Nurses' perceptions of quality nursing care: a grounded theory study of overloading

Jacqueline Flynn

Southern Cross University
Nurses’ Perceptions of Quality Nursing Care: A Grounded Theory Study of Overloading

Jacqueline Flynn
RN, RM, Neonatal Cert, BApp.Sci. (Phillip Institute), Cert Quality Management (QUT), MMed Sci (UQ)

Southern Cross University
Lismore, NSW

A thesis submitted in fulfilment of the requirements for the award of the degree of Doctor of Philosophy

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Declaration of Originality

I certify that the substance of this thesis has not previously been submitted for any other degree and is not currently being submitted for any other degree. I certify that to the best of my knowledge and belief, this thesis contains no material previously published or written by another author except where due reference is made and acknowledged within this thesis.

Signed:............................................

Date:.............................................
Dedication

This work is dedicated to a number of special people in my life.

Firstly to my husband and friend who has been there throughout most of my life and a constant reader in this work?

Secondly to my mother and late father without whose guidance in life I would not have been where I am.

Thirdly to my daughter Natalie who has inspired me to continue even in the most difficult times.

Fourthly, to my other children, Graham and David who have provided support in many ways.

Lastly but no means least, to Dr Barney Glaser, one of the founders of Grounded Theory and whose assistance has been immeasurable and whose friendship I treasure.
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My heartfelt gratitude to Professor Bev Taylor who was always available to talk to and guide me through the turbulent times of this research.

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To my colleagues from the Grounded Theory Institute who provided assistance at the seminars and who were there on line to continue this support.

Finally, I acknowledge Dr Barney Glaser, a wonderful teacher, who invited me to San Francisco to attend one of his seminars and then to a further seminar in New York. His wisdom, support and advice greatly assisted me see the light of codes and be true to emergence.
Abstract

This PhD study aimed to explore nurses’ perceptions of quality nursing care and why they were unable to provide this. The specific aims of this study were to; compare actual quality of care provided to patients by clinical nurses rather than perceived quality of care that should be provided; identify significant nursing care issues impacting on quality; and make recommendations on behalf of nurses working in the clinical area with patients for the purpose of improving the quality of nursing care.

For these nurses, who work directly with patients, in clinical hands on roles, care comprises up to 90% of their daily activities. Worldwide, various Nursing Boards and Regulatory Bodies have developed standards of practice, which identify what a nurse should do, as well as ensuring safe and competent practice (QNC Scope of Nursing Practice 2005; American Nurses Association, 1998).

The findings from this research indicate that the ability of nurses to provide quality nursing care is being raised as a significant issue with practicing nurses, with nurses now questioning their ability to provide patients with the care they should have, rather than what they have time to provide. By exploring nurses’ perceptions of what they believed constituted quality-nursing care, nurses’ described what quality nursing care means to them within their own clinical areas. This research was able to identify that nurses do indeed take shortcuts in their endeavours to complete their daily activities.

For this study, I utilised a Grounded Theory (GT) methodology, using a systematic set of procedures to arrive at a theory about basic social processes (Glaser, 1992). The aim of this approach was to discover underlying social forces that shape human behaviour and in particular clinical nurses working directly with patients. This was achieved via interviews utilising open-ended questions, skilled observation and various forms of documentation, such as nurse’s notes, professional standards and job descriptions.

The value of using a qualitative research method such as GT is often emotional and embedded in the subjective. With an emphasis on understanding quality from a practicing nurse’s perspective, a descriptive study such as GT seems logical as its aim is to generate rather than verify theory (Glaser and Strauss, 1967). Simultaneous analysis guides GT, with data collection and data analysis informing each other.
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CHAPTER 1

BACKGROUND

"It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm" (Nightingale, 1859, p. iii).

Introduction

The aim of this research was to describe and explain what clinical nurses believe to be quality nursing care. For nurses working directly with patients, in clinical hands on roles, care comprises up to 90% of their daily activities. This chapter will provide an insight into the background for this study, the researcher’s background, significance of the study, its aims and objectives and the rationale for the subsequent literature review. Key terms and definitions are outlined as is a chapter overview.

Background to the study

There is increasing concern coming from nurses about their daily workloads and the impact this is having on their ability to provide quality-nursing care. It is acknowledged that inadequate nursing staff levels can lead to poor care outcomes (Watson, 2005) with adverse affects including increased infection rates, post-operative complications and mortality. Lundstrom, Pugliese, Bartley, Cox, & Guither (2002) go as far as saying that research in the UK has demonstrated that mortality can be reduced by more than 12% with good management of hospital staff. It is further suggested with information coming from Magnet hospitals that a mortality reduction of 5% can be achieved (Lundstrom et al. 2002).

Nurses are constantly complaining about nursing shortages and this is now a world wide phenomenon, with rural areas tending to be the most under served areas (Wickett, 2003; Watson, 2005). It is also well recognised that the nursing workforce is aging and this is expected to get worse as the baby boomers reach retirement age over the next 10 or so years (Productivity Commission 2005), Australia’s Health Workforce, Research Report, Canberra). There have been positive moves by the Government to address this by
increasing student numbers over the past 5 years or so (Australian Government Productivity Report, 2005), however, an appropriate increase in clinical educators and/or facilitators has not matched this increase (Buchanan, 2005). The impact of this supervision and mentoring falls onto the bedside clinical nurses, who are already over-stretched with patient care activities (Wickett, 2003).

Roman (2005) indicates that quality care is dependant on a number of factors such as patient acuity, the competence of staff and the skill mix of those staff rather than the minimum requirement being nurse-patient ratios. The impact of workloads, high acuity of patients and a skill mix that is often lacking in staff with the appropriate competency leads to problems of burnout and stresses that are caused by emotional and physical overload (Grealish & Carroll, 1998; Usher, Nolan, Reser, Owens, Tollefson, 1999; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002).

Consequently, nurses require an enormous amount of emotional investment when caring for a number of ill patients (Stockdale, 2002). Frequently, this is not psychologically possible, due to the often-competing demands on these nurses such as family issues, and study that make caring in the relational sense impossible.

The nurse-patient relationship is considered the foundation of nursing care, the context in which nurse’s practice patient care (McQueen, 2000; Ronayne, 2001; Tanner, 2006). Consequently, this relationship becomes an interpersonal process that is developed over time and is between the patient and the nurse. Elements of this process generally include a beginning or development of trust, middle or working phase, and an ending or termination phase within the context of caring, sharing, and goal orientation (Hagerty, Arbour, Patusky, 2002). Nurses in this study identified that building relationships with patients and their significant others is difficult, if not impossible given the current health care environment with shorter hospital stays, fewer financial and personnel resources, and limited opportunities for community contacts.

Fundamental for all nurses is their ability to communicate, with adverse events and preventable incidents, being critical factors of error rising from communication breakdowns (McQueen, 2000; Mock, 2001; Chant, Jenkinson, Randle & Russell, 2002; Foxhall, 2002).
Good communication is the heart (and soul) of good health care. It is also an essential component in the safety and efficiency of service delivery. One-on-one communication between individual clinicians and patients will always be the cornerstone of how care is given and received. However, with the increasing complexity of Health care systems, workers in all areas of Health care also need to acquire the skills of good communication within and between teams.

Breakdowns in communication between Health care professionals, or between clinicians and patients, are a factor in almost all adverse patient events, or 'medical mistakes'. Some of these cause serious harm to patients, and trauma to their families, as well as being devastating to the clinical staff involved (Jones, 2002a).

Further, the impact of long hours, shift work, and stress are known to affect mood, mental health and emotional wellbeing, as well as impacting on vigilance, alertness, clinical decision making and communication (Centre for Disease Control and Prevention, Fact Sheet, 1997). Miscommunication or conflict can be resolved with patience, respect and extra time, however, this research has identified that nurses may have difficulty finding the extra time to explore such issues.

On the Job Training or Customised Training provide unique opportunities for participants who already possess some job-related skills and the knowledge to "learn as they earn". By participating in training as an employee, the participant not only acquires new skills and knowledge, but also receives knowledge and wisdom from mentors and preceptors. The employer benefits by being reimbursed in part by increased skill and knowledge acquired following the training period.

Customised Training further benefits an employer by tailoring a training program to the specific needs of the employer, especially in the area of introducing new technologies or procedures. Nevertheless, the development of enhanced skill for all levels of staff is variable with many nurses opting for on the job training and gaining additional skills through advanced practice competencies.
Elkan & Robinson (1991) assert that with the move of nursing to the universities some years ago, a new era of nursing knowledge, the socialisation era of nursing science, emerged. The perceptions of nursing students as they progress through their experiences in an educational institution can be seen in part as the beginning of this socialisation process (Elkan & Robinson, 1991, Wilkerson, 2005). As these students move through each year and progress to their graduate year, clinical role modelling and mentors are important as they assist the graduate and new staff in the facilitation of socialisation to the workplace environment and work unit.

**Researcher background**

I have been aware of the impact of workloads as an issue facing nurses for some time. I have been a Director of Nursing for 10 years and held senior nursing positions for many years prior. I am also a surveyor with the Australian Council of Health care Standards and have a passion for quality. However, as a Director of Nursing in a rural community, I was becoming increasingly worried about a number of issues that nurses were raising with me on a daily basis and at staff meetings. Firstly, there were the numbers of complaints I received from patients both in writing and when I was with staff on their units, that the nurses had no time to spend with them. Secondly, the nurses themselves were constantly complaining to me about the lack of time they had and the number of additional tasks that were being given to them on a daily basis. These tasks were for example, Occupational Health and Safety and direct patient care.

My reasons for undertaking this study were that lack of time issues were being raised by staff on such a regular basis, that I decided to undertake a qualitative research project to identify why nurses believed they were unable to provide the care they should or would like to provide. Grounded theory methodology attracted me once I gained an understanding of its ability, and later, as I met and respected the work of Dr Barney Glaser, I was able to relate this methodology and its potential for clinical application to nursing.
Significance

The significance of this research lies in its potential to improve nurses’ ability to provide patient care by providing information and direction to administrators and bureaucrats who are responsible for providing the financial resources required for staff and patient care. The findings from this research will assist administrators gain an understanding of the complexities and the real issues facing nurses today.

Aim

This research explored and analysed the issues that impact on what nurses do each day and in their quest to provide quality-nursing care to their patients.

Objectives

Originally the objectives were to determine how nurses in the clinical area explain quality patient outcomes of care and methods by which high quality care may be better achieved by:

- Establishing a range of quality benchmarks for high quality nursing care;
- Determining if nursing care actions provided to patients are those that should be implemented;
- Comparing actual quality of care to perceived quality benchmarks of care;
- Identifying significant nursing care issues impacting on quality and;
- Making recommendation on behalf of nurses working in the clinical area with patients for the purpose of improving the quality of nursing care.

However, once I started analysing the interviews I had to modify the objectives somewhat, as it became clear that nurses’ ability to provide quality outcomes, the original focus of this research was not emerging as a major category. Therefore the following objectives became the new focus for this research:

- Comparing actual quality of care provided to patients by clinical nurses rather than perceived quality of care that should be provided;
- Identifying significant nursing care issues impacting on quality;
Research questions

Two main questions highlight this research
• What is it that nurses do each day that takes them away from direct patient care?
• What do nurses perceive to be quality nursing care?

Rationale for literature review

In the traditional type of research methodologies, the researcher will first examine the relevant literature, with studies often not starting until well into their research process. Therefore, in this approach, a traditional literature review was not undertaken as per the guidelines in GT. Rather the literature was searched as it became relevant to the topic as it arose. In an emergent study the researcher begins collecting data as soon as a research situation is identified. It is only then that the researcher accessed the relevant literature.

This rationale will further be described in chapter 2 on methodology.

Key Terms and definitions

Clinical Nurse Consultant (CNC). A registered nurse appointed as such to a position approved by the Area Health Service, who has at least 5 years full time equivalent post registration experience and in addition who has approved post registration nursing qualifications relevant to the field in which s/he is appointed, or such qualifications or experience deemed appropriate by the Area Health Service.

Clinical Nurse Educator. A registered nurse with relevant post registration certificate qualifications, who is required to implement and evaluate educational programs at the ward or unit level.
**Clinical Nurse Specialist (CNS).** A registered nurse with relevant post basic qualifications and twelve months experience working in a clinical area of his or her post basic qualification.

**Enrolled Nurse (EN).** A person enrolled by the Board as such and who can take on restricted duties under the direction of a RN.

**Nurse Manager (NM).** An employee who is allocated to a nurse manager grade in accordance with the Award.

**Nurse Practitioner (NP).** A registered nurse appointed as such to a position approved by the Director General and who is authorised by the Nurses Registration Board (NRB), pursuant to Section 19A of the Nurses Act 1991, to practise as a practitioner.

**Nurse Unit Manager (NUM).** A registered nurse in charge of a ward or unit or group of wards or units in a hospital or health service.

**Patient/client/customer**

The literature does not discriminate among the term patient, client, or customer. The three terms are used interchangeably (Australian Council of Health Care Standards Guide 2004). Consequently, I have used the terms interchangeably throughout this paper.

**On-the-job training.**

Gaining of knowledge and skills in the workplace rather than in a formal classroom setting.

**Registered Nurse (RN).** A person registered with a Board ie Nurses Registration Board of New South Wales or Queensland Nursing Council.

**Trainee Enrolled Nurse (TEN).** A person who is being trained to become an Enrolled Nurse in a hospital recognised by the Board as a training school for enrolled nurses.
Assumptions

A number of assumptions are made in this thesis. Nursing care refers to supporting and providing hospitalised patients to do what they cannot manage themselves in a safe clinical manner. In this research I assumed that all levels of nurses could undertake this at a level that meets their competencies and within their scope of practice. There is an assumption that all nurses want to provide the best care they can to their patients and that all nurses would perceive quality care in a different way.

Thesis chapter overview

Chapter one described the background to this research including an overview of issues contained in this research. My background and the reasons for undertaking this study have been put forward and the aims and objectives with key terms and definitions were described.

Chapter two provides a history of Grounded Theory and then continues by describing the methodology of a Grounded Theory research. The process chosen for this research was the Glaserian method as developed by Glaser (1978, 1992, and 1996) and modified over the past 25 years. It was chosen as this type of research supported the emergence of issues as identified by nurses in the clinical area. Rather than describing what is going on, Grounded Theory explains what is actually occurring in practical life and this is one of its strengths. Therefore the aim of this project was to uncover the main problems for clinical nurses on why they were unable to provide quality nursing care.

Chapter three explains the methods and processes undertaken during the research, as the recruiting and selecting participants, the setting where the research was undertaken, process for ethical approval, the process for interviewing participants, coding, constant comparison and other processes for undertaking GT research.

Chapter four is a collection of stories from the participants and describes their journey through their nursing career as well as their thoughts on nursing. A short background of
each participant is provided to explain their history and the stories are presented virtually unedited so the impact of their stories could remain intact.

**Chapter five** describes this study as conducted in accordance with the original methodology as described by Glaser and Strauss (1967) and subsequently refined by Glaser (1978, 1996 and 1998). This chapter describes the design, method and process of grounded theory utilised in this study. The ethics processes, recruitment of participants and the data collection are described. A diagram is presented explaining development of the substantive theory. The basic social problem is described as it relates to the study data and the relevant literature is reviewed and incorporated to support the theory. The development of the basic social process or core category of overloading is overviewed, and the data analysis section of constant comparative analysis is detailed.

**Chapter six** contains the discussion and the related literature. In following the true approach by Glaser (1992) I have not done a preliminary literature review. Rather, with advice and assistance from Dr Glaser through personal communication, I have done a literature review in the substantive area and then woven this into the theory as data were analysed and compared. In this manner the process has allowed me to be as open as possible to discovery and to the emergence of concepts, problems and interpretations from the data.

**Chapter seven** provides the summation for the study and its implications (for the study) as well as implications for health managers and Area Health Services.
CHAPTER 2

METHODOLOGY

We will not cease from exploration and the end of all our exploring will be to arrive at where we began and to know the place for the first time. T.S.Eliot

Introduction

This chapter begins with the reason for selecting Grounded Theory as the theoretical framework for this study, then moves to a history of Grounded Theory and the Glaserian model chosen for this research. The differences between the Glaser and Strauss and the Corbin approach are discussed, followed by a detailed description of the key concepts of Grounded Theory, concluding with GT contribution to knowledge and its future application.

In my research I wanted to develop creative guidelines with substance. GT procedure makes it possible to find out the underlying attributes that nurses identified that impacted on them delivering quality care to their patients. During the inductive stage of the scientific process, the use of observation occurs whereby descriptions, explanations and eventually predictions are produced in the form of hypotheses and theories. Because of the enormous complexity of the inter-relationships involved, the process of inducing general principles from observed data in the field of human study is difficult; however, it is essentially the same process of theory generation that occurs in other fields. The induction of principles which allow description, explanation and prediction has arisen from Empiricism (Chalmers, 1999).

By formalising the process of induction and grounding it in data, Grounded Theory has the ability of producing theory, in the form of working hypotheses, from the level of description and explanation through to the level of prediction. In utilising Grounded Theory methodology it is argued that superior predictability is produced because of its attention to detail, and the rigour built into the inductive process (Chalmers, 1999).
Building theories by testing pre-existing hypotheses that came from somewhere else was the traditional technique of the social sciences. The move to GT development procedures uses data in a new way: to stimulate, and then to shape, the inductive thought processes of the researcher. It is a systematic approach to hypothesis building and theory testing, and it has proven to be very powerful. GT is an emergent methodology and numerous writers have provided arguments to support this approach, for example, Glaser (1978), Strauss & Corbin (1990) and Dick (2005). Dick (2005, p.2) asserts, “the Glaser approach is more clearly emergent and is more clearly justified as emergent” and as such was the methodology of choice for this study.

History of Grounded Theory

GT, Glaser style, is an emergent methodology. The phrase "GT" refers to theory that is developed inductively from a body of data. If done well, this means that the resulting theory at least fits one data set perfectly. This contrasts with theory derived deductively from grand theory, without the help of data, and which could therefore turn out to fit no data at all.

GT was developed, not invented, in the 1960s by two sociologists, Anselm Strauss and Barney Glaser. Anselm Strauss came from the University of Chicago, often referred to as the Chicago School of sociology (Baker et al. 1992), which had a long history and tradition in qualitative research methods (Strauss & Corbin, 1990). Influences on Strauss' writings whilst he was at the University of Chicago were the interactionist and realist approaches. The impacts upon Strauss thinking therefore came from writers such as Robert E. Park, W.I. Thomas, John Dewey, G.H. Mead, Everett Hughes, and Herbert Blumer. This background of information therefore contributed to the Strauss GT method as he became aware of the following: “(1) the need to get out in the field to depict and understand accurately what was going on, (2) the importance of theory grounded in reality to the development and advancement of a discipline, (3) the nature of experience as dynamic and continually evolving, (4) the active role of persons in shaping the worlds in which they live, (5) the importance of change process, the variability and complexity of life and (6) the interrelationships among conditions, meaning, and action” (Strauss & Corbin 1990, p.90).

In contrast, Barney Glaser received his training at Columbia University. At Columbia he was a student of Paul F. Lazarsfeld and Robert K. Merton and received a Ph.D. in
1961. The dissertation was published in the book *Organizational Scientists: Their Professional Careers*. Glaser was strongly influenced by Paul Lazarsfeld, and his colleagues, Herbert H Hymen, Allen Barton, Bruce McPhee, Bernard Bereldson, and considered at that time to be the innovators of quantitative methods. Further, his inductive theory generating methodology was influenced by his adviser Robert K Merton (Glaser 1998, p.21). While involved in some qualitative analysis Glaser realised the need for an explicit and systematic set of techniques and procedures for both coding and testing hypotheses generated from qualitative research methods (Strauss & Corbin, 1990).

In 1967, after developing their method of GT, both Glaser and Strauss joined the faculty of the nursing doctoral program at the University of California, San Francisco (Stern, 1985). As one of their first projects for University of California, San Francisco, Glaser and Strauss obtained a grant to study patients dying in hospitals, which ultimately led to the development of what they subsequently described as a new approach to scientific investigation. These early GT nursing studies focused on: the nurse and the dying patient (Quint, 1967), the politics of pain management (Fagerhaugh & Strauss, 1986), affiliation in stepfather families (Stern, 1978), and the management of chronic illness (Corbin & Strauss, 1988). However, whilst studying dying patients, Glaser and Strauss identified the core categories of dying awareness. This methodology became the “GT Methodology” discussed in the Discovery book (Glaser and Strauss, 1967).

The Discovery of GT (1967) emerged, and has come to represent one of the hallmarks of qualitative research methodologies. Glaser and Strauss went on to publish a number of articles and books either alone or collaboratively over a thirty year period. In doing so they used “Discovery” as their springboard for subsequent research and refinement of the methodology. Possibly the best known of these books are Glaser's *Theoretical Sensitivity* (1978), and *Basics of GT Analysis* (1992) and for Strauss, it was *Qualitative Analysis for Social Sciences* (1987). Strauss and Corbin then collaborated in 1990 to write *Basics of Qualitative Research and GT Procedures and Techniques*.

None of these, however, compares to Glaser's (1992) *Basics of GT Analysis* for evoking controversy and acting as a catalyst for the unfolding drama which would ensue between the numerous supporters and critics of this methodology.
Consequently, there are two major versions of GTM, the Glaserian and the Straussian. Students of Glaser and Strauss in the 1960s and 1970s knew the two had quite different modus operandi of teaching GTM. The differences include the understanding of “constant comparison” and “theoretical memoing and sorting”. In relation to verification, Glaser argued that “rigorous verification methods” could be used for testing a few of the central hypothesis only (Glaser 1992, p.116-117; Glaser 1998, p.22). Moreover, Glaser argued that the Strauss version has its own merits, however it is not GT. Further, Strauss only hinted that, “although many of the essentials of the original method for GT were maintained, there were some differences” (Glaser 1978, p. 56-58, Glaser 1998, p. 25-26).

Assumptions of the GT method

Although Glaser and Strauss never state that assumptions (or label certain criteria as assumptions) underlying the GT method explicitly, assumptions are inherent in numerous writings. The major general assumptions of GT methodology can be summarised as follows:

- Inquiry is structured by discovery of social and social psychological processes.
- Data collection and analysis phases of research proceed simultaneously.
- Both the processes and products of research are shaped from the data rather than from preconceived logically deduced theoretical frameworks.
- Analytic processes prompt discovery and theory development rather than verification of pre-existing theories.
- Theoretical sampling refines, elaborates, and exhausts conceptual categories.
- GT methodology is not only aimed at studying processes, but also assumes that making theoretical sense of social life is itself a process.
- The systematic application of GT analytical techniques leads progressively to more abstract analytic levels (Glaser & Strauss, 1967).

Glaser vs Strauss and Corbin

In his book, Basics of GT Analysis (1992) Glaser critically analyses the work of Strauss and Corbin (1990), as well as other work conducted by Strauss since “Discovery” (1967). Glaser wrote this critique to correct what he believed to be errors made by Strauss and Corbin in order to set “the average researcher back on the
correct track to generating a GT" (Glaser 1992, p.6). Glaser believed both authors' books had changed the original concept so completely from “The Discovery” that it demonstrated an entirely different methodology which he called "full conceptual description" (Glaser, 1992).

Glaser (1992), therefore set out to emphasise the differences between his conception of GT and what others had written, convinced that his version was the "correct one” (p. 6). It was Glaser’s belief that Strauss never really understood the GT methodology in the first place. This resulted in two distinct methodologies emerging: (1) Glaser’s GT approach, which appeared in a number of publications including The Discovery of GT (1967); Theoretical Sensitivity (1978), and Basics of GT Analysis (1992); (2) the full conceptual description of Strauss' method, which originated with The Discovery (1967), then moved to Qualitative Analysis for Social Sciences (1987) and then to Strauss and Corbin's (1990) Basics of Qualitative Research. Whilst these different approaches could seem a little overstated, even perhaps petty to some Glaser readers, they are the essential roots for gaining an understanding of GT. It is evident that by missing the essentials, this could profoundly impact on how researchers both conceptualise and operationalise this method. Nevertheless, the differences between Glaser and Strauss are particularly problematic when attempting to assess the potential value of GT studies in nursing. It is how they view the procedures and processes of GT, coupled with each researcher's different position in terms of its potential adaptability or flexibility of use. As a result, it can be argued rather convincingly (Glaser, 1992) that two somewhat distinct methodologies have evolved based on the original work, each with its own underlying epistemology and attendant properties.

The main force behind Glaser's critique of Strauss' version of GT is that it makes pains of the data through "heaps of rules and fracture methods that are hard to remember and follow, as well as yield low-level abstract description" (Glaser 1992, p. 81). Glaser insists that too many rules hinder effective analysis and serve only to produce a description of a full range of behaviour rather than a GT in a substantive area. However, his belief that the analyst must simply trust in emergence and "humbly allow the data to control him as much as humanly possible" (Glaser 1978, p. 87), is marred by his insistence that GT relies on a series of steps "none of which can be skipped if the analyst wishes to generate a quality theory" (1978, p. 16). He posits that "one must
study thoroughly the methods set forth in Discovery and Theoretical Sensitivity and be prepared to follow them" (Glaser, 1992, p. 17).

Similarly, Strauss and Corbin insist that flexibility is required in this method, stating that "individual researchers invent specific procedures" (1994, p. 276), and "while we set these procedures and techniques before you, we do not wish to imply rigid adherence to them" (1990, p. 59). At the same time, they remind their readers that the procedures and canons of GT must be taken seriously "otherwise researchers end up claiming to have used a grounded approach when they have used only some of its procedures or have used them incorrectly" (Corbin & Strauss, 1990, p. 6).

It is along these lines that Strauss and Corbin (Corbin & Strauss, 1990; Strauss & Corbin, 1990) outline their process for analysing and evaluating GT, which include judgments about generalities, validity and reliability. Also they make judgments about the research process itself and the empirical grounding of the research findings. Judgments made about the research process itself include seven criteria which for example, relate to such factors as how the original sample was selected, what categories emerged, how theoretical sampling proceeded and how and why the core category was selected. Further, both authors make judgments about the empirical grounding of studies that also consist of seven criteria (eg. those relating to questions regarding how concepts were generated, if they are systematically related and if the categories appear well developed (Corbin & Strauss, 1990).

Glaser, on the other hand, takes exception to the guidelines systematically outlined by Strauss and Corbin (1990) in their text concerning the modus operandi they recommend for all three coding strategies. This point becomes particularly evident with regard to Strauss and Corbin's treatment of axial coding, which they view as a process of putting "data back together in new ways by making connections between categories and subcategories" (p. 97). This is done, they argue, through "conceptual elaboration of categories by means of a coding paradigm denoting causal conditions, context, action/inter-actional strategies, and consequences" (Strauss and Corbin, 1990 p. 97). In Glaser's view, this process can all too easily result in researchers missing the relevance of the data by forcing data into a preconceived framework. He believes that Strauss and Corbin's overemphasis on extracting detail from the data by means of a pre-structured paradigm yields full conceptual description at the expense of theory development or generation.
Glaser also makes a number of other points that are of interest here. For example, in Basics of Qualitative Research (1990), Strauss and Corbin (1990) suggest several sources of research problems including suggested or assigned (for example, by a professor to a graduate student), technical literature, and personal and professional experience. They believe that "the research question in a GT study is a statement that identifies the phenomenon to be studied" (p. 38). On the other hand, Glaser constantly stresses that the research problem itself is "discovered" through emergence, which is a natural occurrence from open coding, theoretical sampling, and the constant comparison method.

**Glaser's concepts applied to this study: Overview of GT**

GT begins with a research situation. The situation for nurses in this study was nurses' inability to provide quality-nursing care. Within that situation, the task was to understand what was going on and how the nurses managed their roles within it. This was undertaken mostly through observation, conversation and interview. After each session of data collection it is important to notate the key issues. This is labelled "note-taking".

Constant comparison is the heart of the process whereby there was a comparison of interview to interview to a stage where a theory emerged, as this can occur quickly. As a theory began to emerge it was a matter then of comparing data to theory. The constant comparative method discovers the latent pattern in the numerous participants' words, such as, for example, "not enough time to finish my work", "or the need for constant supervision of junior staff".

The results of this comparison were written in the margin of the note taking as coding. The purpose then was to identify the categories or variables and their properties. During the coding phase, certain theoretical propositions started to occur, for example, the links between categories, or about a core category which was the category that appeared central to this study. As the categories and properties emerged, they became the links to the core category that provided the theory.

The literature is only accessed as it becomes relevant and it is not given any special treatment. Glaser makes the point that most research including qualitative research is
hypothesis testing. In this study, I followed the advice of Dr Glaser and reviewed the literature relevant to my study (Personal contact March 2005).

In summary, data collection, note taking, coding and memoing occur simultaneously from the beginning. Sorting occurs when all categories are saturated, with writing occurring after the sorting.

**Hypothesis testing versus emergence**

What most differentiates GT from much other research is that it is explicitly emergent. It does not test a hypothesis. It sets out to find what theory accounts for the research situation as it is. In this respect it is like action research: the aim being to understand the research situation, as Glaser (1992) states “it is to discover the theory implicit in the data” (p.2). This distinction between “emergence and forcing”, as Glaser frames it, is fundamental to understanding the methodology. It was apparent to Glaser, that the majority of researchers have been exposed to hypothesis-testing research rather than emergent research. In my discussions with Dr Glaser (2005), I was advised that it was important for me in adopting GT methodology that I had to unlearn my previous research techniques acquired through previous readings and retrain myself to the GT approach.

In fact, Glaser reinforced with me the three main criteria for judging the adequacy of the emerging theory; (1) that it fits the situation (2) that it works and (3) that it helps the people in the situation to make sense of their experience and to manage the situation better.

**Data collection**

One of the key points in data collection is to keep one’s eyes open. There is a lot to be learned just by observing, some of it evident within minutes of entering an interview or visiting the research environment. However, in this study, interviews were the main source of information from which the theory was developed. Glaser (1992) however, identifies that any data collection methods can be used. For example, others have used focus groups, informal conversation, group feedback analysis, or any other individual or group activities which yields data. This process occurs in other qualitative research, and is also suitable to GT.
In his book "The GT Perspective" Glaser (2001) discussed data and he states;

"'All is data' is a well known Glaser dictum. What does it mean? It means exactly what is going on in the research scene is the data, whatever the source, whether interview, observations, documents, in whatever combination. It is not only what is being told, how it is being told and the conditions of its being told, but also all the data surrounding what is being told. It means what is going on must be figured out exactly what it is to be used for, that is conceptualisation, not for accurate description. Data are always as good as far as it goes, and there is always more data to keep correcting the categories with more relevant properties." (Glaser 1992, p.145).

The statement "All is Data" is not applicable to Qualitative Data Analysis as it relates to GT methodology only. Data are discovered for conceptualisation to be what they are a theory. The data is what it is and the researcher collects, codes and analyses exactly what s/he has, be it baseline data, proper data, interpreted data or vague data. There is no such thing for GT as bias data or subjective or objective data or misinterpreted data. It is what the researcher is receiving, as a pattern, and as a human being and it all depends on the research.

**Note-taking**

While Glaser (1992) recommends against recording or taking notes during an interview session, in this study it was decided to take the approach of tape recording all interviews. Many first time converts to GT, do not want to miss opportunities for data collection and want to be able to concentrate on the non-verbals of the participants as these can also be revealing. Others who discussed their interviewing techniques at the GT seminar (San Francisco, March 2005) had mixed ideas. For example, one suggested he would get more understanding from the extra interviews undertaken than listening to and transcribing a tape recording. Others take down key words. No matter what the method it is important to make notes as soon after an interview as possible.
Following the data collection, it should be analysed concurrently by searching for all possible interpretation by employing particular coding procedures. The coding process analysis is the heart of GT whereby the naming and categorisation of data begins (Babchuk, 1997).

Coding

During this coding process, the analyst compares incident to incident with the purpose of establishing the underlying uniformity and its varying conditions (Glaser, 1978, p. 49). Such a description of coding is applied readily to an 'observed' setting. In the case of written narrative where storytellers are describing their own experiences, this concept of coding must be also include expressed thoughts, beliefs, feelings and described events and relationships. The coding model used by Glaser, is based on first comparing indicator to indicator, then the emerging concepts to indicators. According to Glaser, there are two types of coding without a clear boundary within the 18 theoretical coding families, these being open coding and selective coding. Accordingly, Glaser notes that "it is necessary for the grounded theorist to know many theoretical codes in order to be sensitive." (Glaser 1998, p.170-175).

The coding process, consists of three types of coding, these being open, axial, and selective. Open coding is the initial process in GT that involves breaking down, analysis, comparison, and categorisation of data. In open coding, incidents or events are labelled and grouped together using the constant comparison method to form categories and properties. These labels refer to things like hospitals, information gathering, relationships, empathy, and so on. They are the nouns and verbs of a conceptual world and describe the action and behavior of the participants. Part of the analytic process is to identify more general categories of which these things are instances, such as institutions, work activities, social relations, social outcomes, and so forth. Axial coding, on the other hand, represents the delineation of hypothetical relationships between categories and subcategories. Selective coding is best described as the process by which categories are related to the core category, ultimately becoming the basis for the GT (Glaser, 1978, p. 49).
Figure 2.1: Diagram of page setup for notes, coding and memos

![Diagram of page setup for notes, coding and memos]


Having reached the stage where the researcher has a set of interview notes which are written in the left hand two-thirds of the page, it is important to include any bio-data identified about the person interviewed at the head of the notes. The method suggested by Dick (2005) on writing notes with the margins for coding was utilised and this is depicted above.

Then, it is time to begin coding, taking a sentence at a time and examining it, while at the same time, making memos which will become an essential and beneficial step in the process. The researcher scrutinises each line, sentence, and paragraph in search of the answer to the repeated question “What is this about, what is being referenced here?” As the analysis of the data is scrutinised line by line, it will become apparent that an incident can be found in phrase or one-two sentences or occasionally in a word or a paragraph. It is important therefore to try and code the data in every possible way “running the data open” as Glaser describes it (Glaser 2004, p.13). The researcher must constantly ask themselves the rules for coding data and asking questions as suggested by Glaser (2004 p.13), these being:

- “What is this data a study of?
- What category does this incident indicate?
- What is actually happening in the data? What is going on here? What is happening?
- What is the participant's main concern?
• What is the Basic Social Psychological Process or Social Structural Process that processes the main problem that makes life viable in the action scene?” (Glaser 1978, pp. 56-58).

By following these questions it is possible to maintain theoretical sensitivity. At the same time it is vital that the researchers do their own coding as coding stimulates ideas and from these ideas other ideas are generated.

A simple coding example of being overworked is:
"When I know in advance I will have an awful day, I would take a sickie. The next day I feel guilty".
Condition: have
Phenomenon: awful day
Strategy: take a sickie
Consequence: feel guilty

**Selective Coding**

The next step in the process is selective coding, whereby one category is chosen to be the core category, and then relating all the other categories to that category. The essential idea is to develop one storyline around which everything else is encapsulated. Glaser’s belief is that such a core concept always exists. Selective coding is therefore about finding the driver that impels the story forward.

**Constant comparison**

At the first interview a researcher is merely asking themselves the first questions. What is going on here? What is the situation? How is the person managing that situation? Therefore, what categories has each word or sentence suggested? With the second interview, one codes with the first interview in mind and each subsequent interview with the emerging theory in mind. In this manner, the researcher is undertaking constant comparison, as s/he is initially comparing data set to data set; and then later comparing data sets to theory.

The constant comparative method is central to the data analysis in generating grounded theory. Using this method, all the sample codes generated are compared
repeatedly within and between each other until the basic properties of a category or construct are defined. "Comparative analysis forces the researcher to 'tease out' the emerging category by searching for its structure, temporality, cause, context, dimensions, consequences and its relationship to other categories" (Hutchinson, 1988, p. 135). Additionally, it is appropriate and desirable to compare the data categories and constructs that emerge between various groups of participants in the study. In this way the process of constant comparison is intended to generate a theory rich in detail.

For example, in this study, RNs were asked to explain the work they do. The first two people mentioned having to organise themselves or organise work. This was tentatively coded as "organising" along with other codes. Similarly, other participants were asked what impacted on their day significantly, with answers such as questioning, supervision of others, preceptoring and so forth. These were tentatively coded as "training".

**Saturation**

As the researcher continues to collect and interpret the data around a particular category, a point of diminishing returns is reached. In these instances further interviews eventually add nothing to what is already known about a category, its properties, and its relationship to the core category. When this occurs coding is ceased for that particular category, and saturation had been reached.

This means that no new properties, dimensions, or relationships will emerge during analysis. Saturation is "the state in which the researcher makes the subjective determination that new data will not provide any new information or insights for the developing categories" (Creswell, 2002, p.450). Theoretical saturation is realised when;

- no new data comes out concerning a category;
- the category is intense enough to cover variations and process; and
- relationships between categories are delineated adequately (Brown, Stevenson, Troiano & Schneider, 2002).

According to Goulding (1999) a theory is only considered valid if the researcher has reached the point of saturation. This involves staying in the field until no new evidence emerges from subsequent data. It is also based on the assumption that a full
interrogation of the data has been conducted, and negative cases, where found, have been identified and accounted for.

**Categories and properties**

A category, in effect, is a theme or variable which makes sense of what the participants' have said and in light of the situation being studied. In the two sentences considered above, it has already been mentioned that "planning" was a tentative category. What is different between the two sentences is that one is about planning time; the other is about planning work. As the study progresses these may well end up being a property or a sub-category, of planning.

