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IN SEARCH OF NURSING: THE LONG-TERM IMPACT OF THE NEW ZEALAND HEALTH REFORMS ON WARD NURSING

**A thesis presented in fulfilment
of the requirements for the degree
of Doctor of Philosophy
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I believe, ...that the very elements of nursing are all but unknown. By this I do not mean that the nurse is always to blame. Bad sanitary, bad architectural, and bad administrative arrangements often make it impossible to nurse. (Nightingale, 1859/1957, p. 3).

ABSTRACT

This thesis began with my curiosity about why, despite repeated attention to nurses' health assessment skills (at undergraduate and professional development level), it has remained an under-utilised skill. A focused ethnography was conducted in six acute wards of a provincial New Zealand hospital. Twelve registered nurses were observed and interviewed in the first phase of the research and multiple additional primary data sources were utilised. Early findings indicated that nurses did not undertake health assessment and raised much broader questions about the nature of ward nursing practice and the amount of control ward nurses have over their work environment and their own nursing practice. The research was extended to include seven stakeholders, senior nurses who had good insight and knowledge of ward nursing practice. A structuration theory lens was applied to assist in the analytic process.

The findings of this research reveal the long-term impact of the NZ health reforms on ward nursing practice. The introduction of generic management principles and the continuous restructuring of the health care environment have impacted on nursing practice and reduced nurses' autonomy. Nurses have come to rely on standardised documented processes to provide essential care, relying significantly less on knowledge of a patient's actual health status.

Much recent local and international quantitative research has revealed a number of concerning findings about the reduced time nurses spend at the bedside, the complexity of nursing work flow, the increase in interruptions, missed nursing care, and the vital role nurses have in preventing many adverse events and unexpected deaths. This thesis provides a rich qualitative understanding of the circumstances behind these quantitative findings and reveals that nurses are now struggling to provide care consistent with the ethos of nursing. I argue that challenging the nature of nurse education will not improve nurses' ability to deliver nursing care. Instead I argue that the current acute ward environment does not support registered nurses to provide the nature of care for which their education has prepared them.

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PREFACE

Health assessment has become a much debated topic in the nursing literature and is considered a key skill in nursing practice (Fennessey & Wittmann-Price, 2011; Gelfant, 1985; James & Reaby, 1987; Kelley & Kopac, 2001; KPMG Consulting, 2001; Lillibridge & Wilson, 1999; Milligan & Neville, 2001; Minister of Health, 2001). It is identified as one of the core competencies of professional nursing (Nursing Council of New Zealand, 2007). Having taught the subject of health assessment for well over a decade, I was curious to find out how health assessment theory and skills were utilised and integrated into day-to-day nursing practice, and how it impacted on clinical decision making. Prior to commencing this study, I had been involved in a quantitative study which surveyed nurses' utilisation of assessment skills after completing a health assessment course. The findings of this survey were contradictory in parts and raised questions as to what was really happening at the bedside. My year-long stint as a clinical lecturer, during which time I worked side-by-side with registered nurses in a number of medical and surgical wards, made me realise that there appeared to be a discrepancy between the ideal and the real of nursing practice. This insight galvanised for me that whatever research method I decided to select, it needed to include observational fieldwork. Thus, my original intended research focused on a narrow slice of nursing practice exploring:

- What health assessment skills are most often used by RNs?
- What factors help and/or hinder the implementation of health assessment skills in clinical practice?
- How do health assessment findings influence subsequent nursing care interventions?

I undertook an extensive literature review of the process and application of health assessment in nursing practice and, using focused ethnography, spent time in a variety of medical and surgical wards observing nurses engaged in day-to-day nursing practice. Specific attention was paid to health assessment activities that went beyond the standard greeting of "Hello, how are you this morning?", or the measurement of vital signs such as temperature, pulse rate, blood pressure and oxygen saturation

levels. My observations provided little to no evidence to suggest that health assessment knowledge and skill were utilised to any great depth in actual clinical practice. Although almost all participants indicated that they were committed to, and valued the need to, undertake health assessments, lack of time was cited as the main obstacle to carry out assessments.

Due to unforeseen circumstances the research was interrupted for a three-year period. As I recommenced my research I found a clinical working environment that felt very familiar. Re-interviewing participants revealed that staffing levels had improved, resulting in a more manageable workload and reduced stress levels. However, participants noted that nursing practice and ward routines had remained the same. Participants confirmed that they did not engage in health assessment activities any more than previously despite improved staffing levels. Their suggestion that ward activities and routines had not changed even though new registered nurses, and in some cases new charge nurses, had been appointed to these clinical areas raised many questions as to why this was so. Why is there such a level of stasis in a health environment that is in constant flux?

Having undertaken an extensive literature review of health assessment, it became apparent that this was of lesser relevance than understanding the broader conundrum of nursing practice. It seemed that the failure to implement health assessment was a symptom of a deeper malaise. I became curious about a much broader and more deep-seated range of issues which might be influencing and impacting on the practice of registered nurses in acute medical and surgical ward settings. It became clear to me that nurses themselves, and those managing health service settings, have particular conceptions of nursing. These understandings have historical and far reaching implications worthy of an in-depth examination. Conducting a literature review in the traditional way was not possible because there is no unified body of literature concerning the impact of the health reforms on ward nursing practice. Furthermore, much of the literature referred to in this thesis only became pertinent as the focus of the research broadened. This literature was added to chapter two to provide background information affecting and contributing to the locale of nursing, as well as woven into findings chapters five to eight where relevant.

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CHAPTER ONE

Introduction and Overview

Introduction

With more than 48,000 practice certificates issued in 2009 (Nursing Council of New Zealand, 2009), registered nurses are the single largest group of health professionals in New Zealand (Statistics New Zealand, 2001). Registered nurses make up 65% of the health workforce (Department of Labour, 2005) practising in almost any conceivable setting and context. On this basis, it can be argued that nurses play a key role in the delivery of health care, a fact not overlooked by Thomas (1983) who argued almost 30 years ago that nurses are the glue that binds the health services.

This thesis focuses on registered nurses engaged in ordinary day-to-day nursing situations by observing and interviewing a number of nurse-participants employed in medical or surgical ward settings. As identified in the preface, the original intention of this study was to explore the utilisation health assessment skills by registered nurses, the factors that help and/or hinder health assessments, and the role health assessment findings play in determining subsequent nursing care interventions. Although health assessment is considered a key competency which ought to be at the basis of all nursing interventions, observations in the field found that assessment was given little attention or priority. Instead, the research found nurses being engaged in highly routinised task-focused nursing, exposing discrepancies between what nurses say they do and what they actually did in clinical practice, between what nurses believe should happen and what was observed. The research consequently changed focus and explored why nurse-participants, despite expressing their dissatisfaction with the current working conditions in medical and surgical wards, have accepted their situation even though it has led to feelings of frustration, horizontal violence, and distress.

I argue in this thesis that decisions that matter to nurses and ultimately patients are made or influenced in offices and other locations both in and well outside of the hospital institution. I further argue that this situation has been exacerbated following the health sector reforms of the 1990s when generic management was

introduced ostensibly to increase the effectiveness and efficiency of the New Zealand health care services (Arthur Andersen & Co, 1987; Devlin, Maynard, & Mays, 2001; Gibbs, Fraser, & Scott, 1988; Upton, 1991). These reforms resulted in the dismantling of the more traditional professional practice leadership structure because senior nurses in key practice positions in leadership and/or management were replaced by generic managers, or left the nursing profession on their own account due to frustration and/or moral distress (Annals, 2005; Ashton, 2002; Buchan & North, 2008; Carryer, Diers, McCloskey, & Wilson, 2010). Moral distress is variously described in the literature as anxiety and/or anguish experienced by nurses when they are prevented from giving the care that they consider required for a given patient (Baldwin, 2010; Elpern, Covert, & Kleinpell, 2005; Gutierrez, 2005; Jameton, 1984). The reforms left the nursing profession without sufficient role models, mentors and leaders; the consequences of which are still felt by the nursing profession two decades on. Although the ideology of generic management was officially abolished in the late 1990s, I argue that managerial rationalism has nevertheless infiltrated the bureaucracy of health care services and has permeated all levels of clinical care by stealth.

Managerial rationalism is also reflected in the new vocabulary that has infiltrated nursing practice; 'patient management', 'patient outcomes', 'bed management', 'patient turn-around targets', 'hot bedding', 'cost effectiveness', and 'discharge planning'. This business-like approach to institutionalised hospital care, combined with a decreased average length of stay of in-patients has led to 'conveyer belt' health care. Hospitalised patients are looked after by an increasing number of health care practitioners, each focused on their own specialty which has led to an increased fragmentation of patient care and altered the role of ward nurses and, as will be seen in this study, the nature and quality of nursing care.

Observations in the field and discussions with nurse-participants confirm that nurses are well-aware of these changes. Although nursing rhetoric still asserts 'person-focused' care as the ideal, nurses in diverse ward settings confessed that contemporary clinical practice is 'task-oriented' and focused on getting the job done, rather than patient-centred care. Nurse-participants expressed their dissatisfaction regarding their lack of influence on matters directly affecting nursing care and related activities. With nursing decisions increasingly being made away from the bedside, it appears that nursing has developed a set of highly routinised

practices. While nurses were aware of the altered standards of care, they appeared unable to influence and change their own working conditions. Three factors appear to contribute to the inability to change observed ward nursing practice:

- Lack of nursing/caring identity
- Lack of strong clinical nursing leadership
- Inability to assert self as autonomous practitioner

A range of contributing factors has created a toxic nursing environment resulting in chronic mental and moral distress amongst ward nurses (Fagin, 2001; Peter, Macfarlane, & O'Brien-Pallas, 2004; Rankin & Campbell, 2006). To survive the tough working environment, nurses have responded by utilising ineffective strategies such as reducing their personal working hours and routinising all nursing care (Buchan & North, 2008). The routinisation of nursing care eliminated the need for individualised patient assessments as nursing intervention are prescribed in standardised pre-printed nursing care plans. This has resulted in task- rather than person-focused health care and has further heightened the feelings of distress experienced by nurses in medical/surgical ward settings.

Background

To understand why nursing in this setting is as it is today, it is important to explore the historical development of nursing as a profession as well as the prevailing ideologies and images associated with the health sector of which nursing is an intrinsic part. Much literature has been explored in the process of understanding the vast changes that have impacted on ward nursing, but this does not constitute a formal review of the literature in the traditional sense.

Florence Nightingale remains an influential figure in the history of nursing and her ideas and beliefs about nursing were instilled into thousands of nurses. By describing nursing as a 'practical' activity that comes naturally to any woman, Nightingale not only labelled nursing as women's work, but her emphasis on hygiene and nurturing also connected it firmly to domestic activities (Nightingale, 1859/1957). Nightingale played down the importance of nursing knowledge and considered it to be something that one would label these days as 'common sense', and she differentiated it from the scientific knowledge that was required for a

predominantly male profession such as medicine. Rather than valuing knowledge, Nightingale emphasised the need for good character, obedience, and being disciplined. Not surprisingly, Nightingale's ideals reflected the morals that were common at the time, i.e. the need for a woman to be obedient to a man, and hence student nurses were socialised accordingly. Schools of nursing were connected to hospital institutions and the training, rather than education, of nurses was based on an apprenticeship model. In many countries including New Zealand, the bulk of the nursing workforce was made up of nurse trainees, and for almost a century this system ensured a continuous supply of inexpensive labour. Physicians played a minor role in the training of nurses, but their input in the teaching of anatomy, pathology and treatment modalities, and their powerful presence in the clinical areas, ensured that the medical paradigm was firmly instilled into nursing.

In New Zealand the educational preparation of nurses changed significantly in response to unacceptably low retention rates and increased dissatisfaction amongst nurse-trainees (Wills, 1973). At the same time there had been an increasing recognition by senior nurses within the Department of Health that the level of education received by nurse-trainees needed to be improved (Chick & Kinross, 2006). Following the recommendations in the Carpenter Report (Carpenter, 1971), a decision was made to transfer nursing education from hospital schools to educational institutions, a move finally completed by the mid-1980s.

Alongside nursing education, the health care sector had also undergone major changes since the beginning of last century. Originally unregulated and run privately or by charitable institutions, the Hospital Act of 1885 politicised the provision of health care by placing it under Government control. While some changes in health care delivery were undoubtedly due to improvements in medical technology, most were based on prevailing ideologies concerning health care and health goals, social responsibility, patients' rights to access care, the role of the State in providing and funding health services, and the structure of health care delivery. Given that the majority of registered nurses work in the public health sector, any changes in health services are likely to have a bigger or lesser impact on nurses as workers and earners, and on nursing as a profession. Hence, to gain an understanding of the context of present day nursing, it is important to analyse the effects of health sector reforms on the working environment of ward nurses. Such analysis should include whose ideologies were represented, which vested

interests were being served, and how much influence the nursing profession had to ensure that its interests were also represented. As I explore these aspects in chapter two, I will discuss how these factors have shaped and moulded the nursing profession over time and how they have contributed to the unique properties that make up ward nursing practice today.

Aim of the research

As a result of preliminary data analysis, the aim of my research changed from exploring health assessment activities and their effects on subsequent nursing practice to much broader and far reaching questions about the nature of nursing practice in acute medical and surgical hospital wards. Despite the occurrence of staff turn-over, improved staffing levels, and an expressed wish by ward nurses to increase health assessment utilisation and provide person-centred care, participants said that nursing practice had not changed, I gained a sense of stasis and resigned acceptance of a situation which was considered far from ideal. What are the processes and structures, if any, that have maintained the current observed status quo within the ward environment? In order to explain this, the aim of the research needed to be revised from focusing on health assessment to examining how much control nurses have over their own nursing practice. To research this I needed to explore and find answers to the following questions:

- What is it like to be a registered nurse in a medical/surgical ward setting?
- What is the nature of nursing practice in medical/surgical wards?
- Why does it appear that nursing practice in medical/surgical ward settings has not altering despite changes in staffing levels, staff turn-over, and participants stating they would like to practice differently?
- How much control do nurses have over their own work environment and their own profession?

Rationale for changing research aim

When I recommenced my research after a pause of three years, I wondered about the relevance of data previously gathered. It occurred to me that some, if not most of the data could possibly be out-of-date as nursing practice continuously evolves and responds to changing times. To establish whether previously collected data reflected the current situation, following ethics re-approval, I contacted several

nurse-participants who were still employed by the same hospital. Prior to the actual interviews, I provided participants with a new copy of their own original verbatim transcribed interview to refresh their memory and to allow the nurses time to reflect on their perceptions/comments. Besides being interested in participants' perceptions of their own practice, I needed to find out whether nursing practice within the ward setting had changed during the intervening period. I shared with my participants a short written description of 'An ordinary day in the ward' (see Appendix One). This eclectic description was based on my field observations during the first stage of the research. Participants either read or listened to my description and were asked at the conclusion whether the description remained an accurate account of today's ward nursing or whether it was out of date. Participants felt unanimously confident that the description of nursing practice, based on observations carried out three years earlier, remained an accurate reflection of current day ward nursing practice.

