Research Paper

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Title: **Working as a physiotherapist in a rapid response team: "An emotional Rollercoaster"**

Authors: Rosalie V Barrett and Dr Clair Hebron

Abstract

Background and introduction

Rapid Response Teams (RRTs) are multidisciplinary, 'hospital at home' services which have developed over the last 10 years, aiming to improve recovery from illness more efficiently, prevent unnecessary hospital admission, and prevent early admission to residential care. However, little is known about the experience of professionals working in these roles.

Purpose

The aim of this study was to explore how working in a RRT is experienced and perceived by physiotherapists.

Methods

This study used phenomenographically inspired methodology. Six participants who were working in RRTs were recruited to this study and all were working in the South of England. Data was collected via semi-structured interviews and phenomenographic analysis was undertaken.

Results

Participants working in RRTs described a range of varied, concrete lived through experiences in addition to more rhetorical discussion of how the conceptualised their work. Six main categories of description were generated from the analysis; each was assigned a metaphor. These included: ‘the detective’, ‘the guru’, ‘the lone ranger’, ‘the team player’, ‘the bricoleur’, and ‘an emotional rollercoaster’; all categories were present with varied meaning. ‘An emotional rollercoaster’ was present within and throughout participants’ descriptions of all other categories.

Conclusion

This study provides valuable insights into physiotherapists’ experience and conceptualisation of working within this discipline, which may have implications for physiotherapy practice, workforce development, new and current RR physiotherapy services, RRT health professionals, and physiotherapy education.

Key words: physiotherapist, rapid response team, emerging roles, experience, perception, phenomenography, qualitative research

Introduction

In the last decade, the National Health Service (NHS) has struggled to meet the health demands of the population (Addicott, Maguire, Honeyman, and Jabbal, 2015; Gilburt, 2016). For instance emergency departments (EDs) have seen a dramatic increase in attendance and admissions with admissions increasing faster than the population, identifying that there were 69 emergency admissions per 1000 of the population in 2011/2012, and 77.1 per 1000 in 2016/2017 ((Blunt, Bardsley, and Dixon, 2010); Baker, 2017). EDs in the United Kingdom (UK) are required to meet a target, whereby 95% of patients need to be assessed, treated and discharged within a four-hour target

(Department of Health, 2015; Evans, 2017); however only 85.1% of EDs are achieving this (NHS England, 2013). Iin 2017, 2.5 million waited longer than 4 hours (Murray et al, 2017). This increase in demand on NHS acute services is impacted by more individuals living with chronic and complex illness (Addicott, Maguire, Honeyman, and Jabbal, 2015), and an ageing population (Centre for Workforce Intelligence, 2011; Department of Health (DH), 2015). There are 12 million people over the age of 65 in the UK, and four million are living with long-term conditions (Age UK, 2019) requiring health intervention in acute and community settings (Office for National Statistics, 2013). Evidence has confirmed that unnecessary admission can cause significant health detriment, such as: deconditioning, increased risk of hospital acquired infection, institutionalisation, and disorientation (Mendes, Rodrigues, Preto, and Novo, 2016; Mudge et al, 2017; Oliver, Foot, and Humphries, 2014); potentially leading to longer hospital stays, further deterioration in health, and increased costs to the healthcare system. The upshot is an unprecedented extra strain on clinical resources (Addicott, Maguire, Honeyman, and Jabbal, 2015), costing the NHS an estimated additional £13.5 billion a year (Department of Health, 2015).

In response to this crisis, health and social care has required substantial reconfiguration (Gilburt, 2016), and the NHS workforce has adjusted to provide innovative solutions. One strategy has been to move care away from hospitals, and closer to home (Kings Fund, 2015; NHS England, 2014; The Nuffield Trust, 2017) by developing services that integrate health and social care, such as the community integrated rapid response team (RRT). The RRT is a multi-professional approach to ‘hospital at home’ and is a relatively new service within the NHS in the UK which may include physiotherapists, occupational therapists, nurses, GPs, social workers,

rehabilitation assistants and pharmacists. RRTs provide an immediate response, at home, to individuals with acute complex health care needs aiming to improve recovery, prevent unnecessary hospital admission and delay admission to residential care (Clift, 2015; NHS Benchmarking Network 2013; Stevenson and Spencer, 2002). The 'Long Term Plan' (NHS, 2019) has confirmed further support to develop additional RRTs to continue to keep patients out of hospital, promising £4.5 billion in funding to primary care. For many health professionals such as physiotherapists, this commitment to move more care to the community has meant new roles, ways of working, and clinical environments.