**Core category**

As the researcher continues to code, one category will usually be found to emerge with a high frequency of mention. This in turn will become connected to many of the other categories, which are emerging. In this study a core category began to emerge and this was conceptualised as “workload” which represented the way nurses made the most of their staff resources, managed their daily activities, and undertook staff training. Ultimately, this remained the core category. However, one has to be cautious, as the researcher needs to be aware that it is hazardous to choose a core category too early in the data collection. Nevertheless, when it is clear that one category is being mentioned frequently and it was well connected to other categories, it is safe to adopt this as the core category. Subsequently, as the researcher is coding there is always the opportunity to identify more than one core category, however, Glaser (1998) recommends focussing only on one core category at a time and this occurred in this study.

Once the core category is identified, coding any sentences that do not relate to the core category is ceased. During this stage, the researcher should find that the coding rapidly becomes more efficient as the researcher progresses through the data. Once non related data is identified, coding for the core category, other connected categories, and properties of both is undertaken. The researcher then records any identified connections between categories in the memos, adding to the sample as necessary, until saturation is reached.
Theoretical Sampling

The initial sample in any GT study is defined by the choice of the research situation. As the categories emerge from the data, the researcher seeks to add to the sample in such a way that there is a further increase in diversity, but in useful ways. The purpose is to strengthen the emerging theory by defining the properties of the categories, and how those mediate the relationship of category to category. Glaser and Strauss (1967) refer to this as theoretical sampling. The sample is emergent, as is the theory and the method generally.

Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes the data and decides what data to collect next and where to find them, in order to develop a theory as it emerges. This process of data collection is controlled by the emerging theory, whether substantive or formal (Glaser, 1978, p. 36). Theoretical sampling begins during the data collection phase of the study and involves searching the transcripts for emerging categories that characterize the narrative and seem significant. "Theoretical sampling is used as a way of checking on the emerging conceptual framework rather than being used for the verification of preconceived hypotheses" (Glaser, 1978, p. 39). Saturation is achieved when all the data fit into the established categories and no new categories emerge from the data (Glaser, 1978).

Memoing

This is an integral component in data analysis and as already mentioned, memoing continues in parallel with data collection, note-taking and coding. A memo in effect is a note to the researcher about some hypothesis they have about a category or property, and particularly about relationships between categories. Glaser makes the point, that memoing is given high priority. As an idea is generated, it is important for the researcher to write memos to remind him/her of the idea.

As the researcher continues to analyse the transcripts, the core category and the categories related to it become saturated, at which time the researcher has usually accumulated a large number of memos. These memos have the ability to capture the different aspects of the theory which have emerged from the data. Consequently, the
researcher has to assume the theory is concealed in the data ready to be discovered. In other words, coding makes visible some of its components, while memoing adds the relationships, which link the categories to each other. The next task is to decide on how to structure the report to communicate the theory to others. That becomes the next stage, the purpose of sorting.

Equally important to memoing is the theoretical note. A theoretical note is anything from a post-it that notes how something in the text or codes relates to the literature, to other studies and other information. Writing theoretical memos allows you to think theoretically without the pressure of working on "the" paper. The final theory and report is typically the integration of numerous theoretical memos.

**Sorting**

There are numerous methods used for collecting memos and notes, with a particularly popular method being the use of cards. The reasons are they are easier to carry, so one can jot down ideas whenever they occur and they are easier to sort. Similarly there are numerous methods for sorting the memos and notes such as using a table or sticking them on a white board or even on the floor. The essence of sorting is to group the memos on the basis of the similar categories or properties that they address, and then arrange the groups to reflect their relationship. The intention is that this layout in a two-dimensional space will capture the structure of the eventual report or thesis. These are then gathered together in the sequence that will allow the structure to be described in a logical manner. This then is the framework which provides the basis for the writing up.

**Writing up**

Having done all this coding, memoing and sorting, the researcher will find the writing process is less of a chore than it might otherwise be. This is because the process of sorting the data provides the structure for the report writing. Then, it is often just a matter of preparing a first draft by typing up the memo cards and theoretical notes in sequence and integrating them into a coherent argument. As Dick (2005) explains, grounded theory is a study that works through mostly-overlapping phases and over time. Dick (2005) summarises this graphically and this is depicted below. Therefore, a
simultaneous process occurs whereby data collection, note-taking, coding and writing of memos occur from the start of the data collection. Sorting occurring when all categories are saturated, with writing up of the study occurring following the completion of sorting.

**Figure 2.2: Overlapping phases in GT research**

![Diagram of overlapping phases in GT research]

**Source:** Dick, Bob (2005) Grounded theory: a thumbnail sketch.

**The place of literature**

There are two important points to be made about the literature. The first is that, in an emergent study, the researcher will probably not know at the beginning which literature will later turn out to be relevant. This has implications both for the place of reading in the research process and in writing the report. The second is that the literature is not given a position of privilege when compared to the data. It is treated as data, with the same status as other data (Glaser, 1998).

**Literature as emergent**

In other types of research methodologies, researchers should first examine the relevant literature, with studies usually not starting any data collection until well into the research process. In an emergent study, the researcher begins collecting data as soon as a research situation is identified. It is only then, when the researcher accesses the relevant literature to support data.

Glaser (1978, 1998) makes much of the prior background reading, which provides the models to help make sense of the data. He recommends reading widely while avoiding the literature most closely related to what you are researching. His fear, which is
shared by most grounded theorists, is that the reading may otherwise constrain the coding and memoing. This was reinforced to me personally during a Grounded Theory Seminar with Dr Glaser in 2005. This is further supported by Goulding (1999) who assert that applying grounded theory to the areas where an extensive, reliable and empirically based literature exists may cause some difficulties. Literature which already exists might prejudice or affect the perceptions of the researcher (Goulding, 1999).

The constant comparison of data remains the core process, with the aim being to read and compare literature to the emerging theory in the same way that the data is compared to the emerging theory. For example, the researcher might follow the same procedure of data-collection (in this instance reading), overlapping with note-taking, coding and memoing. Importantly, the key issue is how the apparent disagreement between the emerging theory and the literature is treated. Researchers must never assume that their theory is wrong; rather the concern is that the theory fits the data and its ability to make sense of actual experience. Simply, the researcher seeks to extend the theory so that it makes sense of both the data from the study and the data from the literature.

**Ensuring Rigor and Empirical Grounding of the Study**

Just as the grounded theory method of analysis is not applicable to experimental studies that seek to verify hypotheses; neither should the criteria for scientific rigor derived from positivistic origins be applied to the grounded theory method. Positivistic notions of validity, reliability and generalisability cannot be applied in the same way to qualitative research. Nonetheless, there must be some criteria by which the quality of grounded theory research can be evaluated. Additional GT researchers such as Sherman and Webb (1988) identify six such categories including the degree of fit, functionality, relevance, modifiability, density, and integration.

The degree of fit is described as resulting in codes and categories that are derived from the data and not forced. This lends credibility to the study in that the appropriateness of the fit can be easily understood by others not directly involved in the study. "Since most of the categories of grounded theory are generated directly from the data, the criteria of
fit is automatically met and does not constitute an unsatisfactory struggle of half fits" (Glaser, 1978, p. 5).

Further, Glaser (1978, p. 5) suggests that "it is important to constantly refit [categories] to the data as the research proceeds to be sure they do fit all the data they purport to indicate." Although Sherman and Webb (1988) do not use the term 'functionality' per se, it is their intended meaning for describing a theory that 'works.' As such, a functional theory explains variation in the data and the interrelationships among the constructs in a way that produces a predictive element to the theory (Sherman and Webb. 1988). They further describe a quality theory as one that possesses relevance related to the identified core variable or basic social psychological process. Relevance evolves through the emergence of a core variable from the data in a way that is neither forced nor concocted and is a result of the researcher's theoretical sensitivity to the milieu. Relevance is verified through the immediate recognition by the participants in the study of the importance of the phenomenon - a form of recognition that sometimes has been described as the "ahhh haaa" phenomenon. The fourth criterion of a well-grounded theory is its ability to reflect and accommodate the fluctuating nature of the phenomenon being examined. As such the theory must be flexible and modifiable. The fifth criterion is density. A theory is said to be dense when it "possesses a few key theoretical constructs and a substantial number of properties and categories" (Sherman and Webb, 1988, p. 138). The last criterion described is that of integration. A systematic relationship between the constructs and propositions is thought to ensure an appropriate fit into a tight theoretical framework (Glaser and Strauss, 1967).

A series of questions has been put forth by Strauss and Corbin (1990, p. 254-256 which they view as appropriate criteria for examining the empirical grounding of a study. These questions are:

1. “Are concepts generated?
2. Are the concepts systematically related?
3. Are there many conceptual linkages and are the categories well developed?
4. Do they have conceptual density? Is much variation built into the theory?
5. Are the broader conditions that affect the phenomenon under study built into its explanation?
6. Has process been taken into account? (explanations that describe change must be linked to the conditions that caused it)
7. Do the theoretical findings seem significant and to what extent?" (Strauss and Corbin, 1990, p. 254-256).

The criteria described by Glaser and Strauss (1968), Sherman and Webb (1988) and Strauss and Corbin (1990) provide a sufficiently broad perspective from which to evaluate the quality of a grounded theory. Perhaps one additional criterion that would lend credibility to the theory is a measure borrowed from other qualitative research genres, that of audibility. The provision of an audit trail provides evidence for the way in which processes are carried out and decisions are made, thus making the process both visible and verifiable to others who might wish to closely scrutinise the theory.

**Integration of theory**

Throughout the process of theory generation, there is interaction with the data and the researcher uses memos to assist with conceptualisation of the theory. Three key strategies are used to develop and add density to the emergent theory (Carpenter 1995; Glaser 1978; Stern 1980):

1. **Category reduction.** Initially, a large number of categories are identified. Clustering categories and subsuming categories within larger categories can reduce these.

2. **Selective sampling of the literature.** The existing literature is another form of data, and is integrated within the emerging theory, categories and subcategories.

3. **Selective sampling of the data.** As the theory, categories, and subcategories are identified, more data are collected from the field in order to develop and test hypotheses and uncover properties of the main categories.

**Basic psychosocial process**

Glaser (1978) in his original work was very clear that GT should identify a basic social process (BSP). In his later writings “Doing Grounded Theory”, Glaser (1998) amended this term to include psychosocial processes. In his paper, Cutcliffe (2005) explains Glaser’s concept by stating “the outcome of a GT study should be a core variable, the parsimonious conceptual element that explains how participants resolve their key social/psychosocial problem” Cutcliffe (2005, p. 425). In his own writings, Glaser (1978)
indicated that the variances that occurred over time in BSP came from two or more emergent stages that account for patterns of variance in behaviour. Having identified workload as an issue in this study, participants continuously discussed how they managed to reduce this workload or find ways around it. For example, finding ways to take short cuts, skipping some process steps when undertaking basic care, inducting students to the same methods and delegating jobs to subordinates. In this manner participants were able to how they resolved their key psychosocial problem by "working around" to minimise their workload.

**Future applications**

GT is rapidly gaining momentum in the social sciences, health care, and in particular clinical and other forms of nursing research (Babchuk, 1997). Yet, there is considerable disagreement among its co-founders concerning the implementation of this approach (Babchuk, 1997). Reflective of this ambiguity, and to further confuse matters for the potential grounded theorist, relatively few researchers who have conducted GT analyses have outlined the specifics of their research, often failing to provide information concerning the process they employed or the methodologically related decisions they surely must have made. This methodology, however, appears to hold considerable potential for the study of nursing problems and issues. Given its focus on generation of theory from data collected in the field, it seems ideally suited for clinical nursing situations, a discipline which is characterised by its well-developed theoretical foundation and a strong commitment to the world of practice.

In an endeavour to explain or prescribe the practice of nursing, nursing professionals have tried to apply a number of theories to describe nursing practice. This leads to the exploration of a range of 'models' or conceptual frameworks including for example: Henderson's Nature of Nursing (1969); King's General Systems framework (1971); Roy's Adaption Model (1984); Orems' Self Care Framework (1985); Roper, Logan & Tierney's Activities of Living (1985), and Peplau's Theory of the Deliberative Nursing Process (1988). Consequently, these nursing theorists have each developed their own theories to assist nurses identify the base for professional practice and caring. More recently Van Sell & Ioannis (2001) identified that "The Global Health Web, the Human Being Theory, the Self Observation Methodology and the Complexity Integration Nursing Theory provides a global language in order to describe complex phenomena

Nevertheless, as a framework, GT not only offers nurses a time-honoured qualitative research strategy as an alternative approach to more traditional methods of investigation, but provides a viable means for researchers and practitioners to generate theory grounded in the realities of their daily work and in the philosophy of nursing as a caring profession. Also, GT aims to operate at all three of these levels by using induction to produce descriptions, explanations and hypotheses, which may eventually be put to work in a deductive research enterprise, in the tradition of science.

GT not only offers nurses’ a time-honoured qualitative research strategy as an alternative approach to more traditional methods of investigation, but provides a viable means for researchers and practitioners to generate theory grounded in the realities of their daily work.

**Conclusion**

GT is a useful methodology for the study of interpersonal activities between nurses and patients and others, as social interaction is at the heart of nursing care. It is particularly useful when little prior research has been undertaken in a specific area of research. This methodology provides a helpful framework for guiding data collection and analysis, unlike some other approaches to qualitative studies.

The methodology described in this study provided the basis for understanding the key principles of this approach and how it was used in this study. The chapter begins by explaining the history and background of the founders of GT, and then moves to a critique of the major contributors to this methodology. The chapter continues by explaining the key characteristics of GT, ranging from sampling, data collection, coding, theoretical sensitivity, saturation and write up. The core category of workload was identified and the BSP that participants used to solve their problems was “working around”.

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As a research methodology, GT is still evolving, obvious in the fact that the two co-founders came to disagree about the fundamental philosophical and procedural issues within their methodology. Nevertheless this methodology has provided a valuable tool for studying the clinical situation encountered in this study.
CHAPTER 3

METHODS AND PROCESSES

“The difference between particularistic, routine, normative data we all garner in our everyday lives and scientific data is that the latter is produced by a methodology. This is what makes it scientific” (Glaser 2004, p.1).

Introduction

GT is a qualitative methodology derived from the practice of generating theory from research, which in turn is grounded in the data. The methods and processes utilised during this study are the focus of this chapter. The process of doing GT is outlined in Figure 3.1, p 36. Due to my position in the Health Service at the time of this study, and to eliminate the perceived power of my position, ethical considerations were paramount for each participant. Therefore, the process of ethical approval, recruitment of participants and the setting are described. A description is provided on how saturation of the data was reached and analysis of the data as codes, categories and the Basic Social Process (BSP) of Working Around emerged. The Fit of the project to the methodology is also described in this chapter.

Recruiting and selecting participants

It was anticipated that 20 participants would be recruited, five from each of the four participating hospitals. An expression of interest was distributed via the Executive Officers/Directors of Nursing requesting nursing staff who were interested in participating in the study how and where to apply. It was proposed that if there were large numbers of applicants from the expressions of interest, random sampling would to be used to select those participants considered to be expert nurses in the area of clinical nursing practice (Roberts & Taylor, 2002). However, there was very little interest generated initially so I resorted to advertising in the local paper and word of mouth contacts. Consequently, I was able to attract 18 possible participants from both sexes, diverse ages and backgrounds, both chronologically and professionally. Once I explained the study and the process, there remained 16 nurses willing to participate. Of
these, one moved overseas prior to the interview and I was unable to conduct the interview due to the short time frame and my work schedule. Of the remaining 15 participants, three others withdrew prior to interview and of those who remained, five were male and seven female. Age was not considered a factor in this study due to the wide diversity of all nurses in the workforce. However, length of nursing services was considered, with workforce ages ranging from one year to 40 plus years. Participants were then contacted again and sent a plain language statement (Appendix D) explaining the study. A written consent form (Appendix E) was then obtained from the interested participants.

**The setting**

The settings were health care facilities within the Area Health Service (AHS) in which I worked at the time. One was a 200 bed rural facility and the others were smaller rural hospitals. All interviews were unstructured, and were held at various venues such as coffee shops or at participants’ homes to ensure participants were as relaxed as possible and in an environment where they were comfortable.

**Ethics**

Due to the personal nature of this study, a number of strategies were employed to safeguard the human rights of staff and to ensure the project complied with the ethical standards set down by Southern Cross University (SCU) and the AHS. To initiate the research it was necessary to gain approval from the Area Health Service Ethics and Research Committee and this I did by sending a letter of request (Appendix A). To ensure all participants had sufficient information, I ensured the participants had the right to full disclosure. All participants received a plain language statement (Appendix D) both verbally and written of what the research involved, the aims and the processes of the project, and the participants’ commitments. Bearing in mind that the nurses interviewed were all at different educational status and cognitive ability, written information was provided relevant to their comprehension, with the plain language statement written in simple English.

Participation in the study was voluntary. All nurses who volunteered to participate were offered the right to refuse or to withdraw from the study at any time without penalty or
coercion. Participants were given the opportunity to ask questions, make comments and voice any concerns they had regarding the study.

As a senior nurse within the Area Health Service at the time of the data collection, it was imperative that nursing staff perceived me as a researcher and not as a Director of Nursing. To overcome the perceived “power over” staff phenomenon, confidentiality and anonymity was maintained throughout the study with participants assured that as a researcher, confidentially and ethical commitment was ensured across all aspects of the study. The participants were assured that was an imperative from both the Area Health Service and the University.

The method for recording interviews was using tape recordings, despite the Glaserian model of not advocating this method (Glaser, 1967; 1998). I found by recording interviews I could concentrate on the participants’ body language and expressions rather than taking notes. Nevertheless, I did jot down a word or two and I took field notes immediately following each interview. Prior to audio taped interviews, pseudonyms were developed and used in place of the participant’s real name. Further, audio-tapes did not contain real names of any health professional or setting disclosed during the interviews. All written and audio taped material pertaining to the interviews are stored in a secure place by the researcher. The audio-tapes and transcripts have been secured in a locked cabinet and will remain there for 5 years according to the NHMRC (1992) guidelines, with the safety and security residing with the researcher. Access to the material will be limited to the researcher and supervisors.

The prospective study was discussed with other Executive Officers/Directors of Nursing within the Area Health Service and their letters of approval being retained with the AHS Ethics Committee. As previously stated, full ethical clearance was gained from the Southern Cross University (Appendix B) and the Mid North Coast Area Health Service Ethics Committee (Appendix C) prior to commencement of the study.
Figure 3.1 The Process of Doing GT

Enter Research

Data collection
- Interviews, memos, observation, notes

Substantive coding
- open coding
- selective coding

Memo writing and field notes

Constant comparison of data

Theoretical coding

Concepts and categories

Write up

Author: J Flynn and developed in consultation with the Dr B. Glaser, New York 2005
Unstructured interviews

In depth interviews utilising an unstructured interview process, skilled observation and documentation were used to generate data for this study. During the interview process, participants were asked to share their perceptions of what quality nursing care is and what they perceive to be outcomes of care that they believe should be provided for patients.

The interview process

My interview style emphasised the importance of developing rapport with the participants. It was reflective and, with appropriate cautions, self-revealing. I used the language of the participants so as to avoid naming their experiences for them. Through active listening, I made every effort to provide an atmosphere of engagement and trust which allowed participants to develop ideas and construct meaning, to share attitudes and feelings which typically are not quantifiable and usually are missed in survey and structured interview research.

I then went on to describe the process by discussing with the participant the purpose of the interview, what the project was about and what the interview process would consist of. I then obtained and reviewed their written consent and reminded each participant that their participation in the project was dependent upon their written consent. A copy of the consent was provided to each participant to verify their signature.

I anticipated that participants may wish to introduce new questions of their own and that they would request personal information about me or information about the progress of my study, either or both of which I openly shared with them. I also anticipated that the interview process would evolve in such a way that the narrative assumed a more conversational character. While my own self-disclosure served as a model of openness to aid in building trust with the participants, the degree to which I disclosed information about myself was not without risk to the participants. Regardless of my intent as a researcher, it has been suggested that participants in a study may not always receive a researcher’s self-disclosure in a constructive way (Reinharz, 1992). I proceeded with caution, however participants were open and honest and I was provided with excellent feedback when asking participants how they felt post interview.
The data generation involved asking the participants to describe nursing care in relation to how they believed it should be delivered. The initial interview question focused on the participant being asked "Can you tell me in your own words what quality nursing care means to you?" Other areas were explored as they arose, for example, when participants talked about why they were unable to provide quality care I explored the reasons why they believed this to be the case. The interviews ended when no further information, themes or ideas were forthcoming. The interviewer provided the participants with a summary of the main points and a transcript was sent to each participant for him/her to read as a record of the interview.

**GT nomenclature**

In GT research there are a number of classifications that do not appear in other methodologies. For example, a concept is the overall element and includes the categories which are conceptual elements standing by themselves, and properties of categories, which are conceptual aspects of categories (Glaser & Strauss, 1967). Further, the core variable explains most of the participants’ main concern with as much variation as possible. It has the most powerful properties to picture what’s going on, but with as few properties as possible needed to do so. For example, a popular type of core variable is the “basic social process”. This accounts for most of the variation in change over time, context, and behaviour in the studied area (Glaser & Strauss, 1967).

**Data analysis**

The audio taped interviews were transcribed verbatim and word-processed onto a computer disc. Transcription of the interviews occurred as soon as practicable following each interview and constant comparative data analysis commenced following the first interview. This was to facilitate simultaneous collection, coding and analysis of the data, thus providing a focus for the subsequent data collection as described by Glaser (1978). Constant comparative analysis involves relating data to ideas, then ideas to other ideas. This is done through “coding” the data.
Coding

As tapes were transcribed, the printed interviews were analysed word by word, line by line, and sentence by sentence. As I did this, codes were allocated next to phrases, words or comments. Labels were given to emerging themes and then coded. As I continued to code I would write additional memos of important ideas so they were not lost. Codes were then sorted into categories and redefined into further categories from which constraints and theory started to emerge. Literature was used concurrently to test and validate emerging themes. Glaser (1978) states:

“The essential relationship between data and theory is a conceptual code. The code conceptualises the underlying pattern of a set of empirical indicators within the data. Thus, in generating a theory by developing the hypothetical relationships between conceptual codes (categories and their properties) which have been generated from the data as indicators, we “discover” a GT” (p.55).

Coding is conducted at two levels, substantive and theoretical, and according to Glaser (1978).

“Substantive codes conceptualise the empirical substance of the area of research. Theoretical codes conceptualise how the substantive codes may relate to each other as hypotheses to be integrated into the theory” (p. 55).

During this phase of the study, I used two methods of coding, substantive or open coding and selective coding. In the first instance, I coded freely for as many categories as I could find, in other words, anything and everything that might fit. They were three questions I continuously asked of the data, as indicated by (Glaser 1978, p.57).

1. "What is this data a study of?” In other words, it’s about discovering the core variable.
2. “What category does this incident indicate?” This question helped me think both conceptually and theoretically. I discovered that as the theory emerged, this
question became easier. Also by continuing to ask myself this question I was not
distracted by irrelevant codes.
3. “What is actually happening in the data?” The design of this question is to get at
the social structural issues and problems being addressed by the participants. In
other words, what accounts for the basic problem and process? (Glaser, 1978
p.57).

I continued the process of open coding, or “running the data open” until a set of
categories and their properties had emerged that fitted, worked and were relevant to
the theory.

**Constant comparison**

During the first interview I was asking myself: What is going on here? What is the
situation? How is the person managing that situation? Therefore, I asked myself, what
categories are suggested in each sentence? I then coded the second interview with the
first interview in mind and I coded each subsequent interview with the emerging theory
in mind. By firstly comparing data set to data set and then later comparing data set to
theory, I was undertaking the constant comparison method.

**Categories and properties**

A category is a theme or variable which made sense of what my participants had said
during their interviews and this was interpreted in the light of nursing quality care, other
interviews, and the emerging theory.

**Core category**

After a time one main category was found to emerge with high frequency and it
appeared to be connected to many of the other categories which were emerging. This
became my core category. I had to avoid choosing the core category too early in the
data collection, however, it was clear that one category was mentioned frequently and
that is was connected to other categories. Consequently, I believed it was then safe to
adopt this as the core category. Had there been more than one core category
emerging, Glaser recommended focussing at one time on one only, and then re-code for the others later (Glaser 1978, p.61).

When the core category had been identified, I ceased coding any sentences that did not relate to it. Consequently, as I progressed through the interviews, I found that in most instances the coding rapidly became more efficient. I then coded for the core category, other connected categories, properties of both and recorded any identified connections between categories in memos until I reached saturation.

Saturation

In collecting and interpreting the data about a particular category, I reached a point of diminishing returns and eventually the interviews added nothing to what I already knew about a category, its properties, and its relationship to the core category. When this occurred I ceased coding for that category as I had reached the point of saturation.

Selective coding

As visible patterns emerged and a core variable was discovered, I moved to “selective coding” or “theoretical sampling”. In other words, I was theoretically sampling data that supported the emerging theory. However, I had to be cautious that it was safe to move to selective coding and to achieve this I had to ensue total saturation had occurred and that no additional information was forthcoming from the data. Selective coding therefore is about delimiting the coding to variables that only relate significantly to the core variable (Glaser 1978, p.61). For example, in this study all participants discussed their workloads and this then became the guide for other data collection and to limit the study to this one core variable.

Theoretical coding

Theoretical coding conceptualises the substantive codes and how they relate to each other as hypotheses that are integrated into the theory (Glaser, 1978, p.72). For example, the category “dialoguing” reflected the codes within that category such as talking to patients, managing complaints, team meetings and so forth.
Field notes

At the end of each interview, notes were made in relation to the participant’s body language, manner, voice presentation and concerns, which assisted me to understand the person better. For example, a number of participants were angry that management was not listening to them about their working arrangements and the amount of non nursing duties they were required to do. An example of a field note that I had written in the margin is; (1) **I noticed that when I discussed management with staff a number of them became quite frustrated at or by management.** (2) **I noticed T was excited when discussing emergency nursing and obviously loved it.**

Memos

“Memos are the theorising write up of ideas about codes and their relationships as they strike the analyst while coding” (Glaser 1978, p.93). Memoing continues in parallel with data collection, note-taking and coding. In effect, a memo was a note to myself about some hypothesis I had about a category or property, and particularly about the relationships between categories. Glaser makes the point, that memoing is given high priority. As an idea occurred I wrote a memo to myself. To do this I carried a notebook for jotting down these memos.

As I progressed, the core category and the categories related to it were saturated and when this occurred, I had accumulated a large number of memos, which captured the different aspects of the theory that had emerged from the data.

All ideas generated during the process of coding and comparing were put into memos and these were than sorted according to their categories. Memoing provided me with the bridge between the emergent theory and the data and therefore this took precedence. However, during this process, I did discover that memoing, data collection and data analysis were ongoing and overlapped many times. However, memoing prevailed and I found myself writing copiously to the point where I would take a pen and pad to bed to write up ideas when I woke at night. I also discovered, at a personal session with Dr Glaser (April, 2005), I had many other memos that were the transcripts from the participants’ interviews. I was then able to stick and paste themes together as concepts.
Sorting

This refers to the conceptualising of the memos rather than sorting the data. This process is about integrating and organising the many memos and transcripts I had collected as I analysed the data into conceptual relationships. This would then form the outline of the theory as it emerged. My reason for using a small spiral notebook for memoing was twofold. It was easier to carry, so I could jot down ideas whenever they occurred to me, and the pages can be removed easily, thereby making sorting less difficult. For the actual sorting I worked on a large table or on the floor depending where I was at the time. Firstly, I grouped them on the basis of the similar categories or properties they addressed. I then arranged the groups to reflect on their relationship.

As the data collection and coding proceeded, the codes and the memos accumulated, and these were then added to the sample, which is identified by Glaser (1998) as theoretical sampling. Theoretical sampling is the purposeful process of sampling which increases sample diversity by searching for different properties. As the core category and its linked categories saturate, the researcher no longer adds to them or their properties. At this stage it is time to move to sorting where the memos are grouped together with any additional notes that have similarities to each other. These are then placed in sequence, which in turn assists the theory development, with the order of the sorted memos providing the skeleton for the thesis. Once this stage is reached it is time to start writing.

Writing up

Having done all this, coding, memoing and sorting, the writing became less difficult than it might otherwise have been, as I basically had the framework to write by. In other words, this sort structure became the report structure. Initially, I prepared the first draft by typing up the memos in sequence and integrating them with the transcripts from participants as described in the data analysis in Chapter 5.

Theoretical Sensitivity

This refers to the personal quality of the researcher, which has been defined as “the ability to recognise what is important in the data and to give it meaning” (Glaser 1978, p
(3) To gain theoretical sensitivity means that the researcher has no predetermined ideas prior to entering the setting, thereby remaining sensitive to the data that emerges. Therefore, one has to remain open to what is actually happening in the research to be able to record events and happenings without any preconceived ideas or bias (Glaser, 1978). Additionally, theoretical sensitivity, as identified by Glaser (1978), was gained by a preliminary review of the literature which provided sensitising cues about the phenomenon of overloading in both the cognitive area and the clinical environments where nurses work. In reviewing the literature, the researcher was mindful about the risk of tainting her view of the field, thereby hindering the development of categories (Glaser, 1978). Professional experiences, informal discussions, formal dialogue with nurses caring for acutely ill patients provided additional sensitising cues.

Grounded theory begins with a research situation and, with this in mind, the researcher needed to understand what was happening in busy clinical areas and how nurses managed their roles and workloads. This was achieved through observation, dialogue and interviews with staff. As this occurred, I made notes and recorded interviews from participants. As each interview progressed, I compared data and identified that indeed, a theory was emerging. I continued to write copious notes in the margins of transcripts and gradually coding commenced. Eventually as data collection and coding proceeded, categories and properties emerged and links were identified between categories that were central to the study. The written information at this point became my memos. As my core category and its linked categories became saturated, I no longer added to them or their properties. At this stage I moved to sorting by grouping the memos, like with like, and then sequenced them in an order that made my theory clearer to me. I only accessed the literature as it becomes relevant. The literature was not given special treatment, as Glaser makes the point that most research including qualitative research is hypothesis-testing (Glaser 1978).

**Evaluation, Rigour and Trustworthiness**

In qualitative research, the researcher is required to meet trustworthiness criteria which provide the evidence of rigor in the data collection and data analysis phase of the study. There are four processes that Lincoln and Green (1985) support in their establishment of trustworthiness, these being; credibility, transferability, dependability
and confirmability. However, according to Glaser (1998, p.18) GT does not deal with trustworthiness. Rather, trustworthiness is synonymous with validity and is best understood by the GT term “Fit”. Validity in its traditional sense is consequently not an issue in GT, rather, in GT, trustworthiness is replaced by the four other quality criteria, these being: fit, relevance, workability and modifiability (Glaser 1998).

In this study, it became worthy of trust when the concepts I had generated were able to fit the data with relevance and that the data worked to explain what was going on at the same time as the theory was modified when new data enters into the comparative process. Glaser calls it “worrisome accuracy” and emphasises that GT is evidence based, but not accurate in the sense of absolute truth. GT is a set of hypotheses developed through hard work, coding and concept generation and sorting of memos on many, many incidents using a 40-year-old method (personal contact April 2005).

During my discussions with Dr Glaser I needed to gain a better understanding of relevance in a GT study to ensure that what my study was finding was relevant to nursing. Dr Glaser immediately identified that my study was extremely interesting, certainly usable and in his words had “grab”, therefore it was very relevant to my area of research and nursing issues of today. As we further discussed my research, Dr Glaser asked me if I had had any preconceived ideas at the start, because if I had, I would have automatically missed the relevance, as I would have preconceived ideas about the outcome. He reminded me that if my data gained through fact finding, explained what was happening in the clinical area, was able to be interpreted, then it would be relevant. Dr Glaser suggested I read Theoretical Sensitivity many times to better understand his philosophy. To quote Dr Glaser (writing in non-inclusive language):

“Grounded theory arrives at relevance because it allows core problems and processes to emerge. The grounded theorist does not have to spend time to convince others of the relevance of his focus. He need not explain how he deduced the focus or explain why his interest can be seen as general enough to be worthy of research. Rather he spends time modestly, but assertively, searching for and discovering the relevance of his data” (Glaser, 1978, p.5).
Fit

This has to do with how close each concept fits with the represented incidents and this in turn is related to the thoroughness of the constant comparison of incidents to concepts and how this was undertaken. Fit is continuously sharpened by constant comparison (Glaser 1998). In this research I undertook a rigorous process of constant comparison. In other words, this meant that the categories identified from the emerging theory fitted the data, and, since the majority of the categories in this GT have been generated directly from the data then there is an automatic assumption that fit is accomplished.

Relevance

A relevant study deals with the real concern of participants, evokes “grab” (captures the attention) and is not only of academic interest. This study was relevant to all the participants and “overloading” remains a constant issue with all nurses working in the clinical setting.
Workability

The theory works when it explains how the problem is being solved with much variation. The workability of this study is demonstrated by the numerous methods by which nurses’ manage their workloads each day and this is described in the discussion.

Modifiability

A modifiable theory can be altered when new relevant data are compared to existing data. A GT is never right or wrong, it just has more or less fit, relevance, workability and modifiability. This study was modified following coding of the first and each subsequent interview to ensure it met the above criterion.

Construction of a GT

As I collated the numerous writings I had collected, it was evident the substantive theory was beginning to emerge. The basic psychosocial problem or core variable, overloading, was achieved following a remarkable session with Dr Glaser where we viewed the memos, transcripts, categories and codes I had generated and then discussed how these would fit as described above. (Figure 5.2, p.67) presents all aspects of the development of the substantive theory.

Conclusion

The processes described in this chapter have been presented sequentially as they occurred. I have identified how the participants were recruited into this study and the importance of the ethical issues that may have been perceived. The main method of data collection, the participant’s interviews, are outlined and I have summarised how the data collection, coding and comparative analysis was undertaken. I discussed the importance of relevance to the study and I explained how the writing up occurred and mentioned the importance of theoretical sensitivity, fitness and the construction of the GT.

Chapter 4 discusses the participants’ stories as they made their journey through a career in nursing to where they are now.
CHAPTER 4

THE PARTICIPANTS’ STORIES

“Caring then, even when performed with love, is frequently laborious and stressful. It is a highly charged emotional activity, where a carer’s affective positioning can affect the quality of care that person is able to offer” (Opie 1992:109)

Introduction

This chapter introduces the participants and describes the journeys of ten of the twelve Registered Nurses and Enrolled Nurses I interviewed. Two of the participants did not wish to extend the interview to personal or background information and I did not press this with them. Data from the interviews are included as well as some of my notes taken during interviews. All the interviewees were given a pseudonym to ensure confidentiality.

The stories from these nurses have been slightly altered from the original transcripts to fit into stories as told to me but the honesty and integrity remains intact. A number of the participants reflect the information and issues identified during their interviews. It was interesting to note that regardless of the mode of training or hospital memories, the good times and bad times have remained with them.

The original tape recorded interviews lasted approximately 90 minutes each and because of space consideration only extracts will be included, from at times, highly provocative, insightful tapes. The majority of these stories are first hand accounts from the participants about their nursing career and their journeys to where they are now.
The participants

The 10 final participants came from a diverse nursing background and include Enrolled Nurses (EN) Registered Nurses (RN), Clinical Nurses (CN), Clinical Nurse Consultants (CNC), and Nurse Managers (NM). I have used the generic term Nurse Manager for the CNC and Nurse Manager due to the limited number of participants in each category and to ensure anonymity. The participants in order of presentation are presented as Tom, Sarah, James, Jessie, Julia, Harry, Mary, Joyce, Gerald and Sally.

TOM

Tom is in his third year as a RN and graduated from a metropolitan University. Tom spent his graduate year at a large Sydney tertiary hospital before moving to rural NSW where he has remained since. Tom spoke freely of his experiences as a graduate RN and how he progressed to what he believed to be senior RN status. This is Tom’s narration of his experiences as told to me during his interview.

I went to University as a mature age student. During this time I took holidays during semester breaks believing the work I did during semester would get me through the course. My friends worked as Assistants In Nursing during the holidays whereas I didn’t, I enjoyed my breaks. I remember I went to the wards as a fresh graduate with minimal experience because I hadn’t done the amount of nursing my friends had.

I remember that to graduate we had to a simple dressing test and I can still remember the concentration and the detail required to do this simple dressing just to pass the practical exam. There were no distractions, there were ideal circumstances with no hurry or rush but I was concentrating so hard just to do this simple dressing. Well, when you come out onto the ward I found it was very different. Mrs Smith needs this and the engineer wants to get to the bed area and someone needs a shower. I found it was usual to get patients showered first then attend to all the different dressings.

At University you get taught the basic infection control measures, approaching the patient and letting them know what you are doing, looking for infections and what is going on with the wound but they do not teach you anything about being able to juggle all these at once. It is a very different thing to get 4 dressings done in a complex ward.
and you eventually learn that. But on the ward the first day I couldn’t get it done or even come close to it, but as you gain the experience so does your ability to improve the quality of care you provide.

I remember not long after we first graduated and I was in my first placement, there was a time when I was handed the keys and told we (senior staff) are off to lunch. They told me I was in charge and said “You will be fine”, told me about Mrs Blogs in bed 8 and off they go. Gradually I found I started to gain confidence the more this happened. As I worked with a whole range of different RNs, some of whom were more worthy of attention than others, I would gain in confidence and start asking them questions and emulating them, asking them to show me things. I wouldn’t pick someone at random, but would pick the person I felt would do the best job in showing me what to do. There are a lot of nurses out there who are good role models. I now feel confident and ready to tackle the next phase of a busier hospital thanks to those who have mentored me and taught me about quality care.

What is it about nursing I love so much, for me it’s my profession and I take pride in doing my job well. The patient probably doesn’t know what I should or should not be doing but I do. They may have no idea what I haven’t done but I would. I enjoy the constant learning and finding things out. For me, it’s a labour of love, it’s not a job you would could just earn a living for. Ultimately if your heart’s not in it, you are not going to last in nursing. We don’t get any perks in the job, as it’s not a perks job. The wages are getting better just since the time I have been in nursing and I don’t have a quibble about wages for nurses as they are adequate and you wouldn’t do it for the money anyway.

