain (Richards & Hubbert, 2007).

Richards and Hubbert (2007) identified several implications to understanding how expert nurses care for patients dealing with post-operative pain. One limitation of the study was that the differences between novice and expert nurses was not explicitly defined. Research results have illuminated the need for expert nurses to openly discuss their experiences when one participant stated, “we should be teaching the new nurses these things” (p.23). These results support the finding of various studies reporting the significance of narratives from expert nurses could provide a framework for nurses at a lower skill level to learn from and broaden their expertise in areas not always considered in formal education. Richards and Hubbert (2007) also identify the potential for program development to take into account the narratives of expert nursing experience. If these narratives can be used to influence policy, both credibility of the narratives in practice and inspiration can be instilled in less experienced nurses (Richards & Hubbert, 2007).

Bobay, Gentile and Hagle (2009) identified that the ability to research expertise in nursing practice is very difficult for hospital institutions and researchers alike due to the fact that very few institutions have a reliable method in place for understanding and
identifying nursing practice. Through a mixed method study, Bobay et al. (2009) studied 156 nurses from all areas of clinical practice including inpatient and outpatient care areas. The nurses experience levels ranged from 6 months to 5 or more years of experience.

While a previous study by Aiken, Clarke, Cheung, Sloane and Silber (2003) showed that years of clinical nursing experience were not significant predictors of better outcomes in surgical patients, Bobay et al. (2009) identified that experience was a significant predictor of clinical expertise (Bobay et al., 2009). The researchers did identify that similar to Benner (1984), the greatest influence in nursing experience is directly related to how meaningful an experience is to the nurse; which is also difficult to measure.

Bobay et al. (2009) identified that years of experience does not solely determine level of skill acquisition but both the quality of experience and how the nurse reflects on the experience is a greater way of transforming experience into expertise. Additionally, Bobay et al. (2009) indicated that their study results revealed that movement through the stages of skill acquisition from novice to expert may require more time than indicated by Benner. Results from Bobay and colleagues showed that nurses required an average of 14 or more years of experience to achieve expertise in practice (2009). From this study, the researchers concluded that institutions need to reconsider patient loads for novice nurses. It was hypothesized that expecting novice or advanced beginner nurses to competently care for a full patient load may be unrealistic. Staffing decisions should consider the level of experience of nurses as sufficient evidence has revealed the difference that job experience has in competency of care. The research by Bobay et al. (2009) provided empirical evidence that a staffing model based on experience should be considered in hospitals as these results imply that a higher level of clinical expertise may
predict better patient outcomes. Additionally, nursing units should be providing the resources and time to promote continuing education for all nurses regardless of experience. Included in continuing education should be the promotion of peer support and individualized learning plans to encourage all nurses to increase their practice level through formal and practice level education and experience (Bobay et al., 2009).

Similar to Bobay and colleagues (2009), Takase (2012) studied the results of 350 nurses from Japan in a quantitative cross sectional correlational design in order to explore the relationship between experience and levels of nursing competence in order to identify a model of continuing competence of nurses. Results were similar to those of Bobay et al. (2009) with levels of competence increasing with clinical experience. The results, however, showed that nursing competence may not be as linear as Benner’s From Novice to Expert theory has indicated. Takase (2012) identified that certain experiences may catapult nurses from one level to another, meaning that all nurses will have varying experiences throughout their career and will not experience patient situations with the same effect at the same points in their career. Results from the study by Takase (2012) aligned with a similar study by Jantzen (2008) which identified nursing competence as similar to the growth curve model. This model indicated that a nurse’s competence increases significantly in the first ten years of practice then plateaus after year ten. This is explained by nurses being provided with an abundance of learning opportunities through experience, peer support and skill or technique training and education, in order to gain a level of competence in practice (Jantzen, 2008; Takase, 2012).

Two explanations in the literature have been given for the year ten plateau in nursing competence described by Jantzen (2008) and Takase (2012). First, Tabari-
Khomerian, Kiger, Parsa-Yekta and Ahmadi (2007) identified the plateau as a consolidation phase. They describe this phase as a time when nurses are gaining a sense of mastery by refining their practice by taking on new challenges and repeating experiences. In contrast to the explanation of a consolidation period, Tsuji and colleagues (2007), identified this plateau as a stagnation in practice. They explain the cause of stagnation as either nurses not having the capacity to absorb new learning from experience or there are not any new challenges for them to learn from (Tsuji et al., 2007).

Implications of the study by Takase (2012) are that it may be beneficial to understand the varying levels of skill acquisition in order to intervene with education and experience opportunities in order to avoid stagnation or promote consolidation towards mastery. In order for nurses to grow and progress in their competence development, it is necessary to foster a positive environment in the nursing setting to promote continuing education and challenge nurses with new experiences beyond the formative years of professional development (Takase, 2012). Similarly, Orme and Maggs (1993) identified through focus group workshops with 12 expert nurses, that supportive factors including a commitment from management and peers to support some risk taking from novice and beginner staff within professional boundaries is necessary in order to facilitate the development of an expert decision making process. Mentorship from peers has been identified as essential to navigating the nurse from a novice to competent to expert level of decision making by supporting reflection of the decision making process and not focus on the outcome of individual decisions (Orme & Maggs, 1993).

Thornley and West (2010) identified that while it may be significant for management to recognize the varying levels of clinical performance among nurses, it is
also critical for nurses to be able to recognize that growth in each other. Expert nurses are valuable role models for peers and it is crucial that the knowledge be retrieved from these higher level staff, especially as they approach a time where they leave the profession and the knowledge leaves with them. Thornley and West (2010) identified the importance of accurately identifying expert nurses during peer mentorship because accuracy in skill development and expanding knowledge in the novice nurse is critical, and accurate and supportive feedback is found to be pivotal in confidence development and response accuracy. If the expert is misidentified and the non-expert is utilized for peer support and feedback, early career nurses may actually be hindered in terms of development, skill and supportive care techniques (Thornley & West, 2010).

**Understanding the Expert in Alternate Nursing Settings.** Johnston and Smith (2006) published what may be considered seminal work in the area of palliative care nursing and the consideration of what expert nursing means to that setting. From a comprehensive literature review it was identified that prior to this study, only three studies had looked at the role and importance of expert nursing within palliative care.

Johnston and Smith’s (2006) research provides evidence of the differences between novice and expert nurses related to psychosocial elements of nursing. The majority of research uncovered in the literature has related to the identification of cues in relation to patient condition and intervention which is especially important in critical care nursing areas. Results of the study by Johnston and Smith (2006) identified, from both the patients and the nurses’ perspectives, that relationships, communication and comfort elements of nursing care were exemplified in expert nurses. The idea that expert nurses were willing to listen and understood the importance of listening rather than speaking was
a core element identified by both patients and nurses in this study. Breakdown of effective care was identified by the theme of avoidance. Patient statements of ineffective care were related to nurses who avoided contact and did not attempt to form relationships with patients whose diagnoses were poor (Johnston & Smith, 2006). While this study yielded results that contributes to the previously identified research that expert nursing goes beyond experience and education, but adds that psychosocial elements of care may, in certain areas of nursing, be more important than the physical aspects of care in defining expert nurses.

In current practice, nursing settings have a high focus on competence of the nurse in the delivery of technical skills. In labour and delivery, this is seen largely through accreditation standards, continuing education courses focusing on electronic fetal monitoring, emergency procedures, and resuscitation standards; there is little emphasis on interpersonal skills of nurses (Miltner, 2002). As noted in the literature review, nursing settings that have researched the role of nurse expert have been either highly technical (e.g., critical care) or highly psychosocial (e.g., palliative care). Labour and delivery nursing requires a balance of both technical and psychosocial skills providing further rationale for this study.

James, Simpson and Knox (2003) completed a qualitative study in order to better understand the role of expert nurses in labour and delivery as well as how they perceived their ability to influence the labour and birth outcome in patients. Four themes emerged from the focus group discussions and data analysis process related to knowledge, intuition, advocacy and autonomy. Experts described themselves within the typical characteristics of nursing including caring, supportive, and effective, while also being
powerful and autonomous (James et al., 2003). Interestingly, with the study limitation of not describing the characteristics of the non-expert nurse, it is difficult to interpret whether nurses with less than five years of experience relate to any of these characteristics in their practice. Similar to the study by Richards and Hubert (2007) in palliative care, the discussion from expert labour and delivery nurses focused less on the technical skill and more on the element of touch and support during the labour process (James et al., 2003).

Watkins (1998) studied 28 registered nurses whom were considered expert nurses based on six or more years of working in a community health setting in a rural area of the Northeastern United States. The findings support the notion that both education and experience are required for the development of expert level nursing. While the study findings reflect elements of expert nursing practice previously discussed like advanced and intuitive cue recognition, focused and rapid assessment; there was also an emphasis on the psychosocial aspect of caring. Nurses identified their decision making process was often based on both the individual and family’s psychological, spiritual and physiological needs. Nurses were able to identify that at the level of expert practice, they were utilizing both rational and intuitive decision making models fluently in practice (Watkins, 1998).

After a comprehensive literature review, only one study by James and colleagues (2003) has been identified in relation to expert nurses in the area of labour and delivery specifically. While James and colleagues (2003) set out to identify how expert nurses in labour and delivery viewed their role and their ability to influence the birth process of patients, they did not seek to understand what it meant to be an expert. James and
colleagues (2003) utilized inclusion criteria that considered expert nurses as any nurse with five or more years of experience however, there was insufficient rationale from the literature to support that value.

Research from other areas of nursing practice that focus on the role of the expert nurse in relation to Benner’s *From Novice to Expert* theory indicates that the need for research in the area of expert nursing in labour and delivery is valid (Benner, 2001). Within other areas of nursing practice, unique indicators of expert practice have been identified to support the idea that the role of expert is not the same in each area of nursing. In addition, the impact of expert nursing care on elements of practice including staffing ratios, professional development, transition between skill levels and implications on future nursing practice have been discussed in relation to the significance of this study purpose. By understanding what it means to be an expert, future research projects related to the role of expert nurses in labour and delivery and how they can be utilized most effectively in labour and delivery may be supported.

**Role of the Labour and Delivery Nurse**

Labour and delivery nurses are required to be skilled in the technical process of labour and delivery encompassing supportive care for women through the labour process whether that be through vaginal delivery or through operative measures, with many situations requiring the nurse to transition seamlessly and quickly from one method to the other. The skills of labour and delivery nurses range from coaching a women through natural labour to recognizing and responding to critical cases that require immediate life sustaining interventions for both mom and baby. While many consider labour a natural process, nurses require the knowledge and skills to deal with both complications of the
mother as well as the fetus in utero and newborn. Obstetrical complications like gestational diabetes, hypertension, preterm delivery and abnormal fetal heart tracings related to a myriad potential obstetrical complications can manifest in the prenatal and intrapartum period.

On occasion, labour and delivery nurses are required to skillfully manage the labour and delivery of a stillbirth, requiring both a technical and psychosocial skill set. In 2002, Statistics Canada reported a fetal demise rate of 5.4 of 1000 live births (Public Health Agency of Canada, 2008). While this number appears very low, it only reflects neonatal loss over 20 week’s gestation or a fetal weight of 500 grams or more. Loss prior to 20 weeks or an infant weight of 500 grams or less is considered to be a miscarriage and not reflected in the identified statistics. In addition to neonatal loss, the preterm birth rates have been increasing in Canada with 6.4% recorded in 1981 and 8.2% in 2004 (Public Health Agency of Canada, 2008). Labour and delivery nurses are required to manage psychosocial elements of care when supporting a woman through a hardship like a stillbirth or miscarriage, in addition to the both technical and psychosocial elements of managing the maternal care that is expected with any delivery, regardless of the outcome.

Based on the underpinnings of Benner’s *From Novice to Expert* theory and her work within the area of critical care nursing to identify the skill acquisition levels of novice through to expert, my current interest in the area of labour and delivery nursing and the supporting literature presented, the purpose of this thesis is to explore the phenomenon of what constitutes an expert registered nurse in labour and delivery.
Chapter Four: Methodology

This chapter provides an overview of the study method, how rigour was ensured as well as the process that was upheld to maintain ethics. Qualitative research is a methodological approach that places the strongest emphasis on the experience of the participant, rather than the objective of the researcher (Creswell, 2013). A complex and multidimensional understanding of the problem or issue to be studied can only be achieved by talking directly to participants, providing an opportunity for them to tell their stories and understand the setting without the influence of a predetermined hypothesis (Creswell, 2013). Within the scope of qualitative research, it is important to identify a specific approach in order to properly assess the study and prove sophistication as well as guide the process and organization of the study, which is especially important for a novice researcher (Creswell, 2013).

A phenomenological approach was determined to be the most appropriate methodology to answer the identified research question. Specifically, transcendental phenomenology, modelled after Clark Moustakas (1994) was utilized to explore what constitutes an expert registered nurse in labour and delivery. Benner (2001) also identified the importance of and utilized a phenomenological approach to understanding nursing competence and skill acquisition. I have chosen to use the same approach in order to understand what it means to be an expert nurse in labour and delivery by obtaining the direct statements and experiences of labour and delivery nurses.

Phenomenology has been documented in written work since 1765 (Kockelmans, 1967). Phenomenology is defined as:
Knowledge as it appears to consciousness, the science of describing what one perceives, senses, and knows in one’s immediate awareness and experience. The process leads to an unfolding of phenomenal consciousness through science and philosophy toward the absolute knowledge of the Absolute (Kockelmans, 1967, p.24).

Transcendental phenomenology is a branch of phenomenology that studies “the appearance of things, just as we see them and as they appear to us in consciousness” (Moustakas, 1994, p. 49). Moustakas believes that any experienced phenomenon can be the starting point for phenomenological reflection. This method utilizes three phases within the research process including epoche, transcendental-phenomenological reduction and imaginative variation (Moustakas, 1994).

Given the gap in the knowledge of expert nursing and even more specifically expert nursing in the labour and delivery setting identified in the literature review; utilizing transcendental phenomenology to frame this study allowed me as the researcher to both utilize the data without interpretation and immerse myself within the study. The results of this study directly reflect what was spoken by participants about the phenomenon of expert and while not being a direct participant in the study, I was able to draw upon my own understanding of expert nursing as well as the relationship that I have with the study setting and participants in order to portray an accurate and detailed understanding of the phenomenon.

Moustakas (1994) draws from the work of phenomenological predecessors, including Edmund Husserl, to explain how one can best understand a phenomenon. Several concepts must be understood in order to accurately explore a phenomenon
through this method. *Intentionality* is a concept that is used in transcendental phenomenology to explain consciousness and one’s internalization of an experience. Within one’s consciousness of a phenomenon, factors such as pleasure, shaping of judgement and incipient or development of wishes must be considered. In order to have knowledge of intention, the researcher must recognize that one’s self and the world around them cannot be considered separate entities. Rather, we must be present to ourselves and the world as they are inseparable components of meaning. To further understand intentionality, we must understand the two components that comprise it, noema and noesis.

   Noema, is the phenomenon; it has been defined in phenomenological history by the phrase, “perceived as such” (Moustakas, 1994, p. 30). In the context of this research, the noema is the image or notion of an expert, not one actual person. In reference to intentionality, the noema of the expert understands that individual perception of the expert varies depending on their background of experience, angle of interpretation, and their orientation of wishing, willing and judging the role of the expert. While it has already been stated in the literature that nursing experts exist in real time, every individual perception of expert is unique and can only exist in consciousness (Moustakas, 1994).

   Noesis is the true meaning of the phenomenon; it is defined as the “perfect self-evidence” (Moustakas, 1994, p. 30). In terms of the nursing expert, if we can understand what it means to be an expert in labour and delivery we can begin to develop a further understanding of the phenomenon which will also becoming meaningful. Through the understanding of the noetic nature of the phenomenon and furthering that knowledge
through research, the phenomenon may develop multiple more meanings which become just as meaningful as the original (Moustakas, 1994).

The relationship between noema and noesis is what “constitutes the intentionality of consciousness” (Moustakas, 1994, p.30). It is this combination that I intended to identify in this current study. I intended to add to the current gap in nursing literature in order to better understand what constitutes an expert registered nurse in labour and delivery. In order to answer this question, I was required through data analysis to determine common themes and understandings based on the perspective of nurses at any level of experience in labour and delivery in order to get a true understanding of the expert.

**Epoke**

Reflexivity is “the process of reflecting critically on the self as researcher” (Patton, 2002, p. 210). The process of reflexivity allows the researcher to begin to understand the self not only as the researcher, but through the research itself (Guba & Lincoln, 2005). Reinharz (1997) discusses the concept of having many “selves” that we both bring into the research, but also that we create in the research. Each of the “selves” that represent the researcher have a distinct voice within the research in terms of how information is approached, collected, analyzed and implemented throughout the research process. Moustakas (1994) explains the reflexivity process while utilizing the word “epoche” which is a Greek word that means “to stay away from or abstain” (p.85).

