EXPLORING AND CONTEXTUALISING EXPERTISE IN RELATION TO THE SAFEGUARD LEAD NURSE

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ABSTRACT

Exploring and Contextualising Expertise in relation to the Safeguard Lead Nurse

Michelle Felton

Aim and objectives: The aim of this study is to understand what defines an expert practitioner within a safeguarding service. The objectives are to explore the concepts of 'expertise' and 'the expert', to determine what safeguarding leads perceive to be the characteristics of their role and to offer recommendations for supporting and developing the role of the Safeguard Lead Nurse (SLN) as an expert practitioner; a role that developed as a result of increased adult abuse.

Methodology: A phenomenological approach using semi-structured interviews was used to explore purposively selected informants' current practice as an SLN. The informants were selected purposively and several healthcare organisations were approached in order for them to allow their SLNs to take part. The information collected from the interview process was manually analysed using Framework, a manual method that can be used to examine and order data.

Findings: It was determined that the notions of expertise and the expert practitioner develop from on-going practice, in-depth knowledge, related to a specific topic, and experience. It is these three factors that enable a practitioner to develop autonomy. However, it is their interest and personal motivation that drives their continued development, in a specialist area such as safeguarding vulnerable adults, and produces extensive relevant knowledge that others acknowledge as expertise.

Conclusions: The findings demonstrated that expertise, experts and safeguarding vulnerable adults are social constructs that exist as a result of changing societal attitudes. As such, their definitions and understanding can change on a daily basis. SLNs have acquired relevant in-depth knowledge and experience in less than ten years and, as a result, are acknowledged as possessing more knowledge than others in this specialist area. SLNs face a challenge in developing this specialism due to its complexity, within a diverse multi-cultural society, while adhering to anti-discriminatory practice and upholding UK legislation.

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GLOSSARY OF ACRONYMS

CQC	Care Quality Commission
CRB	Criminal Records Bureau
CVA	Cerebrovascular Accident
DBS	Disclosure and Barring Service
DH	Department of Health
DoLS	Deprivation of Liberty Safeguard
EPA	Enduring Power of Attorney
EPP	Expertise in Practice Project
HCPC	The Health and Care Professions Council
LPA	Lasting Power of Attorney
MCA	Mental Capacity Act
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NMC	Nursing and Midwifery Council
PEO	Population, Exposure, Outcome
POA	Power of Attorney
POVA	Protection of Vulnerable Adults
PVG	Protection of Vulnerable Groups Scheme
SAB(s)	Safeguarding Adult Board(s)
SCIE	Social Care Institute for Excellence
SLN/SLNs	Safeguard Lead Nurse(s)
SOVA	Safeguarding of Vulnerable Adults

CHAPTER 1: THE CONTEXT AND DEVELOPMENT OF SAFEGUARDING EXPERTS

1.1 INTRODUCTION

This thesis explores the concept of an expert and expertise in relation to safeguarding vulnerable adults. Chapter 1 explores the social construction of vulnerability and the factors that lead to an adult being viewed as such. Four factors are considered:

- Defining vulnerable adults
- The relationship between the nursing profession and safeguarding
- Protection of vulnerable adults from abuse, a term that can be used synonymously with harm
- A detailed examination of the legal and professional context, in the United Kingdom, in which SLNs operate. SLN is the identity that was adopted for the participants who were nurses employed as a safeguarding vulnerable adults lead. This identity reflected their safeguarding roles which included either the term safeguard(ing), nurse, or lead in the job description they provided during the interview.

The chapter concludes with a research question and sets out the structure of the thesis.

1.2 Social Constructs

Social constructs are a result of changing societal attitudes (Searle, 1997; Fawcett, 2009); safeguarding, vulnerable, expert, and expertise are social constructs.

This draws our attention to the constructivist belief that reality exists only as a result of social exchanges that are interpreted and understood. Therefore, they cannot be measured or quantified because these exchanges are dynamic and change within the context in which they are used (Bryman, 2001). Consequently, this indicates that social constructs are ephemeral and that meanings and understandings are prone to change which makes them challenging to explore, but not impossible.

1.3 Defining a Vulnerable Adult

There is no definitive descriptor for 'vulnerable'. However, the Department of Health (DH) (2000) defines a vulnerable adult as:

> "*anyone over 18 who is or may be in need of community care services as a result of mental or other disability, age or illness and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation"* (DH, 2000:8).

Although, the DH (2000) provides this definition, the meanings and interpretations attached to the concept of vulnerability can frequently change. As a result, the aspiration to protect vulnerable adults may prove challenging to achieve. Additionally, practitioners can lack relevant experience, practice, in-depth knowledge and specific training.

According to the DH (2000):

> *"Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological. It may be an act of neglect or an omission to act, or it may occur when an adult is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation of, the person subjected to it"* (DH, 2000:8).

The task of protecting vulnerable adults is made more complex because more than one type of abused adult exists (Mull, 2017):

1. An abused adult can be the victim of abuse inflicted by a family member, or a close friend. The abused adult may not want to upset their abuser, confront them, believe they would intentionally harm them or, does not view their abuser's actions as abuse. The victim might also be ashamed to admit the abuse is happening.
2. The abused person may lack the mental capacity to understand they are being ill-treated (Mull, 2017).

In addition, there are a number of recognised perpetrators:

1. An abuser who knowingly abuses another (Martin, 2007).
2. An abuser who lacks the awareness to understand abusive actions may act with the best intentions. Nonetheless, their actions might be interpreted as abusive because several types of abuse have been identified (Mull, 2017).
3. The abuser who does not perceive their behaviour to be abusive due to cultural beliefs (Chrome, 2014).

Holistically assessing a case of adult abuse, and achieving an appropriate outcome, is likely to rely on related experience. This experience may have been acquired over a prolonged period of time, or by frequent exposure to the abuse of adults.

1.4 BACKGROUND TO THE STUDY

Safeguarding in the United Kingdom is the term used to denote the protection of vulnerable children and adults from abuse and neglect. The stated intention of this protection is described by the Department of Health as follows:

> *"Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and well-being"* (DH, 2011).

Cases of abuse are managed using the same procedures and policies regardless of whether they happen in a domiciliary environment or within a care, nursing or residential home (SCIE, 2011). When abuse is suspected, there is an expectation that the abused adult is respected, listened to, involved and consulted in each step of the safeguarding process. Not including the abused individual can lead to suspicion, allegation or investigation and further abuse (Nursing and Midwifery Council (NMC, 2015).

Safeguarding is a specialist role which is recognised by various NHS organisations through their job descriptions (Appendix 1); the SLN role developed as a result of various investigations that highlighted the extensive abuse of vulnerable adults (CQC, 2011; Francis, 2013; NMC, 2015). Professionals entering the specialist area of safeguarding vulnerable adults require in-depth knowledge, education and appropriate training related to this growing area of

interest and concern (Nisbet, 2013; Betts et al, 2014). Without the appropriate skill set, the potential for them to make mistakes increases (Martin, 2007). Even with training, knowledge and experience, situations may be interpreted differently by individual assessors and mistakes may still be made.

Besides the NMC, NHS England, the Health and Care Professions Council (HCPC), Care Quality Commission (CQC), NHS commissioners and the Social Care Institute for Excellence (SCIE) are professional bodies regulating practice and ethics related to fitness to practice.

1.4.1 Safeguard Training

Child abuse has traditionally received more attention than adult abuse, and continues to do so. Awareness of child abuse existed for many years before the same could be said of abuse related to vulnerable adults (Martin, 2007; Baeza, 2008). Vulnerable adults and children can be subjected to similar forms of abuse. These can include sexual abuse, neglect and physical abuse (Stevenson, 1996; Johns and Sedgwick, 1999; DH, 2000; Martin, 2007; Nisbet, 2013). Although relevant training, related to safeguarding vulnerable adults, has not been available for as long as training in safeguarding children, the various forms of adult abuse currently identified, establishes the need for increased training in this specialism.

Despite the lack of training and education related to safeguarding vulnerable adults (Martin, 2007; Nisbet, 2013; Betts et al, 2014), there is an expectation that every healthcare professional is able to recognise abuse and report it appropriately (Betts et al, 2014; DH, 2014; NMC, 2015). Adequate training,

tailored to protecting vulnerable adults, would help to minimise mistakes and better enable professionals to navigate their way through the various safeguarding procedures and policies that exist.

Having too many procedures in place to protect vulnerable adults and policies for managing cases of adult abuse, may risk hindering the use of the professional skills required (Stevenson, 1996). While policies have been introduced to protect vulnerable adults, they cannot replace the expert practice and expertise that can be acquired over time in a specialist area. If policies are not to hinder practice, as Stevenson (1996) suggests, they should be used alongside expert practice and expertise for any benefit to be gained in terms of targeting and preventing the abuse of vulnerable adults.

Even though adequate relevant training is lacking, safeguard professionals require specific skills to manage their professional role, which is evident from related job descriptions. Accordingly, they also need relevant knowledge to understand and adhere to safeguarding policies and procedures. In addition, safeguard professionals are required to communicate pertinent knowledge to anyone involved with vulnerable adults, which has the potential to assist others with recognising and reporting abuse (Appendix 1).

1.5 Increasing Awareness of Abuse

Efforts to protect children and adults from abuse are clearly shown by the number of United Kingdom Government Acts that have been introduced with this intention (Table 1). United Kingdom Government Acts also exist that are intended to monitor potential perpetrators in respect of child protection (Table 2):

PROTECTING CHILDREN (DEPARTMENT OF HEALTH)		**PROTECTING ADULTS (DEPARTMENT OF HEALTH)**	
Year		**Year**	
1933	The Factory Act	1983	Mental Health Act
1989	Children Act	1990	NHS & Community Care Act
1998	Human Rights Act		
2000	Framework for Assessment of Children in Need and their Families	2000	No Secrets
		2003	Criminal Records Bureau (CRB)
2002	The Education Act	2005	The Mental Capacity Act
2002	Adoption and Children Act	2005	Court of Protection
2004	Children Act	2006	Safeguarding Vulnerable Groups Act (and the Protection of Freedoms Bill)
2008	Children and Young Peoples Act		
2009	The Borders, Citizenship and Immigration Act	2010	Equality Act
2009	The Apprenticeships, Skills, Children and Learning Act	2012	Disclosure and Barring Service (DBS)
2011	The Education Act		
		2014	The Care Act
		2014	Deprivation of Liberty

Table 1 Department of Health Acts to protect Adults and Children from the late 20th century to the present day

Year	Department of Health (DH)
1997	The Sex Offenders Act
2003	The Sex Offences Act
2003	The Female Genital Mutilation Act
2004	The Domestic Violence, Crime and Victims Act (amended 2012)

Table 2 Monitoring in Respect of Safeguarding Adults and Children

In addition to the various Acts already in existence, the Criminal Records Bureau (CRB) (DH, 2003) was introduced in 2003 and was superseded in 2012 by the Disclosure and Barring Service (DBS) (DH, 2012).

1.5.1 Criminal Records Bureau and Disclosure and Barring Service

In order to manage the exposure of vulnerable adults and children to possible perpetrators of abuse, the Safeguarding Vulnerable Groups Act (vetting and barring) was introduced in 2006 (DH, 2006). This Act required a prospective employee to disclose specific information to their potential employer. The employer then used this information to complete a CRB (DH, 2003) document.

This disclosure enabled employers to monitor applicants, on behalf of the United Kingdom Government, who were seeking employment that involved working with vulnerable adults or children, to prevent abuse from happening. The CRB was introduced following the Bichard Inquiry[1].It was superseded by the DBS (DH,

[1] The Soham murders, committed in August 2002, led the United Kingdom Government to launch the Bichard Inquiry to investigate the methods that people utilise to work with vulnerable adults and children. The recommendations made by the inquiry led to the Government introducing vetting and barring schemes throughout the United Kingdom. The intention was to prevent unsuitable people from working with these vulnerable client groups.

2012) England, Wales and Northern Ireland and the Protection of Vulnerable Groups Scheme (PVG) in Scotland (Legislation.Gov. UK, 2007). The principles of the DBS are the same as its predecessor.

The change from the CRB to DBS was the result of a merger between the Independent Safeguarding Authority and the CRB. Completion of a DBS remains at the employer's discretion (GOV.UK, 2012) but there continues to be a financial cost for the person completing it, unless the prospective employer is willing to pay. This payment may prevent a DBS being completed with the consequence of a perpetrator being employed without one because the payment is viewed as a money-making scheme by an employer, who is financially compromised.

As well as the financial implications for an employer, a correctly completed DBS can take between fourteen days and four weeks to process (DH, 2012). If the employer is short-staffed, this may result in them overlooking the completion of a DBS, in light of the additional time it would take for a new employee to begin work.

Submission of a completed DBS, in itself, cannot prevent abuse because perpetrators can commit an offence the day after completing one and keep the offence hidden until the next search. Thus, the perpetrator can continue working with vulnerable client groups, irrespective of abusive acts they might carry out after they have completed a DBS. Wrongly, we tend to trust these policies to filter out abusers. It is worth considering whether these policies have been developed reactively in the hope that safe environments will be created. This is an expectation that has clearly not been realised.

1.5.2 No Secrets

No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable adults from Abuse (DH, 2000), was introduced to manage adult vulnerability. It involved assessing a potentially vulnerable adult to determine if they were at risk of abuse. This guidance (DH, 2000) was aimed at promoting safety and independence through access to community services. Community services were defined as:

- support from safeguard boards and safeguard specialists
- social care and health support, criminal systems, commissioners and regulators support which would enable the vulnerable adult to become part of a support network without losing their independence.

Assessments conducted in relation to No Secrets (DH, 2000) were guided by two criteria that determined a vulnerable adult's eligibility for community services:

- An individual at risk of harm or abuse not receiving community services and therefore not referred to as a vulnerable adult
- An individual at risk of harm or abuse receiving community services and as a result referred to as a vulnerable adult.

Health related agencies were encouraged to work in collaboration with each other. This collaboration was aimed at achieving better understanding and more effective communication which would prevent abuse continuing (Hughes, 2001). Not all elderly people met the eligibility criteria for community services, when they were assessed, because their assessment was not interpreted as indicative of

being vulnerable by the assessor. Consequently, these adults were still subjected to abuse but it just did not get reported (O'Keefe et al, 2007).

As a result, even though community services existed to prevent abuse and promote independence, the abuse continued irrespective of whether an individual met the eligibility criteria or not. This clearly shows that knowledge of policy, in isolation, is not the only requirement for preventing the abuse of vulnerable adults. Preventing this type of abuse also requires the ability to assess situations holistically and evaluate each case independently by applying previous experience and knowledge.

Furthermore, evaluating eligibility for community services involved disclosure from the vulnerable adult about their abilities and the interpretative skills of the assessor conducting the assessment. These assessments therefore defeated the object of No Secrets because they had the propensity to highlight an individual's weaknesses rather than their strengths (Fawcett, 2009). As previously stated, No Secrets aimed to promote safety and independence for the vulnerable adult, not to increase awareness of their weaknesses.

The DH published Safeguarding Adults: a National Framework of Standards for Good Practice and Outcomes in Protection Work, in October 2005, to build on the information already known about protecting vulnerable adults acquired from No Secrets (DH, 2000). Although an individual was still only referred to as a vulnerable adult if they were eligible for community services, a vulnerable adult fearful of losing their independence was now identified as at risk of harm. This subsequently became included and recognised as a form of abuse (Constable, 2008).

The resulting definition of vulnerable adults had now acquired two main components. The first, which appeared in No Secrets (DH, 2000), was someone who could not care for, or protect, themselves from harm or exploitation; the second, came into existence with Safeguarding Adults (DH, 2005), and added the risk of loss of independence for the vulnerable adult (DH, 2005).

1.5.3 The Care Act

The Care Act (DH, 2014), superseded No Secrets (DH, 2000) and incorporated methods for determining eligibility for social services, in addition to more clearly defining assessment guidelines. Safeguarding Adult Boards (SABs) were established in every area and possessed greater power to acknowledge and protect vulnerable adults (DH, 2014).

The Care Act (2014) introduced a national threshold whereby if a person met three conditions, they were deemed eligible for social services. The required conditions were:

- Do they have needs due to a physical or mental impairment or illness?
- Do these physical or mental impairment or illness needs mean that they are unable to achieve two or more specified outcomes? There are several outcomes, including eating unhealthily due to being unable to prepare meals, or because their ability to swallow is compromised, or because they cannot wash independently and do not understand how to use washing appliances.

- Is there, or is there likely to be, a significant impact on their wellbeing as a consequence of them being unable to achieve two or more of the outcomes?

The Care Act (2014) was intended to support vulnerable adults irrespective of whether the local authority was involved in meeting any of their needs. The Act also considered whether the adult was able to protect themselves from harm or if they were experiencing neglect or abuse. Furthermore, it promoted individuals' involvement in their own care and acknowledged their strengths rather than identifying their weaknesses (DH, 2014).

This approach led to the person who needed community services, becoming part of the process for developing a personalised plan, and not someone who merely used the services as demonstrated in Fig.1. However, an inherent problem exists with the new approach which suggests that professionals should be mindful when involving a vulnerable adult in the process, because this involvement has the potential to be interpreted as interfering, control or surveillance and not protection. Such an interpretation constitutes an extension, or addition, to the growing awareness that initially led to the development of vulnerability and protection. Misinterpreting protection to mean control or surveillance could be viewed as deliberate disregard for basic human rights.

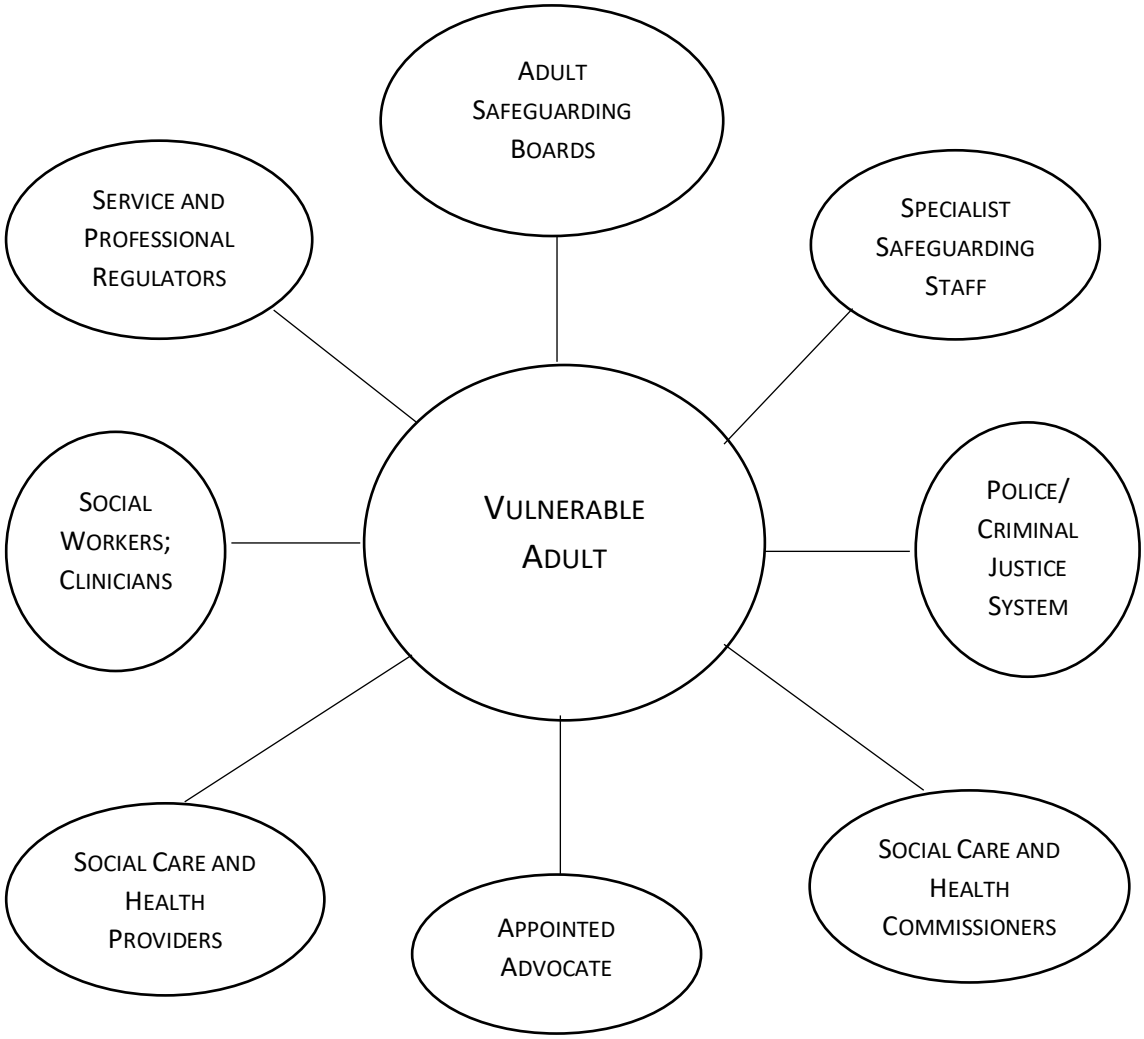


Fig. 1 Making Safeguarding Personal (DH, 2014)

Vulnerability and abuse can have different meanings for different people and, as a result, both concepts have been misunderstood. There has also been a tendency to focus on the adult rather than the cause of their vulnerability. Consequently, the terms *protec*t and *safeguarding* have been utilised more often than *vulnerable* due to the Safeguarding publication in 2005, to encourage the removal of blame from the adult and to situate extrinsic factors (O'Keefe et al, 2007).

Terminology related to the protection of vulnerable adults was instigated by the United Kingdom Government through the Protection of Vulnerable Adults (POVA) and Safeguarding of Vulnerable Adults (SOVA) legislation. POVA relates to the protection of vulnerable adults, while SOVA – the more recent of the two - is intended to prevent abuse and empower vulnerable adults (SCIE, 2011).

Determining whether someone is at risk of harm can be problematic because an adult might not view themselves as threatened or abused. This belief is conceivable due to people's differing perspectives, within cultures and between countries, relating to how the concepts of vulnerable and abuse are interpreted (DH, 2000, 2014; Nisbet, 2013; Chrome et al, 2014). It is likely to be more challenging due to an assessor's lack of relevant experience and training to ascertain whether someone is at risk of harm. Assessments require relevant expert practice, or expertise, acquired over time through on-going practice and exposure to different safeguarding scenarios.

1.6 TYPES OF ABUSE CURRENTLY IDENTIFIED

Protecting adults from harm or abuse is challenging because, irrespective of the type of abuse, the abused adult can suffer significant harm from any of the identified forms of abuse. Types of abuse include:

- material or financial abuse which is defined as the misappropriation of property or finances by family, friends or carers
- emotional and psychological abuse where the abused adult is emotionally blackmailed or threatened (DH, 2000; Nisbet, 2013)

- sexual abuse is the result of a vulnerable adult being pressured into participating in sexual acts or being raped
- physical abuse where the abused is hit, punched or endures other physical injury
- environmental abuse where there exists poor practice and professional misconduct
- abuse can occur in the form of discrimination where culture, gender or disability is also used to abuse vulnerable adults
- domestic violence (Betts et al, 2014).

However, Martin (2007) noted that some forms of abuse, for instance physical, emotional or sexual abuse, can be more harmful to an abused adult compared to stealing money from them. Abuse can take many guises and can be inflicted by individuals in positions of care or who are part of the abused person's family. Abusive acts can be carried out deliberately or may be the result of ignorance, lack of understanding or lack of training (Martin, 2007).

Clearly, professionals practicing in the area of safeguarding require the ability to prioritise and manage urgent cases of abuse, especially when a case involves both physical and financial abuse. Initially, the distinction between these two types of abuse may appear simple but physical abuse is temporal whereas financial abuse has the potential to impact on the abused person's long-term quality of life. This indicates that the subjective and objective aspects of safeguarding should be carefully weighed up, which necessitates expert practice, expertise and experience gained over time.

1.6.1 Thirty Years - Abuse and Vulnerable Adults (1984-2016)

In 1984, Eastman published a few articles on abuse towards older people and adults with learning disabilities, which showed that the abuse of adults was a complex issue and also highlighted the significant inadequacy of health systems nationwide. These issues stemmed from a lack of structured or recognised processes to manage and prevent adult abuse. Although no less challenging or complex, there were clear objectives and procedures to manage and prevent child abuse (Eastman, 1984).

Many years later, the Winterbourne View Report (CQC, 2011) investigated reports of patients not being protected from risk. The investigation included examining unsafe practices of the staff employed at the Winterbourne View private hospital. This was rapidly followed by the Francis Report (Francis, 2013) which investigated the suffering of a large number of patients, and a number of untimely deaths that occurred at Mid-Staffordshire NHS Foundation Trust. Both investigations were independently conducted and received extensive media coverage. As with Eastman's (1984) research some thirty years earlier, the existence of several types of adult abuse was again highlighted because it was still going on (Betts et al, 2014).

Social interactions, for example social media, forums, education and research, have created an increased awareness of adult abuse, although the full extent of it remains unclear (Martin, 2007; Betts et al, 2014). Nevertheless, adult abuse continues to receive societal attention through media coverage. In the cases of the Francis Report (2013) and the Winterbourne View Report (2011), continued

growing awareness has led to increased knowledge related to what causes the abuse of vulnerable adults and ways to eradicate or at least reduce it.

However, thirty years after the first reports of adult abuse were published and despite several Acts being introduced to protect vulnerable adults, increased media exposure and improved safeguard training, as well as the designation of dedicated safeguarding roles, the abuse continues. All that appears to have changed is an increased awareness of the problem, and the introduction of a number of policies which have reacted to changing circumstances.

1.7 LEGAL FRAMEWORKS

In order to protect vulnerable adults from abuse, a number of assessments are undertaken, including Mental Capacity (MCA) (DH, 2005), which is a time- and decision-specific assessment and requires training to complete accurately.

Professionals involved in caring for vulnerable adults may be required to complete either a Deprivation of Liberty Safeguard (DoLS) (DH, 2014) application or an MCA. A Lasting Power of Attorney (LPA) is prepared by legal representatives and is only valid when it has been registered with the Office of the Public Guardian (GOV.UK, 2013).

1.7.1 The Mental Capacity Act

The principle of safeguarding adults is linked to the Human Rights Act (1998) which advocates:

- everyone has the right to life

- death of an individual through abuse is unlawful
- the prevention of suffering
- protection against captivity and enforced work
- the right to freedom
- protection from lawless punishment and the right to a fair trial
- respect for privacy and respect for family life
- the right to marry
- freedom of thought and choice of faith
- the right to peacefully protest and freedom of speech
- no discrimination
- protection of property
- the right to an education
- the right to free elections.

In 2000, the Human Rights Act became law in the United Kingdom (DH, 2000).

Subsequent to carers' concerns raised in 1989 about adults in their care, the Law Commission was motivated to develop guidance to protect individuals who were unable to make their own decisions. This guidance applied to those working on behalf of the vulnerable adults. Although not evidence based, in 2005 the MCA emerged and, following amendments, was formally recognised in 2007 (Parliament UK, 2010). Although assessing individuals is part of safeguard training, producing an accurately completed MCA relies on the professional completing it to possess relevant experience and the ability to apply this to each individual situation.

The MCA assessment is time- and decision-specific. Completing an MCA helps to ascertain whether an individual has the mental capacity to recall and retain information to make an informed decision about a specific topic, for example washing and dressing or self-medicating. Completing an MCA only empowers professionals to work on behalf of the person in relation to the specific issue for which it was completed. Implementation of an MCA often leads to best interest decisions being made on behalf of an individual because they are unable to make complex decisions for themselves (DH, 2005).

Preventing vulnerable adult abuse can be complicated when an adult lacks the mental capacity to make their own decisions. Assessing whether someone has mental capacity involves making a unique clinical judgement that supports the completion of relevant documentation. Complications can occur in assessing someone's mental capacity when the person being assessed makes a decision that makes reasonable sense to him-/her-self, but that the assessor perceives as unwise. The difficulty increases when the person being assessed possesses mental capacity (DH, 2007; Martin, 2007).

Impaired mental capacity can be the result of, for instance, dementia, a brain injury, a cerebrovascular accident (CVA), mental health issues, a sudden accident or unconsciousness caused through being anaesthetised. Even so, these conditions do not automatically lead to loss of mental capacity and loss of mental capacity does not in itself make someone vulnerable (BMA, 2011).

Possessing mental capacity can increase the risk of vulnerability due to an assumption that possessing cognitive ability removes the likelihood of allowing

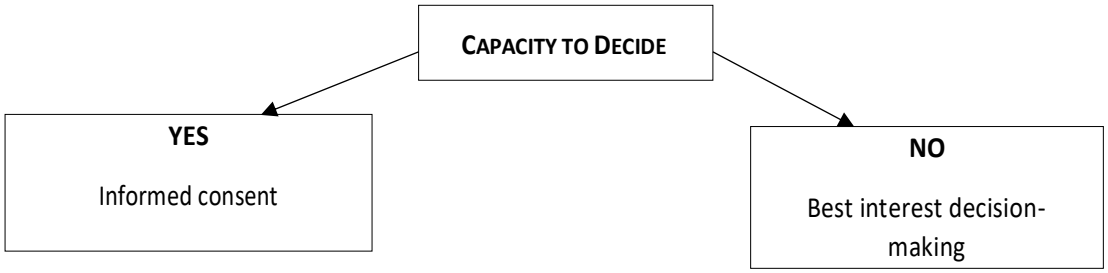
others to take advantage. Countless people who have full mental capacity can still find themselves at risk of harm from others (BMA, 2011; USH, 2015).

Therefore, completing an MCA does not in itself remove the risk of being vulnerable simply because an adult has the ability to make an informed decision. This can be demonstrated by a decision made by a vulnerable adult that makes little or no sense to the assessor but makes sense to the adult concerned, for example choosing to remain with an abusive partner. It then becomes challenging for the assessor to protect the adult without interfering in their life (Martin, 2007).

A separate MCA is completed for each care intervention and activity that the individual is unable to make a decision about which can include medications, personal hygiene and more complex decisions, such as finance or accommodation. Guidelines exist to assist with conducting an MCA assessment to ascertain if an individual is able to make informed decisions (Fig.2)

Best interest decisions and judgments are made on behalf of someone else but take into consideration a person's previous views and wishes prior to losing the ability to make decisions. This approach can promote a positive experience by empowering the adult to live in a way they chose when they were still able to, despite no longer being able to make their own decisions (Martin, 2007).

There are five main points to address when completing an MCA which are outlined in Fig. 2. Completion of an MCA requires experience, knowledge, practice, clinical judgement and appropriate training. These skills enable professionals to complete MCAs competently and accurately in relation to the individual being assessed.



The MCA's 5 main principles:

- •Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
- •A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- •Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- •Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests
- •Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms (DH, 2007).

Assessing the Ability to Decide

People are unable to decide for themselves if they cannot:

- understand the information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate any decision (whether by talking, using sign language or any other means).

Check List for Best Interests

The MCA (2005) and associated Code of Practice state that:

- Working out what is in a person's best interests cannot be based simply on age, appearance, condition or behaviour.
- All relevant circumstances should be considered when working out best interests.
- Every effort should be made to encourage and enable a person who lacks capacity to take part in making the decision.
- If there is a chance that a person will regain the capacity to make a particular decision, then it may be possible to put it off until later if it is not urgent.
- When the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.
- A person's past and present wishes and feelings, beliefs and values should be considered.
- The views of other people who are close to the person who lacks capacity should be considered, as well as those of an attorney or deputy.

Fig. 2 Assessing the ability to decide (adapted from Owen, G, 2011)

An MCA is completed bearing in mind the five main principles of the MCA. Therefore, a vulnerable adult is given every opportunity to consider information that they have been provided with, which is associated with a specific decision to be made. The adult is asked to recall the information they have been given, to determine whether they can retain it, and they are advised of options relating to their care. If they are unable to recall or retain the information and do not have legal representation, an MCA is completed. Legal representation would include a registered LPA, a Court Order or a Guardianship. If an assessor doubts that the representative is acting in the best interests of the vulnerable adult, the views of the representative can be overridden.

1.7.2 Deprivation of Liberty Safeguard

Deprivation of Liberty Safeguards (DoLS) (DH, 2014) was developed from the MCA and can be applied to anyone lacking mental capacity. A DoLS offers protection if there is a restriction being imposed on an individual's freedom. Restrictions can include physically restraining the individual by using a lap-belt to prevent falling out of a wheel chair, preventing an individual from leaving the home environment unaccompanied and bedrails being utilised to prevent falling out of bed. Other types of restraint may be necessary and appropriate to keep a vulnerable adult safe because the adult is unable to make an informed decision about their safety and also lacks insight into how to avoid harm (DH, 2007).

Arguably someone lacking mental capacity may not comprehend the loss of freedom, but decisions to use any type of restraint must be taken in an adult's best interest and to promote their safety and should not be used to deprive an individual of their freedom. For example, bed rails should not be used to prevent

someone from getting out of bed because they might fall and they lack insight into this risk. If this is the case, sensor mats could be used to alert care staff to the individual mobilising, which maintains their independence (DH, 2014).

1.7.3 Lasting Power of Attorney

An LPA only grants legal authority to act on behalf of the vulnerable adult at the vulnerable adult's request or when they lose mental capacity to act for themselves (DH, 2007, SCIE, 2007). There are two types of LPA: one for health and welfare; and the other for finance and property. An enduring power of attorney (EPA) relates only to finance and, if registered prior to 2007, still remains valid. It has been replaced with the Lasting Power of Attorney (LPA) which offers more flexibility about how an adult's affairs are managed, and by whom, if the adult loses their mental capacity and is unable to manage their own affairs (GOV.UK, 2013).

There remains a risk of a vulnerable adult being pressured by the potential representative into completing an LPA. This pressure can lead to the perpetrators misappropriating funds and, as mentioned previously, is deemed an act of abuse towards the vulnerable adult (Johns and Sedgwick, 1999).

1.8 PURPOSE OF THE STUDY

This research study intends to examine what defines expert, and expertise related to safeguarding, and to show that that the terms are socially constructed and exist only as a result of the meanings that individuals apply to them, but would not exist otherwise.

It is the duty of every nurse, irrespective of experience, to protect patients from harm (NMC, 2015). In practice, this is unrealistic due to the complexity involved in protecting adults at risk of harm, because nurses must possess related experience and knowledge in order to successfully manage the safeguard role.

Inadequate training has led to safeguard professionals understanding their role through social engagement with others in addition to utilising transferable skills, knowledge and practice from a previous role.

If SLNs have acquired specialist knowledge, or expertise, and have become experts in safeguarding vulnerable adults, how have they accomplished this in what could be considered a short time compared to other specialist fields? Is there a common meaning for the perception of the 'expert' and from where has it originated: previous professional roles, training and education, professional practice and/or experience, or a combination of these?

1.9 Structure of the Thesis

Chapter 1 has introduced the concept of the vulnerable adult, explored safeguarding and its associated legal frameworks and outlined the purpose of conducting the study.

There are five further chapters: Chapter 2 reviews the literature related to the terms expert and expertise. Chapter 3 describes the research design and the methodology selected to conduct this study and Chapter 4 details the data analysis and interpretation. Chapter 5 discusses the findings in relation to relevant literature. Chapter 6 identifies the limitations of this study, makes

recommendations for future safeguarding practice and summarises the conclusions drawn as a result of conducting this study.

CHAPTER 2: THE LITERATURE REVIEW

2.1. INTRODUCTION

In the previous chapter the terms vulnerable, expert and expertise were introduced. These terms were described as social constructs because they have been created by society, a concept that can also be applied to the context and legal framework of safeguarding; these were outlined and the support that such structures offer to protect vulnerable adults was discussed.

This chapter begins by explaining the etymology of the term expert and describes the strategy used to access the literature. Subsequently, the characteristics associated with an expert, in generic terms, and the expert nurse, are presented in addition to their relevant expertise. The expert is considered in relation to the training, competence and confidence required to be an SLN. The chapter then concludes with a brief summary.

2.2. ETYMOLOGY

The etymology of the term *expert* has been included because it demonstrates the origin of the meaning and how it relates to contemporary understanding.