What I have had to focus on each day is giving myself a pat on the back and be satisfied with the care I have given rather than go home dissatisfied with the care I haven’t given. Over the years I have come to realise there will be sections of stuff that I haven’t been able to get done well enough or could have done better.
SARAH

Sarah is a Registered Nurse and an Endorsed Midwife, and commenced her nursing in the hospital-based program some 20 years previously. She has worked in numerous fields of nursing including general medical and surgical, emergency and midwifery as well as hospital management. This is Sarah’s story.

I have seen many changes in nursing practice with varying models of care being introduced, phased out and another similar model reintroduced. I finished my training when the first students came out of university and found it was interesting to watch them over the first few months. They had no communication skills and no common sense approach to nursing, but it didn’t take them long to learn. I work with the new graduates and found it would take them about 6 - 12 months to gain these skills. They have the knowledge base and ability in most cases, but it is up to the experienced RN to guide and support them in the beginning.

Nursing for me is about caring as part of the caring profession and as a senior RN I find myself having to remind staff that is what it is all about. I have worked in many health care organisations from small to the large and over the years I frequently go home frustrated and angry that I have not done what I should have. I can remember many times trying to spend time with a dying patient, giving them my full attention, only to be called out by another nurse who has no idea what to do for a similar patient she has. I suppose the more senior you get the more others depend on you but this has not helped my other patients that I have had to leave.

Sometimes I go home and vent my anger on my family and as often as I try not to, I can’t hide my emotions. My partner is also a nurse and I am grateful that he can understand how I feel but I feel for those nurses who don’t have anyone to support them, it’s very emotional.
James is a senior clinical nurse and undertook his training as a hospital graduate. James has an additional qualification at Masters level in his area of speciality. James became a nurse by accident as he was looking for something to do until he worked out what he wanted to do.

In the olden days a nurse was paid to train on the job. In those days most psychiatric hospitals had beautiful ovals, which included cricket pitches and football grounds. A young man therefore could play cricket and football in lovely surroundings and be rostered to work on Saturdays and Sundays. This meant (if you were any good) you would be allowed out to represent the hospital by playing cricket all day.

The other perk was the flexible roster. If you worked and played cricket on Saturday and Sunday, you picked up the penalty rates and then only had to work 2 other days because they were 10 hour days. Several years went by and because also for a young man there were many pretty young nurses around, a smorgasbord so to speak, time went by unnoticed. Suddenly 3 years were up so I did the State Registration Exam and to my surprise I passed. The major influences in my life at that time was nothing much to do with nursing apart from the fact I had a fondness for genuinely mad people. I had no intention of remaining a nurse, but I had decided I no longer wanted to be a pathologist. I also found myself married and before long had a family to feed. Hence, I was now making reasonable money for the times and thought "what the heck".

Highlights of my career, well there are a few. Let me tell you about the lows and finish with the highs, this would be the best. Some of the low moments of my career have usually corresponded with poor managers. I believe poor managers are those who profess to love the profession, but usually are those who impede the progress of others through vitriol, spite or a genuine inability to empathise and care for their staff. It seems sad, but there have been few managers who could be called thoughtful and assisted others and mine careers.

Now the highs. Academically, even though I had a Graduate Diploma and a Master of Nursing, my second Masters was in my speciality field, and accordingly, I became one of the first five nurses in the State to achieve Nurse Practitioner status. Also to have
become one of 27 nurses selected to achieve a CNC Emergency Department Consultation Liaison position was a real buzz.

Probably my most remarkable achievement is a very personal one in that in over 35 years or more of nursing I never held a permanent position in administration, not even as a NUM. For me this is an achievement as I have been able to move through the ranks in the clinical stream that I have specialised in.

JESSIE

Jessie is an experienced RN who has worked most of her career as a surgical nurse and clinical nurse in large metropolitan hospitals in Sydney. Jessie is an early graduate of the University program.

I became a nurse because as long as I remember that’s what I wanted to do. I had high ideals and wanted to save the world. My first few years were hectic as I was a university graduate and had an awful lot to learn. I did not have any prior learning but a desire to do well and make a difference to the people I care for.

I remember I followed the lead of nurses that I believed would give me the best grounding for what lay ahead and believe I have been given that grounding. As a senior nurse I now try to emulate what was done for me but find it frustrating in a small town to do this, as there is a lack of support for our junior staff.

We came here to this area to look at a safe future for our children, away from the frantic lifestyle of Sydney. What we have discovered though is, it the total lack of privacy that exists in a small country town as you see so many of your patients when you are out shopping or at a restaurant. There is no way one can escape from the stress of work except stay at home.

I can remember trying to be everything to everyone when I first came here but slowly I have had to withdraw because I am so overwhelmed with my workload, especially when I am in charge of shift. I have to balance the work of others to make sure they have some form of equity in their workloads but often they will come and have a bitch
that so and so is not helping. I am really wondering how long I can keep this up before I have to return to the sanity of Sydney

JULIE

Julie is a hospital graduate and has attained further qualification in critical care. Julie also has a Masters degree in clinical nursing with her major in critical care. While Julie no longer works as a critical care nurse, she has maintained her skills in the area through a regular shift in the unit. This is Julie’s account of her career and reflections about nursing.

I have no altruistic reason why I became a nurse. For me it involved a process that was set in motion by the circumstances of my life at the time. I was working as a receptionist in a GP practice, my first job. A nurse also working in the practice collecting pathology specimens encouraged me to give nursing a try. I had worked in the GP practice for about 3 years. I like the uniform so decided to give nursing a go. I was influenced by another nurse, but I never thought I was taking on a career, rather it was just another job.

I guess another influence in my life was a childhood experience where I spent a number of weeks in the Camperdown Children’s Hospital following a perforated appendix. I have vivid memories of the experience and in particular one nurse with a long plait, who stood out from the rest. I remember her kindness, her staying back late, and her love of the job shining through and the way she interacted with the children in the ward.

I have had a number of career highlights that have covered different aspects of my career. As an ICU nurse being able to conquer the various technologies in ICU and gaining various clinical skills mastery on the trajectory of moving from novice to almost expert. Academically, it was graduating from university with my Masters of Nursing. This was an important day for me, because of the achievement, and my family because it was all over, or so they thought. Professionally, I think one of my main highlights was presenting at the 2004 RCNA Conference, as it was the first time I have ever presented in a large public forum. The second highlight was being offered a conjoint appointment in a teaching role with a university.
There have been some low times as well where I have experienced bullying in the workplace and being a witness to bullying. It's sad coming to a realisation that not all health care workers value nursing's contribution to health care.

As I reflect on my career I recollect the time when I was completing a post graduate qualification and was required to spend time in a large city tertiary ICU to gain intracranial pressure monitoring skills. I had had 15 years post graduate experience, but here I was like a new graduate. I had returned to a place I hadn't been to for many years, and on reflection, found this experience fairly enlightening. I went back to not being sure of myself, having to control my shaking hands, being afraid when my buddy nurse went to morning tea. It took me about a week for me to feel somewhat relaxed, comfortable with my surroundings and start to enjoy and learn from the experience. What stood out for me the most was the fact even though I was a relative novice in this environment and with this type of patient, the other nurses were either too busy or didn't care who looked after the patient as long as it had no impact on them.

This disturbed me, because in the rural ICU where I worked there was a totally different culture. We did watch out not so much for the nurse but for the patient, we did care if the person allocated that patient looked like a novice, looked unsure or looked concerned. It doesn't take much to assist staff to feel comfortable in their surroundings by being welcoming. This was not the case of the bedside nurses in the tertiary centre. I have used this experience in the way I manage junior staff and students today.

HARRY

Harry is an experienced RN with qualifications in emergency medicine, critical care and education. He is a university graduate, graduating in the early years following the introduction of university training in NSW. Harry commenced his story by reflecting on his time as a manager.

Why did I become a nurse? Is the question really answerable? Looking back the reasons for my choice of career seems so long ago. I have always been interested in the “helping aspect” of people’s lives, not always the caring but more the helping. I enjoyed relieving pain and getting the credit for being part of it. Both my family and I seemed to always hold the nurses of our small rural community in as higher esteem as
the doctors. It was the nurses who helped the injured first and people remembered that and the nurses appeared to have a great deal of social standing.

But sadly, I feel it was the influence of a TV show called “A Country Practice” and the role that Shane Whittington played as the nurse. This role began to destigmatise the male nurse and provided a role model for me to follow. So sadly I was influenced by a 1980’s TV drama. Apart from this, I had a life changing experience whilst on work experience placement at the local small town hospital. The “Matron” advised me not to get involved with any emergencies and to “go and have a cup of tea” if anything happened.

Day one fatal car accident, I got the look from the “Matron” and scurried off to have a cup of tea, only to be asked to help get a patient out of the ambulance (driven by a police officer). I was then thrown in as the facility was stretched to breaking point with two critically injured patients. One child, one mother and without registering the incident (fatality) the dead husband. I assisted with the intubation and management of the child (untrained but for St Johns first aid certificate) and was then left supporting the wife with potential spinal, chest, abdominal and extremity trauma. All patients were successfully transferred out within about 6 hours, but I received my baptism of fire (and loved it).

Perhaps it was this introduction and adrenaline surge that led me down the path of emergency critical care nursing. Perhaps it was the fact as I said “A Country Practice” was a popular and socially challenging TV show. I know that the nurses were all well respected and not portrayed as handmaidens.

There were also important people in my life that were nurses. Some aunts and family friends were nurses and these people had a lot of influence on my growing up. The job security issues when unemployment was high was always an issues and the challenge of this career on my fathers ideals (a nurse in his eyes was considered to be gay).

I had considered the role of Ambulance Officer as they got all the good stuff; they were in the action and provided a service so respected by others. But it was harder and harder to get into the service and they did not like the school leaver, so what to do between then and now? Perhaps nursing would provide a great stepping stone.
It was not the thought of travel or the art of caring that attracted or influenced this choice. Nor was it the money or job security. It was the fact that you were paid to train as I went to uni and tried to enter through the Victorian system and get paid. It was not the uniform or the fact that the majority of the workforce was female although that was a line I used to justify my career choice with many of my male friends.

I have had a number of career highlights apart from my first day’s experience. My first witnessed birth although I never went on to Midwifery (hated the name) was memorable. My first solo C section as scrub nurse in theatre, the continued learning that occurs daily, the ability to help others through death, to death and near death. During my career I spent time as a military nurse I was posted overseas and at one time required to do aero medical evacuation and run a trauma without the medical officer whilst serving in Africa. This adrenalin packed experience maintained my lust for emergency nursing, which I still prefer today. The other highlights were the incredible people (other nurses) you meet. (I married one) and the chance to work with brilliant people (Nurses and Doctors).

My career has had some low times as well. We all have ego problems and mine hit rock bottom when I didn’t get the job I thought I would walk into. Another low was being a member of the Nurses Association as a delegate and I have honestly never been so embarrassed to be a nurse than at that conference. But there have been very few low times.

As I reflect of nursing, I feel sadness when I see nurses themselves restricting their own development and the development of their peers. Why it is that nurses are unable to insert an IV Cannula without some torturous training package, followed by some assessment and yearly update or competency assessment without a single consideration given to current practise? Why is it that nurses from one facility can’t bring with ease their credentials to the next facility? For example, CNS. We place the greatest restriction on nurses’ development by quoting incorrect and out of date processes with little to no consideration for what are best for the nurse and the patient.
MARY

Mary is an experienced RN who graduated from her hospital training in the 1960’s. Whilst having no additional qualifications, Mary has experiences as a manager, clinician and supervisor and is now looking forward to retirement.

*I can recall when I was in high school, form 4 we were to decide where we wanted to visit as a form of work experience. I didn't know what I really was interested in, so my girlfriend talked me into visiting Liverpool Hospital with her. So I put my name down for that and went with her. The visit totally turned her off nursing, and got me thinking about it.*

The visit as above influenced me as the nurses on duty that day seemed to have an "air" about them. I think it was probably confidence, if I really think about it. I'm not sure I was aware of that at the time though.

When I was 5 years old I had to have surgery for TB in the parotids, and I was in for quite some time. With most occupations you find good and bad as we all know, and I can really remember the good nurses, the kind ones to a 5 year old, so when I decided to do nursing I often reflect back on my time as a child in hospital.

The biggest highlight of my career was my first solo delivery. First day in labour ward, I was asked to prep a woman that had just presented while the midwife took her other new mum to the ward. When I had the patient roll over to start the prep that was as far as the prep went. I managed to get one glove on before I "caught " the baby, a beautiful baby girl. I shook for hours, after that, the rest of my stint in labour ward seemed like a breeze.

I have had some low moments and it's hard. There are so many moments when you wonder what the hell you are doing, why you are still doing the job, why is there so much illness, trauma, are you making a difference to anyone, can the "system" be improved, how does it need to be improved? Then as you can't find the answers to these questions you accept what is happening around you and just continue to do your job the best way you can. I would love to have the answers. I thought when I was a manager I might have been able to help some change happen, but the day to day work
was just so full on that there never seemed to be a spare moment to try to become creative.

I have always been quite a stubborn person. When I had to admit to myself that I was not making the impact I wanted for my ward, I decided to step out of the way hoping that whoever took my place would be able to achieve what I was unable to do. I felt like a sort of failure. Now in hindsight, I am pleased for my own peace of mind. I am back doing what I love, hands on nursing. I have so many good memories to fall back on, but some not so good either.

When I was still a student nurse and the work pace seemed so slow in comparison to today’s, you would have time to spend time with your patient to chat with them about their families, their lives, and what they wanted. It was very special time. I can still remember vividly how the really elderly patient would want to give you a cuddle, or a kiss, for taking the time to listen to them. I didn't mind letting them either. In fact it made the day worthwhile.

JOYCE

Joyce is an experienced RN who graduated form her hospital training in the 1960's. While having no formal qualifications, Joyce has experiences as a manager, clinician and supervisor and is now looking forward to retirement.

Why did I become a nurse was because my mother encouraged and supported me, as she said that from an early age I kept telling her that I wanted to become a nurse. Again as a young person nurses appeared “like angels” to me – this may have been through my experience with terminal illness. Also, I enjoyed helping and caring for people and have always been compassionate. I was influenced by being around sick people as my father died when I was 13 years old and I helped care for him and my love for babies and wanting to do midwifery.

There were a number of career highlights for me that included graduating from my general nursing training, meeting other wonderful health care workers/nurses, establishing a pre-admission service at a previous hospital 1995. The ultimate
achievement though for me was obtaining my Degree in Health Science in nursing whilst working full time, being a wife and mother to 4 children.

I have had some low moments as well and I think that not completing midwifery. I wanted to move back to the country from the city and was therefore unable to continue with my studies. There were no distance programs then and with a young family it was not possible. I have had some low moments clinically as well and one I remember vividly was an unsuccessful resuscitation of a teenager and then having to comfort his family and friends. In the work environment I have had some low times I can remember once when working with a difficult nurse who was a senior staff member. She liked authority and was always ordering other staff members around and it made the work environment very tense. The other bad time we are having at the moment, especially in the past few years, is the constant pressure of increasing workloads and stress, and it’s not getting any better.

Generally though nursing is great and as I reflect I think about the fun times, when we had the time to “muck around” whilst working, for example, playing pranks on each other and having time to spend with the patients.

GERALD

Gerald is an experienced RN who had his initial training as a hospital graduate. Gerald has undertaken a Bachelor of Health Science and a Graduate Diploma in management and has had numerous years’ experience both clinically and as a manager.

I am not sure really why I became a nurse, because when I left school I was undecided on a career. I remember nursing opportunities were being advertised so I applied and got accepted. I guess in looking back though, I was somewhat influenced as my mother, sister and 2 brothers were all in the nursing profession. Never the less, my family did not actively influence me, rather it now seems more like an osmosis creep than anything.

I have a number of career highlights with completion of the hospital program being perhaps at the top, because I also received a letter of commendation from the training
hospital. Completion of postgraduate studies also ranks highly as another of my achievements. I think perhaps though I get the most satisfaction when I have been able to have a day where I have been able to provide hands on clinical care. These times are rare now, but the satisfaction I get from a simple thank you is wonderful. Another high for me was travelling overseas and working in London where Australian Nurses were highly thought of and respected and that was good.

I have had some low moments as well and whilst these are not specific I have thought of leaving the profession. It’s such a thankless job at times with no thanks from senior management over the past 5 years. My rewards are intrinsic and self driven.

As I reflect on nursing I remember that the times I spent as a student during my training, the friendships that developed and still last today and the satisfaction I had providing patient care. I believe I have been able to influence others by mentoring them and I believe I made a mark as a Unit Manager. I insisted on, and had high standards of care, documentation was great and my staff knew and respected the high performance standards that I maintained and insisted on.

Nursing in 2005 is a major challenge to all levels of nurses. Governance is rightly at the forefront with the expectations by others that nurses provide safe care, but with the current workload demands our standards are slipping.

SALLY

Sally is an experienced registered nurse and midwife, having undertaken her training through the hospital system. Sally completed her first year, but subsequently failed her exams so became an Enrolled Nurse and then undertook her training again to become a Registered Nurse. Sally has worked clinically in acute areas, maternity as well as becoming a Unit Manager. Subsequently Sally became a Nurse Manager, taking herself through the “ranks” through further tertiary education and a lot of family sacrifices and support. This is Sally’s story.

When I was 15 years old, I became a volunteer with the St John’s ambulance and we had to go into aged care facilities on a weekly basis. I really enjoyed the appreciative
response I got from the clients and I felt I was making a difference in some small way. Initially I was going to teach, but could not afford the college fees plus the living expenses. My next option was to do nursing where I could study, have a certificate and get paid at the same time with the bonus of having on site accommodation.

My first year was not that crash hot. I had met my husband to be and mainly concentrated on social outings. Subsequently, I failed my first year exams so I became an enrolled nurse so I could remain in nursing. I did this for some two years and was very frustrated by the limitations placed on ENs so I went and re-enrolled to do my general, which I might add I had to start again from PTS. I then discovered I really enjoyed the work, even the shifts, odd hours and tragedies. I felt I was now able to give the empathy and support patients needed, but the thing that I most valued and still do, were the friendships one makes with your colleagues who are feeling the same things you are. These friendships have become lifelong despite infrequent catch ups.

Highlights of my career go back to when I did my midwifery as I was determined to be a midwife as this area of nursing interested me the most. Obviously the down side of this was leaving my husband with 4 children to care for, but there were more positives that negatives. We struggled with me being away and travelling to and from the hospital I did midwifery at some 400km away on my days off. However, the children adapted well and my family were as proud of my achievement as I was once the year was over. The rewards that this afforded me later on in my midwifery practice were greater than any of my expectations. I was so chuffed when I received the “Nurse of the Month” from the hospital with the recommendations having been put forward by the obstetricians with whom I worked during that year,

I have had some low moments personally in relation to work. When you look into you children’s faces and tell them you can’t attend something at school because of the shift work, or when your family has the holiday off but you can’t go away with them because you can’t get the time off. You have this guilt and conflict of interest, but also a devotion to the work you do. Twice throughout my nursing career I have sacrificed my family’s need to pursue further studies which were midwifery and neonatal intensive care. On both these occasions I felt alone and extremely guilty on leaving them behind. Nevertheless, my husband and family were at all times very supportive but I was being
a “mother”. Unfortunately, living in rural Australia does not enable you to undertake much professional development and further education.

I have some good and bad recollections of my career. The hierarchical culture was very archaic in the earlier years and nursing students were never listened to. It was only when you became a third year that the expectations and responsibilities were dumped on you and the pressures became enormous. You were left in charge of the ward as the only senior on, became responsible for the junior staff and it was scary at times. You had to hope there was a good supervisor on when you got stuck. In reflection it was only sheer good luck that serious things didn’t happen. Fortunately today, we are moving away from this and hopefully we are presenting the profession to nurses as one of value and one to be proud of. We were not nurtured as students and many failed. You had to have the strength of an ox to get through the barriers in the seventies, but nurses were very stoic and were able to deal with a lot more than they do today. Task orientation was a deplorable notion for nursing back then, for example TPR rounds and pan rounds. At least today we acknowledge the holistic approach to care. I am extremely proud of my profession and I am thrilled that we now have a voice and the recognition we deserve.

Conclusion

As the stories of these nurses were recorded and transcribed, I felt privileged to have listened to their stories and reflections as they journeyed to where they are now. Each nurse had a very different reason for becoming a nurse and very different reasons for following the pathway they chose. A number of participants had some difficulty sharing their experiences, but never the less did so and for this I was grateful. The stories speak for themselves; however, some of the reflections in these stories also come out in the analysis of the data.
CHAPTER 5

DATA ANALYSIS AND THEORY GENERATION

“As Registered Nurses, few of us think of the hospital we work in as a battlefield or of ourselves as soldiers. But the truth is, there are more similarities than you might think. We show up for our shift each day, not knowing what challenges we might encounter. Our job requires us to be in the moment at all times, and to make split second decisions on the run. What we do or don't do can mean the difference between life and death. We often work under extreme stress, yet must remain calm and in control. Although there are others who function in a supportive capacity, we are the ones on the frontline” (Deborah Lynn, Working Nurse, Working World Magazine, p 95.).

Introduction

The intent of this chapter is to describe the theory of “Working Around”, the basic social process identified in this research. In qualitative research such as Grounded Theory, data analysis is an ongoing process and, as I constantly reflected on the transcribed participants’ interviews, themes began to emerge. The strategy utilised for analysing the data were the constant comparative method developed by Glaser and Strauss (1967) and is explained fully in the methodology chapter. The constant comparative method enables the generation of theory through the systematic and explicit coding and analytic processes whereby theories are generated and a plausible theory that is close to the data emerges. As I conceptualised codes to categories I was searching for the basic social process and core variables in the transcribed interviews. The core variable, the one to which all others related, was identified when it emerged as nursing workloads. As categories became saturated and relationships among them became clear, the substantive theory of working around was identified (figure 5.1, p. 66).

The major categories or variables that emerged from the data as demonstrated (figure 5.2, p.67), included: professionalism and being socialised into the profession, organising
daily workloads, preparedness for practice both clinical and management roles, emotional overload, dialoguing and quality activities. In this research, it was clear that nurses working in the health care settings in which this research was conducted were concerned about a number of issues. These included their inability to meet both patients’ and service needs and be able to go home at the end of the day having done a good job. These realistic concerns were a direct result of working around.

The sample consisted of 12 registered and enrolled nurses. Five were male and seven were female. Participants were generally well educated with a number holding Bachelor and Masters Degrees. As the interviews were coded and analysed, it became clear that nurses’ ability to provide quality outcomes, the original focus of this research, was not emerging as a major category and as the data unfolded; it became evident that the core concept of working around emerged as the new basic social process.

The area of inquiry in this research was identified prior to commencing as a topic that needed further exploration in the current health care environment, as the researcher wanted to learn from the participants an understanding of the factors that impacted on nurses’ ability to provide quality nursing care.

The researcher utilised unstructured interviews, aiming to get rich, detailed data and to peruse interesting concepts as they emerged. Data were coded as there were collected following each interview and then as the codes emerged, they were defined and categorised. The in-depth interviews explored how participants viewed their practice and their ability or perhaps inability to provide quality nursing care. As data were analysed and coded, simultaneous analysis of memos and notes taken when observing participant were compared together to ensure in-depth analysis was occurring.

In GT methodology data collection and analysis are deliberately fused, and initial data analysis is used to shape continuing data collection. The intention is to provide a number of opportunities for increasing the "density" and "saturation" of the recurring categories, as well as for follow up of any unexpected findings. This method of interweaving data collection and analysis suggests an increase in insights and clarification of the parameters of the emerging theory.
Figure 5.1: Theory of Working Around

Internal factors
- Staff skills and mix
- Daily Workload
- On the job learning
- Communication
- Supervision of staff

External factors
- Budget
- Student training
- Management pressures
- Community expectations
- Professional image

Overloading → Working Around → Poor Quality Nursing Care

Author: J Flynn (Researcher 2007)
<table>
<thead>
<tr>
<th>Basic Psychosocial Problem</th>
<th>Participant’s data</th>
<th>Code</th>
<th>Concept</th>
<th>Categories</th>
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<td>Knowledge</td>
<td>Sense of team and worth</td>
<td>Professionalism</td>
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<td>Nurse/patient relationship</td>
<td>Image</td>
<td>Sense of team and worth</td>
<td>Professionalism</td>
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<td>Organisation</td>
<td>Realisation of work</td>
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<td>Supervision</td>
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<td>Outcomes of care required</td>
<td></td>
<td>Doing the right thing</td>
<td>Quality activities</td>
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<td>Being able to “read” the patient</td>
<td>Safety</td>
<td>Perception of quality</td>
<td>Quality activities</td>
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<td>Fulfilling clinical role</td>
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<td>Perception of quality</td>
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<td>Accreditation</td>
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<td>Perception of quality</td>
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Figure 5.2: Overview of the basic psychosocial problem with participants data, development of codes, categories and core category to explain the basic psychosocial process of Working Around.
Professionalism and Socialisation

The acquisition of values, attitudes, skills and knowledge pertaining to professionalism is professional socialization (Page, 2005). Nursing is not just a body of knowledge; it is an attitude, a commitment, and a way of thinking. Professional socialisation, according to Page (2005), begins with the educational process which provides the knowledge and skill necessary to practice as a professional. It is through this process of learning that students learn about appropriate professional behaviors and attitudes (Nathanial, 2004). It is suggested that before you can be a successful professional nurse, you have to become a successful nursing student. The transition from naive dreams of benevolent care to the all-too-real hard work required of students is accomplished by a series of choices they make as undergraduates (Weidman, Twale & Stein, 2004).

The inculcation of certain cultural norms learned as an undergraduate and during early clinical practice defines what professionalising for nurses means. Professional norms are considered to be those conceptual ideas that contribute to nurses’ perceptions of what a good nurse should be. For the most part, nurses’ professional norms complement their core beliefs, thereby internalising the profession and professional norms as unique for that individual (Nathanial, 2004). At a very early stage in their career, nurses learn they have a unique relationship with their patients and that they are bound professionally and morally to keep this relationship professional, through codes of conduct and promises implicit in the relationship. The dilemmas arise as new graduates progress through the institution, from novice to expert, gaining skills and knowledge to enhance their practice as well as becoming accepted as part of the work team.

Nurses work in a wide variety of settings, holding numerous different positions within the health care delivery system. The nurse’s social position and the context will determine role expectations for nurses in which nursing care is delivered (Creasia & Parker, 1996). Becoming a professional involves role socialisation. This occurs at various levels in a person's life as we are constantly being socialised and re-socialised into new roles (Page, 2005).
The process of professionalisation has powerfully shaped nursing history. Likewise, the process of becoming re-socialised into a different way of looking at the profession can be a powerful experience (Weidman, et al 2004). How nurses access information, find guidance and support and fit into the work environment is largely determined by the workplace (MacPhee & Scott, 2000). This workplace socialisation is often dependant on the socialisation processes used in a specific workplace and can significantly impact on a new comer's adjustment to an organisation and to their new work area (MacPhee, 2000). There are certain socialisation tactics such as role modeling, preceptorship and clinical guidance that assist a new graduate achieve an easier transition to the workplace (MacPhee & Scott, 2000). Consequently, first impressions provide very powerful perceptions on a newcomer's socialisation process, and how nurses communicate their professional image can influence how a neophyte perceives s/he will be taken care of (LaSala, 2005).

During the early phase in professional socialisation, the novice's perception of the environment is limited (Page, 2005). With progress in the educational program, an awareness of the breadth and depth of the interaction between Nursing and the Environment evolves (Weidman et al, 2004). As Professional Socialisation continues, the neophyte develops an understanding of the potential nursing has for influencing
numerous structures in the environment. Consequently, there is a requirement that new graduates begin to understand the interlocking language, concepts, relationships, structured ideas, disciplined inquiry, and outcomes of nursing practice (Page, 2005). This information provides valuable insight for a nurse to be socialised into the nursing profession (LaSala and Nelson, 2005). Therefore, nursing, either as a discipline, or indeed as a profession, requires nurses to learn this organisational culture through socialisation within the nursing profession and within the environment in which s/he works (MacPhee & Scott, 2000). This is supported by Van Sell & Kalofissudis, (2005, p2) who indicate “Nursing as a discipline or as a profession require from nurses as individuals to acquire organizational culture through socialisation within the nursing profession”.

In relation to skills and knowledge, RNs indicated graduates had the theoretical knowledge and ability, but they needed time to acquire their professional nursing skills and to be accepted as part of the team. To be able to accomplish this, senior RNs indicated new graduates required a time of professional socialisation. In support of new graduates, most RNs interviewed indicated there was a need for the seniors on each ward to nurture and support our young staff, but this was an additional workload issue. However, nurses did identify if graduates were mentored well, had a good role model, gained skills quickly and supported with a recognised preceptor, they were more readily accepted into the team (MacPhee, & Scott, 2000; Maben, Latter & Macleod Clark, 2006).

Nevertheless, an increasing number of activities and phenomena come to be seen as part of the profession’s responsibility (Turkoski, 1995; MacPhee & Scott, 2000; Maben, et al., 2006). This professionalising process can also be seen from the point of view of new members being socialised to achieve congruence with the lore and language of the group. The profession of Nursing recognizes socialisation into a discipline is “guided by theories, use of language, identification of concepts, and definition of relationships, structured ideas, and facilitation of disciplined inquiry, practice and communication” (Van Sell & Lalofissudis, 2005, p.1).

All participants discussed the socialisation, acceptance and preparedness of new graduate nurses, indicating that this aspect of socialisation and the theory practice gap from University to Hospital was in deficit. Also, there appears to be a gap in the process
of education and socialisation in respect to an individual becoming a member of the team and fitting in. As one participant indicated:

*The University Deans need to see and listen to what nurses and previous students in the real world are saying about their being unprepared to enter acute care settings, the difficulties with being accepted as a team member and be ready to care for really sick patients. We don't understand any of these issues prior to graduating and believe there is a significant theory practice gap for many of us.*

It is acknowledged that each new graduate will start in an organisation with different skills, knowledge and interests. Some of these graduates will overcome deficits and develop more quickly while others will struggle as identified by the differing developmental needs depending on the clinical area assigned to them. For example, a nurse assigned to the children’s ward will have to undertake additional training in paediatric drug dosages sooner than a nurse assigned to the aged care setting.

These difficulties with new graduates being accepted as part of the team were discussed with numerous suggestions from participants on how to manage this with role modeling, mentoring and nurturing being the most favored approaches. The expectation of role models in any profession is considered by most adult educationists as of extreme importance (Westra & Graziano, 1992). When asked how we can better prepare and assist junior staff develop their clinical skills, most of the clinicians indicated that many organisations have well-developed mentor and preceptor programs in place.

The concept of nurturing and socialising new graduates continued to be a topic of discussion with all participants during their interviews, with statements such as “nurturing helped me develop”, “I developed as a nurse through good nurturing” and “nurture a nurse should be a catch phrase for all of us”. Participants, when questioned further, believed that as a hospital student doing your training you were socialised early, constantly building on your skills in a supportive environment, they were observing all the time, assisted by the senior RNs and being socialised into the hospital system and on graduation you were considered “one of us”.

One was able to make mistakes without feeling stupid as one of the other RNs would come to your aid. It was reinforced that you were a student and there to learn. Now students come mostly with a facilitator, look and learn for a few weeks and go again, it doesn't seem to be conducive to good learning.

On numerous occasions RNs and EN came back to the same issues relating to the unpreparedness, lack of time management skills and the theory practice gap of the junior staff:

I finished my training as the first students came out of university and it was interesting to watch them develop. They had no common sense approach to nursing care, took a while to fit in, but somehow between the 6th to 12 month, they developed these skills and it all clicked.

Two of the participants indicated they had had experiences as CNEs and both believed nursing has made significant progress in preparing graduates since the first students graduated from University, as one of them explained:

Previously staff were certainly apprehensive about having graduates on their team, but they seem to be coming out with more competencies in practice and are better prepared. Their time management needs some assistance but by the end of the year they are pretty good and our previous apprehension has now gone.

As I further explored this information during subsequent interviews, it was interesting to note that all participants agreed that by the time graduates had completed their first year of practice, they had developed the necessary skills, in the majority of cases, to become moderately skilled and an accepted team member. Acceptance as a team member was a difficult process for many of the junior staff and this was acknowledged by many of the participants in this study.

It was also interesting to note the differences in how RNs perceived the transition of graduate nurses during their first year in the clinical environment. One RN identified she was amazed at how quickly today’s graduates get up to speed and how they have mostly excelled by the end of the year. There appeared, however, to be a number of
differences in the preparedness of some graduates as compared to others and one example cites graduates who had been ENs were previously assimilated much more quickly than those with no prior health care knowledge. Another RN identified the differences to be that some graduates embrace nursing for what it is as soon as they put on that uniform, whereas others are not in control and don’t pick things up as quickly as expected. Generally though, participants acknowledged that graduates would seek out information even if it meant delays to their work to ensure they provided a safe option for the patient.

As indicated above, there is a general supportiveness for new graduates with one participant indicating graduates come out of university as RNs and have a level of practice that meets the ANCI competencies; therefore, we should not be expecting them to practice outside this level. Nevertheless this happens on frequent occasions as has already been identified. Regardless, what these graduates have been able to contribute has been a lot of innovation into our practices. I asked him to qualify this and he explained from a recent personal experience;

*I was alerted by a first year RN that we were still using mercury thermometers and that this was an OH&S issue. I immediately reviewed the policy and noted she was correct and changed our practice at once. These kids have an excellent knowledge of computers and use the Intranet as well be able to complete electronic data forms. They also know their way around literature reviews and where to find things.*

Professional nursing is an essential resource to the health and well being of the Australian public. The ability of experienced registered nurses to support new graduates and support their transition from student to practitioner is important. However, there are a number of issues that have been identified in this study that hinder this process and need addressing so that health care organizations can maintain the retention of a viable workforce. This has been recognized in Australia in reports such as the Royal College of Nursing, Australia (2003) and the Productivity Commission (2005) Australia’s Health Workforce Research Report.
Workloads

One of the variables that recurred frequently in this research was workload. Allocation of a specific workload (number of patients assigned to a nurse) was the way participants started their day; it remained a constant throughout their day with participants continuously aware that their daily assignments and organization of their activities constituted their workload. Today's health care workplace is a complex knowledge environment in which the flow of information and practices is mediated often by an ill-understood array of technologies, available resources, changing practices and shifting teams of staff. Given the complexity of tasks nurses are required to do on a daily basis, it is no wonder they have trouble effectively managing their daily physical activities and coping with the extraneous environmental issues such as telephone calls, interruptions, supervision of others and patient demands.

Workload and stress are not individual issues - these are collective problems resulting from problems with how work is organised, and demand collective solutions (Productivity Commission 2005, Australia's Health Workforce, Research Report, Canberra). Some of the root causes in this study lie in patient complexity, patient acuity, the rapid turnover of patients, requirement for multiple tasks, short cuts, technology, incident reporting, paperwork, supervision of others, non nursing duties, mandatory training requirement, management responsibilities and lack of time to spend with patients.

Work intensification, lack of recognition, poor career paths, unsupportive administration from the organisation and inadequate opportunities for student mentoring were identified in this study. Also, the need to establish safe nursing workloads and safe patient care were identified as principal issues for nurses in this study. The majority of participants interviewed indicated current workloads and increased patient acuity impacted significantly on their ability to provide the nursing care they should or would like to provide. Intrinsically intertwined with nurses preparedness and acceptance of change is the understanding of current best practices. As one RN indicated:

*Workloads combined with the number and skill mix of staff were intertwined. There is also an impact on the supervision of the junior staff who needed a lot of support but don’t get this as they are left to flounder under the pressure of their work. This happens on a regular basis, as we don’t have enough nurses to look*
after the patients, supervise others and teach, despite management telling us we have the approved NHPPD ratio.

I probed participants on the various ways their workloads were divided up each shift to maximise skills mix and ensure quality care. Nurses indicated there were a number of ways this was done depending on the In Charge or the Team leader. Usually, the preferred method was a team nursing approach, but it was variable. An EN explained:

Team nursing works if you are working with someone who, at the beginning of the shift says you do this and I will do this and we will do this together and there is a plan for the day. You know it will be a good shift.

As I continued to explore issues related to equity of workloads and how staff believed they were overloaded, it was apparent that there were problems with many of the participants’ peers and how much they were prepared to help each other. The conscientious ones would help all the time but there were others whose first priority was to complete their work, do their documentation and go home. “Again it’s about working in a team environment” as one EN repeated.

ENs don’t understand the responsibilities we have as a RN to ensure a safe environment for our patients and staff and a high standard of care. ENs often forget that according to their scope of practice they must work under the supervision of a RN. Also, new grads have to be constantly supervised and helped especially with their drugs. I often have to oversee a new grad and EN and a TEN as the clinical educator is only part time and therefore feel responsible for 20 patients not just the 4-5 allocated to me. Now TEN’s……that’s another story, well they can’t do anything at all to start with so we have to give them the basic cares, such as showers and bed making as the RNs just don’t have the time. I know the ENs are frustrated. They raise it all the time at unit meetings, but while we have the situation where management requires us to have the current skill mix with the limited number of experienced RNs and more formal supervision, this situation will get worse - it comes down to money and how cheap the unit can be staffed. RNs are expensive and TEN’s are cheap.
I questioned participants whether they believed that with their current workloads, they were able to provide quality care, with the majority believing they were not able to, given their current ward situation. Nurses were very clear and honest in their answers indicating that the reality of care at the coalface is nowhere near the ideal they should provide. They indicated they were unable to provide the emotional and physical support that is an important component of quality care because of time constraints. I asked this RN to qualify what she meant, and she responded:

*The elderly patients we have on our acute wards are increasing and they need a go-slow approach. This is to support them spiritually, emotionally and physically, but we get so bogged down in paper work, phone calls, mandatory education and so on that it takes us away for the care and caring at the bedside.*

This RN went on to discuss how she believed nursing had changed for the worst when it really should have improved, especially with all the quality that everyone is exposed to nowadays. She discussed the introduction of the holistic model of care and for a while it seemed to work as you were able to do everything for that patient. The RN indicated there are now so many juniors, such as graduates and TEN's, who you have to support and supervise in their patient care, that it is not holistic care any more, rather it seems to be team nursing of a sort.