In regard to the transcripts of the interviews, participants were asked whether their views and answers provided at the time, would be any different if the same questions were posed now. None of the participants disagreed with what they had stated in their original interview and many said that they had not changed their views, confirming that their response would be very similar if the same questions were asked again. I was aware that the staff shortages, identified as a major factor effecting nursing practice at initial data collection, were largely resolved. With additional staff being employed and workloads said to be more manageable, I expected that participants would now do some of the things that they had identified previously as important activities, things such as health assessment and person-focused care which were not performed because of lack of time/increased workload. While the participating ward nurses confirmed improved staffing levels, a more 'realistic' workload, and lower stress levels, they informed me that their practice had not really changed.

Puzzled by the finding that little had changed in the working environment of the ward nurses; I extended the research to include charge nurses, clinical nurse educators, and clinical nurse specialists. I will call these nurses 'stakeholders' to distinguish them from the participating ward nurses. All stakeholders involved in the study had a previous background in medical/surgical ward nursing. They were well-aware of the work environment, the type of presenting medical conditions, as

well as the ward routines. Commencing the interview, I shared the same written description of 'An ordinary day in the ward' and invited stakeholders to comment on the accuracy of the description. Their answer was affirmative. Stakeholders indicated awareness of significant staff turn-over and also noted an overall improvement in staffing levels resulting in increased staff - patient ratios. The repeated influx of new graduates into nursing practice was seen as a positive development bringing 'fresh blood' into the system. Stakeholders commented that significant resources in the form of staff development and courses had been made available to ward nurses to develop nursing practice, but this had not resulted in any significant change in nursing practice.

As a researcher and a nurse, I felt uncomfortable about this finding. Lack of time had been mentioned as the major contributing factor preventing nurses from engaging in health assessments. Three years later ward nurses acknowledged that staffing levels and skill mix had improved, that stress levels had reduced, and that more time was available to care for patients. Yet, despite these improvements, ward routines remained the same. Even the influx of new graduates and transferring registered staff with different clinical experiences had no measurable influence on existing ward routines and nursing practices. Although one could argue about the critical mass that must have been reached given that so many registered nurses and new graduate nurses had completed health assessment courses over the last decade or more, the use of health assessment skills in the clinical setting had not increased. These observations, confirmed by the participating ward nurses and the stakeholders, raised questions as to what is really happening in clinical ward settings and as such influenced the direction of my research. Why is there significant inertia in a health setting that has undergone significant changes over recent years? What holds nurses back from using their considerable knowledge and skills for the benefit of their patients? Despite criticising some of their ward routines as outdated or even ineffective, nurses continued to engage in these ward routines and this raised questions as to how much control nurses have over their professional practice.

Research approach

For this study I utilised 'focused ethnography' which is much more direct and goal-focused than the traditional ethnographic approach used particularly in

anthropology. Focused ethnography requires a good knowledge base of the area under study as well as a set of well-defined research questions (Kleinman, 1992). Focused ethnography is an ideal research approach in very specific settings where the researcher is interested in examining a narrow slice of a larger culture (Savage, 2006), and for this reason I considered it a highly appropriate approach for my research. As my original research was focused on the implementation of health assessment practices in a medical/surgical ward environment, a topic and a clinical area with which I am very familiar, focused ethnography was ideally suited for the purpose.

Recommencing the research and checking the relevance of data previously collected, I realised that, not only did I need to widen my data collection to include stakeholders, I also could no longer rely solely on a focused interpretive research approach for analysis as it would not provide me with sufficient answers. Giddens theory of structuration provided such a lens and it is his concept of 'locale' that I will turn to next.

The concept of 'locale'

Giddens (1984) maintained that in order to understand human actions, we must include and move beyond the actual actors and examine all the factors that impinge and influence social practice because events do not take place in a 'vacuum' and neither do they 'just happen'. Giddens argued that the physical, social, cultural, spiritual, economic environments, conditions of work, gender, and religion are all crucial factors in shaping human behaviour and social practices, as are the effects of shared history, traditions and routines. Giddens conceptualised all of the above factors as 'locale'. Locale is thus much more than just a space or a physical environment in which events take place. My understanding of Giddens' concept of 'locale' is that it can be defined as the all inclusive arena of past and current social interactions in the widest possible sense of the meaning. My choice of the word *arena* is deliberate because I see it as a place of struggle, a struggle for survival, for recognition, for autonomy, for growth, a place for everything. The concept of locale is much more complex than the sum total of the identifiable components that contribute to it. Applied to nursing, it can be argued that to gain an understanding and appreciation of nursing as it is today, it is necessary to explore its historical development as a calling for women of good character, the preparation and

training, later to be called education, of the nursing workforce, the conditions of employment including the financial rewards, and nursing's pursuit to free itself from medical dominance and to be recognised as an autonomous profession in an interdependent relationship with a multitude of health professions.

To understand contemporary ward nursing it is vital to explore the historical and contemporary locale of nursing and health service delivery in New Zealand. Health politics involves a continuous positioning and repositioning of stakeholders in an ongoing struggle for power and control over finite resources in which the voices of doctors, politicians, and increasingly managers, hold a privileged position. Other voices, including those of nurses are frequently ignored or the profession remains silent. It remains of considerable interest to consider just how much influence individual nurses have over their own nursing practice and this question was part of the analytical lens through which I viewed the data. What types of activities are nurses engaged in and whose interests do these activities serve? What, if any, is the influence of hospital policies and expectations on nursing practice and what is the role of hospital management? All of these aspects impact on the locale of nursing and hence have the potential to influence nursing practice and nurses' ability to take control and respond to changes in the health care setting.

Thesis Outline

This thesis is divided into four parts. The first part consists of chapters one and two and provides a general introduction to the focus of the study and a historical overview of the development of health care in New Zealand with a particular focus on nursing. The second part covering chapters three and four concentrates on the research methodology and the conduct of the research. Chapters five to eight form the third part and contain the data chapters, while chapter nine as the final part contains the discussion, concluding remarks as well as recommendations for further research.

Preface

The preface sets out the original intention of exploring health assessment practises in medical/surgical ward settings, and the subsequent change in direction when preliminary findings suggested that little time and effort was spent on this activity. Discrepancies were noted between what nurses said they do and what they

actually did, between what nurses believed should happen and what was in fact taking place. It became evident that the failure to undertake health assessments was a sign of a much bigger underlying issue justifying a change in research focus.

Chapter one: Introduction and overview

Chapter one introduces the reader to the research topic and the aim of the original as well as the revised study. Originally intended to explore health assessment practices in medical/surgical ward settings, the initial research findings suggested that little time was spent on this activity. It was noted and will be further confirmed that despite altered levels of staffing and a considerable turn-over of staff, ward routines have not changed. What is more, despite ward nurses expressing their dissatisfaction with the current conditions of work and criticising some of the ward routines, they continued to engage in them. The latter part of the chapter introduces the research approach and Giddens' concept of 'locale'.

Chapter two: Health care and nursing: an historical perspective

This chapter explores the historical development of health care in New Zealand. Attention is paid to the underlying structures and forces that have shaped health service delivery and which in turn have influenced the development of nursing as a profession. The role of nurses, the underlying assumptions and beliefs about what nursing is and what nurses do are discussed. The influence of political will and the hegemony of the medical profession will be explored in particular as these have affected health care services in hospital settings.

Special attention will be given to the report written by the 1.6 Committee (1972) in regard to nursing education. This historical document serves as an example to illustrate how the nursing profession is manipulated and disempowered in order to serve the needs of others' interests rather than nursing.

The Anderson (Arthur Andersen & Co, 1987) and Gibbs (Gibbs et al., 1988) reports heralded a new age in health care services by advocating generic management principles and a competitive model of health care. In describing the many restructurings that have taken place during the 1990s, I set the scene to better understand the 'locale' of nursing.

Chapter three: Methodology

In chapter three I discuss the research approach selected for the current study. After a general introduction to qualitative research, the ethnographic approach will be discussed. Specific attention will be given to 'focused ethnography' which was the chosen research methodology. The importance of fieldwork and the role and the place of the researcher during the observations are discussed. Concepts such as the 'emic' and 'etic' perspectives will be explored as will the concept and role of reflexivity. The use of a critical lens for the re-evaluation and re-examination of research findings is explained. Giddens' structuration theory is used as a lens to examine how nurses themselves produce and reproduce the very structures that limit autonomous nursing practice.

Chapter four: Conduct of the research

This chapter outlines the application of the research method in the clinical setting and discusses ethical considerations, the process of gaining research approval, and approaches to gain access to participants. Field work and other data gathering strategies such as informal discussions, attending various meetings and patient documentation are discussed. Twelve participants volunteered for what turned out to be the first stage of the research.

Four of the original participants were re-interviewed as part of the second stage of the research as well as seven stakeholders (one charge nurse, three clinical nurse educators and three clinical nurse specialists), to provide additional information and create a broader picture of ward nursing practices. Finally, the chapter outlines the preliminary data analysis.

Chapter five: Nursing practice within a ward setting

Chapters five to eight are data chapters. Chapter five introduces the hospital in which the study takes place, and provides a detailed description of the physical layout of a hospital ward. The remainder of the chapter describes in chronological order the daily experience of a registered nurse in a medical or surgical ward. Task-focused interventions appear to be a characteristic feature of contemporary ward nursing, as is the continuous and unrelenting stream of interruptions which impact on all nursing activities.

Chapter six: Nursing: The interruptible health profession

Chapter six takes a closer look at the different types of interruptions to which ward nurses are exposed, ranging from interruptions by colleagues and other health professionals to running out of consumables or needing to follow up on incorrect medication prescriptions. The impact of interruptions on the work flow as well as on the nurses' own perception of worth are examined.

A second major theme of the chapter relates to the apparent need of ward nurses to "mind other people's business". Observations in the field suggest that nurses are increasingly required to engage in compensatory activities that are not part of their responsibilities. Nurses largely accept this expectation if only to ensure patients' well-being or their ability to keep delivering nursing care.

Chapter seven: Capturing nurses' work

In chapter seven I explore more specifically the impact of the health reforms on contemporary nursing practices in medical and surgical hospital wards. Particular attention will be paid to the impact of reduced length of stay and the increase in patient churn. The utilisation of clinical pathways and patient classification tools to manage hospital beds will be explored and the impact on nursing practice examined.

Observations in the clinical setting suggest that standardised care plans have impacted on ward nursing practice such that nurses rely more heavily on clinical pathways, protocols, and ward routines, than knowledge of and response to a patient's actual health status. This emphasis on documentation has transformed nursing and significantly reduced the autonomy of the nurse over nursing matters.

Chapter eight: Nursing identity

Chapter eight briefly revisits the socialisation process that assists nurses to develop a professional identity, noting that people choose nursing because of a set of expectations about what that will mean. As this chapter reveals, the acute hospital context no longer supports delivery of the kind of care nursing considers appropriate. This has begun to erode the sense of identity held by these nurse-participants.

Strong clinical leadership is seen as a significant contributing factor to nurse identity but ward nurses note that charge nurses can no longer uphold professional

nursing standards as they have increasingly become managers of resources. The changes in ward leadership means that ward nurses felt often unsupported and disillusioned, with little opportunity to work in harmony with their own beliefs about nursing.

Ward nursing practice is significantly influenced by generic management decisions in its effort to reduce cost and raise efficiency. Increased case mix marginalises nursing knowledge and expertise and prevents nurses from developing expertise due to a number of contributing factors. Contemporary ward nursing practice is characterised by rationing nursing interventions and keeping people alive. This is in direct contrast to the practice of clinical nurse specialists who were able to focus on the patient, identify needs, and respond to those needs. The existence of a climate of silence will be explored in order to assess its impact on professional attitude and behaviour.

Chapter nine: Discussion

In this final chapter I discuss the research findings. In particular I will argue that nurses' autonomy in the study setting is significantly eroded and this mirrors the failure to take nursing seriously at all levels of health service decision-making. There is a long standing failure to ascribe value to nurses' contribution to patient safety and patient outcomes.

I argue that nursing's ability to provide essential surveillance as a key source of patient safety is compromised by the way in which nurses in acute wards are now working. I further note the persistent conflict between operational and professional leadership as a source of tension and the process by which nursing's disciplinary autonomy is eroded.

I conclude by arguing that even current efforts to address nurses' lack of autonomy are already colonised by managerial agendas and an overriding concern for fiscal restraint. This continues to silence competing voices and any real recognition of the value of nursing attention to patient care.

Summary

This chapter introduced the research topic and described how the research altered over time from a narrow focus on the utilisation of health assessment skills and their impact on subsequent nursing interventions, to a wider focus which explored the nature of ward nursing practice, what it is like to be a nurse in a medical/surgical ward, and the amount of control that nurses have over their own work environment. The research approach is introduced as well as Giddens structuration theory which is used as a critical lens to analyse the data. Finally, an outline is provided of all the chapters.

CHAPTER TWO

Health care and nursing: an historical perspective

Introduction

In preparation for this study, a comprehensive literature review was undertaken to explore the development and utilisation of assessment skills in clinical nursing practice. The preliminary research findings, based on observations in the field and interviews with participating ward nurses, revealed that registered nurses in the selected medical and surgical wards seldom engaged in health assessments beyond the measurement of routine vital signs and the assessment of pain using a numerical rating scale. Participants expressed a degree of frustration about their own lack of health assessment utilisation and pointed to heavy workloads and lack of time as the main contributing factors. As I recommenced the research, there was strong evidence to suggest that little had changed in day-to-day ward nursing practice. While there was a numerical increase in ward staff, participants still found themselves running out of time to engage in health assessment and deliver person-centred care. Interviews with participants as well as stakeholders revealed a nursing culture that appeared inert and steeped in routines that are so deeply ingrained that nursing interventions were more likely determined by ward routines than assessed actual patients' needs. This degree of stasis in a health setting that has undergone almost constant change, which has seen significant staff turn-over and an improvement in staffing levels, and a setting where considerable investments in staff development have been made without any evidence of changing practices, not only demanded a change in the research focus, but it also rendered the literature review on health assessment largely superfluous.

I came to realise that nursing practice at the bedside does not occur in isolation of a range of external impacts. I began to see bedside practice as a microcosm and a site where the activities of powerful players in the health sector have an almost invisible impact on what nurses do, or are enabled to do. This meant that rather than a formal literature review which would have been impossibly broad I needed to explore and understand the historical trajectory of those influences as a lens for analysing the present locale of acute ward nursing practice.