To achieve epoche, the researcher must set aside any prejudgements, biases and/or preconceived ideas about the research material (Moustakas, 1994). Through this process, the researcher cannot and should not eliminate all thoughts, but rather attempt to
eliminate any scientific knowledge obtained from scholarly sources as well as any biases put into our thoughts by science, society, politics, family, friends, even enemies (Moustakas, 1994). By achieving a state of epoche, the researcher is able to enter into the phenomenon with a purer sense of self, ready to embrace and challenge new ideas. However, as the researcher, I must still acknowledge myself and remain present. Notably, this was not an easy task to accomplish and I recognized that I was required to reflect and hold back my personal thoughts often throughout this process. Even throughout interviews, I found myself wanting to express my own opinions and answers that may have changed the course of the interview and thoughts of the participants had I chosen to express them. Through epoche, I was able to avoid, for the most part, expressing more of my thoughts than were required of me in the interview.

As described in chapter one, I have utilized reflective practice to achieve epoche. Through reflection, I have been able to utilize the concept of self-dialogue as identified by Moustakas (1990) to both understand my relationship with the phenomenon and attempt to remove what may manipulate or predispose influence over my thoughts, while still being “completely and solely attuned to just what appears, to encounter the phenomenon, as such, with a pure state of mind” (Moustakas, 1994, p.88). Acknowledging my current position within the study setting was an important aspect of this process. Even though epoche was completed throughout the research process, I struggled multiple times with maintaining my position as an objective researcher due to my closeness with the participants.

Adhering to Moustakas’ (1994) approach to transcendental phenomenology, epoche was used numerous times. This included decision making moments and between
each initial and follow up interview. This was achieved through reflection, debriefing with the thesis supervisor and reflective field notes. An initial and final reflection was also completed and included in this thesis report. While epoche was completed prior to research development and data collection, I did struggled multiple times throughout the study with being an objective researcher due to my closeness to the participants which is described in further detail within the final reflection.

**Site Selection & Participants**

The chosen study site was a labour and delivery unit within a hospital setting as previously identified. Due to my connection and familiarity with the unit, the position I currently hold on the unit and the queries that have arisen from my own experience-based practices there, it is a natural fit for the study site. Additionally, the amalgamation from three sites into one new site location provides a unique circumstance to study.

Personal history, excitement and curiosity bring the purpose of this study into focus (Moustakas, 1994). More specifically, Moustakas (1994) describes research questions based on human science research to “reveal more fully the essences and meanings of human experience; it engages the total self of the research participant, and sustains personal and passionate involvement” (p.105).

Purposeful sampling was chosen to be used within this study because it allows the researcher to select participants that will provide an understanding in answering the research question (Creswell, 2013). Three considerations go into the process of purposeful sampling including participant criteria, type of sampling strategy and the size of the sample required based on the qualitative approach chosen to guide the study (Creswell, 2013).
Within Moustakas’ approach to phenomenology, there are no identified parameters or requirements for recruitment and selection of research participants. However, the methodology does attest to the fact that several factors should be considered during participant recruitment including demographics, race, religion, culture, and ethnicity, political and economic positions (Moustakas, 1994). Although these factors should be considered, there are several essential factors that the researcher needs to assess during the selection process in order for the project to be successful. According to Moustakas (1994), the participant must have experienced the phenomenon, have an interest in further understanding the phenomenon, is willing to fully participate in the data collection process, will consent to being recorded for the purposes of data analysis and willing to have their data published in any type of publication.

In keeping with this type of sampling, participants were asked to participate based on the criteria that they can provide an information-rich description of the phenomenon, which in this case was their perspective, understanding and experience of what constitutes an expert registered nurse in labour and delivery (Patton, 2002). For the purpose of this study, registered nurses working in labour and delivery at the selected site were asked to participate. It was determined by the researcher that the perspective of all labour and delivery RNs was valuable, so the only criteria for inclusion was that they were RNs working in labour and delivery with at least one year of experience.

Moustakas (1994) does not explicitly state a minimum or numerical range of participants when performing data collection in qualitative research. However, when summarizing the participant recruitment process of qualitative researcher’s vanManen (1990) and Creswell (2013), suggest a range of as few as 3-4 and as many as 10-15
participants. Therefore, the recruitment goal of this study was determined to have a minimum of ten participants and continue until data saturation had occurred.

Participant recruitment was done by email and poster advertisement created by the researcher (Appendix A). The nurse educator on the labour and delivery unit, who is also working as the Locally Responsible Investigator, agreed to distribute the recruitment poster through the hospital email system which allowed her to email the recruitment poster to the entire labour and delivery RN staff, exclusively. Utilizing an administrator who works under the practice and education department and is not in a management role, eliminates a level of coercion that may be perceived if distributed to staff by their own manager. To eliminate a potential bias, the Locally Responsible Investigator was not considered eligible to be a participant in the study. On September 7, 2016, the recruitment poster was emailed to the entire RN staff working in the study site. Within a few days of that email, twelve participants responded to the researcher expressing interest in participating in the study. A second reminder email was not required to be sent because a diverse experience range was received among the first twelve respondents. The recruitment poster was also posted in the staff lounge of the unit at the hospital. In total, twelve participants responded. The participants were not required to be screened for inclusion criteria as my personal knowledge of each responding participant meant that I was aware of their experience level and eligibility for the study; all participants who volunteered for the study were included as they were all eligible. All participants were female registered nurses who held current registration with the College of Nurses of Ontario (CNO) and ranged in experience from one year to greater than 25 years.
The participant demographics are identified in Table 1 below. At the start of each interview, participants were asked to read a brief description of Benner’s five levels of skill acquisition and self-identify their current skill level. One of the twelve participants identified herself as a novice/advanced beginner, one as an advanced beginner, one as advanced beginner/competent, four as proficient, two as proficient/expert and three as experts. In addition to this data, three participants identified that they had only worked in the current amalgamated setting while nine participants identified that they had worked in one of the three community sites prior to the amalgamation as well as being currently employed at the new site. The participants did not disclose which site they had previously worked at. Five participants reported having previous nursing experience in emergency, surgical and long term care settings. In order to maintain anonymity, all participants were given a pseudonym which will be used to report the findings and in discussion.
Table 1

*Participant Demographic Data*

<table>
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<tr>
<th>Pseudonym</th>
<th>Maternal Child Nursing Experience</th>
<th>Theory Level</th>
<th>Worked Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cadence</td>
<td>1-5 years</td>
<td>Novice/Advanced Beginner</td>
<td>New Only</td>
</tr>
<tr>
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<td>1-5 years</td>
<td>Advanced Beginner</td>
<td>New Only</td>
</tr>
<tr>
<td>Rebecca</td>
<td>1-5 years*</td>
<td>Advanced Beginner/Competent</td>
<td>New Only</td>
</tr>
<tr>
<td>Emma</td>
<td>1-5 years</td>
<td>Proficient</td>
<td>Old &amp; New</td>
</tr>
<tr>
<td>Helen</td>
<td>6-10 years*</td>
<td>Proficient</td>
<td>Old &amp; New</td>
</tr>
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<td>6-10 years*</td>
<td>Proficient</td>
<td>Old &amp; New</td>
</tr>
<tr>
<td>Beth</td>
<td>11-25 years</td>
<td>Proficient</td>
<td>Old &amp; New</td>
</tr>
<tr>
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<td>Proficient/Expert</td>
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<td>Proficient/Expert</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Alice</td>
<td>25+ years</td>
<td>Expert</td>
<td>Old &amp; New</td>
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*Experience in clinical settings other than labour and delivery*

**Data Collection**

In phenomenology, interviews are the most common method of data collection. The interview process is an “informal, interactive process and utilizes open-ended comments and questions” (Moustakas, 1994, p.114). Prior to beginning each interview, the researcher engaged in the process of epoche that was described earlier. A semi-structured interview guide was developed within the framework of Moustakas’ (1994) description of the three stages of the interview process including introduction, experience
with the phenomenon and conclusion. The content of the interview questions was
developed from multiple sources including Benner’s (2001) *From Novice to Expert*
theory relative mostly to the concept of a nursing expert and the qualities of expert that
Benner describes, specifically intuition (Benner & Tanner, 1987). Finally, considerations
from the study by Johnston and Smith (2006) related to the qualities of expert within the
palliative care setting and the psychosocial elements of care that were significant to
understand the expert were adapted into questions relative to challenging the theory
through research. While there were a detailed set of pre-determined questions created to
guide the interview, it was still considered semi-structured and was delivered in such a
manner. The participant was guided into discussion of the phenomenon through the
interview questions and then allowed to discuss the phenomenon through their own
experiences and examples. Because of this, not one interview was the same and
questions were either added or removed as appropriate within the conversation
(Moustakas, 2013) (Appendix D).

**Interviews.** The introductory section was included to establish trust and create a
relaxing atmosphere between the interviewer and participant. This consisted of casual,
social conversation and an introduction to the phenomenon to be discussed (Moustakas,
1994). All participants expressed interest in the topic as it was identified to them.
Because the nursing unit has been in a state of change and restructuring over the last few
years, all participants expressed an understanding of the topic and why it would be an
interesting phenomenon to research among this participant sample at this time.

The section following the introduction focused on the participants’ experience
with the phenomenon of expert nursing in labour and delivery. Details were asked of the
participants related to particular impact of the phenomenon of expert nursing and a full
description of the experience they have had personally, with coworkers or what they
understand to be true about experts. The goal of the interview at this point was to
maintain and build on the level of comfort that was established from the start of the
interview so the participant answers the questions factually and comprehensively
(Moustakas, 1994). The conclusion phase allowed the participant to have the opportunity
to provide any thoughts about the phenomenon of expert nursing that they feel is
important that may not have been asked about or they had forgotten to provide
information on when the question was asked.

Through a recommendation by the thesis committee during the proposal defence,
a pilot interview was conducted on January 25, 2016 with an experienced labour and
delivery registered nurse in order to trial the interview guide. This was an effective step
in guiding the researcher towards obtaining the appropriate answers relative to the stated
research question. Modifications were made to the interview guide based on the pilot and
reviewed by the faculty supervisor prior to REB submission. The modifications were
predominantly made to ensure the questions were specific to the research question yet
open ended allowing for open discussion and encouragement of the participant to provide
examples and share narratives relative to the topic. Questions within the body of the
interview or as Moustakas (1994) describes as experience with the phenomenon, were
categorized into three sections including process, theory and challenging the theory
through research. The deconstruction of this section of the framework allowed the
researcher to shift through elements of both the theory and practice while still having an
element of data and topic organization in data collection. Within the participant
interviews, questions were modified and changed as required based on the experiences with the phenomenon of expert they were willing to share. The participant interviews were semi-structured and ranged in length from 27 minutes to 70 minutes in length; both the shortest and longest interviews were conducted with the two most novice participants. At the time of the initial interview and consent process, participants were asked if they would like a copy of the final publication at the completion of the study to which all participants recorded that they did and provided an email contact. A request to participate in a follow up interview was requested by the researcher to each participant in order to perform member checking of themes after data analysis was complete and all participants agreed to be contacted when required.

Seven of the twelve initial interviews took place at Brock University in the department of nursing between the months of September and November 2016. All interviews were audio recorded. Five participants requested interviews at a location other than Brock University and they were accommodated with those requests which included two different coffee shops, two participant homes and one in the hospital setting in a quiet conference room after the participants shift was completed.

As a form of member checking, follow up interviews were offered to all participants. Follow up interviews were requested of all twelve participants, at the time the initial interviews were conducted. The request to arrange for a follow up interview and brief explanation of the expectation of the interview was sent to all participants on August 31, 2017. Two participants responded immediately and their follow up interviews were completed on September 6, 2017. Three additional participants responded that they would be interested but could not yet commit to a date; a follow up
email was sent to these three participants without response. Another email request was sent to the remaining ten participants on January 2nd 2018 which yielded responses from three participants and interviews were completed on January 5th, 10th and 18th, 2018. A summary of all relevant themes that emerged from the data analysis from the initial interviews was provided to the participants for review with the opportunity to provide feedback, clarifications and further insight into the developing themes (Appendix E). All five follow up interviews were also transcribed by myself with all participants agreeing with and expressing that the findings they reviewed resonated with their experiences. With the follow up interviews being a year or so after the initial interviews, one participant requested to provide further clarification and insight toward the topic related to end of career nursing which was included and identified within the next chapter of findings. She was able to further reinforce her feelings and provide strength to the theme related to loss and the notion that expert is a fluid concept throughout a nurse’s career.

Data Organization and Analysis

According to Moustakas (1994), the researcher must analyze all written material through “the methods and procedures of phenomenal analysis” (p.118). For the purposes of this study, I chose to use Moustakas’ modification of the Stevick-Colaizzi-Keen method because it has been noted by both Moustakas (1994) and Creswell (2013) as the most practical, useful and efficient framework for analysis of transcendental phenomenological research data.

Stevick-Colaizzi-Keen Model. There are four stages to Moustakas’ modification of the Stevick-Colaizzi-Keen model of data analysis (Appendix F). Step one and two have been eliminated as I chose not to include myself as a participant in the study.
In keeping with the Stevick-Colaizzi-Keen model, each interview was transcribed verbatim by the researcher and reviewed multiple times for transcription accuracy and as a means to remain close to the data. The way in which I completed this was to listen to the entire recording after completion of the transcription and then review the printed transcript. Completion of the transcriptions and assurance of accuracy and understanding took approximately 80 hours which occurred between November 2016 and February 2017. Reflection and informal analytical notes were completed between each interview.

*Horizontalization*, in which the researcher reviews and values every statement made by the participant equally valuable as the next, was completed (Moustakas, 1994). Each participant statement was coded or *invariant horizons* (Moustakas, 1994) were assigned. This was completed initially on the written transcripts with the codes stemming from the participant comments. As part of peer debriefing, the research supervisor independently coded the first two interviews on paper and the results were compared to those of the researcher, finding similar results. For the remaining ten interviews, the researcher coded independently. After coding was completed and all meaning units were inputted into NVIVO with an initial total of 105 nodes (NVIVO, 2017) (Moustakas, 1994). In keeping with the Stevick-Colaizzi-Keen method, all *invariant horizons* were then clustered into themes. At the start of analysis, the nodes were categorized into eight initial themes with each having sub themes to further categorize the data. With the guidance of the research supervisor, the themes were restructured and reorganized into five themes, then ultimately three overarching and final themes. As the themes were developed, the nodes were merged into similar groupings with many renamed from very specific terms to more generalized titled. For example, the original nodes impact of nurse
patient relationship, characteristics of nurse patient relationship, quality of nurse patient relationship, family centered care, patient centered care, personality of the nurse and quality of presence were merged into one node title nurse patient relationship. A similar process was done for all nodes in order to streamline the content within each theme and provide clarity and organization of the content.

Textural descriptions related to the phenomenon of expert nursing practice in labour and delivery were identified. Textural descriptions of the phenomenon were the actual descriptions reported to the researcher during the interview and exactly “what” each participant described without interpretation (Moustakas, 1994). Development of the structural descriptions of the phenomenon was completed by analyzing the textural descriptions and identifying the meanings that describe how the participants have experienced expert practice within themselves and/or within others. The element of how the phenomenon was experienced with consideration to the context and conditions the phenomenon was experienced (Moustakas, 1994). The textural and structural descriptions from each participant interview were analyzed and clustered along with the guidance of thematic analysis to determine appropriate textural-structural descriptions of the phenomenon. While this process went smoothly, it was lengthier than anticipated with the formal coding process starting in February 2017 and analysis continuing through July 2017. The amount of content received from the participant interviews was extensive and it was difficult to finalize the themes within the depth and breadth of a Master’s thesis expectation and the time allotted to complete this research.

At the completion of the analysis process, the three themes which will be described in detail in chapter five, express what Moustakas (1994) refers to as the essence
of the phenomenon of expert nursing in labour and delivery addressed by participants through the research question, what constitutes an expert registered nurse in labour and delivery?

**Trustworthiness**

In keeping with Moustakas’ (1994) methodological process, credibility and confirmability were explained and utilized in the research process to ensure trustworthiness.

**Credibility.** Member checking is one form of promoting credibility of data and one that Lincoln and Guba (1985) deem the “most crucial technique for establishing credibility” (p.314). It is an ongoing process throughout the research project. This process involves taking all data, analyses, interpretations and conclusions back to the participants for review to determine accuracy and credibility (Creswell, 2013). Within this study, a summary of overarching themes that were identified by the researcher from the first interviews were offered to the participants for review during the follow up interview (Appendix E). As indicated previously, the five participants that completed the follow up interview were encouraged to make any revisions or changes to the information at that time. As explained previously, one participant provided further description and explanation of one of the themes. The follow up interviews were used to amend, clarify and include any further information deemed necessary by both the participant and the researcher.