Workloads and a lack of time were raised by most participants, whether it was juniors, clinical nurses or managers. For nurses working on the floor, lack of time to complete patient related activities weighed heavily on them. A clinician explained:

*I would have to manage 10 patients during my shift as I would have my 5 plus supervise and be responsible for the EN, TEN or Graduates patients. At break time I had the lot to care for. In comparing here to my previous position in a metropolitan Sydney hospital, here there is a total lack of infrastructure and support for the junior staff. We had more graduates but had the clinical support to help them. It’s this lack of initial support that changes the ideals graduates arrive with. They come here with high ideals on how they will save the world and be this expert nurse immediately, get given 10 patients with an EN or worse a TEN and they*
end up providing the same minimum standard of care that we do. It's a never-ending cycle to survive the day.

Patient Acuity

Hospital activity and patient acuity rates (degree of patient illness) have increased over the past ten years. Associated with this increase is a decreasing length of stay. Consequently, patients treated as day patients today would have stayed in hospital a number of days, and a patient who may have required intensive care ten years ago may be a ward high dependency patient today. In support of this, RNs indicated they believed patients were sicker now than some years ago. While hospital data did not identify a shift in DRGs, nurses strongly believed there was a significant change. All participants identified that it took longer now to give the majority of patients their drugs and that the complexity of dressings had changed. They identified they are now doing complex dressings which never occurred before and these take a long time to do.

The ever-increasing size of hospital wards or units, increased patient acuity and numbers, is impacting on the workloads of the NUMs as well as their staff. With the advent of pre-admission clinics and early discharge, patient turnover appears to be increasing, as does their acuity. Prior to pre-admission clinics patients for elective surgery would come into hospital a day or so prior to have all their tests undertaken. In most instances, these patients were not sick, were mobile and required minimal care. Post operatively they would then stay in bed for a day or so prior to being sat out of bed. Now patients come directly from the operating theatre on the day of admissions, require high care at least for the first 4 hours and as soon a practical, these patients are out of bed and showered. According to the participants, this shift in patient care has adversely affected their workloads without what they believe is an increase in staff. As one nurse explained:

Years ago, patients came into hospital a few days before they had surgery, they had their operation and stayed in bed a few days, had bed baths before getting up and becoming mobile more slowly that today. When they were ready to go home they were usually mobile and self-caring. Now, they come in on the day of surgery, have their operation and usually get out of bed the same day or next and have a shower and mobilised very quickly.
They are often sent home within a few days with home visits by RNs visiting for a number of days. We used to have big ups and downs with our workloads, but now its all ups because there is average length of stay and patients have to conform. So it's all go and nurses in my observation are getting burnt out with this constant activity.

Nurses indicated they are allocated sicker patients and, given the current processes of patient allocation, the primary nurses have no idea what is happening at the other end of the ward. One RN stated:

One night on evening duty there was a cardiac arrest and I was covering for the nurse who had gone to supper. I did not get any hand-over so had no idea what was going on for her patients. I just did a round to check IVs and patients were OK. One of these patients arrested and I felt a complete idiot when I was unable to give the MET any relevant information about drugs, history etc. This caused treatment delays and I believe adversely affected this patient’s management. Where was the quality there?

Increased throughput and decreasing length of stay in public hospitals, combined with significant health and information technology development over the past ten years have resulted in work intensification for nurses (Duffield, 2003; Productivity Commission (2005) Australia’s Health Workforce Research Report; Wilson, 2006). As patients are admitted for shorter periods of time, the level of dependency for an admission is higher. That is, patients are sicker and as they improve they are discharged for their recovery phase with community nursing support. The implication for nurses and nursing are that nursing work has intensified and is much more complex than it was in the past.

Similarly, nurses in acute wards have to deal with this constant movement of patients with increased admissions and discharges within their wards. Added to this are the managers’ or team leaders’ perceptions that, by constantly moving the other patients around the ward, this evens up their team’s workload. An EN expressed her frustration at the increased workload that managers cause by this seemingly unnecessary
movement of patients which in turn they believe, decreases nurses’ effectiveness to complete their allocated tasks and develop appropriate nurse-patient relationships;

Every day I come to work hoping and expecting to have some or most of the patients I had the day before. I guarantee though, the NUM will move some or all of my patients and mix up the acuity sometime during the day. I will then spend ages finding out about the new ones (patients) get to know then a little and try to give the care required for the rest of the day. I come the next day and the same thing will happen again and as each day goes by frustration increases and then I may take a sickie as I am worn out.

Nurses have identified that there are numerous tasks, all due at the same time which impact on their workload. For example, one RN explained to me that you could be doing a complex dressing which could take up to an hour, but your other patients may need to have their IV changed or drugs administered. Being able to juggle these multiple tasks is an important component in the development of time management and assessment of workload. This is a skill that develops over time and not something with which you come out of university. Additionally there have been other factors imposed on nurses that have affected workload and participants cited examples such as Occupational Health and Safety, which they believe has taken over to such an extent that nurses are looking after themselves first and then worrying about the patients.

Additionally, there have been numerous changes to the documentation nurses are required to undertake and complete. One significant change over the past years has been the introduction of clinical pathways or care pathways. The care plan has long been associated with nursing and many people believe (inaccurately in my opinion) that it is the sole domain and responsibility of the nurses. This view is damaging to all members of the interdisciplinary team as it shortchanges the non-nursing contributions while working around the nursing staff (Sox, 2001).

I believe the introduction of clinical pathways and care plans is part of the problem of workload. We want the patient to get from A to B and the focus is in the wrong place. It means having their pills at a certain time, getting up and showered at a certain time. I know there are variance reports that can be done, but I really think it’s a mismatch of nursing care and caring.
The majority of participants discussed the concerns that nurses are left to provide the patient with important information that should have been provided by the medical officer:

*It’s left up to the nurses to tell the patients if they can have sex again after their heart attack because the doctors won’t do it or are too embarrassed to do it under this current medical model. They stand at the end of the bed with their entourage and tell the patient absolutely nothing, yet they will chastise me if I am half an hour late with my drugs. It’s a ridiculous scenario as are left wondering and have to ask the nurse.*

The expectations of nurses from other health professionals, particularly medical staff, appear to be increasing, with nurses taking on an increased burden of responsibility for what appears to be medical management. Suggestions by nurses are that they are required, rather than need, to undertake these additional duties. For example, one RN indicated that unless she reviewed all the pathology reports and contact the client’s GP about abnormal results, many of the client’s results would slip through without appropriate treatment and on going management.

Nurses identified issues with workloads and agreed that to ease the burden they had abdicated many of their traditional roles to other carers such as the discharge planner, bed manager and physiotherapists. As a workload issue, it is highlighted that staff do not have the time to be able to make the number of calls necessary today to appropriately discharge a complex patient or a nursing home patient. It’s easier to give this to someone else to do so you don’t get bogged down. As indicated, discharge planning rated highly as an activity that impacted to a major degree on nurses’ workloads. Nurses identified that patients are discharged sooner and sicker today and much more time is consumed arranging discharges. Nurses have now shifted this role to a discharge planner where a position exists, for the complex cases, to ease the burden.

Nurse Unit Managers as well as their staff described their feelings and the difficulties associated with workloads. They have had a significant number of jobs assigned to them, such as cost centre management, quality programs, workplace health and safety and patient complaints management to name a few. Most have no additional resources to support them, such as administrative support, so they take a large amount of work home. One of the major issues identified by a senior RN was the escalating health care
costs, the impact of current medical practices and a lack of awareness of costs. It was explained in the following manner:

*The majority of medical staff are not financially driven and have no hesitation or remorse in ordering the most expensive drugs or additional pathology tests. This is especially obvious when a patient comes from the Emergency Department, has had a battery of tests but the results are not there when the ward RMO comes to admit the patient, so they reorder them.*

**Skill mix**

For nurses working in acute services there was recognition that each shift required appropriate organising to enable nurses to undertake their duties. It was also recognised that this included the need to have the right mix of staff on each shift to allow each nurse to meet their workload obligations, i.e., the right skill mix. The skill mix, comprising registered, enrolled and trainee enrolled nurses, had an impact on an individual's ability to undertake and complete their days allocated workload. The majority of the nurses working in the acute wards spoke of the importance of an appropriate mix of trained and untrained staff to ensure safe patient care. They believed that a good mix of Registered Nurses (RNs) to Enrolled Nurses (ENs) was essential in their ability to provide safe quality care. This is supported by findings from a number of studies (Duffield, 2006; Productivity Commission (2005) Australia’s Health Workforce Research Report; Wilson, 2006). It has obviously been identified by these research projects that appropriate skill mix is important. However, Tom provided an example from his first clinical placement in 2001 when he described what he believed was an unsafe skill mix and that the care he provided was not appropriate for his patients. Tom stated;

*On many days I was in charge of a busy 20-bed unit in Sydney. I was not experienced as a second year RN having just finished my grad year but nevertheless, I was left in charge. I had an agency RN there for the first time, an EN and a new grad and it was hell as I had to check and double check everything for them and as a result my patients suffered.*
Mary’s interview supported Tom’s feelings on the difficulties senior ward nurses are facing each day with skill mix and nurses effectiveness to undertake care required in a busy unit day after day:

On any given day I will have 5 to 6 patients of my own and have to supervise either a junior RN, an EN or even worse a trainee enrolled nurse as well as give all their meds, check their charts and their documentation. I would love to go home sometimes and feel comfortable that everything possible has been done for the patients - because I know it’s not and I have had to learn to turn off as I can’t be everything to everyone given the type of help I had.

In relation to skill mix, the roles of ENs were discussed by a number of participants and all agreed that ENs do an excellent job and are a valuable member of the team. In exploring this further with RNs they raised the ongoing issue of supervision required as ENs are expected to abide by their Scope of Practice. While RNs recognised the importance of this supervision it became frustrating, especially as many of the ENs were experienced and been in the health system for many years. One RN explained that:

It’s a shame ENs cannot have more autonomy in their roles. It’s a terrible step for them to have had it else where and then have it taken away. When you see what ENs in the Army and some country hospitals are able to do and expected to do and then look at what they can do here it must be very exasperating for them. There is a huge role identification problem in NSW that needs to be looked at.

Participants were questioned about the relativity of skill mix and quality care, with the majority of participants indicating this should make no difference except in specialised areas such as the Intensive Care. As one EN explained:

Basic patient care is taught the same way, whether it’s at University for a RN or at TAFE for a TEN. We take a temperature the same way, do a basic dressing the same and make a bed the same. What is not taught is communication or basic common sense.
While skill mix did not appear to impact on basic patient care provision, it did impact on the quality of complex care provided. This was indicated by a participant who suggested to me that the amount of supervision one could give a junior staff member meant it was quicker and easier to do the job yourself rather than take precious time in showing someone how to do it. As the participant explained:

_In Sydney we had CNEs and CNCs whose role it was to take the juniors under their wing and show them how to do complex procedures properly. I am not saying I don’t do things properly, I do, but because I am jack of all trades as a senior, teaching comes way down on my day to day list._

Given the changes in demographics, an increasing demand for nursing care and the current crisis in nursing workforce, skill mix continues to be an important debate in nursing (Spilsbury & Myer, 2001; Goodin, 2003; Wickett, 2003; Queensland Nurses Union Submission to the Queensland Health System Review, 2005; Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra). Consequently, there is a constant issue with always ensuring a safe skill mix which also impacts on the Nurse Unit/Ward Managers (NUMs), who are constantly faced with recruitment of suitable skilled staff to replace those retiring seniors and staff who leave or move across to other less demanding positions. The aging workforce and subsequent loss of skills is impacting on NUMs and management alike. Added to this the increasing demands to reduce costs, highlights pressures NUMs are under in the recruitment of more junior RNs, ENs and TENs while at the same time, ensuring appropriate skill mix for a safe environment for both the staff and patients.

The evidence suggests that Registered Nurses do make a difference. However, the research was unable to offer guidance on what is the most effective skill mix (Spilsbury & Myer 2001). There are now fewer experienced RNs on the busy acute units where this study was undertaken and therefore, the expectations from RNs and of those who work with them, seems to have increased. Due to their own workloads, many RNs expect the ENs and TENs to do the mundane, daily tasks such as showers, bed making, cleaning and so forth. From an interview with ENs it was apparent that the unwillingness of RNs to support and help them with their additional workloads played a key role in their experiences:
If you have to take some of the RNs here, they just seem to swan around only doing what they have to get through the day. This is probably the drugs, IV, dressings and any other complex procedure.

I have been around for some time and I know who the good RNs are. I wait for the RNs to put their roster in and then work my shifts around the good ones. In this way, I know that for most of my shifts, I will work with a RN who is a team player and will share the workload except for the complex things, which I know I can do. We will do the showers and make beds together and then I will do the obs while the RN does the meds. It's about teamwork and sharing the load to enable both of us to get through the day.

Supervision

In comparing skill mix, many of the RNs indicated inappropriateness of their high workload as a result of the increased supervision, education, mentoring and checking required of the other staff on their shift. This degree of supervision was mentioned by a RN, who had recently moved from a large city hospital and found there was an expectation by staff to go that extra yard because of the lack of support:

In metropolitan hospitals the difference (skill mix) is nowhere as noticeable as there are much more support processes in place and more staff resources such as full time clinical nurse educators (CNE) and Clinical Nurse Consultants (CNCs), and there was often this support on evening shift on the more complex units. In these smaller places these resources don’t exist and ultimately it is both the junior and senior staff who suffer with stress, burnout and poor patient care.

In discussions with RNs about teamwork and workloads, they identified their role involved a lot of supervision and education and if they did not devolve the “dirty” work to others there would be an inability for them to do their role. RNs who are frequently working as the senior on many shifts spoke of the inadequacies of informal support for them and the need for greater formal supervision in the workplace of junior staff.
Clinical supervision of others has become another task in the numerous duties nurses do each and every day. All RNs interviewed indicated they should be providing the clinical supervision of juniors and students but few RNs agreed or are able to do it. RNs and ENs alike identified frequent interruptions as one of the main reasons they were unable to provide this clinical supervision, especially when they were the only senior on that shift. There was no time to spend with a junior and assist with patient care. As a consequence of multi-tasking, nurses are constantly interrupted. They begin a procedure, a bell rings, relatives want to know a condition of another patient and then if they are not drawn off to a new problem, they try returning to the original procedure.

ENs interviewed indicated they were feeling equally frustrated at the constant supervision and checking but were aware it was required. They all felt the RN’s anxieties at the constant supervision required of them and frequently asked those (RNs) if they could help. There was unwillingness by RNs to help and/or support ENs and TENs or even delegate additional tasks to these staff.

There are not enough RNs and many of them need supervision themselves. It’s also frustrating to get a RN to check your meds as many of them don’t want to do this - supervise - as they are so busy themselves or just don’t pull their weight. On the other hand if you get a good one (RN) to work with you know you will have a great day, there will be good teamwork and the patients will get good care.

Patient allocation

From interviews with both RNs and ENs it is apparent that the current method of patient allocation and lack of supportiveness played a key role in inability to organise their workloads. In principle, most nurses interviewed held the notion of patient allocation in high regard. However, this allocation was dependant on who was allocated the patients in the next part of the ward, as there was a requirement that this RN or EN would assist as necessary. It was apparent from all participants that the method of patient allocation and their acuity was a major concern for them and affected their workload significantly. It was indicated that one could have six patients assigned to you and these could be easy to manage but conversely if you had high dependency patients, theatre patients and more complex care then there these six received minimal care.
Peer Support

Evidence from interviews indicated there should be support from peers when one’s workload became excessive but this did not occur as frequently as it should, often due to the other staffs’ own workload. One RN describes a recent experience:

*If you have to go and take a patient to X-Ray, theatre or something and you are gone for some time, no one follows up or cares for your patients despite having asked another EN or RN to do so. I came back from a long stint in X-Ray because the X-Ray nurse was off, only to find one of my elderly ladies in a wet bed and crying and meds had not been given. No one had answered her buzzer and it took me some time to settle and comfort her. Consequently I had gotten very behind and was late off.*

As I interviewed participants the lack of resources to assist them with patient movement, bed transfers and assisting with showers for heavy patients was raised a number of times. It would appear that orderlies or ward assistants were infrequently available when really needed. It was explained that:

*While they have a list of things to do each day, they are often taken away or called away to do other things. They are also now required to do security duties and get called away for an incident somewhere in the organisation or have to respond to a medical emergency call. This adds to their workload and delays us.*

In many hospitals throughout the State of New South Wales, there is an acceptance that a 70/30 RN/EN ratio is satisfactory, again depending on the level of the RNs. However, where this exists there are additional staff support persons and networks to manage this. The transition from Student Nurse to Registered Nurse can be confusing, daunting and often frightening. In tertiary centres, there are many processes in place to assist, support and educate acute care nurses caring for patients. These include clinical educators, senior nurses, peer support, multidisciplinary meetings and specific graduate programs designed for beginning practitioners.
However, in the remote and rural areas, this infra-structure often does not exist and staff have to rely on their peers or each other for support. A number of these nurses spoke of the inadequacies of informal and formal supports and the need for greater formal supervision in the workplace. However, it is often the various skills of the staff that will impact on the effectiveness of new staff’s ability to become part of the team. Non nursing duties were raised a number of times by participants with duties such as filing, cleaning stock rooms and answering the phone as the major ones identified:

*I know we shouldn’t do these things, but if you don’t have the pathology tests ready for the VMOs rounds it may compromise their care and heaven forbid cause them to have their length of stay increased. Also if you don’t chase around and fix up their meals they will often miss out, or hassle the pharmacy for medications it just doesn’t get done.*

A Nurse Manager stated there was zero clerical support, in many units, therefore the nurses were doing all the clerical duties in that areas as well as try to provide good nursing care. As a result there are numerous patient complaints that have to be addressed, but again the patients don’t understand nurses’ workloads. All the patients want is the nurse to provide care, answer the bell quickly and talk to them if they are worried.

**Other Nursing Roles**

During an interview with an EN, workload and lack of support were cited as her biggest issue, because if you are overloaded, you cannot give the care that you would like to give. Additionally ENs interviewed asserted it was time their roles were seriously reviewed. Accordingly it was suggested that:

*No one really looks at what we do or how we do it as compared to the RNs. I see the only difference being complex procedures and medication administration. I enjoy my job, love having my own patients to care for but get annoyed when I can’t get the RN to do the drugs for my patients. I hope this will change in the future once we have undergone the medication endorsement.*
Closely allied to skill mix, is types of staff on each shift, where both skill mix and staffing types are factors which influence the amount of time staff can spend with a patient. Participants in this research identified that Trainee Enrolled Nurses (TENs) were counted in staffing establishments as one full time equivalent, which is the same as a Registered Nurse. Similarly, they argue that a beginning RN is also given the same status. In reality there is no comparison in the ability of a TEN or a junior RN to undertake the same workload or complexity of care as that of a senior RN on the unit due to their unpreparedness to undertake complex care or procedures. A number of RNs stated that there was:

A major fault of a system that believes a nurse is a nurse is a nurse and health bureaucrats don’t understand what the real world of a busy medical ward is like.

Further, one Registered Nurse was very vocal in her opinion stating that:

While the system recognises that a TEN is the same FTE as RN there needs to be recognition that a TEN is totally ill prepared to undertake the responsibilities as even an endorsed EN would. Most come into training off the street and have no b… idea of what nursing is all about and we spend so much time helping them that our work suffers and so do the patients. It’s about time management of the Health Department got a grip on the real world. Its disappointing even our Chief Nurse is of the same opinion.

The issue raised in relation to the TEN program was the requirement that TENs become a full member of a ward staff profile once they had completed their first TAFE Block. The implications for nurses on the wards were the significant increase in their workload due to the amount of supervision required as well as having to undertake many of the tasks an untrained worker without the requisite skills and knowledge is unable to do. In other words, a RN working with a TEN has to manage 10 patients rather than his or her allocated 5 patients.

From experiences with the TEN program, RNs and ENs alike were extremely concerned that TENs were exposed to almost the same workload as an EN, despite the TEN probably only have been in the health care industry a few weeks. TENs are therefore
forced into an accelerated “on the job” training process whereby they have to develop the necessary skill to manage a patient load. The key to successful on the job training is the provision of quality resources, time to learn and structured supervision (Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra). RNs indicated this is not possible in the current work environment and believe it is foolhardy and unsafe both for the trainee and the patient, as well as placing an undue burden on the supervising staff.

As a result, TENs who have no acute health experience and often new graduates have difficulty assimilating into the workplace as Registered Nurses resent them and feel they carry them. According to a number of the participants, there are similar assimilation issues with new graduates, especially if they have had no pre entry nursing experience. Participants indicated that those graduates who had either worked as Enrolled Nurses or Assistants in Nursing were one step ahead and were able to cope with numerous interruptions to their daily schedules. Conversely, other graduates were unable to manage disruptions, particularly on the busy wards where prioritisation is vital. Participants also identified that many nurses and especially new graduates do not speak up early enough that they are overloaded and cannot cope with their workload.

Interestingly a number of the senior RNs who had significant contact with management, indicated Management (non nurses) had a different idea about staff numbers. They firmly believed “a nurse was a nurse was a nurse” regardless of their skill level. To all participants this was seen as insulting and fostered a retrograde step for nurses. Nurses strongly believed they would not function safely in an area outside their expertise and questioned how management expected a trainee to function without the appropriate training and education. One RN likened it to a first year resident performing a heart transplant. The medical staff would not accept this and nurses are not accepting of TENs acting outside their scope of practice, despite it impacting on their workload.

In line with this argument it was interesting to note that all those non-managerial participants interviewed identified they were not financially driven, but rather it was the health system that was driven by the dollar. Their interest lay in providing their patients with appropriate care, not how much it cost.
Staff shortages

The shortage of RNs was a major issue identified during this research, with a number of factors impacting on this. RNs are the largest group of health professionals in the health arena, with nursing experiencing its largest influx of women into the profession during the 1960s and 1970s (Goodin, 2003; Wickett, 2003). Since then there has been an explosion of other female career opportunities resulting in a steady decline of women entering the nursing profession (Goodin, 2003). Consequently, the baby boomers are now dominating the nursing workforce and the retirement age of these women is imminent. Subsequently, more experienced middle aged women will be leaving the workforce at an alarming rate, taking with them vast amounts of skills and knowledge that can never be replaced (Jones, 2002b; Goodin, 2003; Wickett, 2003; Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra; Duffield, 2006).

The aging workforce came up a number of times during various interviews with staff suggesting that the older nursing workforce have more sick leave and more time off for workers compensation related injuries such as back problems and surgical procedural requirements. Nursing staff also indicated that older nurses have more difficulty with new technology and require more supervision with this. This is demonstrated by the following statement from a senior RN:

There are a lot of nurses, who have a problem with new technology, even now, but it is not the young ones, it will be the older ones who have the issues. They will learn the basics to get the machine to operate, and I did the same thing, but when you ground them down to find out what their knowledge of the equipment is, the basics are ok, but anything complex they had not bothered to learn. Once things start to get complex, they do not have the knowledge to manage and it shows up. The classic is changing ventilator settings and we have all seen that and they are good at hiding behind the lack of skills and admit they are deficit in these skills and you have to use all your own skills and techniques to get them to learn. This takes time and requires heaps of supervision.
Conversely, the aging workforce will have an impact on the supply of nurse educators and leave numerous gaps in educational arenas such as staff development centres and university programs (Goodin, 2003; Wickett, 2003). This in turn is going to impact on the organisation’s ability to provide clinical and theoretical programs and the supervision of staff. Also, given the current shortage of nurses and the current situation of the aging workforce world wide, it has been identified that education options for older nurses have been found to be variable (Attree, 2001).

There has been a great deal of literature written and spoken about the aging nursing workforce (Jones, 2002 (b); Productivity Commission (2005) Australia’s Health Workforce Research Report). Participants indicated there is a need to look strategically at recruitment especially in rural areas. It was suggested by one RN that:

_We need to look at the current journals about Magnet hospitals and how they have no problem attracting and retaining staff. I know Australia is behind the USA, but this is one area we should catch up on rapidly and be on par with. There is one hospital in Queensland that has attained Magnet Hospital Status and this is an excellent achievement and we should all be working with this as our aim._

The nursing education system until recently has not been geared for the older nurse in terms of professional development and return to practice decisions. However in NSW, because of the acute shortage of nurses, the Department of Health (DOH) has initiated a re-entry program for RNs who have been out of the workforce for many years. Those who have approached the Health Service where this research was conducted have been out of mainstream nursing and appear to have none or little knowledge of today’s complexities of care, for example the high pace of technological processes and occupational changes. For these reasons constant clinical supervision is necessary for the initial settling in period. Additionally, these re-entry older nurses have been identified as lacking the physical stamina to undertake effective cardiac compressions during simulated CPR:

_They (re-entry nurses) need constant supervision and assistance and often because they are in the older age group, don’t readily grasp the concepts or the acuteness of the clinical situation, or acknowledge the deficit in their_
own technological abilities and physical stamina, especially when it comes to working IV machines, monitors, reading ECGs and keeping pace with younger staff on an acute busy unit. It all falls back on usually the RN who is in charge as s/he is the only skilled person on the unit.

A number of participants discussed opportunities for improving staff numbers without significant cost to the organisation, with support being given to the concept of replacing a RN or EN with two 3rd year student nurses per group who would then be supervised by a RN. The RN would not take a patient load; rather s/he would supervise and teach the students. In this way, the RN would be the mentor, preceptor and teacher for time management as well as clinical skill development. Students would learn about quality concepts as well as be able to develop their knowledge base on clinical issues. It was thought this would enable graduates to “hit the ground running” once they graduated as well as have the confidence to manage patient care.

Another participant indicated that a change in unit culture would have an influence on clinical outcomes as this is heavily linked to skill mix. All participants when asked to qualify their reasoning for this indicated that first year RNs and trainee Enrolled Nurses are not going to be able to provide the same level of nursing care as a senior RN or Clinical Nurse. While it is recognised that it is neither cost effective or educationally sound to run a unit on all senior staff, participants indicated there were a number of ways in which organisations could positively influence skill mix, for example:

I believe we could look at having more junior staff such as new graduates and TENs, but to do this we need to have a different method of supervision rather than have the busy RN with a heavy clinical load do this. Some Metropolitan hospitals have achieved this by having a supernumerary RN, who can supervise a couple of juniors who have direct patient responsibility. This RN can then teach, supervise complex procedures and administration drugs in a timely manner.

Another participant supported this:

Without this type of supervision, there is no quality and no time to do quality activities as we are struggling to get through our shift each day. As
As I continued to explore team nursing with participants, the issue of power bases emerged. This was especially so for the junior RNs, ENs and TENs. It was explained to me by an EN:

*A number of RNs are hesitant at allowing us to do some things because they feel some of their power has been taken from them.*

I investigated this concept with a number of RNs once it had been raised with me. These RNs agreed there were some RNs who had not adapted to the changes of having TENs and graduate nurses around despite this having been the norm for a number of years. It was suggested that some of the “older” RNs had still not moved from the hospital based concept and the power and intimidation they exerted over students then. However, I was unable to substantiate this at other interviews. The current participants in this research all appeared to support university graduates, but were not supportive of the current TEN TAFE program.

**Preparedness for practice**

**Mentoring and preceptorship**

The concept of mentoring is not new to nursing. Florence Nightingale was known to have had multiple mentors as well as being a mentor to others. Mentoring promotes the psychosocial and instrumental development of the new RN over an extended period of time. The psychosocial role of the mentor promotes acceptance, confirmation, and role acquisition in the individual being mentored. The instrumental role of the mentor involves coaching, teaching, and a firm belief in the charge’s ability to succeed (Gordon, 2000).

As I further explored and questioned the participants, there appeared to be an overwhelming support for the new graduates and how to role model, mentor and nurture neophytes and develop their on the job skills. Most health care organisations have developed a new graduate program in one form or other and this was wholeheartedly supported by all the participants. However, what was pointed out was that the smaller
rural and country hospitals do not have the infrastructure or resources to support this type of program. As one RN explained:

The RN’s here certainly help students and graduates, it’s our role and responsibility to teach them, but the bottom line is its another job we have to do on top of our already busy workload. You are consistently drawing knowledge out of your head of past experiences or, have to demonstrate how to do something. It’s very draining and stressful to have face this each day but in the end you get there and it’s worth it when they say “Thank you”, I really learnt something today. Nevertheless the expectations on them and us are huge and often unrealistic.

The discussion continued with participants indicating that programs in their specific organisations have only commenced for a little while and the results are variable, as many of the juniors believe they are still " being thrown in the deep end". One RN indicated that the first 6 months on the ward was the most stressful experience ever and cited the example:

On my first day on the ward I reported to the NUM’s office and she told me “We are very busy her. We are grateful you have come but it’s a sink or swim situation here. Surely it’s about nurturing our young not cannibalising them as happened to me. The University needs to explore options for more hands on experiences. At 21 or 22 most graduates don’t know anything about death and dying, drug and alcohol problems, palliation or dealing with grieving relatives and what to say to them. Ultimately we learn, carry on but, at what price? I am still nursing but some of my friends didn’t make it; it was too stressful.

Skill development

A great deal of discussion occurred with participants on how they developed their skill to be able to provide quality patient care as they progressed through their career. There was an acceptance by most RNs interviewed, that progression through experiences was how their learning occurred:
I was able to learn only through watching my peers and on going experiences. I remember when I first graduated and all new grads go through the time when you are handed the keys and said: “We are off to lunch and you are in charge you will be fine”, tell you about Mrs. Blogs in bed 8 and off they go. You start to get a bit of confidence and as you work with a whole range of different people and for me I felt some were more worthy of attention than others and I would start asking them questions and emulating them, asking them to show me things. I wouldn't pick someone at random but would pick the person I felt would do the best job in showing me what to do. There are a lot of nurses out there who are good role models. I am university trained and was one of the early ones and I learnt a lot of anatomy and physiology and learnt about the body and systems.

For acute medical patients, the readiness in the skills and abilities of nurses to care for these patients is imperative. Many of these patients are connected to monitors that need constant review and interpretation as well as being on complex drug administration regimes. In most instances these drugs are administered though IV, CVC or PIC lines' which all require the RN to achieve competency attainment prior to being able to administer the drugs. This in itself is partly managed by the RN’s own motivation, the availability of educational resources and requirements of the job. If a patient suddenly developed chest pain, the MO will want to know all the details. As described by one RN:

The first thing they (the doctor) is going to ask you is: “Have you done the ECG”, and so the nurses have to do the ECGs and you have to understand what you are looking at. What’s the point of doing it if you can't read it, so this is another thing we have taken on and have had to learn”.

During many of the interviews it became obvious that self motivation and drive were key factors that kept nurses going to provide the care that patients required. However, during this research I was able to identify that many nurses had been in one stream of nursing for a long period of time, but had not continued with their own education and skill development. This in turn impacted on their ability to supervise and teach others, as they were not putting the effort into their own skill development. For example they were unaware of the statutory regulations or their obligations under various Acts.
Nevertheless, nurses are expected to maintain their skills over months and years and be consistent with these skills. Staff interviewed explained that this expectation included dealing with relatives, managing acute clinical issues and interacting with a whole range of people. It was further identified that senior nurses managed to develop the skill to juggle multiple tasks and this was supported by most of the participants who identified that they learned this through watching, emulating their peers and experience. As one RN stated:

_I didn’t think I would ever learn how to juggle these multiple tasks but now I can do a phenomenal amount in a day and it gets better all the time as you yourself develop._

Clinical Supervision

Clinical supervision has been adopted as a professional function not only in specialised areas of nursing, but also other health related disciplines for some years (Page, 2005; Productivity Commission (2005), Australia’s Health Workforce, Research Report, Canberra). Also, clinical supervision is multifaceted and covers a wide range of practices. In exploring the concept of appropriate skill development and clinical supervision, a number of participants indicated there should be more controls on this aspect of our development i.e. clinical supervision. Additionally, clinical supervision is an important part of clinical governance and should be considered as important for the patient’s well being as well as maintaining and improving standards of care (Wilson, 2006). With the changes of nursing education moving to the higher education system (Productivity Commission, 2005), Australia’s Health Workforce, Research Report, Canberra) clinical supervision was lauded as a strategy for managing some of these changes. However it appears that the hospital and the profession have been left to manage this change for itself under the banner of clinical supervision (Yegdich, 1999; Madsen, 2000). One participant put it to me that:

_We need our clinicians to actually understand what clinical supervision is all about, and it’s about improving your own clinical skills. There must be some way of knowing at what level you are. Without clinical supervision, there is no
way you can evaluate your own practice, it’s that peer review process that is lacking.

As I continued to explore this concept with nurses, Jess indicated in her interview that other methods some specialised nurses utilised to evaluate their practice was feedback from medical staff and being told you are doing a good job. In areas where there may only be one specialised RN (nurse practitioner) working with a medical specialist it appears to be the preferred method of assessment. There would be little opportunity for a more experienced RN to undertake this assessment. In the case of one participant, he regularly received feedback from a medical officer about his practice. Additionally, in specialised areas, staff get together, support each other and supervises each other’s practices.

For nurses working in specialised areas there are more opportunities for a group to get together, study or undertake regular in-service. For example the Emergency Departments have Clinical Nurse Educators, Staff Specialists and a Director in most instances that will provide in-service for nurses as well as medical staff. It’s also mandatory for medical staff to attend and it’s easier for nurses to attend these sessions in the department. This all helps to improve clinical practice especially now that Nurse Initiated Procedures are in place as these specialised nurses have to attain competency as well as maintain it.

I continued to discuss this with the particular participant, who indicated there were similar opportunities in other specialties such as Intensive Care and Psychiatry where there are Graduate Diplomas, Masters Degrees and Professional Doctorates should one wish to advance to a high level. However he indicated there was reluctance by nurses generally to do this further education, as the current career structure does not support or remunerate clinical advancement.

Participants indicated the current NSW career structure was geared to the management stream with little opportunity for the clinical stream. As one of the senior clinicians suggested:

There is something like 10-12 management steps, which start at Nurse Manager or Nurse Unit Manager and progress up to Senior Nurse Manager.
level 9. These are not offered to clinicians with the top clinical position being Nurse Practitioner which equates to about NM3, Why would we do this when there is no incentive to progress clinically? It's no wonder we clinicians who are single parents or the breadwinners are opting out and moving into management.

Skill development is also about learning how to do your jobs the right way and in a safe way rather than doing it unsafely and poorly. As one of the participants explained:

*There is a good way and a bad way to do even the simplest tasks, for example, taking someone off the toilet. Do it wrong and you can really hurt the patient. Other examples such as inserting a catheter or removing a chest tube incorrectly and the patient can suffer serious consequences. These skills are only learnt over time, sometimes following your own mistakes. The development of core nursing skills is an apprenticeship that only time can help you acquire.*

The concept of lack of human resources was explored further with this lack of resources to assist skill development being reiterated throughout all the interviews, with an emphasis placed on the need for clinical education and clinical educators for each clinical unit. These educators were identified as essential and necessary to assist students, graduates and experienced staff learn and develop new skill for practice improvement. As nurses grow and develop additional skills, the dependence and need for educational experiences increases.

Two of the participants had worked as AINs during their University undergraduate years and believed they would not have been the nurses they are today without that the educational support provided to them. Both also believed that these educational opportunities assisted them assimilate into hospital routines much easier than their friends.

Additionally, participants identified that not all skill development occurs in the clinical arena, as there are many other methods of learning for all levels of staff. For example, one RN identified;
Conferences and seminars used to be excellent places to learn clinical information as well as network with similar experts. However we now get information of financial trends, government initiatives and university guff. No longer are conferences about clinical bedside care, which is what nurses go to conferences for. The focus has been lost to commercialism with costs now too prohibitive for most of us to attend.

In a similar vein, a senior RN indicated there was a skill deficit even in those nurses who had advanced to CNS status. Concerns raised suggested these nurses were not practicing at an advanced level as required by the NSWNA, but there were options to either remove the status or ensure appropriate skill enhancement. There was some debate with this participant on why CNC status had not been addressed previously and he indicated a number of reasons. Firstly he believed RNs had achieved the recognition but had failed to progress any further skill enhancement and secondly there was not an appropriate performance review process in place.

Rural hospitals have difficulties attracting suitably qualified staff, as there are limited benefits for those wishing to relocate. One of the participants indicated one hospital in his area had been trying to recruit to a level 3 position for 6 months without success. It was also identified that staff employed at rural organisations have very limited opportunities for attending tertiary centers for ongoing education and skill development. Reasons cited for this were distance, cost and inability to leave home, as they were the sole parent.

The balance between senior and junior staff is integral to assisting the junior’s skill development and to be able to provide safe quality care. As one clinician explained:

All nurses are educators and they all eventually educate themselves or receive formal education on how to teach others. I know most of the seniors on my ward have done the university preceptor program. It’s our responsibility whether it’s via a formal program mentoring or preceptorship to teach and this needs to occur. This is especially so where there are junior staff, however, this does not occur as it should as we get so bogged down in the paperwork and so on.
In discussing the concept of skill development for specialised areas, Harry indicated it is becoming more and more difficult to attract staff and he believes this is because of the current requirements needed to enter nursing. As he explains:

> You have to get a high TE score to go to university for 3 years and probably not get any income during that time. You also get limited exposure to these specialised areas during your training so you can get your appetite wetted so to speak. So when it comes to specialising say in psychiatric nursing, there is no incentive as it is not attractive, it’s not “cutting edge stuff”. Also you have to pay the course fees and having just paid for your three-year training we are not going to attract new graduates to this area.