As an adjective, in the late fourteenth century, the term expert described an individual as someone who was skilled and possessed experience. At the same time, the French expression *espert* defined a person who was experienced, practiced, and skilled, which was in addition to *experiri*, the past participle, meaning *to try or test*. The term *expertus*, which is of Latin origin, developed from the term *experitus*, which meant tried, proved, and known by experience. This

term was applied to someone acknowledged as having acquired wisdom through experience and therefore considered to be an expert. Within the etymology, there is a clear link between expertise and experience.

In the nineteenth century, an expert was identified as someone with special acquired knowledge or experience in a specific subject. This knowledge and experience, or expertise, is defined as the quality or state of being an expert and superior to others. Recognition as an expert allowed the expert to testify in a court of law where their opinion was readily accepted because their testament was based on fact, compared to other witnesses who testified based on personal opinion (Skeat, 2007).

Similar definitions can be found for a present-day generic expert since the term is applied to someone who has special skill in, or knowledge of, a subject, or who has an extensive skill in, or knowledge of, a particular field. Expertise is also defined as the result of possessing a special skill, or knowledge, or an expert skill, knowledge or judgement, in a specific area of practice (Allen, 1991; Gilmour et al, 2005).

The subtle differences between expertise and expert have resulted in both terms being used synonymously, and the ability to recognise either is subject to individual perspectives (Dowling, 2000; Hutchinson et al, 2016).

2.3 Accessing the Literature

In order to undertake a systematic search of the literature a Population, Exposure, Outcome (PEO) table was created (Table 3). PEO (Bettany-Slatikov, 2012) is a

method that can assist in determining the appropriate key words with which to conduct the literature search.

P	Population	**SLNs** **Training** Time in Role; **experience; practice**
E	Exposure	**Adults:** working with adults (eighteen years of age or older) being abused or at risk of abuse. **Adults** who are unable to protect themselves from harm: **vulnerable adults**
O	Outcomes or Themes	To determine whether **SLNs** are **experts** or possess **expertise** related to **safeguarding** and how they have acquired this **knowledge**

Table 3 PEO application

A list of keywords: **Safeguard Nurse, Training, Experience, Practice, Vulnerable Adults, Experts, Expertise, Safeguarding, Knowledge**, was extracted from the PEO guide and used to conduct a systematic search of the literature. The words were input singularly, in combination and synonyms were also used as well search symbols, for example *, to increase the number of results retrieved. The results of the search are shown in Table 4 and include those from the JSTOR, CINHL, and PsycINFO and MEDLINE databases.

SEARCH NUMBER		DATABASES				
		CINHL	MEDLINE	PsycINFO	JSTOR	Total
#1	Nurse* and vulnerable adults	351	451	288	2	1192
#2	Safeguard* and vulnerable adults	46	80	71	6	203
#3	Safeguard* and nurse* and vulnerable adults	25	21	0	0	46
#4	Search #3 and experience and practice	18	29	11	0	58
#5	Search #4 and knowledge and training	10	15	7	0	32
#6	Search #5 and expert*	6	12	5	0	23
Duplicates: 14			Total after duplicates removed			9

Limits applied: English Language; Year Published 2005-2016

Table 4 Results of the Literature Review

The articles found as a result of the literature review are detailed in Table 5:

AUTHOR	YEAR	TITLE	METHOD	FINDINGS
Manley et al	2005	Changing patients' worlds through nursing practice expertise: A Royal College of Nursing Research Report, 1998-2004	Emancipatory action research and fourth generation evaluation	Through identification and testing the attributes and enabling factors of practice expertise, the Expertise in Practice Project revealed a language nurses use to articulate their clinical influence
Estabrooks et al	2005	'Sources of Practice Knowledge Among Nurses'	Ethnography: focus groups, participant interviews and participant observations	Practice knowledge was divided into social interactions, experiential knowledge, documentary sources, and a priori knowledge by the participating nurses: nurses use informal and formal social interactions to communicate, form relationships, and exchange information with others
Hardy et al	2006	'Re-Defining Nursing Expertise in the United Kingdom	Action research cohort study using a process of co-operative and collaborative inquiry	The evidence supported the attributes and enabling factors of nursing expertise found in the literature; knowledge base is differentiated from the self-awareness of the application of knowledge but a lack of self- reflection, and self-awareness, can hinder the appropriate application of knowledge and skill can prevent achieving expert status
Naumanen, P.	2007	'The expertise of Finnish occupational health nurses'	Structured pre-tested questionnaires sent randomly to selected Finnish occupational therapists	Finnish occupational health services are mostly based on the activities of nurses; occupational health professionals devote more time to individuals than tasks. The majority of physiotherapists, physicians, psychologists share their working hours between occupational health care and

				some other areas of health care and have little time for emergency care, as many units are lacking adequate resources
McHugh and Lake	2010	Understanding Clinical Expertise: Nurse Education, Experience, and the Hospital Context	Secondary analysis of cross-sectional data from a 1999 statewide survey of registered nurses in Pennsylvania	The composition of a hospital's staff, specifically the average level of education, contributes to clinical nurse expertise independent of individual education and experience level; evidence from prior, smaller-scale studies show individual nurse level of education and years' experience are related to clinical nursing expertise
Drew, D.	2011	'Professional identity and the culture of community nursing'	Ethnographic approach, data collection carried out using participant observation and semi-structured interviews	Sharing information and planning ahead helping across teams and businesses and how other professions view community nursing. Issues of community nurses' invisibility and the articulation of expertise are presented
Hutchinson et al	2016	Nursing expertise: a course of ambiguity and evolution in a concept	Characteristics of nursing expertise gathered from published sources; secondary peer- reviewed sources used to explore what has been defined as nursing expertise in addition to the analysis of pattern of usage	Expertise refers to the attributes of nurses who practice beyond the level of the competent or proficient nurse while an expert nurse possesses skills that result in superior practice to others; an expert nurse possesses both practical and theoretical knowledge they can apply to practice
Phelan and McCormack	2016	Exploring nursing expertise in residential care for older people: a mixed method study	Mixed method design	Both the focus groups and the case studies revealed seven themes of expertise in nursing homes: transitions, context of the nursing home, saliency,

				holistic practice knowledge, knowing the resident, moral agency and skilled know how
Marshall and Sprung	2016	'Community Nurses' knowledge, confidence and experience of the Mental Capacity Act in Practice'	Mixed method approach in addition to a sequential explanatory design to inform the study: the first stage was a quantitative approach aimed at identifying statistical relationships and the second stage was a qualitative approach and explored the results obtained in stage one	Participants had a wealth of nursing experience but when asked to self-appraise their MCA knowledge and confidence; the answers were non-committal with 'fair' and 'neutral' being the highest ranked responses suggesting that participants did not feel confident in this area

Table 5 Detailed results of literature review

As a result of the literature search, which was conducted using the aforementioned keywords, this chapter follows the following structure:

- the expert who is recognised and understood in generic terms across a variety of disciplines: expertise, qualifications and the value of experience, characteristics and traits and regression
- the expert nurse with the nursing profession: from novice to expert, the expert in nursing – contemporary articulations, nursing expertise, peer support within the nursing profession culture: utilising nurse expertise and the expert nurse
- the expert SLN in relation to vulnerable adults: competence, confidence, training and the mental capacity act.

2.4 DESCRIBING THE GENERIC EXPERT

The literature indicates that, irrespective of the discipline, there are a number of perceived attributes that distinguish an individual as an expert. These attributes include experience, personality and peer influence (Manley et al, 2005) which in themselves encompass other skills, for example motivation, intuition, confidence and competence (Alexander, 2003; Baylor, 2001).

An influential framework which enables us to understand expertise was developed by Dreyfus & Dreyfus (1980). An expert is described as an individual who is an experienced and an intuitive practitioner, a description that resulted from a study conducted to explore the way that skills were acquired and developed (Dreyfus and Dreyfus, 1980). This study resulted in the Five Stages of Skill Acquisition being developed (Dreyfus and Dreyfus, 1980) (Table 6).

Skill Level	Components	Perspective	Decision	Commitment
Novice	Context free	None	Analytic	Detached
Advanced Beginner	Context free and situational	None	Analytic	Detached
Competent	Context free and situational	Chosen	Analytic	Detached understanding and deciding; involved outcome
Proficient	Context free and situational	Experienced	Analytic	Involved understanding; detached deciding
Expert	Context free and situational	Experienced	Intuitive	Involved

Table 6 Five Stages of Skill Acquisition (Dreyfus and Dreyfus, 1986)

The Five Stages of Skill Acquisition (Dreyfus and Dreyfus, 1980) is a theoretical framework that depicts novices relying on rules and instructions while the experts are regarded as experienced, intuitive practitioners. The Dreyfus Model (1980) relies on personal interpretation. However, it can provide useful direction and has the potential to be applied to other studies, as was the case when Benner (1982) applied it to nursing practice. Subsequently, Benner developed her own conceptual framework: from Novice to Expert (Benner, 1982).

Although Dreyfus and Dreyfus's (1980) study was conducted forty years ago, the terms they used to describe aspects of the expert such as experienced, intuitive, autonomous and self-aware remain the same, as shown by various subsequent studies (Baylor, 2001; Manley et al, 2005).

Additionally, an expert may also be described as a person who is aware of their own limitations and ability and who also possesses leadership skills (Hargreaves and Delya, 2001; Smith et al, 2003). However, despite these perceived attributes, recognition of experts may be merely a result of their professional role and qualifications. Hoffman (1996) notes that, although never actually referred to as experts, researchers and forecasters at the US National Atmospheric and Oceanographic Administration and National Weather Service were accepted as possessing expertise based on their professional role (Hoffman, 1996). Other than their professional role, no criteria were used to determine their expertise.

2.5 EXPERTISE

An expert practitioner has acquired extensive knowledge in a specialism which can be applied to practice in situations which have been previously experienced. The difference between being an expert and having expertise is having the ability to apply pertinent knowledge to practice. However, developing into an expert can be thwarted as a consequence of being unable to apply knowledge in this way (Ericsson and Smith, 1991; Smith et al, 2003).

Merely possessing technical knowledge, which has been suggested as representative of expertise, does not equate to being an expert practitioner (Dowling, 2000). Expertise has been examined in relation to various activities and, as a result, expertise is acknowledged as requiring many hours of continued practice, experience and specific training to gain subject-specific specialist, in-depth knowledge (Guest et al, 2001; Berliner, 2001; Ericsson, 2004). For example: novice pianists initially only recognise single notes but with continued practice acquire the ability to use this knowledge to identify notes as part of a

complete piece of music. Becoming an expert pianist is the result of perseverance and motivation and overcoming hurdles to achieve expert performance (Ericsson et al, 1993).

2.6 Qualifications and the value of Experience

Qualifications can strengthen the role of the expert by evidencing an individual as educated, successful and committed. This can lead to the perception that an accomplished practitioner is meeting the required standards of their professional role (Marrone, 2016).

Behaviours associated with the expert may elude description or analysis (Chi, 2006) (Naumanen, 2007; McHugh and Lake, 2010). Such behaviours have been described as ‘tacit knowledge’ (Polanyi 1974) and include ‘intuition’ (Herbig et al 2001) or ‘knowing-in-action’ (Schön, 1983).

Intuition is linked to expert practice but it can be overlooked in favour of the technical knowledge that is associated with expertise (Dowling, 2000). A differing view suggests intuition is a component of expertise that links theory and knowledge to ways of understanding, i.e. academic knowledge, practical skill, and amassed experiential knowledge (Naumanen, 2007; Hutchinson et al, 2016). This dichotomy is likely to be the result of different interpretations and understandings of both intuition and expertise.

Intuition has not been received positively by quantitative researchers in the past and can sometimes still meet with disdain, because it cannot be measured or quantified (Benner, 1982; Sinclair, 2005). It is questionable whether tacit

knowledge and intuition can be taught or clearly articulated to others. As a result, neither is viewed as a basis for clinical teaching without condition of acceptance:

> *"If intuition and tacit knowledge cannot be explained or modelled for students, they would not make a good basis for pedagogy for clinical education. However, we do not see tacit knowledge as a barrier to developing pedagogy of expertise so long as it is viewed as poorly articulated links between chains of practice and underlying networks of understanding"* (Kinchin and Cabot, 2010).

Tacit knowledge is embedded in practice and is acquired implicitly and is situation- or person-specific (Herbig et al, 2001). Increased exposure to different situations leads to the practitioner relying less on the obvious facts that present themselves within a situation, and more on less apparent ones. While successful nurses use their emotion and tacit knowledge to manage situations, less successful nurses are unable to do this due to their lack of experience from fewer exposures to a variety of situations. Consequently, the less successful nurses find intuition annoying (Herbig et al, 2001).

Emotional intelligence has been linked to intuition and can be understood as an indication of someone who is aware of personal feelings, or emotions, and those of others and, as a result, responds appropriately in any situation. Therefore, the emotionally intelligent person is effective in a team because they can motivate others and motivate themselves through their actions and thought processes. This ability has also been cited as fundamental for clinical nursing practice (Taylor, 1994).

Although not measurable, due to being a social construct, emotional intelligence has nonetheless been cited as significant in nursing practice, particularly with regard to intuition, 'gut' feeling and expert practice, as well as being linked to

enthusiasm, persistence and empathy (Gigerenzer, 2007). Emotional intelligence has also been associated with the ability to solve problems and develop therapeutic relationships with others (Cadman and Brewer, 2001).

Schön (1984) describes knowing-in-action as activities that are completed without conscious awareness, for example, picking up and throwing a ball without knowingly thinking about the action of throwing beforehand. The action of throwing could also be understood as 'knowing-that', because the thrower knows that where the ball lands will depend on the direction and the strength of the throw, in other words cause and effect.

Despite intuition often having been disregarded, logical thinkers who are renowned for their rationality have recognised the link between experience and intuition, including Einstein, who wrote:

> *"To these elementary laws there leads no logical path, but only intuition, supported by being sympathetically in touch with experience"* (Holton, 1988).

2.7 CHARACTERISTICS AND TRAITS

Experience is influenced by an individual's level of practice, combined with personality traits which can include intuition and/or motivation (Greenhalgh, 2002; Alexander, 2003).

Motivation, in an individual's development, is supported by many hours of practice, increased knowledge and experience in a specialism (Alexander, 2003). Although extrinsic factors are likely to contribute to an individual's achievements, it is unlikely that achievements could be attained without strong personal

motivation which is a key factor in further professional development (Alexander, 2003).

2.8 REGRESSION

When an expert is forced to deliberate, for example in unknown situations, regression to a previous stage in the acquisition of skills, can occur because the expert is no longer thinking as an expert. Regression is indicative of practising at a previous stage of learning, for example either the proficient or competent stage, although it has been acknowledged that an expert never regresses to the complete novice stage (Dreyfus and Dreyfus, 1980; Benner, 1982; Pena, 2010).

Engineer designers who are considered to be experts in their specialist area, tend to focus on finding a solution to a problem and not on the problem itself (Cross, 2004), which supports the idea that experts do not deliberate about problems, or spend time rationalising them. This is significant because, as detailed previously, deliberation has been shown to lead to negative outcomes as regression to a previous stage of development occurs (Dreyfus and Dreyfus, 1980).

An expert can frequently apply past experiences to unknown situations that present themselves. In a new specialism, this ability prevents them from regressing to the complete novice stage and enables them to begin at the competent stage (Table 6) (Dreyfus and Dreyfus, 1980; Benner, 1982). The ability to transfer skills to another specialism, is recognised as being an expert trait (Bonner, 2003). However, it is proposed that the term expert is frequently used without the evidence to support the expertise of the individual on whom it is

bestowed, for example the ability to make clinical decisions, to reflect, problem solve and to critically analyse (Woodhall, 2000).

2.9 NURSING – FROM NOVICE TO EXPERT

Benner (1982) applied the work of Dreyfus and Dreyfus (1980) (Table 6) to nurses' acquisition of skills and their development and concluded that nurses acquire skill in a similar way to aircraft pilots. Benner (1982) proposed that it could take at least three years to achieve expert status. However, there was no advice forthcoming on how to quantitatively measure the achievement of any of the stages.

The participants in her study were selected on the basis that they were considered to be experts by their peers and managers who in turn were considered to be experts by Benner (1982). The choice of participants and experts appears to have been arbitrary which, from the outset, would have introduced bias.

The conceptual framework, from 'Novice to Expert' (Benner, 1982), does not have quantifiable stages and thus the notion of achieving expert status remains vague and difficult to assess. As a result, Benner's framework has also been criticised for its ambiguity (English, 1993). Arguably, while positivist methods can measure skill acquisition by employing quantitative strategies, as yet, no method has been found that can measure intuition or tacit knowledge which are intrinsic attributes of both expertise and the expert practitioner. Despite Benner's work being ubiquitous in nursing since the 1980s, her theoretical model, 'Novice to Expert' (Benner, 1982) is seldom used beyond acknowledgement that it exists.

2.10 THE EXPERT IN NURSING – CONTEMPORARY ARTICULATIONS

Bonner (2003) used grounded theory to understand the role of the expert in relation to seventeen experienced and inexperienced nephrology nurses. Participating nurses were recognised as expert practitioners because they were more passionate and committed than others, in their specialist area. They were perceived as able to teach other nurses to a high standard due to their extensive relevant knowledge and clinical skills (Bonner, 2003).

These nurses were also recognised as being expert practitioners because they possessed an awareness of personal limitations which in itself demonstrated a disposition that prevented practice beyond their capabilities.

Even so, the expert nephrology nurses extended the nursing role into nurse prescribing, which is not unusual and is accepted practice, but only applies to a limited number of medications and is only undertaken by expert nephrology nurses and not less experienced ones (Bonner, 2003). Experienced nurses in other specialisms may also find themselves in extended or expanded roles which incorporate non-traditional duties, for example prescribing (Duffield et al, 2017).

The emotional support these nurses may give to patients cannot be measured and is therefore likely to be undervalued except by those receiving it, although the nurse patient relationship has been viewed as the core of nursing practice (Moyle, 2003). This support may seem unimportant to the onlooker but in an acute setting, a patient's fear of the unknown situation they find themselves in may be alleviated by this support. This is knowledge based on theory but extends

beyond theory and encompasses holistic understanding and the various types of knowledge nurses are perceived to possess (Carper, 1978).

Being recognised as either possessing expertise, or being an expert, are clearly not attributable to a single skill but to a combination of many skills that individuals employ in order to practice. However, although professional practice that is superior to others is viewed as expert practice, individuals possessing expertise may be identified as competent or proficient practitioners rather than experts (Ericsson et al, 1993; McHugh and Lake, 2010).

2.11 NURSING EXPERTISE

Like generic expertise, nursing expertise is also difficult to define due to being socially constructed. As a result, personal appearance, well-being, and demeanour - for example sense of humour and attitude - have been identified as expertise and were found to have greater influence than other factors in a situation (Naumanen, 2007).

Nursing expertise is also perceived as a mixture of both practical and theoretical knowledge that are fundamental for effective patient care to be delivered. There are four forms of knowing (Carper, 1978) related to nurses' practical knowledge (Fig. 3).

Empirical knowledge	can be validated, for example evidence-based practice
Personal knowledge ….	learnt from experiences and reflective practice
Artistry knowledge ……...	delivers effective nursing care in different situations
Ethical knowledge …….	personal moral principles, for example impartiality

Fig. 3 Four Patterns of Knowing (Carper, 1978)

Nursing expertise, and its perceived attributes, can be found across a variety of specialisms, although holistic care requires a discrete knowledge repertoire and skill that is only evident in other specialist areas to a certain extent (Hardy et al, 2006). Although nursing expertise is recognised as a significant aspect of professional practice, expertise alone does not necessarily lead to an individual developing into an expert (Benner, 1982, 1984; McHugh and Lake, 2010). It is clear, from the literature, that experience is linked with the development of expertise and with acquiring expert status, although expertise is more likely to develop than expert status.

The Expertise in Practice Project (EPP) (Manley et al, 2005) was undertaken between 1998 and 2004. The aim of the EPP was to develop a process for acknowledging expertise in the nursing profession. A number of participants were selected due to their involvement when the EEP was being developed, or because they nominated themselves, because they were recognised by others as possessing expertise, or because they were nominated due to being specialist members on RCN forums (Manley et al, 2005).

The EPP pilot study (Hardy et al, 2002) involved thirty-five participants and was aimed at exploring the ways that nursing practice is influenced through discourse analysis and interpretation. Four excerpts were selected, due to their diversity, and used to explore the way that nurses articulate and formulate practice expertise. Nurse expertise was determined as being the result of several types of knowledge in addition to personal involvement in administering patient care. It was also found that, in an effort to empower and give patients a choice, nurses could take action that went beyond typical care (Hardy et al, 2002).

The selection of the four excerpts was subjective and had the potential to add bias and discredit the study as others may have made a different selection or questioned the choice of excerpts. Selection of participants for research studies requires objectiveness to avoid the introduction of bias (Grimes and Schultz, 2002).

Of the sixty-one participating nurses, twenty-nine withdrew. The nurses had an average of nineteen years nursing experience, with thirteen of them being graduates. Eight of them were based in hospital settings, two worked in primary care and the rest were employed in a variety of specialist roles across hospital and primary care settings. The participants were also researchers for the EPP, researching their own expertise with support from structured reflection or action learning (McGill and Beaty, 2001) and a critical companion (Titchen, 2003). The nurses participating in the EPP selected their own companion and researched their own expertise (Manley et al, 2005)

The reflexive relationship that would inevitably exist between the participants and their own experience could have biased the study and its objectivity, something

which does not seem to have been accounted for. Furthermore, personal ability is likely to have been underestimated or overestimated as it has been shown that individuals may incorrectly gauge the depth of knowledge they possess, mistakenly believing it to be greater than it is (Thompson and Dowding, 2002).

Even so, the EPP determined that nurses' development had been dominated by theories that had muted their ability to describe the intricacies related to nurse expertise. Through feedback, observation and reflection, five attributes of nursing expertise emerged:

- Reflective ability (reflexivity)
- Organisation of practice
- Autonomy and authority
- Interpersonal relationships
- Recognition from others (Manley et al, 2005).

These skills are central to nurses' clinical expertise and, combined with nurses' fundamental ways of knowing (Carper, 1978), emerge as nursing expertise (Manley et al, 2005).

As a result of exploring nurse expertise in care homes, Phelan and McCormack (2016) determined that specialist skills were required to manage complex situations and therefore the nurses possessed expertise. Their skills were enhanced because they enjoyed the environment they worked in and felt satisfaction at being able to meet their patients' needs. The study also found that the length of time it can take to acquire expertise, the motivation of the individual

nurses, and the environment they were practising in, helped them achieve expertise in less time than previously suggested (Phelan and McCormack, 2016).

Guest et al (2001) also drew our attention to expertise being the result of experience that is not merely the length of time an individual practices in a specific specialism, but that is driven by personal motivation to complete many hours of deliberative practice to improve specific skills applicable to the specialist area.

McHugh and Lake (2010) explored nurses' expertise in the hospital setting as contextual factors that had previously been overlooked in favour of nurses' personal attributes, for example experience and education. Their study involved 8622 registered nurses, in the practice setting, to determine if the setting influenced nurse expertise. They determined that the depth of expertise differed from person to person irrespective of their experience, hours in practice or training (McHugh and Lake, 2010).

It is unclear how the depth of expertise was measured and how comparisons were made with other settings. However, a multi-level framework was subsequently developed to demonstrate the research findings (Fig. 4). The framework outlines contextual factors, such as setting and personal attributes, that can lead to nurses' developing clinical expertise. The study also highlights the significance of promoting opportunities for nurse expertise within organisations (McHugh and Lake, 2010).

Perceived attributes of expertise can be credited to competent nursing practice while not removing the possibility of expert nursing practice. Greater clinical expertise is required in the healthcare climate which is evidenced by an

increased need for better quality care and cost-effectiveness (Ballard, 2003). Defining expertise is aimed at encouraging healthcare providers to allow nurses to utilise their expertise to affect the environments in which they work (Hardy et al, 2006).

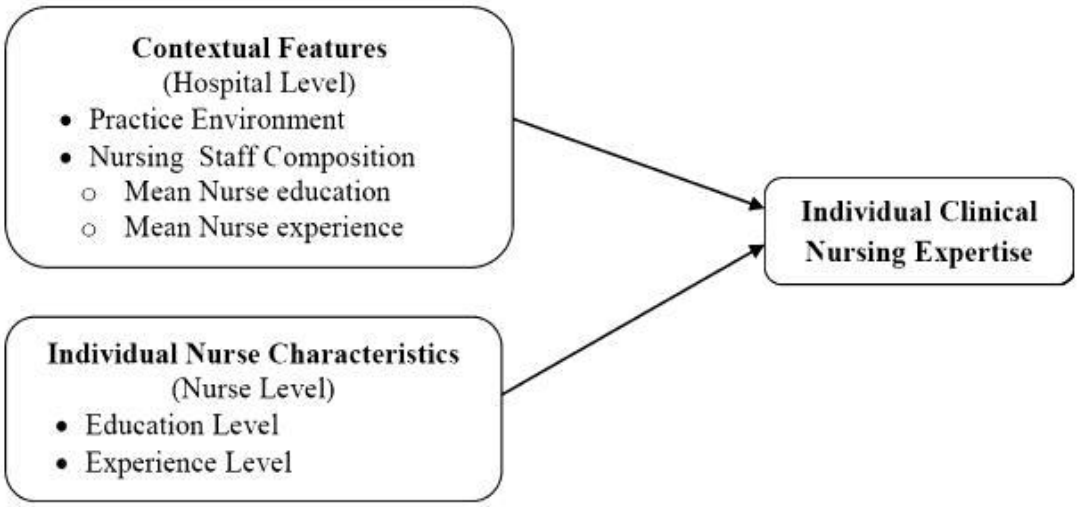


Fig.4 Conceptual framework: relationships between individual nurse characteristics, hospital contextual features of nursing and clinical nursing expertise (McHugh and Lake, 2010)

However, cost effectiveness and attempts to reduce nurses' expertise to positivist values have not been favourably received, as attempting to diminish nursing skills in this way undermines the qualitative skills nurses employ to manage their role (Christensen and Hewitt-Taylor, 2005). Expert practitioners employ skills such as tacit knowledge and intuition which cannot be quantified or articulated (Alexander, 2003; Baylor, 2001; Herbig et al, 2001). Therefore, that explains why these perceived attributes are unlikely to be reduced to positivist values, besides which, if they were measurable, it is likely to have happened before now given the number of studies that have been conducted to explore nurses' expertise.

2.12 PEER SUPPORT WITHIN THE NURSING PROFESSION CULTURE: UTILISING NURSE EXPERTISE AND THE EXPERT NURSE

There are a limited number of SLNs and little training is available to enhance their safeguarding practice. A resource that has several functions and has been cited as valuable in terms of social support, exchange of information, and mentoring is peer support (Fig.5) (Sias, 2008). This type of support has been described as providing an accessible resource during difficult times and is credited with being more likely to alleviate nurses' immediate worries compared to academic resources (Estabrooks et al, 2005). In addition, it is a resource for teaching and learning, leadership and guidance (Drew, 2011).

Mentoring
- Factors influencing mentoring relationships (sex, race, technology)
- Mentoring networks

Information Exchange
- Peer relationship quality and information exchange
- Information-seeking tactics

Power, Control, and Influence
- Colleague talk and control
- Peer relationships and mutual control
- Bullying and mobbing

Social Support
- Peer relationships as sites of instrumental, informational, and emotional support

Fig. 5 Peer Relationship Functions Adapted from Sias, 2008

Collegial relationships can develop if supportive relationships exist with peers while giving more experienced nurses the opportunity of sharing their expertise, and expert practice, with less experienced nurses, and giving the latter the chance to learn. Nursing expertise and expert nurses are utilised and shared

within the nursing profession at times of *handover*[2] (Drew, 2011). SLNs have the opportunity to experience exchanges with each other at network forums and training days and on a daily basis with their teams.

Peer support is relevant to safeguarding because it has been shown that within nursing, relevant training in safeguarding vulnerable adults is lacking (Phair and Heath, 2010). Having access to peers may be the only support available in relation to this dynamic, constantly developing concept. Peers can offer guidance and informal teaching about a subject in which they have knowledge (Drew, 2011; Estabrooks et al, 2005).

2.13 The Expert SLN: Competence, Confidence, Training and the Mental Capacity Act

Having previously considered the general usage of the concepts expert and expertise, in the following sections they are applied to safeguarding vulnerable adults, beginning with the Mental Capacity Act (DH, 2007).

The Mental Capacity Act (MCA) (DH, 2007) is a significant tool in safeguarding vulnerable adults because it assists in determining whether an individual lacks mental capacity and needs help to maintain their personal safety and protect them from risk of harm. However, training in how to complete MCA assessments is inadequate and therefore the potential for them to be completed inaccurately exists. Inaccuracies can result in the assessments being viewed as a form of abuse (Phair and Heath, 2010). On-going practice, continued training, direction

[2] Handovers are informal meetings held at times when one nurse, finishing his/her shift with a group of patients, informs the nurse who will be looking after them next of all relevant information pertaining to those patients, enabling him/her to continue with their care.

and regular updates have been cited as necessary for MCA assessments to be completed confidently and competently (Samsi et al, 2011; Stevens, 2013).

Nevertheless, there is a lack of knowledge relating to the MCA among practitioners because it is not embedded into professional practice (Marshall and Sprung, 2016). Although the MCA is currently legislative, relevant training is intermittent and as a result challenging to grasp. It has been proposed that the MCA is made mandatory and becomes a routine part of everyday practice which will help to overcome the problem of assessments being inappropriately and incorrectly completed. Lack of knowledge and training increases the likelihood of MCAs being incompetently completed and errors being made by a badly informed assessor, which in turn may risk removing an adult's autonomy and choice (Marshall and Sprung, 2016).

Specialists have acknowledged feeling less than competent at completing MCA assessments (Marshall and Sprung, 2016). Nonetheless, they continue to complete these assessments despite training having been reported as inadequate, but significant in the completion of an MCA. Safeguard specialists may have a distorted perception of their knowledge base and, although they manage this specialist role, lack confidence in respect of MCA assessments (Marshall and Sprung, 2016). It is conceivable that specialists in this role are unlikely to be challenged unless the challenge originates from an advocate or Court of Protection, because they are perceived, and expected, to have greater knowledge than others within this specific area. However, lack of knowledge can place a vulnerable adult at risk of abuse.

The aforementioned specialists who acknowledged not feeling competent when completing an MCA assessment (Marshall and Sprung, 2016) are not dissimilar to participants who took part in a different study related to the Mental Capacity Act (Myron et al, 2008). The study was conducted to explore carers' understanding of mental capacity and completion of an MCA assessment. Questionnaires completed by seventy-five carers together with semi-structured interviews conducted with a further twenty carers, found that, although the carers knew the principles for determining mental capacity, they lacked training and practical experience, and thus further training would be beneficial to their practice. Further training would also enable the continued autonomy of those being assessed (Myron et al, 2008).

Without the appropriate training, education and knowledge, an MCA assessment can be completed paternalistically and subjectively by the assessor, thus creating bias, rather than ascertaining someone's mental capacity to retain and recall information. Poorly completed MCAs can be the product of both lack of confidence and competence and have the potential to encourage abuse. Furthermore, generic assessments should not exist as each assessment should relate to specific decisions relevant to each person, for example feeding, dressing, and medications (Marshall and Sprung, 2016). The skills necessary to facilitate increased confidence and competence, in order to protect vulnerable adults, involve acquiring the ability to recognise abuse and those at risk of it (Hunt, 2014; Straughair, 2011).

When an adult is assessed as vulnerable, the assessment should be individualistic and aimed at protecting them from harm. A pre-requisite of

completing an assessment is relevant contemporaneous safeguard knowledge that is applied to practice. This knowledge and exposure to safeguard scenarios can increase specialist knowledge and situational experience or time-specific experience or both (Griffith, 2015). An MCA is the result of personal interpretation and clinical judgement (Lennard, 2016) and therefore has the potential to differ from another assessor's views. Therefore, a vulnerable adult can remain at risk of abuse due to the assessment being incorrectly completed as a result of personal interpretation and lack of training.

2.14 SUMMARY

In this chapter, the etymology of the term expert was discussed and demonstrates that, in the fourteenth century, an expert was recognised as being experienced and skilled. This definition altered slightly over the next five centuries as an expert, as well as being recognised by these attributes, also came to acquire knowledge and experience, or expertise, in a specific subject.

The strategy used to access the literature was described and the characteristics associated with an expert, in generic terms, and the expert nurse, were presented. The notion of expert was also considered in relation to the training, competence and confidence required to be a safeguard specialist.

Having reviewed the literature, the aim was confirmed as understanding how an expert practitioner is defined within a safeguarding service. The objectives were established as: exploring the literature and associated links related to 'expertise' and 'the expert'; determining SLNs' perceptions related to the required

characteristics of their role; and offering recommendations for supporting and developing the role of the SLN as an expert practitioner.

The following chapter introduces the research design.

CHAPTER 3: RESEARCH DESIGN

3.1 INTRODUCTION

Chapter 2 reviewed the literature in addition to discussing the etymology of the terms expertise and expert. The chapter concluded with a summary of the main points.

This chapter begins with a review of the aim and objectives of the study. As the researcher, my theoretical standpoint is expressed and the rationale behind the research design is detailed and each stage explained. The chapter addresses reflexivity and ethics and concludes with a summary.

3.2 AIM AND OBJECTIVES

As first alluded to in Chapter 1, and confirmed in Chapter 2, the aim and objectives of the study are as follows:

Aim

- To understand what defines an expert practitioner within a safeguarding service.

Objectives

- Explore the literature and associated links related to ‘expertise’ and ‘the expert’
- Determine what safeguarding leads perceive to be the characteristics of their role

3.3 ONTOLOGY

The concept of safeguarding vulnerable adults exists as the result of increased awareness, interpretations and shared understandings. Although it has been shown that variations exist in the ways these concepts are perceived, between individuals, cultures, and countries (Martin, 2007; Chrome, 2014), they have nonetheless become part of a reality that cannot be quantified due to its interpretive nature.

Given the diversity of the population, what constitutes abuse in our culture may not be understood in the same way in others. This adds further complexity to the role of the SLNs as cultural migration increases and with it the accompanying beliefs and attitudes of different cultures. This can lead to the SLNs managing sensitive cultural differences related to abuse and vulnerability related to adults in the context of the United Kingdom legislation. However, exploring safeguarding vulnerable adults in different cultures and countries is beyond the remit of this study and has therefore not been included.

Both qualitative and quantitative methods are designed to investigate reality and reflect it from objectivist and constructivist perspectives. The objectivist approach views reality as being measurable and quantifiable and is strongly associated with numbers and statistics (Bryman, 2001). Constructivism is based on assumptions made about learning, knowledge and reality; a reality that cannot be quantified because it is dynamic and the result of social exchanges, without which it would not exist (Kukla, 2000). Safeguarding vulnerable adults is a concept that is fluid, cannot be expressed numerically, and is the result of growing societal awareness.

Individuals interact with other people in the world and from divergent perspectives, and through these social exchanges, knowledge is constructed about reality which would not exist otherwise. During these exchanges, meanings and understandings can be attached, for example to objects. Thus, objects are assigned labels that are mutually understood (Adams, 2006), leading to shared meanings (Zeitlin, 2001). If there is mutual acceptance related to knowledge, it may not be questioned irrespective of whether it is accurate (Adams, 2006).

Due to media coverage and investigative reports, for example CQC (2011), and Francis (2013), awareness related to the abuse of vulnerable adults has clearly increased. This knowledge has led to mutual understanding and meanings being attached to the abuse of vulnerable adults. Increased awareness of adult abuse has also led to professional roles being extended or created with the intention of safeguarding or protecting vulnerable adults who are being abused or at risk of being abused (NMC, 2015).

Changing societal attitudes have led to a reality that exists in relation to the abuse of vulnerable adults and ways of protecting those at risk. It is a reality that is dynamic and relies on growing awareness to maintain continued attention.

3.4 EPISTEMOLOGY

Safeguarding vulnerable adults is a concept that exists as a result of growing societal awareness and, although abuse exists in tangible form, the concept itself does not. Given the interpretative nature of societal conversations, the method for exploring safeguarding vulnerable adults must be appropriate and should enable an honest and accurate study to be carried out. Epistemology relates to

how knowledge can be acquired or created, and how it is accessed and justified. For knowledge to be accepted by others, the method for finding it needs to be accurate and authentic (Soini et al, 2011).