Peer debriefing is another way to demonstrate credibility of the research study (Lincoln & Guba, 1985). Debriefing was a way to provide the researcher with a protagonist against the research (Lincoln & Guba, 1985). The research supervisor was
predominantly used for this process through regular face to face meetings and email feedback throughout the entire research process. Meetings occurred between the researcher and supervisor on a monthly average basis, fluctuating less or more often depending on the status of the thesis progress. Within these meetings, the supervisor provided the researcher with alternative questions and meanings, clarified interpretations of meanings, probed biases and in addition to personal reflection and epoche, alleviated doubts and provided reassurance as required. The supervisor coded the first two transcriptions independently of the researcher and a comparative analysis was completed in order to ensure the coding effectiveness of the researcher before completing the remainder of the transcriptions independently. The supervisor closely monitored the analysis process and assisted in the continued condensation of data into the final three themes. Between face to face meetings, email communication was used between the researcher and the supervisor in order to keep on track with deadlines, provide support to the researcher and clarify questions as they arose. The thesis committee members were utilized for feedback and debriefing in a similar manner as required and at appropriate times throughout the research process with four meetings occurring throughout the research process and write up. While the thesis committee members were less involved in the research process, they provided their time to review and provide written and verbal feedback to the researcher at various stages as well as direction and clarification of how to proceed effectively. For example, the implementation of a pilot study to review the interview tool was a suggestion of the committee at the proposal defence. Within the pilot study, committee member Karyn Taplay identified that I was continuously referring back to a bias related to Benner’s theory that not all nurses become experts rather than
keeping my questions open ended and allowing for the participants to express their own thoughts and opinions around the notion of expert. The committee member brought this bias to my attention reinforcing the importance of epoche and reflection throughout entire study process.

**Confirmability.** The main technique for establishing confirmability is through audits. An audit trail is a transparent, systematic report of the steps of the research project. As per Lincoln and Guba (1985), the following were kept in the audit trail: 1) verbatim transcripts 2) research notes 3) pilot and final interview tools 4) consent forms and 5) all reduction, reconstruction, analysis and synthesis of data materials. Decision making moments were documented through reflective practice as suggested from a committee member at the proposal defence. The final research report provides a clear description of the research path from purpose through to analysis and discussion (Lincoln & Guba, 1985).

Creswell (2013) states that qualitative researchers should utilize at least two evidences of trustworthiness within their studies. For the purpose of this study, member checking, peer debriefing and an audit trail were utilized as they were cost effective and attainable within the time constraints placed on this study.

**Ethical Considerations**

Within the scope of human science research, there were several general ethical principles that were established and explained to the participants prior to confirming their participation, and maintained throughout the study and potential publication including confidentiality, establishing a clear agreement of the requirements of the project with informed consent and full disclosure of the nature, purpose and need for the research
(Moustakas, 1994) (Appendix C). All participants were given the option to withdraw from the study or interview at their discretion (Moustakas, 1994).

The participants were advised that the interviews would be audio recorded prior to the interview and this was also identified in the participant consent form (Appendix C). The audio recording device used to record the interviews had a USB compatibility in order to store all interviews on a password protected digital file. All recordings were transcribed verbatim, using pseudonyms to protect participant identities. Hard copies of the transcripts were printed by the researcher for reference purposes only. All hard copies were kept in a locked file along with all signed consents in order to maintain confidentiality. All digital and hard copies of transcripts and consents will be kept for two years. Ethical approval was obtained from both Brock University and the affiliated health care system prior to data collection. REB renewal from Brock and the affiliated health care system were received as required without complication.

**Limitations**

There were several limitation that need to be noted within this study. First, the participant recruitment was done within only one labour and delivery unit. Due to the immediate response and fulfillment of recruitment numbers and saturation of data, it was not required for the purpose of this study to recruit beyond the unit that was utilized. While many of the nurses that participated in the study had worked in other types of care settings, they had not worked outside of the health care system in another labour and delivery setting.

The second limitation was that this particular unit had undergone significant change having amalgamated three small sites into one site at a new hospital. Nine of the
12 participants had worked through this experience and not only had to move into a new building, but were forced to work together. The amalgamation was heavily discussed within the participant interviews and one of the study themes uncovered the concept of loss within the expert. Because this is not a constantly occurring phenomenon, it could be assumed that the impact of loss on the expert nurse would not be as monumental as with this current participant group due to the amalgamation and the loss that was experienced.
Chapter Five: Findings

The participant reports will be highlighted in this chapter through quotes and paraphrases from the twelve interviews. The researcher analyzed all data from the participant interviews in order to identify the statements that were most significant in answering the research question and contribute to the phenomenon of what constitutes an expert registered nurse in labour and delivery. Through this analysis, three major themes emerged: 1) Characteristics of an Expert RN in Labour and Delivery, 2) Significance and Impact of Loss and 3) Difficulty with the Word ‘Expert’.

Theme #1: Characteristics of an Expert RN in Labour and Delivery

Participants described an expert as one who is autonomous, educated, experienced, exudes passion for nursing, communicates well and works well as a team member (with other experts, junior staff and interdisciplinary team members). Participants described expert nurses as being able to manage crises, be reflective, intuitive, provide mentorship and be storytellers/relay nursing narratives related to past experiences to those less experienced.

They [experts] are able to be leaders in quickly changing situations on adverse situations. They take control, they take responsibility for delegating nursing roles to different nurses who they know are competent in different areas…they are able to step in and help where they already know help is needed (Cadence)

I would say an expert is someone who is enthusiastic about what they are doing, they have a confidence but not an arrogance, and their willingness to help everyone...they have a willingness to share knowledge…they’re approachable, confident, enthusiastic, and like I said they have a passion to share what they’ve done…you know they love their job…(Parker)

Expert nurses were described as being appreciated for their expertise as well as able to use their expert level skill to provide safer care, stronger and more meaningful
nurse/patient relationships and balance both the psychosocial and physical elements of patient care required to nurse effectively in the labour and delivery setting. 

I think an expert in labour and delivery would be a person who has been working there for a long time…has experience in almost every scenario that could come their way…has the ability to interact positively with their patient and improve their care, not improve but have a positive impact on their care and how they are feeling… (Charlotte)

An expert to me means someone who has worked with labouring patients, antenatal, and postpartum patients for a long time. Long enough to know and have experienced all of the obstetrical emergencies, complications, know how to prioritize care, know how to identify situations that can become critical, look at the patient situation more as a whole; identifying quickly an issue...knowing how quickly an emergency can escalate and how to prepare what steps are needed and what resources are needed…using past experience. (Alexis)

Four characteristics including autonomy, intuition, effective communication and appreciating the novice stood out and require further explanation because they provide further insight into the descriptions that Benner (2001) identified within the From Novice to Expert theory, or they refute or challenge the theory.

**Autonomy.** Within the nursing profession, the ability to practice autonomously depends on several factors including experience, culture/environment and available resources. The participant who self-identified as experts in this study articulated that their perceptions of being expert nurses were stronger when they worked in the smaller hospital sites because they had a greater level of autonomy than in the current setting. Several expert and proficient nurses who worked in one of the three individual sites described the environment as one that was predominantly nurse centered. Prior to the amalgamation, obstetricians were not required to remain on site 24 hours a day, which required the nurse to often assess and manage obstetrical patients through consultation with the physician from an offsite location. Nurses who worked in these settings
expressed that they felt a greater sense of autonomy and worked within a larger scope of practice than they do in the new setting. Examples were provided by these nurses that exemplify the reasons that they felt more confident in their skills, more respected by physicians and self-directed.

[In the old site], the responsibility totally fell on the nurse, so she would be more inclined to look for clues in the patient…to be more keen…to assess more thoroughly and to just observe with a better eye. I don’t even know how to explain it…having the doctor present at all times on the unit definitely it’s an asset, but at the same time it takes away from the nurses’ abilities or opportunities to assess the patient…and garner that expertise. (Brenda)

In addition to having an obstetrician constantly present, another major change was the inclusion of an operating room within the labour and delivery unit. Previously, only one of the three old sites was equipped with an operating room (OR) in the labour and delivery setting, meaning only one third of the amalgamated staff were trained and competent in those skills; requiring many nurses who were competent, proficient and even expert at the time of the amalgamation to add a new skill set to their practice. Within the participant group, several nurses who had identified themselves as experts in both the past and current settings identified the impact that adding skills had on their feelings of autonomy and being an expert in general. However, it was also discussed by some participants that they did not feel they needed to include this new skill in their scope of practice in order to continue identifying themselves as experts.

The significant changes that have occurred in the physical environment of the labour and delivery unit with the added skill set of working in the operating room has impacted nurses’ perceptions of their own level of skill and expertise. Nurses who identified as experts in their role prior to these changes, expressed feeling less confident in their title of expert, but most maintained that they would still consider themselves an
expert. Data collected from the expert participants reveals how their perceptions of themselves as expert has been variable in their career, but more so since the amalgamation.

I still feel good about my practice…there’s just a new area now right and I’m not fully functioning in that area. But if you took what I did before…doing those same things here I feel just as good about that part of it but there is that one area that I am lacking in because I am not trained in it. (Alice)

I feel like less of an expert in this place. I feel like my skills to coach a patient in labour have been stripped…I felt like I was just in a pool of similar skills. I know that’s not true, but I don’t feel like I am any more expert than this girl here because I feel like there is always a doctor around and I can’t exercise my expertise anymore. (Alexis)

The ability to provide quality mentorship to a novice nurse was described by expert participants as something that was significantly impacted by changes to the nursing role and the confidence of the expert at the time of mentorship. A nurse with more than twenty-five years of experience in maternal child nursing identified that part of the reason she was not able to confidently place herself in the expert role was because she didn’t feel she had the knowledge base to support everything she would be required to teach to new nurses. She felt as though many expert nurses may have the clinical experience level to facilitate mentorship to the level required to perform the job, but felt that there has been such an expanding knowledge and skill level within the role that she did not have the required knowledge or confidence to be a mentor.

Well because if you are the one that is expected to teach someone what your findings are you should to have the roots of it. And I don’t find I have the roots of all of it. So, I’m not going to say I am completely an expert, I’m probably going to say I am more proficient and because of my experience I am going to say I am more expert on that level, because I find you have to have the ABC’s on everything to be able to teach it to somebody else. (Connie)
Scope of practice was a large part of the discussion with Connie as she felt that she had never worked with nurses who had a true understanding of the pathophysiological root of any action to the level she believed should be understood by an expert. She expressed that she felt that this deep knowledge level had been previously understood by nurses to be the responsibility of the physicians and not many nurses she had worked with in her 25 years in labour and delivery had this type of knowledge. This belief raises the question of whether there is a need to redefine the expert or whether the definition of expert in labour and delivery is slightly different than Benner’s definition.

I’m just thinking about all the senior nurses that I worked with back in the day, and they were experts, but they were experienced…now whether they clinically knew the ABC’s and the roots of it…I don’t think so. I just looked up to them because they’d done it for years and years and years and they know what they are doing and maybe it was their gut feeling. I don’t think I’ve ever worked with someone who knows the deep pathophysiology except a physician…like I really don’t think that we all…except you and a couple other people…you know what I mean. I get the pathophysiology of names and stuff like that, but to be able to…I know that a decel is because there is placental…whatever…and you explain all that stuff but to go a level deeper than that…I don’t know that part. So, the experts that I believed were experts when I was learning, they were experts because of clinical experience. (Connie)

Connie’s report identifies that she has already seen a change in how the expert is perceived. There is description that the expert, at least in labour and delivery, was valued and perceived as expert relative to their experience level with potentially less emphasis on understanding through research based knowledge.

Alternatively, mentorship was also portrayed by some experts in response to the increased skill, knowledge and expectations of the nurse in labour and delivery by identifying mentorship as a way to revitalize their own perceptions of the expert nurse during times when they are questioning their status as an expert. Alexis identified throughout her interview that she was struggling with feeling like an expert since the
amalgamation of the three hospital sites, but credited a mentorship relationship with helping to regain her confidence as an expert and a passion for her job again which had been lacking. Alexis discussed in detail the impact that being a mentor had on her which is unique in that most mentorship discussions often relate to the impact on the mentee. Also, Alexis provided an interesting perspective on the quality of the mentee and how that impacts on the quality of mentorship and the desire to continue mentoring.

...as much as I say ‘I don’t want a student, I don’t want students’ honestly, having [my last student] with me, it made me sort of...it made me re-evaluate myself and really believe in myself as an expert because I think nursing for so long becomes mundane, but when you start to mentor somebody and teach them it’s like, ‘yeah, I really know what I am doing and I know how to act and react’ and I love to share that with the novice girls. But I think it’s really important to have somebody who is willing to learn and is not having those attitudes of ‘I know that, or, I’ve done it once.’ (Alexis)

During the amalgamation of the three hospital sites into the current, new site many changes were required to be made in order for the new site to function efficiently and effectively. While positive changes were initiated, some changes resulted in the loss of what many nurses knew as “normal” in terms of environment, staffing, physician presence and most notably autonomy. Through the loss of these things, many expert nurses felt that their internal perception of expert was threatened and that through these losses, their autonomy was also threatened. These findings begin to illustrate the notion that when you take elements of the nursing role away from the expert, the definition of expert will change from what they understood it as, but they still perceive themselves to be an expert. This contributes to the emerging notion that there is a fluid movement within the level of expert.

**Intuition.** At the start of the interview, all respondents were given a simple definition of how Benner defines intuition as an “understanding without rationale”
(Benner & Tanner, 1987, p. 23). While Benner describes intuition in great detail and offers examples of such throughout her theory, a small number of participants were able to understand the concept of intuition and accurately identify times when they had used or observed intuition in practice. Many participants did not understand intuition in the way that Benner (2001) defines it or they attempted to rationalize that intuitive thoughts were not possible, but rather guessing, objective data, advocacy or thorough assessments were actually being utilized.

Participant statements revealed that they understood the concept of intuition differently than presented by Benner (2001) within her theory. All of the expert participants reported that they felt that they did have intuitive moments in practice and have used intuition. While they were able to recognize this, they provided examples that contradicted Benner’s (2001) definition of intuition that they read at the start of the interviews. The majority of the examples provided by participants reflected an element of objectivity or assessment that guided their actions rather than intuition alone. One expert participant confidently identified that it wasn’t until she reached the level of expert that she was able to acknowledge and appreciate her intuitive skills but her example of intuition was one that had clear objective data guiding her thoughts and actions.

I always get gut feelings about things and most of the time I think as an expert you pay more attention to your gut feelings because you know they are there for a reason. I got a patient up to the bathroom and she was spilling like 3+ protein, but her blood pressure was like 128/84 and I thought, ‘ok’, and there was nothing different about her except for the protein and I just thought, ‘I don’t know…she gives me a funny, funny feeling’ and she was…I kept calling [the doctor] and I would say ‘you know what, everything’s good, but I have a funny feeling about her. She’s got 3+ protein in her urine but her blood pressure is ok’, and he’s like, ‘she’s fine, she’s fine, she’s fine’ and I said, ‘I don’t know…she just, I don’t know’. (Alexis)
I will never forget the day that I used my intuition and I said, ‘there is something going on and you better get the doctor back in here’…and it was a ruptured uterus. And he had just left the room and went to his…umm…car, and the patient was just in excruciating pain and it didn’t seem like normal pain to me, and umm…her blood pressure was dropping and I just felt like something was wrong. (Brenda)

Similarly, Connie provided an example of what she believes is using her own intuition but demonstrates her understanding of intuition reflecting her knowledge foundation and years of experience.

I think a lot of intuition I’ve used. And again I am just going to say…the example I am going to use is that you get that gut feeling and you can’t figure it out…but the one part is just like when you have a multip- she is 6cm and you sedate her with Gravol, or morphine and Gravol…you know in an hour she is going to deliver…it’s just that intuition! And you know it, and these people who do that and leave the bedside and I’m like, ‘she’s going to deliver’ because I’ve seen it over and over and over again. (Connie)

A self-identified proficient nurse, who felt that the concept of intuition was what was holding her back from declaring herself an expert, she identified her continued lack of confidence in whether she had used intuition or not with an example of intuition that largely reflects past experience.

Having a primip delivering, right and umm she was un-medicated and I wasn’t sure as to how long she was going to be in labour for, right, but when you are listening to their…listen to their voice and the way that they are reacting to the contractions, not just by examining them I could kind of like have an idea as to like how dilated they are…..so that’s kind of using my intuition by kind of not examining them but knowing what they were beforehand but then having a patient that’s a primip deliver really fast, right, and I knew that was going to happen so that’s kind of using my intuition based on my experience the ways, hearing the ways patients react to how to progress in labour. So that’s one example of…if that makes sense? (Emma)

While not being able to completely understand intuition in the way that Benner (2001) describes it, the novice, advanced beginners and competent nurses who participated
attempted to rationalize the concept of intuition and the thought of nursing on instinct was one that they weren’t able to fully accept.

I think that an expert nurse sometimes acts in situations on intuition without rationale but…based on their experience from their vault of knowledge (Cadence)

I think part of, like, what you are observing is a rationale…do you know what I mean? Even though it may not be a very clear thing…like for example, if you are pushing with somebody for hours and the heads not coming down- like that is a rationale…but you have a gut feeling about it. Or if you are like seeing things on the strip… (Charlotte)

Interestingly, the most ‘accurate’ examples of intuition, according to Benner’s (2001) definition, are from participants reflecting on their observations of expert nurses.

I’ve witnessed that in others too where they use their intuition or they have an inkling about something and like for example patient’s blood pressures a little bit on the higher side and they have that inkling, but there’s no other symptoms. Nurses have actually caught like you know, preeclampsia ahead of time right with that just feeling that feeling of intuition that thinking that you know there must be something wrong. (Emma)

…it wasn’t a strip that you would get excited about. She was kind of just circling the room a little bit and I could tell that she was picking up on something. It was intuition…definitely….she said she gets feelings like that when something isn’t right and she can kind of just….can kind of sense it. And this nurse in particular, doesn’t normally come around very much to see what it going on. (Helen)

These examples are clearly in line with Benner’s (1984) notion that “expert nurses are not consciously aware of their practice because it becomes part of their being” (p. 381).