**Nurse Manager Training**

Additional skill development and on the job training is required for senior nurses to enter the management arena. However, it was identified by participants that a number of managers had been “head hunted” to undertake management roles despite their lack of educational preparedness as well as not being in line with organizational policy. One RN suggested there were two types of people who went into management, who were the business minded person and the clinical leader type. Those who were financially driven and make the best business managers were not necessarily good leaders and failed to get the best out of their staff while those clinicians who went down this the management road were good clinicians, motivated their staff, but were poor managers. It was rare, according to the participants, to have someone who was worthy as a leader and a manager.

> I believe the problem is that nursing has managers not leaders. Good managers will tell you that you have done a great job and give you a pat on the back.

> Most supervisors or managers rarely praise their staff so you have to pat yourself on the back when you know you have done a good job

Senior RNs were quite outspoken and identified that a lack of leadership goes back to the university and stated:
I had a lecturer who was a feminist and a Marxist, who had no idea about management or clinical leadership or the real world for that matter, but who professed her clinical expertise of 20 years ago.

There is a particular type of senior RN who can organise their shift, delegate well and allocate workloads fairly, however this is rare as most are unable to organise themselves let alone a team of staff. I believe many of the RNs should go back to the classroom and learn the art of delegation and leadership.

Delegation and the ability of senior ward staff to do this well was raised a number of times throughout the interviews. A number of the participants clearly indicated that senior RNs should carry the whole load, while others indicated it was this lack of delegation that caused frustrations.

While it is recognised that both today’s workloads and patient turnover appear to have increased, it’s clear many RNs in ward leadership roles don’t change with the times. There is an expectation that as an RN who progresses up the hierarchal ladder by length of service rather than skills, that they will take on the in charge role, despite often not having done any previous management training or education for a leadership role. It was explained that:

In being allocated in charge of shift, you really need some previous experience, as you have to take account of your staff and their capabilities. Most don’t want to do this, as they are not trained in management and often become antagonistic towards their junior staff and this then reflects on patient care. There is then an atmosphere created and it’s very straining for staff, quality goes down and complaints start. It’s a snowball effect. Experienced team leaders, managers or leaders don’t have these same problems as they consider all the issues.

For health care organisations across the USA and UK, Magnet Hospitals have become the models for nursing care (Buchan, 1994; Buchanan, 1999; Kramer & Schmalenberg, 2002). Magnet Hospitals have created an environment that supports nursing practice and focuses on professional autonomy, decision making at the bedside, nursing
involvement in determining the nursing work environment, professional education, career development and nursing leadership. Quantitative evidence indicates that organisations that have achieved Magnet status have improved nurse patient ratios, patient care outcomes are better and there is a higher degree of patient satisfaction (Sochalski et al. 1997).

Emotional Overload

Stress and burnout

One of the key issues identified by participants was the degree of stress associated with nursing in busy clinical areas. Stress and burnout are very costly to individuals and organisations. In addition to affecting well-being and health, stress has also been identified as a reason nurses leave the profession. Additionally, stress and burnout can also have economic costs in the form of high absenteeism, labour turnover, industrial relations difficulties, and poor quality control (Jones, 2002b; Hegney, Plank & Parker, 2003). Undoubtedly, if burnout among nurses is to be prevented, it is critical that key sources of stress be identified.

It is quite possible that nursing is one of the most underrated and misunderstood professions. The public adores nurses, but they just don't 'get' that nursing is a complex and demanding profession that exacts a toll on every nurse who gives patient care his or her all. And surprisingly, I think that sometimes nurses don't get it either. Nurses don't get how extraordinary they are, or all they bring to their practice. Instead, they run at full speed trying to do all that's asked of them and then some. Here we sit, in the middle of a severe nursing shortage, as many exhausted and burned-out nurses struggle to make it from one shift to the next. Where did the idealism go? When did the hopes so many nurses started out with disappear? And more importantly, how can nurses find it again?

It was interesting when I talked to staff about stress and how they individually managed this that a number of them identified that humour was a key factor for them. As one RN explained:
The ways many of us deal with stress is by humour and have a bit of a laugh with ourselves or with the patients. Laugh at things that you would normally brush off, laugh in the tearoom and at jokes that would normally not be funny. It’s about de-stressing, that’s life, but if you didn’t laugh you would cry an awful lot.

The nurses I talked to openly discussed having to consistently hide their emotions from their patients and the difficulties they had in doing this, rather than justifying what they felt. One RN told of a recent event when he had to do this:

I had a patient in one room that needed his dressing done and I told him I should be back in about 10 minutes. In the next room I had a man who was dying; he had no family and was alone. When I checked him he was going very quickly and he asked me to stay. I made a conscious decision this man needed me more than the bloke who needed his dressing changed. Not really a hard decision. When I finally got back to the other man he was angry and his relatives were tut tutting about the delay. I bowed my head, said I was sorry something had come up and got on with the dressing so I could get out of there and debrief. Perhaps in hindsight I should have told them the truth and I had just helped a lonely man die in peace, but I didn’t, it was none of their business. I was like all the others before me; I just carried on with my job and kept my emotions to myself.

I talked to participants about apologising to patients and all of them indicated they would not talk about the real reasons they were delayed, but rather made up some excuse to the patient, otherwise they would spend all day apologising and not get anywhere. As someone put it:

They (the patients) don’t have the insight into what we really do all day and we don’t expect them to. Regardless of how well educated the patients are, they really don’t have a clue as to the stresses and emotional fallout we have each day with having to deal with people dying who shouldn’t, children being mistreated, traumas and so forth. Most patients think they are the only ones on the ward and want and expect attention as soon as they call or earlier. We just can be everything to everyone.
During all the interviews with the participants it became apparent to me that emotional overload, burnout and stress related issues were major factors in nurses changing jobs and leaving the clinical areas for what they believed would be less stressful positions. Participants indicated either they had moved or colleagues and moved to positions, such as management, community nursing, day surgical units and education. As one senior RN explained:

_We as women and mothers don’t need all this stress and emotional baggage to take home every day after work. We don’t want to go home too stressed to enjoy our children or not be able to go out. As a mother my family comes before the job that’s why I have moved from the shift work and the hectic chaotic ward to this job. Its Monday to Friday, no shift work and I am dealing with mostly well patients who come and go each day._

Interesting concepts emerged as I questioned nurses about why they chose nursing as a career and these are identified in their individual stories contained in Chapter 3. These ranged from good pay, needing a career, liking the idea of travel and nursing giving that opportunity and image. In exploring image one RN identified with nurses on TV and explained:

_There is an image that is depicted on TV and in the movies where nurses are put on pedestals and shows like A Country Practice exemplified what I wanted to be. Brendan was worshiped by the local community and by the staff and I thought as a naive teenager that’s how I would like to be treated as a nurse. Little did I know of the real world!_

All participants interviewed indicated the pay structure does attract nurses, but believed this did not keep nurses in the workforce. Issues such as unsociable hours and poor flexibility of work times were identified. Many of the participants interviewed indicated they were often on an emotional roller coaster when it came to arranging their private family and social lives, as they often had no idea what their roster would be next month. Uncertainty is a key factor in driving nurses away from acute areas into Monday to Friday positions of education, management, Day Surgeries and so forth. Participants
identified with relatives who worked in other service industries and who knew their rosters a year ahead. As one explained:

Look at the fire brigade, my brother knows what shift he has next Christmas, I don’t know what I am doing next week, and it’s so frustrating. Despite there being Union requirements the NUMs struggle every month in putting the roster together.

As these issues were identified during interviews, I asked the participants whether this had anything to do with the basic introduction of potential nurses in undergraduate programs. The university graduates identified there was a lack of information given to them as students about the realities of nursing in general. Participants also believed that university lecturers don’t understand the importance and requirements of current acute clinical experiences shift work and the impact of workloads and stress. As one RN explained:

There are many educators who are lousy clinicians and they are unable to provide students with lived experiences of nursing. It is rare to find an educator who can give a lecture and include real examples into the picture, for example, talk about a case and build the lecture around that. It is this image of our lectures that we learn from, but when we get to the real world there is no comparison.

There were a number of suggestions on how universities could achieve this with the obvious choice being the increasing move to conjoint appointments of expert clinical nurses to teach the clinical component.

Job satisfaction and workloads came out at most interviews as an important stressor for all nurses. Participants indicated that inappropriate patient allocation often caused resentment as one staff member was having a “cruisy day” while another was flat out and “stressed to the max”. Participants suggested that if this occurred too often then someone would take a sickie the next day to recover, particularly if they knew they would have the same patients the next day. This in turn only added more stress to the other team members as there would be a reliever sent at short notice who didn’t know the patients and stress levels would be worse.
As I explored further, participants identified that many of their work peers were dissatisfied with their lot, but had no where they could go. Reasons included family commitments, financial liabilities and fear of moving. In exploring the workload issues in this category I identified that job dissatisfaction impacted on staff morale and that frustrations were often vented in the tea rooms either at each other or, in some cases may adversely affected patient care. In exploring this I was able to determine that as workload and dissatisfaction increased, nurses often became short tempered with their patients and often rude to their peers.

As RNs discussed their concerns for the staff they worked with such as ENs TENs and new graduates, it was apparent they were quite stressed about the amount of work these staff had to contend with. One RN explained:

We have feelings of responsibility and concern that we are unable to show these staff what is needed during the shift. Its not that we don't trust either the EN, TEN or grad, but rather it was being aware that they were doing things they shouldn't be doing and because the RNs were having problems with their own workload often let these practices continue which compounded their feeling of inadequacy.

The impact of moving to and living in a small town also has an adverse affect on some with one RN still coming to terms with this. As she identified:

I thought we had moved from Sydney to here to get away from the rat race only to be hit with another type of stress. In moving here I thought we would have a degree of anonymity, but I see my patients at the shops, school and even if we go out to dinner they are at the next table. I find this intrusive and intimidating with patients intruding on our private life.

Continual stress related to patient workloads, expectations of nurses and grief has an emotional impact on many nurses especially in small country towns where everyone knows everyone. These comments support the previous participant’s views of living with your work.
This isn't about quality care, but can impact on the care you give. Nurses get to wear an awful lot of grief and emotional strain over the years that never get talked about. I am not saying there isn't counseling available and I am not sure how many use it and not saying there isn't support on the wards, there is, but little things build up year after year and I have noticed it more in a small country town as you know so many of them (patients that is). They come in and are sick, in pain and some die, that's life. But sometimes it crosses over the line when you are working in casualty and it's a young person, you know them and their families and it's hard and don't know if the Health Service recognises this.

Being recognised for a job well done rated highly as most participants interviewed were rarely acknowledged for this. Staff identified this was important for their daily morale to have someone in management recognise their efforts. Participants also identified there was a concern amongst ward staff that the organisational hierarchy rarely visited the ward and then it was mostly to investigate a complaint.

**Dialoguing**

**Communication**

Communication is a method of drawing together the health care team, patients and their carers. Participants were observed to be constantly conversing with medical staff, peers, management, patients and significant others in their everyday activities to provide patient care. Nurses in this study identified they talk formally and informally, casually and collectively, to ensure service provision and to meet patient needs.

Participants identified it was important to be able to communicate with their patients and they believed we are losing the art of doing this. An experienced Emergency Nurse explained to me that he found he could usually defuse most unpleasant situations by talking to patients and their relatives and giving them a cup of tea. This is especially so in a busy Emergency Department where everyone focuses on the patient, forgetting this patient probably has relatives out there in the waiting room who are anxious and need support as well.
Communication between nurse and patient is a continuous interactive process and is not limited to verbal narrative. The use of language, either verbal or non-verbal is an important skill that all nurses need to acquire. This non verbal communication is about being able to look, listen and feel, whether it’s a child or an elderly person and gain an understanding of their needs. Communication is fundamental to nursing and the ability to recognise individual communication/interpersonal skills is frequently a result of the socialisation process that occurred early in ones nursing career. As early as 1976, Davies (1976) identified communication skills as a deficit in the basic nurse training and according to (Stein-Parbury, 2000); it still continues to be given little recognition today. It is important therefore, that communication competencies need to be developed by nurses and that this is essential to good nursing care (Mock, 2001; Chant, Jenkinson, Randle & Russell, 2002).

We should have learnt how to communicate and we need to give staff permission to talk to patients at a language they understand. That goes for the lower socioeconomic to the privileged private patient. I have seen nurses spend time with patients and their clinical practice and techniques were hopeless, but the patients loved them, because they could communicate at their level. To the patients the clinical care did not matter, or perhaps they didn’t know, it was the face to face communication that counted, but how do you measure this or teach this?

However, it would appear that the ability to communicate at all levels and with various people is something nurses learn through experience. Nevertheless, it is suggested that the use of interpersonal skills in nursing is the concern of all nurses working in specialist areas and it is recognised that in practice, communication and interpersonal skills often leave clients and nurses dissatisfied (Hughes, 1999; Foxhall, 2002).

I always freak out my students when I tell them I love the Emergency Department as well as the Oncology Unit and I tell them its not about making the patients better and sending them home, rather its about communicating with them, making them feel comfortable and that makes the difference. It’s what the patients want, to be able to talk to someone who will listen, from the young adolescent who needs to be kept busy to the elderly lady who needs comfort.
Staff indicated technology has impacted on their communication with patients as well as their workloads. As suggested by one participant:

"We have tools and machines for everything today and we don’t even have to touch the patient any more. If you talk to ICU nurses they will tell you they are unable to get along without their machines and monitors. The patients rarely hear verbal communication rather it’s the beep beep of the monitors."

A number of the participants discussed that a few years ago we would communicate with patients a lot more as we used to take a temperature, pulse and blood pressure, and as we did this we got to know them a little better. We were able to develop that instinctive feeling experienced nurses have, just through our regular communication. This was exemplified by an EN who explains:

"Some years ago patients came in a day or so before their procedure so you had a chance to get to know them. After their procedure they usually stayed in bed a day or so as well and you had to do the bed bath thing and it was during this time a good nurse patient relationship developed. We don’t have that any more; there is no rapport with our patients."

**Patient advocate**

Dialoguing with patients is an integral component of a nurse’s everyday work. This includes patient education, providing information, understanding the family dynamics, social issues, advocacy and patient/family information sharing (McQueen 2000; Mock, 2001; Chant et al., 2002; McCabe, 2004). Participants all identified that little or no time is available to enable communication with their patients and it is usually left up to the very busy Nurse Unit Manager to do this

It was disconcerting to me that participants felt they were not able to provide the amount of communication necessary to develop the nurse-patient relationship, however they were reluctant to do anything about this. I discussed options and the more senior RNs indicated that nurses need to be empowered through leadership to advocate for their patients. The requirement for nurses to be patient advocates is included in position
descriptions, nurses registering bodies’ codes of conduct as well as other professional bodies’ documents, thereby identifying the role of the nurse as patient advocate as a formal expectation. However, like any performance expectation, it requires the knowledge and skills as well as an empowered environment for a nurse to fulfil this requirement. It would appear that many nurses while espousing patient advocacy, do not use their power or their skills to advocate for their patients. As one RN explained:

> We have allowed ourselves to become disempowered; we don’t stand up for our patients or ourselves any more and it seems like we are no more than doctor’s handmaidens here in the country hospitals. Nurses seem to be afraid of the power exerted by medical staff, not be exposed to their tantrums if we argue with them. It’s about being an advocate for the patient.

Nurses were consistently identifying with me that they were unable to spend time with their patients, but the reasons were not always the same. Some identified work pressures, and additional duties while others suggested it is because our work practices have changed. One participant gave the example of the time one spent “behind the curtains” washing patients post operatively. During these times patients were able to talk and the nurses felt more comfortable talking to the patients as they spent more time with them. Participants also believed they were more able to be the patient advocate as they had a better knowledge of the patient and their problems. Also, nurses identified that they had been able to develop a rapport, whereas nowadays, nurses appear to be flat out, patients are showered and there is little time for conversation and communication. It was identified that participants were no longer able to empathise with their patients.

**Communication and Empathy**

Empathising is described as the ability to share someone else's feelings or experiences by imagining what it would be like to be in their situation. Empathy is a process whereby an individual attempts to think and feel like another individual. The critical care nurse who practices empathy places him or herself in the patient's shoes and experiences that patient's situation from the patient's point of view, rather than his or her own. To practice empathy is to maintain one's own identity while feeling with another, to be objective while at the same time offering support and understanding.
Empathising with patients should be the starting point for improving nurse/patient relationships with the goals being to pursue perfection. Imbedded in these goals were no needless deaths, no needless pain, no helplessness, no unnecessary waiting and no waste for any patient, at any time. Nurses need to think about what they would want from the health service and how they would want to be treated. The integral component, for example, in preventing helplessness is to share information with patients, give them choices and follow their orders. It is also important to remember them, know their names, and make sure you are there if they have questions.

Empathy is the act of communicating to our fellow human beings that we understand how they are feeling and what makes them feel that way. Sitzer (1996) describes empathy as being able to maintain one’s own identity “while feeing with another” (Sitzer, 1996, p.78), while Weinstein (2002 p. 56) describes it as the ability to "get inside another skin" and “feel with a client”

As I explored this concept with nurses the conversation returned to the preparation of undergraduates and their preparation for practice. All argued graduates are well prepared academically but there is no preparation on empathy or communication with sick and dying patients. Most participants interviewed believed there was unpreparedness on the part of universities to teach graduate how to communicate with patients, or to take on that caring role. Many organisations have initiated the graduate nurse program to meet the deficit and provide the grounding for graduates to learn the communication skills required.

There was no doubt that during a number of interviews with senior staff that an understanding of patient body language was an important issue in communication ability. As one experienced midwife identified:

>Body language tells you a lot about a patient and as I walk around the acute wards seeing those frightened faces, they are scared and they don't ask the nurse for help as they don't want to be a nuisance and can see the nurses are busy.

Senior RNs and those in management who were not attached to a particular unit, believed there are times, such as change over of shift, where staff could spend time
talking to their patients. Ward staff, however, identified this was the time they caught up on documentation, attended mandatory educational and ward in-service as well as having to attend to imperatives called on by management. “It's as if no one has factored communication into our 8 hour day” as one EN moaned.

Regardless of what was happening on their wards, participants agreed that all staff needs to be more aware of the importance of talking to patients and making them comfortable physically and emotionally. Many of the nurses indicated patients commented on how busy the nurses appeared, as no one would answer their buzzers or stop and talk to them. As one RN put it:

> It is about allowing the patient to be comfortable to ask for something or for someone to sit with them and support them when they are frightened or alone….If you spend more time with the patients, the number of complaints go down; patient recovery rates are better which in turn decreases occupied bed days ad cost.

**Patient Education**

Patient education rated highly as an important component of communication, but according to most of the participants was not being done well or not at all.

> This used to commence on the day of admission and would include the family members. Information would be given and discharge planning commenced. Now there are too many fingers in the pie or its someone else's job and it's not well done any more. We don't see the patient usually on a surgical unit until they come back from theatre as they have been to pre admission. This is where it should start, but education is lacking there due to time constraints except perhaps for the knee and hip replacement patients, who seem to have a good knowledge of what should happen.

In exploring this with the RN it appeared the medical specialist provided a great deal of education, as did the physiotherapist at the pre admission visit. All participants agreed that patient education used to start on the day of admission and would include family members. Information would be given and discharge planning commenced. Now it
seems there are so many staff involved and its someone else’s job and its not well done any more except for those patients who are deemed to be complex and then the Discharge Planner gets involved.

As I explored patient-related issues, participants indicated their patients frequently commented on how busy their nurse seemed to be as no one answered their call bells or stop to assist them or a relative. One senior RN indicated that most patients will not complain at the time of an incident as they don’t want to be labelled as a “problem patient”. Rather, they would wait until they are discharged to complain, by writing a formal complaint letter. This would then twice as long to follow up as the medical record would have to be retrieved, staff interviewed and possible the patient would have to be contacted to arrange mediation and closure. This complaints management all adds to the manager’s workload, rather than “putting out the fire” at the time.

An additional slant on nurse/patient communication came from an experienced RN who indicated patient perceptions of questions could lead to misunderstanding and confusion. She cited an example of a patient who was unable to sleep and constantly rang the bell for attention. The participant attended to this patient, sat, talked and asked questions to see if there were additional factors causing the sleeplessness. The next night she had a “Please explain” as the patient complained that the night nurse had been nosy asking all those questions, when in fact all the participant had done was try to determine if there were any problems that needed to be addressed.

Communication between the nursing and medical staff was raised a number of times, with medical staff behaviours causing major problems for nurses. One experienced RN explained to me that in her experience orthopaedic surgeons were like prima donnas and if something does not go right, they scream, yell and abuse the nurses. While it is explained that inappropriate behaviours like these are unacceptable, it appears to make little difference to a number of medical staff. Poor communication between nursing and junior medical staff occurs frequently with one RN indicating that frustrations on the part of medical staff are causing the team to be dysfunctional. The example she provided was a Registrar being called out of theatre to write up fluid orders only to find someone else had come along and done this. While it may have seemed to be a good hearted gesture on the Resident’s part it was a major issue on a busy theatre day for the Registrar as he changed, came out of theatre, and then had to change again to go back
in. It is these types of intra-disciplinary miscommunications in large busy units that lead to dysfunction in the team, lack or support and lack of educational opportunities.

In one of the participants team however, because they are a small unit, communication flows well and the team works together harmoniously. Students enjoy being assigned to this unit and patient care appears to be excellent according to patient feedback.

Quality activities

For one experienced RN, her philosophy was that if she had done everything she was supposed to do, leave nothing undone, was able to converse with the patient, provided them with some education, ensured their wound was OK and they went home, she had provided quality care.

The concept that nurses’ knowledge bases, rather than general nursing care has improved in relation to quality was explored further with each participant identifying the strong focus health care organisations have with quality and accreditation. However, nurses themselves generally identified they had a knowledge deficit when it came to discussing nursing outcomes of care and were at a loss on how to measure this care. For example:

> In a small country town it’s incredibly broad what we do as quality and its all the things you do during the day like dealing with relatives, acute clinical issues, interactions with a whole range of people, its all part of my quality practice.

Interpretations suggested outcomes were only a moment in time rather than an outcome of care provided. Others thought it would rather be compliance with care, such as those included in care plans, documentation, or giving medications on time as per the drug chart. Yet another interpretation was the number of complaints and compliments received or the boxes of chocolate given by grateful patients and relatives. Generally though, the majority of participants had similar thoughts:

> Quality is about providing the best care you can in the time you have. Quality care is being proficient and there is the expertise in the care given to the best
of that person’s ability. It’s about providing the patient holistic care, which incorporates general care such as ADLs, mental wellbeing, and meeting the needs of the family.

A number of RNs and ENs interviewed indicated that quality care is about being able to provide evidence of care such as what happens with accreditation and going back to basics and providing pressure area care and wound management.

I believe we are doing quality care but we are not providing the evidence to support this nor does it support best practice. I know we are moving in that direction here but we have a long way to go. I know we don’t have nursing clinical indicators in place for pressure area care or for wound care but we need to do something.

Yet another RN indicated that quality was about understanding the patient’s diagnosis, interpreting orders correctly, giving the correct drugs on time and being able to look after your patients. As I discussed this further with this RN, she continued by indicating quality is about observing your patient and being able to interpret what you see. From interviews it was apparent that many nurses believed that observation not only included the medical, but also the physical observations, psycho-social and behavioural observations. Participants identified that family issues impact significantly on recovery rates and a patient’s ability to be discharged.

The ability to understand the physical signs and “read” the patient’s body language has been identified as one of the immeasurable indicators of quality care. I explored these concepts with a participant and it was apparent that he was looking for answers on how we could measure the immeasurable things nurses do, such as patient and family interactions, laying on the caring hand, listening to the patients and all the psychosocial things we do every day as a nurse but we don’t know how or what to do with this information.

One of the senior clinicians interviewed indicated we as nurses should be more accountable to our patients today as we are much better educated and have more opportunities to learn about the provision of quality care:
There are some nurses who are real self-starters and have gone out and done this training. It's also these RNs who are prepared to participate in quality projects. One of our outcomes of care that is lacking is that there are not enough controls on our practice to indicate whether we are providing a standard of care that is acceptable to us.

Methods of improving quality care were identified and participants discussed workloads and changes to models of care, however, participants indicated many of their peers were not keen to peruse other models of care as they have tried them before with “It didn’t work” being the main catch cry. The changes that have occurred due to the increase of short stay wards, day of surgery admission and day unit focus on a wellness model rather than the traditional illness model, thereby enhancing better patient outcomes. Additional ways RNs indicated these outcomes could be improved were to educate the patient via the pre-admission clinic so they were fully aware of what was going to happen to them. Many patients come into hospital expecting to stay and are disappointed when they are unable to remain rather than go home.

Additionally, nurses suggested there should be better discharge planning as well as adequate follow up post discharge. I explored this with one RN, who suggested all discharged patients should have a follow up phone call one to two days following discharge to see how they are and to assess if their management was satisfactory. When floated with other participants the idea was received well, but it was identified by clinical staff that there is no way their time constraints would allow this. I continued to discuss this with participants who generally agreed that we need to get smarter and this could be achieved if the non nursing duties were removed from their daily tasks. This would allow them to have more time to provide quality care.

Other measures of care included audits but generally compliance was poor and staff steered clear of these, as they were extra work they didn’t have time.

It’s the time it takes to dedicate one’s time to meet the needs of the individuals and this includes their medical care, psychosocial needs, physical needs and so forth. In other words it is a holistic approach to care.

It’s having a focus on nursing care and making a difference.
A senior nurse, who has since changed her role from the clinical area, indicated she now has a very different outlook on quality to what it was in the clinical area. At the time it was fulfilling her clinical role to the best of her ability and to meet the patients’ needs. She did not see the relevance of the copious amounts of documentation required of her, rather there was an obligation on the early recognition of clinical changes in the patients’ condition:

As a clinical nurse I believed it was attention to detail such as drug administration, that drugs are double-checked, I have read the orders checked the chart, alarms are on and the patient’s hygiene has been attended to. I never believed in picking up after others and it was one of the critical things I used to impart was early recognition of clinical changes in a patient. I didn’t want to find the subtle changes that can occur too late.

In exploring this further, the participant believed that the early intervention of MET from the ICU or ED in acute areas frequently prevented poor outcomes for the patient.

Important factors that were raised by participants to improve or ensure patient outcomes were met included the provision of a safe environment for the patient. For example, checking everything around the patient such as the bed, buzzer, monitors, electrical plugs and so forth were in good working order, as well as physically checking the patient from head to toe. Further, a senior RN explained identified:

Nursing knowledge is a major factor in quality care and good outcomes. If you don’t know what you are looking for you can fail to detect those subtle changes in a patient often with dire consequences and adverse outcomes.

In continuing along the safety line, a number of RNs indicated there were numerous other safety issues that health care organisations are required to meet such as the ACHS Accreditation Guidelines, part of which include the mandatory components in Safe Practice and Environment.

An additional safety issue identified by participants to improve or ensure quality care was the various types of audits that most organisations undertake as part of their quality
programs, for example, infection control, drugs counts, patient falls, pressure area care and chart audits for documentation completeness. Additionally, it was explained that:

*Incident reporting is undertaken and these are usually investigated particularly when they relate to a clinical outcome. If an error is detected then improvement processes are usually put in place to correct this. However, systems need to be in place for near misses as we can learn a lot from them. We have recently been doing RCA investigations and these have proved to be really valuable in improving outcomes for patients. Also its important for nurses’ to get some feedback on these incidents so we can close the loop, especially if there were procedural issues that need to be corrected.*

Another RN supported this by stating:

*It is the procedural direction and access to procedural guidelines that assist me to provide quality care. I don’t kid myself that I can remember everything and I am always happy to download them to have the information and be able to share with team members.*

Interpersonal communication and quality of care has been raised frequently by participants and most indicated that being able to converse with the patient and on behalf of the patient is a critical component of quality care; for example:

*Without this you cannot include the patient in the whole process of care. Its important to me that we relay information to the patient as well as being able to listen to the patient and identify with them and looking behind what they are saying. What concerns me though is that this is all related to time and workloads which all impact on quality.*

A number of the more senior participants indicated there was a concern about the amount of measurement we are doing as nurses and if we continue to do so much, we will lose sight of what nursing is all about and we will miss the immeasurable things that matter. One participant explained:
What are the immeasurable things we do, such as a smile, a word of encouragement, a touch of reassurance, providing comfort, positive reinforcement during a difficult procedure? How do we measure this? I am sure we have all been there and held a hand in tough times, having the patient know you are there, helping a mother nurse a dying baby, we can’t measure that.

Nurses rely heavily on policies, procedures or clinical guidelines to assist them with their practices. This is especially so when undertaking new procedures or familiarising themselves with current practice methods. As one EN identified:

An important component of quality care is having the procedural direction in place and ensuring all staff has the time and ability to access these procedures.

Measurement of what nurses do is not new, with various types of audits or monitoring processes having been conducted for many years. Nurses have become skeptical over time that these audits do not achieve what they are intended to do, that is, improve nursing practices. As one RN indicated:

I can see we monitor medication errors and patient complaints, but I don’t believe we monitor enough clinical outcomes. For example, we have no idea what percentages of IV drugs are given safely and if we don’t measure it we simply don’t know. We have to trust that the nurses preparing and administering the drugs are honest and if it’s done wrong they report it. On the other hand, we are doing numerous audits but why should we continue to monitor the alarm systems when they are OK, but then identify month after month that patients don’t have an armband on? This should therefore continue to be monitored with appropriate improvement strategies in place. It’s about closing the quality loop. If there were appropriate monitoring systems in place in each unit, such as patient falls or pressure area care, and then the loop gets closed.

As I probed with additional questioning, nurses themselves indicated that we should be looking at a few key areas that are not being done well in each unit, and then blitzing
these for a few months to raise the profile. In this way, it is hoped change will occur and that it will become entrenched into practice and become a sustainable cultural change. When asked who would be the main drivers of these changes it was unanimous that the clinicians at the coal face are the only ones who can influence a cultural change and improvement in clinical outcomes.

I believe the following statement by a RN says a great deal:

*I think quality care would be for nurses to rediscover how to deliver patient care, pat themselves on the back occasionally and say “Well done; you are doing a good job”. Everyone likes praise; everyone wants to feel they have done a good job. It doesn’t need to be fanfares or things like but it needs to come from the nurses themselves on the wards and working together. Yes, we have done a good job today, then it has to move up the ladder and management needs to recognise this. I think most managers have forgotten what it’s like to be busy and they need to recognise their staff and praise them as well.*

As I discussed the many options nurses had for improving quality I directly questioned the participants on reasons why they were unable to provide quality care; all participants gave the same reasons. These reasons included workload, frequent interruptions, lack of time, skill mix and staff numbers. As I further questioned these issues it became apparent that frequent bed moves and patient movement were contributing significantly to workload. This was discussed under the workload category. It was suggested by an EN that:

*We should be looking at all the things we do each day and keeping a log book and writing down everything we do, the time it took say to do an admission, do a shower, complete a care plan and so on, it’s like a time and motion study with the times as our outcomes.*

As I explored this further the various participants indicated that it was related to a number of reasons, which were interrelated, including individual skills and knowledge and the aging workforce. When I asked participants to qualify this they indicated that senior RNs at the end of their career were not accepting of change, would not undergo
further education and did not have the knowledge base to undertake best practice initiatives. In exploring this further, participants indicated that due to the rapid move to electronic data input it is becoming increasingly difficult for the older RNs to gain these skills. As one participant stated:

*Validation of our practice comes from being evidence based and getting this evidence from experts such as the Joanna Briggs Institute, literature reviews or systematic reviews requires us to have computer literacy and know how on various search engines. The older RNs do not have this know how to find the information required supporting such changes in practice.*

Opportunities to change practice are very much dependant on those who are committed to best practice, innovation and an ability or willingness to participate. Victor confirmed this in the following statement:

*We are participating as a pilot site in a project with NICs on the implementation of Clinical Practice Guidelines. This requires us to put in place specific guidelines of care and undertake pre and post chart audits to determine whether outcomes of care have improved. This is an exciting opportunity for a rural facility to be involved in a National study.*

I was personally able to support one participant’s comments having had experience with another NICS projects that enabled significant advances in care delivery. For example, the Emergency Department collaborative in 2003 provided the opportunity to explore care options for ED nursing staff. Outcomes of this project included the introduction of Nurse Initiated procedures such as ordering narcotic analgesia, ordering X-Rays, application of plasters, and suturing. Nurses undertook specific competencies to enable them to proceed, but the outcomes for the patient were excellent, specifically a reduced waiting time and better pain relief.

**Accreditation**

The quality of care provided to patients in NSW hospitals has been of interest to numerous people and groups, with an increasing recognition of a concentrated effort needed to improve quality of care further. To enhance this quality improvement the NSW
DOH (2004) has developed an overarching coherent framework for managing the quality of health care, within a systematic manner and that this framework has been supported by all health care organisations. Nursing staff’s knowledge of this framework ranged from little to expert with the majority having some knowledge which was obtained from various in-service sessions. Many staff were aware of the accreditation process with the Australian Council of Health Care Standards (ACHS). During interviews however, it was identified that the senior staff were involved in the preparation for EQuIP, whereas the “floor” staff had little input or involvement. When they were involved, it was at survey time when management came around. As an EN indicated:

“The senior staff came around and reminded us that we should know where the fire extinguishers were, know about manual handling, what to do with needle-stick injuries and where the policy and procedure manuals were kept”.

As I investigated the concepts of quality and the framework with participants, they all provided me with a very different picture of what they believed to be quality of care and how it can be measured. A number of participants agreed that one of the measurements of care is to make a difference, while others qualified this by suggesting:

It’s making the patient comfortable, happy and safe, but you can’t measure that can you?

It’s going that little bit extra, thinking ahead and doing holistic care.

Another commented that the only measurement is a patient saying thank you and that at the end of the day s/he has had a good day and it’s all thanks to the nurse. Yet another thought that having the right person in the right job with the right qualifications meant quality care could be given. A number of participants suggested that the accreditation process identified various types of measurement as important, such as quantifying medication errors, falls and so forth. Another indicated that a good nurse should be able to deliver quality care. A totally different thought came from a senior RN, who indicated his way of providing and continuing quality care is to be allowed to work within a multidisciplinary team
Magnet Hospitals

An additional methodology that was suggested by a number of participants was the concept of Magnet Hospitals. While not exploring this in depth, participants identified that Magnet Hospitals had an excellent record of staff satisfaction, patient satisfaction, improved recruitment and retention and strong leadership. One RN suggested that we also look at “Magnetism” as a way forward.

As I continued to interview Victor, it was evident he was passionate about improving quality of care and he fully supported the Government decision to implement the Quality Framework. He believed the essence of clinical practice is to continuously strive to provide the patient with the best care possible and to be able to improve the health of the consumers and the community. Another project a participant discussed which has improved patient care as well as safety is the Falls Prevention Program.

This project has enabled me to become involved in the standardising of the patient assessment using evidence based nursing tool. As a result we have been able to reduce the incidence of patient falls in our facility which is a good outcome for both the patient and the staff.

Patient Satisfaction

As far as the general communities were concerned, the majority of participants did not believe they (the community) really knew what nurses do all day and certainly had no idea about quality of care provision. Similarly, many patients do not complain about their quality of care as long as they have a clean bed and have their meal on time. Participants indicated they did not think it was the under 50 year old patients who knew their rights and demanded more information about their care and complained when they did not get this information nor had nurses spend time with them.

All participants generally believed organisations should be asking the community what they want from their health care facility. They believe people who come into hospital want specific things, which include comfort and safety. They want to know that their hospital stay and operation will go smoothly and they will go home as expected and told by their doctor.
This led to a number of participants suggesting we go back to patient questionnaires and ask the patients about care provisions and their hospital stay, from care, to meals, to cleaning. While this is not a new concept, it’s a normal process in many of the tertiary hospitals’ quality programs. However, in the settings where this research was conducted this was not normal practice, rather it would probably fall back on the already busy nurses to do. As one RN suggested:

*To do this properly, we need to interview patients, as we can’t ask them to fill in a form. Many of them are illiterate. Interviews take time and someone trained to do interviews should do it.*

On the other hand, two of the participants believed that patient surveys should be the method of choice to measure quality care. Patients, they asserted, are more aware of their rights are more informed and in some cases often waiting for problems to occur so they can complain or worse sue. These RNs indicated the only way to improve quality of care was to have more staff, either at the unit level, or to have a dedicated quality person attached to each area to assist staff, short circuit complaints and interview patients.

As I concluded my interviews, I asked participants if there was some way we could measure outcomes of care, with the majority indicating patient falls and medication errors as the main ones indicators of their care. They identified a number of immeasurable outcomes, for example, being happy at work, knowing yourself you have given good care, a thank you from a patient, good feedback from peers and importantly, provided recognition from hospital management that they have all done a good job often under difficult situations.

**Conclusion**

This chapter has described the theory of working around, the basic social process identified in this research. A Grounded Theory analysis of interviews provided by the participants provided the information used in this chapter and this has been supported by current literature. The participants’ data provided information on the major reasons why they believed they were unable to provide the nursing care they really wanted to provide.
As I interviewed the participants in this study, I felt an enormous sense of pride and comfort in the fact that these staff would care for a patient to the best of their ability. Their workload was frequently excessive, skill mix inappropriate for the type and number of patients they were required to care for, and the amount of supervision required of others demanding of their time.