There is a relationship between ontology and epistemology (Scotland, 2012) and there is also an association between epistemology and knowledge that involves four components: methodology, method; data collection; and analysis (Fig. 6) (Carter and Little, 2007).

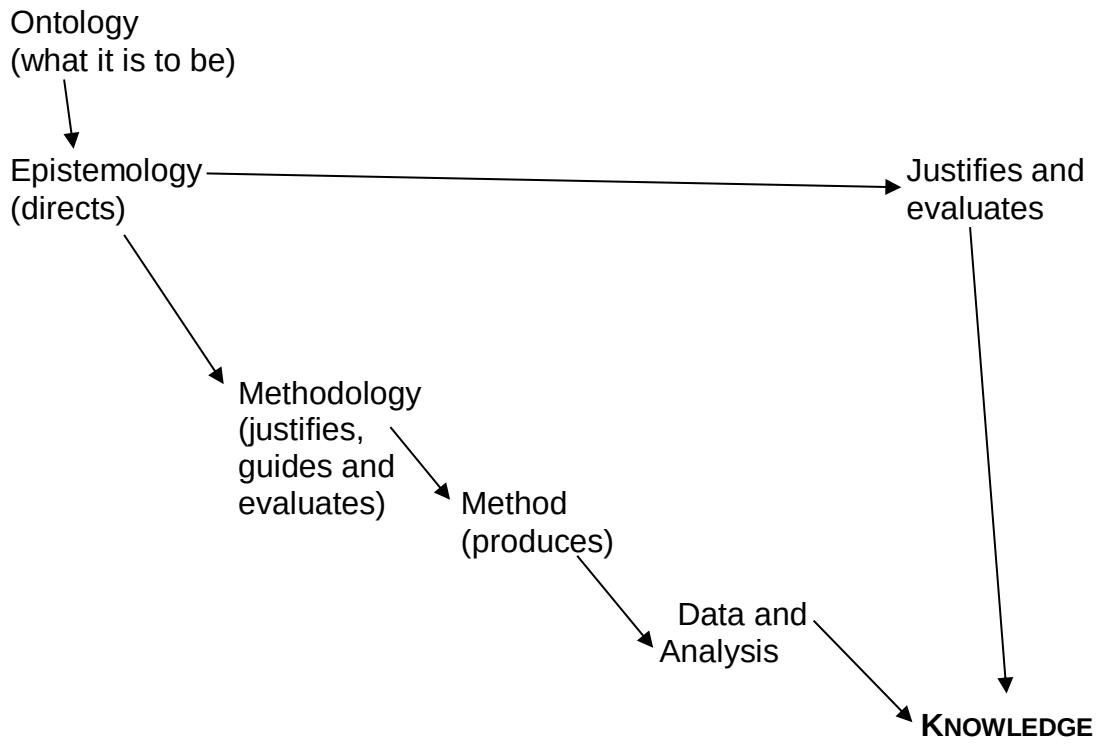


Fig. 6 The Simple Relationship between Ontology, Epistemology, Methodology and Method, adapted from Carter and Little (2007)

3.5 METHODOLOGY

Based on my ontological and epistemological understanding of the subject outlined above, the most appropriate method was phenomenology; I wanted to

hear the SLNs describe their lived experience and the meaning they attached to the experience. Phenomenology could facilitate exploration of the practices of safeguarding vulnerable adult leads because:

> *"Phenomenology is the study of human experience and of the ways things present themselves to us in and through such experience"* (Sokolowski, 2010).

Phenomenology involves seeing the world from someone else's perspective, using language and behaviours rather than numerical data, with the aim of exploring prior to formulating a theory (Schwandt, 2001). It offers researchers the opportunity to explore the mind and being, and understand the meanings that people attach to their experiences (McDonnell et al, 2009). Two philosophers argued for different forms of phenomenology Edmund Husserl and his student Martin Heidegger (Moran, 2000):

- the Husserlian method (descriptive phenomenology) describes the world while suspending judgement, or presumptions, and is associated with putting aside, or bracketing, personal beliefs (Moran, 2000; Chan et al, 2013). Bracketing prevents personal views and experiences from intruding on, influencing, or biasing the study and as a result, the focus is on the involvement of the participant with the world itself, i.e. the actual experience and not the world as it is generally accepted (Kvale, 1996).

  Through bracketing, there is less opportunity for data collection to be the result of researcher interpretation, based on personal views and assumptions, compared to being the lived experiences described and experienced by the informants (Lopez and Willis, 2004). This objective

approach can validate both the analytical process and the method of data collection (Chan et al, 2013).

- The Heideggerian method (hermeneutic phenomenology) rejects Husserl's assumption that it is possible to suspend judgement. Heidegger argues that in order to understand the lived experience of informants it must first be interpreted by the researcher (Moran, 2000). Although Heidegger argued that bracketing is not possible, to not bracket risks data being affected by both the informant and the researcher (Koch, 1994).

From Husserl's perspective, individuals complete routine activities without conscious thought. In order to capture the essence of such activities, the researcher must accurately record and describe the informants lived experience, in the world, without contaminating it with his/her own assumptions and prejudices. In this way, an accurate description of the phenomenon can be determined. Phenomenology offers a way of exploring experiences and environments, where those experiences occurred; it is an approach that enables the acquisition of knowledge that is both relevant and indicative of the people whose lives are being explored (Lopez and Willis, 2004).

Through the interviews, I was able to explore the SLNs world as they described the meanings they attached to their lived experiences in their own words. However, in order to explore these experiences, but not alter their uniqueness with any preconceptions I might have, I needed to address my personal beliefs and assumptions. I did this by keeping a reflexive journal which can lessen the influence a researcher has on their study (Tufford and Newman, 2010).

3.6 METHODS

I wanted to develop a trustworthy understanding of the informants' *lived experience* of safeguarding through the words they used to describe the experience. The interactions of a qualitative interview would encourage informants to describe the meanings they attach to the terms expert, expertise and safeguarding vulnerable adults. As a result, the informants' specific understanding, and the meanings they attached to those terms, would become accessible, through interpretation and organisation of the data, while allowing the extent of the informants' specialist knowledge to be examined.

A qualitative paradigm captures interactions related to a phenomenon under examination (Caelli, 2001). Therefore, the preferred method was qualitative interviews because they would enable contextual knowledge to be captured as it was generated by the informants (Carter and Little, 2007) using their own words (Snape and Spencer, 2003). Additionally, interviews allowed sufficient time to focus on the language informants used while they told their stories (Rubin and Rubin, 1995; Arskey and Knight, 1999).

A small number of participants can produce a wealth of rich data that can contribute to meeting the aims and objectives of a study (Lincoln and Guba, 1986). The value of having a small number of participants was a significant factor in selecting a method, because interviews offer the potential for obtaining in-depth data with limited numbers.

For clarity, during and after the interviews, the term *participant* was rejected in favour of *informant* to more aptly describe the contribution they made to the study

because I felt I was being informed by the SLNs, about their everyday experiences, rather than them merely responding to scheduled questions.

Interactions would occur between myself, as the researcher, and the informants during the interview. Interviews were intended to promote exploration of informants' individual opinions and perceptions about safeguarding, albeit through my interpretation and understanding of their words.

Verbal and non-verbal communication during interviews constitutes both an activity and a social experience (Aksana et al, 2009). Both types of communication occur during everyday conversations so there was every reason to believe that the same would be true of interviews.

Non-verbal communication includes gestures that can be significant or non-significant. They can also be unintentional and the person making the gesture might be unaware of their subliminal communication to others. It is the unintentional gesture that can communicate emotion and invoke similar feelings in others and may create disagreement or harmony if they are noticed by the observer (Aksana et al, 2009).

The idea of discord being created by unintended gestures applies to both the interviewee and the interviewer, because although gestures of this nature can be made intentionally, in the first instance, incorrect interpretation can result. This discord has the potential to make the interview a pleasant or a difficult experience, the latter potentially hampering the informant's fluidity and openness.

Gestures can be useful for supporting comments made by informants or revealing unspoken feelings during an interview, for example rolling the eyes, shaking the

head or closing the eyes. During an interview a participant may say one thing but their body language might indicate something else. These non-verbal communications, which included lowering the voice and raising the eyebrows, were noted alongside the section of text to which they applied in the reflexive journal.

3.6.1 Semi-Structured Interviews

I sought flexibility within the interview process and therefore chose a method that could meet the aims of this study and allow me flexibility. Semi-structured interviews were selected as they enabled me to change the order of the interview questions, within reason, to suit the way that the interview progressed. They could also be used as prompts for acquiring more in-depth descriptions about the informants' lived experience of safeguarding when the opportunity arose. Adhering to asking the questions in a rigid order may have interrupted the continuous flow of the interviewee's narrative and not encouraged their train of thought to develop freely. Semi-structured interviews encouraged me to maintain focus, while enabling the informants to talk freely, but remain within the scope of the interview schedule (Rabionet, 2011).

Although semi-structured interviews offered flexibility in terms of the order that questions were asked, the interviews were planned around the same set of questions being asked to each informant (DiCicco-Bloom and Crabtree 2006).

The semi-structured interviews were designed to last for forty-five minutes but, with the exception of one interview, the remainder took longer than the allocated time to complete. Listening to the informants' own words and their stories during

the interview process gave me the opportunity to understand the informants' experiences from the first-person point of view (Flick, von Kardorff and Steinke, 2004).

3.7 INTERVIEW GUIDE

Based on the aim and objectives of the study, an interview schedule and interview questions were developed (Appendix 2 and 3).

Well planned questions would foster communication between the interviewer and the participant because, as the interview developed, the questions would be asked in response to the information given by the informant (Rubin and Rubin, 1995).

The interview questions included qualitative words such as 'how', 'where' and 'why', which enabled an area of interest to be explored. The inclusion of these words discouraged the use of one-word answers and instead prompted informants to describe their experiences in detail.

3.7.1 Pilot Study

As the researcher, I recognised that a pilot study could highlight any changes or clarifications that were needed prior to conducting the main study (Barriball and While, 1994). In addition, a pilot study had the potential to discover the type of information that could be expected and the ways that this data could be captured (Fielding and Thomas, 2008). However, conducting a full pilot study was not feasible due to the limited number of SLNs working in this relatively new specialist role.

Nevertheless, piloting my data collection strategy was accomplished by practicing personal interview skills with comparable healthcare professionals who were given the opportunity to comment on the interview process following the interview. In their opinion, the questions were not ambiguous or leading and they were given ample time to answer each one. In addition, the healthcare professionals felt confident that I had understood what they had said because, at various times during the interview, I asked them to confirm my understanding. Following a review of the pilot, I did not find any necessary format changes and therefore the interview schedule remained the same.

3.8 SAMPLING FRAME

For optimal results in relation to collecting the data for this study, a sampling frame was developed (Ritchie & Spencer, 1994; Devers and Frankel, 2000; Ritchie et al, 2003). This ensured that the sites to be accessed were considered, identified and had the potential to contribute to the recruitment of the participants. This systematic approach added structure to the study (Devers and Frankel, 2000).

The aim was to recruit ten to fifteen participants, which constitutes an adequate sample for a qualitative study to be conducted (Kvale, 1996); ten SLNs were ultimately recruited.

Inclusion and exclusion criteria were included in the research design, because they can add structure as they establish boundaries for selecting participants (Richie, Lewis and Elam, 2003). The following inclusion and exclusion criteria were applied to this study:

3.8.1 Inclusion Criteria

- *Registered General Nurses (RGN)*
- *Lead Safeguarding Role*
- *RGNs with a minimum of six months' experience in the safeguarding role*

3.8.2 Exclusion Criteria

•*Social Workers or other health and social care professionals with a role in safeguarding*

•*RGNs with less than six months' experience in the safeguarding role*

Nurses who had been employed in the role for longer than six months were included because less than six months is unlikely to be adequate time to have acquired the practice or experience required to fulfil the safeguard role. This assumption is founded on the studies conducted by Dreyfus and Dreyfus (1980) and Ericsson et al (1993) who determined that, to develop as an expert, and acquire expertise in a specialism, could take three years or longer which I felt, as the researcher, supported my exclusion of nurses with less than six months experience.

Social workers were excluded because my research interest related to safeguarding leads who were nurses. Furthermore, social workers who were spoken to had received training in safeguarding vulnerable adults which is recognised and accepted nationally, and therefore are likely to perceive safeguarding vulnerable adults differently to nurses.

3.9 RECRUITING PARTICIPANTS

Selecting participants with knowledge and experience in an area being investigated can guarantee an in-depth exploration of the phenomenon and result in a viable study (Tongco, 2007). The participants for this study were SLNs because they possessed knowledge and experience related to safeguarding vulnerable adults, although the depth of their knowledge has not been measured.

Fielding and Thomas (2008) suggest that purposive sampling can introduce bias. However, although this might be true, there was little point in inviting health organisations to take part unless they employed nurses who were working specifically in the role of safeguarding vulnerable adults. Following the initial invitation, no further contact was made with any participant until the health organisations had selected them.

The strategy used for participant selection involved contacting several local health organisations within the South East of England to ascertain if they had safeguard teams. A number of contact details were obtained by contacting my own organisation's safeguard team; the remainder were found by conducting a search for health organisations in the targeted areas. Subsequently, an email was sent to each contact asking if they would be willing to permit their safeguard team to take part in the study. At the time, I had no previous knowledge of which health organisations had safeguarding teams or who would participate.

It was the choice of the health organisation as to who replied and allowed their SLNs to take part, and not myself. This enabled the elimination of bias relating

to participant selection, although it did not avoid any potential bias that might result from the health organisation's selection.

3.10 Obtaining Permissions to Access Participants

To obtain access to potential participants, permission has to be sought and granted for the study to proceed:

3.10.1 Ethical Considerations

Guidelines exist to protect both human participants in studies and researchers and include ethical approval and informed consent (NMC, 2015; Rubin and Rubin, 1995), as well as ensuring the study is justified (Lewis, 2003). The applications submitted to relevant ethics committees to obtain approval to conduct this research were an assurance that the participants were not being placed at risk of harm by participating, and with the intention of the study being concluded within six months of receiving ethical approval.

However, this period was prolonged due to the work commitments of the informants and reduced resources of their organisations. When ethical approval had been obtained at the outset of this study, I agreed a date for the interviews to be completed with a number of the health organisations' ethics boards. These ethics boards were advised of the time delay and agreed that the study could continue.

3.10.2 Ethical Approval

Ethical approval was obtained from the University of Essex Ethics Committee and the Integrated Research Application System (IRAS) as part of the NHS requirement for conducting research (Appendix 7). The NHS has Research and Development teams attached to different healthcare organisations across the region to ensure that research is conducted within the boundaries of what is ethically approved; several of these were approached prior to conducting this study.

3.10.3 Ethical Guidelines

Four main principles should guide ethical considerations in respect of participants, namely: autonomy, beneficence, non-maleficence, and justice. These principles are implicit to the respect and sensitivity that are expected to be given to participants in order to protect them from harm as a result of participation in research studies (Purtilo and Doherty, 2011).

Autonomy

To enable participants to appraise the extent of their involvement, they were given the study details before participating in the study, including the information sheet (Appendix 4). This gave them the opportunity to digest the information and appraise it, which in turn enabled them to make an informed choice about whether to participate or not. *Informed consent* represents an individual's self-directed authorisation which is one of the main ethical principles (Beauchamp and

Childress, 2013:59). Consent was required from each participant before they took part and was the result of respecting participant autonomy.

Informed consent was obtained through a form containing boxes that required a signature in each. The participants were given a copy of the signed consent form which also incorporated a section advising them of how to withdraw from the study, should they wish to do so (Appendix 5).

Beneficence

Beneficence is defined as doing good towards others (Bartter, 2001; Parahoo, 2006). This study is intended to do good by increasing awareness of safeguarding vulnerable adult roles and what is involved in managing them. Heightened awareness can increase what may, or may not, already be known about the complexities of the safeguard role and the issues that the SLNs are confronted with on a daily basis.

Non-maleficence

Non-maleficence originates from the adage, *primum non nocere:* above all do no harm (Beauchamp and Childress, 2013), and is considered to be the responsibility of everyone (Bartter, 2001). To do no harm means protecting individuals by not placing them in danger, which covers physical, emotional or psychological harm, for example ruining a good reputation (Beauchamp and Childress, 2013). This study did not intentionally place any participant at risk of harm by maintaining anonymity, confidentially and privacy, although the informants were advised that if I heard anything that I considered to be cause for

concern, the information would be shared with relevant service managers. Additionally, if informants became overwhelmed or distressed during the interviews, health and well-being advisers could be contacted to support them: the contact details having already been sourced prior to interview.

Justice

Justice or fairness is concerned with impartiality towards all participants. Implicit in this principle is the notion that every individual is offered the same opportunities and is made aware of any benefits, costs and risks as a result of taking part in a study (Beauchamp and Childress, 2013).

No benefits, financial or otherwise, were offered to any informant involved in this study before or after giving consent although they were advised of the ways their participation could enhance what is already known about the topic.

Impartiality was also maintained through reflection and note-taking. Informants were treated fairly and with respect during their involvement in this study. The same questions were asked of all informants but none were asked that would knowingly harm them for example, questions pertaining to breaches of confidentiality.

3.11 GATEKEEPERS

Gatekeepers (Gilbert, 2008) act as the link between researchers and health organisations and have the authority to grant researchers permission to approach informants directly. Gatekeepers' acceptance of a study has the potential to

credit, validate, or prevent it from continuing. Developing a relationship with the gatekeeper can assist with building trust, obtaining support for a study and gaining access to participants (Dempsey et al, 2016).

Gaining access may be challenging because, although gatekeepers can allow researchers access to organisations and participants, they can also prevent it. Preventing access may be the result of their perception that the group being accessed is too vulnerable or due to being 'over-protective' towards the potential participants (Seidman, 2013). Consequently, the participants do not get the opportunity to take part in a study because of the gatekeeper's beliefs (Sixsmith et al, 2003).

Access to adult safeguarding leads/nurses was controlled by a *gatekeeper* who represented each organisation's Research and Development (R&D) team. In addition, the health organisation's management teams also acted as gatekeepers and included Clinical Auditors, Research Facilitators and Chief Nursing Officers. The informants remained inaccessible until any issues had been resolved by the gatekeepers. Gatekeepers also assisted with signposting other potential health organisations who might be interested in their safeguarding team participating in the study. Additionally, they were able to facilitate and/or expedite contact with the informants from their organisation, once they had approved their participation (Gilbert, 2008).

Gatekeepers had immediate access to both the health organisations and their safeguard teams, which was helpful because it meant they could ask them if they would like to participate. Contacting the SLNs, and the different health organisations, probably proved more challenging for me due to the substantial

work commitments, and the various shift patterns, that each of the health organisations and the SLNs manage daily.

Once the gatekeepers had received detailed information about the study and were satisfied, access to both the organisation's property and potential participants was granted. However, in one case, the health organisation declined to participate in the study due to being short-staffed and having to manage seasonal demand within their hospital: they felt their team would be placed under undue pressure if they participated. As a result, the potential participants did not take part in the study which reflects the control gatekeepers possess.

Attachments included in the email to the gatekeeper included:

- the interview schedule (Appendix 2)
- the interview questions (Appendix 3)
- the information sheet (Appendix 4)
- the consent form (Appendix 5)
- permission to access participants: to be completed by the gatekeeper: giving me permission to contact and interview the potential participants and authorisation allowing the interviews to be conducted on the premises of their individual health organisation (Appendix 6)
- the ethical approval form (Appendix 7)

The documents were numbered, dated and a version code applied. The interview guide was based on the interview questions to give the participating health organisations an indication of the type of questions that might be asked.

Following these communications, I contacted the potential participants directly via email with details of the proposed study.

3.12 REFLEXIVITY

Irrespective of observing or interacting, the choices that researchers make have the potential to influence data collection. Therefore, researchers need to be aware of, and recognise, any preconceived assumptions they have in order to reduce their potential to cause bias (Roberts, 2004).

However, the potential influence and contribution researchers make to a qualitative study can be explored through reflexivity and bracketing (Benner, 1982; Roberts, 2004; Chan et al, 2013). Both reflexivity and bracketing involve researchers being honest about their personal views in relation to the area being explored and the influence this might have on the study; bracketing is largely associated with phenomenology (Chan et al, 2013). Nevertheless, choosing the correct research design, preparation and planning and accurate documentation, can enhance qualitative studies (Morse and Field, 1996).

Bias can unknowingly be introduced into a study by researcher influence. This can cause the results to veer towards the researcher's values rather than the truth of what has been determined by the study. A method that researchers can use to ameliorate their influence is reflexivity (Levy, 2003; Chan et al, 2013). Being a reflexive practitioner encourages researchers to address their own beliefs and assumptions in relation to the phenomenon being explored and is a significant part of any qualitative study (Roberts, 2004).

By acknowledging their own beliefs and assumptions, researchers can develop original understandings which should enhance a study and not damage it, as Levy explains:

> "…*not in order to suspend subjectivity but to use the researcher's personal interpretative framework consciously, as the basis or developing new understandings"* (Levy, 2003:94).

Reflexivity is beneficial before, during and after conducting a study, to reduce the potential for bias and to encourage researchers to monitor their own assumptions and behaviours in relation to the study (Ahern, 1999).

I could not assume that, just because the study had started, it would continue but I needed to be aware of possible reasons that might prevent it from proceeding. Therefore, prior to beginning, I considered who had control of the study because, although I was conducting it, the study could not be completed without approval from the ethics committee, participation from the health organisations involved and the informants themselves. Withdrawal from the study by any of the organisations could have prevented the study from progressing; this had the potential to influence my behaviour towards organisations in order to maintain their continued participation.

Reflecting on my ten years as a nurse working on an emergency ward and then in the community, I recognised that in both roles I used clinical judgement and practical experience to complete assessments of patients' physical and mental health. These roles required excellent verbal and non-verbal communication skills and the ability to build trust and develop rapport with others, in a short space of time as is required when undertaking a research interview. Reflecting on these

skills, I divided them into sections, related to the interview process, and explored the concept of transferability of these skills, further.

Pre-interview reflection

Ritchie & Lewis (2003) suggest that a researcher should reflect on their own social worlds as well as the informants; this will allow researchers to respect, listen and appreciate the informants' narratives. I have cared for patients who have described their experiences of health and illness to me. These narratives motivated me to look at my own social world and helped me appreciate the value of understanding different perspectives; these narratives have been a valuable influence in my practice.

Researchers' interpretations of narratives should be constructed to enable others to see, for themselves, the conclusions that have been drawn. Interpreting and transcribing narratives is interpretive and thus narratives will vary between researchers' due to the interpretative nature of qualitative study which cannot be measured (Roberts, 2004).

Structuring the interview time/space

Measures can be taken, prior to the interview, to elicit good interview outcomes; these include organising a suitably quiet and private environment for the interview to take place and one that is free-from interruptions that will enhance the information collected (Kvale, 1996; Edwards and Talbot, 1999).

I identified commonalities between my nursing experience and the interview process. For example, in order to discuss private and confidential issues with

patients and relatives, consideration needs to be given to the appropriateness of the environment where the meeting will take place. Likewise, the environment where interviews are conducted needs to be private, quiet and allow informants to speak uninterrupted and freely.

In relation to the positioning of the researcher and informant, I drew on the experience of talking to patients in clinical environments. I have found by positioning myself at a similar eye level to the person I am interacting with, rapport can be established. This postural method of non-verbal communication can assist with developing relationships and trust (Argyle, 1988; Barkai, 1990).

The first impressions the informants formed about me, had the potential to impact our relationship and the way they interacted with me during the interview. Although I had previously emailed documentation including an information sheet outlining the study, I took a copy of any documentation to each interview, in case clarification was required by the informant. I felt this would convey preparation and confidence to each of them which I perceived as important.

I was mindful that my potential influence on the interview might begin with the way I dressed, behaved and generally presented myself. When I arrived for each of the interviews, I introduced myself, accepted a drink if it was offered to me and asked where the toilet was situated; I dressed smartly but casually.

In both semi and unstructured interviews, the interviewer/researcher is an instrument for collecting data and it is their individual interviewing style that affects the type (and quality) of information they will acquire. The conversation space created between the interviewer/researcher and the informant is unique and

much of the interview process depends on this relationship and the characteristics of the interviewer/researcher (Pezalla et, 2012).

The interviewing characteristics to which Pezalla et al (2012) refer include showing interest in what the informant is saying and how words are being used, having the ability to actively listen, being sensitive and empathic, and allowing time for the informant to respond. Additionally, asking the informants questions about what they have said confirms they are being listened to, but can also extend the information they are sharing (Kvale, 1996). All these techniques are transferable skills from my nursing practice.

The clinical assessment of a patient is comparable to a semi-structured interview. As a nurse I have specific areas of information that I need to ascertain; but I am also mindful of other information the patient may want to share that may be relevant to their biological, psychological and social well-being in the health care system.

As in a clinical interview with a patient, I remained during the interviews consistent but flexible in my approach. In doing so patient (and participants) can feel safe that I am confident and competent in relation to the interview process but also able to accommodate additional information that the informant (patient) might want to share.

During one interview another person was in the room where the interview was taking place (detailed on p.122 of this text). In hindsight, I questioned, whether I should have objected as another person in the room may change the dynamics between me, as the researcher, and the informant. There is evidence to suggest

communicative activities can be influenced in the presence of others altering the context of the conversation and losing its honesty (Kring and Gordon, 1998). Although I was conscious that there had been a momentary communication, the interview proceeded and the informant repositioned themselves of their own accord. There had clearly been communication between them but we cannot know what it meant.

The interview process

The use of self-disclosure with patients and relatives may help to facilitate the development of trusting relationships. I have found this to be the case when working with patients who are anxious or mistrustful of health services. The extent of self-disclosure depends on the individual situation and the learned experiences of the professional. However, it can adversely affect professional relationships because others may mistake self-disclosure with friendship (Hall, 2016).

I used self-disclosure to encourage the development of relationship where informants would feel comfortable to talk about working with vulnerable adults. An example of this is when I arrived at one of the interviews, it was raining. As I drank the cup of tea I had been given, I shared with the informant that rain reminded me of sitting in the warmth and comfort of my dad's arms when I was a small child, a happy memory for me.

Throughout the study, I monitored my behaviour and or questioned any assumptions related to what I heard from the informants so that my assumptions and personal views did not blur the way I interpreted informants' narratives (Ahern, 1999).

Interviewers require an in-depth understanding of social exchanges and possess the ability to communicate well in order to successfully complete a study (Kvale, 1996). I believe I have developed such in-depth understanding of social interactions and possess excellent verbal, and non-verbal, communication skills. This has been demonstrated on numerous occasions, when I have needed to be empathic, supportive and understanding, with patients and relatives in sensitive or difficult conversations; allowing them to speak for as long as they have needed while maintaining impartiality to prevent my beliefs and values from influencing them. I ensured that I was reporting, objectively, the words of the patient or carer not mine.

I drew on my nursing practice with patients and carers, to employ a range of communication skills during the interviews e.g. nodding my head indicated understanding, verbally confirming that I had understood correctly, and asking questions if appropriate to help clarify an issue. Similarly, as a nurse I have often needed to draw patients and carers back to a question in order to get the information I needed, to provide therapeutic care. Equally, the ability to maintain focus, in an interview, ensures the semi-structured interview progresses as planned.

Gender in interviews

It has been proposed, by Padfield and Proctor (1996) that information obtained by female researchers differs from their male counterparts because female researchers generate different types of information. A possible explanation may be emotional intelligence (EI) which, although not differing significantly between gender, favours females in the social skills. For example, compared to men,

women have been shown to have greater empathy, are better communicators and possess greater skills in respect of developing social relationships (Eagly and Johnson, 1990).

Differences have also been found in the approach men and women use to communicate with others; while men tend to be direct, women have the propensity to be subtler during social exchanges (Haas, 1979; Mohindra and Azhar, 2012). This suggests that different approaches have the potential to determine the type of response given and how the information is interpretation.

I considered these factors during a subsequent period of reflection related to the interview transcripts. I questioned whether the data I obtained, and interpretation of it, may have been the result of being a female researcher. It is likely that viewing the world from a female perspective, I had the potential to have an impact on the study, although the extent of this could not have been calculated.

Nevertheless, personal interpretation can lead to new concepts and knowledge being revealed which is the main reason for conducting research in the first instance (Lewis, 2003).

3.12.1 Recognising Personal Assumptions

Neutrality can be demonstrated by researchers recognising and noting their own assumptions (Morse and Field, 1996). I had developed assumptions about safeguarding and the individuals in the associated roles. Prior to conducting this study, I had worked closely with safeguarding teams and had formulated assumptions about the safeguarding role and whether the safeguarding nurses were experts or had expertise.

I was confident that phenomenology was the appropriate methodology, but my personal beliefs related to descriptive or interpretative phenomenology needed to be addressed to validate my research. Despite revisiting the work of Husserl and Heidegger and applying each to safeguarding, I found bracketing difficult to do. For me to disregard any prior experience I had with safeguarding, in addition to the knowledge I had gained from reading the safeguarding job vacancy descriptions during the developmental stages, was unrealistic.

Furthermore, there was a strong possibility that, when interviewing informants, I would unconsciously compare what I already knew to what I was hearing from them, although I knew my personal knowledge about safeguarding would increase as a result of conducting this study. Not addressing my personal beliefs towards the reality of safeguarding would have significantly influenced the study in the same way that a good or bad rapport between interviewer and interviewee had the potential to do.

Exploring the safeguarding role from the perspective of the people living this experience on a daily basis by listening to their own words, the meanings they attach to the relatively new safeguarding role, and interpreting what they are saying through their narratives could be achieved through interpretative phenomenology.

3.12.2 Reflexive Journal

There are no guidelines for effective bracketing, but keeping a reflexive journal, memos and having an awareness of personal beliefs and assumptions can help researchers understand how they might influence a study. Through continued

reflection, throughout the duration of a study, researchers' influence may be lessened (Tufford and Newman, 2010).

Maintaining a reflexive journal (Ahern, 1999) from the outset was a reminder of the assumptions I already held about safeguarding and the people in the role of safeguarding lead. Examples of the notes written in the journal included:

- Protecting vulnerable adults: fraught with challenges but does it need specialist knowledge to discharge the role?
- People leading adult safeguarding must be experts because of the way they behave and portray themselves; is this behaviour simply a way of hiding their lack of relevant knowledge?
- SLNs perceived as *arrogant* due to their confidence and how they express themselves: are they? Reflect: where is this view coming from?
- Safeguarding leads must have had a great deal of training and education to effectively manage their role.
- Is a specific role really needed to protect vulnerable adults; all nurses are expected to do this?

The reflexive journal was continued until the end of the study and used to aid reflection and to explore whether my personal assumptions were influencing any part of the study; keeping a journal helped to bracket these assumptions by questioning them, recording them and exploring their relationship with the study and prevented contamination of the data (Ahern, 1999). This technique therefore enabled the exploration of any personal preconceived ideas, contrasting and

comparing them to the data collected from the informants through continued reflection and reflexivity. By recognising and addressing personal assumptions at the outset, the topic of safeguarding in relation to expertise and being an expert was fully explored but with an awareness that I had the potential to influence the study.

During the interview process and while I was transcribing the interviews, inwardly I heard myself making comments along the lines of: 'I never knew that' or, 'that's not what I thought'; these comments demonstrated my preconceived ideas. Such comments were duly noted along with the data they related to, in the reflexive journal; the comments were referred to throughout the analysis and interpretation of the data which enabled the informants' views to receive exclusive attention rather than my personal opinions interfering with these.

Written notes were kept that related to my own feelings during the interview process which allowed exploration of them as the study progressed and encouraged me to question whether objectivity was being maintained.

In these ways, impartiality was sustained throughout the study: self-monitoring and keeping a reflexive journal (Ahern, 1999; Tufford and Newman, 2010); helped me to overlook any knowledge of safeguarding I had previously acquired.

3.13 SETTING THE SCENE

An interview plan was devised to direct the interview process (Fig.7). The interview plan constituted an advisory tool to inform the informants what was expected from them and to give each of them an opportunity to ask any questions before the interview took place.

Introductions given by both the interviewee and the interviewer including the interviewer confirming identification and access/authority
Reiterating the area of exploration and confirming the informant's willingness to continue with the interview: this information was also explained on the information sheet they were given prior to the interview
Informed consent explained and signature obtained from the participant reiterating their right to withdraw at any time at no detriment to themselves
Reiterating that there would not be any financial payment or other incentive before, during, or after the interview made to the participant for participating
Confirmation that participant information would be secured and confidentiality and anonymity maintained for the entirety of the study and securely destroyed at its completion; reiterating that information that called into question matters related to professional practice could not be kept secret in accordance with the NMC (2015) Code of Practice
Participant's willingness to validate the transcript from their interview once completed
Reminder to participant that I would be note-taking throughout the interview
The interview (recorded with participant's permission)
Closing discussion

Fig. 7 The Interview Plan

3.14 THE INTERVIEW

The interviews took place on the premises of the various organisations involved at a mutually suitable time for both the participant and researcher. For each participant, the interview questions (Appendix 3) were presented in the same way and were based on the interview schedule (Appendix 2).

Prior to the interview, participants were given an information sheet (Appendix 4) outlining the rationale for the study, advising them of what they were consenting

to by taking part in this study and informing them the interview would last for about forty-five minutes.

An interview can be represented accurately by transcribing it from an audible recording (Barriball and While, 1994). However, DiCicco-Bloom and Crabtree, (2006) do not support this idea and claim instead that interview transcripts can be far from accurate. They reason that omissions of punctuation and misinterpretation of terms can result in inaccurate information being transcribed.

To ensure that I had understood what each informant had meant during the interview, a first rough draft of their interview was sent to the informant to read; informants being given the opportunity to read their own interview transcripts is known as member checking (Simon and Goes, 2011). This might have led to an informant choosing to agree, disagree or remove themselves or the transcript from the study, once they had read it (Carlson, 2010). However, member checking prevents the researcher adding information to or removing information from the interview which might discredit the study (Simon and Goes, 2011).

3.15 Evaluating Qualitative Studies

Evaluating qualitative and quantitative data differs due to the nature of the methods used to acquire the required information. It was appropriate to meet the aim and objectives of this study to adopt a qualitative approach.

Quantitative data results from objective methods of collection such as questionnaires, survey and experiments, and can be quantified and measured, whereas qualitative methods tend to be used in natural settings and are

interpretive; results are challenging to quantify as a result (Dyson and Brown, 2006).

Besides evaluating the data, a further issue involves evaluating the study itself. For many years, assessment of these types of research studies has been completed using the same predictable methods which cannot be applied due to the subjectivity of qualitative research (Lincoln and Guba, 1986). The problem of evaluating qualitative research was addressed by Lincoln and Guba (1986) who looked for rigour comparable to that associated with quantitative studies in qualitative design; they concluded that the answer was trustworthiness (Lincoln and Guba, 1986).

3.15.1Trustworthiness

Rigour in quantitative studies can be demonstrated through external validity, internal validity, replicability, and objectivity. In qualitative studies the equivalent of rigour is trustworthiness which can be demonstrated through other comparable methods. For example, truth value can be seen as the equivalent of internal validity, applicability parallels external validity, while consistency and neutrality can be likened to replicability and neutrality, the latter through objectivity (Lincoln and Guba, 1986; Morse and Field, 1996).

Authentication approaches can help to reinforce the trustworthiness of a study and include member checking (Bradbury-Jones, Irvine and Sambrook, 2010), audit trails, examining the methods and processes used throughout the study with peers or involving informants in the results (Morse et al, 2002).

Trustworthiness in qualitative studies needs to be assessed by considering the ways in which the findings have been produced. Granheim and Lundman (2004) suggest that this is done by describing the different steps of a study through transferability, credibility and dependability, which are recognised as elements necessary to demonstrate trustworthiness (Granheim and Lundman, 2004).

3.15.2 Credibility

The credibility of a qualitative study specifically relies on the intention of the study being met in two ways. The first is that the intention of the study remains unchanged; while the second relates to the data and the associated analysis addressing that intention. This involves the rationale for participant selection, the methods used to collect information and whether the data analysis reflects the intention of the researcher (Granheim and Lundman, 2004).