While these examples appear to fit the definition of intuition in practice, Helen was describing what she felt was almost a supernatural or mystical sense of the patient situation by another nurse who she viewed as an expert. Both of the previous examples are from proficient nurses who identified that they felt they were not yet able to qualify themselves as an expert according to Benner’s (2001) definitions which provides support for the concept that expert skill level is a requirement to fully understanding intuition.
Alexis identified her recognition of the fact that she has the awareness now that she had felt in the past that she was an expert and felt as though she had intuitive moments in her practice but was not able to truly recognize them and utilize them accurately in practice until she was truly at a level of expert with a richer level of clinical experience behind her.

…when I was younger and I thought I was expert but I really wasn’t…I never really was in tune to a gut feeling…I didn’t think I got gut feelings- I didn’t know. It was not until later when you have experienced a lot of things that went bad that sort of…you develop it or you tune into it. Maybe you always had it but you didn’t tune in to it…I think for sure there was a period of time where I didn’t feel it or didn’t know about it…(Alexis)

Several participant narratives speak to the notion that intuition is not recognized as valuable or respected by coworkers or physicians.

She was a PPROM…and it was funny, the events the night that everything played out- she lost her IV and she had had the IV for three or four days-- it was lost and no one could get it…we finally got it and she was like, ‘do I really have to have this?’ and I thought…should I? I don’t know. She’s like ‘I don’t really want it’…and I’m like, ‘you know what…you should just have it, just because’…you know? I popped in a line. She called me and said she was bleeding at like 5 o’clock in the morning and it was just this little trickle, but you know what you just had this bad feeling because why are you bleeding and not having any contractions or anything?—you just know it’s just not going to be good. Or…you just had a feeling it was going to be bad. So we ran her into another room to check the baby and she was abrupting…the baby died. That night, people thought I was nuts I think because…that’s one of the nights where I was like…I’m calling the anaesthetist…this patients going to the OR’, I got her ready and I literally said, ‘meet me in the OR’ to the obstetrician. (Parker)

There is evidence through narratives that intuition is often an accurate part of the experienced nurses skill set and should be valued and trusted. Questions related to how to accurately determine how and when to trust intuition in the care setting is still to be determined.
Effective Communication. Communication was reported on frequently throughout the participant reports related to expert nursing. It was clear that patient and family centered care was deemed important, with participants reporting mixed views on which care model was most significant when providing care in the labour and delivery setting. How the patient communicated with the nurse and what elements of care were categorized as priorities were unique among those nurses who classified themselves as experts.

Physical care of the patient was discussed throughout every participant interview. There was a large focus on how to effectively care for patients, how to keep them safe and how to develop the ability to predict outcomes. While these elements of care are vitally important to practice, the psychosocial element of care was discussed in greater detail from those who identified as proficient and/or expert nurses.

The most experienced participant discussed her feelings about how a nurse should interact with patients. While most respondents discussed prioritizing, anticipating and acting on the physical needs of the patient, Alice discussed her observation that newer nursing staff may not always prioritize something as simple as ‘presence’ as a priority for care. In the following statement, Alice highlights the difference between physically being present in the room with a patient and quality of presence.

…you do have to spend time in the room. I find that newer nurses…and I don’t know if they feel uncomfortable, they don’t spend…they do but they don’t spend a lot of time with their patients (Alice).

Understanding the patient situation through therapeutic and meaningful communication allows the nurse to make appropriate clinical decisions and prioritize care based on the
needs of each individual patient was also discussed. One participant identified a patient situation in which a woman experienced a fetal loss.

I had a patient…she had a stillborn…I think I spent two shifts with her, I remember sitting there…we just talked and talked and talked and finally she ended up delivering. She cried and I cried with her. It was just a very quiet situation and the next day when I came back to see her she actually said to me, she’s like, “you were absolutely fantastic and you actually got me through this” and she sent me this big huge letter and it was just like, ‘ahh…this is what I am doing this for’. (Beth)

Beth’s narrative expresses the idea that physical care is not always the priority for the patient. In the case of caring for a woman going through a loss, the psychosocial element of care may be the most critical part of her care experience as in the example given by Beth. In addition, Beth discussed her feelings that a labour and delivery nurse may not be able to reach an expert level of practice without being able to create a strong therapeutic relationship with the patient or be able to identify when the psychosocial element of care may in fact be more complex and valuable to the patient than physical care.

…because without having that relationship then how do you gain that knowledge to be in that situation and learn from them and learn about that situation and become an expert if you aren’t proficient with that and you’re not…and you don’t have that connection, then ya, I feel you will never get to that expert level without it. (Beth)

To further accentuate the skill of the experienced nurse, it was acknowledged that the clinical priorities of a less experienced nurse were very task oriented and care is focused on the physical needs of the patient. This was illustrated well in the discussion with Cadence who admits that, due to lack of experience, she is often unable to integrate the psychosocial element of care in to her care because she is still so focused on completing care tasks.

…not that I forget about the family but…I time manage less well than an expert nurse because I forget little things…so I’m thinking about those things, and not
that I’m missing out on caring for the family but I’m less focused on the family or others potentially equally as important but I cannot focus on the family and still maintain safety for mom and baby. (Cadence)

It was acknowledged by another expert participant that being able to communicate effectively and efficiently with the patient may not be exclusively the capabilities of the expert registered nurse. Novice nurses may have excellent communication skills and patients may feel that they are able to create a very trusting and strong relationship with a more novice nurse. However, through discussion with participants, it was acknowledged that experience is key to understanding the true psychosocial needs of the patient.

…a lot of novice people have great communication skills…it’s whether they know what to ask and what to look for is more the question. So, as a novice they may pick up on something and then become more experienced…but it is key and sometimes novices don’t know what to ask because they don’t have the experience of what to look for. (Brenda)

Through analysis, it was identified that while the proficient and expert nurses were aware of the value of therapeutic communication, relationships and presence, they felt that it was an important and inclusive part of their nursing care. When discussing expert practice with the novice and advanced beginner nurses, it was evident that the nurse with less experience values the experts for their ability to seamlessly care for patients’ physical and psychosocial needs. The novice nurses expressed an element of appreciation for the experts in practice and their ability to manage all elements of holistic nursing care.

They [expert nurses] are able to be compassionate in a vulnerable and intense and quickly changing situations. And compassion, what I mean by compassion in a situation is being able to address a patient with questions, a patient with uncertainty, a patient whose experiencing something for the first time; with adequate resources, like you are able to provide them adequate resources to feel taken care of in many different ways in that situation… (Cadence)
Charlotte, with only one year experience, has already identified that in labour and delivery, the communication and relationship with the patient is the pivotal skill required to be an expert.

I think that part of being an expert is to be able to have a well-rounded practice…in labour and delivery, you would be an expert in the communication and focusing on the patient, and then all the other skills come with it. (Charlotte)

While therapeutic communication and nurse patient relationships are pivotal in all types of nursing, labour and delivery is a unique setting in the sense that the patient is often reliant on the nurse for support rather than the skills they possess. All participants, regardless of skill level, recognized the importance of strong communication skills and nurse patient relationship as a priority for the labour and delivery nurse.

**Appreciating the Novice.** One respondent expressed her understanding of how expert nurses treated her while she was a novice. The participant identified that experienced nurses have a history of devaluing the novice until they could prove themselves as a competent nurse in labour and delivery. It was identified by Alice, who was the oldest respondent with the most experience, that she had poor interactions and felt devalued by experts when she was a novice nurse.

…what I mean is that they never came to me and said ‘what would you do?’, because they are basically saying when you are a new nurse you really don’t know and I’m not going to ask you. (Alice)

Interestingly, Alice did acknowledge that it was initially the physician group that noticed and appreciated her potential, long before she felt valued by her nursing colleagues.

Surprisingly enough, it was the doctors who would say to me…’that was excellent…your call and what you did…’…which is great, right? So it was more the doctors at the beginning. Then I guess you start to prove yourself…that’s
when the nurses start to come. And I mean come to you for guidance and they come to you to ask your opinion and your expertise. (Alice)

However, she acknowledged that the behaviour was poor and has taken that experience and the observations of experts devaluing novices to change her practice. In an effort to change this behaviour and set a different precedent of the attitude of senior nurses, Alice reports that she tries to include novice nurses in order to not mimic the behaviours of the past.

…I always remember when I first started how I felt. And you know when you feel like that, you would hope that…you make somebody else feel comfortable. I always tried to do that. (Alice)

It was reported by four participants who all self-identified as either proficient/expert or expert that novice nurses entering practice currently are in a unique position. While many nurses who worked prior to and through the amalgamation are still in a position of learning and relearning skills like the operating room roles and electronic charting; new nurses to the unit are starting their clinical education, training and experience with these elements as a routine part of their job. These skills will be built into the foundation of a new nurse’s practice and they will continue to build experience in them as time moves on which is different than the radical changes that many of the proficient and expert nurses have had to navigate recently within this particular nursing unit. Additionally, they are entering practice with a natural comfort and confidence in technology in general, making it easier for them to learn and accurately use these resources to care for their patients

…I am not as efficient in the computer end of it because we didn’t start out with it. So these people who come and can go through computers like its second nature and think…that’s just an example…which is not part of nursing but still part of it. (Alice)

I am impacted by not their nursing abilities, but I’m impacted more probably by the technical part of it…where they are a little more savvy with stuff like
that…they can help us with that…I have to ask the younger ones, ‘where do I find this? Where do I go? What do I do?’ Like even yesterday, a newer nurse, when I was relieving her was like ‘just click on that and that and that’. (Connie)

…the new ones come in and some of the way that they can rattle off things and I’m thinking, ‘holy smokes’ and sometimes I feel stupid because I can’t rattle [information] off the way they can. Like, to me I just find them very intelligent and I learn from them. (Grace)

This comfort and confidence that novice nurses have in navigating computers and electronics has not only been identified by the self-identified experts as a barrier to feeling confident in their own practice today but the indication of a change in the nursing culture between senior and novice staff. Alexis, a self-reported expert nurse discussed that while she also felt that there are some excellent novice nurses who are providing quality care to the patients that they were not appreciating or valuing the experience and breadth of knowledge that, as an expert, she was contributing to practice.

I feel undervalued…by the novice nurses (Alexis)

There is evidence within these reports that the culture of nursing is changing from what the experienced nurses had experienced in the past. The concept of novice nurses entering practice with a developing skill set, yet non-clinical skills that provide them with confidence and value in practice is a phenomenon that should be further explored.

**Theme #2: Significance and Impact of Loss**

As times passes, change and transition are anticipated. While change can be a positive experience, change can also leave people with feelings of loss or grieving elements of what used to be. The environment that the participants were recruited from can be described in two unique ways. First, the area of maternal child nursing is a specialized area of care with unique characteristics from that of other nursing units. Second, the physical working environment has changed significantly over the last four
years with major transitions accompanying these changes. Participants who had worked in the smaller community hospitals acknowledged that the larger centre allowed for additional resources and support for the staff and patients, but almost equally and more impactful, expressed a loss associated with leaving the small hospitals and the subsequent change in their nursing role.

Loss was identified as one of the major themes that emerged through the participant narratives with two very different relationship characteristics, however both linked to the environment. The loss of physical environment and perceived sociocultural changes were most predominant among participants. While autonomy was discussed in detail in theme one, linked to these feelings of loss of autonomy were feelings related to loss of physician respect, specifically in relation to the nurse’s ability to function autonomously in the new setting. The participants reported several times that they felt that the physicians they worked closely with in the old sites had a greater respect for them than in the new site. The participants also stated that the physicians who amalgamated to the new site were unfamiliar with the nurses and were not confident in their skills and clinical judgement, regardless of years of experience.

When I reflect, I think I’m thinking mostly about how things are run now than knowledge and all of that…and how I feel like I’ve lost control of my labouring patients. Like, I don’t really have a say, I don’t really…I’m not respected for my opinion…I’m just there to document fetal heart rates and contraction patterns and start the oxytocin and get an epidural. And then…don’t have her pushing until I tell you so. So it’s all controlled by the system or the doctor (Brenda).

Currently…I don’t feel like I could practice at that level at that hospital just because of the way it runs. Except when I’m working with Dr.*** and Dr.***, then they seem to be working in the old fashioned way where they are on call and they depend on your observations and assessments. (Brenda)

Having to have OB’s now look at NST strips. If it’s a very good strip, and it’s like kind of obvious if things look really, really good. You can tell if there is like
a beautiful strip compared to one that doesn’t look very good. I think that can be a nursing judgement…if it’s very clearly meeting the criteria of a Non Stress Test, which we all very what that is… (Charlotte)

You know because you’ve done it…especially in our units where we didn’t have the access to epidurals so we managed our labouring patients a lot without epidurals, which we don’t do here at the new site (Connie)

The participants reported that within the new site and changed organizational structure, the same nurse physician relationships do not exist. It was identified by the researcher throughout the interviews that scope of practice and autonomy were being used in a similar context. Nurses identified a loss of autonomy because they were feeling that their scope of practice was significantly reduced in the new site. The scope of practice for labour and delivery registered nurses had not changed between the old site and new sites, however the level of autonomy that they were given certainly had. Changes in autonomy related mostly to the fact that there was now in-house obstetrician coverage on the unit, a new resource for all nurses who had previously worked in the community settings. Interestingly, the increased resources (i.e. physician presence, equipment upgrades, increased staffing) provides nurses with a greater amount of support and increased patient safety. Alexis emphasized strongly throughout her interview that she has felt like less of an expert related to the change in autonomy in the new site but was also able to recognize that the new site was ultimately safer for the patient in regard to physician availability.

…when the OB is not available now (they are in the OR), then that part of me kicks in again and it’s like, ‘ok, this is it, it’s just me and my other girls…we’re it’…so like that instance where I had that patient who came in and the fetal heart tanked and the OB was not around [in the old site] and it’s like ‘call this person, call this person, call the second team, get her to the OR, get her on the table’…that’s when…that’s what I miss. I know…it’s much safer for the patients where we are now (Alexis)
Brenda expressed conflicted feelings related to the physician coverage when she identified that it often ‘weighed heavily’ on nurses in the old site when they had to assess and manage patients without a physician in the hospital.

…there was never a doctor in house. They may have occasionally stayed in house if there were problems, but even then they would go to their sleep room, but very rarely…very rarely. Mostly…it was even the assessments that came in…the doctors did not come in to see them in the night…they relied totally on our assessment…which weighed heavily on the nurse. (Brenda)

Other participants also expressed feeling undermined and undervalued now that the physicians are present and readily available.

These external factors are all of the technology, the order sets, the epidural initiation rate, the fact that there are OB’s and anaesthetist and a lot of people around…all of these things that don’t require you to really have to use your expertise to your full potential. I think because we are not using it to our fullest potential anymore that you almost forget or undervalue your expertise as a nurse. (Alexis)

…you had a gal come in bleeding, she’s probably abrupting and you can’t get a fetal heart…you would organize the OR and call [the OB who was at home] saying, ‘you need to come now, we’ll meet you in the OR’-click [hanging up phone]. And it wasn’t that the doctor had to call the anaesthetist, the doctor had to call the assistant- we did it. I had to do it a couple of times because I’m like, ‘this girl needs to be in the OR and I don’t really care’- called the assistant, called the anaesthetist, called the OB…I said, ‘get here now, I’ll meet you in the OR because this needs to be done five minutes ago’. You don’t do that now … we can’t even call the anaesthetist ourselves (Parker)

The participants identified that a major loss within the amalgamated unit is related to changes in nursing staff and subsequently the loss of experts; those with not only decades of experience with coaching patients through the labour process, but also decades worth of nursing narratives, clinical stories and the knowledge transfer that goes along with that.

…listening to their stories was very enlightening and nerve wracking...I had anxiety listening to what they said because I’m thinking ‘God, if that ever happened to me would I know what to do?’ (Grace)
I think sharing things with those girls, you know…I think that it might help them to know or convince them maybe that you really are an expert, that you really know what you are talking about. (Alexis)

Staff turnover and the impact of having an increased number of junior staff were identified as barriers to this type of knowledge transfer that had happened in the past. Also, increased patient volume and acuity within the new unit is leaving little opportunity and time for this type of interaction to occur. Finally, there were significant changes to the physical environment including the increased size of the unit and the change from a central nursing station to pod style nursing with nurses being separated into four care stations. This physical change created barriers toward the facilitation of these types of interactions with the expert nurses that remained on the unit. Nurses spend less time together as a group sharing narratives and providing informal mentorship to each other. Participants who had been part of this sharing experience and knowledge transfer in the past acknowledged the value in both sharing and hearing these stories while also acknowledging that they didn’t feel the nurses who had not been exposed to this would be receptive to these sharing moments, which was identified as a loss.