This study focuses on the physiotherapy profession specifically, and the perception and experience of physiotherapists working within community RRTs. To date, the literature investigating avoidable admission teams like the RRT is predominantly quantitative and the main focus of research has been to evaluate the impact of the whole team rather than consider individual roles, for example whether RRTs are cost effective, safe, can reduce avoidable adult admissions and provide patient satisfaction. Literature undertaken in the UK, Australia, Italy, and New Zealand that has reviewed avoidable admission teams such RRTs and hospital at home teams, has shown that they can improve patient satisfaction, reduce readmission and mortality rates (Caplan et al, 2012; Facultad and Lee, 2019; Lee and Titchener, 2017; Lee, Pickstone, Facultad and, Titchener, 2017; Montalto, 2010; Montalto, Lui, Mullins, and Woodmason, 2010; Shepperd et al, 2009; Varney, Weilland and Jelinek, 2014; Wilson et al, 1999). Although physiotherapists have been working in avoidable admission and hospital at home services such as the RRT for over a decade, little is known about their experience of working within this discipline. The qualitative evidence exploring

the RRT and the experiences of clinicians working in this field, as well as patients receiving care from these teams, is scarce. These insights will add rich understanding of working in these teams, which may inform successful implementation of RRTs in practice. Thus, to address this gap in the literature, this study aims to explore how working in a RRT is experienced and perceived by physiotherapists.

Method

Methodology and study design

This interpretive qualitative study used a phenomenographic approach (Giorgi, 1999; Marton, Dahlgren, Svensson and Saljo, 1977; Marton and Svensson, 1979; Saljo, 1979). Phenomenography seeks to discover variances in the way individuals experience and understand phenomena in the world they live in (Barnard, McCosker, Gerber 1999; Larsson and Holstrom, 2007). It is concerned with describing how things appear to, and are experienced by, individuals (Pang, 2003). Phenomenography sits within an interpretivist paradigm (Cibangu and Hepworth, 2016), recognising that there are many ways of interpreting reality. Ontologically phenomenography is based on a nondualist world view, in which there is just one world, and it is that world which is experienced (Akerlind, 2012; Marton, 1981; Sin, 2010). In this non-dualist view 'the internal (thinking) and the external (the world or activity) are not seen as isolated entities' (Svensson, 1997). Epistemologically phenomenography employs a 'second order' perspective which focuses on individual's experiences of a phenomenon. Specifically, analysis focusses on

'what' is the focus of attention and 'how' it is experienced or perceived by an individual (Yates, Partridge, and Bruce, 2012). Thus phenomenography offers great value as an approach for researching healthcare (Holmström, Halford, and Rosenqvist, 2003).

Recognising how healthcare phenomena are understood and experienced by clinicians, patients and providers, is vital to help improve, shape and develop efficient and effective future healthcare practice (Barnard, McCosker, and Gerber, 1999; Larsson and Holmström, 2007). For this reason, a phenomenographically inspired approach was appropriate for this specific study, which aimed to explore a new healthcare phenomenon – physiotherapists' experiences and perceptions of working in a RRT – as conceptualized by the therapists themselves.

Sampling and participant recruitment

Purposive sampling was used to recruit 6 participants, who had at least 12 months experience of working in a RRT in the UK. Purposive sampling was chosen to provide the best chance of revealing the various experiences and perspectives of the phenomenon (Creswell and Poth, 2018 p100,157-159; Braun and Clarke, 2013 p56) and is commonly used in phenomenography (Yates, Partridge, and Bruce, 2012). There is no prescriptive number of participants suggested for phenomenographic studies (Yates, Partridge, and Bruce, 2012), but in common with other qualitative research includes a small number of participants, seeking to elicit rich (thick) descriptions, and aiming for deep analysis of the data (Braun and Clarke, 2013 p45-50). Participant volunteers were recruited via the Chartered Society of Physiotherapy (CSP) using their website by posting a research invitation on relevant Interactive CSP (iCSP) web pages. All participants were provided with an information sheet and asked to complete a consent form before participating.

Details of the six participants can be found in Table 1. Due to the small number of physiotherapists in RRT roles, further information on participants is not included due to a risk of compromising their anonymity.

Table1: Participant characteristics

Characteristic	Age	Gender	Years qualified	Years of experience in RRT	Additional training
Participant					
1	36	Male	14	5	Masters degree
2	35	Male	12	4	Masters degree
3	36	Male	12	4	Masters degree
4	42	Male	13	5	Masters degree
5	44	Female	9	3	Master level module
6	48	Male	25	5	Masters degree

Data collection

Data was collected through semi-structured interviews via Skype or face-to-face (depending on participant choice) and lasted between 40 and 80 minutes. All interviews were audio recorded and transcribed, and participants were anonymised by number. Face-to-face interviews occurred in a location convenient to the participant in a private room. The participants were asked to discuss their experience of working in a RRT in as much detail as possible, and encouraged to speak freely about their experiences. The interview was initiated by asking the question*: "Can you tell me in*

as much detail as possible about your experience of working in a rapid response team?". Although the researcher allowed the participant to lead the direction of the interview and the content discussed, prompts were used to encourage participants to engage and aid elaboration of any meaningful situations. For example, prompts included: *"Can you tell me a little bit more about that experience?"* and *"Can you give me an example of what that was like?"*