The exploration presented will concentrate on the underlying structures and forces that shaped and moulded health care in New Zealand over time, and examine how these structures and forces have had a major influence on the development of nursing as a profession and the role of nurses within the larger health sector. Developments in social services such as health and education always reflect the social-cultural values and attitudes that are prevalent at the time. Hence, when I explore nursing education, I pay attention to the underlying assumptions and beliefs of what nursing is and what nurses do, the role of nurses within contemporary health care settings, and the influence of nursing on health care policy making. As my study took place in general medical and surgical wards, my exploration of the nurses' autonomy to make nursing decisions and influence their own nursing practice will be limited to medical and surgical wards within the hospital setting.

The nurses' role in health care delivery

Unlike medicine which focuses on ill-health, the diagnosis and treatment of diseases and disorders, nursing is focused on health (Ministerial Taskforce on Nursing, 1998). This difference between medicine and nursing becomes rapidly clear when one looks at the settings where doctors and nurses work. Doctors work in health centres, clinics or hospitals, which might be privately owned or part of the public health system. Nurses on the other hand are able to provide health services in schools, factories, and the wider community. Nurses work in home settings, caring for babies, children, young families, the elderly, and the disabled. Nurses care for clients in diverse institutional and residential settings. Nurses work in a range of community mental health settings; they care for drug addicts, and homeless people of all ages. Nurses work in primary health, public health, prisons, the defence forces, and of course in all those settings where doctors work too, health clinics, doctors' practices and hospitals. Nurses work in every setting where health care, health prevention, or health promotion is required.

Nurses work in close cooperation with other health professionals which requires not only an overview of all those services, but also an understanding of the others' roles. Nurses support medical treatment regimes by administering prescribed medications; they monitor the effects, and report on patients' progress/improvements. Nurses engage in treatments when they debride and dress wounds, irrigate urinary bladders, and insert nasogastric tubes. Nurses act in emergencies and in life-threatening situations both in institutional settings and in

the community, requiring clear analytical thinking under extreme pressure. Nurses support physiotherapists by assisting, or encouraging patients to mobilise or exercise, or dieticians by monitoring patients' nutritional intake; they arrange for multi-disciplinary input whenever this is considered in the interest of the patient. Nurses advocate on behalf of patients and their families by representing their views or suggestions for change, or by expressing concerns about the patient's ability to manage independently or safely. While curing has finite boundaries in terms of what is medically achievable, caring has no such boundaries. It is the nurse who spends time with the patient when sleep does not come because of worry or concern. It is the nurse who, when nothing else can be done medically, comforts and cares for the dying patient and those surrounding the patient. Even in death it is the nurse who will care for the deceased body and support family members in their grief. Caring never ceases.

Despite much theorising and debate about nursing roles and responsibilities there is no general agreement as to what nursing is (Royal College of Nursing, 2003). I attribute the difficulty to define nursing to the specific foci nurses may have as well as the profession's versatility and ability to adapt to local circumstances and needs. That this necessarily results in different professional needs, collaborations, and interests is to be expected. However, the versatility of nursing also contributes to its vulnerability as the lack of clearly defined boundaries leaves it open to manipulation and domination by others.

From nurse training to nursing education

Historically, politicians and the medical profession have had a major impact on the nursing profession on several fronts. Dominating health care, politicians and the medical profession have had a powerful influence in the development and the shape of the nation's health services which had a direct impact on the role and responsibilities allocated to nurses. Furthermore, both parties also played a major role in determining and shaping the type and level of education that nurses received and this too had a major impact on the nursing profession. Examining the historical developments in nursing education will not only illuminate the perceptions and philosophies that underpinned the decisions of the past, but it will also serve as an example of how decisions concerning nursing were made with minimal or no input from the nursing profession. Illuminating the past will explain why things are

the way they are and how decisions made for nursing have influenced relationships with other health professionals, in particular the medical profession.

I will start this exploration with Nightingale because of her profound influence on nursing education as well as the profession of nursing. The first Nightingale Nursing Schools were opened in Wellington and Auckland in 1883, followed by Christchurch in 1892, and Dunedin in 1893 (Wills, 1973). These nursing schools were attached to, and operated by hospitals and were set up to meet the service needs of the hospitals. In those early days, nursing was seen as a 'calling' rather than a profession, and nursing was clearly linked to domestic duties (O'Brien, 1986). In the Preface of her book 'Notes on Nursing', Nightingale stated that:

Every woman, or at least almost every woman, in England has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid, in other words, every woman is a nurse (Nightingale, 1859/1957, p. 3).

The above excerpt clearly reflects the spirit, and the role of women, at that time, and it is obvious that in Nightingale's mind nursing belonged 'naturally' to women. Nightingale maintained that Notes on Nursing was not meant to be a manual of rules to teach 'nursing knowledge'. The knowledge that nurses needed was 'sanitary' knowledge related to maintaining standards of tidiness and hygiene. She went on to say: "It is recognised as the knowledge that everyone ought to have, distinct from medical knowledge, which only a profession can have" (p. 3). Reflective of the time in which she lived, Nightingale argued that medical knowledge was the scientific knowledge of a professional, more naturally aligned to a male, while nursing knowledge was a sort of 'common sense' knowledge that most, if not all, women possessed by virtue of having cared for or nurtured someone. Nightingale made use of the 'womanly virtues' and relied on the concept of 'duty' rather than 'rights', and stressed the importance of 'discipline' by setting up a female hierarchy for nursing (Reverby, 1987a). For Nightingale, nursing was not to be a profession (Nightingale, 1859/1957).

The Nightingale schools were an answer to the need for trained nurses and rapidly expanded to all the corners of the British Empire, including New Zealand. Nursing schools became a constant source of cheap labour for hospitals due to the implementation of apprentice-type practical training in which the service needs of the hospital took precedence over the educational needs of the mainly student-

nurse workforce (Chick & Kinross, 2006). The current values of society were reflected in the nursing workforce. For example the gendered roles which required women to be obedient to their husbands were reflected in the hospital where nurses had to be obedient to the (male) doctors, as is beautifully illustrated in the following quote from Nurse Maude in Kai Tiaki.

Whatever the nurse may think, her duty is to obey without expression of opinion as after all the patient is in the doctor's charge, the nurse being required simply to carry out his instructions faithfully (Maude, 1908, p. 36).

The introduction of the psychiatric nurse training in 1944 allowed males to apply for enrolment in these particular programmes only. It was not until after the major curriculum revision of 1969 that men were allowed to enrol in the general nursing programme. Despite this change, nursing has remained a predominantly female profession. Figures released in the 2010 newsletter from the Nursing Council revealed that only 7% of the current nursing workforce is male (Nursing Council of New Zealand, 2010a).

Until nursing education was transferred from health care to educational settings, teaching was undertaken by nursing tutors and medical doctors and financed by the Board's 'building maintenance' grants (Wills, 1973). Larger Hospital Boards offered a range of post-certificate courses such as neurosurgical, neo-natal, cardio-thoracic and orthopaedic, all of which focused on the medical care aspects of these patients. Because nursing programmes were situated in, and geared towards the service needs of hospitals in which medicine was the dominant ideology, the focus of teaching was not on health but almost exclusively on medical conditions and medical treatments, and the important role that nurses played in assisting and supporting the medical profession. Little attention was paid towards the teaching of health promotion, disease prevention, or patient advocacy. With medical staff teaching in the programme, and nursing textbooks also being heavily focused on medical conditions and treatments, nursing became firmly embedded within the medical paradigm. It is therefore no surprise that the Chambers Combined Dictionary Thesaurus (1995, p 851), still identifies nursing as: "... the branch of medicine which provides care for the sick and injured, the very young, and the very old..."

In the 1960s the first New Zealand nurses with postgraduate Masters qualification were appointed to key positions in the Department of Health (Chick & Kinross,

2006). The Division of Nursing within the Department of Health, together with the Nursing Council and the Nurses Association were instrumental in pushing for change. The attention raised by these senior nurses to review and improve the educational preparation of nurses led a decade later to the decision by the Government of the day to invite WHO consultant Dr Helen Carpenter to review and provide advice on nursing education. The Carpenter Report (1971) noted that training programmes were so highly hospital-focused that nurses were not well-qualified to work in other settings such as public health or district nursing. There was little recognition of patient care being the essence of nursing. Paramedical personnel had accepted responsibilities for activities regarded to be part of nursing, leaving nurses to fill the gaps (Carpenter, 1971). Retention statistics over the period 1960 – 1964 revealed that only 60.6% of those who passed the first year's exam graduated. Unfortunately no statistical information is available about the first year attrition rates. Of those who left the programme, 27.6% did so because they could not manage the theoretical content, 23.8% left for marriage, while another 'large category disliked' nursing (Workforce Development Group, 1988).

The dissatisfaction amongst student nurses regarding study and work conditions was well known by the medical superintendents according to Carpenter, who stated that they were reluctant to discuss or deal with the identified difficulties. Reading between the lines, it is clear that the superintendents chose to ignore the problem as the lesser of two evils. Being senior medical doctors, superintendents were responsible for managing hospital budgets, and required to remain within the funding allocated. Any changes to nursing education or conditions of work were likely to result in increased cost which was not acceptable. The fact that nursing education was paid for out of the hospital maintenance grant, and the fact that no cost analysis of nursing training had ever been undertaken by either the Hospital Board or the Department of Health says something about the prevailing attitudes towards nursing by those who occupied key positions within the health care system.

Lupton (2000) noted that nursing was seen as 'women's work', strongly linked to such feminine traits as caring, nurturing, gentleness, and empathy. Being socialised in a work setting that is dominated by the male culture of medicine, nurses were not only portrayed as a docile and willing workforce, but they complied with those expectations, even at their own expense. Thus, when student nurses

left the programme prematurely, the problems were not conceptualised as caused by the institution's failure to provide an environment conducive to learning, a lack of support or guidance, poor working conditions and frequent shift work, or the medical hegemony that was not helpful to the ideals of nursing. Rather, dropping out of the programme was seen as personal failure, the student's inability to cope with the demands of the clinical environment, and the student being unsuitable to become a nurse (Lupton, 2000). Those student nurses who managed to stay in the programme accepted the situation and got on with the work as 'good' nurses ought to do.

The Carpenter Report (1971) recommended the abolishment of the apprentice model of nurse training and proposed the delivery of nursing education at three different levels as summarised below:

- Fifteen to twenty percent of future nurses to be educated at University level for the most responsible positions in the clinical setting including specialist nursing, administration and nursing education;
- Sixty to seventy percent to be educated in so called 'Colleges of Health Sciences', in a three-year 'comprehensive' programme leading to diploma or certification. These nurses will become the 'general practitioners' of the nursing profession;
- The remaining nursing workforce to be prepared in Polytechnics as 'community nurses' for as long as the need for this group in the workforce is required and justified. Length of educational programme to be nine to twelve months.

In July 1971 the Minister of Education appointed a special Committee to study Recommendation 1.6 of the Carpenter Report (1.6 concerned the development of Colleges of Health). This Committee, known as the 1.6 Committee, published its report in 1972. I focus in particular on this report as it documents in detail the beliefs, attitudes, and perceptions of the diverse stakeholders regarding nursing as well as the politics behind the decision-making, while the nursing voice was largely absent.

Wynne-Jones who represented the NZ Medical Association was personally supportive of Carpenter's recommendations, although the Association he represented opposed the transfer of nursing education and argued for the status

quo despite concerns regarding the continuity and quality of care. There are several plausible reasons why the Medical Association elected for the status quo. Firstly, having a student-dominated nursing workforce in a health care environment that was chronically underfunded ensured that spending on nursing was kept to a minimum, allowing more resources to flow towards medicine. Secondly, a nursing workforce consisting largely of student nurses educated by and dependent on medical input was more easily to manipulate and dominate thereby ensuring the continuity of medical hegemony.

The Hospital Board Association was supportive of the review but insisted on a continuation of the hospital training. By taking this stance the review was more like a window-dressing exercise without the willingness to seriously consider alternative approaches in nursing education. The rationale for their stance was partially influenced by the Board's expressed concern about their ability to attract sufficient qualified nurses to staff the three shifts. Likewise, the NZ Public Service Association opposed the move to transfer nursing education and was adamant that hospital training should not be eliminated but improved (Workforce Development Group, 1988). The Committee members from the Departments of Health and Education represented the official points of view of these Departments. Not surprisingly, the representatives from the technical institutes, who were to make significant gains in student numbers and kudos, were all in favour of the transfer.

There were five members on the 1.6 Committee who were nurses; Miss Boyd was Assistant Director of Nursing (Education) and Mrs Fieldhouse from the School of Advanced Nursing Studies represented the Department of Health. It could be argued that these members were not at liberty to express their own opinions as they were expected to uphold the Department's stance to transfer nursing education to the polytechnic rather than establish Colleges of Health Sciences, as originally proposed in the Carpenter Report. Miss Gardiner and Miss Persen represented the NZ Nursing Association which advocated the transfer of nursing education. Any proposal to improve the education of nurses will have been preferable to the alternative of a status quo. Lastly, there was Miss Stewart, the representative of the NZ Student Nurses Association. One could pose the question how confident Miss Stewart to speak up in a Committee dominated by powerful males in positions such as Director-General, Senior Inspector, Doctor, and

Professor. The Nursing Council was not represented nor consulted by the Committee at any stage.

Of special interest is the minority report written by Wynne-Jones of the Medical Association. In it, Wynne-Jones challenged the decisions and outcomes of the majority report. He noted that two names recommended by Dr Carpenter were omitted and replaced by two or possibly even three representatives of technical institutes. He maintained that the Committee did not keep to its brief as it included discussions on Recommendation 1.7, and he argued that the Committee strove to adapt nursing to make it fit within the technical institutes by making assumptions about the role of the nurse:

- *“I don’t think a nurse need know (sic) any pharmacology, she would just count out the pills”;*
- *“I don’t think it necessary that provision should be made in a new course for nurses to be allowed time off to take part of their course at University in fact we should make it difficult for them” (1.6 Committee, 1972 p. 3, Appendix E).*

Wynne-Jones accused the Committee of failing to take account of the Fifth Report of the WHO Expert Committee on Nursing, and to interview people with expertise in the area of nursing education. Instead the Committee belittled the task of nurses by stating repeatedly that the sole function of a nurse was to dispense a bed pan and that:

The main stream of nurse therefore was not considered to be capable of university work thus defining her as being someone who must be trained not educated, a technician not a professional, a non-intellect rather than a key person occupying a vital role in decision making (1.6 Committee, 1972, P. 5 Appendix E)

Wynne-Jones favoured nursing education in Colleges of Health or Universities, and proposed the establishment of a student internship on completion of the programme. During this internship the nurse was to be employed, providing considerable services while still completing definite educational components. It took almost forty years before his proposal of a general student internship was realised with the establishment of New Entry To Practice (NETP) programmes.