Credibility was strengthened in this study in the following four ways:

- The intention of this study, from the outset, was to explore safeguarding vulnerable adults and the idea of an expert and expertise from the perspective of SLNs. The intention, or aim, did not change and remained the same throughout this study, as did the context. The interview question guide was formulated and the appropriate recruitment method selected. Data analysis was completed consistently for all the interview transcripts. The aim and objectives were echoed in the method for collecting the data, which allowed exploration, and the analysis, thus strengthening credibility, as proposed by Granheim and Lundman (2004). The participants were purposively selected

because of the safeguarding roles they hold and the experiences they had acquired in such roles.

- Interviews were the medium which enabled the participants to tell their stories, in relation to safeguarding vulnerable adults. These interviews produced data that was rich enough to explore the lived experiences of the SLNs.
- Emergent themes and sub-themes that evolved are supported by direct quotes from anonymised transcripts.

3.15.3 Transferability

Transferability refers to the applicability of a study's results to other groups or settings; this is achieved through rich description of context (Granheim and Lundman, 2004).

To assist with transferability of this study's findings:

- Pen portraits of the informants have been made available for readers in Chapter 4 of this thesis which offer brief, anonymised synopsis', including their context.
- A description of the environment in which the SLNs work is included. If I had studied a different environment, the results would have been transferable.
- The themes and sub-themes are consistently reinforced with excerpts from the transcripts.

3.15.4 Dependability

Dependability refers to changes a researcher makes during data analysis as a result of the research process and assessing whether the same results would be obtained if the study was replicated. The researcher needs to state any changes that happened during the context of the study and whether this had an impact on it (Lincoln and Guba, 1986; Trochim, 2005).

3.15.5 Confirmability

Confirmability refers to researchers being honest about personal assumptions and beliefs in relation to the phenomenon they are exploring. It also involves identifying the limitations of their study, reporting the research methodology and ensuring that each stage of a study is clearly presented, to enable others to examine the study in detail. This approach helps to confirm the findings as the actual views and experiences of the informants and not the researcher's predilections (Rolfe, 2004; Shenton, 2004).

Throughout this study, I have been candid about my assumptions and beliefs, in respect of the phenomenon under exploration, including acknowledging the possibility that my gender could have had an impact on the study. Furthermore, excerpts from the interview transcripts have been used to illustrate the informants' experiences and also show how they described their experiences. This confirmed that the findings were the result of the informants' experiences and not covertly due to my assumptions and beliefs. I have given detailed explanations related to every part of the process throughout.

3.16 DATA ANALYSIS

Data analysis was completed by applying Framework, a method that was developed to assist with manual examination and ordering of data; it involves five stages: familiarisation; identifying a thematic framework; indexing; charting; mapping and interpretation (Ritchie & Spencer, 1994; Ritchie et al, 2003).

Framework (Ritchie & Spencer, 1994; Ritchie et al, 2003) is utilised in qualitative health research: the benefits of using Framework are increasingly acknowledged in respect of the management and analysis of such data (Gale et al, 2013).

Gale et al (2013) propose Framework might not answer every qualitative research question and might not suit all qualitative data analysis e.g. if the data are too dissimilar to index but unlike other methods of data analysis, Framework is not associated with a particular discipline. Therefore, this method does not have to be underpinned by specific philosophical ideas as others data analysis methods are, for example ethnography, grounded theory, phenomenology; Framework is an adaptable, flexible tool that allows data analysis for any qualitative research that intends to produce themes (Gale et al, 2013).

Although a novice researcher, the Framework (Ritchie & Spencer, 1994; Ritchie et al, 2003) method offered me a methodical way of analysing my data by following the aforementioned different stages of Framework; the contextual meaning of each informant's viewpoint was preserved and comparisons were possible between, and within, each date set obtained from each informant which assisted with structuring the collected data (Gale et al, 2013).

Data analysis was further assisted using MAXqda (1989-2015) which is a software programme designed to accommodate large amounts of collected data and to assist with its organisation (Gibbs, 2013). Software programmes offer an alternative to completing the analysis entirely manually by aiding the identification of a thematic framework through electronic means. Nevertheless, data analysis decisions are ultimately the responsibility of the researcher irrespective of the method selected to assist with completing it (Gibbs, 2013).

Although MAXqda (Gibbs, 2013) was used to assist with indexing and coding, I preferred to familiarise myself with the hard copies of the transcripts because I was able to relate to the informants and their stories more easily. Also, it was satisfying to move from one transcript to another and less challenging to ensure that significant data remained in context. I was able to recall the interview and the informant's voice by reading the transcripts which may have been lost through MAXqda.

3.17 Application of Framework

Framework (Ritchie & Spencer, 1994; Ritchie et al, 2003) was used to structure the data analysis, and as already stated comprises of five stages:

- Familiarisation
- Identifying a thematic framework
- Indexing
- Charting
- Mapping and Interpretation (Ritchie & Spencer, 1994; Ritchie et al, 2003).

The different stages of Framework make it easier for others to grasp how data was collected during a study, how it has been interpreted and the subsequent conclusions drawn (Ritchie & Spencer, 1994; Ritchie et al, 2003).

3.17.1 Familiarisation

Data analysis began with familiarisation and involved examining and reading the transcripts several times, which facilitated familiarity with them. To achieve credible study results, the data was considered in context and any relationships that existed between and within topics were identified (Ritchie & Spencer, 1994; Ritchie et al, 2003).

Familiarisation with the transcripts revealed the existence of many commonalities. After visiting and revisiting the data several times, commonalities were grouped and divided into potential themes (Fig.8).

Main Themes	Sub Themes	
Personality	*Confidence*	Knowledge base impacts confidence levels Experience impacted by previous role and transferable skills Practice increases self esteem Feedback: boosts confidence: realisation of knowledge on par with others
	Self-doubt	Underestimates knowledge held: presentations in front of others= nerves Believes others better/ more experienced
	Arrogance	Result of personality: does that sound arrogant but I am an expert? Fear of failing Does not attend courses if they have nothing more to offer
	Motivation	Result of passion: I love my job! Independent learning from reading, courses and networking
Experience	*Domain Knowledge*	Current knowledge assisted by previous role: transferable skills Training Courses On the job Increased with practice
	Practice	Intuition becomes finely tuned with exposure to more situations and experiences Acquired expertise through practice and increased experience
	Expertise	In depth knowledge Specialism; Specialist knowledge Gut feeling: comes with experience and tacit knowledge Expert perceived to have expertise; different perspectives Training courses: on the job
Peers	*Motivation*	Can assist in motivating peers or douse their enthusiasm
	Self-Doubt	By having specialist knowledge in the same field, peers can assist in others self-doubt Can unwittingly intimidate
	Confidence	Can increase or decrease confidence
	Forums	Sharing knowledge Like minds Networking Qualifications can indicate greater knowledge than experience; can reduce self-belief and self-esteem

Fig. 8 Emergent Themes

3.17.2 Identifying a thematic framework

To familiarise myself with the data, I read, re-read and scanned backwards and forwards through the collected data. By comparing the transcripts, recurrent themes were identified (Ritchie & Spencer, 1994; Ritchie et al, 2003). These patterns initiated the development of a thematic framework (Fig.9). The emerging themes were categorised, indexed and charted, as proposed by Ritchie and Spencer (1994) and Ritchie et al (2003); an anonymised transcript is given in Appendix 8 and further short excerpts are shown in Appendix 9.

1.0 PERSONALITY	
1.1 Confidence	Knowledge base impacts confidence levels; Practice increases self esteem Feedback: boosts confidence: realisation that knowledge on par with others Male vs Female
1.2 Self-doubt	Underestimates knowledge held: presentations in front of others= nervous Believes others better/more experienced
1.3 Arrogance	Result of personality: does that sound arrogant but I am an expert? Fear of failing Does not attend courses if perceived as having nothing to offer
1.4 Motivation	Result of passion: I love my job! continued interest: independent learning from reading, course and networking
1.5 Qualifications	Indication of an expert No faith in qualifications: no better than experience "Titlitis"
1.6 Peer influence	Peer can offer support but also cause doubt Qualifications say more than experience and can reduce self-belief and self-esteem Sharing knowledge
2.0 EXPERIENCE	
2.1 Domain Knowledge	Current knowledge assisted by previous role and transferable skills Training courses On the job training
2.2 Practice	Intuition becomes finely tuned with exposure to more situations and experiences Acquired expertise through practice and increased experience
2.3 Knowledge	Increased with experience
2.4 Expertise	In depth knowledge; specialism; specialist knowledge Gut feeling: accompanies experience and tacit knowledge Expert perceived to have expertise; different perspectives Training course: on the job
3.0 PEERS	
3.1 Motivation	Can assist in motivating peers or dousing their enthusiasm
3.2 Self-Doubt	By having specialist knowledge in the same field, peers can assist with increasing others' self-doubt Can unwittingly intimidate
3.3 Confidence	Can increase or decrease confidence
3.4 Forums	Sharing knowledge Like minds Networking

Fig. 9 Coding of Emergent Themes

The reflexive journal (Ahern, 1999) helped me to monitor my own beliefs and determine whether they were influencing the data analysis. As a result of self-monitoring and continued re-reading of the data, I could validate the developing themes as being the result of the informants' words and not the result of my influence as the researcher. Subsequently, I used the informants' words to formulate a thematic framework which was used to code, index and map the collected data, which was refined as analysis continued.

An example of self-monitoring was evident following a discussion with one of the informants, prior to their interview: the informant claimed to be 'Benner's expert', when arranging a date for the interview to take place. This comment influenced me because I immediately perceived it as arrogance. However, when I met the informant face-to-face, I listened to their narrative and put aside my preconceived beliefs. This allowed the informant's lived experience to dominate the interview instead of my own views.

3.17.3 Indexing and Charting

Familiarisation assists with a preliminary identification of recurrent patterns and intensifies as the data is repeatedly re-visited. It is preparation for the next stage of Framework and involves indexing and charting. This stage enables the data to be managed while, at the same time, reducing its volume (Parkinson et al, 2016).

The indexing stage involved manual examination of each interview transcript and highlighting of similar comments, which were cut out and placed together to begin the indexing process. An example excerpt, from one of the transcripts with highlights, is shown in Fig.10.

Line Number	Manual highlighting
162	…*an expert? Um… as I said I think that it is about, certainly in terms*
163	*of, definition I say that it is somebody who has a broad and deep*
164	*knowledge of a particular subject matter coz it's subject specific isn't*
165	*it? Um but I also think that it's how others perceive it but then it*
166	*comes to risk because everyone will call themselves an expert and*
167	*I often say why do you trust me? What is it that makes me the right*
168	*person to listen to because you are basing your professional*
169	*judgement on advice I am giving you? So it comes with responsibility*
170	*as well, certainly in this setting when you apply- but to be an expert as I say, is to have a broad, up to date knowledge being able to tap into areas of the subject matter and I don't think necessarily, or…*

Fig.10 Segment of informant's transcript (adapted from Rabiee, 2004)

Once this task had been completed with the individual transcripts, the same process was also completed, manually, across all of the transcripts while looking for differences and similarities between them. The indexing stage of the Framework process led to themes and sub-themes being identified.

Charting the data involved removing the highlighted pieces of text from the context they appeared in and recording them under the emerging themes and sub-categories (Srivastava and Thomson, 2009).

3.17.4 Mapping and Interpretation

Mapping was the final stage of Framework and involved using the charted information to assist with the interpretation of the data. At this stage, it was important that my focus remained on the information being expressed by the informants and was not the result of extrinsic factors including researcher bias (Ritchie & Spencer, 1994; Ritchie et al, 2003). Losing focus and becoming

distracted during this stage of Framework had the potential to interrupt my thought processes which could result in my views being recorded and not those of the informants. However, the themes (Fig.11) that ultimately resulted from utilising the stages of Framework (Ritchie & Spencer, 1994; Ritchie et al, 2003) reflected the interactions between the informant and myself, as the researcher, from the informant's perspective:

MAIN THEMES	SUB THEMES
Aspects of Personality	Motivation Passion
Expert vs Specialist	Defining expertise Previous experience Perceived attributes
Experience and Training	Formal/Informal Practical/Theory Training Do qualifications matter?
Perceptions of safeguarding expert	
Peer Influence	Support

Fig. 11 Main themes and sub-themes emerging from data

The themes developed using sentences that were removed from the transcripts and then placed back into the context from which they had been extracted. From their interview transcript, each informant had a line of text assigned to the themes, as suggested by Ritchie & Spencer (1994) and Ritchie et al (2003). This

demonstrated the commonalties that existed between the transcripts and how themes were developed (Appendix 9).

In context, the meanings that informants attached to their words were explored; this is recognised as the mapping stage of Framework (Ritchie & Spencer, 1994; Ritchie et al, 2003). Themes and sub-themes were subsequently established.

3.18 SUMMARY

Qualitative research has the potential to increase our understanding of the world because qualitative methods explore individuals' beliefs, attitudes and behaviours. Through qualitative methods, informants are encouraged to reveal the world in which they live by sharing the meanings they attach to situations that happen in everyday life.

Therefore, I needed to consider and select an appropriate research design, to explore my area of interest, to ensure that time and resources were not wasted and research discredited, due to insufficient or inadequate preparation.

Although avoiding bias may be challenging with qualitative studies, the risk can be reduced by researchers being honest, transparent and aware of any presuppositions that may influence the study.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

The previous chapter detailed the research design. In this chapter an anonymised pen-portrait of each informant is given and the findings are outlined using excerpts from informant transcripts. Informants' perceptions of the terms expert, and expertise, and the meanings they attached to them, specifically in the context of safeguarding vulnerable adults, are demonstrated. The chapter ends with a brief summary.

4.2 ANONYMISED PEN PORTRAITS

Ten practicing safeguarding lead nurses, from various counties in the South East of England, were recruited and interviewed using semi-structured interviews. Fewer male than female SLNs took part in the study; this difference might have been the result of the limited number of SLNs within the geographical area included in this study, or because the nursing profession has always been predominantly female (Evans and Frank, 2003). There were, however, no obvious differences between the associated responsibilities of the safeguarding role or in the passion and motivation for the job that exists among the SLNs, irrespective of gender.

Once the interviews had been transcribed, they were sent to the participants for member checking as part of the validation process (Bradbury-Jones, Irvine and Sambrook, 2010). There were no requests received to make any amendments to the transcripts.

Participants' ages played no part in this study, as it has been pointed out that age is not an indicator of experience, but is determined, instead, by the number of situations that someone is exposed to, during the course of their professional practice (Benner, 1982; 1984).

To provide pen portraits of the informants, summaries were extracted from my field notes and anonymised in line with ethical guidelines to maintain informants' privacy and confidentiality (Rubin and Rubin, 1995; NMC, 2015). Gender has been removed from the ten pen portraits to ensure anonymity is maintained and replaced by numbers i.e. 1-10. In relation to the interview excerpts, fictitious names have been assigned to each of the ten informants to prevent any association between the numbers and the names, further enhancing anonymity.

The pen-portraits are presented to demonstrate the extent of healthcare experience each SLN has acquired, jointly and individually, as nurses, in a variety of specialist areas, prior to becoming SLNs. This is relevant as these nurses reportedly discharge the duties of the safeguard role without adequate training which they are likely to do as a result of their experience and relevant transferable skills.

Informant 1

Informant 1 is an experienced practitioner who has held various roles spanning over 20 years including working in the community with vulnerable people.

Safeguarding was in its infancy when this informant began to practice in her current role and there existed inadequate support to fulfil the position. Consequently, as a result of their motivation to protect those who are unable to

protect themselves, this informant gained safeguarding experience through networking, reading and learning while carrying out daily tasks, and via new situations that frequently present themselves.

Informant 2

The second informant has held the safeguarding role for less than ten years, although qualifying as a nurse several years earlier and holding previous roles that have included caring for groups of vulnerable people. Having a network of colleagues and increased in-depth knowledge has increased the informant's confidence in their professional practice.

This informant has acquired safeguarding knowledge through ensuring that their personal knowledge about safeguarding is greater than others due to the personal belief that the role requires greater knowledge than others possess. This informant would not want to work in another role and is inherently motivated to protect abused adults. Although in this role for a relatively long time compared to previous nursing positions, this informant's interest in protecting vulnerable adults from harm, has not wavered.

Informant 3

Informant 3 has held various roles involved with protecting vulnerable adults for more than a decade. This informant currently works with vulnerable groups and is motivated towards increasing personal relevant knowledge through reading, networking and looking for opportunities to develop further, including clinical supervision and personal reflection. This is not a pre-requisite of the informant's current role but something that would assist with protecting vulnerable adults.

Informant 4

This informant has held the safeguarding role for five years but has been qualified as an adult nurse for many more and is committed to protecting patients from any forms of abuse. Involved in networking assists this informant to further develop their safeguarding knowledge which is further developed as a result of being in safeguarding situations on a regular basis. This informant finds it satisfying to have the knowledge, skill and a professional role that assist with safeguarding vulnerable adults.

Informant 5

Reorganisation of specific nursing roles led to informant 5 working as a safeguard lead. Prior to this, informant 5 cared for vulnerable groups of patients as the extent of adult abuse becoming more prevalent. This SLN keep up to date with relevant safeguarding knowledge through networking, peer support and the everyday situations that present themselves.

Informant 6

Prior to this role, informant 6 spent several years caring for the elderly in various roles. Predominantly with older people, part of this SLN's passion for nursing focuses on ensuring that the most vulnerable people do not get discriminated against. Informant 6 is motivated to protect the vulnerable and is passionate about ensuring that as an SLN, they possess the necessary skills and knowledge to maintain the safety of vulnerable adults.

Informant 6 advises the benefit of supportive colleagues, especially those who have held the role for longer; enhanced personal knowledge has been increased. Informant 6 has not had any formal education as there was little education related to safeguarding available and the training insufficient. This SLN regularly attends relevant safeguarding meetings and views the safeguard lead role role as part of personal development which can also be increased by always seeing opportunities to learn new perspectives.

Informant 7

This SLN has held the safeguarding role for less than two years and held previous roles for a greater duration working in several clinical environments before becoming an SLN.

Informant 7 has a wealth of experience gained from various healthcare areas which has helped personal professional development due to the knowledge and understanding that has been acquired as a result; this informant also networks, reads relevant literature and attends safeguarding forums.

Informant 8

This informant has been practicing in the safeguarding role five years with previous roles spanning over twenty years and also incorporating safeguarding elements. This informant has completed mandatory training for safeguarding in addition to studying various safeguarding educational sessions; personal interest in safeguarding has continued and has led to employment as a SLN.

Informant 8 believes that increasing personal safeguarding knowledge requires a person to look beyond what they already know and be confident about their own practice. Linking with people who are knowledgeable about safeguarding can help to solve difficult problems: when a decision needs to be made, or a stance needs to be taken on an issue, it should be informed by other specialists, as well as the SLN's own thoughts and decision-making ability.

Informant 9

This informant, although possessing twenty years' experience in other specialist roles and working for other organisations, has been in the safeguard role for only a short time. Although possessing a wide range of experience gained in a variety of specialist areas, this informant believes that this personal experience does not make them an expert but views others as the experts but people who underestimate themselves and their ability.

Informant 10

Informant 10 has been working as an SLN for a less than a decade but has a long history of practicing in healthcare spanning over twenty years working across different disciplines within healthcare and transferring to the SLN role because the informant felt they were capable of delivering better care to patients but was failing to do so; this informant believed that stagnation would develop without a change in career path and has since developed a passion for the SLN role.

Although this informant has acquired relevant qualifications through their career, does not believe qualifications should be a measure of someone's ability to

effectively carry out their role and that experience, intuition and commonsense are more important.

This informant likes getting bite-size pieces of information because this assists with personal learning and growth and this informant genuinely enjoys working through situations, and believes that small chunks of information can best help assist with this; gleans a lot from conversation and a great deal from observation and *snapshots* of things.

Section 4.2.1 is a synopsis of the pen-portraits provided; this offers an overview of the informants and will serve to enhance the transferability (Lincoln & Guba 1986) of the findings.

4.2.1 Overview of the informants

All of the informants have extensive backgrounds in a variety of healthcare settings that span from fifteen to over twenty years; this has included caring for adults deemed to be at risk of harm, for example adults with learning disabilities. Although none of the informants had previously worked in specific safeguarding roles, they are now employed in specialist roles as SLNs and have done so for between one and six years.

Each of the informants is a team leader based either in the community or in a general hospital; they are responsible for managing safeguarding across all fields of practice, for example the elderly, mental health and learning disabilities. Between them, the informants possess a vast amount of relevant experience and knowledge that assists each of them to continue to effectively discharge the requirements of their professional role.

4.3 FINDINGS

Having worked through the stages of Framework (Ritchie & Spencer, 1994; Ritchie et al, 2003) to analyse the data, the following emerging themes are illustrated by excerpts from the interviews.

4.3.1 *"I don't like that word…"* Expert or Specialist – what's in a name?

The informants revealed mixed feelings about the terms expert and expertise, in respect of their safeguard role and, more generally, from both a personal perspective and based on others' perceptions. A number of informants disliked the term expert and could only relate the term to others rather than themselves.

Cathy talked about a variety of roles she has held in a number of different environments, but despite her extensive experience she did not consider herself to be an expert. She described having many years' experience of exposure to different situations and had also learnt a great deal from reading, sharing knowledge and from colleagues. She felt that she is able to recognise an expert, who she described as someone who has been exposed to various situations and can appropriately apply the knowledge learned from them to practice.

Despite being exposed to many different situations, Cathy did not consider herself to be an expert, yet she believed that others who had experienced similar exposure were experts. She rejected the idea that she is an expert:

> *"I think it's somebody who is experienced and exposed to different situations. When you first start to drive, you can't do anything else except*

> *drive, and then you reach the stage when you stop thinking about it and its part and parcel of who you are as an individual*" (Cathy, 4/130).

Although some of the informants were uncomfortable with the idea of viewing themselves, or having others view them, as experts, in safeguarding, other informants felt more comfortable being viewed as a specialist:

> *"I don't like that word. I do think people see me as an expert but what I prefer to call myself is a specialist"* (Anna, 6/234).

Although all except three of the informants did not agree with being thought of as experts or did not consider themselves to be so, they felt more comfortable with the term specialist. However, even the term specialist was rejected by one of the informants who felt uncomfortable acknowledging that she possesses either specialist knowledge, or that she is a specialist in safeguarding vulnerable adults, which was indicated by her body language and facial expressions.

Although a number of informants believed themselves to be experts in this specialist area, more than half of them were uncomfortable with the notion of expert status because they felt this perception could lead to them to being ridiculed if they made mistakes. The informants were far more comfortable with the term specialist because in their view this did not denote the same level of responsibility as the term expert:

> *"Responsibility comes with a title if I thought about it and the responsibility I hold, I would give it up but being passionate, being committed that's what I do"* (Julie, 9/366).

The informants indicated that they preferred the term specialist to the term expert, because they perceived particular connotations to be associated with the word expert and the ways the term is understood by others. They intimated that the term expert has the effect of placing some individuals above others which can

lead to disharmonious relationships between the expert and non-expert, a conflict that results in the person viewed as an expert frequently feeling that they have to try to prove themselves.

Ingrid believed that when an individual is viewed as an expert in a particular specialism, there is an expectation they will not make mistakes and will possess greater knowledge that anyone else working in that specialism. She believed that someone placed in this position is put there for a reason by others and explained in the following excerpt why she prefers the term specialist:

> *"I prefer the word specialist instead of expert because in a way you set someone up if you call them an expert …We call people an expert and then we let them burn themselves. Individuals do not need to be put in the position of expert by others"* (Ingrid, 5/184).

Those who believe themselves to be experts can sometimes be unsafe practitioners, taking unnecessary risks because their practice is not based on evidence. In Ingrid's view, experts convince others that they know everything and are not forthcoming in either sharing their knowledge or learning from others, which can lead to them making serious errors of judgement.

SLN roles involve taking on responsibilities that accompany protecting vulnerable adults. Several of the informants expressed the opinion that being thought of as an expert, places the expert in a position of responsibility, but they also believed it is the way a situation is managed in practice that demonstrates to others whether the expert label is appropriate. Although they demonstrated discomfort about being thought of as an expert, informants did not raise any objections to being given the responsibilities that go with carrying out a specialist role, only to the expert title itself.

Edith appeared to feel insulted at being asked about her safeguarding experience, but she voiced her discomfort at being thought of as an expert because she admitted she does not know everything and is frequently asked for advice by other people, placing her in a position of responsibility in their eyes. She explained:

> *"Yeah, I struggle with the word expert and maybe is a psychological thing, maybe because people would see me as an expert because they have to come to me for advice but I know that I don't know everything so I know I'm not an expert!"* (Edith, 8/292).

4.3.2 *"Just my 20 years…"* – What do you need to be a good Safeguarding Lead?

Although various views exist about how an expert should be defined, there has been a broad consensus about what constitutes expertise, which is described as in-depth knowledge in a specific area of practice. However, the precise level of the knowledge attributed to expertise remains unclear, other than the general proviso that it should be *in-depth* knowledge obtained through experience and practice in a specific domain.

Possessing in-depth knowledge linked to a specialism, having the passion to apply that knowledge to practice and utilising their past experience, demonstrates expertise, according to the informants. However, it was felt that not everyone would become an expert or possess expertise even after spending many years in the same professional role:

> *"…and never be an expert, equally something in some people will develop expertise quicker than others* "(Fred, 7/207).

Even though expertise was depicted as in-depth knowledge, some of the informants preferred to view expertise as specialist knowledge, because this allowed them to avoid any association with the word ‘expert’. This could be detected though their body language, although they exhibited a lesser degree of discomfort towards the term expertise than expert:

> *“I consider myself to have an in-depth knowledge but I don't consider myself to be an expert. It depends on the word you're using, expertise is to describe really. I have expertise in relation to the organisation, that I'm working in, but I wouldn't say I have expertise as there is no training that I have ever undertaken that has given me a title in relation to being an expert in safeguarding”* (Grace, 5/174).

Experience was defined in numerous ways and was associated with qualifications, time spent in a specific specialism, age or exposure to a variety of relevant presenting situations; an example is shown in the following quote from one of the informants:

> *“I would say that I class myself an expert by experience, rather than as a result of any formal qualification much as I think that a formal qualification in nursing does not make you an expert” (*Bert, 3/91).

Although not all of the informants shared this view, in several instances, experience was related to the length of time an individual had spent in a role. This was demonstrated by Edith when she was asked about relevant training for her current role; her tone suggested amusement, and sarcasm was evident in her response:

> *“So… other than my 20 years in nursing, with a background of predominantly in elderly and where the concept of safeguarding elder abuse was first coined?”* (Edith, 1/30).

Following this response, the informant glanced at the other person in the room, who she had invited to be present, and waited before continuing with the interview; this communication has been discussed on p.87 of this text.

Another informant became indignant and raised her eyebrows when she was asked about relating her safeguarding experience to her previous broader experience and questioned whether more than twenty years as a nurse was deemed insufficient. These nurses had acquired extensive experience, over many years, across a variety of specialisms, that has been associated with vulnerable adults, such as care of the elderly.

Clearly, questioning their experience in relation to safeguarding vulnerable adults met with disapproval. However, ascertaining whether these SLNs were experts, or had acquired expertise in this specialist area, in a relatively short period of time, is thought-provoking and as challenging as determining the attributes that make a good SLN because the informants perceived these to be many and varied.

The informants possessed vast previous experience in specialisms that involved individuals with learning disabilities, individuals with impaired cognitive ability and care of the elderly, in both the community and hospital setting, all of whom the informants considered to be vulnerable. Even though the informants had extensive experience in these specific areas, until becoming SLNs they had not had any formal involvement with safeguarding vulnerable adults.

The informants had utilised previous experience, professional practice skills and knowledge by applying them to safeguarding. Being new to a specialist area,

compared to someone who has been involved in that particular specialism for several years, does not mean that the more experienced person has been exposed to an extensive number of relevant situations or that they have the ability to apply the knowledge to practice. However, the informants did not feel that the knowledge they had acquired from their previous specialisms automatically made them an expert in the role of safeguarding or meant that they possessed relevant expertise, only that it assisted them to carry out the safeguard role.

Previous experience enabled the informants to recognise similar situations within adult safeguarding that they had experienced previously while practicing in other specialist areas, for example care of the elderly, and working with people with learning disabilities. They felt that this ability had assisted their development in the safeguarding role.

As a result of previous experience in clinical practice, many of the informants had developed the skill of noticing significant changes in situations which they attributed to pattern recognition and intuition. These were perceived as skills that alerted the informants, as experienced practitioners, to signals that might be overlooked by a less experienced practitioner. Cathy referred to this as being on *automatic pilot*:

> *"… you are as a nurse, that you see the big picture, you see the world around you and that you are aware of all the potential drivers that make people behave in certain ways, you are aware of the cues and the things you should be looking out for and you are doing that on almost automatic pilot"* (Cathy, 4/135).

When considering the tasks, he undertakes on a daily basis, one of the informants explained that he finds it difficult to write about action he has taken because he carries out most of it without conscious awareness:

> *"I use my intuition but when I think about what happened and I then become aware of taking action without thinking about it but then writing it up becomes difficult because I just know what I did was the right thing to do but I didn't think about what I was doing at the time"* (Derek, 5/164).

A number of the informants aimed to acquire all the relevant facts to ensure that vulnerable adults are protected from the most basic forms of abuse to the more complex ones. They believed they were viewed as an expert and a leader due to possessing more safeguarding knowledge than others. Informants felt they have a responsibility to share knowledge with each other; however, they did not attempt to prove their expertise but instead preferred to focus on caring for and keeping vulnerable adults safe.

Possessing more safeguarding knowledge than others in order to maintain their status as either an expert, or someone possessing expertise, in the safeguarding role, was the view of a number of informants. They felt that someone requiring assistance with issues pertaining to safeguarding vulnerable adults is likely to be encouraged to approach an expert or someone possessing expertise for help in solving their problem. Having greater knowledge than others in their specialism often enables them to answer others' questions but also places them in a position of power which was perceived as a requirement of fulfilling the SLN role.

Other informants were content to learn from their peer group and also to share safeguarding knowledge and had no desire to maintain greater knowledge than others. It concerned a number of informants that they might be unable to answer questions related to safeguarding which they felt they should know about, even without adequate training and relevant experience.

There was a difference of opinion between the informants related to relevant training courses. Some informants resisted the idea of attending courses if they had attended them previously because they considered that nothing further could be learned from doing so:

> *"…I don't think that going to anything that does not add any value to what I currently know so my best efforts are concentrated on my day job"* (Bert, 4/152).

On the other hand, enrolling on courses, even if they were similar to courses that had been attended previously, was perceived by other informants as an opportunity to learn something new about safeguarding, because safeguarding is a fluid concept which can alter every day. Repeating a safeguarding training course was believed to have the potential to improve professional practice with the added opportunity of learning something new:

> *"I learn something new from somebody every day; you have something to learn from everyone you meet"* (Julie, 9/376).

The notion of what constitutes training differed between informants, which became evident when the same training course was mentioned as part of the interview process. In relation to this particular training course, one informant advised that she had not completed any formal safeguarding vulnerable adult training while another stated that she had received formal training, even though they were both referring to the same course. This indicated that the two informants had a different understanding and expectation of training, and that it had different meanings for them. In response to a question about the training she had received, one informant answered:

> *'Um genuinely? absolutely none'* (Julie, 2/49).

Julie was referring to technical training rather than practical training and it was clear from the interview that she strongly believed safeguarding required more practical than theoretical training. She did not believe that safeguarding could be understood and carried out, simply based on completing training courses alone, and did not perceive someone as an expert on the grounds of the qualifications they had acquired.

Although Julie believed there is a need for theory as well, she thought it was continued practice and professional growth that could demonstrate an ability to effectively safeguard vulnerable adults. She understood that people learn in different ways and that theory alone might be adequate training for some to fulfil their professional role, but from a personal perspective, she found it challenging to digest theory and therefore preferred to practice and then consider theory and apply it to practice.

For a number of informants, an important aspect of their role as a SLNs was possessing greater relevant knowledge than others. However, they did not feel that completing a course for a second time was either necessary or beneficial to enhance their professional practice or maintain their interest and motivation because they were self-driven.

In order to maintain contemporaneous safeguarding knowledge, several of the informants participated in safeguard networking and safeguarding vulnerable adult forums because they felt they could learn more from these informal training sessions than from attending formal ones. The networking sessions, forums and other forms of informal learning were undertaken of their own volition and not as the result of any pressure from others.

Safeguarding forums were described as an invaluable support system for exchanging ideas, discussing concerns, or providing feedback which helps to ensure that vulnerable adults remain protected. A number of informants shared their knowledge and learnt from others and were not concerned whether they possessed the same level, less or more, knowledge than their peers, in respect of safeguarding, as long as the knowledge they possessed was up-to-date and their practice was effectively protecting vulnerable people.

Having qualifications was believed to improve an individual's self-belief and confidence, whereas a lack of them could lead to self-doubt and reduced motivation:

> *"Me? an expert? I don't know, you see, I think that's about my self-esteem and how I see education and how people have portrayed me: if you haven't got this qualification then you can't do that and I think that's how I feel about it"* (Julie, 6/236).

From the interview data, it was clear that qualifications were not viewed as the only attribute of an expert. Instead, depth of knowledge, behaviour, leadership and attitudes were regarded as important qualities for an individual to possess, although qualifications may be regarded as supplementing these. There was also an association between age and expert status, as age was deemed necessary to have acquired sufficient experience. However, although one informant recognised that she is deemed an expert as a result of her experience, she did not feel like an expert:

> "… *I think they just assume being older, you've been around a while and they're under the assumption that you know what you're doing and to some degree people have to believe that*" (Ingrid, 205/207).

Three of the informants did not feel that qualifications make an expert although a precise definition of *qualification* was not provided or discussed during the interviews. There was also a view expressed that what people perceive an expert to be differs according to the types of attributes required in a given situation:

> **"…***what an academic is looking for in an expert it is something very different from a frontline practitioner so it's relevant to each individual in what they look for in an expert"* (Grace, 4/319).

4.3.3 *"They value my opinion…"* – how can Safeguarding Lead Nurses work with others?

Peers were reported as assisting with learning either through networking, forums or by spending time with each other which, in the case of safeguarding, involved sharing safeguarding knowledge and observing, or being observed, as Julie explained:

> *"There's an awful lot to be gained from working alongside someone and getting that relationship and seeing: oh, that's how you do it or that's how that happens"* (Julie, 3/85).

Fred concurs with Julie that observing others was:

> *"… the most helpful learning and supportive mechanism so I shadowed a number of people that have been doing the role longer than me and I found that helped a lot with learning"* (Fred,1/28).

The views of other people are influential and can make a difference to how we perceive ourselves. Julie believed that others judged her negatively for her lack of qualifications, in relation to her safeguarding role, and as a result she judged herself in the same way.

A number of informants had been practicing SLNs for less than four years at the time of being interviewed for this study. They did not believe their experience equated to being a safeguarding expert because, although being viewed as an expert can be the result of reputation, it is more likely to be because someone has held a specific role for many years:

> *"I'd say I'm experienced. I think… it worries me when people say they are the expert; I have a real thing about titlitis. I think it's obviously the outputs of what people do; some of its reputation and unfortunately, some of it is if somebody has been around a long time, then there's an assumption that those people are experts"* (Ingrid, 4/160).

Perceived attributes of an expert included age, the length of time they had spent working in a role, possessing greater knowledge than others in their specialism and the status of the role they hold. Experience applied to the length of time spent in previous roles and transferable skills to the current role, and was not the result of age or qualifications. Less experienced SLNs believed they were experts while the more experienced ones did not consider themselves to be so.

An expert was viewed as an individual who has obtained qualifications or who carries out their professional duties autonomously or both. Experts were also viewed as intuitive, reflective people, who have an awareness of what they do not know:

> *"…besides newspapers it is very much about reflection. Reflecting on my own practice and I am very aware sometimes I could have approached things differently when it has not gone as well as I would have liked"* (Fred 3/79).

Ingrid disliked role titles which she felt led to what she referred to as *titlitis.* She believed that 'titlitis' automatically led others to the misconception that the bestowed title denoted an expert, irrespective of whether they were new to a

professional role or had been in the role for several years. Ingrid did not call herself an expert even though others believe her to be one. She is perceived as an expert by others due to the role she manages and her many years of experience in the health profession. Ingrid was unwilling to call herself an expert as she felt that those *she* views as experts have a greater safeguarding knowledge than she does. Nonetheless, she has found that the so-called experts who have closed their minds to learning tend to make more mistakes.