Data analysis

This study has followed an idiographic phenomenographic analysis process guided by Larson and Holmström (2007) (Table 2). Each transcript was initially read twice to get a sense of the whole (step 1) and then divided into meaning units (step 2). Phenomenographic analysis is an iterative process whereby the researcher engages in dialogue with the text, trying not to predict any outcomes (Åkerlind, 2005). To aid this process, the main researcher kept a reflexive diary. Notes were made during this process, specifically on the participants' focus of attention, *what* this was on, and *how* they described their way of working, and therefore the phenomenon (step 3). Initial descriptions of participants' understandings were made, and these were grouped into categories constructed on similarities and differences. Connected or related statements were grouped into dimensions of variation. Quotes were arranged into piles, uncertain cases were reviewed, and eventually the criterion characteristics for each group were made explicit (Åkerlind, 2005 (step 4). Next these were developed into descriptive categories of meaning and were assigned metaphors (step 5). The descriptive categories were then arranged into an outcome space (step 6). The relationships and any hierarchies between categories were considered, as well as

non-dominant ways of understanding (step 7). The steps of the analysis are further illustrated in the Appendix.

The first author (an advanced practitioner physiotherapist with postgraduate training in research) undertook the analysis, and the second author (an experienced researcher, musculoskeletal physiotherapist and academic) acted as co-reader, providing dialogic discussion and alternative interpretations of meaning, findings, the descriptive categories, and final outcome space.

Table 2: Steps of the phenomenographic analysis (Larsson and Holmström, 2007).

1. Read and re-read each transcript to get a sense of the whole.
2. Divide text into meaning units ('fragments' of the text containing a meaning).
3. Look for 'what' the focus of the participants attention is on and 'how' they describe it.
4. Group descriptions into categories based on similarities and differences.
5. Assign a metaphor to emergent categories of description.
6. Develop and find a structure in the outcome space.
7. Identify 'non-dominant' ways of understanding.

Ethics

Ethical approval was granted by the Health and Social Science, Science and Engineering Research Ethics and Governance Committee at the University of Brighton in November 2015.

Findings

Six categories of description were generated from the analysis of the participants' accounts of their experiences, and these categories were present with varied meaning. Each category was assigned a metaphor to illustrate understanding and meaning relating to working in a RRT. These were: 'the Detective', 'the Guru', 'the Lone Ranger', 'the Team Player', 'the Bricoleur,' and 'an emotional roller coaster' (Table 3). The category 'an emotional rollercoaster' intertwines with the five other categories of description, which were derived from various, but equally important, conceptions. As the 'emotional roller coaster' category was present throughout participants' descriptions of all categories, this will be discussed throughout and not separately as is illustrated in the outcome space (Figure 1).

Table 3: Descriptive categories

	Descriptive category (metaphor) of working in a rapid response team				
	An emotional roller coaster ← →				
Varying perceptions of working in a rapid response team	**The Detective**	**The Guru**	**The Lone Ranger**	**The Team Player**	**The Bricoleur**

The Detective

The metaphor 'the Detective' illustrates that participants conceptualised working in a RRT as investigative work. This category was characterised by descriptions of clinical assessment, utilising knowledge, reasoning and problem solving. To be 'a detective' participants described the act of reviewing a wide spectrum of clinical information gained through history taking (including an attention to current symptoms), physical assessment and specific test results.

"… in this rapid response setting, oh yeah there's quite a broad range of answers, and having a broad spectrum of advanced knowledge helps us to …decide on our next steps" (P1)

They perceived this information facilitated problem solving and clinical decision-making to aid diagnosis/and or formulation of a treatment plan. Within their descriptions was a perception that in the RR setting, these detective skills need to be broader and more advanced than those required in other settings (requiring additional training) and yet recognition that the investigative tools at their disposal were not always adequate.

"… we took the observations…her blood pressure was very high, and temperature…and we did check the urine… all the ketones and nitrates and we did not notice an underlying infection…presenting with symptoms like confusion and drowsiness… we had to send her into the hospital for further investigations to see what exactly the underlying illness turned out to be…" (P2)

Participants conveyed the importance of taking a holistic perspective, with their role as a detective involving consideration of broader aspects of health and wellbeing. For some participants this meant considering the psychosocial factors and for others this also included a broadening of their detective work into domains traditionally considered the work of other health professionals.

"…you see the patient from a holistic approach, so not only just for the physio, but you see and assess them for all aspects of health, the nursing, and OT wise and all the social problems… and problem solve and bring a solution for them…" (P4)

Participants acknowledged that this detective role is an 'emotional roller coaster'. Each

participant described a wide and varied range of emotions in relation to their experience. The highs and lows in their accounts of working in a RRT were meaningfully related to the speed needed in their detective work, having to make decision with uncertain and incomplete information and the potential consequences and responsibility associated with their decision-making.