Mr Wicks, representing the Hospital Boards Association, wrote a supplementary report because he too disagreed with some aspects of the main report. Wicks diametrically opposed Wynne-Jones’s ideas as he argued that a two to three-year

nursing programme with full student status was an "...extravagant waste of public moneys" and a "...waste of valuable time of young potential nurses" (1.6 Committee, 1972, P. 3, Appendix D). Wicks argued for the present apprentice-type system as it provided "practical on-the-spot training" (P. 4). He doubted that Colleges: "... could provide anywhere near the level of clinical experience to each girl that the current system provides..." (P. 10). 'Learning by doing' he argued, was favoured by those who feared that highly academically-trained nurses may have limited practical ability.

Wicks was not alone in his views on nursing education, there were many other members who favoured the status quo. Neither were his views unique or new. Commenting on staffing shortages in 1920, Stewart, an American nurse educator, noted that: "It is perhaps inevitable that the difficulty of securing nurses during the last year or two should have revived again the old agitation about the 'over-training' of nurses and the clamour for a cheap worker of the old servant type" (I. Stewart, cited in Reverby 1987a). Wicks criticised the Committee for not consulting the Nursing Council given that it had 'exclusive jurisdiction'. Indeed, the main 1.6 report stated that once approval had been given for the programme, the Department of Education would approach the Nursing Council.

Wicks's report revealed that the decision to transfer nursing education to technical institutes had already been made by the Department of Education before the 1.6 Committee was set up. Thus, the 1.6 Committee, like the Nursing Council, needed to rubber-stamp a political decision that had already been made. As a historical record the report and the Appendices provide insight into the attitudes, beliefs and values about nursing and nurses. The information about hospital finances showed a chronically underfunded hospital service, which was only able to balance its budget by means of understaffing and allowing nursing vacancies to remain unfilled. It was the student-nurse workforce who paid the price for balancing hospital finances, and the nursing profession that was denied an opportunity to determine its own future and reach its full potential.

Needless to say, the Colleges of Health Sciences were never established. Political manoeuvring resulted in nursing programmes being transferred to technical institutes as had already been decided prior to the establishment of the 1.6 Committee. In the old system nursing training served the employment needs of the hospital, in the new system nursing education served the needs of the technical

institutes by ensuring their growth and future viability. Instead of being free to search for ways that would release the full potential of nursing as a profession, nursing education had to fit-in yet again and adapt to the needs of a new master. The locale of nursing can thus be described as a profession disempowered, ignored, and short-changed by political interests working in tandem with a small segment of the educational establishment.

The establishment of a comprehensive nursing programme

The transfer of nursing training from hospitals to educational institutions occurred progressively during the mid 1970s and early 1980s. More emphasis was placed on health sciences, nursing theory, and social sciences, while at the same time a wider scope of nursing experiences was offered (the 'comprehensive' nursing programme). The liberalisation of nursing education resulted in less emphasis being placed on the medical/hospital model although this shift in emphasis was not unanimously considered desirable by nurses from the old apprenticeship programme who felt threatened by this new breed of nurses. I remember the discussions in the late 1980s when nurses from the 'old school', supported by medical staff, questioned the need for such academic or theoretical nurses. A much heard comment was that nurses needed to be practical and that the 'new' programme lacked sufficient hands-on practice for students to learn the 'real' nursing skills. Often these discussions were supported with frequently recycled examples of events that had taken place in the past and involved a 'polytechnic' nurse. The transfer of nursing education did cause a rift between nurses from the 'old' and the 'new' programmes, a rift that took more than a decade to slowly reduce although it has not entirely disappeared. Even in contemporary discussions about graduate preparedness for nursing practice, voices are still periodically heard calling for a partial return to aspects of the apprentice-type nursing training and for nurses to 'fit in' with the service needs of health agencies, especially in hospitals.

Learning from clinical experiences

Despite all the changes in nursing education and the increased emphasis on primary care and health promotion, I am aware that there is still a strong belief by many nurse-educators and students alike about the importance of clinical learning in general hospital-type settings (Benner, Sutphen, Leonard, & Day, 2010). I am also aware of the expectations of my colleagues in the practice setting who feel that

students do not get enough experience in the hospital and the preferences of my students who, when given the choice, are much more likely to elect hospital placements over any other clinical experience. It is therefore no surprise that in contemporary nursing education, much of the clinical learning is still undertaken in hospital settings which are dominated by the medical profession (di Luzio, 2008; Gair & Hartery, 2001; Lupton, 2000; Ministerial Taskforce on Nursing, 1998; Sullivan, Francis, & Hegney, 2008). Learning to nurse in the shadow of medicine has an ongoing impact on the development and perception of nursing as an autonomous profession. Lupton (2000) maintained that the difference in power between nurses and medical staff is largely due to gender, social class and status, as well as the differences in the type of tasks performed. Indeed, doctors tend to engage in clean/sterile procedures and utilise special tools or instruments whereas nurses perform many of the so called hospitality services including tasks generally considered unpleasant such as dealing with body excrements and washing patients' genitalia. Washing bowls, flannels, bedpans and urinals are thus more associated with nurses than doctors. The difference in accessibility and interactions with a patient also contributes to a significant difference in power, certainly from the patient's point of view. Nurses are present for eight to twelve hours a day and spend significantly more time with the patient doing tasks that might despite their complexity appear to be mundane, while doctors are not readily accessible. Doctors tend to come in for a few minutes, talk with the patient while undertaking an assessment, document the consultation findings, make decisions about discharge or treatment options, and instruct nursing staff. Nurses have on occasions to contend with paternalistic behaviours, authority and sexism, and the profession has assumed a submissive position towards medicine, fulfilling an assisting role in carrying out doctors' orders (Lupton, 2000).

Notwithstanding a more liberal nursing curriculum and a significant increase in technology, the fundamental nursing activities that have signified the profession for well over a century have remained largely unchanged. The legacy of a century of medical dominance over nursing can be recognised by the fact that many of the nursing practices remain tied to the medical model with its focus on manifestations of diseases rather than a focus on the range of human responses to ill-health. Although relationships between professions have changed, the clinical environment of the hospital remains dominated by medical values, beliefs and practices. Ward rounds are still arranged to suit doctors with nurses adapting their work routines so

that doctors do not have to wait and 'waste' their valuable time. Within the hospital setting nurses are undervalued in the way they can make a difference in the health outcomes of patients (Ministerial Taskforce on Nursing, 1998). Whilst nursing in other contexts such as primary health, community mental health, or well-child services has been able to develop more independently into holistic nursing services focused on the health of the individual person or family, nursing within the hospital ward environment has remained firmly embedded within the biomedical paradigm as reflected in the illness focus that dominates nursing practice in these settings.

Health as a political enterprise

The health sector is an incredibly complex environment that is governed and influenced by competing interest groups who attempt to impose their rules and regulations on the entire sector based on vested interests and political or managerial power. In the next section I will explore the influence of these interest groups on the development of the New Zealand health care system in general, and on the locale of nursing in particular.

Since the beginning of the last century the delivery of health services has undergone major changes. While improved hygiene practices and waste disposal, higher living standards, and new medical and nursing knowledge and technology led to changed health care practices, I will demonstrate that other changes were not of that nature but were based on ideological/political dogmas. Indeed, examining a selection of historical and contemporary publications concerning the health services in New Zealand (Arthur Andersen & Co, 1987; Cook, 2009; de Raad, 1998; Department of Health, 1974; Easton, 1999; Gauld, 2000, 2008; Gibbs et al., 1988; Hanson, 1980; Quin, 2009; Sutch, 1966; Upton, 1991), it is difficult not to come to the conclusion that health care equals politics. These publications reveal the politics of health as a continuous struggle between stakeholders for power and financial control over finite resources, a struggle in which the nursing voice is barely if at all heard.

During the early colonial period health care was unregulated, it was mainly delivered privately (general practitioners) and via charitable institutions. Hospitals in those early years were meant to be for the 'destitute' (Sutch, 1966). The first Hospital Boards (HBs) were established following the implementation of the Hospital Act in 1885, and over the following years their numbers grew to a total of

30. When the Labour Party won the general elections in 1935 it inherited a hospital system that had remained very much as it was in the 1880s. There was no invalid or sickness benefit, and no free health service (Sutch, 1966). The introduction of the Social Security Act 1938 was Labour's attempt to create a free national health care system (Hanson, 1980). The legislation was the tool that would ensure that health would become a right for all rather than the privilege of a few. However, the original intentions of the Social Security Act 1938 were never fully achieved because of fierce resistance from the general medical practitioners who saw the move as an attack on their business interests, and their right to charge patients for their services (Gauld, 2008). The persistent resistance of the medical profession resulted in a continuation of the dual system of public and private health care provisions (Quin, 2009).

More than thirty years later the second Labour Government (1972-1975) issued a White Paper called 'A health service for New Zealand' (Department of Health, 1974). This discussion paper suggested the establishment of 14 Regional Health Authorities (RHAs), decentralisation of responsibilities, and population-based funding. The White Paper proposed changes to funding reminiscent of the proposals in 1938 which again caused resistance from medical lobby groups. The doctors saw in the proposals a renewed threat to their autonomy and income as it reduced their ability to work in both private and public health systems simultaneously (Gauld, 2000). A subsequent change of Government in 1975 did see some of the Labour recommendations implemented by the National Party in an adapted form, i.e. a pilot scheme of Area Health Boards (AHBs). As the formation of Area Health Boards was not compulsory, change was only very slow. It took almost a decade before the Area Health Boards Act was finally passed into law in 1983.

The two-term Labour Government (1984-1990) introduced a raft of legislative changes to reduce the State's financial liabilities while aiming for more efficient, responsive public services that would return a profit. Three of these legislative changes have been selected for closer examination due to their impact on health service delivery; the State Owned Enterprise Act 1986, the State Sector Act 1988, and the Public Finance Act 1989.

The State Owned Enterprises Act 1986 redefined the role of the State as the owner of public services through such strategies as corporatisation, deregulation and

privatisation (State Services Commission, 1998). The State Owned Enterprises (SOE) legislation enabled the Government to reduce its role as a major employer by selling off some of its state assets while exposing the remaining SOEs to market forces and expecting them to return a profit. The establishment of the SOE Unit, later changed into the Crown Company Monitoring Advisory Unit (CCMAU), was to provide advice to the Minister holding the SOE portfolio, as well as other Ministers responsible for the performance of specific Crown Companies. Having changed the nature and structure of the Public Service through the SOE Act 1986, the State Sector Act 1988 transformed the employment status of public servants. Departmental heads became chief executives appointed on fixed term contracts and responsible for the running of their department, including all aspects of staff management within the Government's parameters and as delegated by the State Services Commissioner (State Services Commission, 1998). The State Sector Act 1988 decentralised the appointment and management structure of public servants by removing their special status and applying the same employment conditions as for employees in the private sector. Vacancies needed to be advertised and all appointments and promotion opened up to all suitable candidates and not just current public servants. The Act spelled out the 'good employer' principles such as safe working conditions and equal employment opportunities, as well as the functions of the State Services Commissioner as the employer of the chief executives (on behalf of the Crown). The State Sector Act has changed the look of the Public Service by introducing the incentives and positive features that are the hallmark of the private sector by delegating control over inputs to the chief executives to shape and restructure their departments in an effort to increase efficiency for meeting agreed targets. Although increased clarity of departmental goals and objectives and the performance expectations of the staff have had a positive effect and resulted in greater efficiencies, repeated restructuring has contributed to increased uncertainty and turn-over of staff, especially at the senior levels (State Services Commission, 1998). The Public Finance Act 1989 changed the way in which the Government funded its Public Services. Up till 1989 funding was based on previous budgets with minor corrections based on GNP and inflation figures. Budgets took into account the input that was needed to run the service rather than the outputs produced. As allocation of funding was based on previous years, departments made sure that all money was spent by the end of the financial year. The Act provided a framework to scrutinise Government's management of

the SEOs, set specific financial reporting obligations, and established management incentives to stimulate effective and efficient use of allocated budgets. The Government, through its Ministers became the purchasers of services supplied by the departments and other agencies by means of purchase agreements. The effects of these key legislative changes were felt right across the country including the health services.

The Labour Government abolished Hospital Boards and established 14 AHBs. Much of the 1974 'White Paper' was implemented albeit in a modified version to reflect the passing of a decade (Quin, 2009). In 1986 the Chicago accounting firm Andersen & Co was invited by the 'Hospital and Related Services Task Force' to review the performance and operations of New Zealand public hospitals that were spending around \$1.8 billion (budget year 1986/1987). The consultants' report claimed that between \$450 and \$600 million dollars could be saved annually, representing a saving of 24% to 32% (Arthur Andersen & Co, 1987). The data on which the financial conclusions were based were flawed as the authors calculated the lowest cost of operations/treatments across a mix of 45 public hospitals and used this figure as the actual estimated cost level for all hospitals (Easton, 2002). Interestingly, the authors noted that: "... we have quantified the results as dollars gained even though we recognize the intention is not necessarily to cut money from the health system..." (Arthur Andersen & Co, 1987 p. 1). The report stated that it did not pass judgement on 'quality of care' and that the potential effects on geriatric and psychiatric services were not examined. However it did point out that: "There have been no conclusive studies to date that prove that a lower cost per patient day results in lower quality of care..." (Arthur Andersen & Co, 1987 p. II-8). It is worth considering in what circumstances it is ever possible to reduce expenditure to that magnitude without impacting on the quality of the health services.

The tone of the document, and the way the data were presented, suggested that the 'assessment of performance' was a highway under construction, aimed at cutting health care costs and preparing New Zealanders for a new ideology underpinning the health services of the future. This ideology was not based on care, compassion, and health for most if not all citizens, but an ideology of health as a commodity in which price, location, and patients' potential future productivity determined the provision of health care services. The report proposed to close down any public hospital smaller than 100 beds if admissions could be absorbed by

surrounding institutions within a 100 mile radius. Furthermore, it was suggested to separate geriatric and long-term care from acute care by transferring the former categories of patients to lower cost centres or, if not possible, to employ second level nurses/unregulated staff to lower the cost. Money would remain available for funding the curative services (patients who can be cured to regain their productive capacity) whilst resources for carative services would be limited. There is no evidence that nursing bodies such as NZNO or the Nursing Council were consulted about the proposals, but if they were, their voices did not come through in the published report. The proposed changes were nothing short of radical and it is hard to imagine that nurses would support any proposal that would deliberately introduce inequalities in health care delivery based purely on patients' age, medical condition, or potential for future productive capacity.