All of the staff interviewed tried to support new graduates to the best of their abilities but found it difficult given their clinical workload. It would appear these stresses have an impact on patient safety and staff morale with new staff such as trainee enrolled nurses and new graduates being expected to practice outside their scope of practice, taking on more and more as participants have identified.

In conclusion, the researcher believes the following extract from the recent Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra, clearly identifies all the issues raised in this study.

“Participants nevertheless identified a range of specific factors that adversely affect job satisfaction including: a lack of career path and inadequate recognition of skills; inadequate remuneration; limitation of skills, scope of practice and capacity for innovation; unsupportive organisational and workplace culture; inadequate access to training and professional development, mentoring and support; inflexible working arrangements; unmanageable workloads; poor status of working in the health area; stress and burnout; and heavy physical and psychological demands” (Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra, p.43).

In summary this grounded theory study aimed at a rigorous research method by providing a detailed and systematic procedure for data collection, analysis and theorising, as well as being concerned with the quality of emergent theory.
CHAPTER 6

DISCUSSION AND LITERATURE REVIEW

Introduction

This chapter compares the current literature with the participants’ interviews and thoughts to explore their perceptions of undue workloads and how this affects the quality of care provided to clients on a daily basis. The literature was searched in accordance with grounded theory methodology for findings that referred to similar phenomena. For example, in the literature that discussed socialisation, it was noted that there was interplay between educational experiences and being socialised to a clinical area.

In this context, this chapter discusses concepts of nurses’ workloads, which directed the focus of this study leading to overloading and nurses “working around” to enable them to manage their every day task allocation. In following the Glaser methodology, the categories that were represented in the development of the Theory of Working Around vs. Quality and the relevant literature will be discussed as they were presented in Figure 5.2, p.67) and then the categories of professionalism, workloads, preparedness for practice, emotional overload, dialoguing and quality activities will be discussed along with relevant literature.

The context of workloads and working around

The nurse of the 21st century, according to a submission from Flinders University to the Senate Committee, “is required to provide high quality care to a discerning consumer whilst dealing with increasingly complex work issues that demand s/he make astute clinical judgements premised on higher order thinking” (Senate Community Affairs Reference Committee 2002, p.121).

Consequently, in today's workplace, the massive flow of information, the array of technologies, at-hand resources, and shifting teams of people makes the current
workplace a complex knowledge environment. Professional health care workers are frequently confronted with multiple tasks such as telephone calls, interacting with computers, speaking with patients, other personal and nurses and doctors. This information processing, according to Cicourel (2004), constrains information processing, resulting in cognitive overload. Consequently, listening, observing, talking, note taking and report writing constrain attention and memory resources (Cicourel, 2004). Additionally, work demands in busy clinical areas, create cognitive overloading as there are numerous, difficult demands on the immediate working memory (Cicourel, 2004). Consequently, nurses at the study hospital, report a sense of being overloaded and frustrated with their inability to provide the nursing care they should. This is supported by work from Heller & Nichols (2001) and the Department of Human Resources, Victoria (2006), indicating that clinical units are busy work environments and that current nursing care methodologies are no longer straightforward and routine. Further, the Senate Community Affairs Reference Committee (2002) as well as the Productivity Commission (2005), Australia’s Health Workforce, Research Report, Canberra, indicates that changes to the delivery of current health care, aimed at reducing the time patients remain in hospital, with its resultant greater patient acuity, has lead to increased workloads for nurses (p2).

It has already been identified that nurses engage in multiple tasks and, due to their workloads and time constraints, nurses constantly develop methods of short cuts to their standard unit/ward policies and procedures. Additionally, nurses who supervise junior staff are required to undertake other complex procedures, teach students and assist medical staff (Aiken et al. 2001).

A nurse’s main work area is not confined to the physical region that is within arm’s reach, or near their patient. Rather, nurses are required to constantly move around the ward, to areas near their key resources such as treatment rooms, computers, telephones, other resources and other staff they are required to supervise. Additionally, the clinical staff have their patient and family demands, care demands, pagers, doctor’s requests, medications and treatments to give on time. Participants in this study indicated they had to utilise the strategy of short cuts to help them get through the day.
Given this complexity of tasks and spaces, it is no wonder that nurses have issues with effectively managing their clinical activities and coping with their patients. For nurses in this study it was no different. As one RN explained;

As a Registered Nurse here on medical ward on night duty I was handed eight patients to care for. As for the rest of the patients, I knew nothing so when a cardiac arrest happened I knew nothing about the other patient. When I was asked to get ready with the crash cart and the defib paddles, I had no idea who or what the patient was, what medications he was on or even if he had a NFR in place. When the team arrived and organised, I went, as I could not tell them anything. I felt useless that night, but this seems to be the way we are going, handing over only your patients.

It is the same for nurse unit managers who experience constant bombardments of e-mails, telephone calls, doctors’ rounds, letters and memos, pagers, complaints, conversing with staff and management as well as the numerous meetings they are required to attend. As a result, today’s working environment within all clinical areas, with its increased complexity and saturated with multi-tasking and frequent interruption has resulted in profound information overload (Corey-Lisle, 1999; Kirsh, 2000; Hegney, et al. 2003; Kerfoot, 2006). Consequently, because of this cognitive overload, tension develops with colleagues, a culture of poor job satisfaction occurs and strained personal relationships develop between team members (Gaudine, 2000; Senate Community Affairs Reference Committee 2002; Hegney et al. 2003). Therefore, given the prevalence of multi-tasking and interruption, how do clinical nurses manage to switch their attention from one task to another without making serious mistakes? Similarly, how do the managers manage to maintain control over their numerous responsibilities as well as their staff’s responsibilities? One senior manager explained:

Nurse Unit Managers today in busy large wards have a huge workload and huge staff numbers, but also have a lot of information to remember. If you take a large surgical ward with a huge flow through then you have an even worse workload. In the worst-case scenario with a very busy theatre list, we have had to change hand-over to a
brief chat and discuss what has to be done. So, during the week I rarely get a satisfactory or complete hand-over of all patients.

It is suggested that the variety of approaches to ward organisation indicate that NUMs and team leaders utilise different methods for workload management, with these approaches possibly involving different skills, competencies and management styles. This poses the question in respect to the preparation this group of nurses have in readiness for their role as a leader. It is suggested that the dominance of the team model, which is probably a mixture of the traditional and primary care systems, could possibly reflect attempts by NUMs to move nursing from the traditional hierarchical approach to a more patient-centred approach. However, Doherty (2003) suggests that without having the necessary educational support, NUMs are struggling and this causes dissatisfaction for junior staff as they are aware that they often have a better theoretical knowledge base than the NUM.

It would appear that excessive workload reduces the nurse's ability to provide care. As early as 1984, Chenitz & Swanson (1984) discussed the dichotomy of nursing practice, the need to carry out medical orders and that sometimes the nursing needs of patients are ignored. They give examples of giving medication to patients who may have a need for knowledge that is overlooked due to poor staffing levels and time constraints. They discuss the need to explore the process(es) of nursing rather than focusing on tasks and outcomes. These, often hidden, aspects of nursing practice need to be identified and articulated. What difference does it make if a nurse gives care to a patient? The nurse-patient interactions, caring and observation form the core of nursing practice but what do they involve in relation to the underpinning conceptual framework informing practice.

One process of observation is Empiricism, with scientific enquiry having empiricism at its base. A key element in both the inductive and deductive processes of enquiry, and the tool by which the external world and the world of theories are linked, is observation. In an endeavour to argue that the external world and the world of theories are both very real, but distinct, Chalmers (1999) uses a position of 'Pluralistic Realism'. Further, he argues that they are linked by a third reality - the reality of scientific practice. Consequently, to make meaningful links between the external world and the world of theories means that the onus falls back on scientific practice.
Professionalism and socialisation

How nurses fit in or how they access information, activities, guidance and support largely determines workplace socialisation (MacPhee, & Scott, 2000). The adjustment of a new graduate, or indeed any new employee to an organisation, is dependant on appropriate tactics used to socialise newcomers. The use of good socialisation strategies has identified that there are lower levels of role conflict and role ambiguity, while at the same time providing higher levels of job satisfaction and job commitment (MacPhee, & Scott, 2000).

Further, the ability to develop critical thinking and analysis skills are an essential component for nursing students (Alfaro-LeFevre, 2001). Critical thinking is comprised of two dimensions: cognitive skills and affective disposition (Colucciello, 1997). These dimensions can best be addressed in nursing in a variety of experiences that allow the students to employ reason, manage diversity, and engage in contextual decision making. According to Schriven & Paul (2004) critical thinking is the identification and evaluation of evidence to guide decision making. Further, it is suggested that the broad, in depth analysis of evidence used to make decisions, identifies a critical thinkers beliefs (Schriven & Paul, 2004; Alfaro-LeFevre, 2001).

Clearly, the process of critical thinking requires a response to situations and subjects and the ability to find the interconnections (Schriven & Paul, 2004). Therefore, the intellectually disciplined process of actively and skilfully conceptualizing, applying, analysing, synthesizing, and/or evaluating information are components of critical thinking (Schriven and Paul, 2004; Alfaro-LeFevre, 2001). To be able to think critically it is necessary to generate information from, or by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action (Schriven and Paul, 2004).

Unlike the theoretical environment, bedside nursing is rarely logical and sequential and requires the ability to mentally multiskill and do more that one thing at a time (Alfaro-LeFevre, 2001). While it is suggested that theoretical aspects learnt at university, are critical to learning, it is unable to replace practical knowledge and application (Alfaro-LeFevre, 2001). However, unless one has been at the bedside, for example, caring for a trauma victim, under extreme situations, there are key gaps in knowledge (Alfaro-LeFevre,
2001). This was supported by participants from the study hospital that identified the initial inexperience of new graduates, the theory practice gap, and the inability to analyse a situation thoroughly and take immediate action, impacted on the clinical teachers and their workload. Therefore, critical thinking requires a person to be self directed, self disciplined, self motivated and self corrective thinking. All of these skills require effective communication and problem solving skills. It is these skills that are so necessary for the neophyte to develop during their orientation to a new area and to become socialised to the unit (Alfaro-LeFevre, 2001).

There are a few aspects that make the Australian nursing situation quite unique, especially when one compares it to nursing and nursing education in other countries. For example, the vastness of the country, with the large number of rural and remote hospitals (around the country), requires nurses with a huge diversity of skills. According to a progress report to Parliament in February (1990) the Commonwealth Government of Australia had, in 1984, decided that all nursing education be 'transferred from hospital based courses to tertiary institutions'. As a result of this transfer, it was envisaged that a more appropriately educated, flexible and career-oriented RN would be produced, who would be able to meet the current and future nursing needs of the Australian community (Lusk, 2001). This also meant that the nursing profession in Australia found itself in a period of rapid expansion at pre and post graduate level. Consequently, this event invariably had an impact on the nursing curricula and, in the process, that of the professional socialisation of nurses. As one RN indicated:

As a hospital student doing your training you were socialised early, constantly building on your skills in a supportive environment, you were observing all the time, assisted by the senior RNs and being socialised into the hospital system and on graduation you were considered “one of us”.

As humans enter the world of work they are socialised into the future role they are to perform, and also into the ethos of the organisation where they are to work (Wilkerson, 2005). How nursing students today develop their perception of nursing as they progress through their educational experience can be described in part as their socialisation process
The process by which individuals acquire the specialised knowledge, skills, values and norms required to undertake their professional role is professional socialisation (Tanner 2006). For new graduates, it means adjusting to work in a busy clinical area, requiring the development of more that just the skills of bedside patient care. Professional socialisation also requires the development of ethical values as well as an understanding of the complexity of human beings (Wilkerson, 2005).

There are assumptions that we take for granted and which shape the way we think and act. Nurses have their own discrete culture which consists of various rituals, meanings, roles, myths, practices and theories which are differentiate their culture form other health care professionals (McPhee, 2000). Clinical nurses notice the unnoticeable; making visible those practices taken for granted (Tanner, 2006) and is able to notice the subtle changes that occur in a patient that the untrained novice practitioner would not recognise, for example, slow deterioration as a patient develops respiratory distress. Alfaro-LeFevre (2004) indicates this is part of the process of mental multi-skilling and requires experience and knowledge. This is a key component of the clinical nurses’ role which is very difficult to teach and even more difficult for the novice to learn and role model (Hauck and Hussey, 1997, Alfaro-LeFevre, 2001; Scriven & Paul, 2004).

Tanner (2006) indicates mental multi skilling is akin to clinical judgement, and is viewed as an essential skill for nurses that is both complex and only learned through experience. The ability to be able to judge clinical situations, interpret their meanings and respond in a timely and appropriate manner, requires the nurse to have an understanding of pathophysiology, diagnosis and substantial experience with the patient and their family. It also requires them to have knowledge of the patient’s psychosocial and coping mechanisms (Tanner, 2006). This is supported by Ebright (2003), who suggests that busy clinical nurses must manage complex patients, resolve family conflict, and arrange complex admissions and discharges as well as contending with frequent distraction. This in turn causes a loss of focus on their clinical reasoning and judgement (Ebright, 2003).

The implications of the changes in nursing education for professional socialisation are that, prior to the transfer to the tertiary sector, student nurses were exposed to role models based mainly in the practical nursing situation, professional nurses and patients/clients,
with periodic exposure to nurse educators in the hospital schools (Madsen, 2000). As hospital students progressed from year to year they developed other skills such as watching peers, developing clinical skills and knowledge, communicating with patients and relatives as well as having excellent opportunities to develop relationships with other nurses. Often these relationships formed the basics of role modelling which is so important today. Role models are seen as important agents in this process, for instance Earnshaw (1995), Andrews (1999) and Taylor, Westcott, & Bartlett (2001), all consider that clinical role modelling is the primary socialiser in learning professional roles and behaviours.

Consequently, as nurses and nursing progress into the 21st century, there are enormous challenges in the current health care system, whereby university faculties and health care organisations, should position themselves to prepare nurses at both pre and post registration to enable nurses to successfully practice in their chosen field.

**Definitions of professional socialisation**

Over the years, various researchers have defined the process of professional socialisation. Moore (1970) argued that “professional socialisation involves acquiring the sense of occupational identity and internalisation of occupational norms typical of the fully qualified practitioner as well as acquiring the requisite knowledge and skills.” Similarly, professional socialisation according to Cohen (1981, p. 112) is: "the complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession. It involves the internalisation of the values and norms of the group into the person's own behaviour and self-conception. In the process a person gives up the societal and media stereotypes prevalent in our culture and adopts those held by members of that profession" (Cohen, 1981 p.113). Interestingly, almost 20 years later, Wilkerson, (2005) defines professional socialisation as “the process by which individuals acquire the specialised knowledge, skills, attitudes, values, and norms needed to perform their professional role” (Wilkerson, 2005, p.1). Similarly, Weidman, Twale and Stein (2004, p.4) define socialisation in a broad sense as “the process by which persons acquire the knowledge, skills, and disposition that makes them more or less effective members of society”. Page (2005, p.105) on the other hand identifies professional
socialisation as “the acquisition of values, attitudes, skills and knowledge pertaining to a professional subculture”.

**Stages of professional socialisation**

Professional socialisation, according to Shuval (1980) is a process that takes place over time and consists of three stages:

- **The pre-socialisation stage.** This is the time when the stage is set for professional socialisation process to begin, when a student is part of the secondary school population. It is also the time when organisations values and the values of socialisers occur.

- **The formal socialisation:** This is the stage that students search for ‘one right answer’, and where one learns to behave in an appropriate professional manner

- **The post-socialisation stage:** This occurs in the period of practice after formal socialisation and remains until retirement. Apart from the stages of professional socialisation, it would be appropriate to narrow the scope of analysis to the influence of role models on the process of professional socialisation.

Another thought is identified by Weidman et al. (2004), who indicate that the education process shapes professional socialisation, with both the formal and informal processes occurring through learning and participation. The formal process consists of the required knowledge necessary to practice as a professional, while the informal processes responsible for the development of professional behaviour, values and attitudes. Interestingly, in reviewing both Shuval (1980) and Weidman et al. (2004), there are remarkable similarities in both definitions, indicating little has changed over time. Additionally, ward culture - including ward philosophy and teamwork - has an impact on student nurse socialisation into nursing. It is nurses' responsibility to provide an acceptable environment in which patients' diverse needs can be met, and also to ensure that new graduates are socialised within a positive learning environment and by role models who give individualised and holistic care (Weidman et al. 2004).

Davies (1996) has argued that nurses should search for other ways of organising nursing activity rather than aspiring to the medical profession's syndicalism. The researcher
believes this is easier said than done when nursing now has so little formal power in health care. As one senior RN stated, “I was pulled aside by doctors who said this is not your responsibility to talk to patients about their health issues”. This nurse was amazed as it demonstrated a complete lack of understanding of the nurse’s role and as the patient’s advocate. However, due to the reduction in junior doctors' hours, nurses are now required to take on clinical work that was previously the realm of medical staff. These areas include Triage Nurses in emergency departments and Nurse Practitioners. These roles include pain management, ordering X-Rays, ordering pathology tests and so forth. This is supported by findings from Dowling et al. (1995), who investigated the impact this was having on patients as well as medical and nursing staff. The outcomes of their study indicated nursing could be undervalued by taking on these roles not only because of its complex nature, which makes it difficult to define, but also because of insufficient knowledge among doctors about the nature of nursing (Dowling et al. 1995).

The professional nurse is now expected to function well within a technologically advanced health care environment, carry out higher-level, complex activities, and is held responsible and accountable for the systematic planning of holistic and humanistic nursing care for clients and their families (Swan, Lang & McGinley, 2004). What is expected to occur within a system plagued by a nursing shortage, heavy workloads and long shiftwork hours, tight budgets, modest wages for work rendered, and an increasingly ill hospital population (Richards, 2001)? Nurses are expected to keep abreast of technological implementation within their work environment with little time for professional development activities or in-service attendance (Swan, Lang & McGinley, 2004; Kaminski, 2005). This is further supported by Richards (2001), who indicates that technology does not function in a vacuum but within a social matrix, interacting with individuals in an organization, and, if nurses are to integrate technology into their culture, many factors and forces must be addressed in the future.

**Image of nursing**

Throughout history, stereotypical and negative portrayals of nurses such as the physician's handmaiden or ministering angels have continued to dominate society's perceptions of the nursing profession and professionalism (The Centre for Nursing Advocacy, 2005).
Additionally, television shows such as “House”, “Grey’s Anatomy” and “ER” continue to demoralise and insult nurses and nursing in general, with inaccurate and damaging portrayal of nursing (The Centre for Nursing Advocacy, 2005). First impressions transmit very powerful messages to the public and sadly, many of these stereotypes and impressions are shared by some nurses and the general public (Gordon, 2001) with a number of health care organisations touting nurses who are entrepreneurs, hospital CEOs, lawyers and politicians, claiming future nursing opportunities (Gordon, 2001). Sadly these campaigns aimed at returning nurses to the bedside in fact ignore the issues of bed closures, increased waiting times and theatre cancellations.

Further, the public health and health promotion roles of Nightingale nurses became secondary to the establishment of the profession in hospitals (Kitson 1996). Additionally, it is asserted that “nursing practice is still dominated by the medical model and that nurses are stereotyped” (Kitson, 1996 p. 1648).

Nursing and midwifery have changed significantly over the last 50 years. Developments in technology, shifting community demographics, the move to university education and the emergence of new allied health roles have all contributes to the constantly evolving role of nurses in the community (Department of Human Services, Victoria, 2006). Unfortunately, public perception has not kept pace with the contemporary reality of nurses and nursing in the 21st Century. The persistence of stereotypes, outdated images and perceptions cause a devaluation of the roles and contributions nurses make to the community (Department of Human Services, Victoria, 2006). The media is a powerful tool in shaping the community perceptions of nurses and nursing and will continue to be so long into the future community (Department of Human Services, Victoria, 2006).

Although nurses are ranked very highly as a trusted profession in Australia, they are often undervalued with a continuing lack of understanding about what they really do (Nevidjon & Erickson, 2001). This confusion could be a result of awarding the title “nurse” to different levels of educational preparation, for example, in Australia there are Assistants in Nursing, Enrolled Nurses, and Registered Nurses. Further, in the United States, the variety of educational pathways, has led many students and school guidance counsellors to under value nursing as an intellectual enterprise or profession (Williams, 2001).
In Australia significant data has revealed that there will be a mass departure of RNs from the workplace over the next 10–20 years, in addition to the continuous attrition of those currently employed who leave nursing for various reasons (Jones, 2002b; Submission to the Senate Community Affairs Reference Committee, 2002). The Productivity Commission (2005), Australia’s Health Workforce, Research Report, indicates that Australia is facing extensive workforce shortages and that the demand for health care workers will continue to increase. Over half the 450,000 paid health professionals in Australia and in particular nurses (Productivity Commission 2005), Australia’s Health Workforce, Research Report), and shortages will continue despite the fact the workforce has increased. It is further reported that by 2006, Australia’s nursing shortage will rise by 31,000 (Jones, 2002a). Additionally, fewer people are choosing nursing as a career and the image of nursing has been deteriorating (Jones, 2002a). Based on projected nursing shortage statistics, there is an immediate need for a call to action to protect and support the nursing profession. According to Hoke (2006) this call to action must address the poor image of nursing as a career which is a major contributor to the nursing and workforce shortage.

Nevertheless, there is now more interest being shown by the public in professional regulation, especially in the health care arena. The regulation of the health profession was not widely appreciated until the public became aware during the Bundaberg inquiry in 2006 of examples of poor credentialing and unregulation of medical staff. It is hoped, this may show us a new path and go a long way in explaining to the public the risks involved in not empowering nurses and allowing the self-confidence of the whole profession to collapse.

**Workloads**

It is not unusual to enter a clinical unit and immediately be confronted with a culture of busyness. This busyness and turbulence continues for most of the morning shift and is a result of admissions, discharges, nursing procedures and “rounds” (personal observation). Nurses at the study hospital indicated they see many patients being discharged sooner and sicker today than some years ago and that this is a major factor that affects their workloads. Further, changing models of care has reduced length of stays for patients, leaving RNs to care for and stabilise patients in a shorter period of time (Hughes, 1999;
Nurses at the study hospitals indicated that patients are sicker today on admission and are living longer with chronic conditions such as heart failure, renal failure and respiratory failure. What was a key issue for them and was reiterated throughout the interviews and is supported in the literature, where it is identified that the greater life expectancy of individuals with acute and chronic conditions requires more complex nursing care (Heller & Nichols, 2001). Additionally, increased bed occupancy rates, shorter patient stays and the diversion of less-ill patients into day surgery centers have placed hospital ward nurses under enormous pressure (Jones, 2002b). A senior nurse administrator identified:

“The wards were staffed way back for about 85 percent occupancy of patients and now they run at over 100 percent. The patients that used to come in for 10-day stints now come in for 2. The throughput and the movement and what nurses have to do now in the ward area are just incredible.”

This is further supported by Leigh & Krier (2001) and the Productivity Commission (2005), Australia’s Health Workforce, Research Report, Canberra, who suggest other models of care have reduced length of stays for patients, leaving RNs to care for and stabilise patients in a shorter period of time. For example, as one RN indicated:

*When I first started nursing, a patient would come in the night before, or even two days beforehand, so you did virtually nothing for that patient. I believe it was an absolute waste of bed space if I think about it now. But at the time it was good, you had patients that came in, they were well, they weren’t operated on straight away. They were admitted on Sunday afternoon for Monday theatre and on Sunday night, if you had four or five of those on the ward you weren’t doing a thing. They went to bed, you woke them up and they went to theatre. They came back and for the next couple of days they were bed bound 90 per cent of the time. So you would go in you would sponge and*
make them comfortable, that sort of thing. Then a few days later they would get up and walk around, and then they would have another few days in hospital before they went home. So your acuity was really like a big sore tooth, it was up and down. Now we bring them in to day surgery, they go to the ward; they are instantly full on care. The minute you say you can clean your teeth or do something yourself, they can go home. And then you bed is filled by somebody else who is really acute.

Additionally, to meet the demand of early discharge into the community, Community Services and Community Nurses have insufficient funding and numbers of staff to cope with large numbers of ill patients being released into the community. This deinstitutionalisation, while being introduced with excellent rationales has impacted significantly on acute services nurses. This is supported by the Australian Institute of Health and Welfare (AIHW) report (2004), which demonstrated hospital admissions have increased by 3% to 6.8 million in 2003-4, while the total number of patient days in hospital rose 1.3% to 23.6 million. However, due to the increase in procedures undertaken as day activity, the average length of stay in hospitals has continued to fall. The AIHW continue by asserting that hospital admissions and patient days have continued to rise over the past 11 years. Between 1995-95 and 2003-04, hospital admissions increased by about 40% overall, with public hospital admissions rising be 22% and private hospitals by about 80% (Health Business Daily News, 30.5.05).

There is also a concern that as nursing becomes more specialised, there will be fewer experienced and competent nurses taking up nursing in specialty areas such as critical care, midwifery and mental health (Diehl-Oplinger & Kaminski, 2001). It is believed that these changes as well as workload expectations are among other contributing factors affecting the RN work climate, and that this has contributed to a decrease in the overall quality of health care generally (Hegney et al 2003). An additional factor is the increasing average age of health care workers.

Further, Kerfoot (2006) has identified that health care organisations are challenged to transform health care from the inside, otherwise the continuing pressure on staff from
aggressive productivity and workloads will increase the levels of stress, burnout, resignations, turnover and absenteeism. This is identified in the Australian context by the Senate Community Affairs Reference Committee (2002), who indicated that workloads have a significant effect on stress and burnout of nurses. Kerfoot (2006) continues by indicating organisations pay a high price for operating at this level with extreme risks of errors and staff attrition.

International situation of workload

A large study on nurses' reports of hospital care in five countries was undertaken by Aiken, Clarke, Sloane, Sochalski, & Silber (2002). These studies were conducted in the USA, Canada, England, Scotland, and Germany. Reports from 43,000 nurses in more than 700 hospitals, revealed similar and confirming data to support the claim that nurses across all these organisations identified commonalities such as low morale, job dissatisfaction, burnout and intent to leave their current employers. It was further reported that nurses experienced increases in workload, non-nursing tasks and a decrease in their ability to complete their nursing tasks fully. It was concluded by Aiken et al. (2001, p.1990) who state, “if inadequate staffing becomes chronic, the quality of care delivered would be compromised and result in adverse patient outcomes”. Kerfoot (2006, p 169) indicates that “the culture of high pressure, hurry up, busyness and fear, destroys productivity, people and organisations”. It was obvious that the participants in my study had similar issues as their international colleagues, with increased workload, increased throughput and an inability to complete their allocated tasks on time. This is supported by Hegney et al. (2003) in her study of Queensland Rural Hospitals.

It has been identified that there are now increasing demands on nurses in general medical and surgical wards. As previously discussed, these workload demands include more acute patients and the increasing age of the population requiring care. However, at the study hospitals additional impacts included decreased support services for many nursing roles, and hospital cost-cutting. Williams (2001) also indicates that these decreased support services are encroaching on the practice of clinical nurses and taking them away from patients requiring acute care. Previously, there were a number of support persons, for example, wards-persons or orderlies who would shower male patients, undertake male
shaves or assist with heavy patients and so forth. Today it seems many of these roles have been combined into the “all round” Hospital Services Assistant, who has now taken on security, delivering meals and transporting patient’s to their previous roles. It is little wonder they are unable to assist nurses as they did previously. As one participant indicated;

Previously they (wardies) were there to support the nursing staff with lifts and the difficult patients. Now it is really hard to get someone to help you.

A survey was conducted by the American Nurses Association on the health and safety of RNs in their current health care environments (ANA 2001b). This study was undertaken because of increasing and repeated assertions that today's nurses are overburdened, overworked and overstressed. This study was undertaken via an on-line health and safety survey and attracted 4826 respondents from across the USA. A cross-section of nurses from various age groups, years of experience and work environments were the representative population in this survey.

Collation of the survey results indicated that the top three health and safety concerns of those who responded were acute/chronic effects of stress and overwork (70·5%); a disabling back injury (59·4%); and becoming infected with human immune-deficiency virus (HIV) or hepatitis from a needle-stick injury (45·3%), (ANA 2001b). Also, 80% of nurses surveyed indicated that there were safety issues and they did not feel entirely safe in their current workplace (Needleman, Buerhaus, Mattke, Stewart, Zelevinsky, 2002). In a different study by McNeese-Smith (1999) it was identified that many nurses were primarily satisfied by the patient care they provided. However, nursing roles are becoming increasingly difficult, with evidence suggesting there are many variables that contribute to current changing RN work climate, and the probability that most nurses are not satisfied with these changes (Nevidjon & Erickson, 2001; Needleman, Buerhaus, Mattke, Stewart, Zelevinsky, 2002).

Clinical nurses have learnt there are many physical, technical and psycho-social activities they need to complete each day. Also, there is the expectation they will teach other nurses
and patients, supervise junior staff and perhaps coordinate the duties of others, giving them a sense of not being in control of their own workload unless they can keep ahead. Often this is a result of an excessive workload, constant demands and not enough time (Hughes 1999; Turner, Landeivede & Van Merode, 2002; Buchanan & Considine, 2002). Interestingly, Hegney et al. (2003) identified in their research that many nurses in the Queensland Public Sector were unable to satisfactorily complete their allocated tasks to an acceptable professional or safe manner. Further, Hegney et al. (2003) continues by indicating workload is directly related to the number of staff and skill mix of staff in each area. In New South Wales, the Nurses Association implemented in 2003 Clause 48 relating to Reasonable Workloads for Nurses, which entitles nurses working in the public health system to a reasonable workload (Public Health System Nurses’ & Midwives State Award).

Ideas of time influence how nurses practice and are constructed in ways that are evident in their own language. For example, participants discussed – ahead; behind; keeping up; going well and so forth (Tanner, 2006). Participants in this research, like those in the study by Hegney et al. (2003), indicated there were pressures on them to hurry up and complete their allocated duties, leading to frustration, haste and possible errors. This is further supported by Buchanan and Considine (2002) who identified frustration and anger at the declining ability of nurses to deliver quality nursing care.

Additionally, extra responsibilities and increased workloads are imposed upon nurses, causing severe stress. Because of other cutbacks such as allied health workers, nurses at the study hospitals were often expected to perform a wider range of duties. For example, physiotherapy, cleaning, secretarial jobs and ward security. They often had to work outside their area of expertise, putting patients and their own safety at risk. New technologies and increased demands for financial accountability have been introduced without due consideration for staffing implications (Jones, 2002b).

These daily frustrations are causing many nurses to question their reasons for staying in nursing, rather than join hundreds of other dedicated nurses across the country quitting the system, believing that hospitals across the country have been transformed into business propositions (Jones, 2002b). Jones (2002b) continues by asserting that “hospitals have
become businesses with ruthless cost control measures, accelerated patient throughput, and acute understaffing make it impossible for nurses to properly care for their patients” (Jones, 2002b p.1).

Many business factors significantly impacted on the managers’ role, particularly in acute areas (Kerfoot, 2006). Savage (1995) eloquently describes two opposing views of nursing and how the emphasis on cost containment inhibits the nursing development appropriate for patient focused care. The emphasis on productivity and cost efficiency places the focus on tasks, with implications for skill mix ratios and the extending roles of nurses and support workers. Nevertheless, Savage (1995) questions whether patient-focused care and an appreciation of the nurse-patient relationship, in terms of its therapeutic outcome, are sustainable in the present climate of economic efficiency (Kerfoot, 2006). Participants in the study hospitals commented that, even though the concept of holistic care was espoused by the new graduates on the ward, often, staff shortages, skill mix and budget constraints, compelled senior staff to organize care and staff to meet these requirements. Consequently, nursing care frequently became task orientated rather than one of holistic care (Hegney et al., 2003). As one new graduate observed:

Our work each day has to be 'task oriented' rather than individualised care because there are not enough staff or money to do otherwise. In the worst case scenario, there are number of high acuity patients with three nurses – one senior nurse, one graduate and one enrolled nurse - to care for them. If the work wasn't task orientated nothing would get done.

As previously discussed, new graduates and experienced nurses alike commented that they were unable to spend time talking to patients. In addition and be able to provide individualised patient care on these very short-staffed wards. The new graduates also commented that there was thus no opportunity for them to draw on their interpersonal skills (Jones, 2002b; Hegarty 2002).

As well as staff shortages, it was also evident that problems on the inpatient units were exacerbated by an inability to discharge patients to, and/or of resources to provide care in the community. There were a number of reasons for this, for example, many patients who were eligible for discharge were not being collected by their relatives until later in the day,
there were long delays in waiting for an ambulance and there were delays in discharge scripts being provided. The nurses felt that they were bearing the brunt of these economic/social problems in that their work load was increased by being unable to discharge patients at the appropriate time.

**Staffing and skill mix**

Issues of nursing retention will not vanish. Rather, there are very real economic, social and personal costs associated with the lack of retention as the nursing shortage has become a global challenge. Demand continues to grow but in many developed countries the supply continues to fall, with an ageing nursing workforce caring for increasing numbers of elderly people (Submission to the Senate Community Affairs Reference Committee, 2002). Low levels of trained nursing staff could lead to poor care, low morale and loss of staff (Hegney, 2003). A landmark study of the effect of nurse/patient ratios in acute surgical units in Pennsylvania hospitals showed that the chance of patients dying within 30 days of admission increased by 7% for every patient over four for whom a registered nurse was responsible. (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002).

Studies from the United Stated indicate that educational and training strategies will be of little use if retention of RNs is not addressed (Kenny, 2001). With each specialised RN lost to the system, it will take four years and an investment of many thousands of dollars to replace (Kenny, 2001). Due to the severe shortage of nurses aged 30 or under, there will be fewer RNs available to take on senior positions (Jones, 2002b). Consequently, there will be fewer experienced clinical nurses available to support students in their clinical environments (Jones, 2002a; Submission to the Senate Community Affairs Reference Committee, 2002), suggesting that students will not receive good quality educational experiences in the clinical environment. The Productivity Commission Report (2005, p.V111) indicates that due to the ever increasing age of the health workforce, “service providers will be seeking to replace greater numbers of retiring workers……”

Already the health care system is showing unmistakable signs that it is unable to support new graduates without placing undue pressures on them. As one RN indicated he was placed in a position where he had to cope without support, leaving him and the patients
compromised (participant story 1, p 40) on a number of occasions during his first post graduate placement. This is supported by the Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra, (p.XXXX1) that indicates “restricted clinical training is limiting the expansion of the workforce in various professions”.

Increasing concern over quality assurance in nursing has led many nurse managers to address the relationship between staffing numbers, skill mix, workload and standards of care (Gibbs et al 1991; Needleman, Buerhaus, Mattke & Stewart, 2002; Kerfoot, 2006). Over the years, demands by Health Departments have meant that Hospital Management have highlighted the necessity for providing nursing services through different combinations of nursing skills, reflecting the increasing interest expressed in this area by senior nurse managers. This trend has continued today, and the current demand for cost effective use of staff keeps the subject of skill mix high on the agenda of many service providers. McKeown (1994); Hegarty (2002); Jones (2002a); and Kerfoot (2006), warned, however, that accepting reviews of nursing skill mix and measures of productivity without using appropriate measures to assess nurses' value, is likely to worsen the quality of service.

Research in the USA suggests that changes to nursing skill mix may have adverse effects on qualified nursing staff and, somewhat paradoxically, have a clear potential contribution to the nursing shortage (Hegarty, 2002; Submission to the Senate Community Affairs Reference Committee, 2002; Kerfoot, 2006).

Participants in this research indicated that the demands made on them as health professionals to work with a poor skill mix have significantly increased and will continue do so. In virtually all contexts in which the participants provided patient care, they believed there had been an increased patient acuity, complexity of the care required, volume of patients/clients, diversity of casemix, expectations that practice is based on evidence and demands for accountability. At the same time, there has been decreased length of stay and time available for meaningful professional /patient interactions. This situation has increased enormously the need for highly developed critical problem solving and organizational skills on the part of all health professionals, including nurses. This in turn
indicates that nurses should be highly skilled professionals, rather than unskilled assistants.

Similarly, skill mix review continues to be a key industrial relations issue in all Australian States, with dramatic shifts currently underway in the skill levels of nursing units. A study published in the OECD Working Paper (2004) indicated that in the UK, a third of all organisations reported skill mix changes on their wards. Whilst it is, by all accounts, a fashionable management concept, changing the staff skill mix is often fraught with danger (McKeown, 1994). Indications are that skill mix changes deteriorate into a deskillling exercises (Crossan & Ferguson, 2005) whereby relatively expensive qualified staff are replaced with cheaper less qualified staff, with little notice paid to patient outcomes and the quality of care provided (Wing, 2006). Indications from this study have implications for staffing decisions that health care bureaucrats make. Florence Nightingale said, "It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm" (Nightingale, 1859, p. iii). It is agreed by health bureaucrats, that these health care workers must "do the sick no harm," however, in this cost-conscious environment of today's health, these bureaucrats must consider the cost-effectiveness of decreasing adverse events (Pepper, 2003; Johnson, 2004).

Obviously decreasing adverse events has significantly good outcomes for patients, and is obviously beneficial for a hospital's reputation, and usually has cost-effective benefits for the hospitals as well. However, the incidence of hospital-acquired infections may be related to nursing care, in that careful, patient observation, mobility and physiotherapy therapy (e.g., deep breathing, coughing) may decrease the incidence. Conversely, when the numbers of skilled RNs are reduced, RNs may not have time to teach preventive management or be able to have sufficient time to supervise junior RN/EN staff (Wenzel and Edmond, 2001; Seago, 2002). This was supported and identified by RNs throughout this study. In fact, to assist the junior staff survive they taught them the very work arounds that they disagree with but are forced to accept as very day practice.