"…very rewarding…because we problem solve, use our clinical knowledge and make these decisions and it made a difference in that man's life…" (P1)

"Oh yes, this job does get your heart racing! The nurses say, 'You always look so calm.' I say, 'Yes, I look calm but my heart is really going!' I think if it's a life and death situation, I do get a bit nervous, you know, apprehensive, I have to gather information and make decisions quickly, and I can get that butterfly feeling…" (P5)

The Guru

The term guru is used as it reflects participants' perceptions of their educational role in a RRT. 'Guru' is based on the Sanskrit term (language from ancient India) meaning 'teacher, guide or expert' of a certain knowledge or field (Pertz, 2013 p 38). A guru, in the context of RRT will share expert knowledge from their professional experience. This descriptive category was characterised by recognition of their clinical expertise and skills and descriptions of being a guide and educator.

"I would say it is exciting, I feel proud of what I am doing, I think I am utilising whatever knowledge, skill and experience I have gained, still using my physiotherapy expertise to guide others, you know, team members and patients…" (P3)

Participants conceptualised a broad educational role with the RRT, involved teaching their colleagues from other disciplines on physiotherapy specific knowledge and skill, but also educating and guiding their patients and the carers/relatives on their illness and/or management and treatment plan. Participants conveyed a sense of education in this setting as a guiding, facilitatory process moving towards self-management and health promotion.

"…being a physiotherapist, we share our knowledge on this team, share with other professionals, teach others about our own clinical knowledge…" (P2)

Similarly, another individual spoke to the significance of education as a guiding , faciliatory process.

"…education happens quite a lot you know, to educate and guide the patient about their condition or teach them to help themselves and self-manage their condition…" (P3)

The Lone Ranger

The sense of being alone was conveyed as significantly meaningful. Participants' accounts were dominated by descriptions of experiences in their RRT roles where they visited patients and experienced clinical situations alone, thus they perceived themselves at times to be 'lone rangers'. Within this category they conveyed the importance of clinical experience and knowledge in developing clinical competence and autonomous decision making.

"I have to make the decision on my own… is the patient to stay in the community or

go back to the hospital …so here, in this team, I have to think about everything myself, each and every aspect of the patients err situation, their clinical care…." (P4)

Participants conveyed a sense of responsibility when making clincial decisions, in ensuring their skills were up to date, the need to be honest about their knowledge, and to work within their scope of practice.

"..if I'm in doubt and on my own, or I don't know what needs to be done next steps, I know when to ask for help...sometimes you know you are presented with a very ill, acutely ill people and err, sometimes it goes a bit beyond the scope…" (P3)

They also recognised the importance in developing competence in clinical skills that may normally be otherwise associated with different roles (such as nurses or occupational therapists).

"… you need to be competent, especially as you are often on your own …so you need to be competent enough to take blood pressure or competent enough to do blood glucose levels…and make decisions etc…" (P2)

The 'emotional roller coaster' was expressed through varying emotions associated with being 'a lone ranger'. As illustrated in the quotes below emotions ranged from anxiety, uncertainty and a sense of responsibility to confidence in their decision-making abilities.

"It's actually…it's very challenging, especially as we often work alone… It is a

challenge, but again at the same time, how do I put it? I am confident…" (P6)

Similarly, another individual spoke to the challenges of working alone.

"I feel quite good in myself…, I'm reasonably confident with err, what I do……..
"It is a feeling of uncertainty as a clinician… we are left alone completely…so sometimes it feels a bit daunting to be taking such huge decisions, just being alone standing there, the patient looking at you, if they have family, everybody is looking at you…" (P3)

In contrast to descriptions of lone working, participants' descriptions revealed examples of team working.

The Team Player

Contrasting with the sense of being a lone ranger, participants also perceived themselves to be part of a larger team which involved working collaboratively and learning from others. For some participants, the 'team player' was about working closely together with colleagues to improve care, whereby it was perceived that by drawing on the skills of everyone in the team, care could be more person-centred.

"Now when we sit down or work together as a multi-disciplinary team…The good thing is, when there is more than one of you, you can also have these different ideas… somebody can come up with, 'What about this?', and ultimately the care delivered is therefore improved" (P6)

Participants perceived that working in a multidisciplinary team offered multiple perspectives, diverse thinking, and nuanced knowledge and skill, thereby affording learning opportunities and contributing to their own professional development.

"Yes so more heads are better than one… you're constantly learning from each other… that is the beauty of working in the multi-disciplinary team" (P6)

Whilst the diversity of perspectives offered by the team was considered by some participants 'beautiful' and 'reassuring', for others it was at times a source of frustration. Thus being a 'team player' was described with varying emotions and once again the 'an emotional roller coaster' category is embedded and woven into this category.