It used to happen all the time…I found that the expert nurses [in the old site] wanted to share with the novice and advanced nurses; experiences that they had gone through and where they used their knowledge and their skills…I don’t feel like it’s happening as much, and I don’t feel that the novice really want to hear it. (Brenda)

Along with the impact related to a loss of senior nurses, was the inference that the less experienced nurses are not required to work as independently or have the same patient care focus as previous generations of labour and delivery nurses. Participants that self-identified as proficient and expert expressed concern related to the next generation of experts and whether their development towards the level of expert has been jeopardized.
They identified that they were unsure of whether it was even possible for junior staff to achieve expert, or at least the level expert as it has been understood in the past due to the fact that they may not be required to be as independent as previous generations.

We had to prioritize our patients, we had to manage...because maybe there was six people in there and there was just the two of us. So we really had to prioritize who needed the attention first and who could wait a little bit. And they don't have to do that, they have that patient, they are with that one patient and that’s all they see and all they get. They don’t know how to...and it’s not to their...I guess it’s to their benefit, it’s just the way the demographics of the whole thing is. (Connie)

So I think you become an expert more quickly in like the [community] setting as opposed to a [higher level] setting because you have residents and students and...even where we are now, resident, students, clerks...everybody doing the assessment for you and sometimes you don’t even get hands on. So I think our junior nurses are not going to become expert nurses as quickly as we did because they just aren’t always hands on and assessing. (Alexis)

Participants had conflicting opinions about the transitioning environment. Those who worked in both the old and new sites commented on the changes to the nurse’s role, especially in reference to the preferences of the patient. They were able to identify that the patients who were seeking, for example an epidural, were able to access this resource in a more timely fashion in the new site. However, the patients who were planning a natural labour experience, requiring the nurse to utilize her coaching skills, were both exposed to and often encouraged to change their minds at any moment; often at the insistence of the physician. While the predominant feelings related to the nursing impact were related to loss of opportunity to perform these coaching skills, the discussion related to the patient was generally positive.

I think the changes in resources to have the 24/7 coverage is awesome for the patients, but it doesn’t expedite the process for developing your nursing skills and whereas now we have everything is...standard and written...and I mean you are using your critical thinking but not as much as when and if you are on your own. (Alexis)
I don’t necessarily think it has to go back to the way it was…it’s great that there is a physician on call but there has to be more respect for the nurses and their opinions on what is going on…(Brenda)

The focus was on supporting the patient through labour and fulfilling her wishes to the best of our ability. So, to give her the labour experience that she wanted and to have the most optimum outcome…which I think the outcome apart of it is still the same…we all want a good outcome but it’s the process and how we get there that’s changed I think. (Brenda)

In her follow up interview, Brenda articulated again the impact of the changes in the way the patient is managed in labour now. She expressed her displeasure with the changes in practice with the following statement:

I think if I wasn’t close to retirement and knew that I had to work another 10 years here- I would leave for sure. This is not the labour and delivery nursing that I signed up for all those years ago, this is not the way I want to care for my patients. (Brenda)

It was evident through discussion from the expert participant group that they were feeling several impacts to their position of expert toward the end of their careers. As previously discussed, the transition to the new environment, availability of resources and impact of new technology was a common theme throughout the expert’s discussion of how they feel their position as an expert has been impacted. Through all of these elements, all expert participants identified themselves in whole or part as feeling less of an expert than they had in the past.

Alice expressed the impact of working within a new environment and how feelings of comfort within the environment impacted how she felt about herself as a functioning nurse.

You are searching…because that unsureness makes you feel incompetent….for things that you might need in a hurry…so that is going to affect your…everything…because if you can’t run and get something quickly or turn and…so it makes you feel a little…(Alice).
While Alice identifies several circumstances that she felt as though she was less of an expert than she had previously, her confidence in her nursing practice was evident throughout her interview. She identified several barriers to her practice that had not been present until the end of her career, but her persistence that she remained expert due to her confidence in her experience and knowledge of labour and delivery was steadfast.

I still feel good about my practice...there’s just a new area now right and I’m not fully functioning in that area. But if you took what I did before...doing those same things here I feel just as good about that part of it but there is that one area that I am lacking in because I am not trained in it. (Alice)

While the experts described that there have been changes that have affected their performance as an expert now; those who have identified themselves from novice to proficient have identified some limitations that they have observed in what I have termed the “end of career experts”.

They are experts in the actual patient care...but handling the flow and acuity of the unit, they are not. And that’s just maybe age and that’s just maybe, whatever...I don’t know, but I am not as comfortable with them being able to manage the flow or anything like that, but I am very comfortable with them managing a patient because they have seen and done them all. (Connie)

To further reinforce the concept of end of career experts being a valid subcategory of expert level nursing, Brenda, who is close to retirement, identified in her follow up interview that she was feeling even more like a disposable or disregarded member of the team than she had been in the past now that she is coming close to retirement. She states that she believes that she is regarded as “too old” to understand new concepts or technology when she makes the following statement:

I feel like if I ask a question about the computerized charting, like where to find something, and a younger nurse asks the same question- the younger nurse is shown without question and I am viewed as someone who is too old to understand how to use the computer properly; there is a double standard. (Brenda)
All of the experts discussed the idea of having felt less of an expert at various times in their practice since originally feeling they had achieved an expert skill level. It was interesting to note an example from one nurse who self-identified as an advanced beginner observing the experts in practice. While not impacting her the same, she was able to identify examples of how she has observed these experts struggle to maintain an expert level of practice due to the continuing changes within the expected scope of practice within labour and delivery.

The expert nurses who are now, going back to just the example of just learning computer charting—absolutely, I think that they can feel like they are back in that expert level once they have enough support and practice…feel comfortable. (Rebecca)

All participants placed emphasis on the understanding of technology in defining success in practice. Rebecca provided an example of how comfort and understanding technology can assist in the re-achievement of performing at an expert level for those who have felt they have lost it or feel less of an expert. An impactful statement related to the significance of technology in practice was made by one expert participant while comparing her level of competency in an area of nursing to her level of understanding of the electronic charting system.

I am very comfortable in triage, because I can navigate that computer there…it’s pretty simple…I know once I do it more and more I will be fine, so I’m feeling a lot. I’m feeling kind of novice in that area…because I do, I have to ask the younger ones, ‘where do I find this? where do I go? what do I do?’ Like even yesterday, a newer nurse, when I was relieving her was like ‘just click on that and that and that’. I remember learning that but I don’t use it. So in that sense, and maybe it is just my role as the charge nurse because you don’t do stuff like that. So in that sense I am feeling lessened, less than proficient for sure. (Connie)

…with computer charting I think that a lot of the expert nurses that I view are expert nurses are now trying to take on this new skill which is a huge portion of our care…it’s changing their confidence I would assume and how they view themselves and maybe even they are starting to think that some of those
competent or between advanced beginner and competent people are becoming closer to the same level they are at…I think that they can feel like they are back in that expert level once they have enough support and practice…(Rebecca)

Now, I just honestly…I feel like I am nursing a frozen patient and I’m nursing a computer. I feel like I am not able to fully utilize my skills as an expert. (Alexis)

The reports from these expert participants not only suggests that expert is a fluid rather than a linear concept as described in theme one, but that there are multiple levels of expert and not a point of finality within an individual’s career. It could be said that when nurses reach a level of expert practice and have a deep knowledge base and high level of skill obtained throughout a rich career that their confidence in themselves as an expert is easily compromised.

**Theme #3: Difficulty with the Word Expert**

The environment that participants were recruited from consists of an obstetrical triage unit, operating room and an integrated intrapartum, postpartum and antepartum care unit. There were strong and differing opinions among the respondents as to whether nurses could be considered experts if they were not expert in all of these clinical areas. This was reflected most when the participants were asked to classify themselves within Benner’s skill levels based on the definitions provided. Half of the participants classified themselves either between two skill levels (i.e. between advanced beginner and competent, or as proficient rather than expert).

I think a lot of us are very proficient, but to be expert…like that’s a big word…and that’s a big title. (Connie)

While Benner defines the term expert, it was identified throughout the interviews that participants ascribed to a belief that has a somewhat negative connotation of the word expert. However, while every participant contributed an answer to the research question
when asked, several participants also stated that becoming an expert was either not achievable within the labour and delivery setting, that the word expert too closely resembled the word perfect, and nurses could never be perfect. This understanding of expert affected participants’ willingness to embrace Benner’s definition of an expert nurse. It was even explicitly stated in one participant interview that the term expert is one that is ‘scary’ to use to describe nurses.

I mean we are all like…experts…even experts…expert scares me… (Connie)

Several participants reflected on the notion that an expert would be required to know everything or the concept of an expert being perfect. Several participants stated that while they could place themselves within Benner’s descriptions of expert, they would never call themselves an expert due to a preconceived idea that they would be required to know everything and expected to represent perfection.

…it’s like assumed that I know everything about it…and I don’t, I don’t know everything. Sometimes when you read a strip I’m reading it ok and then someone else will decipher it differently and I’m like, ‘I’ve looked at them for twenty five years and there was never a thought about that being an issue’…maybe I am going to rescind on my expert thing because I don’t know everything…because really I don’t know it all…I do know a lot, but I don’t know a lot…if that makes any sense? (Connie)

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…I don’t even think the expert nurses out there…I think they may not even identify themselves as expert nurses but I think that other people would view them as being experts…but to call yourself one, I think it would be difficult because you don’t want to be overly confident saying that…and there’s always something to learn. (Helen)

More than one participant was able to identify with the definition of expert after reading the description of Benner’s levels but still questioned the meaning outside of the described definition. Several participants described themselves as being between the
proficient and expert level simply because they didn’t think they should call themselves experts. After reading the definition of expert one participant expressed that she could place herself within the definition, but labelled herself proficient, simply because she could not justify calling herself an expert.

Experience wise I would probably say expert but I don’t consider myself an expert…so I would have to say more proficient. (Grace)

While the negative connotations of the word expert were evident throughout the participant interviews, environment was a significant factor in defining expert for many respondents. Parker self-identified as proficient, although her description of her own skill level, knowledge and experience aligned closely to Benner’s definition of expert. It was identified through Parker’s interview that her definition of an expert nurse was impacted by her experience in other care areas.

In the ER, you have people coding all the time, you have people having STEMI’s [M.I.] all the time, you see traumas all the time—would you be an expert in trauma nursing, I think you can be proficient but maybe not expert because there’s so many things that can go wrong with a trauma but the STEMI can you be an expert in, yes. A stroke can you be an expert in, yes. Respiratory distress, yes. (Parker)

The impact of working within alternate care settings was reported to impact the definition of expert for several participants, but the physical environment within the same nursing unit was also noted to change some participant’s definition of expert. Alice described herself as an expert nurse for years in the old site but admitted that the move to the new site made her feel like less of an expert for a period of time, but that she was eventually able to overcome and be confident again in her practice. She admitted that her perception of herself as an expert had waivered after moving to the new site, but eventually she overcame the barriers related to familiarity of the setting, culture and increased skill set.
that were keeping her from feeling like an expert in her current labour and delivery setting.

I did feel unsure of myself…you are searching…because that unsureness makes you feel incompetent…it probably took six months to a year to feel that same level that I felt there [old site], doing what I did there. (Alice)

Similar to Alice, several respondents expressed a lack of comfort within their current physical environment, despite the fact that they had been working in the same practice setting for two decades or more. The concept of whether confidence in partial versus full scope of practice within a care area defined the feelings of expert was explored by several participants.

From a novice perspective, one participant identified that due to the nature of the unit and the experience backgrounds of each nurse, it would be expected that the time it takes for a nurse to achieve expert level depends on the care area they are working in.

There’s a lot of different areas of labour and delivery nursing and I think that part of working with a team who I perceive as being in all these different categories [referring to Benner categories of Novice to Expert]…if you ask me to like perceive nurses that I work with in these different categories in triage, in the OR, in labour, in postpartum—they are all different, so ya, I think an expert nurse is just very aware of where they feel most competent and most confident. (Cadence)

While the concept of partial scope versus full scope of practice within the physical environment came into question when defining a nursing expert in labour and delivery, the definition of full scope of practice was also questioned. Several respondents admitted to expert level experience but then questioned whether they actually had the knowledge base to support stating they were an expert. Having a strong knowledge of the physiological processes involved in every clinical situation in the labour and delivery setting was questioned and could undermine the true meaning of expert in today’s
practice environment, and perhaps is an element of emphasis that is missing from Benner’s definition of expert.

I feel like I have a good knowledge base but I feel like it’s not as complete as it could be, or as wide as it could be. I feel like there’s always more room for learning and I feel like I haven’t encountered every scenario or at least close to every scenario in labour and delivery to have a knowledgeable answer for that scenario or to predict that outcome or maybe to know what to do in that situation so I feel like I need to experience some of that before I can say I am an expert. (Beth)

I’m just thinking about all the senior nurses that I worked with back in the day, and they were experts, but they were experienced…now whether they clinically knew the ABC’s and the roots of it…I don’t think so. I just looked up to them because they’d done it for years and years and years and they know what they are doing and maybe it was their gut feeling. I don’t think I’ve ever worked with someone who knows the deep pathophysiology except a physician…So, the experts that I believed were experts when I was learning, they were experts because of clinical experience…(Connie)

Parker was strongly against the concept of any nurse being able to identify or as deemed an expert. She described the concept of expert in great detail as one that could never be achieved. Although she described the general characteristics of an expert that all the other participants described she insisted that being an expert was not only an unachievable goal, but one that is not possible.

I will not ever see everything. I will not confidently be able to navigate every situation…and to me, that’s an expert. And that’s a physically impossible thing to achieve. You always are learning…you’re always building experiences…you’re always seeing new experiences. To me, an expert is something…is maybe someone who know it all…I guess…I don’t know, but in the nursing profession—no one knows it all…Yes, you can be confident in your skills…yes, you can be confident in what you’re doing—I’m not saying that, but that’s a proficiency…I feel that you can’t be an expert because there is always something more to learn…you can never narrow mindedly say I’m an expert and I have everything I need to be equipped to do something…if you feel that you know everything, you should probably not be in this profession because its changing forever…it’s a forever changing thing…we are seeing way more comorbidities to these patients that are coming in that people haven’t seen before. So how can you say you are an expert if you haven’t seen that? (Parker)
While several respondents waivered in their position of whether they could ever consider themselves as expert, one participant (Alice) was very certain that while she had not experienced all obstetrical emergencies or situations, she felt that her knowledge of how to handle these situations that she had learned through education and experience during her career would assist her in managing whatever situations she was faced with.

There is some that I have never been exposed to…but I’m educated if it came up…Like I’ve never seen an inverted uterus…I’ve never seen it. I’ve never had it happen, am I educated to know what to do? Yes…I guess you can’t be an expert in everything. (Alice)

Parker and Beth indicated that an expert was not possible because it would require a labour and delivery nurse to have seen every situation, which was not stated to be possible; in contrast, Alice indicated that it was not necessary to have experienced all clinical scenarios because you simply needed the knowledge to maintain confidence in expert status; Brenda and Alexis stated that while it took many years, they felt they had experienced every obstetrical scenario and were confident that it is achievable to become an expert nurse in labour and delivery.

Summary of Findings

Twelve participants with a wide range of clinical experience in the area of maternal child nursing discussed their experience with the phenomenon of expert nursing specifically in the area of labour and delivery. They all described the characteristics that they considered an expert nurse has from what they have observed in practice, what they feel that they as expert nurses contribute to practice or what they feel are characteristics an expert nurse should contribute to practice. A large number of participants expressed uncertainty in the ability to become an expert at all. Regardless of the level of experience
and confidence in their practice, many participants expressed discomfort with both the word expert and the expectation that society has placed on the definition of expert.

Another major theme related to expert practice in labour and delivery was that of loss. The unique environment of change that the recruited participants are working in brought about, in most participants, feelings of loss related to changed scope of practice, changes in technology, culture, increased volume of patients and patient acuity. The changes that led participants to discuss how they feel in the labour and delivery setting brought forward rich conversation, especially from those who identify that they are at a level of expert. The experts were able to identify and discuss an array of thoughts related to feeling disrespected, replaced by technology and pharmaceutical intervention that undermines their labour coaching, comfort skills and environmental changes. While there has been discussion from participants that expert practice is still questionably accepted in clinical setting including labour and delivery, there was much discussion of the importance of expert nurses in the clinical setting and clear examples of expert practice in the labour and delivery setting.
Chapter Six: Discussion

The purpose of this chapter is to summarize and expand, through discussion, the findings from this research as well as highlight how these findings enhance the body of knowledge related to what constitutes an expert registered nurse in labour and delivery and how this research advances Benner’s (1984) *From Novice to Expert* theory. Insights as to how the findings impacts policy, education and future research will also be discussed.

Since this research study was grounded in Benner’s theory, and her definitions were used for participant self-identification of perceived skill level, it is not surprising that the findings support her theory; specifically as it relates to the characteristics of an expert registered nurse. What this study has added to the literature is further insight into the constructs of autonomy, intuition and challenging Benner’s (1984) theoretical model of expert skill development in nursing practice, specifically in the labour and delivery setting.