The Andersen report signalled for the first time a strong belief in the effectiveness of generic management. The authors suggested the abolition of the triumvirate structure of hospital management based on consensus and involving the superintendent, the chief nurse, and the administrator. The report favoured the establishment of a generic CEO position responsible for all decisions. The order in which the authors discussed key operating departments might be indicative of their lack of appreciation/understanding of health care services in general, and the importance of nursing services in particular: radiology, laboratory, housekeeping/orderlies, dietary, operating theatres, administration and finally nursing services.

An increasing number of reports appeared over a short period of time, each focusing on improving the efficiency and accountability within the health sector. 'Choices for health care: Report of the Health Benefits Review Committee' (C. Scott, Fougere, & Marwick, 1986), focused on the primary health services but went further by suggesting that funding needed to be merged with secondary health services at the local level. While this report was supportive of some limited competition between providers, overall it emphasised a cooperative model of health care. Subsequent reports, although still focused on raising efficiencies and accountability leaned on 'Choices for health care' as well as 'borrowed' ideas from subsequent papers (Quin, 2009; C. Scott et al., 1986).

The Hospital and Related Services Taskforce report, commonly referred to as the 'Gibbs report' was published in 1988 (Gibbs et al., 1988). Leaning heavily on the

Andersen report, it reiterated that 'conservative' estimates suggested annual savings potential to be in the vicinity of \$450-\$600 million. It is worth noting that health spending had meanwhile increased by more than \$500 million in only one year (1987/1988 estimates). The report did little to assist informed decision-making due to the lack of quality research information. Apart from unacknowledged advisory staff from the Prime Minister's Department and senior staff from the Department of Health, all consultants came from overseas (USA 5, UK 2, and Australia 1) claiming expertise in health economics, policy development, health service management, and accountancy (two of the eight consultants came from Andersen & Co and had also been involved in the Andersen report). Given that the USA health system is different from ours, and the most expensive in the OECD, it is interesting that the Health Department looked to United States consultants for answers (Easton, 1999). If anything, the United States model of health care demonstrated that generic management, increased privatisation, and competition was not synonymous with reduced health care spending, on the contrary it was much more expensive (Flood, Stabile, & Tuohy, 2001). Furthermore, when health services are privatised, the pursuit of profit becomes a major determinant in the type and quality of care provided (Lupton, 2000).

In line with the legislation that was introduced at the time, the Gibbs Report argued for a funder-provider split so that both public as well as private health providers competed on equal terms for publicly-funded services. While the Andersen Report acknowledged the need for expertise in hospital management, the Gibbs Report argued for generic business management skills. The Gibbs Report quoted Dr Bassett, the Minister of Health at the time, as having said that a manager should: "... not be in a position where you are subject to management by ambush from your employees... Top management must be able to manage. It must not be managed by the workforce" (Gibbs et al., 1988, p. 19). The comments of the Minister reflected his unwavering trust in the power of generic management. In the Minister's view managers needed to make all the decisions required to run an efficient health service, based on sound management principles and without being contaminated by clinical consideration of what would be best practice. Health professionals on the other hand should not waste their time engaging in management. Rather, health professionals should do what they are good at which is delivering health care according to the instructions received by the generic managers. The comments of the Minister suggested that either decisions made at

the macro level had no influence on what happened at the micro level or that a well-run efficient health service automatically resulted in improved high quality health care services.

To strengthen the call for generic management, the Gibbs Report alleged that the current system lacked a coherent management policy resulting in a lack of cooperation between health professionals. Noting that the system is open to manipulation and hijacking, the report stated an expressed but unsubstantiated opinion that nursing staff made incorrect decisions which had "caused operating theatres to remain idle and wards closed" (Gibbs et al., 1988, p. 20). The statement that health providers had become 'over-professionalised' and 'inflexible' was based on one single opinion only. None of these allegations were backed up by evidence and often the report remained vague. For example, it was argued that: "Key people within the system have indicated that they could double or even triple their productivity..." (p. 20). Who were these key people, what was their area of expertise, and on what did they base their statement?

The report commented on the low level of morale within the public health sector: "It would be surprising if those who work in the health and hospital systems, as well as many outside the system, had not developed a deep cynicism to both the process of analysis and the political will and ability to bring about change and improvement" (Gibbs et al., p. 16). While the general rhetoric talked about change and improvement, the authors noted that the current lack of cost information was a major impediment to establishing exactly where the money was being spent. They also pointed out that the potential consequences of their own proposals had not been fully explored and yet their report was meant to be used for health policy development. If health professionals were indeed deeply cynical as claimed by Gibbs, then their own report did very little to reduce that. While producing a range of reports with similar messages might create the impression of a need for change, there was no evidence to suggest that New Zealand's health services were less efficient when compared to other OECD countries (Gauld, 2000).

Although the Andersen and Gibbs Reports were commissioned and published during the second Labour Government, the government of the day decided not to commit to a complete overhaul of the health services. Instead, the Minister of Health elected to implement a number of smaller recommendations including the introduction of a general manager to replace the triumvirate management team.

Changes to the AHB allowed for the appointment of up to five members by the Ministry of Health to ensure expertise and appropriate skill mix, but otherwise it remained business as usual (Ashton, 2002).

After the elections a new health services taskforce was set up by the National Government to examine how the health services could be improved in terms of efficiency and responsiveness to consumer needs. The outcomes of this taskforce resulted in the Green and White Paper 'Your health and the public health' (Upton, 1991) which was secretly developed without public consultation or input from health professionals (Hornblow, 1997). Many of the Green and White Paper recommendations reflected suggestions also found in the Gibbs report. A competitive market approach to health care would result in productivity gains, stimulate efficiency, and create more choices for consumers (Upton, 1991). As with most of the previous reports and discussion papers, the loudest voices came from consultants, managers and business people praising the benefits of generic management, top down management strategies, effective resource management, and profit-making as the bottom line. The proposed changes were 'ideological' and nothing short of 'revolutionary' (Devlin et al., 2001; Easton, 2002; Gauld, 2000).

Yet there were other voices at the time. A report was published in 1991 by a study group who visited five countries to explore their health systems (USA, Canada, United Kingdom, The Netherlands, and Germany). The resulting report 'Reforming the New Zealand health system: Lessons from other countries', was a very thorough in-depth discussion on the strengths and weaknesses of each system (Ashton, Beasley, Alley, & Taylor, 1991). The report stressed that the timetable set for the implementation of the proposed Upton reforms was unrealistically short and the authors argued for an extension of the implementation phase. The authors were critical of the Government's failure to properly consult with the various parties concerned. The study group found that, although all five countries visited had a funder-provider split, there was very little competition between providers except for the USA which happened to have the most expensive health care system (11.5% of GDP as compared to 7% in NZ). The authors noted that New Zealand should learn from countries where the integration between primary and secondary care had resulted in a more seamless delivery of health care. They argued against an across-the-board funder-provider split because of the uncertainties surrounding potential efficiency gains, the additional administration costs, and the lack of a well-

developed managerial system in health care. They advocated for a single funding agency for primary and secondary services on a regional basis with clinicians at the interface making the final decisions about resource utilisation. Despite the fact that this report was factual, well-researched, and evidence-based, the 1990s became the decade where pro-marketeers pushed a business model of health care led by generic managers (Easton, 1999). Meanwhile, the report 'Reforming the New Zealand health system: Lessons from other countries' gathered dust for another decade before it was picked up again and largely implemented with the establishment of District Health Boards under a Labour-Alliance Coalition.

The health reforms outlined in the Green and White Paper were led by the National Interim Provider Board chaired by business man Sir Ronald Trotter. Four Regional Health Authorities (RHAs) were established to purchase health services from 23 Crown Health Enterprises (CHEs) in a competitive market. In the area of primary health independent GP practices started to cluster together into 'independent practice associations' in order to achieve better contracts based on numbers.

Despite the fact that the Andersen Report noted that New Zealand had low hospital admission rates compared to other countries, the Government introduced the infamous and very unpopular 'user charges' for patients admitted to hospital in 1992. The implementation caused such an outcry that it was withdrawn again the following year (Ashton, 2002). The Government decided to set up a Public Health Commission (PHC) to develop goals and objectives for the overall health of New Zealanders. The PHC started to raise concerns about increasing poverty levels and decreasing access to health services for the most vulnerable groups in society (Gauld, 2000). Soon the PHC became more or less a health consumer advocate, raising concerns about the use of alcohol, tobacco and particular food items. In doing so it came into conflict with the Government's interest in protecting and supporting the business sector (Ashton, 2002; Gauld, 2000; Hornblow, 1997). The PHC was abolished by the Government within two years, and its functions were taken over by the Ministry's Core Services Committee.

In line with the proposals outlined in the Andersen and Gibbs reports, public hospital capacity was reduced by more than 30% with the bulk of the 'long-term stay' beds being transferred to private hospitals and residential care facilities. In 1987 there were 171 public hospitals with 24,488 beds and 173 private hospitals with 6,157 beds. By 1998 this was reduced to 101 publicly-funded hospitals with a

total of 14,298 beds. Over the same period 105 more private hospitals were added to the pool bringing the total to 278 with a capacity of 15,984 beds. In 2002 there were 85 public hospitals left with a capacity of 12,484 beds and a surge in private hospitals from 278 to 360 although bed numbers were reduced by 4,643 to 11,341 hospital beds (Quin, 2009). The funding for hospital services steadily declined between 1991 and 1998 from 73% to 60.2% of central government spending with very high rates of people on waiting lists for surgery (Flood et al., 2001). The financial contributions to health care required from individuals, based on the so called 'user pays' principle, increased significantly. Comparative figures from 1998 showed that patients in the United Kingdom paid less than 3% of the total health care expenditure, in The Netherlands this was 5.9% and in the USA 17.7%. In New Zealand patients' contribution to total health care spending amounted to 22.9% (Flood et al., 2001).

As noted before, the introduction of generic management in health care led to clinical decisions effecting the provision of nursing services at hospital, ward, and even bedside level being made by non-health professionals. For nursing this was a devastating development in terms of loss of professional autonomy and lack of acknowledgement that nursing was valued for the expertise it brought to bear in every day nursing practice. The direct consequence of the implementation of the generic management model was the casualisation of the nursing workforce and the loss of nursing's voice in health care matters (Ministerial Taskforce on Nursing, 1998). Ashton (2002) maintained that the reforms contributed to conflict and discontent and were not well-received by many health professionals. The discontent was not only noticeable amongst health professionals but also by those who were supposed to be the new leaders in the health sector. Within a three-year period (1993-1996) 13 of the 23 CHE chief executive officers resigned from their position as did six of the board chairpersons and many more board members (Hornblow, 1997).

The changes during the mid 1980s to mid 1990s were not unique to New Zealand and need to be seen in a bigger picture. Worldwide, economies were in transition. There was the fall of the 'Berlin Wall' in 1989, the collapse of the East European trading block, followed in 1993 by the disintegration of the former Soviet Union (Easton, 1999). Free trade and global economy became key achievement goals, while subsidies, import taxation and trade barriers needed to be phased out and

abolished. The introduction of the Employment Contract Act 1991 abolished compulsory unionism to free up the labour market. Rather than a carefully implemented step-by-step approach focused on incremental improvements in health service delivery, the Government of the day opted for radical health reforms which took place over such a short period of time that Easton (1999) referred to it as 'blitzkrieg', while Gauld (2000) labelled it the 'big bang'. Health care cost had increased by 40% since the reforms started and yet surgical waiting lists had increased (Coney, 1996). Despite \$57 million spent on international consultations (McCloskey & Diers, 2005), the health reforms had not achieved the promised objectives and more restructuring was needed.

The elections of 1996 resulted in a coalition Government of National and the New Zealand First party. For those employed in the health sector this meant yet another round of reforms and a growing bureaucracy. The market model was partially abandoned as the Government opted for a more cooperative rather than competitive approach (Quin, 2009). The Transitional Health Authority (THA) was established to oversee the transition of the four RHAs into one Health Funding Authority (HFA) in 1998. At the same time the 23 CHEs were renamed Hospital and Health Services (HHSs) and were no longer required to return a profit (Ashton, 2002). Disagreement between the Government coalition partners resulted in much uncertainty and only partial implementation of policies (Quin). The worsening employment situation, the ever present threat of redundancy, and a chronically underfunded health sector contributed to staff, in particular nurses, seeking employment elsewhere (Ashton, 2002). The resulting staff shortages placed additional stress on the remaining staff. Over a period of eleven years (1980-1991) health expenditure had risen from 7 to 7.3 % of the GDP representing a growth of 1.6 % in real terms, while the Government proportion of this expenditure had declined from 87 % to 77 % (Gauld, 2000). In the 1990s New Zealand expenditure was below the average of other OECD countries, as it has been for many years, and hence it is difficult to explain why the Government was so obsessed in pursuing market-oriented health care services.

The effects of the politicisation of health care had become so dire that in her Annual Report, Robyn Stent, the Health and Disability Commissioner, felt compelled to ask political parties to act in partnership and in the interest of the nation's well-being. Stent maintained that the increased politicisation of health services had led to an:

"...endless source of emotionally charged, and often frightening, media stories" (1997, p. 5). Indeed, the unrelenting pace of political manipulation resulting in continuous restructuring of the health sector, had a negative influence on the delivery of health care in general, and the working conditions of nurses in particular.

A Labour-Alliance Coalition Government was elected in 1999 and another round of health reforms was imminent in which significant aspects of the report 'Reforming the New Zealand health system: Lessons from other countries' (Ashton et al., 1991) was implemented. In 2001 twenty-one District Health Boards (DHBs) replaced the twenty-three HHSs following the implementation of the New Zealand Public Health and Disability Act 2000. The funder-provider split was removed and each DHB received population-based funding not only for the tertiary health sector (public hospitals) but also for the newly established Primary Health Organisations (PHOs). Although the policy could be interpreted as a sign that the Government wanted to emphasise the importance of preventative health services, there was no evidence to suggest that the independent practitioner associations (IPAs) were not effective (Devlin et al., 2001). Hence, it could be seen as a political strategy to circumvent the monopoly of GPs who had formed (IPAs) in the early 1990s to increase their bargaining power and ensure stronger representation of their interests. Following the failures of 1938 and 1974, the establishment of PHOs was another attempt by Labour to break the medical domination in health care (Gauld, 2008). PHOs were community-owned multi-disciplinary health centres delivering a wide range of health services. Additional funding would enable the PHOs to deliver free health services in first instance to the lower socio-economic and other disadvantaged groups, but with the aim to extend it over time to include the whole population.