"… we try to always work together but sometimes this is hard, when people have different thought processes and opinions…sometimes I find this frustrating" (P3)

The emotional rollercoaster was also woven through the final category of description: The Bricoleur.

The Bricoleur

Bricoleur is a French word that means a handyperson who uses all tools and types of knowledge that are available to complete a job (Kincheloe, 2005). The concept of the Bricoleur resonates with participants conceptualisation of their role in a RRT. They described their role as an unconventional role that crossed professional boundaries and was not 'traditional' physiotherapy as the job went beyond 'core' physiotherapy.

“I have to be flexible and move away from some of the traditional boundaries of the profession and there is some cross over with other disciplines like occupational therapy...” (P1)

In such, they conveyed the importance of gaining and using additional skills and knowledge to facilitate complex clinical reasoning and decision making. Participants perceived that exposure and experience in this setting is required to craft and master these additional skills and embed them into their practice.

“…in rapid response…you are doing a different role, not just a physio role, a different role, in the sense that…you need so many other skills, new skills, liaising with different professionals, and getting trained into many skills…” (P2)

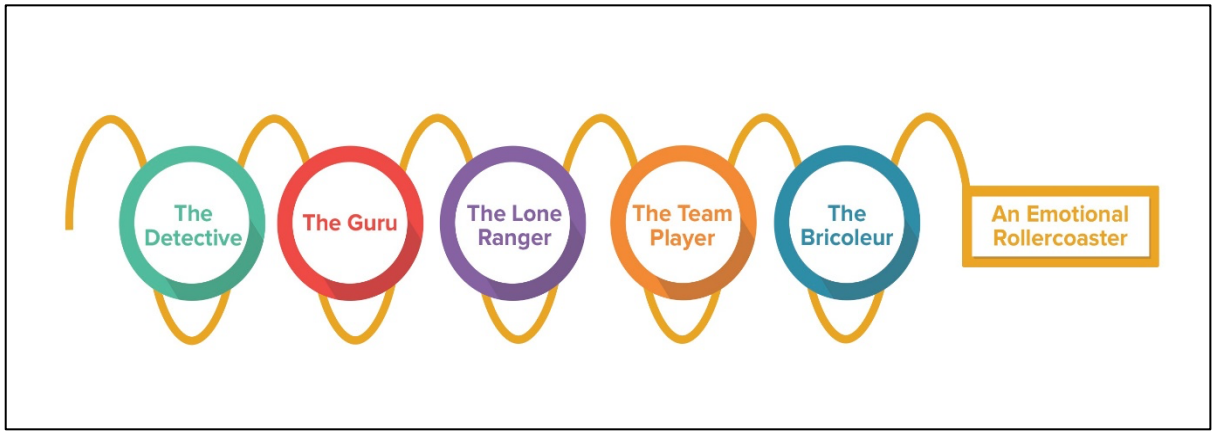
The challenges and emotional labour associated with the role, alongside the satisfaction experienced in becoming a bricoleur are reflected in the ‘emotional roller coaster’ category.

“…it’s very challenging wearing all of these different hats. It’s at the same time very rewarding. When you can see the change in that person and especially when you even hear it and they end up saying to you, ‘Thank you for whatever you have done,’ you feel oh wow, I’ve fulfilled my role” (P6)

<u>The Outcome Space</u>

The six categories of description and their relations to each other are presented in an "outcome space" (Figure 1). Figure 1 illustrates the relationships and connections between the categories of description found in this study and provides a way of viewing the collective experience of working in a RRT despite the fact that this same phenomenon was perceived differently by different participants (Åkerlind, 2005; Larsson and Holmström, 2007). Working in a RRT for these participants, at this point in time, was represented by the first five categories of description which illuminate the complexity of the multiple roles or 'hats' that participants described as fundamental to working in a RRT. The final category 'an emotional roller coaster' intertwines throughout all other categories and is presented as the most dominant category. it illuminates the varied emotions associated with the complexity, uncertainty and responsibility of working in a RRT experienced by these participants.

Figure 1: The outcome space



Discussion

Participants (physiotherapists) working in RRTs described a range of experiences and perceptions of how they conceptualised their work. Participants understood RR work to have various meanings including: 'detective' problem solving; working as a 'guru' in

guiding and educating colleagues and patients; working as both ‘lone rangers’ and ‘team players’; and working as a ‘bricoleur’ by using a pluralistic range of knowledge. To work in RR, participants openly perceived and expressed many emotions. These emotional meanings varied, and formed ‘an emotional roller coaster’.