According to a number of studies undertaken of hospital inpatient mortality rates, it has been found that the nurse-patient ration to be the single most important factor affecting mortality rate after controlling for all other hospital structural and financial factors with use
of risk-adjusted measures (Lundstrom, Pugliese, Bartley, Judene, Cox, Guither, 2002) The authors indicate that a higher ratio of RNs to patients or RNs as a percentage of total nursing personnel has been associated with lower hospital mortality rates in several studies (Lundstrom, et al. 2002). A recent study indicated that hospitals who have an increased nurse patient rations have significantly lower surgical mortality rates as compared to those in which nurses care for more patients (Rafferty, Clark, Coles, Ball, James, McKee & Aiken, 2006).

Nevertheless, most skill mix reviews are unfortunately and primarily driven by the dollar. While securing value for money is important it should not be at the expense of lower standards and fragmentation of care. Although much lip service is paid to providing a better quality of service, a report from the UK by the NHS states that ‘quality is rarely given prominence in skill mix reviews ‘value for money’ and cost cutting dominate the expressed rationale for most studies’ (Wing, 2006).

**Preparedness for practice**

**Theory- Practice Gap**

There is a great deal of nursing literature concerning the conflicting values between nurse education and the subsequent experience in practice, the gap between theory and practice. With the increasingly complex requirements of current nurse practitioners educational facilities have had to investigate new methods of clinical teaching (Camiah, 1996). The complexity of nursing care in the 21st century has seen nursing education undergo significant changes through the integration with universities. However there still appears to be a dichotomy between theory and clinical practice which remains problematic (Ferguson & Jinks, 1994), with theory providing the basis for understanding (Dale 1994).

Literature from the UK focused on traditional nurse training prior to the advent of Project 2000. A project commenced in 1988 whereby the UK government accepted a new university-based system of nurse education. This aim was to create a programme that was more firmly placed in educational hands, where trainees had real student status. Entry to nursing had previously been controlled partly by nursing schools associated with a training
hospital, and partly by the regulations governing the state based examinations that the nurse would ultimately sit that included academic criteria (Elkan & Robinson, 1991).

A study on the implementation of Project 2000 in England (Elkan & Robinson, 1991) noted a conflict between Project 2000 students and the traditional hospital trained staff, but as yet there is little research on the experiences of qualified Project 2000 nurses. However, in these early studies it has been identified there is evidence of uneasiness regarding the process of occupational socialisation of new graduates. It is suggested that Project 2000 aims will be impeded in producing nurses who are “knowledgeable doers and confident analytical thinkers”, if student nurses become socialised into the so-called 'traditional ward cultures where routine approaches to patient care and task allocation are still valued “ (Jowett et al. 1991).

Another possible route to understanding theory-practice dissonance in nursing was suggested as early as 1968 by Goffman, who theorised institutional life. It was recognised that the hospital is a powerful institution in itself where staff are subject to (and must learn) various formal and informal rules and regulations, where staff behaviour is shaped by the institution. It is therefore possible, that new graduates entering a hospital environment are likely to experience theory-practice dissonance in that hospital because they have different rules and objectives from the educational establishment and also different power relationships from their educational institution. Although the hospital undoubtedly presents a different culture from the educational establishment, some writers suggest that it would be misleading to suggest that hospitals, as institutions, possess a unitary culture (Davies, Nutley & Mannion, 2000). Support for Goffman (1968) is identified by more recent research (Scott, Mannion, Davies, & Marshall 2003; Manyon, Davies & Marshall, 2005) who assert that the hospital is portrayed as a series of separate work units, each with their distinctive cultures and working practices Clearly, an exploration of processes of socialisation into hospital cultures requires acknowledgment of this cultural diversity.

Alternatively, Landers (2000) asserts that what the theory practice gap represents is an inadequate attempt by nursing theorists to represent knowledge which cannot be represented in this manner. Further, Landers (2000) claims nursing is practice based profession, it is not theory, if it is then, the term “nursing theory” seems to be oxymoron.
Nevertheless, Maben, Latter and Macleod Clark (2006) assert there is disparity between educational facilities and what nursing is being taught and the reality of a busy clinical area. In fact, Maben et al. (2006) go as far as indicating that while new graduates come to the clinical area with high ideals and values, professional sabotage, such as work overload, organisation pressures and staff shortages will effectively remove these ideals. They continue by suggesting that this disparity will have profound affects not only in the UK but internationally in terms of morale, job satisfaction and staff turnover (Maben & Macleod, 2006).

Some reasons for the growth of the theory–practice gap in nurse education have been proposed by a number of writers (Landers 2000; Corlett 2000; Bullock and Manias 2002; Maben & Macleod, 2006). Corlett (2000) performed group interviews to investigate the perceptions of nurses, student nurses, and clinical preceptors on the theory–practice gap. Issues, which all groups felt contributed to the theory–practice gap were, the shortness of clinical placements, sequencing of theory and practice, and lack of communication between placements and educational institutions (Corlett, 2000).

Bullock and Manias (2002) found that nurse lecturers were concerned at the lack of theory–practice integration in pre-registration nurse education. In her discussion of the literature Landers (2000) concluded that in order for students to be successful in linking theory with practice, theoretical and clinical learning must be given equal status. She suggests that nurse teachers must be clinically skilled to support their claim to be able to integrate theory with practice.

The interviews undertaken during my research supported the suggestion that the subjective experience of socialisation for newly qualified nurses working in acute areas most closely paralleled the model identified by previous writers (Allmark, 1995; Camiah 1996; Williamson & Webb, 2001; Maben et al, 2006). In other words, new graduates experienced dissonance between the ideology of their educational institution and that of the clinical area - the gap between theory and practice. In these areas, relationships between new graduates and the hospital trained nurses were often described by participants as difficult, with the new graduates feeling that they were prevented from providing the nursing care they had been taught in the educational establishment. This
they believed was to do with the manner in which the clinical area was organised by more senior (traditional) staff. There was also significant peer pressure for the new graduates to begin their socialisation and take “short cuts” to save time. For example one neophyte explained;

> If I didn’t conform to the ways of the other nurses and their short cut methods, I got left behind; I couldn’t finish my allocated duties and was late off. I very soon became socialised to their ways and started taking short cuts. I felt very guilty about this but I had no choice. It was sink or swim.

The new graduates provided numerous examples of incongruity between their values and those of the ward in which they were working. For example, in some instances, it was not possible for them to provide the holistic, individualised care advocated in current nursing theory and in education because, under the instructions of senior nurses, patient care in the ward was broken down into specific tasks to be performed by a number of different nurses and support workers. For example, as one neophyte on a surgical ward commented:

> We don’t often have holistic care on this ward, we mainly just do tasks - work straight through. You know, we wash them all, do their beds, and do the ‘obs’. I hate it, it seems all higgledy-piggledy.

Moreover, the picture emerging from the accounts of the hospital trained nurses was that they were often suspicious of the greater theoretical knowledge the new graduates brought with them. Comment from senior nurses such as 'argumentative' and 'more interested in theory', were very frequently expressed, as was their opinion that the new graduates’ lack of experience in practice areas meant that they lacked practical and clinical skills. As one senior RN explained;

> I don’t think they’re on the ward long enough during their three years; they don’t get enough of the practical side of things.
Similarly another traditional RN had an opinion that:

_They don't have the clinical skills that the hospital trained nurses had._
_They can't perform basic techniques like catheterisation or passing naso-gastric tubes._

The concerns expressed by hospital nurses in acute areas about new graduates, often focused around a perceived lack of 'organisational' skills, and this deficit was seen as arising from reduced time allocated to clinical practice in the university curriculum. Thus, variations of the following comment (from senior nurses) were often made:

_They are not able to prioritise. They come from Uni with this idealistic view of holistic patient care, wanting to provide individual patient care one at a time. It's all very nice but you can't possibly do that for 16 people, especially when you're only here for eight hours such as night shift. You have to have the ability to flip from one to another and have the priorities mapped out beforehand._

Interestingly, the Senate Community Affairs Reference Committee (2002) identified that there continues to be issues with the theory practice gap from university to clinical placement and makes a number of recommendations to universities to bridge this gap.

There continues to be serious concern surrounding the dichotomy between the theoretical input students receive in the classroom and what occurs in the clinical environment (Landers, 2000). Nevertheless, there are a number of initiatives that have been introduced in an effort to bridge the theory-practice gap, with the focus on clinical educators, mentors and preceptors (Landers, 2000; Myrick, 2002). However, while the debate on the theory-practice gap continues, nursing executives and university educators continue to search for solutions to this long standing issue in nurse education.

One of the initiatives introduced at the beginning of this study at the researcher’s hospital, was the introduction of clinical educators to most clinical areas. While still in its infancy, participants in this study indicated this had already made a difference in bridging the gap
between theory and practice. This is supported as an essential strategy by the literature, indicating the importance of clinical support and clinical supervision (Kilminster & Jolly, 2000; Saarikoski & Leino-Kilip, 2002; Bartram, Joiner & Stanton, 2004; Chang, Daly, Hancock, Bidwell, Johnson, Lambert & Lambert, 2006).

Interestingly, a very different culture existed in the long stay areas of the study hospitals, such as rehabilitation units or long stays medical patients. Here, nursing was more distanced from the medical model and the patients had a more active role in their care. In this environment, the new graduates appeared to experience less dissonance between ward and education ideology. In these areas, traditional nurses made positive comments about the different skills, such as interpersonal skills and greater knowledge of social and biological sciences that the neophytes brought to the wards. For example, the following remarks were made:

*They're valuable members of the team because they're skilled in communicating with patients and other members of the multidisciplinary team. They don't see their role as being subservient; they'll speak out for the patient to the consultants.*

**Mentoring and preceptorship**

The concept of mentoring is not new to nursing. Florence Nightingale was known to have multiple mentors as well as being a mentor to others. Mentoring promotes the psychosocial and instrumental development of the new RN over an extended period of time. The psychosocial role of the mentor promotes acceptance, confirmation, and role acquisition in the individual being mentored. Gordon (2000) believes the key role of the mentor is coaching, teaching, and a belief that the student has a keen sense of achievement and wants to learn.

Preceptoring on the other hand is widely used for socialisation of nursing students and new staff (Usher, Nolan, Reser, Owens & Tollefson 1999). Preceptor programs are widely used in both undergraduate and post graduate nursing education in the United States,
Canada and Australia (Usher et al. 1999). For the new graduate entering a busy clinical area, the role of the preceptor is critical to facilitate their learning, skill development, and role modelling, coaching and supporting their professional and personal growth (Henderson, Fox & Malko-Nyhan, 2006).

It has been identified that the primary reasons preceptors engage in this activity is to share knowledge, facilitate integration of new staff, and obtain recognition and job satisfaction (Ohrling, 2001; Boychuk, 2001). According to Dibert & Goldenbeer (1995), nurses identified that assisting students integrate into the ward/unit as a preceptor where they taught, shared knowledge and gained professional satisfaction was professionally rewarding for both the student and preceptor. Ohrling & Hallberg (2001) on the other hand identified that preceptors are directed by the university curriculum, and frequently preceptor programs are developed outside a preceptors’ realm and may affect a preceptor’s commitment to the program, whereas commitment to the values of a curriculum by academics are attained by their familiarity with them (Kansanen, 1997).

Nevertheless, it is agreed that the creation and maintenance of a preceptor program involves organisational expenditure both in terms of financial investment and human resources (Dibert & Goldenberg, 1995; Usher et al 1999; Henderson et al 2006). However, such an investment has the potential to be lost if administrators fail to support preceptors once they are appointed to the role (Henderson, Fox, Malko-Nyhan, 2006). It is suggested that this may be due to the risk of stress related burnout occurring from the additional requirements placed on them (Letizia & Jennrich, 1998). The role of a preceptor is often stressful, and while offering many rewards, can be perceived by the RN as an additional burden for them by adding to their already busy role (Greakish & Carroll, 1998; Usher et al 1999). As one RN indicated;

*The bottom line is it's another job for the RNs and this is not the environment where there is a paid educator and there wasn't systems in place to help these students.*

Nevertheless, RNs interviewed who were preceptors at the study sites, supported the view that being a preceptor was important with responses such as:
I get an immense sense of satisfaction when a new graduate thanks you for all the support and guidance you gave them.

It’s really great to see the grads develop and especially so when you know you have done your bit

I wish this had been in place when I first started rather than be thrown in the deep end. It is also great to learn along side them

Despite increasing numbers of expectations placed on preceptors, preceptors at the study hospitals remained committed to the role. This was surprising in view of the number of concerns identified in the literature regarding 'burnout' associated with the frequency of preceptor occasions (Greakish & Carroll, 1998; Usher et al.1999; Young 2002; Henderson et al. 2006). The risk of 'burnout' exists if they are repeatedly asked to assume additional obligations without appropriate rewards and support (Greakish & Carroll, 1998; Usher et al.1999; Young 2002).

Additionally, there are identified essential success factors such as preparation for the role for those staff wishing to become preceptors and become part of a preceptor program Fehm (1990). The literature also demonstrated that the important components of preceptor training include required preceptors to have a number of additional skills, including; a knowledge of the principles of adult education, understanding teaching/learning strategies, possessing good communication skills including conflict resolution and an ability to undertake an assessment of individual learning needs and evaluation of novice performance (Yonge, 2002; Henderson et al. 2006; Pickens, 2006). Additionally, Ohrling, (2001) indicated that the prior training and experience of a preceptor enhanced preceptors' comfort and perceived skills. For example, prior experiences such as declining conscious state, allow the preceptor to describe case experiences which in turn will explain nursing actions and outcomes.

Literature has identified a number of problems that were associated with the preceptor role (Young et al. 2002; Gallo & Siedow, 2003; Henderson et al 2006). These included; lack of
flexibility in the orientation program, whereby an individual’s learning needs should be met, lack of support from staff who are not preceptors, inability to spend enough time with the preceptees and frequent roster changes. This is supported by new graduates from the study hospital who indicated;

I get really frustrated when I come to work and find my preceptor has had her roster changed. I know skill mix is important, but so is our preparation for the roles we want to take on. This lack of support from management leaves us wondering of our worth.

Nevertheless, reports published in the literature mention positive aspects of the preceptor and preceptee roles (Greakish & Carroll, 1998; Usher et al. 1999; Yonge, 2002), to be associated with personal and professional growth (Pickens, 2006) and job enrichment (Henderson, 2006), all of which were supported by staff from the study sites. Negative aspects relate more to a lack of administrative support (Henderson et al. 2006), workload adjustment (Yonge, 2002) and financial recompense (Yonge, 2002) for the additional responsibilities. All of the above issues were raised during interviews with staff from the study hospitals, indicating the literature does reflect contemporary thinking of preceptors and preceptees.

**Emotional Overload**

To help others was the very reason why Florence Nightingale went to Scutari and Linda Richards to Boston City Hospital, and became the foundation of nursing. Baer (1987) believes that there are a number of unanswered questions to be resolved and that this general responsiveness to people in need and this love of ministering has yet to be answered or even understood.

Nurses complain that in the current health care environment with shorter hospital stays, fewer financial and personnel resources, and limited opportunities for community contacts, building relationships with patients and their significant others is difficult, if not impossible. This problem in turn provides a rationale or excuse for why appropriate nursing action cannot be accomplished fully. Given the current pressures in health care, often resources
are inadequate to routinely build nurse patient relationships over time and to progress to any meaningful empathetic relationship (Reynolds & Scott, 2000). Because of time limitations, nurses identified they had a decreased ability to provide care, increased emotional stress and a decreased ability to provide quality care.

**Nurse Patient Relationships and Empathy**

Nursing theorists over the years, either implicitly or explicitly, have invariably identified empathy as central to the nurse-patient relationship, caring and competency (Mock, 2001). It is not surprising therefore, that as early as 1953, Kandler addressed this very issue. Since this time, numerous reports have been published addressing similar topics (Baillie 1996; Iruita, 1999; Kagen & Evans, 1996; Stein-Parbury, 2000; Mock 2001). However, research to date, has provided only minimal support for the belief that empathy affects health care outcomes. Moreover, findings from studies of nurses' empathic ability have appeared contradictory. For example, Baillie (1996) reported that closeness is intimately linked to empathy. This in turn is aligned to 'getting to know' the patient. Empathy as defined by Reynolds & Scott (2000, p.226), is: “the ability to perceive and reason as well as the ability to communicate understanding of the other person's feelings and their attached meanings”. Reynolds & Scott (2000) continue by describing empathy as an essential prerequisite for good nursing practice, and if nurses fail to empathise with their patients, then they cannot help them to understand or cope effectively as individuals with their illness. Accordingly, McCann & Baker (2001), assert that open and honest communication helps patients to deal positively with their illness.

Empathy can be described as a feeling, portrayed non-verbally, and includes thoughts and emotions related to understanding patients' situations all of which contribute to the development of good nurse-patient relationships (Fawcett, 1995). It would appear that nurses' own attributes and previous personal and professional experience impact on their ability to empathise. Similarly, a person’s knowledge about people’s feelings is important for developing empathy (Tanner, 2006). In trying to understand how nurses empathise with their clients, it became obvious that empathic feelings are difficult to generate when nurses have not had any similar experience. This in turn can lead to stress and burnout (Omdahl & O’Donnell, 1999). In their study, Omdhal and O’Donnell (1999) identified that
the variable associated with empathy included sharing patient emotions; being concerned for the patient and being able to effectively communicate with the patient and their family, therefore, significantly contributing to stress and burnout in nurses.

Nevertheless, this perspective of the nurse-patient relationship has continued despite dramatic changes in health care environments, economics, and patient and family needs that have affected this relationship. As previously discussed, nurses now find themselves providing care to more acutely ill patients with increased workloads and fewer resources, thus interfering with the ability to develop a satisfactory relationship with their patients (McQueen, 2000; Ronayne, 2001; Tanner, 2006). As one RN indicated during an interview:

> When we trained way back in the dark ages, you literally were with the patients almost all the time. You actually spent a lot of time behind the curtains with the patient washing them, and it is very intimate when you are doing that with a patient, and they open up and tell you a lot more, that is how we developed empathy and understanding then. Now we don't have time.

Additionally, nurses identified that it is difficult to empathise with a patient when the patient is difficult to get to know or understand and communicate with, for example people from non English backgrounds or culturally diverse backgrounds. Further, there are additional barriers to empathy identified by the participants that include the current working environment often being stressful, and they had lack of time to actually get to know their patients, for example:

> How can I empathise with my patients when I have no idea about them post operatively? Most of the time I don't get to see them until after their operation

> So it is really being able to have that empathy with the patient and as I said interpret what is going on. Besides, as I said, naturally just doing the actual day-to-day care, from making sure their toenails right up to their teeth. They are the sort of things, the purely physical things that we have
always been taught to do. But also understanding that beyond what you are looking is a whole world that you need to be aware of.

A study by Mock (2001) indicated that respondents considered being empathic was valuable to the patient's psychological care. Additionally, nurses were able to understand patients' physical needs and respond to them by being empathetic and communicating with them.

It is suggested, (Chant et al. 2002) that nurses do not communicate well due to the organisational culture, where traditionally nurses were not encouraged or supported to establish therapeutic relationships with patients. This is supported by Cheng et al. (2000) who identified that a number of features of nursing practice lead to declining work performance and staff health over time; for example, demands from highly stressful tasks, poor management practices and inadequate support from peers and management. It is suggested that a possible explanation for the negative attitude of peers is related to unit staffing levels, workload, rapid discharge of patients as well as a lack of understanding of the therapeutic potential of empathy, which in turn prevents empathy from being regarded as a normal process (Reynolds, Scott & Austin, 2002). It is no wonder that nurses themselves perceive that developing an empathetic nurse-patient relationship is a very stressful process for them.

The challenge for the “caring professions”, including nursing, has always been concerned with how to maintain professionalism, not to become divorced from practice and to be able to offer a certain expertise without losing one's humanistic approach to empathise with the patient and their family and provide the nursing care expected by the patient.

What then is “care” and “caring”. Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. According to the ICN Definition of Nursing (2005), care includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (ICN, 2005).
Watson (1988) defines nursing “as a human science of persons and human health—illness experiences that are mediated by professional, personal, scientific, aesthetic, and ethical human care transactions” (1988b, p. 54). In addition, she also views nursing as both a science and an art. Unfortunately, artistry, along with creativity, is often seen as incongruent with an institution’s policies and procedures. However, according to Watson, being an artist is part of our role and certainly part of caring for patients and their families. In 1999, she exemplifies the artistic domain of nursing as emerging transpersonal caring-healing modalities. Such transpersonal caring-healing modalities correspond to providing comfort measures, helping the cared-for to alleviate pain, stress, and suffering, as well as to promote well-being and healing.

Congruent with other nursing scholars, Watson (1988b) acknowledges caring as the essence of nursing. She also adds that caring can be viewed as the nurse’s moral ideal of preserving human dignity by assisting a person to find meaning in illness and suffering in order to restore or promote the person’s harmony. You may be inclined to view such a “moral ideal” as being extremely intangible and inaccessible. However, as one usually aspires to be the best nurse possible, one tends to evaluate oneself to such ideal. Consequently, the nurse can experience frustrations if he/she feels incongruent with his/her own moral ideal. Instead, an ideal is a guide for shaping practice.

Watson’s (1999) present definition includes caring as a special way of being-in-relation with one’s self, with others, and the broader environment. Such relationship requires both an intention and a commitment to care for the individual. In other words, the nurse has to be conscious and engaged to care in order to connect and establish a relationship with the cared-for to promote health/healing.

The path from perceptions of nursing care to overall satisfaction with the hospital experience validates the substantial contribution nursing care makes to patients’ overall ratings of their hospital experience. Considering nursing care is the one constant presence in the care of hospitalized patients, this finding is not surprising and is also consistent with the previous work of others (Abramowitz, Cote, & Berry, 1987; Lemke, 1987; Woodside, Frey, & Daly, 1989).
Stress and Burnout

According to (McGowan 2001, Shader et al. 2001), workforce stress within the workplace is having a greater impact today than 10 years ago, suggesting that the most frequently recognised sources of stressors such as workload, increased technology, patient activity and acuity and increased demands from management, has intensified and increased for nurses today (Demerouti et al. 2000; McGowan, 2001). Nurses at the study hospitals identified additional sources such as increased student supervision, lack of educational opportunities, lack of reward and recognition, lack of job satisfaction, inability to complete work and patient demands also contributing to the cumulative effects of stress. Both international and local situations are very similar. Participants also indicated that inadequate pay and career structure is increasingly becoming a source of distress which is exacerbated by high workload and decreased staffing numbers.

High levels of occupational stress undoubtedly have negative consequences for clinical nurses. Stress associated with death and dying as well as failed resuscitation attempts has been shown to produce frustration, anger, guilt, resentment, professional failure, personal loss, helplessness, powerlessness and sorrow (Isaak & Paterson 1996, Perkin, Young, Freier, Allen, & Orr, 1997) and the stress producing these feelings has been linked to burnout (Oehler & Davidson 1992). People who experience stress restructure their role expectations or decrease their involvement in the role through distancing (Biddle 1979). While resigning from a position certainly decreases involvement in the role, less severe manifestations of distancing include casualness and inappropriate communication. Not surprisingly this is supported by additional studies indicating stress, burnout and dissatisfaction are precursors of nursing resignations (Lake, 1998; Sheward, Hunt, Hagen, Macleod & Ball 2005) and patient dissatisfaction (Vahey, Aiken, Sloane, Clarke & Vargas 2004). Additional findings indicate that better staffed hospitals may be more successful in retaining staff (Aiken et al. 2001).

Nurses working in demanding areas such as ICU, acute wards and Emergency Departments spend considerable time working and interacting with critically ill patients and their families (Gillespie & Melby, 2003). As such, the nature of this type of work is demanding and stressful, requiring of the nurse great skills and abilities such as empathy,
compassion and sympathy (Malach-Pines, 2000). Continued exposure to this type of nursing often leaves staff emotionally drained, with the eventual outcome being stress and burnout (Malach-Pines, 2000). Nurses in this study identified what they perceived to be a lack of support from management, believing they did little to assist in difficult situations. It was suggested by one RN that “just being around could help us to know what we are going through”. It was also perceived by participants that the limited time they had to spend with patients and their families was a failure by them to meet patient requirements, leaving participants anxious and stressed. Participants themselves believed that if they continued to work under such constant pressures and demands that left them feeling frustrated and drained at the end of each day with little job satisfaction, then burnout will occur. This is supported by Kilfedder (2001) who identified that nurses who are continually exposed to unremitting stress will demonstrate negatively towards their job.

The Australian Government is seeking opportunities to improve the situation but, whilst initiatives such as increased university places, improved career structure and an increased recognition for clinical supervision requirements will help, it is questionable whether they will remove the problem altogether in the near future.

**Dialoguing**

A review of the literature identified similarities in the definitions offered for the terms 'communication' and interpersonal skills'. As a result, it is understandable that many writers use the terms interchangeably and I have also done this.

Effective communication/interpersonal skills are central to expert nursing (McQueen 2000; Mock, 2001; Chant, Jenkinson, Randle & Russell, 2002; McCabe, 2004). Communication issues are continuously raised in discussions with and between clinical nurses and their patients, with good communication being the essence of good health care. Within the clinical arena, the nurse-patient relationships are both dynamic and diverse, with nurses' response depending on how each (nurse and patient) participant perceives the on-going interaction (Mock 2001). While both nurse and patient clearly contribute to the type of relationship, it is the nurse's role to encourage the development of a relationship that can be therapeutic. Chant et al. (2002) indicate that for nurses to develop this relationship, it
requires them to call on their personal qualities, such as social skills and the ability to work in difficult conditions and situations.

The literature is abundant with articles about communication and identifies that good communication is an essential component in the safe and efficient provision of nursing service delivery (McQueen, 2000; Mock, 2001; Chant et al., 2002; Foxhall, 2002). The corner-stone of how and why clinical care is provided and received is the one-on-one communication between individual clinicians and patients. For example, how do you break bad news to a patient? How do you make an open disclosure of the events that have led up to a medical error? How do you communicate effectively within a cardiac arrest team that has only just arrived on the scene and don’t know the patient? As one RN explained previously he was at a loss to assist the team with current information as he had no knowledge of the patient. Another participant said:

“You are only able to carry out basic nursing care. You don’t have time to sit with patients, to discuss their diagnoses or any concerns they may have. In the case of a dying patient, you don’t have time to sit with them and hold their hand and just be there for them, because you have so much of a workload to complete before you finish your shift”.

Communication is essential and it matters to the patient. Foxhall (2002) identified that good nurse-patient communication eases the path to recovery and that the relationships between nurse and patient is significantly improved when the nurse spends time talking to the patient. The poor communications on the part of clinicians, relating to poor outcomes for a patient, are frequently a cause for litigation (Mock, 2001). This occurs simply because there has been a lack of understanding by the patient and a failure by the clinician to engage the patient in dialogue (Mock, 2001).

While it is acknowledged that effective communication is essential to good nursing care, it is also suggested that the use of interpersonal skills in nursing is the concern of all nurses working in all specialities (Clark, 1999; Foxhall, 2002). However, skilful communication, according to Mock (2001), appears to be routinely ignored in the education of all clinicians. While it is acknowledged that almost everyone engages in communication when in social
encounters, this is often overlooked and disregarded for its therapeutic value (Mock, 2001; Foxhall, 2002).

If, as suggested (McCabe, 2004) that good communication is an essential component of quality nursing care (Oermann & Templin, 2000), then it is important that these skills be developed to ensure clinical nurses are able to provide patient centred communication skills that are fundamental to the delivery basic, quality nursing care (McCabe, 2004).

Nevertheless, it does not necessarily follow that all nurses will be gifted with good interpersonal skills. Accordingly, if good interpersonal skills have a bearing on nurse-patient relationships and outcomes in terms of the quality of care, then this should be overtly acknowledged in preparing nurses for their work and socialisation into the ward environment (Foxhall, 2002). However, it would appear that the power of the socialisation process is recognised as being greater than the influence of undergraduate teaching (Foxhall, 2002).

**Patient Advocacy**

A key component in patient care is being an advocate for them. The nurses’ advocacy on behalf of patients plays a critical role in maintaining patient safety throughout their hospitalisation, and indeed in the community. Advocacy also plays a significant role when nurses are caring for the patient and their family (Boyle, 2005; Beyea, 2005). The recognition of a patient’s vulnerability that is associated with an acute illness, unconsciousness or anaesthetised in the operating theatre, challenges nurses to protect the patient and the facility from potential harm or risks (Bull, 2004). Advocacy can be defined as: the act or process of pleading or arguing in favour of something (American Heritage Dictionary, 2005), or the giving of aid to a cause or the active support for a position (Encartera Dictionary, 2005). On the other hand the nursing literature describes advocacy as: an act of informing and supporting individuals so that they may make the best decisions possible for themselves (Schroeter, 2002). In other words, advocacy in nursing is about speaking up for someone who is unable to speak for themselves. However, for some nurses this is easier said than done as indicated by a participant (p.133) who was acting as the patient's advocate. Similarly, the notion of patient advocacy
was voiced a number of times and as one RN indicated the following comment was made
new graduate:

They don't just report things back to me; they're prepared to use their
initiative. They're not afraid to speak out either on behalf of the patient,
whether it is to a member of the nursing staff or to a consultant.

Significantly 'not being afraid to speak out and be an advocate on behalf of patients' was
attributed with high value on this ward, in contrast to the label of 'argumentative' applied in
some instances in acute areas. Subsequently, the new graduate described sharing their
knowledge with patients and staff, and in some cases changes that they had introduced to
the ward. For example, a neophyte working on a medical ward who had been qualified for
15 months reported the following:

I'm trying to introduce a change in to the ward regarding handover. I
think a bedside handover is more effective than all the staff stuck in
the office with only one person on the ward. I'm going to show the
Nurse Unit Manager this week on my ideas so as not to leave the
ward unattended and ensure the safety of the patients.

This certainly supports the concepts that new graduates are prepared to speak up,
advocate for their patients and seriously attempt to become a team member.

Quality Activities

Patient satisfaction

Nurses at the study hospitals identified their concern with the numerous complaints they
heard about. These were received usually by management from patients and were mostly
related to the nursing care they received whilst in hospital. Given their time constrains and
workloads along with their inability to spend time with their patients, they also realised that
complaints were a “fact of life”. As one EN explained;
Until management and bureaucrats can come up with a reasonable workload methodology to support nurses and their increasing workload, patients will continue to make complaints about the poor quality nursing care they receive. They complain nurses don't answer the bell quickly and that nurses do not spend enough time with them.

So, why is the quality of nursing care important to patient satisfaction? The main reason appears to be is that hospitalised patients receive the majority of their care from nurses, with nurses being the largest proportion of personnel providing health care service to the community (Hann, Connolly & Canham, 2003).

Among the first to report the positive relationship between the increased hours of professional nursing service available in hospitals and patient satisfaction in general were Abdellah & Levine (1957). Additional research over the years by authors such as Carey & Posavac (1982), Cassarreal (1986), Abramowitz et al. (1987), Brice (1994), and Kerfoot (2006) supports this, with all studies documenting that patient satisfaction with nursing is the most important predictor of patients' overall satisfaction with their hospital care. Whilst patient satisfaction is the most commonly measured outcome of patient care, other than mortality and morbidity, research has not identified a finite definition, and, there is no consensus regarding what the concept of patient satisfaction is. Understandably, this may account for the surprising number of studies that purport to measure patient satisfaction without explaining the concept (Strasser & Davis, 1991; Wilkin et al. 1992; ANA 1996; Urden, 2002, Kerfoot, 2006). Urden (2002) indicates that patient satisfaction is more often dependant on the timing of the survey, mode of data collection and the ability to accurately assess the information. Therefore, it is even more imperative that researchers attempting to measure patient satisfaction should first answer the question, what are we truly trying to measure and how should we do it?

The classic tripartite framework of structure-process-outcome for the nursing process was provided by Donabedian (1969), who identified the relationship of satisfaction to health: 'achieving and producing health and satisfaction . . . is the ultimate validation of the quality of care' (1966 p. 166). It was also later recognised by Donabedian (1980) that the expectations of care from a patient were important, as well as the central role a patient
plays in the evaluation of their own care. “Client satisfaction is of fundamental importance because it gives information on the provider’s success at meeting those client values and expectations which are matters on which the client is the ultimate authority” (Donabedian, 1980 p. 25). More recently, researchers such as Jarrett (1995); Omdahl (1999); Urden (2002); Chant, Jenkinson, Randle and Russell (2002); Swan (2004) and Norby (2005) have identified that patient satisfaction is a top priority for every health care system’s quality improvement and for management programs to meet and exceed customer expectations, detailed attention must be directed toward patient satisfaction assessment.

Further, the ability to influence patient satisfaction with nursing care is recognised with staff’s expectations, perceptions, and previous experience. This is defined in this particular aspect of satisfaction as” the greater the patient satisfaction with nursing care, the greater the satisfaction with care in general” (Urden, 2002, p.2). This was certainly supported by the staff from this study hospital.

Consumer satisfaction surveys and consumer participation groups are evolving rapidly as methods of measuring quality care. Current national and international trends toward health care reform have placed increasing emphasis on health care cost, quality, and consumer satisfaction (Bailey & Moin, 1997). Consequently, it is the patients who are now in a position whereby they can evaluate certain aspects of their care by completing satisfaction surveys (Oermann & Templin, 2000), and, provided with this information administrators will hopefully review care processes in consultation with staff (ACHSEQuIP 2005).

**Magnet Hospital principles**

A number of the participants in this study indicated that the magnet hospital principle would be one method of improving quality of care, identifying that many of the attributes of Magnet status would assist retention, workloads, skill mix, patient safety and staff satisfaction. A review of the Magnet status identified that the Magnet Recognition Program was developed by the American Nurses Credentialing Centre, a subsidiary of the American Nurses Association, to recognize health-care organizations that provide the very best in nursing care (American Nurses Association web site, 2006).
The effort has its roots in the 1980s when nurses began to grapple with the short and long-term reality of national nursing shortages. More than 126,000 nursing positions are vacant today, and that number is expected to skyrocket just as 78 million Baby Boomers begin placing unprecedented demands on the American heath-care system.

In 1983, the American Academy of Nursing Task Force on nursing practice in hospitals conducted a study of U.S. hospitals (Herron, 2004), that identified and described variables that created an environment that attracted and retained well-qualified nurses. These variables were called "forces of magnetism," and the institutions were called "Magnets", because they attracted and kept good nurses within their organisation (Herron, 2004). The study found that quality patient care was provided through sustaining excellence in nursing services.

The Board of Directors of the American Nurses Association (ANA) approved the initial proposal to recognize excellence in nursing services in 1990. Since 1994, the program has expanded to include organizations from diverse locations with varied practice setting, with recent additions being New Zealand and Australia. For a number of years, Australian and New Zealand nursing leaders and key academics have followed the research and literature linking nurse staffing, patient outcomes and hospital environments. The Magnet model has been identified as the only evidence-based nursing workforce improvement management model that has dramatic and scientifically measurable benefits for patients and nurses (Vickerstaff, 2005).

Nurses are vital to the delivery of quality health care and successful patient outcomes. Hospitals with magnet organisational characteristics have demonstrated better patient outcomes (lower mortality and morbidity rates, reduced infection rates and medication errors) and higher patient satisfaction because of 'patient-centred care' than matched non-magnet hospitals (Oermann, 2000). Costs are reduced because of lower staff turnover and shorter lengths of stay. Research has demonstrated a positive impact on organisational culture and increased institution stability. In terms of nursing outcomes, magnet hospitals have demonstrated enhanced recruitment and retention of highly qualified nurses, lower rates of needle stick injuries, higher rates of nurse job satisfaction, higher nursing ratings
of quality of care, and significantly lower rates of nurse burnout (Lundstrom, Pugliese, Bartley, Cox, & Guither, 2002).

In relation to administration (Lundstrom, Pugliese, Bartley, Cox, & Guither, 2002), highlighted organisations with a decentralised structure, had nurse executives who were well qualified, utilised participatory management style with an emphasis on two-way communication with staff were typical of Magnet Hospitals. It was also identified that when flexible staffing occurred, there were adequate nurse staffing levels (they reported an average ratio of 1:1 registered nurses per occupied bed), and there was an emphasis on the provision of clinical career opportunities. This is in direct contrast to the study hospitals where registered nurse levels were 1 RN and 1 EN to 10-12 patients, depending on patient acuity. Low levels of qualified nurses could lead to poor care, low morale and staff turnover. A landmark study of the effect of nurse/patient ratios in acute surgical units in Pennsylvania hospitals, showed that the chance of patients dying within 30 days of admission increased by 7% for every patient over four for whom a RN was responsible (Aitken et al 2002). This is partly supported in a more recent study by Bennett, Plint & Clifford (2005) who indicated that burnout was most prevalent in the non medical cohort. However, Bennett at al. (2005) in their study were unable to substantiate that nursing staff as opposed to non medical personnel suffered from job dissatisfaction or stress. This is in direct contrast to the findings of nurses at the study hospital.

It is reported in the magnet hospitals that nursing attrition rates, and vacancy were found to be significantly lower, and staff reported excellent job satisfaction (Lundstrom, Pugliese, Bartley, Cox, & Guither, 2002). Again this is in direct contrast to the study hospitals who displayed low morale, poor job satisfaction and a high attrition rate. These findings provided some statistical support to the conclusions made by McClure, Poulin, Sovie, & Wandelt (1983) in the original study, which indicated there were links between the characteristics such as reported nurse job satisfaction, and lower rates of turnover and vacancies in the magnet hospitals.