What is unique to this study is the concept of loss as it relates to one’s perception of self as an expert registered nurse. The concept of varying levels of expert and the perception of experts at the end of a nurse’s career will be explored in relation to whether the definition of expert can be maintained or if the title of expert will cease to exist as it is understood today. While participants were easily able to describe the characteristics of an expert in labour and delivery, they were not all able to identify with the title of expert regardless of their skill or experience level.
Characteristics of an Expert RN in Labour and Delivery

**Autonomy.** In this study, autonomy was discussed in relation to how the nurses felt they used to work and how they feel that they have lost autonomy as the role of the labour and delivery nurse changes over time, due to environmental and technological factors. Participants commented on these aspects of autonomy related to how they feel that they are no longer valuable to their labouring patients, they do not feel they are required to use their assessments skills as they used to and they identified that the environmental structure has allowed new nurses to feel a sense of comfort and safety in this environment because they are not required to practice with much autonomy in this setting.

The description of nursing autonomy within this study and its impact on expert nursing furthers what is currently in the literature. When nurses are empowered and supported in their autonomy in practice they are influential, advocate their position within the healthcare system, define their areas of expertise and work autonomously within their expertise (Manojiovich, 2007). Manojiovich (2005) describes the significant role of bedside nurses because of their ability to provide immediate care and action based on subtle patient cues and trends as they have the closest relationship with the patient while in the hospital setting. Nurses have been identified as the individuals with the ability to have a high level of power and autonomy within their practice but too often are unable to effectively utilize the depth and breadth of their professional preparation because there are barriers to their ability to practice autonomously.

Aligning with Manojiovich (2007), the self-reported experts in my study reported that their feelings related to loss of autonomy, feelings related to loss of control of their
patient, physician’s lack of trust, confidence and respect in their assessment skills, abilities and judgement have contributed to the feelings of being less of an expert at this point in their career.

Benner (2001) identified that a nurse is unable to acquire the expertise required to be an expert nurse on units that experience high turnover. The study site has experienced a significant amount of turnover since the amalgamation in 2013. Human resources statistics from the hospital site identified that the labour and delivery unit hired 42 new nursing staff between April 2015 and March 2018. One explanation for the influence of turnover on the ability to achieve a level of expert may be that while still being accountable for their practice, nurses who do not feel autonomous in their practice expressed feelings of frustration and failure and therefore left the unit for other opportunities (Laschinger & Havens, 1996). Bednash (2000) determined that a significant factor in nursing recruitment and retention was dependant on whether the nurse felt autonomous in practice and the respectful encouragement of clinical decision making.

**Intuition.** Benner’s (1984) *From Novice to Expert* theory includes the concept of intuition. She describes it as an “understanding without rationale” (Benner & Tanner, 1987, p. 23). After the publication of her theory, Benner continued to produce research and publications related to intuition in practice in an effort to clarify the position of intuition in nursing practice (Benner & Tanner, 1987). At this time, the literature provides no consensus on how a nurse develops intuition. Not only has intuition been difficult to understand within nursing literature; many attempts have been made to redefine or attribute it as a personality trait rather than a learned practice (Hassani, Abdi
& Jalali, 2016; Robert, Tilley & Petersen, 2014; Wyneham, Parkinson & Denholm, 2008). The findings from my study provide further evidence that intuition continues to be perceived in a subjective manner depending on the background, experience and perception of the nurse. Participants within this study provided narratives that align with Benner’s definition of intuition identifying that experience driven understanding of a situation guides the nurse to be able to make decisions intuitively with minimal to no pre-existing symptoms or quantitative results leading them to make that decision. Despite this understanding and articulation of intuition, all but one of the participants in this study provided an example of intuition that included objective data that led them to their insights or actions while also labelling it as intuition.

Helen described intuition as a sixth sense, not because she felt she exhibited it, but because she had observed it in others who also self-reported that they possessed this unexplainable intuitive characteristic. Intuition described as a sixth sense stemming from experience is recognized by Benner (1984) yet in reference to mysticism or a supernatural inspiration has been firmly refuted as a completely inaccurate understanding of intuition (Benner & Tanner, 1987). A pilot study was completed after identifying the need for a better understanding of the role of intuition in expert practice. It was identified through previous studies and narratives that intuition was an element of practice viewed as an excuse for incorporating guessing and irrational acts into practice. However, the pilot study yielded results that identified and solidified Benner’s understanding that “intuitive judgement is what distinguishes expert human judgement from the decisions and computations that might be made by a human or a machine” (Benner & Tanner, 1987, p. 23).
Trustworthiness is another consideration when discussing intuition in practice. If intuition is a key performance indicator of the expert, developing a protocol for identifying clinical credibility and trustworthiness is essential. Benner and Tanner’s (1987) work also touched on the notion that intuition was not an element of practice that was highly recognized as valid or “has seldom been granted legitimacy as a sound approach to clinical judgement” (p.23). Marshall, West and Aitken (2013) studied the way nurses sought validation and answers when uncertain in practice. It was identified that nurses regularly sought out each other for answers as a first approach when uncertain. Clinical experience, trust, role and approachability were the primary characteristics nurses based their decision on when approaching a colleague for guidance and answers. If a level of trustworthiness and credibility could be placed on nurses once reaching a certain capacity in their career in expert performance, it is possible that their intuitive decision making ability could be deemed as credible. Trust and respect in both clinical decision making and expert use of intuition in practice could provide nurses with a higher level of autonomy also; feeling valued for their contributions to practice at this stage of their career.

Given that nursing as a profession is trying to develop an objective, research base to identify itself as truly a professional discipline, it could be debated whether there is room for acknowledging intuition in its true form (Benner, 1984). Benner debated this fact in her original theory publication when she stated, “perhaps in our quest to achieve objective, evidence based performance in practice we are in fact losing a level of the subjective art of nursing” (Benner, 1984, p.390). The findings from this study further contributes to current literature that the concept of a clear and concise understanding of
intuition is not known but adds additional concepts related to intuition that are worthy of further examination. This study poses more questions than answers in terms of how intuition is defined, understood and it’s safe, appropriate and respected use in clinical practice, specifically in the area of labour and delivery.

**Effective Communication.** Within this study, communication was a characteristic that participants described as important for all level of nurses, but with a unique element for the expert. The participants reported that the experts exhibited qualities of strength and awareness of a meaningful nurse patient relationship. They reported that the expert understood the significance of meaningful presence and communication with the patient as well as the family, and the ease and comfort of including effective communication and relationships within their nurse’s practice. The participants also identified the ability to process and prioritize their plan of care when the patient requires prioritizing these non-technical skills (e.g. presence) over any technical skill or tasks that the expert could offer. Beth identified this concept well when she describes caring for a patient who had just experienced a stillbirth. Beth realized, after verbalization from the patient, that while the clinical skills required in this situation were limited, the time she spent sitting with the patient and sharing tears with her were acknowledged as what was needed and most valued by the patient in that life shattering situation.

The value of the nurse patient relationship to the patient experience was a finding that similarly reflected the findings of Richards and Hubert (2007) discussed in detail in chapter three, which challenges the definition of expert within Benner’s theory. Similar to Richards and Hubert (2007), the findings from this study show that although all nurses
are present in their interactions with the patient; an expert truly has a presence with the patient and can effectively include the family within care, an ability that is challenging for the novice RN. Richards and Hubert (2007) described that a therapeutic patient experience may be completely determined by the strength of the relationship formed between the patient and the nurse even when few medical interventions are performed. The capacity for the nurse to listen, spend time, be compassionate and understanding to both the patient and the family while also fulfilling the medical needs of the patient, which the patient may actually consider a less valuable act, should be part of the defining characteristics of expert nursing in labour and delivery.

**Appreciating the Novice.** Experts in this study reported that the nursing culture where they began working was very different from today. In particular, Alice shared that she felt, as a novice nurse, she brought nothing more with her to the nursing setting than her experience that was limited to the brief time in clinical training. She also reported that the experienced nurses were the ones that respected her least, with the physicians being the first to acknowledge her skill and contributions to clinical practice. Presently, novice nurses are coming to the practice setting with not only a university degree in nursing, but valuable non-nursing skills related to technology, software programs, and even simply computer skills. The experts in this study identified a lack of comfort and confidence with the recently implemented technological expectations. The novice nurses are more eager, excited and able to not only understand and utilize technology effectively, but they are in turn supporting the experts as they continue to learn. This was expressed by experts within my research that the fresh ideas, eagerness and excitement
that novice nurses bring to the clinical setting, at least within this participant population, was evidently valued.

As education changes, organizational culture will hopefully change as well. For more than two decades, the saying that ‘nurses eat their young’ has circulated throughout nursing units and was accepted as truth (Meissner, 1986). It is well documented in the literature that this culture of devaluing the novice nurse is very real. Research has been done to determine the best course of action to eradicate this cultural norm between senior and novice nursing staff resulting in a multitude of suggested changes including policy change within institutions as well as emphasis within nursing regulatory policies surrounding respect between nurses and students within the workplace (Sauer, 2012). However, the literature is reflecting that the culture of zero tolerance has not eradicated this problem (Sauer, 2012). Novice nurses continued to be devalued due to lack of experience and little sense of value within the clinical setting. The study findings have shown that the culture of nursing could potentially be changing and requires further exploration into this positive change phenomenon.

The experienced nurses within this study reported that they have struggled with the large number of technological advances and changes including electronic fetal monitoring, electronic charting, electronic order entry programs and upgraded equipment with built in technological elements that are more complicated than they are used to. The environmental factors that are causing the experts to feel less of an expert due to changes in technology may also allow for a greater level of acceptance of novice nurses as they are deemed valuable and useful to the experts.
Connie had self-identified as an expert at the start of the interview and then began to think about the changes in documentation format from paper format to electronic format and the struggles she has with it since it was initiated and actually changed her skill level to proficient. She discussed that she feels very novice at navigating the computer charting and is often asking the novice nurses for help. According to both these study results and current literature, novice nurses are coming into practice with not only a deeper knowledge base but they are also growing up technologically savvy, comfortable and confident navigating computers and more complex equipment (Eley, Fallon, Soar, Buikstra & Hegney, 2008). According to these study findings it appears that what might be limiting our expert nurses may actually be supporting the novice nurses to be viewed as more valuable. While this may be a temporary phenomenon during a technologically heavy time of change, perhaps it will be enough that novice nurses’ translatable skills will be appreciated and as mentees provide benefit to the mentor as well.

Within this study, an expert nurse identified that the quality of the novice mentee was impactful to the mentor. Alexis noted that through mentorship, she was rejuvenated and her confidence within her own practice as an expert nurse was strengthened because of the attitude, personality and eagerness of the mentee. Through mentorship, the expert redefined strengths in practice that had been weakened since first reaching the level of expert. It was expressed by the expert that while she was feeling like an inadequate mentor previously, the positive experience she had with her mentee was just as valuable to her feeling confident in her role as expert as her expertise was to the novice level nurse. Further research should be done focusing on understanding the role of mentorship
and specifically the role of the mentee to the mentor, in order to support a positive and collaborative leaning environment and potentiate or even solidify a nurse within her own practice as an expert.

**Difficulty with the Word Expert**

Five participants identified difficulty relating with the word expert, with three adamantly insisting that achieving an expert level is not possible. Although they reported meeting the qualities that Benner describes as an expert nurse, they were unable to identify with the word expert specifically. One participant reported that the concept of expert scared them, while another reported that they felt the term expert was related to arrogance or a *know it all* kind of attitude. Connie, a participant with more than twenty five years’ experience in labour and delivery, identified a lack of confidence within herself as an expert related to knowledge deficits, also alluding to the fact that when she entered nursing there was more emphasis on the physicians for a strong knowledge base rather than nursing. In a female dominant profession, it might be expected that self-identification as an expert may be difficult.

During the emerging feminist movement of the 1960’s, women in many professions benefitted greatly while nurses, for several reasons, continued to be on unequal footing compared to men in health care. First, nursing education originated within the hospital setting which may have accentuated nurses’ position as less educated and less respected members of the health care team than physicians and other providers who were receiving formal education (Manojiovich, 2007). Second, a diploma nursing education program replaced the hospital based training potentially contributing to the notion that nursing may not be a true professional practice because they are not required
to be university prepared like physicians or other healthcare professionals (Manojiovich, 2007). Third, nursing continues to have multiple entry level classifications, the registered nurse and registered practical nurse, with limited differences in the scope of practice between both (CNO, 2018).

In a female dominated profession, it can be questioned whether the struggle with the word expert is actually reflected from a practice or a social conceptualization that is limiting nurses from accepting accolades that many deserve. The term expert could be viewed as a lofty title that women may not feel they can live up to in a hierarchal healthcare system. It was evident from several participants that they could recognize similar characteristics between their own practice and Benner’s (1984) definition of expert but still would not consider themselves an expert nurse. While Benner identifies in her theory that not every nurse will achieve a level of expert, resistance to the term may inhibit some nurses from striving to that achievement due to the gender and hierarchal norms within society related to the word and within the health care system itself.

Perhaps the difficulty or hesitation for nurses to self-identify with the term expert is not related to gender at all. Depending on the nature of the patient complaint or condition, multiple physicians may be consulted according to their expertise but the nurse is required to continue to manage and care for this patient independently. Within this study, the reports from the experts related to autonomy as well as clinical skills that they identified as important to their personal feelings of expert practice were related to labour coaching and support. In the old sites, labour coaching and support skills were the focus of the role of the labour and delivery nurse, which now are identified as something that is
less valued and used minimally in relation to the expanded skills and role expectations in the new setting. In consideration of the expanded role of the labour and delivery nurse, it may be plausible to consider that a nurse can only become an expert in a narrow scope. Parker speaks to this in her statements related to working in the emergency department when she describes that a nurse can be an expert in managing a STEMI, stroke or respiratory distress because they are seen so frequently. Parker further reports that because labour and delivery requires a broad and diverse skill set and major obstetrical emergencies like uterine rupture or amniotic embolus are rare, it is impossible for a nurse to be an expert in managing them. It is possible that the experts in the old sites felt confident in their roles as an expert because the resources were limited and they focused much of their skill on labour support and coaching in a relatively autonomous setting. Perhaps the role of the nurse in labour and delivery has expanded so greatly that it is no longer possible to become an expert or perceive others as expert. Interestingly, those who were insistent that an expert level of nursing was not possible, were also nurses who had experience in other areas of nursing in addition to labour and delivery.

**Significance and Impact of Loss**

In this study, the findings revealed that the self-identified experts experienced loss in many different ways which impacted their perception of themselves as experts at various times throughout their career. The self-identified experts like Alexis, Brenda, Connie and Alice discussed in great detail the loss of not only their skills to coach women through labour, but also the opportunity available to do that because of significant changes within the physical environment, increased available resources and use of technology.
The obstetrics setting is unique in the sense that it seems to fall into a continuous pattern of evolving and devolving. Historically, birth was considered a natural and normal process that was often done at home with a midwife assisting with the delivery. Increased morbidity and mortality rates brought women into the hospital setting where the process saw midwifery care being replaced with physicians and a medical model of care that saw pain relief options increased, breastfeeding decreased and almost complete separation of mom and baby during the almost 14 day hospital stay (Manojiovich, 2007). Late in the 20th century, labour and birth evolved again with increased research and a return to understanding of the natural elements of the labour process which resulted in promoting and empowering women to consider breastfeeding as the preferred feeding method, increased childbirth education for patients and families, the development of family centered care models that included creating home-like environments within the hospital setting and zero separation of mothers and babies unless medically required (Manojiovich, 2007). These cyclical changes in care require nurses to continuously modify their practice and care with the expectation that they are educated on the most current and up to date standards of practice, even if the new practices negated what had been previously understood. With more than one of these models being practiced throughout a nurse’s career, the skills and routine interventions were both initiated and removed from their practice.

Technology is changing the way nurses care for patients (Barnard, 2002; Davis-Floyd, 1987; Forman, 2011). A large part of hospital training is now technical, whether it is equipment or computer technology. With electronic documentation and central monitoring becoming a new normal, a large part of nurses’ professional obligation is to
understand and utilize the computer. Nurses are being valued on their ability to navigate these systems and use them competently. Within the study participants, Connie discussed her experience in relation to her ability to navigate the electronic documentation system. Connie’s comments focused less on her experience with patients and more on the computer. Three decades ago, a study done by Davis-Floyd (1987) had already identified that obstetrical nurses were focusing their attention away from the patient when one study participant stated “as soon as I got hooked up to the monitor, all everyone did was stare at it. The nurses didn’t even look at me anymore when they came into the room—they went straight to the monitor.” (p. 486). We have been given clues for decades that we are too reliant on the machine and need to refocus our nursing attention and skill back to the patient, and the patient experience. Regardless of these warnings, current research has identified our continued lack of patient support.

Evidence based research in the area of obstetrics is something that continues to evolve and be used more consistently as the art of passion, time and patience is becoming compromised (Zwelling, 2008). The objective of evidence based practice is to conduct and utilize research to improve outcomes such as patient safety, patient satisfaction and promote wellness. However, while this process has created desirable outcomes in order to standardize care for all patients, as well as support the professional standards established for nurses to work within, the dilemma is whether the art of nursing continues to be compromised (Zwelling, 2008). When resources were limited, a large portion of the skill set of the labour and delivery nurse was to act as a labour coach who used skills to assist in managing a patient through labour that were both learned through education, but even more through experience and guidance from expert staff. Labour and delivery
nurses utilized these skills (i.e., breathing technique reinforcement, therapeutic touch, nursing presence, focus techniques and comfort support) to guide the patient through the labour process successfully by giving the patient her time, compassion and patience. This was especially true for those patients whose chosen birth plan was not to use pharmaceutical pain relief and limited medical intervention (Zwelling, 2008).