In this study, participants perceived that a broader range of knowledge, skill and investigations were essential to undertake detective work in the RRT setting, and that by using their knowledge they could then make informed clinical decisions, problem-solve or determine the next decision. However, participants did not explicitly outline the details of how they embarked upon this process. Working like a detective has been found in other disciplines of healthcare practice. Studies exploring clinical reasoning in physiotherapy emphasise that there is a dialectical reasoning process, which involves combining multiple knowledge sources (Edwards et al, 2004), and this resonates with this study’s findings. However, little is known about how therapists in certain situations interpret this information to decide what the clinical issue or next steps may be (Ahlsen, Mengshoel, Bondevik, and Engebretsen, 2018). An exploratory study which reviewed physiotherapists working with patients suffering chronic muscle pain identified that to develop clinical reasoning and problem-solving, physiotherapists consider clues, weigh up different stories and question the information available (Ahlsen, Mengshoel, Bondevik, and Engebretsen, 2018). This detective work and clue construction (which triggers questioning and drives reasoning) was considered to be driven by ‘uncertainty’ (Ahlsen, Mengshoel, Bondevik, and Engebretsen, 2018). Doody and McAteer (2002) also found that physiotherapists, like detectives, undertake a process of cue acquisition, hypothesis generation, and evaluation, which aids clinical reasoning and decision-making. Working like a ‘detective’ is not unique to the RRTs

or to the physiotherapy profession, with both tele-nurses (Kaminsky, Rosenqvist and Holmström, 2008) and a life history reflection by an occupational therapist describing 'detective' work (Yerxa, 2000). . Future studies may want to consider how other health professionals undertake problem-solving and clinical reasoning within their practice, as advanced insight into this is likely to contribute towards improving care delivery.

Participants in this study perceived themselves to work as 'gurus', educating and offering expertise. What was emphasised was that, in the RRT setting, in addition to recognising themselves as 'educators' for patients, they considered that they had an extended education role with carers and relatives, helping them to better support those needing care at home. Additionally, they conveyed their role in educating other team members which they conveyed as meaningfully related to their close working relationship with other professionals and the overlapping of professional boundaries in the RRT setting. Participants predominantly described didactic education methods, however, some participants referred to 'guiding', and described encouraging their patients to 'self-manage', indicating that they may be moving towards providing more person-centred educational methods. What was absent in the data was explicit descriptions of a more patient-centred model of healthcare (Wittink and Oosterhaven, 2018): For example, the data did not include concrete descriptions of participants asking whether education was wanted or needed, exploring patients' and carers' pre-understanding, or eliciting what information they considered might be helpful. Other research has also found health professionals consider education as a key aspect of their work (Forbes, Mandrusiak, Russell, and Smith, 2017; Lundh, Rosenhall and Tornkvist, 2006). It has also been suggested that experienced physiotherapists may be more likely to report using self-management education strategies that are patient-

centred, and look for patients to obtain full understanding as a means of evaluating their teaching, compared to novices (Forbes, Mandrusiak, Russell, and Smith, 2017). A more person-centred educational approach was conceptualised in a phenomenographic study in tele-nurses; they perceived their role as encompassing a large educational aspect, and described themselves as coaches, perceiving validating persons complaints and creating a pleasant atmosphere for the caller as 'coaching' strategies, and emphasised the importance of listening and being a discussion partner (Kaminsky, Rosenqvist and Holmström, 2008). These descriptions of educating in this way are less didactic in nature, and are related to encouraging patient empowerment over their situations (Gibson, 1991; Jotterand, Amodio and Elger, 2016).

Participants in this study perceived that being an 'expert' was essential. They considered themselves as experts by providing an array of expert physiotherapy clinical skills and knowledge to their patients and their wider team. Other research has found physiotherapists consider themselves 'experts', but this appears to relate to a physiotherapy speciality, rather than being a generalist physiotherapy expert. For example, physiotherapists treating people with anterior cruciate ligament described themselves as rehabilitation experts within this discipline (von Aesch, Perry and Sole, 2016) and physiotherapists working in EDs viewed themselves as musculoskeletal experts (Lefmann and Sheppard, 2014). Recognising 'expertise' and specifically 'generalist expertise' amongst physiotherapists and other allied health professionals is important for future workforce planning, especially if services are required to adjust to meet the changing healthcare demands. If there are specific 'expertise' skills amongst professionals working in various disciplines, then they could be utilised more effectively.

Participants described their role as working both as a ‘lone ranger’ and a ‘team player’, which might be considered contradictory. Traditionally in healthcare, doctors have described themselves as ‘lone rangers’ accountable for their patients’ care (Saha, 2016), but the findings of this study suggest that as physiotherapists take on more autonomous advanced practice roles, they also face the challenges of being ‘lone rangers’. This resonates with physiotherapists working in EDs with amplified autonomy, who also described their work as ‘lone rangers’ with feelings of isolation from their peers (Kilner and Sheppard, 2010). Transitioning from one role to another, such as registered nurses to advanced nurse practitioners, has been described as a lonely experience due to increased autonomy, loss of professional identity, and having limited people to consult (Jangland, Uhlin and Arakelian, 2016). Moving from one role to another can trigger loss of confidence and insecurity, and this may be intensified without support from a wider team (MacLellan, Levett-Jones and Higgins, 2015). Conversely, despite increased autonomy, participants also perceived themselves as belonging to teams. In today’s healthcare system, teamwork is considered essential to providing effective patient-centred care to minimise adverse events (Babiker et al, 2014). Nursing research has also identified that clinicians who work alone also recognise the necessity of collaborative team working to solve challenging clinical situations (Jangland, Uhlin, and Arakelian, 2016), but those in new roles, such as advanced nurse practitioners, do not always feel welcome and supported (Jangland, Uhlin, and Arakelian, 2016). Physiotherapists in EDs have also expressed the challenge of trying to work autonomously and be accepted in a team, perceiving that it was a struggle to build strong relationships and gain approval (Lefmann and Sheppard, 2014).