Although she has acquired experience over many years spent in nursing and other professions, Ingrid questioned what led to her current professional role with its associated title. She believed that others were waiting for her to fail and felt that was likely to be part of the reason why she was employed in her current post.

She believed that, generally, if you profess to be an expert, you are an unsafe practitioner:

> *"Ah well, that worries me…. because if you think you are an expert, then that is when you stop learning and being open and make mistakes" (Ingrid, 4/142).*

The interviews suggested that becoming an expert developed from the perceptions of others, from self-belief about one's own ability, or both. Even so, being thought of as an expert puts pressure on the individual to prove that they are worthy of this designation.

The degree to which peers influenced an informant depended on how the individual viewed themselves. Peer influence was also associated with confidence levels and whether the individual wanted support, rather than whether

they needed it. Whatever the reasons, peers were shown to have a significant impact on another person's professional practice.

The narratives of several of the informants indicated that their need to be part of a group was greater than their need to be a leader because they derived a sense of comfort from being an equal within the group. The informants were also open-minded and showed a willingness to learn from others through forums and networking:

> *"…with my colleagues, they have asked me to consider other things and I would consider that very helpful and it has changed my view. I loathe the arrogance that because you are in charge that you know better than other people"* (Fred, 4/141).

Data analysis from this study demonstrated that individuals have the ability to positively or negatively affect others within their peer group or outside of it:

> *"…staff have no hesitation in coming to me and asking me, they value my opinion so I think expertise isn't just about how one feels about oneself but it is tested and is the perspective of others" (*Bert 3/101).

Valuing another person's opinion indicates that the other person is assumed to have knowledge that can be trusted and is respected, which has the potential to promote good working relationships. However, Bert pointed out that valuing someone's opinion is the result of judgement and examination of an opinion. However, the opinion might be questioned and lead to failure and loss of leadership. In the event of this happening, the leader must re-establish themselves as someone worthy of respect and of leading others.

It is clear from the data that sharing knowledge and experience with peers increases knowledge in the field. The informants were influenced by their peers who had the potential to affect their self-esteem and confidence. The informants

viewed constructive feedback as helping them to understand how others viewed them and also enhanced morale, confidence and self-esteem. A number of the SLNs relied on their team for honest feedback about their professional activities and guidance in areas of their role where they were less competent:

> *"I do delegate all the stuff I am not very good at, the IT work and the electronic referrals and that's partly why I have to recruit people who complement my skill set"* (Fred, 4/128).

Although the SLNs asked peers for feedback they tended to comment solely on the positive feedback they received and did not include any negative remarks. However, the SLNs admitted they may have received negative feedback but only in the context of any tasks they were unable to complete because they were not part of the safeguard role.

The individual receiving the feedback felt able to give feedback to others related to a specific topic. This practice proved mutually beneficial and was highlighted in one of the interviews:

> *"…because everybody around you can be saying no that's not safeguarding and you can sometimes feel like a real lone voice in an organisation but then actually, if you cross check with others it kind of almost brings back your sanity thinking so I'm not going mad, not sure not that it's about being right or wrong but my thinking has been substantiated, if that makes sense?* (Hattie, 6/236).

4.3.4 *"I am very self-driven…"* – how motivated does a Safeguarding Lead have to be?

In identifying themes, it became apparent that personal motivation resulted in a willingness to learn and to excel. Knowledge can be acquired as part of a

motivational personality but also through continued practice which is shown by the following two excerpts:

> *"I am very self-driven so I will put myself in scenarios where I am likely to benefit from interactions"* (Bert, 4/149).

Julie claimed that she remains motivated:

> *"…because I didn't want to be the grumpy old woman in the corner: saying been there, done that and actually it's all comes round again and I don't want to be like that" (*Julie, 7/280*).*

SLN's levels of interest and motivation cannot be quantified because they are personal and subjective. However, the lack of relevant training, resources and continuing adult abuse was acknowledged by the SLNs as motivating them to protect vulnerable adults. They continue to rely on their own resources, without which they would be unable to manage the safeguard role as they currently do.

The informants used similar words when talking about their relationship with protecting vulnerable adults: interest, passion, and motivation. Although the following excerpt is taken from one interview, it is an exemplar for the views of all the SLNs who verbalised their interest in finding ways to protect vulnerable adults either as a result of their personal experiences of abuse, or that of others. It is this personal interest that initiates their motivation which, in turn, increases their interest and instigates a cycle:

> *"…an interest in something because it's new, it's a new concept so it's exciting, that's the motivation isn't it that get you more interested so that you read more or you explore more about what other opportunities there are and that sense of learning, in that subject matter, and again that leads you on to other things as well. Networking, that's another big one, you know your colleagues, and that, are exploring different avenues so they start talking about it and you'll become aware of it and then go and research on that as well. So, there's a lot of different ways, reading journal*

> *articles, forum meetings. I do try and attend all of the adult safeguarding meetings as well; that's a really valuable learning place …"* (Grace, 2/72).

All of the informants were significantly concerned with safeguarding and alluded to the fact that if they lost their motivation and passion, they would no longer want to continue in their safeguarding role. Nonetheless, they implied they might be persuaded to continue if they had the support and approval of peers.

Irrespective of the lack of safeguard training, the participating SLNs were driven, individually and as a group, by their desire to protect vulnerable adults which extended beyond the clinical environment. They perceived the inability to protect vulnerable adults as failure, regardless of how difficult a situation may be, as shown by the following excerpt:

> *"… if I saw somebody leaving their kiddy in the car and abandoning them, watch it and if no one has come back in 10 minutes, then that's a phone call to somebody" (*Julie,178/5*).*

Several of the informants advised that they shared their safeguarding knowledge with others as they believed they have greater specialist knowledge than the majority of people and thus, by sharing this knowledge, awareness of the abuse of vulnerable adults could be increased. Although they voiced the belief that they possess more safeguarding knowledge than most people, the informants confessed they would not openly declare this but would leave it up to others to decide.

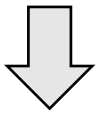
4.4 SUMMARY

The findings show that internal and external factors exist that are fundamental to the SLNs' ability to discharge their professional role; these factors are indicated in Fig.12:

"I don't like that word…", Expert or Specialist – what's in a name? External

"Just my 20 years…" – What do you need to be a good Safeguarding Lead?

"They value my opinion…" – how can Safeguarding Lead Nurses work with others?



"I am very self-driven…" – how motivated does a Safeguarding Lead have to be? Internal

Fig. 12 External and Internal Factors

Each of the informants had experienced similar extrinsic factors, in relation to safeguarding vulnerable adults, for example, peer influence, ineffectual training and educational resources, and lack of support and leadership, while working in the SLN role. In addition, the informants had encountered a multitude of definitions, understandings and various ways that adult abuse can manifest itself. The informants also revealed commonalities in the intrinsic factors they had experienced: motivation, interest and passion.

In a relatively new role, SLNs undoubtedly felt the need to prove themselves, but they utilised their relevant experience, knowledge and practice to assist them with meeting the demands of the safeguarding role. Few of the informants considered themselves experts in safeguarding vulnerable adults although they acknowledged that they are likely to possess in-depth knowledge. The descriptor *expert* was similarly viewed by the informants but, while some were happy to be thought of as experts, others were not as comfortable with this identity.

Expertise implied having relevant in-depth knowledge but a number of the informants preferred the term specialist knowledge. The informants interpreted experience in a variety of ways, for example the length of time someone had been in a specific role, the qualifications they had obtained, their title, their age or a combination of these.

Although the interview transcripts revealed that the informants attached various meanings to the notions of expert, expertise and safeguarding, they also revealed that personality had been a significant factor for the SLNs to acquire the ability that they rely on, and require, to remain in their current role.

The findings show that both internal and external factors exist that influence the SLNs behaviour and there is a link between these factors and their experience, practice and skill. For the SLNs, this has culminated in a common denominator that motivates them to continue to protect vulnerable adults. In order to demonstrate this relationship, the findings will be revisited in the next chapter, where the External and Internal Factors of the SLNs and The Conceptual Framework are explored in more detail.

CHAPTER 5: DISCUSSION

5.1 INTRODUCTION

The previous chapter revealed that specific extrinsic and intrinsic factors exist that drive the SLNs to protect vulnerable adults from harm. External factors included appropriate training, education, peer impact and relevant practice opportunities. On the other hand, intrinsic factors related specifically to the informants' personal motivation that was fueled and reignited by each of the SLNs' continued interest in protecting vulnerable adults. These factors were highlighted throughout Chapter Four and summarised in Fig.12.

Subsequently, the findings indicated that the extrinsic and intrinsic factors that influenced the informants to protect vulnerable adults, could be divided into two halves: those in the first half could equally be applied to any specialism, while those in the second half were more specific and, in this case applied only to safeguarding vulnerable adults. This idea resulted in the development of a conceptual framework (Fig.13). This chapter explores the framework and the common denominator between the SLNs that emerged. The chapter concludes with a summary.

PART 1: GENERIC APPLICATION

5.2 THE CONCEPTUAL FRAMEWORK

Developed as a result of this study, the first half of the conceptual framework is generic as it can be applied to any specialism although, in order to explain its meaning relative to this study, it has been applied to safeguarding vulnerable

adults. The second half of the framework relates specifically to SLNs but has the potential to be applied to other specialists.

Analysis of the interview data revealed that, prior to becoming SLNs, the informants had previously worked in similar professional roles to each other. These roles included caring for vulnerable adults which enabled them to transfer relevant skills to the new role, for example, completing MCA assessments.

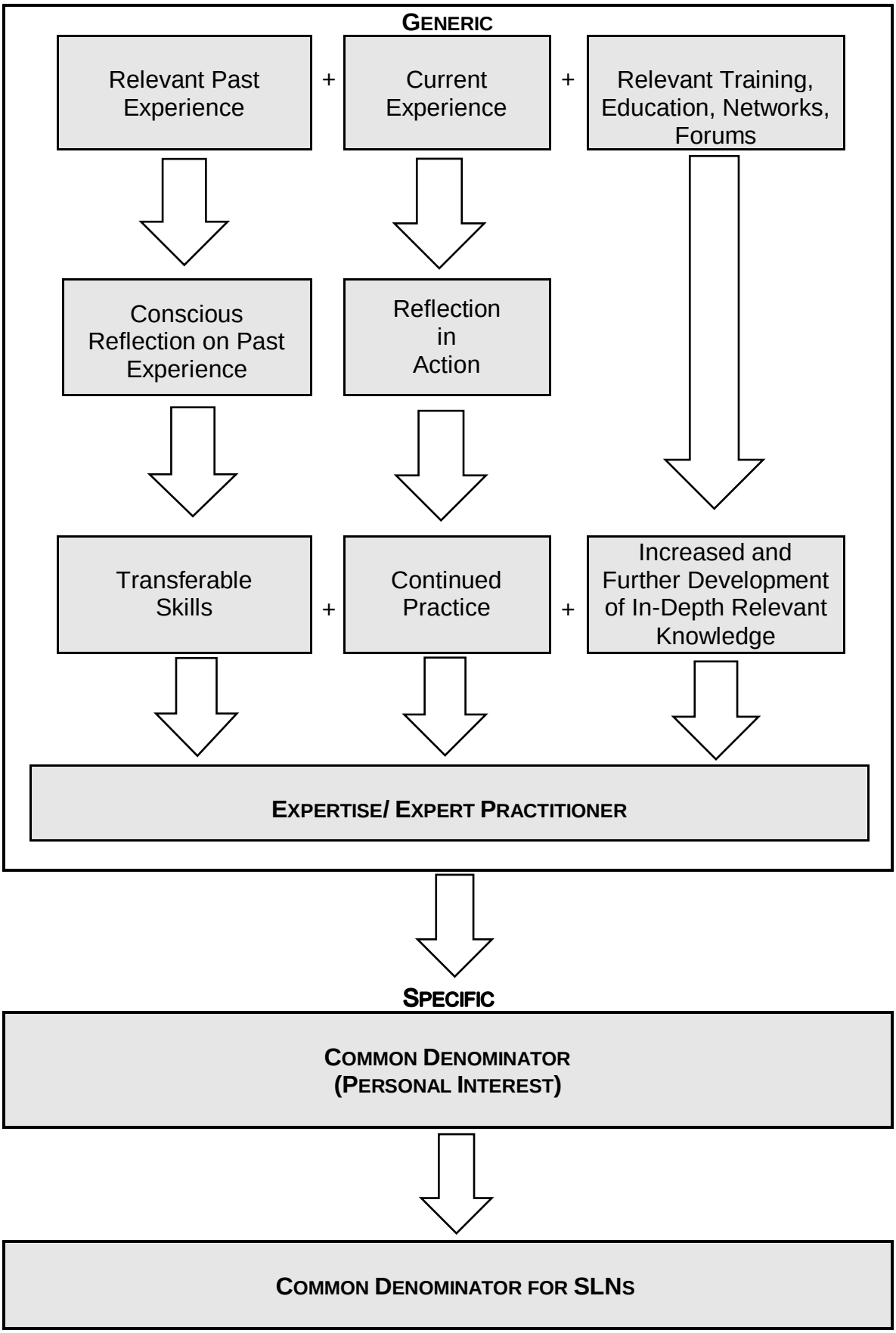


Fig. 13 Conceptual Framework

On a daily basis, the SLNs discharge the duties of their professional role through on-going continued practice, a practice that helps with their professional development. Exposure to a variety of scenarios has increased their experience and specialist knowledge and is further developed as this cycle repeats itself: continued practice» increased experience» continued practice» increased experience.

The SLNs have sourced training, attended relevant forums and supported each other, all of which have extended their specialist knowledge and as a result they have developed knowledge that is more advanced than others:

> *"…yes, I've got extra knowledge that other people don't have, I have specialist knowledge and yes, I've got the time to go read which I can then pass down to people …"* (Anna, 237/240).

As a result of their past and current experience, on-going professional practice and completing available training and education, the SLNs have developed relevant specialist knowledge, or expertise, related to safeguarding vulnerable adults.

The common denominator, referred to in the conceptual framework (Fig.13), is the medium through which generic knowledge is developed into specialist knowledge. In this case, it is the informants' initial interest in protecting vulnerable adults from harm that has motivated them to use pre-existing generic practice, knowledge and skills developed elsewhere, to effectively discharge, and continually improve, their safeguarding role.

Each stage of the conceptual framework is now explored in the context of this study.

5.3 Relevant Past Experience, Conscious Reflection on Past Experience, Transferable Skills

Experience alone does not lead to expertise even when an individual has spent extensive time acquiring relevant knowledge and skill, while being involved with a particular specialism, (Ericsson and Smith, 1991; Hoffman, 1996; Smith et al, 2003). Exposure to various situations that present themselves in professional practice can, however, result in the development of experience that extends beyond the time spent involved in a specialism. This experience relates to someone who has the ability to apply acquired relevant in-depth knowledge and skill, as well as the aptitude to apply them to similar situations:

> *"Experience is necessary for moving from one level of expertise to another, but experience is not the equivalent of longevity, seniority, or the simple passage of time. Experience means living through actual situations in such a way that it informs the practitioner's perception and understanding of all subsequent situations"* (Benner and Wrubel, 1982).

It is the ability to apply relevant knowledge and skill to practice that enables the development of expertise (Benner, 1982, Dreyfus and Dreyfus, 1980). Being able to achieve this becomes possible when the transfer is between comparable specialisms, although further research is recommended to confirm this (Perkins and Salomon, 1989). Transferring ability acquired in a previous role helps SLNs to protect vulnerable adults from harm, or the risk of it. By comparison, other nurses may possess relevant information and skill, related to a specialism, but lack the ability to apply it (Smith et al, 2003). The ability to transfer relevant knowledge and skill from a previous role to a current one, demonstrates a relationship between prior experience and practice and current experience and practice (Bonner, 2003).

Clearly, current experience develops in a new role and ultimately becomes past experience although it is unclear when this happens. It is evident from the interviews and is depicted in the conceptual framework (Fig.13), that SLNs have applied previous experience and relevant knowledge to protecting vulnerable adults. This has been possible because, over many years, these nurses have undertaken on-going professional practice in similar roles to safeguarding vulnerable adults. These roles have included working with adults who have learning disabilities, or caring for the elderly, both of which have been identified as vulnerable groups at risk of harm (Martin, 2007). The similarity between roles has enabled them to utilise their formerly acquired knowledge and ability, in the absence of adequate training and leadership, to assist with fulfilling the requisites of the safeguard role.

5.3.1 Enhancing current practice: transferring previously learned Skills

The ability to apply relevant skills and knowledge to comparable situations in practice can be achieved in the current role or a new one (Bonner, 2003). The transfer of skills from one role to another has been associated with expert practice (King and McLeod, 2001).

Leadership, managerial skills and problem-solving ability can be understood as transferable skills (Bridges, 2006), that is, skills that have been acquired in formal settings (Pellegrino and Hilton, 2012). Transferable skills are an integral part of the conceptual framework (Fig.13). Besides using skills learnt in formal settings, for example, lectures in the classroom, the SLNs used their cognitive awareness, for example pattern recognition and intuition (Benner, 1982; Dreyfus and Dreyfus,

1980), to deal with presenting safeguarding scenarios. Pattern recognition is a component of the unconscious and is recognised as an attribute of expert practice (Benner and Tanner, 1987; Tiberius et al, 1998).

Pattern recognition allows SLNs to recognise factors, in a presenting situation, that they may have encountered previously and apply their previous experience to the current situation. Consequently, they can draw conclusions about the presenting situation (Naumanen, 2007; McHugh and Lake, 2010).

Being able to recognise patterns in presenting situations and relating them to previous experience could indicate that various scenarios remain in the subconscious, surfacing when they are triggered by similar situations. This idea can be applied to the SLNs whose cognitive awareness assists them when they are faced with an unknown situation. The SLNs did not consciously look for similarities between situations but in hindsight, reported that they can frequently detect such similarities. They believed pattern recognition exists as a result of being exposed to a variety of situations, in similar specialisms, over an extensive period of time. The ability to recognise patterns, in this way, forms part of their skill repertoire.

Another part of the SLNs' repertoire, or tool kit, is intuition which, evidentially, is significant within nursing practice (Dowling, 2000). Unless the SLNs deliberate about their actions, they will remain unaware of why they acted in the way they did making intuition challenging to explain to others.

In order to access intuition, individuals need to recognise feeling uneasy in a situation they are faced with. Although there is no apparent tangible basis for

these feelings, the practitioners make decisions based on them. While it is intangible and therefore not quantifiable, being intuitive involves having awareness of personal feelings and acting on them (Taylor, 1994; Gigerenzer, 2007). It is therefore challenging to describe intuition because it is the product of implicit knowledge that develops through personal experience and not as the result of formal education (Sinclair, 2005; Kinchin and Cabot, 2010); intuitive knowledge is accessed without consciously thinking about it (Chaffey et al, 2012).

SLNs use their intuition daily in their professional practice which is an ability that has developed from on-going practice and experience, even if initially not directly acquired from working in the specific safeguarding vulnerable adults' role. SLNs described intuition as having a 'gut feeling' that frequently guides their actions and can lead them to act, without deliberating first. SLNs may not initially understand the action themselves and acknowledge that this makes intuition problematic to explain to others. Nevertheless, irrespective of the difficulties associated with explaining intuition, the SLNs utilise it to fulfil the demands and duties of their professional practice, albeit guided by personal feelings rather than something more tangible. The ability to practice intuitively is the result of reflection on experience, in a specialist area, and is an ability that less experienced practitioners feel comfortable using (Chaffey et al, 2012).

Reflection was fleetingly mentioned during a limited number of the interviews although it has been shown to inform judgement, learning from and making sense of, experience that assists with the development of expertise (Benner, 1982; Schön, 1983).

It has been argued that merely applying theory to situations is not enough to achieve expert practice and needs to be done in addition to having acquired experience; expert practice results when practice has developed beyond applying abstract rules and principles to viewing situations holistically (Benner, 1982; Heath, 1998). Both theory and personal experience assist with reflection which can benefit practitioners because it can facilitate critical self-analysis, questioning and understanding personal practice, resulting in the experience being restructured. Subsequently, reflection leads to a better understanding of personal experience, resulting in improved professional practice and the confidence to rely on intuition (Heath, 1998).

The SLNs are experienced practitioners who rely on past and current experience and knowledge to effectively discharge their professional role and so, irrespective of whether it was significant during the interviews, reflection has been included in the conceptual framework (Fig.13).

5.4 Current Experience, Reflection in Action, Continued Practice

An individual must be able to apply experience and relevant knowledge from a similar specialist area to a new specialism to develop expertise (Bonner, 2003). If they have the ability to do this, SLNs also have the potential to develop expertise, in a specialism where few people possess more than a little knowledge and few, if any, expert practitioners exist.

SLNs may not have initially had expertise related to safeguarding vulnerable adults. However, past experiences, as well as new ones, have helped them build a substantial knowledge base to assist with their new role in safeguarding adults.

Professional practice and experience incorporating intuition, knowledge, pattern recognition and informal and formal training, provides a basis for practice. Applying previous and current knowledge to on-going safeguarding practice is a significant component of being an SLN; this component can be supported by education and training, as presented in the conceptual framework (Fig.13).

5.4.1 The Right to Question Expertise

Related to current practice and past experience, even though an SLN may have acquired expertise related to safeguarding vulnerable adults, when assessing a situation, he or she may nonetheless choose to make *safe* decisions. Safe decisions are those made in preference to taking the risk of being wrong, a practice which is identified as defensive practice (Whittaker and Havard, 2016). This can lead to decisions being made that are based on trying to prevent any risk to self and not made in the best interest of an individual at the centre of the assessment or situation.

Questioning an SLN can be a challenge in itself because contesting anyone's decisions may result in hostility towards the challenger. In the same way that someone may feel uncomfortable about making a decision, it can be equally uncomfortable questioning an individual who is accepted as an expert, or as possessing expertise. Questioning an individual's expertise, in effect, may lead to alienation and doubt from others (Whittaker and Havard, 2016).

Therefore, when others do not agree with a decision or choice that has been made by an SLN, it should be acceptable to question them because even expert practitioners, or those possessing expertise, can make mistakes. Questioning

others' professional practice has the potential to enhance personal learning and prevent mistakes.

Additionally, questioning expert practitioners can encourage a practitioner to question their own practice and ensure that their knowledge is contemporaneous. Challenging should not be done for the purpose of merely proving whether one person knows more than another but with the intention of opening up discussion and to promote an environment for extending understanding and knowledge.

5.5 Relevant Training, Education, Networks, Forums Training and Education leads: Increased Further Development of In-Depth Relevant Knowledge

Experience can be developed further through relevant education, on-going practice and training. Although safeguard training related to vulnerable adults has been evidenced as inadequate (Martin, 2007; Nisbet, 2013), the SLNs reported that they continued to attend relevant courses if available, even if this means repeating a course they have already attended. The other method they used to increase their knowledge was participating in safeguarding forums and networking. This method of informal learning has proved invaluable for exchanging ideas and discussing difficult cases. These methods have been signposted in the conceptual framework (Fig.13).

This study showed that the SLNs protect vulnerable adults in a variety of ways by applying relevant practice and theory. However, there is evidence to support the existence of various meanings attached to safeguarding work (Sherwood-Johnson, 2013) which adds further complexity and confusion to safeguarding

vulnerable adults. This has the potential to prevent consistency within relevant training programmes and in society generally as a result.

Safeguarding networks and forums are reportedly beneficial. However, differences in the meaning applied to safeguarding work needs to be questioned in order to facilitate positive exchanges and reduce confusion. These differences result from the way that safeguarding vulnerable adults is perceived by the person protecting the adult: one person may understand s*afeguard work* as the completion of assessments and relevant documentation whereas someone else understands it to mean practical involvement. The SLNs who took part in this study understood safeguarding work to mean both, although they preferred the practical element to the written one.

Legal frameworks exist for professionals to make best interest decisions for an adult who is unable to do so for themselves and does not have any representation. These legal frameworks involve completing Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) assessments. Professionals completing these assessments may not feel competent to do so due to a lack of training (Marshall and Sprung, 2016), or perhaps because they have overestimated or misjudged their ability to adeptly complete them (Dunning et al, 2003). As a result, mistakes may be made; completing an assessment requires relevant experience, knowledge and practice to do so accurately and appropriately.

The SLNs were employed by their health organisations to fulfil the requirements of the SLN role. Without support and adequate training, the SLNs have needed to draw on previous experiences in order to fulfil the requirements of the safeguard role. It is clear that this role was created by people who were not SLNs

themselves, because SLNs did not exist prior to the introduction of the specialist role.

5.5.1 Employing an SLN: do you trust them enough to delegate?

At the inception of the SLN role, it is doubtful that anyone employing an SLN would have possessed specific safeguarding knowledge because, prior to the introduction of SLNs, safeguarding was accepted as being part of every nurse's role (NMC, 2008) and therefore not recognised as a specialism. Nonetheless, a person employed in the specific safeguarding role would have been expected to achieve and maintain the standard required to fulfil that role, even though their performance was being monitored by managers who did not possess the relevant knowledge to do so. It is unlikely that there was any guidance for monitoring this newly created safeguarding role. This is significant because selecting the right person to succeed in the role relies on the ability of the manager to recognise the attributes needed to meet the demands of the role and thereby prevent failure; this recognition also enables training programmes to be created for new employees (Illgen and Hollenbeck, 1991).

Contrary to Illgen and Hollenbeck's (1991) research, my research revealed that managers frequently have less awareness and safeguarding knowledge than their SLNs:

> *"… sometimes I find the further up the tree you go, the less the basic knowledge is there..."* (Julie, 140/143).

Consequently, managers rely on the leads' clinical judgement, experience and knowledge of safeguarding adults to represent the organisation and to ensure adults at risk are protected.

This means that less experienced managers employ SLNs in the specialist role without fully understanding the complexity of what the safeguard role involves. One of the informants confessed that, although she is employed in a senior position, she relies on her safeguarding team to support her and their organisation in relation to safeguarding vulnerable adults. The differential between the relevant knowledge possessed by the manager and that possessed by the safeguard team has the potential to affect their professional relationship if the manager delegates tasks, especially if her knowledge is less than her subordinates.

If work is delegated, there is an expectation that tasks will be assigned to individuals who are mentored and able to competently perform the task (RCN, 2011). SLNs have not had the support of mentors. It is unlikely they were assessed as competent as the role was introduced reactively in relation to the social context. It is, however, questionable whether anyone would have possessed the relevant knowledge to assess nurses taking on the SLN post, given that SLNs were the first nurses in the newly developed role. The fact that SLNs could be assessed by a less knowledgeable person was a potentially contentious issue, which could give rise to resentment on the part of the SLNs towards the assessor.

Delegating can prove challenging for managers as it entails relinquishing their control to others. Even so, delegating to others can reduce their workloads but requires managers to remove themselves from practical involvement with an organisation and operate at a more strategic level (Pech, 2009).

However, mutual trust can be absent because the manager is not viewed as caring or trusting by the employee(s). This lack of trust can be due to the manager withholding pertinent information from the employee(s) in order to maintain control. On the other hand, the employee(s) can fail to advise the manager when mistakes have been made, or when tasks have not been completed, for fear of the consequences. This mutual lack of trust can lead to errors of judgement being made and any trust that does exist being compromised (Pech, 2009). This study revealed that at least one of the managers had less safeguarding knowledge than her team; although she now routinely delegates work, this trust took time to build.

As was highlighted in the interview transcripts, there is an apparent overall lack of managerial leadership available to the SLNs, in addition to relevant training. This explains why many of the SLNs have learnt their role through day-to-day practice, networking and using their past experiences to become competent, if not expert, SLNs. The informants did not believe that anyone in their health organisations has the safeguarding knowledge needed to competently undertake the role, other than the SLNs themselves.

However, the SLNs may themselves be viewed as middle management; they are answerable to managers of a higher grade while managing staff at a lower grade, which is indicative of middle management. Middle managers have been identified as intending to confirm, create and assert their identity as middle managers by striving for validity, position and purpose within their organisations and society (Thomas and Linstead, 2002).

5.5.2 Double Speak has added further complexity

In addition to reported inadequate safeguarding training, guidance and leadership, the SLNs had also encountered what is described as *double speak.* Double speak is a method that can be used to alter the meaning of a sentence from something that could be perceived as uncomfortable to something more acceptable (Lutz, 1987). Although the safeguard lead nurses did not emphasise the use of different words to describe safeguarding vulnerable adults, it was noticeable that they preferred alternative words for safeguard, for example, protect.

Lutz (1989) considered double speak post-Orwellian. He highlighted that the way in which language can be used is very powerful and can affect others' behaviour and the way they think (Lutz, 1989). This is demonstrated in the film based on George Orwell's novel, *1984*, which explores double speak and how it is used to convince society to believe the messages conveyed by the state.

The film demonstrates that exchanges between people derive mutual understanding through the meanings attached to them. By using specific, carefully selected, terminology, acceptance by the majority is achieved and those who disagree are believed to lack mental capacity, and are penalised and ostracised. Ultimately, persuasion through double speak convinces society of a strong and positive leadership, counteracting any negative associations present in their actions (Radford, 1984).

Similarly, by selecting appropriate words for descriptive purposes, the meaning of a message can be altered (Lutz, 1987). For example, the word 'downsizing'

can be used instead of ‘dismissing’ because it has fewer negative connotations. Double speak can also be referred to as double talk and its use can transform a negative outcome into a more socially acceptable positive one. However, when the use of double speak is considered objectively, the conclusion remains the same because it is merely a matter of semantics and so changes nothing materially, only the terminology.

In relation to exploring double speak, it is useful to consider the definition of Safeguarding Adults as set out in the Care Act (DH, 2014), which states that:

> *“a person aged 18 years or over, who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”.*

This definition is ambiguous and does not clearly state what ‘other disability’, ‘age’ or ‘illness’ refers to and why it requires an assessment of the over eighteen-year-old person to determine if they are at risk of abuse. Neither does it explain exactly what the term safeguard means although it is frequently replaced by the word protect instead, a term often used by the SLNs during this study.

Furthermore, the term safeguard can be broken down into two components: *safe* and *guard*, which can lead to different interpretations and associated meanings. For example, the word ‘guard’ can be defined as, ‘to protect, to control or to watch’, while ‘safe’ derives from salvation and relates to the notion of keeping, serving and protecting (Skeat, 2007). Consideration of the words ‘control, watch, keep and serve’ suggests a meaning other than protection. Interestingly, these words might indicate subservience, or the unquestioning willingness to comply,

on the part of the safeguarded individual, and control on the part of the safeguarding professional.

A more contemporary example of double speak related to safeguarding vulnerable adults, is the emergence of the Deprivation of Liberties Safeguard (DoLS). This terminology has caused concern and is currently under review (Bartlett, 2014). Protective care is one such option that has been considered, but the definition of deprivation is not clearly understood. In the context of vulnerable adults, this can include not allowing them to go into the community unsupervised, applying restraint and administering medications covertly (Schafer, 1985; Shah et al, 2011).

Reportedly, the poorly informed can perceive a DoLS as removing an individual's liberty for no apparent reason. The SLN's role includes explaining this misunderstood concept to others due to the concern they can feel when a DoLS is enacted; even after clarification, the rationale for a DoLS may continue to be misunderstood.

Double speak is a subtle way of manipulating others into believing information that is not honest or transparent and has added further complexity to the notion of safeguarding vulnerable adults because of the discomfort and ambiguity that badly chosen terminology has caused. In respect of policy, in Scotland, the term harm is used in preference to abuse (Executive, 2007). In England and Wales, the term vulnerable adult is being replaced by 'adult at risk' because of the stigma that has been attached to the term vulnerable which implies the individual is to blame and not the environment (Brown, 2012).

However, the SLNs perceived the various uses of terminology associated with vulnerable adults and others' understanding of them, as an opportunity to gain greater insight into other facets of safeguarding vulnerable adults and its relationship with society. Consequently, the SLNs appeared to be coping well with terminology that has the potential to hinder the protection of vulnerable adults due to its lack of honesty.

The SLNs remain motivated and passionate, despite the challenges surrounding safeguarding vulnerable adults, and continue to increase their expertise in a way that can be recognised by others (Hoffman, 1996; Manley et al, 2005). This acknowledgement may lead the person who possesses expertise to be questioned by others. This has the potential to result in informal teaching and learning, both for the person asking the questions and for the person being questioned, in relation to safeguarding vulnerable adults. Consequently, such informal teaching and learning may increase awareness for the person seeking information but also for the person with the expertise who may discover how much, or how little, they know, which will be reflected in their ability to answer the enquiry.

Defining expertise is challenging although, generally, it tends to be accepted as meaning possessing relevant knowledge that is superior to others and representative of someone's competence in a specialism (Schneider, 1993). However, because competence itself is a concept that cannot be measured, or verified, it does not make it any easier to define expertise. The fact that expertise cannot be measured has been demonstrated by various conceptual frameworks including those of Benner (1982), Dreyfus and Dreyfus (1980) and McHugh and

Lake (2010) that failed to offer little more than interpretive views of expertise and have not assisted in measuring expertise, any more than studies that were conducted many years previously.

Expertise develops from an individual's ability to apply experience and knowledge to a specialist area. This indicates that appropriate methods cannot be developed to help an individual achieve expertise because it is something that develops innately and cannot be taught. Therefore, expertise is clearly not the result of qualifications or teaching but is acquired through continued practice in an appropriate practice environment over a prolonged period of time (Adams et al, 1997; Guest et al, 2001; Berliner, 2001; Ericsson, 2004).

At the time of the study, the SLNs had worked in the SLN role for between one and five years, which is less time than is generally considered necessary to develop expertise (Simon and Chase, 1973; Hardy et al, 2006). However, the SLNs had each held previous professional roles for a number of years, in specialisms that involved caring for vulnerable people. The interviews clearly showed that the SLNs had been exposed to many safeguarding scenarios in a short period of time. As a result, they had acquired practical experience, as opposed to experience that had been acquired merely from the length of time they had worked in the role.

As discussed previously, quantifying expertise is elusive because it involves personal, subjective interpretation, which has been confirmed by studies that have shown attributes such as appearance and demeanour to be determinants of expertise (Naumanen, 2007). Other perceived determinants of expertise are

possessing in-depth knowledge, continued practice and experience in a specialism (Hardy et al, 2006).

Arguably, determining the extent of the relevant expertise that SLNs possess is challenging. However, it seems reasonable to assume that they possess more relevant knowledge than others. The SLNs' pertinent knowledge continues to increase as a result of their continued engagement with vulnerable adults, and the challenges they face on a daily basis. The SLNs' expertise is clearly the consequence of previous experience, in-depth knowledge and on-going practice, acquired in similar specialisms, because there has been no apparent leadership and little relevant training to assist them.

5.6 EXPERTISE/ EXPERT PRACTITIONER

During the course of the study, the SLNs spoke about being approached by others who had identified them as experts because of the expertise that they possessed in respect of safeguarding vulnerable adults. Moreover, the SLNs' knowledge was also expected to extend to safeguarding children.

One of the SLNs reflected upon being a safeguarding expert and suggested that, if the role required an expert, it would have been highlighted in the job description, which was not the case as the term specialist was utilised instead. This implies that although society attaches meanings to, and develops mutual understanding of, what constitutes being an expert, job descriptions and the associated roles rarely include the word expert. Instead, being identified as an expert emerges from the role holders' behaviours and their knowledge, in relation to safeguarding vulnerable adults, and how they are viewed by others.

Regardless of where SLNs are positioned on the management ladder, they fulfil specialist roles; this position implies they possess relative experience, specific in-depth knowledge and extensive professional practice in safeguarding. This is likely to be the reason why they are viewed as experts by their colleagues and others who do not possess specialist knowledge in safeguarding.

Grundmann (2017) draws our attention to the notion that being a specialist does not automatically make a person an expert but may simply be the result of others trusting their specialist knowledge. This trust develops through the specialist demonstrating their ability to apply their specialist knowledge to manage complex issues, define situations and show optimal ways for addressing them. Subsequently, their status as experts begins to evolve (Grundmann, 2017).

Anecdotally, individuals who hold titles, or formal qualifications related to safeguarding, do not necessarily have the level of practical experience that the SLNs have acquired. As a consequence, these titled and qualified people rely on SLNs to assist them with managing safeguarding situations because they lack practical experience in this specialist area. They are not identified with either possessing expertise or being experts.