Interestingly, the majority of the expert participants within this study started their career within this era of nursing, and they openly state their feelings of loss as labour and delivery practice moved into a new era of normal. Research, participant dialogue and practice observations indicate that the current challenges in the area of labour and delivery is attempting to balance the normalcy of the birthing experience with the growing technological shift in medical care and its perceived intentions and ‘need’ in order to deliver safer, more effective care (Zwelling, 2008).

Expert participants within this study indicated that the major practice shift that they have experienced since the amalgamation is the loss of skill in labouring and coaching patients and in part due to the normalized demand and availability of pain relief options. Alexis, Connie and Brenda reported that the increased availability of pain relief options, most notably the increased availability of the anaesthesiologists for initiating epidural infusions, is beneficial for the patient if desired; but those patients who are seeking a more natural experience may often be reluctantly convinced that they require these measures in order to have a successful and more memorable labour experience. While the availability of pain relief options are a great resource to the patient who had planned a medicated delivery, it was an easy option for nurses who may be less experienced with coaching a patient through the labour process and removes their
requirement to provide intense support to the patient. As procedures like epidurals are now common options for patients and readily available for them, the less confident the future generation of labour and delivery nurses will be with how to effectively manage and coach a patient through labour. Also, as epidurals decrease the need for the nurse to coach and provide comfort to the patient, the skill set of a labour and delivery nurse will inevitably change. Alexis and Connie clearly articulate their observations that they not only feel that they are personally losing the coaching skills, but that the novice nurses do not have to learn these skills at all. These findings align with the literature well; it has been frequently cited in literature that labour and delivery has become more technical and medicalized and contributes to the reasons that nurses are unable to provide effective labour support while encouraging and implementing low impact interventions like position changes and breathing techniques (David-Floyd, 1987; Edmonds and Jones, 2013; Zwelling, 2008). This loss of skill for the experts and potential avoidance of perfecting these once seamless and mandatory skills contribute to the notion that the definition of expert in labour and delivery in particular is changing.

Since 2005 registered nurses in Ontario have been required to complete a Baccalaureate degree in nursing in order to obtain registration with the College of Nurses of Ontario (Canadian Nurses Association, 2017). Prior to this, college diplomas in nursing were accepted for RN registration within Ontario. Currently, Canadian provinces have inconsistent practice requirements with the eastern provinces requiring BScN prepared RN since as early as 1998 while Quebec and the Yukon provinces are still accepting diploma prepared RNs as entry to practice requirements.
Benner (1984) created her *From Novice to Expert* theory in the early 1980’s when degrees were not a requirement for the RN. Throughout this research participants who identified themselves as proficient yet highly experienced and educated in labour and delivery were not willing to call themselves experts because they felt they didn’t have a solid knowledge of the pathophysiology of all the disease processes and even labour process and complications that they should have to be truly considered an expert. Several of the most experienced participants identified that when they were novice they believed the experts they had worked with also did not truly understand the physiology of care; they identified that the education they received decades ago was not research or theoretically based compared to how nurses are prepared today. Rather, they felt that experience and how to manage complications was the focus of much of their training. As stated by most experienced participants, they felt that those who mentored them in labour and delivery were highly skilled and experienced in managing every obstetrical complication that presented, yet questioned whether they actually understood the root of the problem, what was really happening. Because education qualifications are continuing to change for RNs in Canada, the definition of expert may also need to change or will inevitably change because nurses will have a broader and deeper education base with a better understanding of the rationale for the actions and interventions they are initiating.

Most notably identified by the expert nurse participants, scope of practice was an element of nursing that has changed significantly. With the previously mentioned shift in education requirements there could be potential to see a shift in value from experiential knowledge obtained in the clinical setting to deep rooted scientific knowledge that was not a focus in the past. Some participants identified that they had never worked with
expert nurses who they felt were able to explain the roots of any action to the scientific or anatomical level they determined should be understood by an expert. One expert opinion was that the deep level understanding has only ever been held by the physician and not any of the nurses that she has worked within 25 years in labour and delivery. There was validation among the expert nurses that the past norm of providing care in the way it was always done is not acceptable anymore in practice. Nursing continues to move quickly and deeply into the scientific, evidence based profession it has been attempting to achieve. While this is significant for the profession in order to continue to advance and build credibility as a professional body, it can be seen even in this research that the art of nursing may actually be at risk of being overshadowed by the science of nursing. This challenges Benner’s idea of expert and encourages further research related to whether there is a need to redefine the expert or whether the definition of expert in labour and delivery is slightly different than Benner’s definition.

Redefining Expert

The results of this study challenge both Benner’s (1984) definition of expert nursing and those cited in the literature review of this study. Benner (1984) identifies a linear model of skill acquisition identifying that while possible, not all nurses will reach the level of expert. As stated in chapter three, Takase (2012) identified that the achievement of novice through expert was not as linear as Benner’s theory suggests but rather is a curve that levels out once a nurse achieves expert, Jantzen (2008) reported similar results. Within this study, expert was not described as a plateau in one’s career but rather a fluid concept that can increase or decrease in response to factors like environment and technology. Jantzen (2008), Bobay and colleagues (2007), Tabari-
Khomerian and colleagues (2007) and Takase (2012) strongly identified that education and experience were the driving characteristics toward increasing competence. However, my study identified a stronger link between autonomy, external factors and people’s perception of skill level.

To further challenge Benner’s linear model, the report that experts have felt devalued toward the end of career experts raises the question of whether the expert remains an expert for the duration of their career or if there may actually be a peak performance level. Late career experts and the perception of an expert nurse requires further research in order to further understand the fluidity of expert. Questions related to whether the expert is always valued in the clinical setting or whether their expertise becomes redundant as the environment they work in changes, warrants further study.

Since the study participants were recruited from a labour and delivery unit that had recently experienced an amalgamation of three smaller sites into one large site, there were changes in available resources, staffing and funding which meant more options for patients (i.e. outpatient assessment clinics, triage unit, increased physician coverage, availability of anaesthesiologists for epidurals). With an increase in physician coverage, medical clerks and residents there has been a decrease in the need for independent nursing assessments. For nurses that were used to performing unsupervised assessments and making decisions for admission of labour and discharge in early labour, it was identified by the experienced participants that their skills and assessment experience were deemed not necessary on a routine basis. The physicians were less willing to allow the RN to conduct their own assessments when they were readily present to do them. The availability of physician learners, who were eager for practice of vaginal exams, resulted
in the nurse no longer being expected to perform these skills as frequently. Consequently the nurses began feeling both less respected and a reduction in autonomy leading to a loss of confidence in many skills.

The experts within this study discussed limitations and a sense of loss related to their continued feelings of being an expert and confident in their practice. Many participants identified that they felt more confident as expert previously in their career. Several factors have influenced their feeling toward expert including environment, technology, resources and relationships with physicians and coworkers. This finding contributes insight into Benner’s (2001) expert level, adding further depth to the need to redefine expert. The expert nurse is fluid and variable, not a fixed state of being or final stage of one’s career. The changes and addition of new skills may cause expert level nurses to shift their perceptions of expert or at least provide new insight that additional skills and knowledge are required in order to maintain the perception of expert.

Considering both the present literature and the results of this study, it is reasonable to assume that the definition of an expert in labour and delivery will change from the emphasis that the current self-reported experts have identified as a focus related to labour coaching and support.

While the framework and focus of this study was relative to the way that Benner (2001) defined expert, future study relative to expert nursing in labour and delivery would warrant expansion towards the consideration of additional theories that describe the expert nurse as well as theories outside of nursing that could lend an alternate perspective.
Conclusion

The purpose of the study was to explore the phenomenon of expert nursing in the area of labour and delivery. Through a transcendental phenomenological lens, the question ‘what constitutes an expert registered nurse in labour and delivery?’ was examined. Through utilization of Moustakas’ (1994) modified Stevick-Colaizzi-Keen method of analysis, three themes were identified including characteristics of expert RN in labour and delivery, significance and impact of loss, and difficulties with the word expert. While several identified attributes of the expert nurse were anticipated results and discussed comprehensively within Benner’s theory, what was different was the link between nursing autonomy and environment as well as the relational or psychosocial element that pushes Benner’s theoretical understanding of the expert nurse to a level that suggests further research is required. Within this study, expert was described as a fluid concept, aligning with the literature that refutes Benner’s linear concept of skill acquisition. The findings illustrate that nurses’ perception of themselves as experts can increase or decrease in response to factors like environment, culture, technology and even years of experience. Inclusion of the patient experience would be also be valuable in order to determine how the changes to the nursing role in labour and delivery and reduced amount of continuous labour support impacts the perception of what defines an expert registered nurse in labour and delivery. Notably, it was determined that expert was difficult to define; while Benner (1984) may have come close in her theoretical definition in the From Novice to Expert theory, it remains elusive.
Final Reflection

The decision to complete this thesis within a site and participant population that I am immersed in and know personally was a choice that I reflected on at the start of this project as well as throughout the entire research process. It was determined, with the assistance and understanding of Moustakas’ (1994) phenomenological research methods, that it would be both beneficial to the research process and my professional position within the area of study as the best site for a master’s thesis project. However, even though epoche was completed prior to research development and data collection, I struggled multiple times throughout the study with being an objective researcher due to my closeness to the participants.

As per Research Ethics Board obligation, I made every effort to maintain participant confidentiality from the position of myself as the PI. Because I work with the participants, interviews were completed at Brock University or an alternate public location of the participants choosing; communication was conducted outside of the hospital setting through electronic communication and follow up interviews were again conducted mainly at Brock University. However, after the completion of the interviews, I began to notice and observe discussion within the recruitment setting that occurred related to the concepts of expert nursing within the area of labour and delivery that had been addressed in the interviews. I also started to observe discussions related to the use of Benner’s theory to understand levels of nursing practice (i.e. novice, competent, and proficient). On multiple occasions, participants attempted to engage me in conversation related to the study or I observed discussion from participants to another professional (i.e.
physician, administrator) in the form of excitement of the work that I was in the process of researching.

A memorable experience occurred in the hospital setting when I was working on a shift with more than one study participant who at that time were still anonymous to each other; they began a conversation with each other about the study and ultimately revealed to each other that they were participants in the study. Upon confirmation among each other that the three of them were in fact all participants through voluntary disclosure on their parts, I reminded them that I could not engage in discussion related to study results particular to their individual responses as well as the fact that participants were to remain anonymous, one replied, “is not the decision to remain anonymous or not for our OWN protection and the choice to reveal our participation also our own choice?” While participants are all protected by pseudonyms within the study, this conversation was difficult to navigate and provided me with a moral dilemma in order to maintain and protect the participants. Having chosen to study an alternate labour and delivery setting would have completely removed me from this element of personal interaction with participants outside of the study.

However, apart from the personal conflicts that had to be dealt with throughout the course of the study, the decision to study this labour and delivery unit in particular was still confidently one that I would make again. The major changes that have occurred within this site over the last five years created a platform for data collection that may not have been revealed had I studied a site that had been relatively unchanged related to culture and environment. Interestingly, since data collection was completed almost 18 months ago, the studied unit has had a major turnover losing even more experienced staff
members to work on other units within the health care system and retirement. Through
discussion with the unit manager of the studied site, it was revealed that 20 new staff
have been hired on this unit since the study recruitment began (16 months ago). Of these
20 new staff, only six of them have had any previous labour and delivery experience. If
performing the study now, it is possible that the results would vary significantly
considering there would be a smaller proportion of eligible participants (those with at
least one year of experience) to be recruited. In addition, those that were not eligible to
participate at the time of recruitment, having less than one years’ of experience, may have
considered involvement which would both have decreased the number of experienced
nurses who participated, potentially making it relevant to increase the number of
participants in order to reach data saturation. As well, the valuable perspective of those
who shared their experience with the amalgamation of the three hospital sites may have
been less available as there is now a higher ratio of staff that were hired after the move
than those who experienced it.

After completing this study, I believe it would be valuable to study other units
that have either experienced centralization of services/new build transitions and/or high
turnover rates causing an increased ratio of novice to experienced registered nurses in
labour and delivery in order to have a clearer understanding of this phenomenon.
References


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Appendix A: Participant Recruitment Poster

Labour & Delivery Registered Nurses…
I want to hear from you!

If you are currently working or have previously worked as a Registered Nurse in labour and delivery for at least one year, I invite you to participate in a research study to explore your understanding of what constitutes an expert registered nurse as well as you understanding and experience working with or as an expert, through the study titled:

What Constitutes an Expert Registered Nurse in Labour and Delivery?: A Phenomenological Inquiry.

If you are interested in participating in this study, an in person interview will be requested of you at a time of your choosing. If you are interested in participating or have questions regarding the study, please feel free to contact me.

Kimberley Bowen
MA Candidate Applied Health Science (Nursing)  
Brock University  
kimberley.bowen2@brocku.ca

If interested in participating but do not feel comfortable contacting me for an interview, please contact the following who will ensure that an anonymous interview is arranged.

Dr. Dawn Prentice
Faculty Supervisor, Associate Professor & Chair  
Brock University, Department of Nursing  
dprentice@brocku.ca

As a thank-you for participating, a $10 Tim Horton’s card will be given to all participants at the end of the interview session!

If you have any pertinent questions about your rights as a research participant, please contact the Brock University Ethics Officer (905-688-5550 ext. 3035 or reb@brocku.ca) or Niagara Health System Ethics Officer (905-378-4647 ext. 32202 or nhresearchethicsboard@niagararegional.on.ca). This study has been reviewed and received ethics clearance through both Brock University’s Research Ethics Board [File #15-247-PRENTICE] and Hamilton Integrated Research Ethics Board [File # 08-024].
Appendix B: Letter of Invitation to Research

Date:

**Title of Study:** What Constitutes an Expert Registered Nurse in Labour & Delivery?: A Phenomenological Inquiry.

**Principal Student Investigator**
Kimberley Bowen
MA Candidate
Brock University
Department of Applied Health Science
kimberley.bowen2@brocku.ca

**Faculty Supervisor**
Dr. Dawn Prentice
Associate Professor & Chair
Brock University
Department of Nursing
dprentice@brocku.ca

**Locally Responsible Investigator**
Natalie Doucet
Nurse Educator
Niagara Health System
Women, Babies & Children’s Health
natalie.doucet@niagarahealth.on.ca

**INVITATION**
You are invited to participate in a study that involves research. The purpose of this study is to explore how nurses in the area of labour and delivery would describe an expert nurse.

**WHAT’S INVOLVED**
As a participant, you will be asked to participate in an in person interview with the principal student investigator listed above. If you would like to participate in the study but are not comfortable conducting the interview with the principal student investigator, an interview can be conducted with the faculty supervisor. If you would prefer to remain anonymous from the principal student investigator, please contact the faculty supervisor directly to arrange an interview in a confidential location of your choosing. Interviews will take place on the date, time and confidential location of your choosing without conflicting with your personal work schedule. If applicable, parking fees will be paid by the researcher. As a thank you for your willingness to participate in this research, a $10 Tim Hortons gift card will be provided to you at the completion of the first interview.

You will be asked to provide detailed descriptions of your personal thoughts and experiences in nursing and recall details related to your experiences working as a labour and delivery nurse as well as experiences working with colleagues addressed through an interview style set of
questions. Your participation will take approximately one hour of your time. A second, follow-up interview will be requested which will take approximately 30 minutes of your time. This interview is not mandatory and any remuneration from the first interview will not be revoked if you choose not to participate.

POTENTIAL BENEFITS AND RISKS

While there are no direct benefits to participating in the study, indirect benefits include the potential to contribute to a study that is addressing a current gap in research related to the concept of expert nursing in labour and delivery and the potential advancement of theoretical concepts associated with Benner’s *From Novice to Expert* theory. By understanding the meaning of and role of the expert nurse in this setting we can better understand how the expert nurse may impact staffing ratios, future nursing education, facilitation of nurse advancement in skill level and validation of nursing theory.

If the Principal Student Investigator, Kimberley Bowen, is a known individual to you, there is a potential risk that you may feel coerced into participating in this study. In order to mediate this risk, I would like to remind you that your participation is completely voluntary. If you feel that you would like to participate in the study but would not like to be interviewed by Kimberley Bowen, please contact the Faculty Supervisor Dr. Dawn Prentice who will make arrangements for you to be interviewed and remain anonymous.

CONFIDENTIALITY

Data collected during this study will be stored on a hard drive and password protected flash drive of the primary researcher exclusively. Audio recordings of interviewed will be deleted once verbatim transcripts have been completed which will occur immediately following the interview. Data will be kept for the duration of the study which is anticipated to be completed within two years from data collection. Access to this data will be restricted to the primary researcher, faculty supervisor and thesis committee members as required. All hard copy consents and transcripts will be kept in a locked file when not being utilized by the researcher and destroyed within two years of your interview date.