Working in healthcare is frequently described as ‘uncertain’ (Ghosh, 2004), which is replicated in this study as some participants expressed that working alone can cause uncertainty. Facing uncertainty is a regular occurrence for health professionals, and especially for those training or working in new disciplines (Kim and Lee, 2018). However, in an age of increased transparency and low trust amongst the public, acknowledging and coping with uncertainty is critical (Kim and Lee, 2018). An intolerance to clinical uncertainty can cause emotional distress and burn-out amongst health professionals, and may cause patient harm. Being aware of uncertainty, acknowledging it, and engaging in appropriate coping strategies can aid clinicians in dealing with the emotional pressure and stress uncertainty triggers. One successful strategy used to support health-care staff undertaking new or challenging roles has been the development of the Schwartz Centre Rounds (Maben et al, 2018). The aim of these forums is to improve staff well-being, and ultimately patient care (Maben et al, 2018). The fact that participants in this study expressed uncertainty and loneliness suggests that strategies such as Schwartz Rounds may be needed to support those undertaking pioneering or new roles. The ‘lone ranger’ experience and its accompanying uncertainty raises further questions about how emerging roles are being supported, and whether more support needs to be offered through education to ensure these professionals have an appropriate and effective support system to avoid feeling isolated and uncertain.

Participants in this study expressed that to work as a RR physiotherapist they worked as a ‘bricoleur’ by crossing professional boundaries, and perceived their roles as ‘unconventional’. In response to the challenges facing the UKs healthcare system

traditional roles and responsibilities are converging (Crouch and Brown, 2018), and the 'role extension' of clinicians gaining additional skills improves patient outcomes when coupled with sufficient organisational support (Hourahane et al, 2012). Shaw and DeForge (2012) believe physiotherapists working as bricoleurs will embrace many epistemologies and acquire new ways of clinical reasoning to offer an improved holistic approach to their practice. The 'bricoleur' is also seen in nursing, where practitioners develop their clinical practice by adding different skills for new responsibilities (Daly and Carnwell, 2003; Gobbie, 2005). Nurses working in complex disciplines such as falls' prevention need knowledge of multiple skills, and an ability to undertake multiple tasks (Jangland, Uhlin, and Arakelian, 2016; Kirkpatrick, Boblin and Robertson, 2014). Physiotherapists working in EDs have expressed their clinical role is different from that of a 'traditional' physiotherapist (Kilner and Sheppard, 2010) for various reasons, including skills in differential diagnosis, more autonomy, longer shifts, the need to work under pressure, and taking on roles beyond their previous remit. The crossing of professional boundaries beyond 'traditional' roles may have implications for how pre- and post- registration healthcare education for clinicians is delivered to ensure patient safety and quality care is achieved. Furthermore, drawing on multiple types of knowledge could help professions such as physiotherapists move closer towards an improved holistic understanding of health and illness, improving person-centred care (Shaw and DeForge, 2012).

In this study, throughout every category of description, participants expressed their work as 'an emotional rollercoaster', describing both positive and negative emotions. Other research focused on exploring emotional experience has found clinicians experience a range of emotions in their roles (Larner, Wagstaff, Thelwell, and Corbett,

2017; Röing, Hirsch, and Holmström, 2006). Oncology clinicians have described their role as “riding the rollercoaster” (Philips and Volker, 2019), and surgeons’ expressed a wide range of emotions when undertaking their work (including anxiety, fear, distress, guilt and accountability (Orri, Revah-Levy, and Farges, 2015). However, emotions have also been recognised in a positive sense with research finding that clinician emotion may play a key role in clinical reasoning and decision making, giving credibility to intuition and ‘gut feeling’ (Kozlowski et al, 2017; Langridge, Roberts, and Pope, 2016; Woolley and Kostopoulou, 2013). In this study, participants experienced a wide range of emotions across all categories including both positivity such as confidence and feelings of their roles being rewarding, and also negativity such as fear and frustration. It is unclear whether the perceived emotion in this study is linked purely to RR work, or whether participants were still adjusting to working within a pioneering area. Evidence considering role transitions amongst other health professionals has confirmed that stress is present in those undertaking novice or pioneering roles (Duchscher, 2008; Etheridge, 2007). Other research concludes that previous clinical experience combined with existing clinical skills and knowledge can facilitate confidence for role transitions (Melrose and Gordon, 2011). A potential future avenue of exploration would be to consider whether there is a link between emotion and clinical decision making, and whether acknowledging emotion assists RR physiotherapists in recognising and managing stress and/or burnout.