5.6.1 SLNs and Social Identity

Identity is the result of an individual constructing themselves through communication with others and the way in which they mentally formulate the exchange. Therefore, the self is influenced by society and society is influenced by the self. This results in society becoming an integral part of the self, that plays

an influential role in our thoughts, and subsequently leads to the emergence of an identity which is considered to be that of the self (Gover, 2006).

However, there can be a difference of opinion, related to an identity, because an individual may believe that they deserve acclaim for their achievements. Conversely, an individual might view themselves as underachieving while others might not believe this to be the case (Woodward, 2004). Both scenarios are the result of personal, subjective interpretation which has the potential for individuals to overestimate or underestimate their ability.

Social identities and social information can be understood through the guidance and organisational ideologies of categorisation, and labels, that society attaches to them. Individuals can be inspired to view groups positively as a result of their social identity from belonging to that group, which has the potential to enhance self-esteem. Additionally, someone's position in relation to their organisation, their employment, their professional role and in society generally, requires consideration (Woodward, 2004). SLNs can benefit from considering their position in the world, and their relationship with others, because how they view themselves compared to others may assist or hinder their ability to protect vulnerable adults.

5.6.2 SLNs as Experts

Experts are recognised as a result of their behaviour, knowledge, leadership ability and because they have self-awareness related to their ability (Delya and Hargreaves, 2001). Comparatively, an individual may be unaware of their ineptitude, because they are oblivious to the lack of specialist knowledge they

actually possess. This incompetence can become evident when the individual responds inappropriately to presenting situations (Dunning et al, 2003).

A further issue that has been associated with experts is their inability to accurately assess the knowledge others may possess, which can lead to information being communicated ineffectively or incorrectly (Wittwer et al, 2005). In turn, this may have an influence on communications related to safeguarding vulnerable adults; for example, if the person receiving the information misinterprets it or does not admit they do not understand it.

While some SLNs felt uncomfortable about being viewed as an expert, others welcomed it. The SLNs asserted that experts are expected to cope with responsibility, rarely make mistakes, and possess greater safeguarding knowledge than others. They also confirmed their belief that experts are positioned as experts only for as long as they maintain relevant skills, make few mistakes and are perceived to be experts by others. There was a belief among the SLNs that, if individuals who are acknowledged as an expert by others fail, they lose more than just their expert status; they lose their credibility. Thus, the potential exists for the *fallen* experts to be ridiculed by others, instead of respected, which is demonstrated by Fig.14. This could explain the rationale for the majority of SLNs preferring to be known as specialists rather than experts.

The resistance of several SLNs to being viewed as experts by others is not surprising if an interview with a former cabinet minister is considered. In the interview, former member of the cabinet, Michael Gove, spoke negatively about experts. This led to a light-hearted cartoon (Fig.14) being published in a national journal (Nelson, 2016). Gove's interview is highlighted in the following text, to

demonstrate the fickle nature of societal exchanges and the speed at which they can change or disappear. It also explains why SLNs would rather be thought of as specialists and not experts.

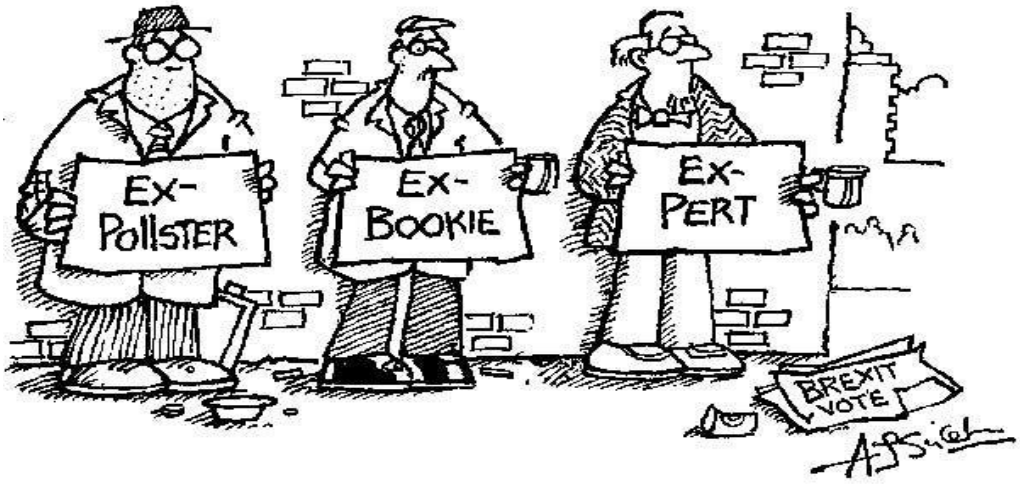


Fig. 14 *The Spectator (Nelson, 2017)*

Gove had apparently stated that he:

> "…*had enough of experts from organisations with acronyms saying that they know what is best and getting it consistently wrong"* (Nelson, 2016).

Mr Gove's words were initially mocked, but later the media determined that the experts he was referring to had been proved to have given incorrect advisory information. The experts' mistakes and their subsequent fall from expert status were depicted in a cartoon which was published in *The Spectator* and related to the aforementioned interview:

By way of a response, an article using auditing methods to refute Gove's defamatory comments and salvage the reputation of experts was published. The article refers to expertise and only mentions experts as a direct result of Gove's comments although, when experts are referred to, they are referred to as academics, a term that is not clearly explained. However, the trust that society apparently places in so-called academics has been shown to be lower than the trust it places in friends and family (Menon and Portes, 2016).

Irrespective of the reasons an individual is perceived to be an expert by society, it is evident that being in viewed in this way can be short-lived and easily undermined by perceived failure.

The SLNs compared being viewed as experts to the role of expert witnesses. Summoned to demonstrate their expertise in court, a number of these expert witnesses have made judgement errors that led to custodial sentences. Although the verdicts were reversed at a later date, it is likely that these mistakes will be remembered because they were highly publicised, whereas good judgements made by expert witness often go unremarked (Perrin, 1995; Heald, 2005).

The expert witnesses had been recognised because of their title, professional role and qualifications. Making mistakes led to their perceived failure and caused them to be discredited. Cases involving vulnerable adults can be presented in court where the SLNs are summoned to testify. Court appearances test the expertise of the SLNs who may be questioned by people who have less relevant knowledge than they do.

According an individual expert status indicates that they have greater authority than others in a specialism and offer a resource that can facilitate sharing of relevant knowledge with others. It also places the expert in a position of authority, in the relevant specialism, with the expectation they can competently and confidently guide others. However, they may offer the wrong advice or, worse still, make inappropriate decisions for others which can lead to their opinions being questioned (Koppl, 2015). If an individual is viewed as an expert and makes a mistake, it could be argued that blame for the mistake being made could be attributed to the person(s) who elevated the individual to expert status in the first place.

Broadening one's knowledge in a specialism can help them to teach others but sharing knowledge might not always be in the best interest of the expert. Shared knowledge becomes common and loses its uniqueness through communal exchanges. These interactions can reduce the expert's uniqueness and status, in turn diminishing the value of expert involvement (Koppl, 2015). Nevertheless, sharing knowledge does not indicate that everyone who acquires knowledge will be able to apply it to practice.

Anecdotally, SLNs are assumed to be an authority in respect of safeguarding vulnerable adults, with responsibility for the lives of vulnerable adults. Their perceived expert status could be discredited or lost through making mistakes in a specialism that is still developing as a result of growing societal awareness. The interviews conducted, showed that not all of the SLNs had chosen to be viewed as experts but had nonetheless been positioned as such.

5.7 SUMMARY

Part 1 of the conceptual framework (Fig.13) can be applied to general specialisms including nursing, teaching, and social work. Now the specific application of the framework is discussed.

PART 2: SPECIFIC APPLICATION

5.8 THE COMMON DENOMINATOR: PERSONAL INTEREST

The ability to transfer knowledge and skill from a previous role to a current one may not be achieved by everyone and may be limited to people who have the interest, desire, and passion to excel. These attributes can be considered as aspects of someone's personality. Therefore, what motivates one person may not provide the same motivation for someone else (Amabile, 1993).

Factors such as individual choices, determination and persistence are influenced by motivation. As a result, acquiring abilities also depends on motivation but includes being able to facilitate the application of these attributes appropriately (Locke and Latham, 2004).

- Extrinsic Motivation

Extrinsic motivation has not always been found to be beneficial because this type of motivation can put unwanted pressure on the person trying to meet targets or deadlines. Therefore, extrinsic motivation can have an adverse effect and prevent them from attempting to meet an objective (Ryan and Deci, 2000). An individual may, however, react positively to external motivation, depending on whether the individual is motivated and interested in achieving a specific goal (Alexander,

2001). For example, SLNs are passionate about protecting those at risk of abuse and are keen to increase relevant knowledge. Although peer support could potentially apply unwanted pressure, due to the expectations it creates, SLNs have, nevertheless, found peer support to be advantageous, particularly in light of the lack of adequate support, training and leadership for the role.

Therefore, SLNs are extrinsically motivated due to:

- ✓ **Peer support** being offered and utilised
- ✓ The **obligation** to source ways of educating themselves about safeguarding vulnerable adults as training is inadequate (Nisbet, 2013).
- ✓ **Deadlines and pressures** associated with the safeguard role being met on a daily basis.
- ✓ The **expectation** that they will be an authority in relation to protecting vulnerable adults, demonstrate leadership, take responsibility and manage safeguarding cases.
- ✓ **Fulfilling** the expectations of their role.

- Intrinsic Motivation

Intrinsic motivation urges an individual to take action that results in satisfaction and enjoyment from being involved with a topic they find interesting. The interest can result from personal or social experiences (Ryan and Deci, 2000). Hidi and Renninger (2006) argue that this develops through four phases of interest development that they have captured in a conceptual model: The Four-Phase Model of Interest Development. This model involves: triggered situational interest; maintained situational interest; emerging (less-developed)

individual interest; and well-developed individual interest (Hidi and Renninger, 2006). These phases are now considered in the context of safeguarding vulnerable adults and SLNs:

- Triggered Situational Interest

  This phase refers to emotional and cognitive processes that are triggered by information that stimulates interest in a topic or situation. The information may be pertinent, concentrated, or relevant to situational interest. It may be intrinsically driven, although frequently the action is reinforced by extrinsic factors, for example working as a team which has been shown to activate situational interest. The interest may also be triggered as a result of prior experiences in similar scenarios (Hidi & Renninger, 2006).

  Application of the four-phase model of interest to SLNs shows that their motivation stems from an interest in protecting vulnerable adults. This began with their involvement in caring for vulnerable adults or as a result of personal experiences. Their interest was reignited when their cognitive processes received information, related to safeguarding vulnerable adults that activated a previous interest, question or link to prior knowledge relevant to the current situation.

  Furthermore, the safeguarding networks and forums enabled peer support to increase motivation and enhance ability. This informal training increases in-depth knowledge and subsequently leads to maintaining interest in safeguarding vulnerable adults. Increasing relevant knowledge and maintaining interest, in addition to motivation, result from either intrinsic or extrinsic factors that can sustain situational interest (Hidi & Renninger, 2006).

- Maintained Situational Interest

The second phase of the model relies on intense and determined personal involvement with tasks that the individual perceives as relevant to the area of interest. This phase may be sustained as a result of external factors such as supportive group work (Hidi & Renninger, 2006). This would indicate the benefit of safeguard networking and peer support in relation to SLNs.

In order for SLNs to establish their ability in this specialist role, they needed to prove themselves. They have done this by acquiring relevant specialist knowledge, continued practice and sourcing relevant training. Consequently, they are viewed by their peers and other nurses as specialists, or experts, which has further heightened their motivation to protect vulnerable adults.

- Emerging Individual Interest

The third stage of the model refers to an individual developing a predilection to repeatedly engage with specific responsibilities. This phase is not reliant on external factors to motivate the individual towards the area of interest. Instead, it is the result of an individual's personal feelings towards the topic, their increased relevant knowledge and the concept that they welcome the opportunity to engage with a context that relates to the area of interest (Hidi & Renninger, 2006). Safeguarding vulnerable adults is an emotive concept that the SLNs have either witnessed or experienced. It is their experiences of abuse that continue to motivate them to protect vulnerable adults and maintains their interest.

SLNs are resources for individuals who possess less safeguarding knowledge than they do. They are able to verbalise their passion and motivation and

benefit from peer support to reinforce their professional practice. They have responsibility, are respected and can call on vast experience that they apply to safeguarding vulnerable adults. Although they practice in the clinical environment, at times this may extend beyond it, whereby they continue to protect vulnerable adults in their own time and not just within work time.

- Well-Developed Individual Interest

  Phase 4 denotes an enhanced version of Phase 3. This phase demonstrates increased relevant knowledge and a tendency towards involvement in an area of interest to which the in-depth knowledge pertains. At this stage of the model, the individual relies on intrinsic factors to drive their interest and less on external ones (Hidi & Renninger, 2006). This phase has developed as a result of personal interest that is now driven internally and, although it reacts to external stimulus, is mainly the result of personal motivation.

The literature suggests that personality is significant in motivating individuals to achieve specific goals (Alexander, 2001). Motivation is an innate quality of personality and therefore everyone has the capability to be motivated, extrinsically or intrinsically. Intrinsic motivation does not result from incentives, and developing skills and knowledge is the result of personal interest in a subject (Ryan and Deci, 2000).

It is the source of motivation that is significant for this study, which has revealed that the SLNs have a long-term personal interest in protecting vulnerable adults. SLNs' motivation and interest are now considered in detail using a number of excerpts from the interview transcripts to support the emergent hypotheses.

A number of the informants spoke about personal motivation and interest, indicating that their interest in the subject, and accountability to the people they protect, are stronger than their loyalty towards their organisations.

Even though there are many inadequacies related to the safeguard role including training (Nisbet, 2013), the SLNs have:

- Acquired in-depth relevant specialist knowledge
- Raised awareness of the complexities associated with safeguarding vulnerable adults, within their teams and health organisations
- Continued to increase their experience and expertise.

Various definitions of expertise, expert practice and safeguarding vulnerable adults exist because they are constructs that have derived from changing societal attitudes (Searle, 1997; Fawcett, 2009). Currently, there are few people who have either the experience, expertise, or motivation, that these SLNs possess, related to safeguarding vulnerable adults. The following is a comment made by one of the more experienced informants during my interview that demonstrates this:

> *"I have a working knowledge of safeguarding but I have a background of district nursing so we had it when it wasn't safeguarding, it was child protection onwards. I helped develop the adult safeguarding because that came latterly so I have a working knowledge but my team are the experts not me"* (Ingrid, 80/73).

This acknowledgement is not misplaced due to the SLNs' acquisition of extensive relevant knowledge and skills. In collaboration with each other, and through networking and forums, they have become a valuable resource that cannot be reasonably ignored. They can be considered an authority with regard to safeguarding vulnerable adults.

The SLNs' motivation is driven primarily by their interest. This interest is the result of personal experiences, in some cases, dating from early on in their lives:

> *"…like our upbringing, school, the way I am with my children and you look at other people. So how did my mum react in that situation, how did my dad react, how do you know? People I work with react to situations so I think you sort of almost build-up that moral, that subconscious moral code, so I find that that is socially unacceptable",* (Enid, 422/427).

Their motivation did not develop as a result of achieving a professional role identified with expert practice. The SLNs were not concerned with being viewed as experts, although they were aware they possessed extensive, relevant knowledge. The lack of relevant knowledge that others possess sometimes frustrated the SLNs. One such incident reported by an informant involved a social worker who had closed a case because there was no evidence to support it. The problem, from the perspective of the SLN, was a lack of insight because there were accompanying photographs to support the notion that there were grounds for concern. This type of behaviour has motivated SLNs to help educate less knowledgeable health professionals by sharing relevant knowledge and understanding with them.

Several of the SLNs were convinced that they succeeded in securing the safeguard role because of their previous professional roles; these roles included working in a professional role that had been extended to incorporate the safeguard role or caring for vulnerable adults for many years. The SLNs also believed it is likely that there were many people, who were in a position to decline applications from such experienced nurses, or to judge the applicants' ability, in this specialism:

> "*…are so vulnerable in all aspects and so you are dealing with some of the most vulnerable people in society and you have to be able to safeguard them. So, I do think that is probably one of the reasons why I got the job and my knowledge background"* (Anna, 91/94).

One of the informants applied for the SLN role because her interest in the specialism grew as a result of her previous nursing roles, as she explained in the following excerpt:

> "…*not thinking that I would then go specifically into a safeguarding role but just because I was the lead and I was interested in it, I found myself in a group full of social workers and mental health staff and very, very, few people with a general nursing background and remember thinking initially quite overwhelmed because I was the only general nurse"* (Hattie, 146/151).

Similarly, another informant became interested in safeguarding vulnerable adults, having worked with vulnerable people for several years. Her interest grew further when she became an SLN. She was required to complete many managerial duties and admits that she became immersed in the safeguarding part of her role, to the detriment of the managerial element. She was surprised when she met with other people who were involved with safeguarding adults:

> *"…but they'd been given it but they didn't really have the interest and passion I did. So, I became more and more interested and I suppose consumed in the safeguarding part of my role than I did the management part of it in terms of managing teams"* (Hattie, 160/163).

In the previous excerpt, the informant refers to other healthcare professionals who were involved with safeguarding. She perceived them to be neither interested nor passionate about this aspect of their work. By comparison, the informant's interest originated from experiencing the devastating damage adult abuse can do, emotionally, psychologically and physically, and the lack of resources to effectively stop or prevent it.

Outside of managing their professional role, the SLNs continued to monitor for potential harm to others. It was noticeable that the SLNs may have completed managerial tasks with less enthusiasm than when they were being proactive and directly involved with the vulnerable adults.

For example, one of the SLNs stated that when she observes behaviour that she perceives as abuse, she will take action: she would rather her interpretation was incorrect than place an adult or child at risk of harm, because she failed to act, as she explained in the following excerpt:

> *"if I saw somebody leaving their kiddy in the car and abandoning them, my response is to go and get somebody and say "whose child is that and you can't abandon them and leave them in the car", and then watch it and if no one has come back in 10 minutes, then that's a phone call to somebody"* (Julie, 178/182).

Another informant explained why he works extensive hours:

> *"I am the kind of person that will sit at my desk 24 hours a day just to make sure that everything is being done right on wards. So actually, I influence me by pushing myself. I influence patients and patients influence me. I want patients protected"* (Derek, 57/61).

These examples highlight actions which are clearly motivated. There is no obvious pressure for either of them to act in the way they do other than inherent interest, satisfaction and because they want to. This demonstrates intrinsic motivation compared to extrinsic motivation (Ryan and Deci, 2000)

The SLNs have a personal interest in the role they hold because they can use their position to help them protect vulnerable adults from abuse, now and in the future. Being viewed as an expert is not important to them because they are aware of the depth of the knowledge and skill they possess, in relation to safeguarding vulnerable adults. If the SLNs found they were no longer in the

safeguard role, they would continue to protect vulnerable adults from abuse. Their loyalty, voiced by a number of SLNs, lies with the people they protect and not their organisations, as shown in the following excerpt from one of the interviews:

> *"…my background is very much about older people and part of my passion for nursing is to make sure that people at risk, the most vulnerable people, don't get discriminated against and that is why I care about the role coz I have a real passion. That is what gets me out to work, out of bed in the mornings. I want to represent the people in our community well …"* (Fred, 105/110).

The SLNs had witnessed abuse and one of them, who was not classed as vulnerable, had been physically and verbally abused. The SLNs have lived with or helped others through abuse. As a result, they do not want to see this abuse continue and neither do they want to be associated with any types of abuse that exists within healthcare settings. The SLN role can help to increase awareness of adult abuse, and empower the SLNs themselves in their efforts to meet this objective.

These ten SLNs all have a personal interest in protecting and caring for vulnerable adults. This interest had resulted from personal experiences, and the need to raise awareness and prevent it continuing. There have been numerous changes in policy, legal frameworks and associated terminology. Nonetheless, regardless of these apparent obstacles, the SLNs maintain their objective: to protect vulnerable adults. This study shows that this motivation is not exclusive to one SLN but is, in fact, shared by all of them and is, therefore, a common denominator.

5.9 COMMON DENOMINATOR FOR SLNS

It takes time for the concept of expertise, and the expert, to develop even though skill and knowledge can be transferred from one specialism to another (Benner, 1982; Dreyfus and Dreyfus, 1980). The SLNs had not been in their roles for long and, in some cases, less than three years when they took part in this study. Even so, they possess the knowledge and skill to support others in this specialist area and have the motivation to do so.

Although the SLNs had apparently acquired expertise in a short space of time, this is the result of their personality, and specifically their motivation, utilising previous skills and knowledge relevant to safeguarding vulnerable adults. Despite this, more time needs to elapse before the concept of safeguarding vulnerable adults can achieve a 'stable state'. However, this is unlikely to happen because the understanding and meanings attached to what constitutes abused and vulnerable alter regularly and are interpreted in various ways.

SLNs deal with safeguarding dilemmas on a daily basis; thus, situations that are viewed as forms of abuse are still emerging (Dong et, 2011). This demonstrates the fluid and dynamic nature of continuing to protect vulnerable adults against abuse.

However, irrespective of the types of abuse that continue to emerge, SLNs need time to establish themselves. Currently, there are no boundaries, and no general understanding in this specialist field, due to the fact that it is still in its infancy, a situation made worse by government legislation frequently changing, as shown by the introduction of DoLS (DH, 2012).

However, central to this study are the findings that the SLNs have both the motivation and interest to continue protecting and caring for the population of abused adults. Irrespective of how long it takes for the concept of safeguarding vulnerable adults to stabilise, SLNs possess an inherent wish to protect vulnerable adults while proving themselves to be worthy of being SLNs. As SLNs, they are well placed to take advantage of their professional role in the fight against adult abuse.

5.10 SUMMARY

This chapter has discussed the various paths that had led the informants from their previous roles to their current roles and how their previous experience has had an impact on the latter.

The conceptual framework (Fig.13) has been presented and explored concluding with the notion that the common denominator for the acquisition of relevant knowledge and experience of SLNs is personality, particularly motivation initiated by personal interest. These aspects of personality have resulted in the SLNs developing as autonomous professionals. They demonstrate both relevant expertise and expert practice related to safeguarding vulnerable adults, but because all of these concepts are socially constructed, they also have the potential to change.

Therefore, it is unlikely that unanimous agreement will be reached that SLNs are experts, or possess expertise, as this depends on personal understanding and interpretation of what constitutes either. It is also unlikely that people in wider

society, including those in the government, have more knowledge than these specialist nurses related to safeguarding vulnerable adults.

If we accept that a person can be motivated to do something but not interested in it, we can accept that a person may be interested but not motivated to act. Therefore, these contextually knowledgeable SLNs will be viewed as both motivated towards, and interested in, protecting vulnerable adults with the accompanying knowledge which that requires. They will not be perceived as nurses simply fulfilling the requirements of a professional role.

CHAPTER 6: LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION

Clearly defined meanings for the concepts of an expert and expertise, in relation to safeguarding vulnerable adults, have not been determined as a result of conducting the study. However, the data have highlighted the complexity surrounding safeguarding vulnerable adults and the numerous ways that this concept can be viewed by society, both across different countries and by individuals within them (Martin, 2007; Nisbet, 2013; Chrome et al, 2014).

Current understanding of safeguarding vulnerable adults, together with the meanings attached to this complex issue, are continually being redefined due to the fluid and dynamic nature of safeguarding vulnerable adults, changes that are a consequence of growing awareness achieved through social exchanges. Furthermore, besides the complexity that relates to safeguarding vulnerable adults there is a lack of consistency surrounding the more general definitions for both an expert and expertise.

Nonetheless, the participating SLNs have all acquired relevant in-depth knowledge over a lengthy period of time through ongoing professional practice and experience, regardless of the label that is attached to their extensive knowledge. However, as with all research, this study had limitations but future studies, particularly those related to the same or a similar topic, can benefit as a result of it having been conducted.

Therefore, this final chapter addresses the limitations of the study, makes recommendations for future practice, and draws conclusions from the findings which are based on the data acquired as a result of the interviews.

6.2 LIMITATIONS OF THE STUDY

- Inclusion and exclusion

Inclusion and exclusion criteria add structure to a study with the aim of recruiting a specific, relevant sample (Richie et al, 2003). Recruiting a sample required to fulfil the aims of the study meant that the viewpoints of other professionals, working in other specialist areas, including social workers, had to be excluded. Including them would have had the potential to reveal different understandings applied to safeguarding vulnerable adults, as well as the meanings they attached to the concepts of expert and expertise which was not the remit of the study.

- Limited Numbers

There was a limited number of SLNs in the geographical area covered by the study which restricted the number recruited to ten; however, this number meets Kvale's (1996) recommendation in relation to numbers of interviewees. While an increased number of informants would have had the potential to produce an unmanageable amount of data (Marshall, 1996), recruiting another five had the potential to yield additional relevant information without necessarily having a significant impact on data management but, as already stated, the number of SLNs was limited and as a result, no more were recruited.

- Organisational Limitation

A factor that hindered sample size was the number of organisations, within the geographical location involved, who were approached to take part in the study. Several organisations declined due to the lack of available resources which represents a limitation in itself. This deficiency was caused by shift patterns, staff shortages and seasonal pressure.

- Social Construct

Even though there are a number of limitations, the most significant limitation of this study was exploring a phenomenon that is not static. Consequently, findings must be considered as evolving, and this study offers a model that captures this fluidity.

6.3 RECOMMENDATIONS FOR FUTURE PRACTICE

This study recommends:

I. Increased Resources to prevent Adult Abuse

The government has been motivated to act following both the Francis Report (Francis, 2014) and the Winterbourne enquiry (CQC, 2011). There remains a need for increased resources to be afforded to the protection of vulnerable adults; these resources include; improved national training; increased financial funding; utilising the knowledge and experience of the SLNs; and increasing numbers of staff assigned to adult protection.

II. Relevant and Comparable training across England

During the course of this study, anecdotal evidence was found to suggest that different organisations have their own agenda, in respect of this specialism, and therefore training is not uniform across organisations.

Existing variations in the training of safeguarding vulnerable adults need to cease. Dedicated training, within the healthcare sector, needs to be consistent across England and must constitute more than an auditable trail, as seen, for example, with both e-learning and the completion of a DoLS. Instead, safeguard training should involve both practical and theoretical training under the guidance of the SLNs who have amassed experience and extensive knowledge in this specialist area.

lll. Utilising SLNs as a Resource

Safeguarding leads have had to function autonomously since their inception, due to lack of resources, consistent training, supervision and leadership. Significantly, they have evolved the safeguarding role themselves as they have been faced with safeguarding situations on a daily basis. Generally, it has been previous experience working with adults who have a learning disability, or are elderly - both of which can make someone vulnerable - that has guided the SLNs' practice.

Leadership has not been available to the SLNs and the acquisition of relevant in-depth knowledge and increased understanding, related to safeguarding vulnerable adults, has resulted from their personal interest and motivation; the SLNs also possessed an eagerness to educate others in this specialism, together with a willingness to listen. These attributes are necessary for effective, future

practice, in the light of the dynamic nature of safeguarding vulnerable adults and, consequently, SLNs have the potential to provide safeguarding leadership that has previously not existed and to offer a valued resource.

Besides the knowledge they have already acquired in protecting vulnerable adults, the SLNs' knowledge base is continually evolving as society defines and redefines vulnerability; SLNs are frequently exposed to, and adapt to, a variety of safeguarding scenarios. This exposure increases their awareness and recognition of abuse and their ability to determine the most appropriate method of managing it. Sharing their knowledge with others makes them a valuable resource in managing abuse of vulnerable adults.

SLNs promoting and delivering safeguard training would offer much more than the delivery of theoretical knowledge, and would be enhanced by the SLNs' experience and knowledge gained from their current and previous roles. Training delivered in this way is not merely delivery by someone who has designed the safeguard training but by an individual who has both relevant theoretical and practical experience and expertise in protecting vulnerable adults.

IV. Valuing SLNs' experience

A significant part of The Care Act (2014), is the safeguarding policy Section 14, which stresses that '*Safeguarding is everybody's business'* and sets out several aims for achieving this, including: where possible stopping abuse; supporting people to make their own decisions; and addressing the cause of the abuse. The safeguard policy explains how local authorities will make enquires in suspected cases of abuse and that each local authority should have a safeguarding adult

board (SAB). As a result, there is an expectation that safeguarding boards, safeguard managers and multi agencies will collaborate with cases of adult abuse to prevent suspected abuse happening or existing abuse continuing (DH, 2014).

However, although these guidelines exist and collaboration between agencies is expected, reportedly DoLS was presented without prior consultation with any of the SLNs involved with this study; they only became aware of its existence once it was in use. It would seem reasonable for the DH to listen to SLNs because they manage safeguarding situations daily and can advise on safeguarding issues. In addition, SLNs can advise on the use of more appropriate terminology than terms like *deprivation of liberty* which is widely misunderstood due to its negative connotations.

6.4 RECOMMENDATIONS FOR FUTURE RESEARCH

Applying the conceptual framework (Fig.13), when a period of time has passed, to another group of SLNs, may produce a different set of factors which influence the SLN role whilst the framework itself may remain constant. This difference would be due to the ephemeral nature of the concepts expertise, expert, safeguarding and vulnerable, which continue to change over time; as well as new meanings and understandings emerging and being applied to them. Additionally, future SLNs might lack the level of interest or motivation that was demonstrated by the SLNs who took part in this study.

The versatility of the conceptual framework (Fig.13) makes it useful for exploring expertise and the expert in specialisms other than safeguarding vulnerable

adults. It can also be utilised to examine whether other specialists have a common denominator that drives them because, as previously proposed, the first part of the framework (Fig.13) is a generic tool and can be applied to any specialism. The second half can be applied to a specific profession with the prospect of producing a different common denominator.

6.5 CONCLUSIONS

The term safeguarding is a concept that is based on collective views that have been developed and maintained within communities and society. As a result, safeguarding can be interpreted in various ways and different meanings can be applied to situations that involve protection of the vulnerable.

This is significant because situations may be viewed differently from individual perspectives and may enable abuse to continue or be prevented depending on the perspective. This notion is supported by the various terms used for safeguarding, for example protecting or caring, which might not have the same meaning for everyone. The result of safeguarding being a socially created construct, added to the different forms in which it manifests, means that safeguarding is a highly complex issue and will continue to evolve indefinitely.

The influence of this study is significant because it contributes a better understanding of the way in which terms such as expert, expertise and safeguarding have developed and can be understood. Societal attitudes will alter as a result of growing awareness, which make them boundless and dynamic. Safeguarding is a dynamic that, as yet, does not have boundaries and may

therefore be viewed as being in its infancy; however, the fact that it has been in existence for at least three decades implies that it should have matured.

Society should not assume that the SLNs are incapable of making mistakes; possessing expertise and expert practice does not equate to infallibility. Nevertheless, the knowledge, experience and practice, possessed by SLNs indicate that they have a greater understanding of safeguarding than others. Consequently, they have the potential to protect vulnerable adults more effectively than those lacking the equivalent knowledge. In the case of DoLS, which has caused controversy as a result of the word *Deprivation,* the SLNs, with their experience, knowledge and on-going practice, are a readily available resource that could help to address the apparent discomfort and lack of understanding.

The SLNs have learnt what is expected of them as SLNs and while they carry out their role, there is an aspect of their personality that drives them to protect, care for, advocate for and take responsibility for vulnerable adults. Neither their interest nor their motivation has diminished and it is apparent that these intrinsic attributes are responsible for their extensive knowledge and skill. However, they are not consulted about the terminology used in relation to safeguarding vulnerable adults any more than they are consulted about issues related to policy and procedural changes; this would seem to be a waste of a unique resource.

Surely it is time to listen to individuals who possess expertise in safeguarding vulnerable adults who are both motivated and interested in preventing harm and abuse from continuing, now and in the future. Increasing resources for the sole

purpose of protecting vulnerable adults may involve financial consequences but surely a life that is not the target of abuse and harm is priceless?

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APPENDICES

APPENDIX 1: Job Descriptions (Three Examples)

Job Description (Example 1)

Job title: Adult Safeguarding Practitioner **Band: 5 (TBA)**

Department: Clinical Governance **Hours: 22.5hrs**

Reports to: Head of Integrated Safeguarding

Accountable to: Head of Clinical Governance and Assurance

Job role:

1. Purpose

To support and assist with meeting the increasing demands of the Safeguarding Adults agenda arising from the Care Act 2014 Provide advice and guidance to all staff across the organisation to ensure good practice in -Safeguarding Adults for patients and service users. This

includes inputting into designing as well as delivering training, responding to queries from staff and gathering information around safeguarding concerns that are raised.

The post holder will work as part of the Integrated Safeguarding Team (Adult, Children, Learning Disability and Domestic Violence) to ensure a robust evidence based integrated safeguarding service is delivered, provide specialist safeguarding advice and support to both XXXX Hospital NHS Foundation Trust and external partners as required

2. Principle Duties and Responsibilities

To promote a culture of best practice across the Trust in relation to Safeguarding Adults, MCA and Deprivation of Liberty Safeguards (DoLS), acting as a role model for staff.

To contribute to the development of and deliver quality training to staff around Safeguarding Adults and MCA ensuring that staff are equipped with the knowledge they need to effectively meet their responsibilities.

To gather information as part of the Trust's responsibility to make enquiries under Section 42 of the Care Act. To contribute to the completion of work as detailed in the Safeguarding Strategy and Action Plan.

Act as a resource of knowledge on Safeguarding Adults, and MCA to all staff across the Trust.

Seek opportunities to increase awareness of the Safeguarding Adults and MCA agenda within the Trust.

In time and with support to be able to demonstrate a clear understanding and awareness of national policy, guidance and legislation in relation to the Safeguarding Adults and MCA agendas.

To maintain accurate records and keep information accurate and up to date.

To escalate concerns as appropriate to the Head of Integrated Safeguarding or appropriate other

To manage sharing of confidential and sensitive information with other agencies as appropriate and in line with relevant policy and guidance, including receiving similar information from outside agencies.

Be a role model for providing high standards of professional practice, demonstrating professional leadership skills that motivate and

Inspire staff to embrace the Safeguarding Adults and MCA agendas and improve practice.

Communicate with colleagues and other agencies in a respectful and effective manner whether face to face, on the telephone or via

email, in order to maintain positive and effective working relationships.

To respond in a timely manner to requests for support or advice from staff across the organisation.

Demonstrate sound communication skills, communicating effectively with all members of the multi professional team, patients and carers as appropriate. Contribute to internal and external meetings as appropriate to the role.

Work in collaboration with colleagues in the multi professional team to achieve optimum patient /service user experience.

Attend any specific training/professional development opportunities as identified by the Head of Integrated Safeguarding to enhance knowledge and practice.

Support the governance department to ensure that lessons learnt within Child Protection and Safeguarding Adults are disseminated to the staff within the trust, informing practice and service development

Participate in complex safeguarding cases, Serious Case Reviews and attend the strategy/ best interest meetings as required

Contribute to the development of Trust policies and guidance and work with the Safeguarding team members and Head of Safeguarding to ensure robust arrangements within the trust.

To keep up to date with current research and legislation and support the implementation of changes where appropriate

Participate and support the development of Trust policies and guidelines in line with national and local policy and guidance and interpretation and implementation of these.

Able to give advice about safeguarding/child protection policy and legal frameworks to team members and other trust staff, including where required Mental Capacity Act/Assessment and Deprivation of Liberty Standards.

Able to support colleagues in challenging views offered by other professionals, utilising local resolving difficulties framework as appropriate

Able to advise other agencies about the health management of safeguarding concerns

Able to participate in a Serious Case Review/Case Management review/significant case or other locally determined review as directed by Head of safeguarding.

As directed by the Head of Safeguarding attend formal Safeguarding Strategy / Best Interest meetings and share appropriate information to guide non-healthcare staff members of the meetings on the implications of health-related issues.

To contribute to the writing of the annual report and annual plan for the Safeguarding Forum and Trust Board on safeguarding activity.

To take part in multiagency investigations being led by Adult / Children Social Care / Police. This will include information sharing and obtaining statements from Trust staff

3. Scope and Accountability

The post holder is responsible to the Head of Safeguarding but is expected to have frequent contact with all members of the multidisciplinary team including medical staff, nurses and allied health professionals.