The election of 2008 resulted in yet another Government, this time made up of a coalition between the National and the Maori Party. Amid an international financial crisis, the Government budgeted just under \$13 billion for Vote Health for the financial year 2009/2010. Of this amount \$9.7 billion is spend by DHBs on primary health and hospital services. In 1970 New Zealand's per capita health expenditure was 28% below the Organisation for Economic Co-operation and Development (OECD) average and in 2000 it was 16% below the OECD average. In 2010 New Zealand spent 10.1% of its GDP on health while the OECD average was 9.5%. Although New Zealand has increased its spending on health, other countries have done relatively better economically, pushing New Zealand further down the list. To

put this in perspective; in 1970 New Zealand's per capita health expenditure placed it 9th on the list of OECD countries. A decade later New Zealand stood at number 16 on the list. In 1990 New Zealand occupied the 19th place, in 2000 the 20th place, and in 2005 the 22nd place (Ministry of Health, 2009a; OECD, 2005).

In the Statement of Intent 2009-2012 (Ministry of Health, 2009b) the Government has made it clear that no extra money will be available for debt servicing and that DHBs need to balance their budgets. The Government indicated that DHBs will need to shift resources to high-value activities such as reducing duplication in planning, enhancing clinical leadership, moving resources from backstage rooms to frontline services, and creating more shared regional and national services. However, the Ministry of Health must know that the so called 'backstage rooms' house the people that gather the vast amounts of statistical information that the Ministry requires the DHBs to produce to demonstrate that the services are cost effective and that the right managerial decisions have been made. The Ministry must also be aware that their proposal to create shared services regionally and nationally is going to take a considerable amount of time and a significant amount of seeding money. Which health care provider is prepared to divert much needed finances into establishing shared services when the long-term benefits are uncertain in a health care environment that is underfunded and in constant flux due to changing political ideologies?

Health equals politics and certainly in New Zealand the health sector has been the focus of much attention by politicians. In the space of a decade the health sector has undergone three major restructurings and hence Gauld (2002, p. 142) maintained that New Zealand can claim the honour of being the "most restructured health sector in the world". The restructuring has failed to deliver the promised savings of 24 to 32 % while reducing waiting lists. It has failed to demonstrate that ideologies such as 'free market competition' and generic management are appropriate strategies for health service delivery. The failed health reforms have demonstrated how complex health care services really are, and that there is a huge difference between health care ideology and the way health care is provided for in ward settings.

I argue now that the lack of genuine consultation with, and input by, New Zealand's own professional clinicians was the most obvious common denominator in all of the failed health reforms. Relying on the advice of overseas consultants, and a

selective focus on cost cutting and generic management to make it all happen was clearly not the right approach; neither was leaning on and referring to like-minded reports based on right-wing ideologies.

Nursing and the health reforms of the 1990s

The principles underpinning the health reforms were based on the philosophy of a market-driven health care system with increased competition between the private and public sector. A competitive health care sector was expected to result in increased efficiency and reduced financial costs. These ideas were not new and neither were they exclusive to New Zealand. Other countries too were pursuing similar reforms i.e. the United States, Britain, Canada, and The Netherlands, but no other OECD country dropped public health care funding as dramatically as New Zealand (Flood et al., 2001). The restructuring of the health service and the reduction in funding resulted in the complete closure of a number of small rural hospitals as well as a significant reduction in bed numbers in the larger hospitals.

The hollowing out of the public health system had a devastating effect on the employment of registered nurses. The loss of beds resulted in a reduction of nursing vacancies and significant numbers of nurses were either made redundant or resigned on their own account. The new generic management system resulted in a working environment for nurses that fostered low morale and inappropriate staffing levels. The inflexibility displayed by the new management system, the inability to accommodate part-time nurses with family responsibilities, the lack of consultation on clinical matters, and the departure of many experienced nurses resulted in a very toxic environment where the standards of care rapidly declined (Health and Disability Commissioner, 1998).

Up until the reforms of the 1990s, nursing as a profession was represented at the highest level in the triumvirate management structure of the hospital. The switch to generic management resulted in the dismantling of the existing nurse leadership structure and career pathways (Buchan & North, 2008). Carryer et al. (2010) maintained that the lack of nursing consultation at the time of the health reforms resulted in a loss of senior nurses in particular. With the loss of experienced senior staff, the nursing profession lost mentors and role models for the junior staff and this had profound effects on retention rates. The percentage of nurses remaining active in nursing three years after registration dropped by 21% from 81% in 1990 to

60% in 1998 (Buchan & North). Between 1991 and 1996 the annual growth in nursing employment was negative while in the following five years the growth was less than half when compared to other professional groups (Department of Labour, 2005). New Zealand-educated nurses left in increasing numbers for better paid jobs overseas (Buchan & North, 2008; Department of Labour, 2005). Cost cutting rather than standards of nursing care became the overriding concern in health care (Annals, 2005).

Besides the restructuring of the health sector there were other factors that had profoundly influenced nurses and nursing and one of these was the introduction of the Employment Contracts Act in 1991. This Act allowed employment conditions and salaries to be determined by local needs and supplies (Buchan & North, 2008). The Act had a major impact on nursing and was instrumental in the fragmentation of the national nurses award, the erosion of conditions of employment, and the casualisation of the nursing workforce (Ministerial Taskforce on Nursing, 1998; O'Connor, 2005). The health reforms combined with the Employments Contract Act produced an environment of uncertainty as constant restructuring resulted in job insecurity and discontent amongst healthcare workers (Ashton, 2002). Nurses were dissatisfied with the conditions of work, the salaries paid, the physical demands of the job, and the high workload which was made worse by staff shortages, increased patient acuity, and inflexible hours due to shift work (Buchan & North, 2008). In an Editorial in Kai Tiaki the Chief Executive of NZNO wrote:

We accept the duty of care and the responsibility to undertake that duty safely, on the basis that we have the authority to arrange nursing services and provide care according to the principles and standards established by our profession. However, most nurses find the reality of their daily practice, more often than not, departs markedly from this. Too often the real authority for making fundamental decisions about how nursing care is delivered does not rest with nurses (Annals, 2005, P. 2).

The Employment Contracts Act had contributed to a deterioration of the practice environment as a result of legal restrictions that prohibited nurses from negotiating a national collective (Carrier et al., 2010). The authors noted that the increased substitution of registered nurses by unregulated staff, the lack of supplies and equipment, and the lack of nursing leadership contributed to increased staff turnover and decreased skill mix. Many rights had considerably weakened under the Employment Contracts Act and nurses' income had dropped in real terms during the 1990s. Pay scales had narrowed, leaving little room to reward nurses

for additional responsibilities or advanced educational achievements. The effects of the reforms were reflected in the nursing employment statistics.

The replacement of the Employment Contracts Act by the Employment Relations Act in 2000 offered increased protection and restored the rights of employees for collective bargaining. The New Zealand Nurses Organisation (NZNO) started a campaign for fair pay, safer staffing levels, improved conditions of employment, and a push for research to study the effects of staff shortages on the provision of health care. The underlying aim of the NZNO campaign was to retake control over the profession (Annals, 2005). The negotiations eventually led to the multi-employer collective agreement (MECA) covering nurses employed by DHBs that saw, amongst other changes to employment conditions, nursing salaries increase significantly in 2004, as well as an agreement to research safe staffing levels. By 2006 the DHBs had improved their staffing situation even though filling vacancies remained difficult with only 54% of vacancies being filled successfully (Buchan & North, 2008). Although the politically inspired reforms have been partially reversed, McCloskey & Diers (2005) argued that nursing has not as yet regained the management positions to the same degree as it had prior to the health reforms. Indeed, research undertaken by Hughes and Carryer (2011) confirmed that the ability of the nursing profession to control its own practice remains significantly diminished. What's more, a report from NZNO warned that nursing workloads and work pressure were once again on the increase while an agreement on safe staffing levels was not expected (Walker, 2011).

Summary

This chapter explored the development of health care in New Zealand over the last century with a specific focus on the nature of changes made. Political will and the medical profession were identified as the most powerful forces in shaping New Zealand's health services with nursing seldom heard in decision-making. The dominant position of medicine within the health sector and their role as budget holders in the management of the hospitals has been discussed. Medicine's hegemony in the health sector enabled it to successfully block Government initiatives for health reform in 1938 and 1974 although it was less successful doing so during the 1990s health reforms. Relying on overseas consultants, both the Anderson and Gibbs reports advocated for the introduction of generic management

principles and a competitive model of health care delivery to achieve significant savings in health care. The legislative changes in the 1980s such as the State Owned Enterprise Act 1986, the State Sector Act 1988, the Public Finance Act 1989, and the Employments Contract Act 1991 turned the health sector upside down, impacting on almost every aspect of the New Zealand health service. Although the promised savings were never realised (Finlayson & Gower, 2002; McCloskey & Diers, 2005), the medical profession retained and even strengthened their control over health care through the establishment of IPAs and PHOs.

From an historical perspective, the medical profession played a key part in the role development of the nurse within the hospital setting, and the position of nursing within the larger context of health care services. Although the medical profession has lost some of its influence over nurses after the transfer of nursing education in the 1980s, it remains the dominant force within the health sector (Gauld, 2008).

The history of nursing education and in particular the report written by the 1.6 Committee illustrated how the nursing locale was shaped and manipulated through interference by dominant forces. While the push for educational reform was initiated by New Zealand's senior nurses in the Health Department, during the actual decision-making process nurses were effectively side-lined and the future of nursing was discussed and decided by 'others'.

Nurses, as the largest professional group occupying a key position within health care sector, appear to have had little concrete influence in the overall policy direction of health care in New Zealand. History has demonstrated that the development and direction of health care services are largely determined by opposing political ideologies. In describing the many restructurings that took place over this relative short period of time, I have set the scene to better explore the locale of nursing. The dismantling of nursing leadership not only undermined the profession of nursing but also contributed to the silencing of the nursing workforce. While generic management is no longer openly pursued in health care settings, I will show that the structures and strategies are still in place and reduce nurses' ability to utilise nursing knowledge and expertise (Rankin, 2009). In this new 'reality' the restructured environment appears to be used as a lever to dismantle nursing practice and to force nurses into nursing practices that benefit the institution rather than the patients.

This exploration of the literature revealed almost no literature specifically examining the impact on nursing of health service reform. Rather I have found evidence of a sustained albeit limited critique of the health reforms in New Zealand. In keeping with the evolving nature of the research and as the data analysis developed it became necessary to utilise international sources of literature in order to understand what I was seeing in New Zealand. Accordingly, and later in the thesis, I have drawn on additional literature sources from those countries who preceded New Zealand in undertaking the specific health reform process experienced here during the 1990s.

CHAPTER THREE

Methodology

Introduction

This chapter begins with an introductory outline to distinguish between quantitative and qualitative research methodologies to highlight the ontological and epistemological differences that underpin these methodologies before concentrating on ethnography and its variant focused ethnography. I will demonstrate that, given my research topic and my expertise in the area of health assessment, focused ethnography was an appropriate methodology to select. I subsequently explore Giddens' (1984) structuration theory and apply the concept of locale to further my analysis in an attempt to better understand the data and explain the findings.

Qualitative and quantitative inquiry

Qualitative inquiry is a collective name for a complex range of concepts and ideas that have been developed over time and which share certain philosophical assumptions about the world and what counts as knowledge that sets it apart from quantitative research (Sale, Lohfeld, & Brazil, 2002). Before discussing qualitative research more in depth, it might be helpful to highlight in what way it differs from quantitative research. Quantitative inquiry is based on an assumption that the subject can be split from the world in order to study it without affecting the subject or the findings. This assumption is based on the fact that there is an objective world out there that exists independently from our perception. There is a clear relationship between cause and effect which can be examined and explored empirically through experimental or correlational study designs (Firestone, 1987). Quantitative research is claimed to be value-free and maintains a clear separation between feelings and rationale. The investigator remains objectively detached throughout the research to avoid bias, while participants or the phenomenon under study are assumed to be unaffected by the research process (Guba & Lincoln, 2008). Adhering to strict protocols, the quantitative investigator uses experimental, quasi-experimental, or randomised controlled trials to establish causal

relationships, or questionnaires with predetermined responses to enable large scale data gathering for effective statistical analysis (Sale et al., 2002). The ultimate goal of quantitative inquiry is to measure and predict causal relationships and to be able to deduct and generalise the findings across situations (Denzin & Lincoln, 1994). Quantitative research has been very successful in explaining and predicting natural phenomena in for example physics, mathematics and chemistry.

Qualitative inquiry on the other hand discards the ontological idea that there is an objective world waiting to be investigated. Rather, the world as we have come to know it, is socially constructed based on our lived experiences and our shared understandings and interpretations (Altheide & Johnson, 1994). What we know, our knowledge of the world in which we live, doesn't exist independently of our minds. Not only is this world socially constructed and constantly changing, it also ceases to exist when the focus shifts away from the phenomenon under investigation (Glesne, 2006; Sale et al., 2002). Qualitative researchers reject the existence of a single truth which typifies quantitative research, and maintain that there are multiple realities and multiple truths. They also reject the quantitative notion that the researcher can act as a detached and objective investigator. On the contrary, a qualitative researcher wants to step into the shoes of the research participants to feel and experience what it is like. Thus, rather than looking from the outside in and ensuring complete detachment in order to maintain objectivity, the qualitative investigator immerses him/herself in the context and becomes part of the situation. Both the researcher and the participant are inextricably linked to the context, influencing and shaping the research. Research findings are thus mutually created within the context in which the research takes place (Guba & Lincoln, 1998). Qualitative research protocols can be adapted to the local context in order to create meaning. Participants are selected purposefully and in limited numbers based on their ability to provide information that contributes to the understanding of the phenomena under investigation. Research techniques include field observations, unstructured informal and formal interviews with individual participants, and focus group meetings. Qualitative research findings are not meant to be generalisable to larger populations.

Denzin and Lincoln's (2005) discussion regarding the commonalities that are characteristic for qualitative inquiry can be summarised as follows. Qualitative inquiry:

- Locates the researcher in the natural setting or context of the world that is being studied;
- Makes use of a toolkit of different interpretive practices to make the world visible from different perspectives. Items within this toolkit are observations, interviews, field notes, photographs, case study/history, personal experiences, and analysis of documents to represent the multiple realities of the world under study;
- Aims to explore these multiple realities in an attempt to grasp, make sense of, and give meaning to these experiences from the perspective of the people and/or social phenomena being studied.