The information you provide will be kept confidential. While every effort will be used to maintain participant anonymity, the employer name will appear on documents included in the final thesis report. The employer name will not be identified in further publications or the oral thesis presentation. Within this research study and with your permission, anonymous quotations may be used within both presentations and publications of the data. Due to the small sample size and inclusion criteria, it may be possible for colleagues to link participant comments to their identity.

In order to strengthen the confidentiality of both yourself and others, please do not share the names, identifiers or personal information of yourself or the coworkers you may be discussing throughout the interview.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of
benefits to which you are entitled. If choosing to withdraw at any point in the study, any confidential data provided to the researcher will not be utilized within the study and all data will be destroyed. Please do not feel any obligation to participate in this study, regardless of the professional relationship you may have with the researcher(s). Please also be advised that your decision to participate in this research study will in no way effect your professional position or standing at the hospital or within the healthcare system.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Confidentiality of participants will continue to be upheld through any publication reports.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact Kimberley Bowen or Dr. Dawn Prentice using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [File #15-247-PRENTICE] and the Research Ethics Board at the Niagara Health System (Hamilton Integrated Research Ethics Board) [File# 08-024]. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca and/or the Research Ethics Board at the Niagara Health System at (905) 378-4647 Ext. 32202, nhsresearchethicsboard@niagarahealth.on.ca

Thank you for your assistance in this project. Please keep a copy of this form for your records.
Appendix C: Informed Participant Consent

Date:


Principal Student Investigator
Kimberley Bowen
MA Candidate
Brock University
Department of Applied Health Science
kimberley.bowen2@brocku.ca

Faculty Supervisor
Dr. Dawn Prentice
Associate Professor & Chair
Brock University
Department of Nursing
dprentice@brocku.ca

Locally Responsible Investigator
Natalie Doucet
Nurse Educator
Niagara Health System
Women, Babies & Children’s Health
natalie.doucet@niagarahealth.on.ca

INVITATION

You are invited to participate in a study that involves research. The purpose of this study is to explore how nurses, with one year or more experience in the area of labour and delivery, would describe an expert nurse.

WHAT’S INVOLVED

As a participant, you will be asked to participate in an in person interview with the principal student investigator listed above. If you would like to participate in the study but are not comfortable conducting the interview the principal student investigator, an interview can be conducted with the faculty supervisor. If you would prefer to remain anonymous from the principal student investigator, please contact the faculty supervisor directly to arrange an interview in a confidential location of your choosing. Interviews will take place on the date, time and confidential location of your choosing without conflicting with your personal work schedule. If applicable, parking fees will be paid by the researcher. As a thank you for your willingness to participate in this research, a $10 Tim Hortons gift card will be provided to you at the completion of the first interview.

You will be asked to provide detailed descriptions of your personal thoughts and experiences in nursing and recall details related to your experiences working as a labour and delivery nurse as well as experiences working with colleagues addressed through an interview style set of questions. Your participation will take approximately one hour of your time. A second, follow up interview will be requested which will take approximately 30 minutes of your time. This interview is not mandatory and any remuneration from the first interview will not be revoked if
you choose not to participate. A summary of results will be sent to the email address you provided within 3 months of the interview completion.

POTENTIAL BENEFITS AND RISKS

While there are no direct benefits to participating in the study, indirect benefits include the potential to contribute to a study that is addressing a current gap in research related to the concept of expert nursing in labour and delivery and the potential advancement of theoretical concepts associated with Benner’s *From Novice to Expert* theory. By understanding the meaning of and role of the expert nurse in this setting we can better understand how the expert nurse may impact staffing ratios, future nursing education, facilitation of nurse advancement in skill level and validation of nursing theory.

If the Principal Student Investigator, Kimberley Bowen, is a known individual to you, there is a potential risk that you may feel coerced into participating in this study. In order to mediate this risk, I would like to remind you that your participation is completely voluntary. If you feel that you would like to participate in the study but would not like to be interviewed by Kimberley Bowen, please contact the Faculty Supervisor Dr. Dawn Prentice who will make arrangements for you to be interviewed and remain anonymous.

CONFIDENTIALITY

Data collected during this study will be stored on a hard drive and password protected flash drive of the primary researcher exclusively. Audio recordings of interviewed will be deleted once verbatim transcripts have been completed which will occur immediately following the interview. Data will be kept for the duration of the study which is anticipated to be completed within two years from data collection. Access to this data will be restricted to the primary researcher, faculty supervisor and thesis committee members as required. All hard copy consents and transcripts will be kept in a locked file when not being utilized by the researcher and destroyed within two years of your interview date.

The information you provide will be kept confidential. While every effort will be used to maintain participant anonymity, the employer name will appear on documents included in the final thesis report. The employer name will not be identified in further publications or the oral thesis presentation. Within this research study and with your permission, anonymous quotations may be used within both presentations and publications of the data. Due to the small sample size and inclusion criteria, it may be possible for colleagues to link participant comments to their identity.

In order to strengthen the confidentiality of both yourself and others, please do not share the names, identifiers or personal information of yourself or the coworkers you may be discussing throughout the interview.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of benefits to which you are entitled. If choosing to withdraw at any point in the study, any confidential data provided to the researcher will not be utilized within the study and all data will be destroyed. Please do not feel any obligation to participate in this study, regardless of the professional relationship you may have
with the researcher(s). Please also be advised that your decision to participate in this research study will in no way effect your professional position or standing at the hospital or within the healthcare system.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Confidentiality of participants will continue to be upheld through any publication reports.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact Kimberley Bowen or Dr. Dawn Prentice using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University [File #15-247-PRENTICE] and the Research Ethics Board at the Niagara Health System (Hamilton Integrated Research Ethics Board) [File# 08-024]. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca and/or the Research Ethics Board at the Niagara Health System at (905) 378-4647 Ext. 32202, nhsresearchethicsboard@niagarahealth.on.ca

Thank you for your assistance in this project. Please keep a copy of this form for your records.

CONSENT

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may be contacted again if further questions, clarifications or content development is required by the researcher in the future. I understand that I may withdraw this consent at any time.

Name: __________________________________________________________________________
Signature: _______________________________ Date: ________________________________

FOLLOW UP

Will you be willing to be contacted for a second interview?
Yes _________
No____________

Would you like to receive a summary of the overall study findings upon conclusion of the study?
Yes _________.
If yes, please provide an email address where you would this information sent.
________________________________________________________________________
No __________
Appendix D: Interview Questions

Introductory Phase: Personal understanding of theory and practice
Please review the descriptions of Benner’s five stages of skill development (handout)
1. Now that you are familiar with Benner’s descriptions of the five skill levels, at what level would you identify yourself based on these descriptions?
2. How long have you worked in labour and delivery?
**Please think about your personal perceptions and realize that you may identify someone as an expert even if they would not identify themselves as one**
3. Considering this, do you think you work with people in all five of these stages?

Experience with the Phenomenon: Process
4. Talk to me about how you would identify someone as an expert in labour and delivery?
   a. How long do you feel it takes for a nurse to become an expert in labour and delivery?
5. Have you ever observed expert performance in your workplace?
   a. What was it about this person that made you think they were an expert?
   b. What is unique about labour and delivery that could influence a nurse from becoming an expert?
6. Talk to me now about process, how does a nurse go from a novice towards the level of expert?
7. How has working with nurses of different skill levels impacted you as a nurse?

Experience with the Phenomenon: Theory
8. Benner defines intuition as “understanding without a rationale” (Benner, & Tanner, 1987, p. 23); have you ever utilized intuition or witnessed another nurse use intuition while working in labour and delivery? Can you share some of these experiences with me?
9. When you are thinking about your practice or reflecting on a shift, is there a general focus (i.e. knowledge, skill, patient outcome)?
   a. Has the focus of your reflection changed since the start of your career?
   b. How would it have impacted your practice if nurses had shared their challenges and/or successes and their thoughts surrounding these experiences with you?

Experience with the Phenomenon: Challenging the theory through research
10. The nurse patient relationship is a really integral part of labour and delivery nursing. Do you think this is an important component of becoming an expert?
   a. Talk to me a bit about some specific examples

Conclusion: Answering the research question
11. How would you answer the question, what constitutes an expert registered nurse in labour and delivery?
12. Are there any other thoughts or ideas you would like to share with me before ending this interview?

Follow Up
Are you willing to be contacted for a second interview at a later date/time?

References
Appendix E: Summary of Findings

After the completion of all participant interviews, all statements were organized and analyzed in order to identify the ones that were most significant in answering the research question and contributed most to the phenomenon of, what constitutes an expert registered nurse in labour and delivery?

Through this analysis, three major themes emerged:
1. Characteristics of an expert RN in labour and delivery
2. Difficulties with expert and its relationship to clinical setting
3. Loss is real; with positive and negative impacts on growth within the nursing profession.

The following is a synopsis of the three themes for your review. Please consider them carefully to determine if you feel they are an accurate portrayal of either what you intended to contribute to the topic. Please feel free to contribute any additional statements or feelings about the question to the researcher at this time and ask questions a required for clarification of content.

**Theme #1: Characteristics of an Expert RN in Labour & Delivery**

Every respondent, regardless of how they classified their level of experience, was asked to identify the qualities of an expert registered nurse in labour and delivery. All respondents described similar characteristics of what they perceive an expert to be. Participants described an expert as one who is autonomous, educated, experienced, exudes passion for nursing, communicates well and works well as a team (with other experts, junior staff and interdisciplinary team members). Participants described expert nurses as being able to manage crises, be reflective, intuitive, provide mentorship and be storytellers/relay nursing narratives related to past experiences to those less experienced. Expert nurses were described as being appreciated for their expertise as well as able to use their expert level skill to provide safer care, stronger and more meaningful nurse/patient relationships and balance both the psychosocial and physical elements of patient care required to nurse effectively in the labour and delivery setting.

The characteristics that were explored in great detail include autonomy, intuition, effective communication, appreciating the novice; these characteristics are unique in the sense that they either challenge Benner’s theory description, provide a unique perspective to what was previously understood in the literature and/or contribute new knowledge or understanding. While almost all qualities of an expert were identified by participants as positive and valuable, two unfavourable characteristics related to reflection and devaluing novice nurses were identified and were further explored.
Autonomy:

- The participant experts in the study articulated that they felt as though their perceptions of being expert nurses were stronger when they worked in the smaller hospital sites because they felt they exercised a greater amount of autonomy than they are able to in the current setting. Several expert and proficient nurses who worked in one of the three old sites described the environment as one that was predominantly nurse centered.
- It was identified by many participants that significant changes have occurred within the physical environment and the culture of the labour and delivery unit, most notably over the last three years with the previously identified amalgamation of the three hospital sites and integration of a labour and delivery run operating suite for caesarean sections.
- Nurses who were feeling as though they were experts in their role prior to these changes, expressed feeling less confident in their title of expert, but most maintained that they would still call themselves an expert.

Intuition:

- Misunderstanding or misinterpretation of intuition as defined by Benner (2001) was common among participants. All of the experts who participated identified that they were able to recognize within themselves that they acted intuitively at this point in their career but provided examples that contradicted the definition of intuition that Benner outlines. The majority of the examples provided by participants reflected an element of objectivity or assessment that guided their actions rather than intuition alone.
- All participants regardless of skill level were able to identify that intuition exists in some sense within practice. While the novice and advanced beginners expressed that they believe they had witnessed intuition at some point in their observations in practice they expressed that they were not convinced it fit the definition that Benner describes. They were less confident in the role that intuition plays in practice. While proficient nurses identified that they definitely had witnessed intuition utilized in practice and most could provide examples these situations.
- Several identified that confidence in the intuitive essence of their practice was one of the elements that was holding them back from identifying themselves as an expert. Expert nurses were confident in intuition in both themselves and in other experts. It was identified by an expert how the process of using intuition in practice only was truly recognized when she became an expert and had the tools to truly accept and integrate intuition into her practice. It was identified that lack of acceptance of intuition in practice was a major barrier to effectively using and recognizing intuition in practice.

Effective Communication:

- Patient centered and family centered care was deemed important with participants having mixed views on which care model was most significant when providing care in the labour and delivery setting. However, how the patient communicated with the nurse and what elements of care were categorized as priorities were
unique among those nurses who classified themselves as experts. Physical care of the patient was discussed throughout every participant interview. There was a large focus on how to effectively care for a patient, how to keep them safe, and the ability to predict outcomes. While these elements of care are vitally important to practice, the psychosocial element of care was discussed in greater detail from those who identified as proficient and/or expert nurses.

- One participant with 25+ years of experience discussed her feelings about how a nurse should interact with patients. While most respondents discussed prioritizing, anticipating and acting on the physical needs of the patient, it was identified that it has been observed that more novice nursing staff may not always prioritize something as simple as ‘presence’ as a priority for care. This observation was reinforced in discussion with some of the more novice nurses stating that due to lack of experience they often feel unable to integrate the psychosocial element of care in to care as they are still so focused on completing care tasks.

Appreciating the Novice:
- It was identified through participant discussion that novice nurses entering practice currently are in a unique position. While the nurses who worked through the amalgamation are still in a position of learning and relearning skills like the operating room roles and electronic charting; these novice nurses are starting their clinical education, training and experience with these elements as a routine part of their job.
- These skills will be built into the foundation of their practice and they will continue to build experience in them as time moves on which is different than the radical changes that many of the proficient and expert nurses have had to navigate recently within this particular nursing unit. Additionally, they are entering practice with a natural comfort and confidence in technology in general, making it easier for them to learn and accurately use these resources to care for their patients.

Theme #2: Significance and Impact of Loss

Loss was identified as one of the major themes that emerged through the participant narratives with two very different relationship characteristics, however both linked to the environment. The loss of physical environment and perceived sociocultural changes among staff were most predominant within the participant’s discussion.

Level of autonomy was expressed as impacting participants most prominently in a new environment. It was expressed that within the nursing profession, the nurse’s level of autonomy depends on several factors including level of experience, working environment and resources available to the nurse. The expert participants in the study articulated that they felt as though their belief of being an expert was stronger when they worked in the smaller hospital sites than once they started working in the larger amalgamated one. Nurses who worked within the old setting expressed that they felt a greater sense of autonomy and worked within a larger scope of practice than in the new setting. Linked to feelings of a loss of autonomy were feelings related to loss of physician respect-
specifically in relation to the nurse’s ability to function autonomously in the new setting. These perceived reductions in autonomy related mostly to the fact that there were now in-house physician coverage on the unit, a new resource to all nurses who had previously worked in the community settings. However, several participants identified that this did increase patient safety.

Nurses who had identified themselves as experts both now and prior to the amalgamation discussed their feelings of being ‘less of an expert’ due to the previously mentioned factors but also due to added skill sets that they were required to learn due to the hospital amalgamation into the larger site. However, it was also discussed multiple times by participants that they did not feel they needed to include this new skill in their scope of practice in order to continue to identify themselves as experts in the area of labour and delivery.

The participants identified that a major loss related to their current working environment is related to changes in nursing staff and subsequently the loss of experts; those with not only decades of experience but also decades worth of nursing narratives, clinical stories and the knowledge transfer that goes along with that. Participants that self-identified as proficient and expert expressed concern related to the next generation of experts and whether their development towards the level of expert has been jeopardized because of the radical changes to the environment, impact of technology and increased resources.

All participants placed emphasis on the understanding of technology in defining success in practice. Understanding and confidence with technology was identified by several participants, even experts as indicators for success. All of the participants who identified themselves as experts discussed that they have felt like less of an expert at times since originally feeling they had achieved a level of expert.

**Theme #3: Difficulty with the Word “Expert”**

It was described by several participants that becoming an expert was either not achievable within the labour and delivery setting or that the word expert too closely resembled the word ‘perfect’, with discussions related to the feasibility of nurses ever being perfect. Several participants stated that while they could place themselves within the provided definition of expert according to Benner (2001), they would never call themselves an expert due to a preconceived idea that they would then be required or providing the impression that they know everything, then expected to represent perfection in the clinical setting at all times.

Working in a variety of difference clinical settings (i.e. medical, surgical, emergency) was perceived to impact the definition of expert for several participants, but changing the physical environment within the same clinical areas was also noted to change some participant’s definition of expert. From a novice perspective, one participant identified that due to the nature of the unit and the experience backgrounds of each nurse, it would be expected that the time it takes for a nurse to achieve expert level depends on the care area(s) they have worked in.

**Reference**

Appendix F: Modifications of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological Data

1. Using a phenomenological approach, obtain a full description of your own experience with the phenomenon.

2. From the verbatim transcript of your experience complete the following steps:
   a) Consider each statement with respect to significance for description of the experience.
   b) Record all relevant statements.
   c) List each non-repetitive, non-overlapping statement. These are invariant horizons or meaning units of the experience.
   d) Relate and cluster the invariant meaning units into themes.
   e) Synthesize the invariant meaning units and themes into a description of the textures of the experience. Include verbatim examples.
   f) Construct a textural-structural description of the meanings and essences of your experience.
   g) Construct a textural-structural description of the meanings and essences of your experience.

3. From the verbatim transcript of the experience of each of the other co-researchers, complete the above steps, a through g.

4. From the individual textural-structural descriptions of all the co-researchers’ experiences, construct a composite textural-structural description of the meaning and essences of the experience, integrating all individual textural-structural descriptions into a universal description of the experience representing the group as a whole.

(Moustakas, 1994, p. 122)