The post holder will be required to support the safeguarding team and ward teams to identify, prevent and reduce harm that may be done to a vulnerable individual and implementing the use of educational materials in respect of quality improvement (e.g. lessons from Serious Case Reviews)

The post holder is not required to manage a designated budget or directly line manage staff within the department.

Budgetary:	The post holder is not required to manage a budget or act as an authorised signatory.
Staffing:	The post holder is not required to directly line-manage staff

Control of Infection

In order to comply with the Health Act 2006 (Code of Practice for the Prevention and Control of Health Care Associated Infect ions) it is the responsibility of every employee to prevent and control the spread of infection following the Trust's infection control policies. These are available on the intranet in the document library under clinical policies and guidelines, infection control. If, as a routine part of your job, you do not have access to the intranet please discuss with your line

manager how you can access this information to ensure that you are familiar with your responsibilities.

Confidentiality

Information relating to patients records, diagnosis and/or treatment of patients, employee records, or information concerning contracts, tenders and other commercially sensitive matters etc. are considered to be confidential and must not be divulged without prior authority. Employees of the Trust must not without prior permission disclose any information regarding patients or staff obtained during the course of employment except to authorised bodies or individuals acting in an official capacity. Data Protection Legislation may render an individual liable for prosecution in the event of unauthorised disclosure of information.

However, as a public body, the Trust has a requirement to publish particular information. Therefore, in addition to the above confidentiality requirements you must also comply with all aspects of the law concerned with information handling. For this purpose, the relevant legislation is the Freedom of Information Act 2000. This Act places a legal duty on all employees to comply with the rights of the public to access information. Any altering, destroying or concealing of information held by the Trust with the intention of preventing the legitimate disclosure of all or part of that information will result in disciplinary action, and may result in dismissal.

Equal Opportunities and Diversity

The Trust has given its full commitment to the adoption and promotion of the key principles of equal opportunities contained within current legislation and the Trust's Equal Opportunities Policy.

All employees hold personal responsibility for the application of this Policy on a day-to-day basis and should not undertake any acts of discriminatory practice during the course of their employment. Similarly, all employees have a responsibility to highlight any potentially discriminatory practice to their line manager, Human Resources Department or trade union/professional associations.

All managers are responsible for ensuring that they positively promote equality of opportunity in service delivery and employment. Furthermore, all managers are responsible for ensuring that they pro-actively manage all reports made to them regarding potentially discriminatory practices and should take advice from the Human Resources Department regarding the management of this.

Copies of the Equal Opportunities Policy are available from the Human Resources Department or via the Trust Intranet.

Protection of Vulnerable Adults and Children

The Trust is committed to ensuring vulnerable adults and children are protected and come to no harm. All employees have a responsibility to be aware of national

and local policies, their individual responsibilities with regards to the protection of vulnerable adults and safeguarding children and must adhere to them at all times.

XXXX Hospital NHS Foundation Trust places a high importance upon respecting, valuing and listening to everyone who visits or works for the Trust. Our ethos has been developed to help focus the whole Trust on key elements of patient care which our patients and employees have told us to improve. Our ethos aims to use feedback from everyone who interacts with the Trust. This will inform and influence employee behaviour in order that our care upholds the principles of: effective COMMUNICATION; positive ATTITUDE; RESPECT for patients, carers and colleagues; an ENVIRONMENT that is conducive to care and recovery.

Mandatory attendance is expected of all employees for courses related to our ethos and to always uphold its principles.

Professional Registration (If Applicable)

To maintain consistently high professional standards, and act in accordance with your code or standards of professional conduct.

Appraisal and Continuous Personal Development

Each year you will have a formal appraisal. During this meeting personal objectives and a personal development plan will be agreed with you. Performance in achieving these objectives, and progress towards completing your personal development plan will be discussed regularly throughout the year.

You should assume responsibility for continuous personal development and attend training, meetings, conferences, workshops and courses as required, thereby ensuring your personal practice is up to date.

Review of Job Description

This job description is not an exhaustive list of duties but is intended to give a general indication of the range of work undertaken within this role. Work will vary in detail in the light of changing demands and priorities, and therefore the duties identified will be subject to periodic change/review, in consultation with the post holder. This will normally occur on an annual basis during your appraisal and a signed copy of this job description must be sent to the Human Resources Department for filing.

Person Specification		
	Essential	**Desirable**
Qualifications	• UK registered Nurse with NMC or Equivalent Health Professional registration • Educated to degree level with post qualifying study / • Evidence of on-going professional development • Completion of Safeguarding Adults and MCA training	• Specialist training undertaken in Safeguarding Adults
Experience	• Knowledge of Safeguarding Adults issues, both locally and nationally • Some experience of working with Safeguarding Adults cases • Understanding of the importance of the Safeguarding children's agenda and how it links with the Adults agenda • Experience in working in partnership with other agencies • Demonstrate an understanding of the roles and functions of other statutory safeguarding and voluntary bodies • Able to demonstrate the ability as an autonomous practitioner and to prioritise appropriately. • Experience of multidisciplinary and multiagency working. • Able to demonstrate knowledge of Mental Capacity Act and Deprivation of Liberty Safeguards • Able to demonstrate understanding of wider NHS	• Best Interest Assessor qualification • Experience of working within the Somerset Safeguarding referral processes. • Previous health care experience an advantage • Knowledge of current Safeguarding Adults practice and local policy • Working knowledge of Mental Capacity Act (Including Deprivation of Liberty Safeguards)

	• and local agenda in relation to Safeguarding Vulnerable Individuals including relevant publications. • Awareness of national / local Safeguarding Policies and Procedures and Regulations • Working knowledge of equality and diversity • Ability to challenge poor practice and support individuals to improve • Experience in the delivery of teaching and training	• Knowledge of the safeguarding section of the Care Act 2014 • Some knowledge of the Prevent agenda
Personal Qualities	• Excellent inter-personal and communication skills with the ability to build personal and professional credibility at all levels of the organisation as well as with external partners • Ability to motivate colleagues/ peers leading through example • Excellent oral and written communication • Excellent organisational skills and prioritisation skills • Able to work independently and under pressure, planning work appropriately to ensure that deadlines are met • Able to communicate clearly and with confidence to a range of individuals orally and in writing • Able to produce and collate information and maintain up-to-date and accurate records • Able to work as part of a team • Ability to work methodically and with precision and attention to detail	

	• Demonstrate the ability to support staff dealing with sensitive, challenging emotive issues. • Demonstrate the ability to speak to distressed patients and their relatives/carers in person or by telephone. • Demonstrate the ability to communicate in a professional way with people at all levels of understanding, either face to face, on the telephone, e-mail or written communications when dealing with incident reports.	

Internal	**External**
Head of Integrated Safeguarding team Head of Clinical Governance and Assurance Executive team Head of Midwifery team Clinical Team	Police Trust Solicitors County Council Clinical Commissioning Group GP Practices Somerset Partnership

Relationships:

Ward Sisters Business Unit Managers Clinical Directors Nurse Consultants Director of Nursing /Deputy Director of Nursing Adult Mental Health Lead Midwifery Service Health and Social Care team.	Social Services Safeguarding Children's and Adults Team Independent Mental Capacity Advocate

Budget holder: No

Line management responsibility for: No

Published:

JOB DESCRIPTION (Example 2)

1. JOB DETAILS

Job Holder	
Job Title	**Safeguarding and Mental Capacity Act Facilitator**
Band	**Band 7**
Department	**Professional Practice**
Accountable to	
Hours	**15**

2. JOB PURPOSE

To work as a member of the Safeguarding Team providing safeguarding adults and MCA advice, training and support across the acute Trust, working with the multidisciplinary team to ensure seamless delivery of patient care and best practice. The post holder will be expected to provide clinical expertise and knowledge, demonstrating a sound understanding of the issues related to the Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLs) and The Care Act.

To work collaboratively with the multidisciplinary team to enable them to complete assessments, applications and referrals in a timely manner on all safeguarding related matters. This will include ensuring sound practice among a wide and multi-agency professional network. The Facilitator has the responsibility for promoting an organisational culture which puts the needs of vulnerable adults first and which places a high value on professional practice standards and the pursuit of positive outcomes for vulnerable adults in Torbay.

3. DIMENSIONS

Champion excellent Safeguarding and MCA practice within bed-based services and contribute to developments at a regional and national level including Safeguarding/MCA networks.

Maintain an overview of the effectiveness of safeguarding and MCA practice for adults and represent the views of ward staff to all levels of management within the Trust and local authority and to partner agencies represented on the Trust Board;

Lead on the development and review of policies and procedures relating to the delivery of safeguarding and MCA practice;

Maintain a current awareness of evidence-based research and developments in adults safeguarding and MCA practice and disseminate this to colleagues and networks;

Escalate concerns about specific service users to the Deputy Director of Social Services and/or the Chief Nurse.

4. PRIMARY DUTIES AND AREAS OF RESPONSIBILITY

To chair Mental Capacity Act conferences in order to ensure that best outcomes for the service user are arrived at.

To check and endorse subsequent minutes.

To ensure that Mental Capacity Act conferences and review procedures have been followed in relation to preparation of participants, provision of pre-conference reports/documentation.

To ensure that all conferences fully take into account cultural, religious and linguistic factors and any access requirements of the vulnerable adult.

To carry out a quality control function in relation to the conduct of Mental Capacity Act work and to follow up concerns about practice standards as necessary through senior managers and/or the Safeguarding Adults Board.

To create and maintain good working relationships with multi-agency partners and appropriate others.

To provide independent specialist advice and information to Torbay Care Trust staff and other relevant agencies on matters relating to the 2005 Mental Capacity Act and to support staff in complex capacity assessments.

To contribute to staff development in the specialist area of Mental Capacity and Adult safeguarding by modelling specialist skills e.g. chairing meetings and case conferences.

To contribute to the design, implementation and monitoring of a co-ordinated quality assurance system including service audit/review, report writing, policy and development and the continuous improvement of practice standards.

To deliver presentations in both local and county-wide forums.

To contribute to the work of the Safeguarding Adults Board as agreed with the Lead for Adult Protection and Mental Capacity.

To work closely with the Lead for safeguarding Adults and Mental Capacity Act and other staff in the Safeguarding Team, to deliver a high-quality service to staff, service users and carers.

Use the Trust incident reporting system to identify areas of non-compliance with Protection of Adults procedures and liaise with Governance leads to correct these.

Provide advice to individual staff members on the management of more complex vulnerable adult issues.

To maintain confidentiality of information acquired in the course of undertaking duties in accordance with the Data Protection Act, Freedom of Information Act and Caldicott protocols.

To be responsible for your own continuing self-development, undertaking training as appropriate.

The post holder must at all times carry out their responsibilities with due regard to the Trust's Equal Opportunities Policy, Code of Conduct, Health and Safety, Data Protection and all Trust procedures.

To undertake other duties appropriate to the grading of the post as required including acquiring an in depth knowledge of the Vulnerable Adults policy and procedures. To support the Lead and the Adult Protection Facilitator in delivering a Safeguarding Adults Service.

To raise the profile of mental capacity issues by the delivery of presentations and training on the 2005 Mental Capacity Act and Adult Protection.

5. KEY RESULT AREAS

Own individual responsibilities and share team objectives.

Lead or contribute to assuring the delivery of outcomes through creating improvement, transformation and innovation of services.

Contribute to creating a work environment that is marked by pride, enthusiasm and collaboration.

Lead by action and inspire others acting as role model, demonstrating the leadership behaviours and values of safeguarding.

Communicate positively and effectively.

Actively give and receive feedback in a constructive manner.

Be adaptable, work with integrity and be trustworthy.

Be committed to safeguarding and promoting the welfare of patients.

6. COMMUNICATION AND WORKING RELATIONSHIPS

Will possess excellent communication and presentation skills to ensure the complex health needs of vulnerable children and adults are highlighted in a multi-disciplinary forum. Often in situations that are highly emotional, complex and sensitive and where parents and others may be hostile to that information or may

have some difficulties understanding due to disability, substance misuse, culture or ethnicity.

Will use highly developed communication and negotiating skills on a daily basis to manage and advise on highly sensitive and complex situations which are often contentious, emotive and unpredictable. Each of these situations are unique and require careful analysis, there may be complicated facets to consider which have no obvious solutions.

Will have excellent interpersonal skills and be able to communicate effectively with staff and managers at all levels.

7. MOST CHALLENGING PART OF JOB

To act independently to prioritise, make decisions and provide expert advice on complex, challenging situations which will ensure health staff to provide an effective service to patients.

ADDITIONAL INFORMATION

Clinical Governance and Risk Management

The Trust believes everyone has a role to play in improving and contributing to the quality of care provided to our clients. You are expected to take a proactive role in supporting the Trust's clinical governance agenda by:

- Taking part in activities for improving quality such as Valuing Everyone's Experience training or (for staff working within clinical specialties) clinical audit
- Identifying and managing risks through incident and near miss reporting and undertaking risk assessments
- Following Trust polices, guidelines and procedures
- Maintaining and improving your skills through continued professional development/your personal development plan agreed annually with your line manager.

All clinical staff making entries into health or social care records are required to follow the Trust standards of record keeping.

Code of Conduct

You are required to work in accordance with the code of conduct for your professional body.

Confidentiality and Information Governance

You must ensure that you adhere to the relevant Trust guidance in relation to Confidentiality and Information Governance, which includes the collection and sharing of information in relation to staff, patients, relatives, partner organisations and third parties. The Trust has created guidance which satisfies the requirements of the relevant Acts of Parliament, including the Data Protection Act

(1998), Freedom of Information Act (2000) and Access to Health Records Act (1990) as well as Department of Health guidance.

Conflict of Interests

You may not without the consent of the Trust engage in any outside employment and in accordance with the Trust's Conflict of Interest Policy you must declare to your manager all private interests which could potentially result in personal gain as a consequence of your employment position in the Trust.

In addition, the NHS Code of Conduct and Standards of Business Conduct for NHS Staff requires you to declare all situations where they or a close relative or associate has a controlling interest in a business (such as a private company, public organisation, other NHS or voluntary organisation) or in any activity which may compete for any NHS contracts to supply goods or services to the Trust. You must therefore register such interests with the Trust, either on appointment or subsequently, whenever such interests are gained. You should not engage in such interests without the written consent of the Trust, which will not be unreasonably withheld. It is your responsibility to ensure that you are not placed in a position which may give rise to a conflict of interests between any work that you undertake in relation to private patients and their NHS duties.

Disclosure and Barring Service (DBS).

Applicants for posts in the NHS are exempt from the Rehabilitation of Offenders Act 1974. All applicants who are offered employment will be subject to a criminal record check from the Disclosure and Barring Service. This includes details of cautions, reprimands, final warnings, as well as convictions. Further information is available from the Disclosure and Barring Service at www.homeoffice.gov.uk

Safeguarding Children and Adults at Risk

The Trust is committed to safeguarding and promoting the welfare of children and adults at risk and is dedicated to robust recruitment checks. Every employee has a responsibility for safeguarding and the protection of children and adults at risk. As such if the post holder witnesses, suspects or is told that abuse is occurring they have a duty to report the incident. Please refer to the Trust policies on Safeguarding Children and Vulnerable Adults.

Review of this Job Description

This job description is intended as an outline indicator of general areas of activity and will be amended in the light of the changing needs of the organisation. It will be reviewed in conjunction with the post holder on an annual basis.

JOB DESCRIPTION AGREEMENT

Job Holder signature		Date	
Head of Department signature		Date	

N E OTHER ACUTE HOSPITALS NHS TRUST JOB DESCRIPTION (Example 3)

Post Title: Lead Nurse Safeguarding Adults

Pay Band: 7

Hours: Full time, 37.5 hours per week

Contract: Secondment, 6 months

Location / Department: N E OTHER ACUTE HOSPITAL

Accountable to: Chief Nurse (Executive Lead for Safeguarding)

Reports to: Deputy Chief Nurse

Key Working Relationships:

Internal: Director of Nursing and Quality and Corporate Nursing Team, Clinical Directors, Divisional, Operations Directors and Divisional Directors of Nursing, Matrons and specialist teams, Medical Consultants, Risk Management and Patient Safety, Clinical teams across the 5 divisions, Children's Safeguarding team and Named Midwife, Professional development & HR Training and Development team, Trust Board, Matrons, ward and department leaders

External: CCG Designated Nurse for Safeguarding**,** WCC Safeguarding Adults Team**,** co-ordinator Social Services Teams as appropriate, Multi Agency safeguarding Hub (MASH), Out of area social care teams/Local Authorities, MCA/DOLs Leads, IMCA services , Community Safety Units (Police), University colleagues, CQC, Charitable and voluntary agencies

Job Purpose:

The post holder leads the development and delivery of safeguarding services for adults within the Trust and will demonstrate highly developed experience and specialist knowledge of the safeguarding process and safeguarding investigations. The post holder will ensure all the key functions of the Lead for Safeguarding Adults are achieved across all of N E OTHER ACUTE sites, through;

- Demonstrating proactive leadership; provide highly specialist advice in the implementation of the adult safeguarding, Mental Capacity Act, Deprivation of Liberties Safeguards and PREVENT agendas, within the Trust;
- Facilitating collaborative interagency working;
- Leading and developing adult protection policies and procedures across the Trust;
- Providing the required assurance both internally to the Trust and externally to the Man's Land Safeguarding Adults Board, Clinical Commissioning Groups (CCG) and Care Quality Commission (CQC) regarding the safeguarding process within the trust;
- Providing and facilitating specialist advice, training and support to Trust staff on the management of safeguarding adult issues, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS);
- Ensuring safe, competent and professional practice in relation to safeguarding adults within the Trust;
- Collaborating with the safeguarding children's team, working together to improve patient care in the context of the whole family.

Key Duties:

- Lead on behalf of the Chief Nurse and Deputy Chief Nurse, the continued delivery and development of the safeguarding adult service across the Trust, providing specialist advice and strategy development in support of national or local policy changes.
- Facilitate delivery of high quality safeguarding services for adults to agreed quality standards which comply with all national legislation, CQC standards and local policy and guidance across acute health care settings.
- Manage and support the Associate Professional Safeguarding Adults in working closely with clinical staff to ensure that decision making is supported by highly specialist safeguarding advice and that lessons learnt or changes in practice are embedded at patient care level.
- Work alongside the HR and Professional Development Team to ensure there is a robust training strategy and training programme to meet all educational/training requirements across the Trust. This will include supporting staff to work effectively within the Safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguards and domestic abuse agenda.

Leadership

- Ensure that the Trust's safeguarding arrangements and services comply with the Data Protection Act 1998, the Human Rights Act 1998, the Mental

Capacity Act 2005, the Care Standards Act 2000and all related national, local and legislative policy.

- Take a lead role in ensuring that the Trust engages its multi-agency partners to provide robust safeguarding adult services that are coordinated and collaborative.
- Provide effective leadership and act as a role model for all staff within the Trust in all areas when safeguarding adult advice is requested.
- Represent the Trust on the PREVENT Countywide Strategic Group, working with other agencies on the PREVENT agenda.
- Represent the Trust at professional adult safeguarding interagency forums and sub groups of N E OTHER Adult Board and undertake work generated from such in order to ensure that local guidance is commensurate with the Trust practices and capabilities.
- Chair the Trust Adult Safeguarding Committee, ensuring risks are managed in accordance with the Trust Risk Strategy.
- Maintain effective communication across all Divisions to ensure that relevant safeguarding adults' issues are appropriately disseminated Trust wide.
- Support a culture of reporting by ensuring that staff can access advice and support readily at the point of need.

Planning organisation/Business development

- In the event of a death or serious injury to an adult who was/is at risk of harm or abuse, to lead on behalf of the Trust, any Individual Management Reviews (IMRs) which may be requested as part of a Domestic Homicide Review (DHR) or Safeguarding Adults Review (SAR).
- Ensure that all recommendations generated by serious case reviews and other investigations which are relevant to the Trust are communicated Trust wide and actions are monitored and reviewed.
- To provide professional advice and strategy guidance as required promoting the effective functioning and governance of safeguarding at ward, divisional and corporate level
- Responds to and delivers an increasing broad range of safeguarding related activities, ensuring the day to day operational delivery of the service alongside more formal strategy planning across partner organisations i.e. (N E OTHER ACUTE Prevent Strategy Group).

Policy Development

- Lead or develop, act upon or make changes to adult safeguarding policies, procedures and systems for safeguarding adults including the MCA and Deprivation of Liberty Safeguards (DOLS) and PREVENT in accordance with

the Department of Health, good practice guidance and in light of legal or national policy changes.

- Ensure this translates into work plans or activities which are reported through into the work of the Adult Safeguarding Committee and the team and these are delivered as planned.
- Formulate strategies and action plans in response to DHRs/SARs ensuring the implementation of all recommendations are achieved across the Trust and audit to ensure compliance.
- The post holder will ensure all reports and documents; data collections and submissions performance monitoring and other records will be maintained, stored and transported and submitted in an effective, accurate and timely format, to high standards and in compliance with all Information Governance requirements.
- Develop a robust system to ensure that there is compliance with the multi-agency policy, MCA and DOLS alongside relevant clinical knowledge to health care professions on safeguarding adult matters.

Analysis & Judgement

- To be responsible for the interpretation and analysis of highly complex

  information such as national guidance and research to inform the organisation.
- and support and promote excellence in practice.
- Ensure that both national and regional policies are interpreted for operational use, including assessment of need and risk with respect to the safety and welfare of adults.
- Translate complex patient level information, into decision making around mental capacity and deprivation of liberty, analysing the individual complexities alongside the legal frameworks of MCA & DoLS.
- Act as an authorising manager for urgent DoLS.

Communication & Information use

- Provide reports or information to provide assurance both internally to the Trust and externally to the WSAB, CCG and CQC regarding the maintenance and further development of effective and efficient systems for the detection, prevention, surveillance, investigation and control of harm.
- Maintain good levels of interagency communication and foster partnership working with statutory and voluntary organisations.
- To attend all external Safeguarding Adults Meetings as appropriate and requests for information as part of adult reviews, ensuring actions are delivered as agreed and on time.

- Prepare and present regular performance reports for the Quality & Governance Committee, Divisional Governance Committees and Trust Board.
- Lead the development of the Safeguarding Adults Annual Report.
- To ensure that staff who have raised an alert or who have been involved in a safeguarding adult investigation receive feedback and debriefing.
- To promote safeguarding of adults to all staff groups.
- Develop and maintain highly effective and efficient communication channels both internally and externally, particularly with partner organisations, patients/families, ensuring well documented communication systems.
- To provide and receive highly sensitive and complex information (in accordance with the Data Protection Act and Caldecott guidance) maintaining confidentiality as appropriate.
- To maintain accurate records of all safeguarding allegations, mental health act detentions, investigations processes and outcomes, using DATIX as a method of recording incidents.
- To notify the CQC of all notifiable DOLs applications.

Staff management

- Providing line management of the Associate Professional Safeguarding Adults and administration staff, ensuring appraisal and on-going professional development is in place.
- Has responsibility & management oversight of the pay & non pay budgets of the team, signing off expenses, ordering supplies to the value reflected in Standing Financial Orders.
- Take responsibility for updating own knowledge and skills, participate in annual appraisal.
- Provides team based safeguarding supervision.

Managerial

- Maintain a high profile for the safeguarding of adults throughout the organisation.
- Provide, support and facilitate supervision for staff involved in safeguarding adults work.
- Deputise for the Deputy or Chief Nurse, in internal or external safeguarding related meetings.

- Working with clinical teams and divisions, ensure that appropriate arrangements for the dissemination and access to policies, practice guidelines, and procedures in relation to safeguarding of adults are available.
- Support ward managers/senior sister/charge nurses and other designated key staff in developing skills to meet the responsibilities for safeguarding adults.

Clinical Practice

- Provide effective leadership on all aspects of the adult safeguarding agenda maintaining clinical/professional competence and credibility.
- Provide an overview of Mental Health Service need within the Trust, advising and ensuring clinicians are supported by expert Medical Mental Health advice when needed.
- Have an excellent understanding of relevant legislation and provide highly specialist advice to clinical staff around MCA/DoLS, Mental Health Act.
- Required to make accurate, detailed and legally binding decisions around MCA & DoLS that can with stand legal scrutiny and challenge.
- Challenge colleagues, both internally and externally, where decision making is not in line with local and national guidance or standards for best practice, ensuring that the process remains patient/client focused at all times.
- To provide highly specialist advice and support to all practitioners and empower them to fulfil their safeguarding duties.
- Advise staff and liaise with appropriate representatives from the Police in response to concerns raised regarding radicalisation and counter-terrorism
- Ensure all safeguarding documentation for patients is appropriate, accountable and defensible, specifically in relation to assessment, recording of consent, DoLS and best interest actions.
- Maintain own clinical/professional competence and credibility.
- Provide specialist advice to professionals when departments are requested to contribute to investigations and safeguarding reports.
- To monitor ward/department-based action plans that are developed as a result of safeguarding investigations.
- To forge links with the Safeguarding Children's Team to share and develop best practice (especially with regard to supporting the Domestic Violence agenda).
- Ensure that advice on safeguarding issues is available in a variety of formats at all times within the organisation, inclusive of the Trust intranet & internet.
- To ensure that the trust achieves and maintains standards for compliance and regulation with the CQC and other external bodies.

Education & Development

- To undertake a training needs analysis, designing and delivering appropriate teaching programmes and maintaining accurate attendance records
- Lead the development of the safeguarding training strategy, ensuring that this covers training for all Trust staff and is reflective of the varying levels of training and knowledge required by differing staff groups. Working with the Children's Safeguarding Team where appropriate.
- Ensure necessary systems are in place to offer appropriate clinical supervision to staff as required when safeguarding adults issues arise.
- Provide training, advice and support to health care staff on issues relating to adults including the MCA, Deprivation of Liberty and PREVENT.
- Monitor and report on, the mandatory training figures for safeguarding, ensuring subsequent action plans are delivered as agreed.

Research and Development

- Ensure that wherever possible clinical practice is evidence based and auditable
- To monitor and evaluate the effectiveness of policies, procedures and training programmes through audit and research where appropriate.
- Undertake/participate in research activities and disseminate information to the benefit of safeguarding adults.
- Undertake/participate in regular clinical and audit activities to demonstrate compliance with safeguarding policies and procedures standards.

Standard Clauses:

The purpose of this post should remain constant, but the duties and responsibilities may vary over time within the overall role and level of the post. The post holder may from time to time be asked to undertake other reasonable duties. Any such changes will be made in discussion with the post holder in the light of service needs.

Competence

The post holder is responsible for limiting his / her actions to those which s/he feels competent to undertake. If the post holder has any doubts as to his or her competence during the course of his / her duties then s/he should immediately speak to their line manager or supervisor.

Codes of conduct

All employees of the Trust who are required to be registered with a professional body, to enable them to practise within their profession, are required to comply with their code of conduct and requirements of their professional registration. Those staff that are not required to be registered with a professional body are required to comply with the Trust's codes of conduct.

Children and vulnerable adults

You have a responsibility for promoting and safeguarding the welfare of the children / young people / vulnerable adults that you come into contact with or are responsible for in your job role and sphere of competence.

Disclosure and Barring Service

The Trust aims to promote equality of opportunity for all, with the right mix of talent, skills and potential. Criminal records will be taken into account for recruitment purposes, only when the conviction is relevant. As the Trust meets the requirements in respect of exempted questions under the Rehabilitation of Offenders Act 1974, all applicants who are offered employment will be subject to a criminal record check from the Disclosure and Barring Service before the appointment is confirmed. This will include details of cautions, reprimands or final warnings, as well as convictions. Postholders may periodically be asked to undertake a re-check.

The Trust is legally required to check all staff against the Disclosures and Barring Services Children's and Vulnerable Adults barring lists if they engage in what is defined as "Regulated Activity" or "Controlled Activity": Regulated Activity is defined as working closely with children or vulnerable adults, paid or unpaid, on a frequent or intensive basis. Controlled activity is work that provides opportunities for contact with children or vulnerable adults.

Post Holder's Signature: ……
Name: ……

Date: ……

Manager's Signature: ……

Name: ……

Date: ……

APPENDIX 2: Interview Schedule

Interview Schedule

In order to achieve the aims and objectives through face to face semi-structured interviews, the interview schedule is as follows:

- **Now**

  Current role

  Length of time in current role

  Any training completed specifically for this role

- **Previously**

  Previous professional role

  Length of time in previous role

  Experiences from former role that have influenced current role

- **Personal views**

  Do you consider yourself to have expertise in safeguarding?

  How has this developed: from experience, training, education, knowledge or somewhere else?

  Would you consider yourself an expert? Each participant understanding of the term expert

  What informs your current professional practice: policy, procedures, experience, or intuition?

APPENDIX 3: Interview Questions

Questions: based on interview schedule (1 of 2):

Can you tell me what your current role is?

Can you describe your current role please?

How long have you been in this role?

What kind of training have you completed to help you fulfil your role?

Do you know if there is a specific training course in relation to your specialism outside of the geographical area you work in, perhaps across the country, is it national?

How do you acquire new skills?

How do *you* learn more about your current role?

Do you apply what you do at training courses to what you do in your everyday practice?

Can I just ask what your previous profession role was?

How long have you been in this role?

What things have influenced your practice in your current role?

Have there been experiences from your previous role that you have been able to use in your current role?

Do you consider yourself to have expertise in safeguarding?

How do you feel this has developed from experience, training, education, knowledge or something else?

Questions: based on interview schedule (2 of 2):

What does the term expert mean to you?

What do you think makes an expert?

Would you consider yourself to be an expert?

How do you know when you are an expert?

How do you think other people recognise an expert?

What informs your practice policy: policy, experience or intuition?

Do you ever make mistakes in your specialism?

APPENDIX 4: Information Sheet

INFORMATION SHEET

Thank you for your interest in this Professional Doctorate Study. The following information should assist you in making a decision to participate.

Section One

The Research Study

Title of the Study **BENNER'S EXPERT: EXPLORING AND CONTEXTUALISING THE EXPERTISE OF THE SAFEGUARDING NURSE**

1. ***Purpose and value of the study*** The aim of this study is to explore the journey of safeguarding nurse/leads/managers from their previous role to their current one in safeguarding and how their safeguarding knowledge and *expertise* has evolved in what is essentially a new concept compared to other specialities with Healthcare,. The study will specifically look at whether these nurses have acquired skill and expertise in safeguarding through the five stages of skill acquisition depicted firstly by Dreyfus and Dreyfus (1980) and later adapted by Patricia Benner (1982) in her model of *Novice to Expert* and have thus become Benner's Expert or if they are at the competent stage in the 5 acquisition of skill stages and are generic experts instead.
2. ***Invitation to participate*** The invitation to participate is being extended to safeguarding nurses, leads and managers in Clinical Commissioning Groups across Essex, Suffolk and Southend and several general hospitals.
3. ***Researcher*** I am undertaking this research as a part-time professional doctoral student at the University of Essex.

I am a Registered General Nurse. After finishing my nurse training I worked in an Emergency Clinical Area in a General Hospital for six years. I am currently working as a Nurse Assessor for the North East Essex Clinical Commissioning Group which frequently involves being faced with safeguarding issues which I have found to be complex, challenging and requires relevant knowledge and appropriate training to manage.

4. ***What will happen to the results of the study***? The results of the study will be written as a doctoral thesis. The study will also be presented at academic and professional conferences and it is anticipated that aspects of the work will be published more widely.
5. Funding: This is an independent study which is funded solely by the researcher.
6. ***Contact for further information*** Participants can contact me at any point in the study; my details are:

Michelle Felton
Address xxxxx
Email xxxxx
Contact number - xxxxx

Section Two
Your Participation in the Research Project

1. ***Why you have been invited to take part?*** You have been invited to take part in the study because you are involved with safeguarding as a safeguarding nurse, lead or manager and have been for longer than six months.
2. ***Whether you can withdraw at any time, and how***? Participation in the study is entirely voluntary and there is no requirement upon you to agree to participate. You can withdraw from the study at any point – before the interview, during the course of the interview and/or once the interview has been recorded. Formal withdrawal from the study is through the withdrawal notification included in the participant consent form.
3. ***What will happen if you agree to take part ?***
   - You will be interviewed which will involve questions about your previous role and associated experience, your current role and associated experience together with how you have acquired your knowledge in relation to your current role The interview will last between 45 and 60 minutes and will be tape-recorded to ensure that your contribution can be properly represented within the study. The interview will be semi-structured.
   - The tape-recording of the interview will be transcribed and analysed along with the interviews of other participants; the findings from the analysis will be published in a doctoral thesis, may be presented at conferences and published as journal articles and in books.
4. ***Safety and well-being*** The study should not pose any risks to yourself or others but if at any time you feel uncomfortable or find the interview difficult to continue with, the interview will be stopped immediately with a view to discuss available options to continue that are agreeable to you. Should you have any concerns or questions about the study I can always be contacted.
5. ***Managing information and data*** All information will be treated in the strictest confidence. All transcripts of interviews and consent forms will be stored in a secure cabinet. Tape recordings will be stored in a password protected file on a password protected personal computer. Paper documents and digital recordings will be destroyed on successful completion of the Doctorate.

Electronic copies of the transcripts will be destroyed after a period of 5 years, unless it is decided to archive them for future analysis.

6. ***Confidentiality*** In all aspects of the study, places and people will remain anonymous through coding: organisations will be given numbers e.g. P1, P2 and individuals will also be coded through number e.g. SG1, SG2
7. ***Benefits of taking part*** It is envisaged that through your participation will contribute to a more significant understanding of 'who' social work and nurse educators 'are', how they practice their work and how and why this practice influences the academy and the profession.
8. Agreement to participate in this research should not compromise your legal rights should something go wrong

YOU WILL BE GIVEN A COPY OF THIS TO KEEP TOGETHER WITH A COPY OF YOUR CONSENT FORM

APPENDIX 5: Informed Consent

INFORMED CONSENT FORM (PART ONE)

Title of Study: BENNER'S EXPERT: EXPLORING AND CONTEXTUALISING THE EXPERTISE OF THE SAFEGUARDING NURSE

Name of Researcher: Michelle Felton

Thank you for reading the information sheet about this research project. If you would like to take part please read and sign this form. Please initial the boxes if you agree with each statement. You will be given a copy of this consent form.

➢	I have read the information sheet for the above study and have been given a copy to keep.	
➢	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
➢	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and to decline answering any question I choose not to.	
➢	I agree to my interview being audio recorded and I understand that transcripts of my interview will be anonymised.	
➢	I understand that the recording will be digitally stored until the end of the study whereupon it will be destroyed/ deleted.	
➢	I understand that the information I give will be kept confidential but that if malpractice is divulged to the researcher she will report it in accordance with her Duty of Care and her Governing Body namely the Nursing and Midwifery Council.	
➢	I understand that I will not benefit financially from this study.	
➢	I know how to contact the researcher if I need to.	
➢	I agree to participate in this study	

INFORMED CONSENT FORM (PART TWO)

PARTICIPANT

SIGNATURE: .....

PRINT NAME: .....

DATE: .....

RESEARCHER TAKING CONSENT

SIGNATURE: .....

PRINT NAME: .....

DATE: .....

APPENDIX 6: Permissions; Letter of Access

BENNER'S EXPERT: EXPLORING AND CONTEXTUALISING THE EXPERTISE OF THE SAFEGUARDING NURSE

I give permission for Michelle Felton to approach my Safeguarding Nurses with the potential for them to participate in the above study. This study will involve face to face interviews that will be recorded and last approximately 45 minutes. I also give my permission for her to interview them on the premises if appropriate. This should result is as little disruption as possible to my staff and at times that are mutually acceptable. I understand that I will be given a Consent Form and an Information Sheet that the participants will also be given prior to the interviews taking place.

FULL NAME…….

SIGNATURE……

DATE……

POSITION HELD……

ORGANISATION……

A.N.Other Hospital Research and Development Department
Post Code xxxxxxx

Tel: 01234 56789
Fax: 01234 56789
1st February 2016

Michelle Felton
Xxxxxxxxxxxxxx
xxxxxxxxxxxxx
xxxxxxxx
Post Code

Dear Michelle,

Letter of access for research: Exploring and Contextualising the Expertise of the Safeguarding Nurse (Benner's Expert)

As an existing NHS employee, you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through A.N. Other Hospital for the purpose and on the terms and conditions set out below. This right of access commences on 01/02/2016 and ends on 18 August 2016 unless terminated earlier in accordance with the clauses below.