Interpretivism

Qualitative research is structured by major interpretive paradigms such as the positivist and postpositivist, constructivist-interpretivism, critical, and feminist-poststructuralist paradigms (Denzin & Lincoln, 2005). The interpretive paradigm is based on the premise that the world into which we are born consists of strictly governed social practices that are mediated through language and through the way people act (Hemingway, 1995). People first learn about the social world they live in through shared understandings before they are able to develop personal meaning which subsequently guides their behaviour. As noted before, intersubjectivity between researcher and participant is a key aspect in interpretivism as the researcher studies the phenomenon through the eyes of the participants within the natural environment. Understanding someone's action, means understanding someone's intentions and motives related to what has been observed. Interpretive understanding requires the researcher to let go of personally held beliefs and to stand in the 'shoes of the other' to grasp the significance of the event. It requires the researcher to focus on the person's perception of the situation and the meaning they ascribe to the event and their action. Whether researchers can truly stand in other peoples' shoes has been questioned by Schwandt (1998), who argued that although researchers can observe participants and gain an appreciation of the contextual factors, they do not share the same history nor the variety of experiences that influence the perceptions and understandings of their participants. However, qualitative researchers are very much aware that a large part of our understandings of the world is unquestioned and taken for granted, and it is assumed that other people

see the world in roughly the same way as we do (Spradley, 1979). Hence, interpretivist researchers focus on the mundane and try to gain an emic perspective of what it all means for the research participants. Interpretivist research strategies such as phenomenology, symbolic interaction, and ethnography are particularly useful in gaining such an in-depth understanding by studying participants' attitudes, understandings, aspirations, values, culture, motivations, sensitivities, concerns, fears, worries and a whole range of other factors that influence everyday decision-making and behaviour. In the following section I will explore the historical underpinnings of ethnography and subsequently introduce a variant of ethnography namely 'focused ethnography' which was selected as the research approach for this study.

Ethnography

Ethnography developed as an interpretive mode of inquiry in the first two decades of the Twentieth Century and is a combination of two words; 'ethnos' meaning people or tribe, and 'graphia' which means writing (Scott-Jones, 2010). Ethnography was originally extensively utilised in anthropology in order to study social structures, communication patterns, nurturing practices, gender roles and responsibilities of people in a variety of cultural settings. Through observation of situations/actions and the production of thick descriptions pertaining to the phenomenon that is being studied, the ethnographer attempts to gain meaning and understanding (Holliday, 2007; Light, 2010). The term 'thick description' was introduced by Geertz (1973) who used it to emphasise that merely describing the phenomenon was not sufficient. Rather, the researcher needed to go beyond simply describing the action or event by including the wider context, the meaning, and the symbolic importance of what was observed.

The social anthropologist Bronislaw Malinowski is considered to be one of the founders of ethnography (Agar, 2006; Gobo, 2008; Scott-Jones, 2010). Based on the notion that human behaviour should be studied within the influences of the natural setting, rather than in artificial environments, Malinowski (1961) urged ethnographers to engage in anthropological fieldwork and report ethnographic data 'in context'. He maintained that there are several strategies through which investigators can access the individual's views on their social system, including

'blending in' with the group by means of long-term residency, or spending extended periods of time with the individuals or group under study.

Malinowski (1961) proposed that the gathering of information should focus on three distinct types of data. Firstly, the researcher should observe for rules and regularities that are distinctive for the group under study. With this he meant all aspects that are permanent and typical for the group and sets it apart from other groups. Secondly, the researcher needs to focus on data that have an influence on actual behaviour of the group but which may not be able to be measured or determined, and thirdly, data should be gathered from individuals that make up the group. Fieldwork, according to Malinowski, enables not only observation of, and participation in daily life, but it also assists in the understanding and use of the local language or vernacular. He stressed the importance of ordinary everyday speech, as he argued that people's feelings and thinking are influenced by the vehicle of thought, namely language. Since the early days of Malinowski, ethnography has developed into different forms of ethnographic practice and it has moved beyond the discipline of anthropology into the fields of psychology and sociology.

Sociologists at the University of Chicago adopted ethnography to study sociological aspects of 'everyday' situations and behaviours. William Thomas and Robert Park introduced theoretical perspectives of phenomenology into ethnography resulting in the 'Chicago approach' (Lofland, 1995; Savage, 2006). This approach was further strengthened and consolidated by the British School of Social Anthropology (Macdonald, 2001). The socio-political movements of Western societies in the 1960s were another significant influence on the social sciences with gender inequalities, gay rights, student up-rises, and critical social theory all topics that impacted on, and resulted in, the development of a whole range of new ethnographic approaches (Scott-Jones, 2010).

Ethnographic approaches

Wolcott (1990) argued that ethnography is only a broad prescription for research but that it always entails a commitment to provide a cultural account of a given group, an attempt to make sense of human social behaviour in terms of cultural patterning. His assertion is confirmed by the wide range of disciplinary groups and contextual settings in which the ethnographic approach has been applied, and the

ability to adapt ethnography to suit local circumstances. Ethnography is a structure or vehicle that enables social action to be better understood by 'others', but it also offers insiders a new perspective into their own social setting, deepening their own understandings, and potentially challenging long-standing taken-for-granted views.

The field of ethnography has become so broad and difficult to define that it is marked by diversity rather than consensus (Atkinson & Hammersley, 1994). The different approaches reflect the researcher's assumptions and beliefs about the world, their aims, the type of knowledge they want to produce, as well as the changing relationships between researcher and research participants. Common to all different ethnographic approaches is the continuous cycle of multiple data gathering, analysis and reflexivity as outlined in the methods section of this chapter. This ongoing process provides a degree of flexibility by allowing data gathering to be adjusted and adapted as a result of preliminary analysis and reflections. The ability to adjust data collection strengthens the research by ensuring a tight relationship between research process and findings; "Research that is designed in the making is research that can be *redesigned* in the making" (Wolcott, 1995, p. 192), an assertion that was particularly helpful in the context of the present study.

Ethnography thus offers a degree of flexibility where the aim and the focus of the research will determine the final process (how to go about it), and the final product (the findings of the research). Typically, in the early decades of the 20th century anthropologists engaged in 'macro-ethnographic' studies, spending years living amongst people from a different culture in order to learn about their ways of life. Most contemporary ethnographic studies are of a shorter duration and may focus on particular social settings such as schools, prisons, hospitals, or social groupings such as adolescents, drug abusers, solo parents and are labelled as 'micro-ethnographies', 'focused ethnographies' or 'specific ethnographies' (Lofland, 1995). Other ethnographic studies combine ethnography with critical social theory or utilise a feminist perspective that shapes the data collected and the analysis undertaken. For the current study I have selected 'focused ethnography' and it is this research approach that I will discuss next.

Focused ethnography

While traditional ethnography was used extensively by anthropologists to study 'others', that is people of other cultures in the remote corners of the world, the use of ethnography by the Chicago School turned ethnography into a research method suitable to study sociological phenomena in one's own society or culture. Focused ethnography is a variant of ethnography which is utilised in specific well-defined settings to research a narrow slice of a larger culture (Savage, 2006). It entails a series of field visits of short duration (Gobo, 2008) rather than the grand field studies that were typical of the anthropological studies during the colonial era. Focused ethnography is concerned with settings and situations while concentrating on the details of situated activities that occur on a daily basis. Hence, focused ethnography is an appropriate approach when researching professionals in the midst of their day-to-day activities, especially when there are constraints in terms of time and scope (Wolcott, 1990). However, there is a warning too. Kleinman (1992) maintained that while there are distinct advantages to highly focused mini-ethnographies, researchers need to be aware that a too limited analytical framework may restrict contextual analysis which undercuts the purpose of ethnography.

Knoblauch (2005, p. 8) maintained that focused ethnography is particularly suited to sociological ethnographers who, focused on small aspects of one's own society/culture, are confronted with 'alterity rather than strangeness'. Alterity is possibly best described as 'differences', differences between settings and situations, differences between participants and/or differences between what participants say they do and what they actually do. 'Strangeness', according to Knoblauch, is not part of the equation because the use of focused ethnography presupposes that the researcher has an intimate knowledge of the field and can claim a degree of expertise.

Expertise is the key in focused ethnography. The researcher cannot be a naive observer as in traditional ethnographic fieldwork. On the contrary, the expertise of the researcher strengthens focused ethnography because the field work is based on much more clearly formulated research questions (Kleinman, 1992). Hence, utilising focused ethnography demands from the researcher a large amount of preparatory work before fieldwork can commence (Knoblauch, 2005). The researcher is required to have intimate knowledge of the field, lines of

communication, the work arrangements, and the roles and responsibilities of the different members likely to be present in the field. Given that my research concerns registered nurses engaging in ordinary day-to-day nursing activities in a variety of medical and surgical wards, and my own background as a registered nurse as detailed in the preface, focused ethnography is an appropriate research approach. In the following section I will outline the methods used in ethnographic research.

Methods used in ethnography

Fieldwork

Fetterman (2010) considered fieldwork to be the hallmark of ethnography, providing a commonsense perspective and considerable information about mundane/routine events which research participants have taken-for-granted and are unlikely to recount during interviews. 'Being present where the action is', and being able to observe the subtleties of verbal and non-verbal communication within a specific context, that is the strength of fieldwork. Being-in-the-field and observing participants in their day to day activities, overcomes the discrepancies between what participants say they do and what they really do (Mays & Pope, 1995; Porter, 1991). Field observations enrich the research data as they expose situations, events, incidents, and points of tension, that may happen outside the participant's area of action but which nevertheless impact on, or influence the practices that are being observed.

As a self-proclaimed 'purist', Wolcott (2008) is critical of the way ethnography is utilised by some researchers and he argued that a distinction needs to be made between an ethnographic study and studies that borrow some ethnographic techniques. According to Wolcott there are instances where 'doing ethnography' refers more to how researchers are intending to gather their data, in particular fieldwork, rather than the final product. Wolcott de-emphasises fieldwork as a defining feature of ethnography, but he does argue that there is still a need for the researcher and the researched to be in the same space, or at least have face-to-face discussions. I agree that too much emphasis on fieldwork may diminish the importance of other distinguishing features of multiple data-gathering techniques, but this does not necessarily equate to a neglect of alternative data gathering. I was attracted to ethnography precisely because of the required observational

fieldwork. As I set out to gather data, fieldwork was the most outstanding feature in terms of time spent in the clinical setting, the richness and volume of the data gathered within the context of clinical practice, and the things I learnt about nursing and about myself. The early emphasis on fieldwork did not lead to neglecting other complementary data-gathering techniques. On the contrary, it was the data gathered during the field days, the casual conversations about ward nursing, maintaining field notes, and the more formal interviews at the conclusion of the observations as well as those performed during the second stage of the research that had a tremendous influence on my research, contributing to a change in research focus. It is the mixture of data-gathering techniques and the way the ethnographer combines the available data, which is of crucial importance for the research outcomes and which distinguishes an ethnographic study from any other type of research approach.

Observations

Much has been written about fieldwork and in particular about the role of the researcher in the field. How active or passive should the researcher be while engaging in observations? Gold (1958) outlined four observational categories which can be summarised as follows:

- Complete observer; the researcher is solely engaged in observing what goes on without becoming involved in the activities;
- Observer-as-participant; the researcher's main task is to observe but from time to time may also engage in the activity;
- Participant-as-observer; the researcher spends most of the time participating in activities while less time is set aside for formal observations;
- Complete participant; the researcher is a full member in the group's activities and observations are done without the group's knowledge.

These categories continue to be discussed and critiqued in the most recent publications (Angrosino, 2007; Flick, 2009; O'Reilly, 2009; Scott-Jones, 2010; Wolcott, 2008).

There is an underlying assumption in all of these discussions that relates to the role of the observer, the required degree of 'connectedness' with the participants,

the potential to influence what is happening in the field, and the desire to produce an 'objective' report. How connected should the observer be with what is happening in the field? Do close connections alter the interactions of others in the field and hence influence the outcome? Would the researcher lose oversight of the field or his/her objectivity when close connections lead to increased identification with the participants? Glesne (2006, p. 50) noted the paradox in all of this when she stated: "The more you function as a member of the everyday world of the researched, the more you risk losing the eye of the uninvolved outsider; yet, the more you participate, the greater your opportunity to learn".

Sarantakos (1998) noted that defining the role of observer is not an easy task and this applies in particular to 'observer-as-participant' and 'participant-as-observer'. The idea of four distinct categories, as suggested by Gold, is difficult to maintain and Couchman and Dawson's (1995) notion that observations occur along a continuum between the extremes of complete participation on one side and complete non-participant observations on the other side is much more useful. Observations, as I experienced it, occur somewhere on that continuum depending on context, the situation, and the participants involved. If the goal of ethnographic research is to obtain richly written accounts of human activities and relationships, if it is to provide an insider's view of what is happening and how it is experienced, then connectedness is a requirement (O'Reilly, 2009). The researcher needs to experience what it is really like by being fully immersed in the contextual setting and closely connected to the participants in the field. Wolcott (2008) added another dimension to participant observations when he proposed three alternative categories to capture crucial aspects of fieldwork which can be summarised as follows:

- Experiencing; that what the researcher gains as a result of personal experiences while in the field. This includes all we are capable of absorbing while being in the field (mainly through our eyes and ears);
- Enquiring; asking participants what is going on either through formal or informal discussions/interviews;
- Examining; archival research into information that might already have been produced by others such as letters, photographs, recordings and similar.

Ethnographic interviewing

“One of the beauties of ethnographic research is that as you learn you ask more questions and as you ask more questions you learn different things that send you off in different directions” (O'Reilly, 2009, p. 181). Indeed, after observations, the interview is considered the most significant technique to gather data in search for understanding and meaning (Fetterman, 2010) but, as O'Reilly pointed out it also can result in researchers looking wider afield in search of the less obvious. Visual observations enable researchers to describe actions and events, but do not provide the meaning of those situations from the participants' point of view. The latter can only be explored when the researcher engages verbally, through a range of techniques from formal in-depth face-to-face interviews to informal chats or casual conversations (O'Reilly, 2005). The author maintained that qualitative interviews are an ongoing activity in which the researcher uses any opportunities to explore the subjective meanings of actions and situations and to listen and learn from participants while being in the field. Brewer (2000) points out that the quality of research data obtained through interviewing depends on two main factors; the participant's ability to provide reliable descriptions of their actions, perceptions and feelings; and on the researcher's ability to ask appropriate questions that are not ambiguous and focus on the research subject. The importance of asking the right questions at the right time was emphasised by Giddens (1976) who pointed out that people frequently engage in actions under conditions that they themselves might not fully understand. Careful selection of questions is thus critical to ensure that participants do not feel threatened or put down. Indeed, questions and discussion should be kept at a level that participants understand and where interviews appear to resemble almost a natural conversation (Brewer, 2000). O'Reilly (2005) suggested that the ethnographic interview and observations are closely intertwined and that there might not be a clear distinction between the two. The author argued that interviewing and listening was ongoing, creating understanding and meaning of observed social relations and events, as well as raising the researcher's awareness of particular situations in the field that require increased attention.