Methodological considerations

Credibility, dependability and transferability need to be considered when determining whether the qualitative research undertaken is of appropriate quality (Rolfe, 2006). There was variation in most of the characteristics of the participants who were

recruited (Table 1), with a mix of ages, years of physiotherapy experience. However, 5 out of the 6 participants were male, and all participants included were from London or greater London (despite the recruitment process targeting all geographical areas of the UK), which could be a limitation. It is important to acknowledge that the work undertaken by RRT physiotherapists may differ depending on location and context. There is no national register of UK physiotherapists in RRTs, which limited the study's ability to target the desired population. We acknowledge that these findings represent the perceptions of these physiotherapists at this point in time, and in line with our phenomenographic approach, do not seek to generalise findings. Instead we provide in-depth insight into these individuals' experiences while working in the context of a RRT and invite readers to consider whether these findings resonate with them and their context.

An appropriate sample size is important to ensure credibility. However, there is no accepted participant number required for qualitative studies as the sample size depends on the research purpose and richness of data. A small data set is normal to allow for in-depth understanding of the phenomenon. There is no set number of participants suggested for phenomenographic studies (Yates, Partridge, and Bruce, 2012); although some authors advocate more than 10 to maximise the likelihood of finding variation (Holmström, Halford, and Rosenqvist, 2003). Six participants were recruited to this study as it explores an emerging role, and only a small number of physiotherapists currently work in this area. Although this study highlights variation between participants, it does not claim to saturate the variations within experience (Braun and Clarke, 2021). To aid dependability, this study undertook a pilot interview to check that the question(s) asked generated information on the phenomenon being

explored (Åkerlind, 2005). During the official interviews, the same key questions and prompts were used to ensure that the same subject material was covered. The findings of this study form a basis for future research by providing some insights into the variation in experiences and perceptions of those working in these roles, so that they and others maybe better supported as these roles develop into more mainstream areas of practice. Interviews varied in length, taking between 40 to 80 minutes. All participants expressed various experiences of undertaking RR work, and in varying ways, providing multiple concrete examples, and rich (thick) descriptions.

The main researcher works in a RRT, which may have compromised objectivity and professionalism. However, the main researcher undertook a process of reflexivity throughout data collection and data analysis, considered any preconceptions and did their best to 'bridle' their pre-conceptions (Dahlberg, 2006) by keeping a reflexive diary, before reaching final descriptive categories. They also closely liaised with the second researcher (an experienced qualitative researcher) during the data analysis and determination of the final categories to help reduce insider researcher bias. These processes promoted methodological rigor, and strengthened the credibility of this study (Åkerlind, 2005). To illustrate how the descriptive categories and the final outcome space was formulated the study has presented a comprehensive and varied selection of quotations from all participants. In line with Graneheim, Lindgren, and Lundman (2017), this study has described the context, methodology, characteristics of participants, data collection, and analysis process as comprehensively as possible to enhance transferability. It is hoped that the findings discovered amongst RR physiotherapists will encourage further research to compare experiences and perceptions of those within similar settings.

Implications for clinical practice

Researching professionals' experiences and perceptions of emerging roles is essential for transforming practice and providing the necessary evidence required to support the development of new care pathways. This study highlights the various ways physiotherapists perceive and experience their roles within RRTs, and provides insight into how they view their skills and knowledge. This could prove useful for future workforce planning, as physiotherapists with RRT expertise and experience could be utilised further by working in other health disciplines and new care models. This study highlights that RRT physiotherapists experience a range of rollercoaster of emotions, emphasising the need to implement support strategies for persons working in these roles to ensure they maintain a healthy emotional wellbeing, enabling them to better care for others. Further research is needed to evaluate how physiotherapists can be better prepared for role transition.

Conclusions

The RR physiotherapy role and discipline is new and largely unexplored. This is the first qualitative study which has investigated how working in RRTs is experienced and perceived by physiotherapists. It adds a human perspective to the RR physiotherapy literature, acknowledging that experience and perception may offer valuable insight into RR physiotherapy and health professional practice. It also considers how current and new RR physiotherapy services could be delivered and developed, and offers food for thought for pre- and post-physiotherapy educational programmes preparing future clinicians to work in the discipline. The numbers of RRTs continue to expand with associated physiotherapy posts being advertised and developed, indicating that

clinical practice in this area is ahead of research. The findings in this study suggest a need for further qualitative research on physiotherapists and other health professionals working in RRTs. This will have important implications for delivering future effective, safe, and quality care within this area of practice.

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Declarations of interest

The authors report no conflict of interest.

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