Purpose: Staff Interviews

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until you have received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to A.N. Other Hospital premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through A.N. Other Hospital, you will remain accountable to your employer but you are required to follow the reasonable instructions of your nominated manager, in this NHS organisation or those given on her behalf in relation to the terms of this right of access.
Where any third-party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with

any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with A.N. Other Hospital policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with A.N. Other Hospital in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on A.N. Other Hospital premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore, you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

A.N. Other Hospital will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely,

Xxxxx

Research & Development

cc: A.N. Other, R&D Manager,
N.E. Other, HR Business Partner

APPENDIX 7: Ethical Approval

A.N. Other Hospital Research and
Development Department
Post Code
1st February 2016

Michelle Felton
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx
Post Code

University of Essex REC Ref: 14029 R&D ref: 2015/050

Dear Michelle,

Tel: 01234 56789
Fax: 01234 56789

Re: Benner's Expert: Exploring and Contextualising the Expertise of the Safeguarding Nurse

Thank you for your application for Trust Research and Development (R&D) approval

A REC review is not required as this research project involves healthcare staff by virtue of their professional role and presents no material ethical issues. Researchers in Higher Education Institutions (HEIs) are advised to check whether, under their institution's policy and internal arrangements, ethical review is required by their HEI research ethics committee

R&D have reviewed the documentation for this project, undertaken a site-specific assessment based on the information provided and submitted a report to The Director of R&D for final review.

The Director of R&D, on behalf of the R&D Steering Group has further considered the proposal and has no objection to the research proceeding within the local NHS Foundation Trust

Sponsor: xxxxxxx
Funder: N/A
End date: 18 August 2016

Protocol: Version 1 dated 28/07/2015

Conditions of Trust Approval

• The project must follow the agreed protocol and be conducted in accordance with all Trust policies and procedures especially those relating to research and data management.
• You and your research team must ensure that you understand and comply with the requirements of NHS Confidentiality Code of Practice and the Data Protections Act 1998 and are aware of your responsibilities in relation to the Human Tissue ACT 2004, Good Clinical Practice, the NHS Research Governance Framework for Health
and Social Care, Second Edition April 2005 and any further legislation released during the time of this study.

• Under ICH – GCP (International Conference of Harmonisation of Good Clinical Practice), a Central Investigator File, containing essential study documents should be set up for this study. Such a file is available from the R&D Office upon request.

• Members of the research team must have appropriate substantive contract or a letter of access with the Trust prior to the study commencing. Any additional researchers who join the study at a later stage must also hold suitable HR documentation.

Amendments

Please ensure that you submit a copy of any amendments made to this study to the R&D Department for review and approval prior to being implemented.

Should you require any further information please do not hesitate to contact the R&D Department

May I take this opportunity to wish you every success with this research.

Yours sincerely.

Xxxxx

Director of R&D

cc (by e-mail)
Academic Supervisor
Director of Nursing
R&D Manager

R&D Reference: 2015/050 REC Reference: 14029
IRAS NO: 193435 Target Recruitment: 15

Document	Version	Dated
NHS R&D form (IRAS Form)	5.2.0	10/12/2015
SSI Form (Only required if multi-sites)		N/A
University REC letter of approval		10/09/2015
Research protocol	1	28/07/2015
Participant Information Sheet	2	16/10/2015
Informed Consent Form	2	16/10/2015
Data Collection Form	1	28/07/2015
Interview schedule	2	08/01/2016
REC Letter of Approval (Amendments to the above)		
Letter from Sponsor, NXX XXX		09/11/2015
Insurance / Indemnity statement		
NHS indemnity		
Authorisation(s) – NHS CCG	xxxxx	09/11/2015
Internal Authorisations	xxxxx	23/10/2105
CV - Investigator	Michelle Felton	20/10/2015
GCP – Investigator	Michelle Felton	16/10/2015
Peer review or scientific critique		N/A
Risk Assessment		21/10/2015
Letter of Access – NHS to NHS		01/02/2016

AN Other NHS Foundation Trust Summary of conditions of approval for all Research studies

1) All medical research involving human subjects should undergo ethical review by an independent ethics committee, visit xxxxxxx

2) All research must comply with current law, good practice guidelines and standards of conduct (all as amended from time to time). In particular, all people and organisations involved in research should be aware of their responsibilities under the following:

- 'Research Governance Framework for Health and Social Care', Second edition 2005
- Trust current R&D policy
- International Conference on the Harmonisation of Good Clinical Practice Guidelines (ICH-GCP)
- Declaration of Helsinki
- Data Protection Act and Caldicott Principles
- Health & Safety Act
- Medicines for Human Use (Clinical Trial) Regulations 2004
- EU Directive on Clinical Trials (Directive 2001/20/EC)
- The Medicine for Human Use (Clinical Trials) Regulations 2004
- The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006

3) Researchers are required to provide the R&D Steering Group with all information requirements for the NHS Executive.

4) Researchers will be expected to comply with all monitoring arrangements, as required by the 'Research Governance Framework for Health and Social Care'.

5) A Central Investigator File must be maintained. The R&D office is able to provide an empty file with dividers and lists of appropriate contents for retention.

6) Any gaps in Directorate or clinical arrangements or practice identified by the study should be notified to the Directorate Manager for inclusion on the Directorate Risk Register as appropriate.

7) Local researchers must ensure that the medical records of subjects recruited to Clinical Trials of Investigational Medicinal Products are clearly labelled, to allow the records to be retained by the Trust for data audit purposes.

WHERE APPLICABLE:

8) All costs for studies are to be agreed by all Parties (Investigator, Pharmacy, other Trust departments involved e.g. Laboratories, the R&D Office and the Company) before the study commences.

9) Trust approval is not complete until all costings have been agreed and contracts and indemnities have been negotiated and signed. Potential participants must not be approached until all relevant documents are signed by all parties.

10) The Chief Executive or a nominated Trust signatory must sign all indemnity agreements and contracts. In instances where unauthorised persons sign contracts on behalf of the Trust, any contractual liabilities and obligations may not be accepted and will then remain the responsibility of the signatory.

11) All R&D income (for both commercially and non-commercially sponsored R&D) should be invoiced by the Trust's Finance Dept via the R&D Manager. All income for R&D activity should be received into AN Other NHS Foundation Trust R&D Revenue accounts, as per the 'Standing Financial Instructions', section 6.2.3 (April 2005 version). Income should not be received into Trust Funds.

12) Income for Commercial research is subject to VAT.

13) Income for Commercial research is subject to the Trust's 15% levy, which will be top-sliced from all income.

UNIVERSITY of XXXXX

10 September 2015
MRS M. FELTON
Xxxxxxxx
Xxxxxxxx
xxxxxxx

Dear Michelle,

Re: Ethical Approval Application {Ref 14029)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative, Dr N E Other, on behalf of the Faculty Ethics Committee, on condition that approval is also granted by your employer's Research and Development department.

Yours sincerely,

xxxxxxx

Ethics Administrator
School of Health and Human Sciences

cc. Research Governance and Planning Manager, REO Academic Supervisor

Application for Ethical Approval of Research Involving Human Participants

This application form1 should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research should not commence until written approval has been received (from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form1 should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then passed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc., should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form1 cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1.

Title of Project: Benner's Expert: Exploring and Contextualising the Expertise of the Safeguarding Nurse

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.

Do you object to the title of your project being published? No

3. This Project is: *Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Michelle Felton	SHHS
Xxxxxxxx	SHHS
Xxxxxxxx	SHHS

5. Proposed start date: September 2015
6. Probable duration: 2 years
7. Will this project be externally funded? NO
8. What is the source of the funding?
9. If external approval for this research has been given, then only this cover sheet needs to be submitted External ethics approval obtained (attach evidence of approval) No

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I have read the University's Guidelines for Ethical Approval of Research Involving Human Participants and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's Statement on Safeguarding Good Scientific Practice and any other conditions laid down by the University's Ethics Committee. I have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my obligations and the rights of the participants.

Signature:

Name(s) in block capitals: MICHELLE FELTON

Supervisor's recommendation (Student Projects only):
I have read and approved this proposal and application.

Outcome:
The Departmental Director of Research (DoR) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.
This application falls under Annex Band is approved on behalf of the FEC
This application is referred to the FEC because it does not fall under Annex B

This application is referred to the FEC because it requires independent scrutiny

Department: .....
Date: .....
The application has been approved by the FEC
The application has not been approved by the FEC
The application is referred to the University Ethics Committee
Signature(s):

APPENDIX 8: Anonymised Transcript

Julie

What is your current role?

My current role is that I am the named nurse in safeguarding in primary care

Can you describe your current role?

Yes, um traditionally um well in the intercollegiate document that management predict in safeguarding roles and responsibilities, most xxxxxxx have a named xxxxxxx for safeguarding in Primary Care and it is usually a children's and young people's remit, and um certain xxxxxxx have found it very hard to recruit so they've gone for a nurse instead and I know, I'm very upfront about it, I'm not a xxxxxxx you know, I know I am not a xxxxxxx and so you know I am very upfront about it and this is the second position in this, my first one was children and young people and this one, the majority is children and young people and a small portion is protecting vulnerable adults so I have the same role level as a designated nurse but the title is named nurse

Okay so what do you do in that role?

I have training responsibility, I give supervision; let's take supervision as a very good example. Within nursing supervision is almost embedded, it's something that you must have. With the medical roles, they don't do supervision, they might do case discussion, they might do peer review but they do not do supervision and I'm not saying that it's not appropriate for them but it's not something that consistently happens and so one thing I might do is, if there's been a difficult case or difficult situation, I might use the framework to help discuss that which then allows for constructive criticism, strengthening, scaffolding, helping somebody move forward, all of those attributes so there's an example of something that perhaps a traditional xxxxxxx might not use but because I'm a nurse I bring that to the scenario and also training, support and a bit of fitness to practice. And then, obviously, there is keeping abreast with documentation, things like that and IMRs, serious case reviews, SRIs, I'm on all parts of those and liaising with agencies but keep primary care the focus of what I do. A big prong is unstapling Section 11 audits and making sure there are embedded in practice and if there's any training requirements needed. So, that is roughly about a snapshot of it is that I've given you

How long you been in this role?

In this role? xxxxxxx months

What type of training have you had to fulfil this role?

Um genuinely, absolutely none. I was, did it for xxxxxxx months in a previous role so you could say there, actually no, let me retract that, I have technically. I did the xxxxxxx of xxxxxxx um named xxxxxxxx training, that lasted two days at level four safeguarding and apart from that, I also did the xxxxxxx supervision course, so very technically, yes there's training.

How do you acquire new skills?

My conversation will start and finish with being xxxxxxx and a lot of how and why I am, is bound up in educational experiences, learning experiences. So, for me, when we come back to Benner, for me I know when a lot of the time, when I am ignorant let alone novice as I am so acutely, have been made aware of my complete and utter lack of skill. Therefore, positives and negatives towards that but also self-esteem and whatever and that's why I ask, and why I am upfront about asking people. I am blisteringly honest about asking people but also when it comes to learning and understanding, where I come from, when I was a practice teacher my methods with assisting learning was perhaps different to our community practice teachers.

But as a result of xxxxxxx you can probably see that I'm very practical I don't, I can't simulate lots of information so I either like getting bite sizes or er I genuinely like to work through it. I take a lot from conversation and an awful lot from watching things, snapshots of things and that is, people are very discrediting about that day, they're all: you haven't read this masters dissertation or you haven't read this book on bladybladyblah.

I debate that people learn this way and retain it. Whereas I might see something and using that method I might retain much more information than someone who has read something. So my method of learning style is very different to the traditional, I think you get so much more from conversation and watching people than you do from reading something and I'm not discrediting reading, I'm not, no, but I think a lot of the education system, and you know, a lot of what they promote in that aspect is to the detriment of the other and I think they're missing out.

There's an awful lot to be gained from working alongside someone and getting that relationship and seeing: oh, that's how you do it or that's how that happens. For me, that's predominantly how I learn

So, you are a doer, you are more hands-on, than distant?

Yeah, I have no problem watching, I love watching people. That was my asset in health visiting. You see so much by watching so there's, so I think there's the theoretical component of sitting down and looking at books and then offsetting it with what you're seeing; I am not so good at that, it is my weakness. I am always upfront and never lie about it

What is your previous role prior to this one?

Okay, I been a xxxxxxx for xxxxxxx years as a paediatric nurse and I am also an adult nurse and in the eons of time I was a xxxxxxx nurse. That was my very, very first qualification (MMBA) and I still hold that almost central to everything I

do. It is that you understand the well child so then you know the unwell child and in the safeguarding context: you know what a normal child should do and then you know when a child is unwell from what they do. I have written in it my little book because I have two books to remind me but to *act right* that's my raison d'etre for safeguarding sometimes in fact a lot of what I have done is acting right. It doesn't mean that I wait and see what everybody else is doing and so it can isolate you and I'm probably quite good at being isolated

How long were you in your previous roles?

Um, I started my adult training when I was xxxxxxx and that was partly again because I was xxxxxxx and I was a nice girl at school but not very bright. So, it took me a long time to get into education and when I got into adult nursing they assessed me fairly quickly, the outcome was xxxxxxx. So, I'd got that far on that basis. Nursing has been very good to me. So, I adult nursed until xxxxxxx and then I was a dual qualified nurse up until xxxxxxx when I became a xxxxxxx and then I did that for xxxxxxx and then joined the xxxxxxx.

What sort of things have influenced your current role?

Erm, all I can say is that my learning skill, xxxxxxx (that's not everyone's cup of tea) but that when you come down to it things like acting right, I find it very interesting slightly but one of the reasons I asked to do this is is because a lot of people talk about learning: I have a masters, oh, you need a masters for what you do? Does that make you any better? I know that some of my safeguarding is done using the most basic skills; you need to be trained, you need the knowledge but that doesn't mean you have to a qualification.

When you look at some of the things that have safeguarded children, it has been either a neighbour picking up the phone. So, I am really worried, now, that is knowledge and not about having a qualification and that's what I think. When I look at serious case reviews, adult or children, it's about people not having done the right thing. That has got nothing to do with the qualification and that is my raison d'etre, that is one of my fundamentals, that is if I can get people just to pick up the phone and do the referrals and that's what safeguards vulnerable people is. Not whether or not you've got a qualification at whatever level or whatever skill set, sometimes I find the further up the tree you go, the less the basic knowledge is there.

So just to reiterate, it is watching and sticking to your principles that influence your role; the way you have learnt and others actions and behaviours?

Yes, I hope so

Okay, can you give me an example of this?

Okay, I get really annoyed when people at the xxxxxxx ignore the notices, the rules. You either need to have xxxxxxx enforce the rules or take the sign down. Not swearing is one of them, it's one of the rules and xxxxxxx swear with clients and with each other am so it annoys me intensely that if you're going to do

something, to say and do something, say and do it. This is in the world of safeguarding, if you're not going to do something then don't say and do that you are going to do it. I know it is really simplistic and I realise that that's a criticism but I think actually, when we come to doing right with lots of people, with different levels of knowledge and they're protecting vulnerable people every day, just by picking up the phone and telling somebody else and if they are telling a professional then that professional then has to act responsibly and that is sometimes where the weakest link is. In that professional, who may have a lot of qualifications behind them (so they are professional) but if they don't make that referral, then that is when they have let everybody down and that is the weakest link in the chain not the little LD person who has just come and said I just saw somebody hit a child; you know you have to act

Do you consider yourself to have expertise?

Laughs! Laughs out loud! a lot long pause……. I think why er I am pausing for so long is my gut instinct says no, that's my gut instinct. I think I feel comfortable when I know what to do is right and I feel very strongly about that because I feel that I am always held by: have you got a masters? Then no, but do I know, at the end of the day, if I saw somebody leaving their kiddy in the car and abandoning them, my response is to go and get somebody and say whose child is that and you can't abandon them and leave them in the car and then watch it and if no one has come back in 10 minutes, then that's a phone call to somebody

Is that expertise? Or knowledge as in common sense?

I will be honest with you and say I don't know that, so I don't, so I don't, I don't feel sometimes…

How would you define expertise?

That is really interesting, in my previous role, I felt very comfortable. I felt very confident

You did that for number of years, didn't you?

Yeah, yeah for eons and then there were things I could do my sleep. I have a lot of vulnerable adult caseloads and I feel because I am so new in this, I haven't got that and there something about xxxxxxx when they talk to you, they say things in a different way to how nurses say it and I find that *wrong foots* me so sometimes I still need to come down to that scaffolding of doing right; however, how are they racking it up have they done it right? I know the English doesn't sound right so I am still gonna, I don't know if you'd call that expertise, I don't know, I don't know.

Where is common sense and expertise? If we look at Benner, it was a good framework for nurses but it has been really criticised and I think sometimes common sense has gone out the window and common sense is fundamental to a lot of us, its knowledge, isn't it? Having a skill is having understanding and I

think it's practical knowledge - safeguarding is practical knowledge; do the right thing
Even if it makes you anxious because safeguarding is fundamentally and anxiety making issue and that I won't ever move away from. I think that if it doesn't create anxiety and you are a safeguarding professional then something's not right. You become blasé to it, you become removed from the fact that actually somebody suffering and that's about suffering and that's not right, it's not right for somebody you care for and love then why is it right for them? So, coming back to expert, common sense I don't know. I suppose because I see Benner in this, you've got all of these so that makes you make sure the expert but we don't acknowledge that. Actually, there's a point, I always get very interested when I come across a professional and ask them when they last did a safeguarding and they say, well, um, I can't remember. Really that makes me immediately anxious because I think, what aren't you seeing, what are you not doing, what are you not responding to and that terrifies the living xxxxxxx out of me. No, I don't think that makes me an expert but I think that makes me think that that person is becoming de-skilled so they need to be reskilled or retrained. So, I still come back to I don't feel an expert but I do think I have a robust practical framework for this role. I've work in xxxxxxx for a long time. I am aware of new systems and how they work out there. I am used to working isolation. I've done a lot safeguarding local safeguarding, you know, but I'm not sure that makes me an expert

What do you think makes an expert?

I don't know, you see, um I think that's about my self-esteem and how I see education and how people have portrayed me: if you haven't got this qualification then you can't do that and I think that's how I feel about it

How do you know if you or someone else is an expert?

I think there's a lot to do with attitudes and behaviours and absolutely. I don't think it's necessarily about citing people but I do think it is about saying, you know, perhaps someone who works… if I were talking about psychology, perhaps someone who works in sexual abuse clinic something like that. I think they will be very, very skilled in sexual abuse or domestic violence for instance or whatever. They have got a lot of immersion and have plenty of facts emerging and they will have had that strengthened and other bits and pieces, so I think there's something about that immersion and what you do and how you see it. I mean it also goes alongside with how you interact with people and how you take people along with you. So, that's probably how I might see it

You said earlier that you know what you don't know?

Yes, like large, large, large, gaps

How do you think other people recognise an expert?

Oh, I think a lot of that is about qualifications. coming back to what we said earlier about porters and cleaners being not necessarily seen as …; an xxxxxxx asked me, he lives abroad: Asperger's, I think, I can't actually remember what we were

talking about but it was how do you recognise a civilised society and for the life of me I can't remember what he said but what I said to him was a civilised society is having a sewage system, you know, if you can't get rid of what we all do every single day and it is a poisonous relationship to us then actually that is not a civilised society. So, I think that says something more about me it's, there are lots of issues, needs. Philosophers when they talk about, you know, doing for the greater good against the individual, I think there's something about communities who can't look after their weakest then… that's appalling really, really appalling. So, when you come back to, I know I'm sounding quite muddy, but I find it so difficult to conceptualise my view is different to other peoples and other peoples are different to me. And I know people look for a title and for how many years you've done it and whatever and sometimes I've come across some of those people and are so conceited, so much so they actually don't take challenge well, they can't see the objectivity, they can't see a fresh… and that's why when I was a health visitor one of the reasons I knew had to leave xxxxxxx was because I didn't want to be the grumpy old woman in the corner: same, been there done that and actually it's all come round again and I don't want to be like that. I thought if I come back to xxxxxxx, I have done something different I have challenged myself and I will bring that to my new role whatever it is and sometimes I think when you see people who are experts, they have become, they have become, actually quite rarefied sometimes. I do think there's a lot of that being open to new ideas absorbing some of those ideas and recognising which of those ideas are not useful; its looking at it, you know, if that works for me or not work for me

There was one of those questions early on when you asked me what brought me or something like that? Some of my most rapid learning has been internal. It's not been about gaining knowledge, is been about, if you've known me, now nearly xxxxxxx years ago, my idea of travelling to work was half an hour tops, why would I want to do more than that? I now do xxxxxxx minutes; it does not worry me; I don't think about it. I am up at stupid o'clock in the morning before it was like no, no, no, no, you know, and I didn't know, I didn't know what an excel spreadsheet was which might surprise you but I didn't need to in my day. And now xxxxxxx says: you like your spreadsheet don't you, I love 'em, the more colour, the better. That's how a lot of my learning has been that I have I can almost find a point of neurological pathways being made that I wouldn't have done if I stayed in xxxxxxx

Would you have stagnated?

No, but I would have said *retarded,* I wasn't going to say stagnated. I was going to say personally; I would have retarded. I would have become a stalagmite. I have become cemented and I would become unhappy, somebody saw me and said you look very happy and I can't believe it and every day um I am challenged by something every day not just about safeguarding but other things, you know, things that …so when you talk to some of your safeguarding practitioners I would be interested in finding out if it is the issues that challenge then or other aspects in the job, that challenge them, that help them to be better safeguarding professionals

What do people generally think when I talk about an expert?

I think that, um, it's a title
Do you think there is any definitive definition for an expert?

People like xxxxxxx, I think sit in a very theoretical world, very political world. Okay so I wonder about how she would feel one day a month as a frontline xxxxxxx which is what she trained for? For me, it is something I'd like to punt later on, is having a day, a couple of times a day, returning to core fundamentals to see if I can still do those core fundamentals, knowing what I know, can I bring the two together, can I experience practice and its inspiration to strategy so there is something about that and I don't think I can quote people who really feel that they're expert in that field but can they go back to their grassroots to revisit that relationship

What do you do in a situation that you are unfamiliar with in relation to safeguarding?

In my last role, I had done nothing with xxxxxxx and I kept thinking thank god, thank god it was the one area where I felt really vulnerable

What does xxxxxxx stand for?

Xxxxxxx

Okay

And I really felt vulnerable when I had that within this case load. I um nearly xxxxxxx myself and it was about recognising, at that point, first encapsulated not like a panic attack, mad sweat, difficulty breathing, me scenario, that was then, all of my emotions manifested on one event. My weakness, my insecurity, my lack of knowledge my lack of practical experience that underpinned my knowledge so there's something. So, as a result of that, I've done a lot more with the xxxxxxx. I felt like that was such a good salient experience that I could take that back to other practitioners I now know what it's like to not know in this job and I recognised that in that scenario. So, this was my first year but I learnt, developed and strengthened and moved forward and was very confident not very confident, that sounds too cocky, conceited, I feel much more robust in my knowledge and there was a training session, and somebody put up the wrong slide and it was wrong, it was about xxxxxxx, and it was wrong and I told them and she said oh does anybody else feel like this so another hand went up it was sort of ooooh: we'll change it then but she didn't like it. I know I'm not leaving this knowing that its wrong because other people are gonna think that's right and that is wrong and I learned that because of that scenario. It's like that woman was a *jobitis.*

Responsibility comes with a title if I thought about it and the responsibility I hold, I would give it up but being passionate, being committed that's what I do, is that part of being an expert? And I'm not these things because I want a title but because I want to protect people. If I had talent and it is to protect people and help other people protect them, then that is my talent and if it's just through some of my conversations that I enable others to protect others then that is my talent

and I think if that gives me some degree of confidence in what I do, then that's fine. I still find it very hard to call myself an expert. I did as a xxxxxxx and I'd done that job for xxxxxxx years and that's one of the reasons I was in a xxxxxxx because people saw me as an expert and still I learnt something new from somebody every day. You have to something to learn from everyone you meet

Thank you

APPENDIX 9: Coded Emerging Themes

4.4.1 PERSONALITY

4.4.1.1 *Motivation*

"I think that was the biggest learning curve for me but it was good because it just made me get on and do" (Anna, 4/145).

"I am very self-driven so I will put myself in scenarios where I am likely to benefit from interactions" (Bert, 4/149).

"some of it's personal and some of it is a desire to be involved and an all-round individual" (Cathy, 6/22).

"I use my intuition but I do when I think about what happened and I then become aware of taking action without thinking about it but then writing it up becomes difficult because I just know what I did was the right thing to do but I didn't think about what I was doing at the time" (Derek, 5/164).

"if you are not seeing that, you're not seeing the individual patient then that's the time to walk away from it I think" (Edith, 4/121)

"the most vulnerable people, don't get discriminated against and that is why I care about the role coz I have a real passion" (Fred, 3/102)

"I get an interest in something because it's new, it's a new concept so it's exciting, that's the motivation, isn't it? that get you more interested" (Grace, 2/72)

"I'd love to be able to do it individually but again I can't, so I do it as a group and then I have a responsibility to supervise the safeguarding leads in the acute" (Hattie, 3/106)

"I felt that the people are really good and I wanted to see if I could help them in terms of the outside issues with the aim of improving systems and processes and opportunities for the staff" (Ingrid, 2/50).

"because I didn't want to be the grumpy old woman in the corner: same, been there done that and actually it's all come round again and I don't want to be like that" (Julie, 7/280)

4.4.1.2 *Self-doubt*

"I presented it very basically and I thought it was too basic but the feedback, the feedback was that it was right. You have people at board level at different levels. You've got experienced people like the directors of nursing and directors and then you have lay members on the board who don't understand it all so the feedback I got was very positive" (Anna, 2/63).

"I don't know, you see, um I think that's about my self-esteem and how I see education and how people have portrayed me: if you haven't got this qualification then you can't do that and I think that's how I feel about it" (Julie, 6/236).

4.4.1.3 *Arrogance*

"I can say with many years backed catalogue of work, I would say that I class myself an expert by experience rather than as a result of any formal qualification much as I think that a formal qualification in nursing does not make you an expert, I think it's more about what you learn and how you apply your role" (Bert, 3/90).

" …some experts get above and beyond themselves like people who have given expert advice in court and have been found out manipulating data. The statistical analysis of the data has been wrong and great miscarriages of justice have happened. That's why I think being humble and being reflective is very important. That's not to say that you're dismissive about what you know, your knowledge is the safeguarding process, your aim is to keep somebody safe isn't it?" (Cathy 6/213).

4.4.1.4 *Confidence*

Some of the quotes were indexed under two themes (Figures 1a and 1b) as they

clearly denoted both personality and peer influence,

"when I first started I found this difficult because I wondered if I was ever going to get to the point of confidence, well be confident enough to sit one of these chairs" (Anna, 8/312).

"I am very much further down the role and in the understanding and there is a comfort that comes from that and that's reinforced so that staff would know and trust my judgement and I think that helps as well when I am answering their questions. I am dealing with scenarios, staff have no hesitation in coming to me and asking me, they value my opinion so I think expertise isn't just about how one feels about oneself but it is tested and is the perspective of others – It's being validated by others isn't it?" (Bert, 3/101).

4.4.1.5 *Learning*

"Yeah, I definitely think working on the job and also what helped me but I did find it very difficult that there was no support when I came in so I had no one to go to and then they drafted someone over from another team and she was very good, she was excellent. I think that was the biggest learning curve for me but it was good because it just made me get on and do it and appreciate you just got to get on and then you work your way through these issues and in safeguarding, sometimes there is no right or wrong: that's what it is, what makes it quite difficult" (Anna 4/137).

"I understand my learning style and I think that's important and when I have deadlines and everything I recognise that I am a procrastinator but I recognise that my best work comes from is a bit of pressure, a deadline. I am always thinking. I have a very good memory for things so "I think understanding my own learning styles allows me to target opportunities to recognise. I'll read the news most days, I don't always read stuff about safeguarding but I kind of filter through, I have some key words and I'll ask and talk to other people to learn from situations" (Bert, 5/183).

"besides newspapers it is very much about reflection. Reflecting on my own practice and I am very aware sometimes I could have approached things differently when it has not gone as well as I would have liked" (Fred 3/79).

4.4.1.6 *Qualifications*

"I find it very interesting slightly but one of the reasons I asked to do this is because a lot of people talk about learning: I have a masters, oh, you need a masters for what you do? Does that make you any better? I know that some of my safeguarding is done using the most basic skills; you need to be trained, you need the knowledge but that doesn't mean you have to a qualification" (Julie, 3/126).

"I'd say I'm experienced. I think… it's worries me when people say they are the expert, because then they, I have a real thing about titlitis. I think it's obviously the outputs of what people do um some of its reputation and I um, unfortunately, some of it is if somebody has been around a long time, then there's an assumption that those people are experts" (Ingrid, 4/160).

4.4.1.7 *Passion*

"*I love my job so much and I can't answer why. I just love it so much. I think it's the range of scenarios you come across but I just love it so much and it's hard to explain"* (Derek, 2/63).

"Responsibility comes with a title if I thought about it and the responsibility I hold, I would give it up but being passionate, being committed that's what I do" (Julie, 9/366).

4.4.1.8 *Self-Belief*

"I wondered if I was ever going to get to the point of confidence well be confident enough to sit one of these chairs and now I am" (Anna, 8/311).

4.4.1.9 *Forums; Training Courses*

"I have done the train the trainer safeguarding adult course which is run by the county safeguarding adult's board. I also did a two day, well it was a sort of supervision course but it was a bit of a strange course, so I think, um, the idea

was to understand our roles and where we were going in the future and look at supervision. So, I did that and I've done MCA and DoLS training (Anna, 1/16).

"to participate in safeguarding groups and um coming out of that as well, although not entirely related to it, was the work coming out of it for the MCA and its inception" (Bert, 1/26).

"I did the county Adult Safeguarding Board train the trainer. Have had some mental capacity act training. I haven't had any DoLS. I have some human rights training on domestic violence" (Derek, 1/22).

"I am responsible for making sure that all our policies and procedures are consistent with legislation which includes the care act, the mental capacity act, deprivation of liberties, safeguards particularly and I also manage other specialists" (Fred, 1/8).

"I have done the train the trainer for safeguarding adults, I have time to train the trainer for MCA training" (Grace, 1/31).

4.4.1.10 *An Expert*

"I don't like that word I do think people see me as an expert but what I prefer to call myself is a specialist. It makes you sound like you are a standalone fountain of knowledge - everything that I don't profess to be and that I don't want to work in partnership with people. Yes, I've got extra knowledge that other people don't have, yes, I've got, yes, I have specialist knowledge and yes I've got the time to go read which I can then pass down to people who don't have time to go off and read. I have the power to go off and do things like that but I don't like - I get a bit panicky with people saying she's an expert, I like to say I have specialist knowledge more awareness more advanced to you and I feel I have the expertise but I do not like that word expert otherwise my title would be safeguarding expert wouldn't it and it isn't?" (Anna, 6/234).

"a novice, uses instructions to get to where they are but an expert knows but then checks back, almost plotting their route and double checking. Yeah, that's very much what I consider myself to be" (Bert, 6/231).

"*So, time and trials are the same as being an expert because its learning from your experiences because I said about, didn't I? having been a nurse for thirty-one years. I might still be operating at the same level if I had never, at the end of the thirty-one years, if I was the same as I was at the beginning of the thirty-one years if I had not taken the opportunity to learn from what I was exposed to but also to seek out new knowledge about different issues"* (*Cathy, 5/173).*

"I do, yes. I feel that I am an expert because I am able to offer advice and support to staff and staff will come and ask for support and advice" (Derek, 3/94).

“Yeah, I struggle with the word expert and maybe is a psychological thing, maybe because people would see me as an expert because they have to come to me for advice but I know that I don't know everything so I know I'm not an expert. So, it's how I perceive myself and how others perceive me. I don't know, I think maybe it's Heald, C. (2005) What future for expert witnesses? Online at: news.bbc.co.uk/1/hi/uk/4637687.stm [Accessed: 21 October 2016].

Husserl, E. (1999) *The Idea of Phenomenology*. England, London: Kluwer Academic

self-esteem, maybe I don't know, a confidence thing should I really have expert in my title, not sure about that, no I think there is an air of arrogance there because I don't think anyone can ever know everything about anything. Does that make sense? But if people. in the organisation, want to call me an expert, hey!” (Edith, 8/292).

“Yes, I consider myself to be an expert” (Fred, 5/173).

“I consider myself to have an in-depth knowledge but I don't consider myself to be an expert” (Fred, 5,174).

“*what an academic is looking for in an expert is something very different from a frontline practitioner so it's relevant to each individual in what they look for in an expert”* (Grace, 4/319).

“*I think a lot of experts are seen as quite precious and I'm going to be honest and they become unapproachable and that's not what it should be about”* (Hattie, 13/515).

“I go around places and some people think I'm a n expert but you know, I’ve never classed myself as an expert” (Ingrid, 4/148).

“if that gives me some degree of confidence in what I do, then that's fine. I still find it very hard to call myself an expert” (Julie, 9/372).

“I think it’s somebody who is experienced and exposed to different situations. Well, first of all you they to be competent in what they do and they’ve reached it’s a bit like driving isn’t it? When you first start to drive, you can’t do anything else except drive, and then you reach the stage when you stop thinking about it and its part and parcel of who you are as an individual” (Cathy, 4/130).

“I have, I consider myself to have an in-depth knowledge but I don't consider myself to be an expert. It depends on the word you're using, expertise is to describe really. I will be comfortable with saying I have expertise in relation to the

organisation, that I'm working in, and I wouldn't say I have expertise, as such, there is no training that I have ever undertaken that has given me a title in relation to being an expert in safeguarding" (Grace, 5/174).

Even so, in some cases the two terms were at times used synonymously by some

of the participants as shown in the following text:

"and never be an expert, equally something in some people will develop expertise quicker than others "(Fred, 7/207).

"Same again in dentistry or whatever, what the nurse has knowledge in is not going to be expert in that service area, so expertise will vary from service to service" (Grace, 3/320).

"yes, you can get expertise but my worry is that once you think you're an expert you close your brain" (Ingrid, 6/212).

4.4.2 EXPERIENCE

4.4.2.1 *Intuition*

"I think about everything but I do work on my gut feeling. I would, do, I think I am intuitive" (Anna. 6/251).

"*The knowledge that I have, will guide me in relation to the situation that I am in"*

(Grace, 8/302)

4.4.2.2 *On the Job*

"I definitely think working on the job as such, is also what helped me" (Anna, 4/138).

"On the job, definitely on the job because every situation is different and you never know what is around the corner. I don't think you can write every scenario because everyone is different and so is every patient and their circumstances" (Derek, 2/34).

4.4.2.3 *Knowledge*

"The knowledge that I have, will guide me in relation to the situation that I am in" (Grace 8/302).

4.4.3 PEER IMPACT

"I get a bit panicky with people saying she's an expert" (Anna, 6/211).

“I was recommended for this role because of the diverse career that two people decided that they needed somebody and the first name at the top of the list was me. That what they said anyway, flattery means the world!” (Bert, 3/120).

*“Even though you may be seen as an expert by your peers you may still be striving to improve and achieve a better performance” (*Cathy, 5/161).
“if I am unsure I will still look at them and ask them if they feel that the information I have given them is correct and do they think that its right” (Derek, 3/94).

“I use the adult safeguarding board a lot, I use my peers a lot, I can also go and talk to other organisations” (Edith, 2/46).

“I found that was the most helpful learning and supportive mechanism so I shadowed a number of people that have been doing the role longer than me and I found that helped a lot with learning” (Fred,1/28).

“I do try and attend all of the adult safeguarding meetings as well; that’s a really valuable learning place because you've got your colleagues that have been working in safeguarding for many years as well” (Grace, 3/81).

“*A lot of the training is done through sort of peer support, other leads and across the county it is not what I would call structured training”* (Hattie, 1/33).

“*I prefer the word specialist instead of expert because in a way you set someone up if you call them an expert when actually all they are doing is they're professing to do their best and have the most up-to-date knowledge and are doing a really good job. We call people an expert and then we let them burn themselves and I know I have had personal experience of this you need to keep your knowledge up-to-date practice up-to-date and keep it as specialist and then we can protect people. Individuals do not need to be put in the position of expert by others”* (Ingrid, 5/184).

“I learnt something new from somebody every day. You have to something to learn from everyone you meet” (Julie, 9/376).