Most of the work on nurse job satisfaction undertaken by magnet hospitals focuses on the satisfaction of nurse’s employment and their nurse job (Kramer & Schmalenberg, 2002) and therefore predates some of the most significant changes in USA hospital organisation.
and configuration. One of the main issues which needed to be examined was the extent to which the original magnet hospitals have retained the characteristics of 'magnetism'. Can these hospitals maintain their approach during cost containment and restructuring? Are they altering skill mix and staffing levels in a way, which may compromise their ability to retain the core characteristics of magnetism? What happens when a 'magnet' hospital merges with one or more other institutions, which do not share the characteristics of magnetism? These issues were explored during case study interviews with managers in a sample of the original magnet hospitals.

Continuing clinical education for nurses and nursing staff skill mix and funding can be characterised as the two features of the original magnet hospitals, which appear now to be questioned, and under cost containment threat. It would appear there were significant staff mix variations within each of the hospitals. It was indicated that over the past few years, in most of the 'original' 10 magnet hospitals, there had been significant changes in nursing skill mix, and in all cases this had been a direct result of increasing the numbers of unlicensed assistance personnel (UAP), and/or licensed practical nurses (LPNs). Additionally, along with the change in RN/UAP/LPN ratios and skill mix, there had been changes in the organisation of the delivery of care. It appeared that primary nursing; the standard form care methodology was no longer the ideal for the day to day organisation of nursing care in most of the hospitals. Other versions and methodologies emerged including of RN-led team nursing, (with UAPs and/or LPNs in the team), or 'paired' teams of RN and UAP being the most commonly favoured system (Buchanan, 1999).

A market context, due to the significant changes which have occurred in the USA health system over the last two decades, has been created (both in terms of service provision and labour). This is very different from that which existed when magnet hospitals were first identified in the early 1980s. It could be argued that the concept of magnet hospitals, which emphasises quality of service provision and 'success' and therefore 'efficiency' in labour markets, is as relevant today as it was in 1983. The recent shift in the focus of magnet hospital research towards assessment of outcomes reinforces this viewpoint.

In the United Kingdom, despite recent alterations to the NHS caused by a change in government, it is argued that all the key concepts and characteristics essential to being
core principles for the magnet hospital concept continues to have relevance today. It is well recognised that the health systems in both the UK and USA are fundamentally different; however, hospital organisation and workforce planning have many similarities. For example, the magnet characteristics of flexible work arrangements, investment in continuing education, professional autonomy, decentralised management structures, have come to the front over recent years in the NHS, if not introduced in the same systematic sustained manner which is the hallmark of magnet hospitals.

The organizational features common among the magnet hospitals are similar to those associated with lower mortality in many other studies. These include decentralized decision-making at the nursing unit level, ward specialisation, standardisation of procedures, qualifications of nurses and physicians, and good relations between nurses and physicians.

The only hospital, which has magnet status in Australia at the time of this study, was a major teaching hospital in Queensland and it is recognised as one of the leading health care provider in the State. This is the Princess Alexandra Hospital in Brisbane which achieved Magnet Accreditation in 2005.

In New Zealand, while there is one hospital that is working towards magnet status, but there is a group of nurse leaders who are working towards assisting other hospitals gain magnet status. This organisation has made significant gains in the provision of quality care in that they have, evidence of improved outcomes; manageable workloads; innovative evidence based practice; nurse leaders shaping the future; 98% patient satisfaction (Press Ganey report, 2005) and importantly, improved retention of nurses (personal communication May 2006).

It should be noted that it is not the magnet hospital label per se (or any other similar label) which is important, but the concepts of good quality care, effective staff deployment and high levels of job satisfaction which signify the attainment of the label. These concepts have a universal relevance and applicability. What is required is that the factors that underpin the apparent success of magnet hospitals are subject to further research-based validation and evaluation.
Quality Activities and Accreditation

More and more public and private groups are developing and using quality measures. Measures are used to check up on and improve the quality of health care, doctors, hospitals, and other providers of health care. One of the major quality indicators in the past has been consumer ratings and performance measures such as patient satisfaction and compliments and complaints. Over the past 20 years, additional processes such as accreditation of health care organisations has been occurring, and this has now become the standard requirement for hospitals who require recognition as safe, health care facilities. Health care organisations who wish to have accreditation status must meet national standards—including clinical performance measures—to be receive and maintain accreditation status (ACHS EQuIP Guidelines, 2006).

Accreditation is a "seal of approval" given by private, independent groups. Accreditation is done by a number of groups in Australia but the main group in Australia is the The Australian Council on Health care Standards (ACHS), which is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through continually reviewing of performance, assessment and accreditation. The ACHS has maintained its position as the leading independent authority on the measurement and implementation of quality improvement systems for Australian health care facilities (ACHS Annual Report, 2004-5).

Another organisation, The Australian Council for Safety and Quality in Health Care was established in January 2000 by Australian Health Ministers to lead national efforts to improve the safety and quality of health care provision in Australia.

Conclusion

Previous literature and current studies in an interrelated context have identified that nurses are stretched in the amount of clinical work they are required to undertake each day. This has been a long standing problem nationally and internationally, with similar findings and no real long term solutions. The magnet hospital principle has gone some way to improve
this but this is not the final solution to the chronic problem of workloads and overloading of nurses.

Studies have concluded that high volume of patients and high workload for the staff may contribute to staff burnout, increased staff turnover and an increased numbers of patient complaints. This increased workload is also indicative of increased harm to patients as nurses take short cuts "working around" to enable them to meet their daily allocation of duties. Also, staff burnout results from a variety of stresses, including situations in which work demands cannot be met because of a lack of resources including a lack of social support from co-workers and supervisors, job control, participation in decision-making, utilization of skills, and reinforcements such as rewards. Stress and job burnout are also related to specific demands of work, including overload, variations in workload, role conflict, and role ambiguity. Workers who perceive a high level of stress and resulting job burnout have poor coping responses, decreased communication abilities and lack of job satisfaction, which often erode commitment to the organization and lead to higher turnover.

Breakdowns in communication between health care professionals, or between clinicians and patients, are a factor in almost all adverse patient events, or ‘medical mistakes’. Some of these cause serious harm to patients, and trauma to their families, as well as being devastating to the clinical staff involved. Open and honest communication between clinician and patient benefits all parties by ensuring safety while reducing emotional and psychological distress, assisting compliance, and speeding recovery.

There are a wide range of factors that can influence the relationship between theory and practice and in particular communication skills. The importance and presence of preceptors and mentors on new graduate acceptance into the clinical unit does much in terms of knowledge enhancement and reduction of the theory practice gap as well as developing their relationship with other members of the team.

The recognition of magnet hospital status has deemed to be important, but not imperative. What is important, are the concepts of good quality care, effective staff deployment and high levels of job satisfaction which provide the attainment of the label. These concepts have a universal relevance and applicability. What is required is that the factors that
underpin the apparent success of magnet hospitals should be further investigated for the Australian hospital.

Additionally, accreditation of Australian health care facilities and quality improvement processes have ensured organisations meet minimum standards to provide patients, staff and the community with quality health care but there are no effective standards that ensure nurses are not inflicted with excessive workloads.

Patient satisfaction can and is used as an indicator to evaluate staff, management, and system performance and effectiveness. Health care organizations that invest in programs to determine how patients evaluate their experiences will have valuable information to make improvements in both clinical care and services. Feedback such as “the nurses did not have time to care for me” can be utilised as an indicator for nurses.

The literature reviewed in this chapter helps clarify current efforts being made to establish links between nursing quality care and patient outcomes. The selected studies focused on professionalism, workloads, and preparedness for practice, emotional overload, dialoguing and quality activities. Issues examined included organizational factors that impact worker performance, such as teamwork, staffing ratios, and quality improvement processes. Overall, the studies provided evidence of direct positive and/or adverse effects on work performance and suggest there are direct effects on the quality of patient care.
CHAPTER 7

SUMMARY AND IMPLICATIONS

“Nurses need to give added attention to the use and subtleties of language, to the need to develop strong linguistic skills, to remain sensitive to the values implicit in varying lexicons, and to appreciate the discretions often “implied” in verbal and written forms of communication” (Henry & LeClaire, 1987, p19).

Introduction

The final chapter reflects on the research process. Following a brief summation of this research, an overview of the grounded theory is presented which briefly explores the implication of “working around” on nursing practice and quality care delivery. Finally, the limitations of this and the recommendations for further research will be explored. This grounded theory study has provided sufficient exploratory evidence of important aspects of nursing care experiences as described by nurses, to be useful in beginning to understand theoretical explanations of nursing workloads and the reasons this impacts on quality patient care.

The literature reviewed in this study (see Chapter 6) helps clarify current nursing issues and the links between nursing workload and patient care outcomes. The selected studies focused on nurses’ inability to provide quality nursing care and the associated explanations. This study further examined and discussed the categories that were representative of the theory of overloading, that is; professionalising, organising, new graduates preparedness for practice; emotional overload, dialoguing and quality activities. Overall, this study has provided evidence of both positive and/or adverse effects on nurses’ work performance that suggest aspects within the healthcare environment that directly affect the quality of patient care.
A Summary of the research

The aim of this study was to explore nurses’ perceptions of quality nursing care and to identify significant nursing care issues impacting on quality care for patients. Grounded Theory was used in this project, utilising interview technique, open questions and constant comparative analysis of the transcribed interviews. The theory was influenced by the theoretical constructs of the basis and psychosocial process as originally described by Glaser (1978) and refined over the years to his latest work.

Originally, the objectives of this study were to determine how nurses in the clinical area define quality patient care and methods by which high quality care may be better achieved by:

- Establishing a range of quality benchmarks for high quality nursing care;
- Determining if nursing care actions provided to patients are those that should be implemented;
- Comparing actual quality of care to perceived quality benchmarks of care;
- Identifying significant nursing care issues impacting on quality;
- Make recommendations on behalf of nurses working in the clinical area with patients for the purpose of improving the quality of nursing care.

However, once the analysis of interview data commenced, it became necessary to modify the objectives somewhat, as it became clear that a nurse’s ability to provide quality outcomes, the original focus of this research, was not emerging as a major category.

As the interview process progressed it became apparent that there were two main questions that were the highlight for this research and this became the main focus for the project. Therefore, as stated in Chapter 1, the purpose of this study was twofold, to answer the questions:

- What is it that nurses do each day that take them away from direct patient care?
- What do nurses perceive to be quality nursing care?
The Grounded Theory approach was chosen for this study as this methodology seeks to uncover what is going on in a situation, taking into consideration relationships, context and meaning. In this study, this related to the theory of nurses working around to manage their everyday workload and provide patient care.

The Grounded Theory of Working Around was developed from information provided from interviews of participants. The participants indicated that knowledge and the socialisation process create the concept of a sense of team and worth and assists graduates become a team member and hence these concepts formed the basis for the category of professionalising. Skill mix issues, patient acuity and staff shortages identified for staff a sense that workloads created a need to organise activity to keep ahead. The need to manage time, preceptor new graduate staff, identified the concept of on the job training in the category of preparedness. Stress, burnout and a sense of helplessness became identified in the category of emotional overload, whilst issues related to patient relationships and communication were categorised as dialoguing. The category of quality activities originated with nurses identifying aspects of quality that define quality nursing care. All the codes, concepts and categories then formed the basic psychosocial process and the theory of overloading.

The answers to the first question of what it is that nurses do each day that take them away from direct patient care began to emerge during the latter stages of the interview process but were confirmed during the coding process. Nurses identified that answering complaints, answering phone calls, excessive documentation requirements, attending mandatory education sessions in allocated work time, paging medical staff to review patients and attending to nom nursing duties such as collecting X-Rays, moving beds around the ward or filing pathology results, impacted significantly on their day. Most of the nurses interviewed identified they were struggling to cope with their allocated patients each shift and, in doing so, they compromised both patient care and patient safety to get manage their day. If nothing happened each shift, it was more good luck than good management. If something went wrong, one considered a number of options. Do nothing if it was minor, keep quiet or talk to your mate and then hope no one else picks it up, complete an incident report and tell management. However, it was recognised if you told management and completed an incident report one got into trouble, so it was best to keep quiet if possible.
The answer to the second question, on nurses’ perception of quality nursing care, became evident throughout all participant interviews. Nurses generally believed they were not providing the patients with the quality of care they required because of workload and time constraints. In the main this was because the nurse was too busy with all the non clinical components of their role to allocate the time educating, counselling and generally spending time with the patient and talking to them. Quality care was about being available for their patient, rather than the patient having to ring their call bell to attract attention. In their endeavour to provide care and manage their daily workload, nurse frequently took short cuts that participants identified as inappropriate but necessary in their quest to provide their patients with basic care requirements.

**Implications and further research**

Given the limitations of this study, it would be premature to discuss some of the implications for nursing practice and education from these findings. However, one important aspect that has been clearly demonstrated is how clinical nurses provide nursing care and the processes they utilise to manage their workload by “working around” with taking short cuts as the most common methodology utilised. Another significant implication from this study is that nursing as a profession must value their own clinical practice and foster a culture that questions current practices that fosters and indeed condones the need to take short cuts.

The issues identified in this research therefore have significant implications for hospital management and clinicians. Nurses have identified they take shortcuts in their every day practice to save time and manage their workload. The Grounded Theory of Working Around implicates health care organisations as the trigger for many instances of unsafe practice and poor quality of patient care. It is recommended that interpersonal communications and dialogue occur between clinicians and management and that the concepts that lead to unsafe practices be articulated, discussed, explored, examined and documented in an endeavour to promote safety and patient care.

To improve the image of nursing, the focus is primarily on things nurses themselves can do. There is a need for nurses to work on their communications skills and assertiveness. Nurses should present to the public clear, concrete descriptions of what nursing actually is
and does, with emphasis on education, research and critical thinking. As an example of what not to do, the media continue to portray nurses as hand maidens and has done little to convey nurses’ real clinical importance, for example “House”, “ER” and “Grey’s Anatomy. Health Administrators and Health care Organisations must promote nursing in order to educate the public and the media. Once again nursing organisations appear to be too easy on the news media, which bears significant responsibility for nursing’s poor image. The media must act affirmatively to address its own biased coverage, not just wait for nurses and hospitals to make things easy.

If nurses are to meet the needs of patients, they need to embrace opportunities to take on positions of leadership. These responsible positions require education. Nurses not only need sound clinical knowledge and practical skills, but also, if they are to be leaders, they need sound managerial and educational competence. Alongside this, there must be an enquiring, questioning approach and an appreciation of research, so that they may show the way to colleagues within the profession.

It is obvious that the current nursing shortage is not being ignored: nursing and health-related organisations, the government, and nurses from every area of the discipline are addressing the problem through Professional Colleges, newsletters and articles, research studies, coalitions, committees, hearings and Senate Committee proposals. Some of the factors contributing to the nursing shortage and potential solutions to address the problems are known. The bottom line is that nurses must act now. It is critical that they communicate and form partnerships with their employers, nursing associations, lawmakers, and other influential key players. If the vision is to help secure the future of the Australian Health Care system, nurses should also ensure that there is continuous interest in their profession. As the largest group of health professionals in Australia (Hegney et al. 2003), nurses now need to also have the leading voice and influence in the decisions regarding the future of the nursing profession.

With the introduction of the Australian Quality and Safety Council it has been identified that there is a relationship between nurse staffing and adverse events. Nurses’ Unions in all Australian States are involved in RN collective bargaining and have already negotiated staffing levels in some States, with Victoria the first to mandate ratios. NSW is well on track,
with research currently underway by the NSW Nurses Association (Chapter 6, p.142) and the introduction of the Reasonable Workloads Clause into the Award.

Nursing organisations need to become political and aware of the current realistic activities within healthcare. If we, as nurses, and the nurses who govern us, do not strive to stop this marginalisation, the areas within nursing such as research, advanced practice and education, nursing will be devalued, and this present downward spiral of non-recognition of nurses' work will continue.

A further recommendation is that hospitals must review the principles of magnet hospitals and incorporate these principles into their core values. Studies that look at nurses’ satisfaction, turnover and absenteeism, identify many of the same organisational factors as the present research. Studies from magnet hospitals report that nurses are more likely to stay at their workplace, have less sick leave and improved morale when appropriate workload strategies are in place. Other negative impacts of high staff turnover and absenteeism include threats to patient welfare that are posed when organisations operate short staffed or with temporary or unfamiliar casual staff (Larrabee, Janney, Ostrow, Withrow, Hobbs & Burant, 2003). Nurses are pivotal in the delivery of quality health care and successful patient outcomes. Hospitals with magnet organisational characteristics have demonstrated better patient outcomes (lower mortality and morbidity rates, reduced infection rates and medication errors) and higher patient satisfaction because of 'patient-centred care' than matched non-magnet hospitals. Costs are reduced because of lower staff turnover and shorter lengths of stay. Research has demonstrated a positive impact on organisational culture and increased institution stability. In terms of nursing outcomes, magnet hospitals have demonstrated enhanced recruitment and retention of highly qualified nurses, lower rates of needle stick injuries, higher rates of nurse job satisfaction, higher nursing ratings of quality of care, and significantly lower rates of nurse burnout.

Stress and burnout have far reaching effects both for nurses in their clinical practice and personal lives. If nurses continue to work in their current environment without issues being tackled, then burnout will result. The science of nursing can at times be stressful, but by recognition of the existence of stress and burnout by professional and governmental bodies,
we can take the first steps towards preventing this phenomenon and resultant loss of nurses.

Administrators need to become sensitive to factors that lead to nurses’ workloads that contribute to stress and burnout and the impact this has on why nurses take short cuts and workarounds as indicated by the participants’ information. This in turn results in poor quality care and possible errors. Workload management should be part of everyday management processes to prevent nurse’s excessive workloads and improve patient outcomes.

Nurse Unit Managers are the spokespersons for their wards and an advocate for their staff and as such must speak up and provide the leadership required to make change. Participants in this current study identified medical staff did not listen to, or did not want to hear from nurses. This suggests strategies are required to improve communication between nurses and medical staff to ensure patients benefit from the vast experiences nurses can offer.

Nevertheless, problems of poor or ineffective communication are evident in nursing and have severe consequences in both human and financial terms. Communication skills training has been widely cited and used as a 'solution' to these communication problems. It is evident that problems in education, at the individual and social levels, inhibit effective communication in healthcare and the implementation of communication skills in practice.

This is an aspect of the theory-practice gap that cries out for attention and this is an area where academics and clinical nurse educators could potentially have an influence when engaging in clinical practice. It is recommended that where conjoint university and clinical positions exist these educators should promote a greater integration of theory and practice in communication skills with both pre- and post-registration students. These practitioners are particularly well-placed in the university and hospital environment and are ideally situated to participate in staff development activities such as preceptor and mentor programs with current clinical nurses and students. However, if these programs are to be effective there is a need for stronger communication links between mentors, clinical teams, nursing management and those responsible for nursing education. It is further recommended that both hospital and university educators accept the ongoing responsibility
for quality monitoring aspects for their courses and for mentoring practitioners undertaking a mentoring role.

The university and health district where this study was undertaken have initiated a number of strategies to improve the theory-practice gap with preceptor programs, conjoint appoints and regular meetings. However, it is yet to be identified if this will have any long term benefits to meet the needs of future students. Since the investment of time, money and human resources is considerable when establishing a preceptor programme, it is important that administrators and educators determine what benefits, supports and rewards are necessary to sustain preceptors in their role. Preceptors are being called upon frequently to integrate and socialise nursing students and newly hired nurses, and in an era of uncertain employment conditions in health care it is imperative that preceptors are recognised for their contributions. Support, rewards and benefits are crucial to commitment to the preceptor role.

Specifically, the Grounded Theory of Working Around to solve workload issues for nurses uncovers a basic social process for which many nurses, and in particular new graduates, come to the workplace unprepared. It is recommended that educators within universities must assist in preparing undergraduates through curricula that include recognition of the socialisation and professionalisation process. To prepare undergraduates for practice, university educators should facilitate dialogue that uncovers sources of conflict between their core beliefs that are being taught to students, professional traditions and organisation and ward expectations. They should acknowledge the unique nurse/patient relationship that exists while at the same time recognising special elements of this relationship such as communication, knowing and understanding.

There are a number of implications for providers of undergraduate nursing programs and the development of nursing curriculums. Nurses in this study identified socialisation to the work environment posed a major challenge for them and in their ability to be accepted and to become a team member. It is recommended that universities and health care organisations together consider alternative strategies to assist students and new graduates socialise into acute care environments. They should assist undergraduates learn strategies and language that will prepare them for ethical dialogue with other health care
professionals, and prepare them for the realities of day to day practice. A significant outcome to the current socialisation process is that new graduates take on the habits of their preceptors in a bid to socialise into their new environment and be part of the ward culture. This in turn perpetuates workarounds and shortcuts which eventually lead to unsafe nursing practice.

This study indicated that the nature of the work being done in any clinical area affects the socialisation process of the new graduate and placements in acute areas were shown to be less likely to be satisfactory for the new graduates than those in chronic areas. However, conclusions on this need to be treated with caution for this study, due to the small sample of new graduates interviewed. It is recommended however, that administrators and educators seriously consider rotations and be mindful when placing new graduates into busy, acute areas to ensure there is adequate support and time for them to adjust.

Nursing workloads and “Working Around” impact significantly on a nurse’s ability to provide safe, quality patient care and gives voice to important aspects of nursing practice. This study has identified that nurses do, in fact, take short cuts (working around) to enable them complete their assigned workload. These shortcuts as indicated by participants, include pre preparation of IV medications, not following the medication policies to the letter, for example not having two staff checking scheduled drugs, relaxation of infection control guidelines and completion of documentation, for example signing omitted drugs to name a few. This in turn may lead to medication errors, missed treatments, patient complaints and limited communication between health care providers which consequently compromise patient care. In order to remove situations where workload impact on patient safety, nurses should examine their core values and their relationship to professional and organisational norms. Also, nurses must take the perspective of the reasonable nurse and deal actively with workload issues and safety as the larger problem. Additionally, nurses need to review their nursing care systems with the aim of reducing technical detail while practicing safely, thus reducing shortcuts, for example placing more emphasis on the use of care pathways and clinical practice guidelines.

Financial constraints and the lack of resources has a direct impact on nurse’s workloads as nurses constitute the largest group of workers in an organisation with the associated costs
of their salaries and associated penalties. As a result, nursing numbers are constrained by the budget allocated to each organisation. Consequently, there are impacts on nurse managers who are required to implement changes to skill mix. Consequently, the chronic problems associated this new market culture of Health Departments, leaves nurses and nursing managers wondering whether altruism, compassion and social justice have places in an organisations balance sheets and short term contracts. These issues all fly in the face of the values nurses espouse to in a caring model and it is recommended these financial constraints be reviewed by management if nurses are to continue to be able to provide the bedside care patients are requesting and demanding.

It is recommended that the medical profession take a serious review of their attitudes towards nurses as the implications from this study indicate the medical profession undervalue the work undertaken by nurses, partly because of doctors’ ignorance about the work nurses do. Nurses’ today are more assertive and well educated which add a new dimension to the interface between medicine and nursing. Consequently, boundaries are shifting and expert nurses are taking on some of the traditional roles that used to be in the realm of doctors. With the additional budget constraints and the high cost of doctors’ salaries and overtime, administrators are searching for alternative staffing methodologies to manage patient care, including the use of expert nurse practitioners.

Nurses themselves must value the work they do and must constantly strive to have nursing input into government polices through political representation, for example, more senior nursing positions, and Chief Nurse positions. In this manner nurses can become active in spheres of political influence. Also, these positions are able to influence Governments to legislate for reduced nurse: patient rations as has occurred in Victoria, thereby improving safety and standards of care.

**Limitations of this Research**

As with many qualitative studies, the data in this study, while revealing a number of themes and categories, generated more questions than were initially posed. Judged against quantitative criteria, the sample size used is considered small and the results must therefore
be interpreted with caution. However, as many of the nurses interviewed in this study had worked in a number of other hospitals in NSW and overseas, the number of participants were sufficient to reach data saturation by Grounded Theory criteria, and these findings are supported by other projects internationally (see Chapter 6), the researcher believes the information supplied is indicative of nurses and nursing in general. Involving more nurses, including new graduates and enrolled nurses, may have enhanced the study and provided greater richness. However, due to limited uptake for participation this would have been difficult to achieve. Qualitative research and in particular Grounded Theory, relies on meaning rather than quality of participants to ensure the trustworthiness of the results (Glaser, 1990). Therefore, even though these research findings cannot be generalised across all health care organisations, it has provided an insight into findings within the study hospitals and can be used as a basis for larger, quantitative studies.

Reflections of the Researcher

This research process has been enlightening, informative and exciting. I am grateful to have been afforded the opportunity to undertake Grounded Theory as my methodology and to meet, relate and discuss this research with Dr Barney Glaser, Professor Bev Taylor and Dr Steve Kermode, who have had significant influence on this project and my journey into Grounded Theory. It was during this journey that I met Dr Glaser, who, on two occasions inspired me to continue and reflect on what I have discovered.

What I discovered during this journey was that Grounded Theory is not clear cut and there are a number of GT processes that have sprung from the truly original version as developed by Dr Glaser. However, I wished to remain true to the original methodology, hence my journey led me down the Glaserian path of discovery and for this I am truly grateful.

Coming from a background of acute nursing and quality, I believed I had an understanding of quality nursing care and the expectations of what nurses should do. As an administrator, I was also aware of the difficulties nurses were having with their workloads and wanted to hear from them directly their issues and if they were able to provide safe quality care.
Future research

While a number of Government Research projects have been undertaken that confirm the findings from this research, it is suggested that future GT research be undertaken, but with a larger and more diverse group of health care professionals, extending into larger organisations and community centers. It is also recommended that consumers of health care participate to provide a consumer’s view of nursing workloads. It is also recommended that future research should investigate the impact of short cuts on adverse outcomes and patient safety. These projects could use quantitative research methods, such as surveys and questionnaires, by adjusting the grounded theory categories within this research to develop reliable and valid items.

It is suggested that future research using GT methodology be undertaken on the current socialisation issues being faced by graduate nurses as this was identified as a significant issue in this study. These issues can also be addressed through collaborative research approaches, such as action research and critical ethnography, which involves nurses directly in identifying constraints and creating solutions to their practice concerns.

Conclusion

The analysis of data from interviews revealed some interesting themes concerning nurses’ perceptions of nursing care. Clearly, providing patient care is a complex issue that is based on a number of profound moral and philosophical beliefs about the patient and the development of a relationship between the nurse and the patient. Many of the comments made by the participants have also been raised in the literature and support the findings in this study.

Seeking to understand the impact of nursing workloads on nursing practice is important as it has identified that nurses do in fact take short cuts to assist them manage their workloads with resultant reduction in quality of care. This research has provided the embryonic stage for further research and I believe further research is necessary to investigate whether this dichotomy persists in other areas of nursing work, such as community centres, rural hospitals and large tertiary settings. Moreover, the size of this study mitigates against the
drawing of any firm conclusions; however, the early indications suggest that it would be a
fruitful area for further research with a wider sample group drawn from more diverse areas
as suggested above.

In conclusion, the results of this study show a clear relationship between levels of nurse
staffing, nursing workloads and methods utilised by nurse to “work around” their daily
workloads. Most important, these findings indicate the importance of evaluating the effect
of workload on clinical nurses and a reorganisation of the affect of “working around” on the
provision of quality patient care, recruitment and retention, stress, absenteeism in the
workplace and the socialisation process of graduates and new staff. More research is
needed to validate findings and to ensure that recommended changes actually produce the
results desired for both workers and patients.
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Mr Paul Corbin  
Executive Officer  
MNC Research and Ethics Committee  
PO Box 126  
Port MacQuarrie  
NSW, 2444

4th June 2003

Re: PhD Research study

Dear

I am currently enrolled at Southern Cross University as a PhD student. My research aims to describe and explain what clinical nurse's believe/consider to be quality nursing care. I am conducting this research in two Phases. Phase 1 of the project, I will interview RNs who work in the clinical areas and ask them to describe and explain the characteristics of high quality nursing. To obtain participants in this project, expressions of interest will be sought from staff at the respective hospitals. Following analysis of the interview transcripts using Grounded Theory coding techniques, a questionnaire will be developed around the concepts and themes identified from the interviews. In Phase 2 of the project, the questionnaire will be used to collect data from the same sample of clinical nurses who were interviewed to determine the actual and relative importance and evidence of quality in practice.

Aim or purpose of the research:
To determine how nurses in the clinical area explain quality patient outcomes of care and could ways in which high quality care may be better achieved by:
- Establishing a range of quality benchmarks for high quality nursing care;
- Determining if nursing care actions provided to patients are those that should be implemented;
- Comparing actual quality of care to perceived quality benchmarks of care;
- Identifying significant nursing care issues impacting on quality;
- Make recommendation on behalf of nurses working in the clinical area with patients for the purpose of improving the quality of nursing care.

I am seeking your approval to conduct this research at Macksville, Wauchope, Bellinger River and Kempsey. I have contacted the EO/DONs and they have indicated they would give permission pending your approval.

Thank you for your consideration in this matter

Jacky Flynn
HUMAN RESEARCH ETHICS COMMITTEE (HREC)

At the meeting of the HREC on 11 August, this application was considered. This has been approved subject to the usual standard conditions and the following special conditions.

Special Conditions:
(a) Approval has been given for Phase 1 only.
(b) The Informed Consent Form is missing the signature section. Please supply.
(c) In the Sample letter of introduction, please check the spelling. In the last paragraph, the word sign is spelt sigh.
(d) At Question 10 on the application form, please change the wording so that the grammar makes sense.

Special conditional approval will lapse one calendar month from the date of this approval if the special conditions have not been fulfilled, and thereafter the University will not accept any further responsibility in regard to the research. The certification for special conditions that have been fulfilled is attached to this letter. Please return this signed certification to the Secretary when you have complied.

Standard Conditions (in accordance with National Health and Medical Research Council Act 1992 and the National Statement on Ethical Conduct in Research Involving Humans):

1. That the person responsible (usually the Supervisor) provide a report every 12 months during the conduct of the research project specifically including:
   (a) The security of the records
   (b) Compliance with the approved consents procedures and documentation
   (c) Compliance with other special conditions.

2. That the person responsible and/or associates report and present to the Committee for approval any change in protocol or when the project has been completed.

3. That the person responsible and/or associates report immediately anything that might affect ethical acceptance of the research protocol.

4. That the person responsible and/or associates report immediately any adverse effects on participants.
5. That the person responsible and/or associates report immediately any unforeseen events that might affect continued ethical acceptability of the project.

6. That subjects be advised in writing that:

"Any complaints or queries regarding this project that cannot be answered by the person responsible for this research project should be forwarded to: Mr John Russell, Ethics Complaints Officer Graduate Research College, Southern Cross University Ph: (02) 6620 3705 Fax: (02) 6626 9145 Email: jrussell@scu.edu.au"

Suzanne Kelly
Secretary, HREC
Graduate Research College, R Block
skellyl@scu.edu.au

Dr Robert Weatherby
Ph: (02) 6620 3671
rweather@scu.edu.au
23 September 2003

Jacqueline Flynn
Director of Nursing
Coffs Harbour Health Campus
Locked Mail Bag 812
COFFS HARBOUR NSW 2450

Dear Jacqueline,

RE: DEVELOPMENT OF QUALITY OUTCOMES OF NURSING CARE

Thank you for your application to the MNC Research Ethics Committee. The following documents were reviewed and approved at its meeting held Thursday, 7th August 2003 and endorsed by the Mid North Coast Area Health Services' Chief Executive Officer on 29th August 2003;

- Application Form for Research Involving Humans
- Declaration of Researchers
- Sample letter of Introduction
- Informed Consent Form
- Letter to Mr Ken Hampson, dated 4th June 2003
- Advertisement for Expression of Interest

The Mid North Coast Research Ethics Committee is both duly constituted and operates in accordance with the National Health and Medical Research Council's Statement on Human Experimentation and Supplementary Notes (June 1999).

Amendments and Reporting of Serious Adverse Events

Researchers should immediately report anything to the MNC Research Ethics Committee which might warrant review of ethical approval of the protocol, including;

- Serious or unexpected adverse effects on participants;
- Proposed changes in the protocol or any other material given to the participants in the study must be known prior to being actioned, including patient information and consent forms; and
Study Progress Reports

At least annually, reports from principal researchers should be submitted to the Research Ethics Committee on matters including:

- Progress to date or outcome in the case of completed research;
- Maintenance and security of records;
- Compliance with the approved protocol;
- Compliance with any conditions of approval;
- If the research project is discontinued before the expected date of completion.

If you wish to discuss any matters further, please contact me on 02 6588 2750.

Your sincerely,

[Signature]

Paul Corben
Executive Officer
MNC Research Ethics Committee
Letter of Introduction (Plain Language Statement)

Dear

Hello, as discussed, my name is Jacky Flynn and I am a PhD student at Southern Cross University undertaking a research project which aims to describe and explain what clinical nurse’s believe/consider to be quality nursing care. The project will take the form of a qualitative type of research using a Grounded Theory approach. In general this type of approach uses interviews to collect data which is then analysed and coded into themes or concepts. Once these themes have been analysed, a questionnaire is developed to further test and validate the themes. The results of this study will attempt to discover insights of care delivered and develop indicators of this care.

I have chosen to study nursing care provided by nurses who are directly involved in patient care to identify if the care given to patients is the care that nurses believe should be given.

As part of this study, I plan to interview nursing staff who provide the direct patient care during the period December 2003 to June 2004. The interviews would last approximately 60 minutes and be audio taped and then later transcribed by me into written text. Should you wish to participate but not be taped, your interview will be hand written as the interview progresses.

Confidentiality and anonymity will be maintained throughout the course of the study. Should you wish to participate in this study, pseudonyms will be developed in consultation with you and used in place of your name. Audio tapes will not contain your real name or place of employment or any other health professional that you may identify during the course of the interview. All written and taped material pertaining to the interview will be secured in a locked drawer by the researcher. Access to the material relating to your contribution will be limited to myself as the researcher, yourself and my supervisors.

At all times I will protect your privacy and respect your rights as well as ensure that the information collected reflects what you have said and the concepts of nursing care delivered by you. This will be provided by you with the opportunity to review the analysed data relevant to you prior to submission of the report. Any information
that you do not want submitted as part of the final report will be removed.

Participation in this study is purely voluntary. If you decide to participate please contact Jacky on (02)66567024 to receive a verbal description of the project and clarification of any issues you may have. Once you have received a verbal description of the project, you will be asked to complete the attached consent form and return to me in the prepaid envelope. On receipt of the consent form I will contact you by telephone to discuss a suitable time and place to conduct the interview. If you sign the consent form and change your mind, you can withdraw at anytime.

If you have any questions regarding the study please do not hesitate to contact me on (02)66567024 during business hours of (02)66582345 after hours or, my supervisor, Professor Bev Taylor is willing to answer questions. She can be contacted on (02) 66203156

Alternatively If you wish to make a complaint about the conduct of the research project you may contact Paul Corben, Executive Officer, Mid North Coast Research Service Ethics Committee on 02 65882750.

Yours Sincerely

Jacky Flynn
SOUTHERN CROSS UNIVERSITY
INFORMED CONSENT FORM

Researcher: Jacky Flynn
Address: Coffs Harbour Health Campus
Director of Nursing
Locked Bag 812
Phone: 02 66567024 BH
Coffs Harbour, NSW, 2450
0266582345 AH

Name of Project: Outcomes of Clinical Nursing Care – A Grounded Theory Approach

You are invited to participate in a study of nursing care which will take place over twelve to eighteen months. This form outlines the purpose of the study and provides a description of your involvement and rights as a participant. This research aims to:

- Establish a range of quality benchmarks for high quality nursing care;
- Determine if nursing care actions provided to patients are those that should be implemented;
- Compare actual quality of care to perceived quality benchmarks of care;
- Identify significant nursing care issues impacting on quality;
- Make recommendation on behalf of nurses working in the clinical area with patients for the purpose of improving the quality of nursing care

Please ensure you have read the plain language statement and received a verbal description of the project before you sign the consent form.

I…………………………………………………..(name) have read the plain language statement and received a verbal description of the project from the researcher. I understand that;

- the research involves me describing the characteristics of quality nursing care
- participating in an unstructured interview
- the interview will be audio taped and transcribed
- if I refuse to be audio taped but wish to participate in the project the researcher will handwrite my responses
- my real name or place of employment will not be used at any point of information collection, or in the final report
- if I grant permission for the interview to be audio taped, the tape and transcripts will be secured in a locked drawer and will not be listened to anyone other than myself or my supervisors
- if I withdraw from the project the tape will be destroyed or returned to me
- I will receive a written copy of the report prior to submission to the university

Signed…………………………………………Witness………………………………Date………………

Procedures to be Followed:
The research will be conducted in 2 Phases. The First Phase will consist of interviewing you and asking question about nursing care and be asked to describe and explain the characteristics of high quality nursing. The interview will be taped and then later transcribed for analysis and coding. The second Phase will consist of a questionnaire being sent to you based on the information obtained from the interview. You will be asked to return the questionnaire into a sealed box which will be collected two weeks after it is distributed. You are encouraged to ask questions at anytime during the process, and have the right to end the interview at any time you feel uncomfortable with the process.

Freedom of Consent
If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time. However, we would appreciate you letting us know your decision.

Inquiries
If you have any questions, we expect you to ask us. If you have any additional questions at any time please ask.

Supervisor Details
Dr/Mr/Ms Professor Beverley Taylor at Southern Cross University Phone 02 66203156 or btaylor1@scu.edu.au …………………………………………………………………………………
Professor Stephen Kermode at Southern Cross. Phone 02 6620 skermode@scu.edu.au who will be happy to answer any queries you may have.
OR if you have any problems associated with this project, please contact;
Mr John Russell, Graduate Research College, (02) 6620 3705 jrussell@scu.edu.au
If you wish to make a complaint about the conduct of the research project you may contact Paul Corben, Executive Officer, Mid North Coast Research Service Ethics Committee on 02 65882750.

You will be given a copy of this form to keep.

Jacky Flynn…………………………………………………………………………………………Signature