However, there is also a place for a formal interview at a predetermined time, in particular in situations where there is an increased likelihood of interruptions in the field or the need for privacy as was the case in the current research. Formal

unstructured interviews allow for a more in-depth exploration of what is going on. Asking questions or clarifying meanings of specific observed events enables researchers to link understandings to contexts and situations and compare and contrast participants' perceptions with similar situations involving others in search for patterns and increased understandings (Fetterman, 2010). Interviews are an essential means to gain access to the 'inside' or the emic perspective (Brewer, 2000) to which I will turn next.

Etic and emic perspectives

Inextricably linked with all types of ethnography are the concepts of etic and emic, technical terms that are derived from linguistic studies and refer to *phonetics and phonemics* (Wolcott, 2008). Ethnography uses the etic and emic concepts to indicate whose perspective is represented. Analysing research data is making sense of research data and this occurs in first instance from the researcher's etic perspective (Carspecken, 1996). Observing phenomena and documenting these in the field notes is the first stage of analysis as the researcher tries to reconstruct the event in the mind's eye. Seeking clarification and increasing one's understanding of the variables from the perspective of 'the other' is crucial to ensure that the emic perspective is well-represented. However, it is the researcher's responsibility to make sense of collected data by overlaying it with a social scientific perspective (Carspecken, 1996; Fetterman, 2010). By moving between the abstract world of social theory and the living world of social practice, the researcher shapes and modifies conceptual frameworks. The etic perspective is thus a combination of the researcher's experiences in the field as reflected in the observations, the 'collateral' data obtained by being submerged in the field, the field notes which contain descriptions, reflections, hunches and ideas, the use of existing theoretical frameworks and social theories, as well as the emic perspectives of the participants.

The emic perspective is the insider's description and is the focus of most ethnographic studies (Fetterman, 2010). When exploring the insider's view, information is collected from the perspective of the participants without it being reinterpreted by the researcher. Applied to the current study, the emic perspective is elicited by exploring with the participants the meaning they give to a particular contextual situation, the background knowledge required, and the specific conditions needed to perform day-to-day nursing activities. The emic perspective is

exposed through informal discussions where the researcher listens rather than talks, and by eavesdropping when participants communicate with clients, colleagues, or other members of the multi-disciplinary team. This type of data is gathered through being-in-the-field, being connected with the participants, experiencing what it is like to be eight hours or longer at the bedside and through subsequent interviews seeking further clarification from the participants (B. Berg, 1998; Street, 1992). This is not to deny that there are multiple and sometimes contradictory views amongst the participants. If anything, it is the emic perspectives that reminds us of the multiple realities that are experienced in ordinary day-to-day situations. The richness of the data is a reflection of how each person carries their own luggage of past experiences, current beliefs, and preconceived ideas which influence how day-to-day situations are perceived and interpreted. It is these variations in perspectives that require the researcher to decide how much weight individual perceptions will be given, or as Denzin (1978) suggested, the researcher needs to '...weave and thread diverse and often conflicting reports into an accurate picture' (p. 319).

Researcher positioning

The type of observational strategies used depends partially on the contextual setting and partially on the researcher. Some settings, and some activities within these settings, allow more opportunities for the researcher to become involved than other settings. However, the researcher too influences the degree of involvement and hence the observational strategy that is being utilised. Knowledge of the setting, the activities, the people, and the researcher's attitude towards the participants play a determining role in any observational activities. Although Spradley (1979) believed that the ethnographer should start with a deliberate attitude of almost complete ignorance, such an attitude cannot be maintained by researchers who claim a degree of expertise or knowledge about the setting. In the latter situation pretending ignorance, or asking obvious questions, is not only inappropriate but could also result in participants viewing the researcher as deceitful and the research as unreal and 'make-believe'. Rather than claiming ignorance, understanding can be facilitated when the researcher is willing to let go of their own position and move freely between self and the viewpoints of the participants. Thus researchers, in particular those who have a degree of familiarity or knowledge of the area under investigation, need to identify

and be aware of their own taken-for-granted views and assumptions to ensure that they suspend their evaluation, and remain non-judgemental and open to the opinions, beliefs and practices of their participants. Carspecken (1996, p.189) refers to these movements when he stated that: "Understanding is intersubjective, not subjective or objective". By understanding the meanings and interpretations given to events or situations by others, and by comparing and contrasting these understandings to our currently held personal beliefs, one is able to come to a new or more refined understanding. Wolcott (1995) emphasised the importance of openness, stressing that the researcher ought to surrender to what the observations reveal rather than superimpose structure upon them prematurely.

Ethnographic analysis

In ethnography research, data collection and data analysis occurs concurrently and cyclically (Carspecken, 1996; Fetterman, 2010; Gobo, 2008; O'Reilly, 2009), providing the researcher with the opportunity to move freely between observations in the field and conversations with participants. Fetterman (2010, p. 93) maintained that an ethnographic analysis is: "... as much a test of the ethnographer as it is a test of the data", as the researcher needs to make sense of a vast amount of data which requires beside ethnographic concepts also elementary thinking skills. Looking for patterns of behaviour and patterns of thought expressed during conversations is a form of analysis.

Information gathered through observations, casual and focused discussions with participants and others, as well as contextual impressions and reflections on specific events form the basis for field notes. The writing of these field notes can be seen as the first stage of analysis as the researcher reflects on, and begins to interpret the events (Fetterman, 2010). Written documents such as patient files and interview transcripts all contribute to a data base which is continuously compared for congruency and contradictions between data sources and between participants perceptions and interpretations of situations. Interviews are analysed for recurring patterns that might contribute to the formation of main themes, but also for breakdowns (Agar, 1986). A breakdown occurs when expectations turn out to be very different, when an observed situation does not make sense or stands on its own. Breakdowns require the researcher to do something about it to come to a satisfactory solution, such as asking the participant how they interpret

the situation because context is socially constructed and maintained (Cortazzi, 2001).

Ongoing analysis allows for an emerging understanding of the phenomenon under study and guides subsequent data gathering to build coherent structures and to create increasing understandings. Carspecken's (1996) five-stage cyclical approach was utilised to guide the process of analysis. Each of the five stages is outlined below but it needs to be emphasised that especially the first four stages are not neatly ordered nor separated, rather they have broad overlaps and were utilised whenever it suited the situation.

Stage 1:

Fieldwork; observer/participant. This stage was concerned with recording 'what is going on'.

Stage 2:

Preliminary analysis of these observations (from the etic perspective) is utilised to establish how things fit together (reconstructive analysis). This activity is part of making sense of one's immediate environment.

Stage 3:

This is the collaborative stage. Although fieldwork and preliminary analysis are ongoing, dialogue with participants is the main tool during this stage as contextual understandings are socially constructed and interactionally sustained.

Stage 4:

Searching for, and comparing phenomena between different observations at different occasions/settings, and engaging in systems analysis by describing systems relations in a broader context are the main activities.

Stage 5:

Explain the findings by linking these to existing macro-level theories.

Reflexivity

The researcher is not a neutral observer; on the contrary any observations are interpreted and shaped by the researcher's understanding, past experiences,

biases, preferences, values, attitudes and culture. Reflexivity is the process of critical self-reflection undertaken by the researcher in order to clarify and evaluate one's role within the research process (Guba & Lincoln, 2008). The reflexive process is thus an instrument of ongoing critical engagement with the 'self', the researcher's own taken-for-granted views and being-in-world. Reflexivity in ethnographic terms is more than reflecting on, or 'looking back' at research interactions that have taken place, its aim is to create a deeper understanding (Scott-Jones, 2010). The reflexive process requires the researcher to be introspective, to justify why certain phenomena are illuminated while others are ignored (Rock, 2001). It demands that the researcher examines what their impact is on the research; how the researcher might have influenced the research process, the participants, and ultimately the research findings. Interpretive research contributes to the development of 'situated knowledge', which is knowledge that is firmly rooted in the social, cultural and historical context from which it has been developed (Haraway, 1988). Hence, clarifying the researcher's positioning within or towards the nursing locale is of crucial importance as it directly impacts on the knowledge development that arises from the research. In a sense, reflexivity is not unlike the bracketing process in phenomenological research where it serves to avoid the misrepresentation of phenomena (Jootun, McGee, & Marland, 2009). By making the researcher 'visible' through the reflexive process, biases can be exposed and the research strengthened.

Triangulation

In research, triangulation refers to the checking of one set of data against data obtained through other means in order to check whether any inferences based on one set of data hold true when applied to a different set of data, or against data obtained at a different stage of the research (Hammersley & Atkinson, 2007). If a significant degree of consistency is found when data, obtained through different collection techniques, are analysed and compared, the research can be judged more trustworthy (Guba & Lincoln, 2005). Flick (2009), maintained that all qualitative research is per definition multi-method in focus in an attempt to obtain a deeper understanding of the phenomenon as well as add rigor to the research process. Mitchell (1986) and Maggs-Rapport (2000) described four different types of triangulation to improve the trustworthiness of the findings: methodological,

investigator, data, and theoretical. Three of these strategies have been utilised in this study and are outlined below:

- *Methodological triangulation* which refers to using two or more strategies to collect data. I have observed participants in the midst of their practice, interviewed them with the aim to gain their perceptions of clinical practice, as well as utilised patient documentation.
- *Data triangulation* refers to using multiple data sources while focusing on the same phenomenon. In the current study I have interviewed Staff Nurses, Clinical Nurse Specialists, Charge Nurses and Clinical Educators which has broadened the data. Exploring perspectives and opinions of others indirectly involved in the day-to-day nursing care delivery will enrich and verify the data obtained.
- *Theoretical triangulation* is the testing of two or more theoretical models or frames of references by 'overlaying' them on the findings in order to test the degree of fit.

Research is considered credible when its findings and knowledge constructions are perceived to be conceivable by those who were involved in the development (Kincheloe & McLaren, 1994).

Using a theoretical lens as part of data analysis

The continuous cycle of data gathering, analysis, and reflexivity are the hallmarks of any ethnographic approach, and strengthen the link between research interventions and research findings (Savage, 2006). Analysis of research data can be further enhanced by viewing the draft findings through a different theoretical lens to illuminate the phenomena being studied. In this study structuration theory was used as a lens through which to view the findings.

Structuration theory lens

Structuration theory, and in particular Giddens' (1984) concept of locale as discussed in chapter one, provided a theoretical lens to view and interrogate the analysed data by exploring the very structures that are produced and reproduced by nurses themselves and which may limit nurses' ability to practice as an autonomous profession.

Structuration theory is a conceptual framework that proposes the duality of structure; structure as the medium and guide of social practices, and structure as the unintended outcomes of social practices. Giddens (1984) concept of 'structure' is based on the idea that rules and resources are the structural properties of social systems that enable and constrain social practices. According to Giddens, social activities are recursive, they are not 'invented' by people but rather these activities are continuously recreated, hence social practices are self-energising and self-maintaining and are at the basis of sustained or routine practices. Giddens (1976) maintained that social life is produced and reproduced under conditions that are not necessarily intended nor fully understood by the members who make up that society. Neither is this production and reproduction of social activities static and/or unchanging. On the contrary, Giddens emphasises its dynamic nature and maintained that in every act there are also the seeds for change, and hence social life is transformative and ever changing.

Giddens (1979) argued that 'structure' has a 'virtual existence' as 'instantiations' in the reproduction of social practices. While structure does not exist over time and space but in the moment, the here and now, it resides within the person as memory traces of how things ought to be done. In its totality, structures contribute to social systems. The longer certain social practices are endured, and the more widely these are practised, the more embedded these structures become. Giddens (1982) maintained that the most deeply-layered and wide-spread practices that make up these social systems are labelled 'institutions'. An example of such an institution would be language which has a solid base, is deeply ingrained, and yet adapts continuously to societal changes as demonstrated by new words and new meanings, and new ways of writing. Giddens (1982, p. 33) noted that when speaking or listening, a person draws on an 'absent corpus' of linguistic rules, both syntactic and semantic, in order to convey a message, but in doing so simultaneously contributes to the perpetuation of the language. The example of language as an institution is very useful. Not only do even the most embedded structures slowly change through the incorporation of new ideas and new practices, but they may also disappear altogether as has happened to many indigenous languages when people stop speaking in their native tongue.

Structuration theory enables us to understand that people create their own social system while at the same time being shaped by that very same social system.

Structuration theory places the social interactions (praxis) at the centre of its concern and it presupposes the performers (agents) to be on the outer, hence the core concern is not the individual but the recurrent social practices and their transformations:

The basic domain of study of the social sciences, according to the theory of structuration, is neither the experience of the individual actor, nor the existence of any form of societal totality, but social practices ordered across space and time (Giddens, 1984, p. 2).

Because of the 'flowing' property of social practices, actions should not be analysed as isolated single acts, nor as a combination of several acts, but as something that is an integral part of the person living in a specific context, influenced by time and space. Thus, social practices are always interwoven and always interconnected and therefore cannot be analysed as distinctively separate from the actor, context, time, or space. Giddens emphasised the importance of the place in which interactions occur and preferred to use the concept of 'locale'. Giddens maintained that 'place' is too limited as it tends to refer to the physical environment while 'locale' refers to the social settings of interaction. 'Locale' links a community of people together; the physical, social, cultural, spiritual, economic environments, religion, gender, working and living conditions, shared history and time, the temporal and spatial presence or absence of others. If social patterns are embedded in the realities of everyday life then time and space are important factors to be included. Time is a critical aspect because all current social practices have their roots in the past in the same way that all future practices will have connections with the present.

Giddens (1984) also uses the concept of reflexivity albeit differently from the way it is used in interpretive research. In the latter, reflexivity is the process of critical self-reflection, enabling researchers to examine and evaluate their role within the research process. In structuration theory, reflexivity should be understood as a process grounded in ongoing 'monitoring' of the flow of social actions. People, according to Giddens, monitor routinely their own actions within the social and physical context and develop an understanding of the reasons for their activities. Because social practices occur to a large extent in a taken-for-granted fashion and concern knowledge that is of a practical nature, Giddens (1984) called it 'mutual knowledge'. Giddens' concept of mutual knowledge closely resembles the concept

of 'practical knowledge' as discussed in the work of Argyris and Schön (1974). It is reflexive knowledgeability, the 'know how' rather than 'knowing that', which enables the recursive ordering of social practices. This is not to say that one will be able to provide detailed analyses of one's actions but, when asked, the person will be able to explain at least to some degree what is being done and why.

Power, according to structuration theory, relates to transformative capacity, the ability of a person to intervene in events or situations and alter the direction or secure specific outcomes (Giddens, 1981). Power relates per definition to relationships between people and it cannot be understood properly without the ever present notion of 'control'. Control refers to the ability to exert positive or negative sanctions. Furthermore, power is connected with 'resources' and the ability of actors to manage/control these resources. Structuration theory identifies two types of resources that generate power; control over the material world, referred to as allocative resources, and control over the social world, referred to as authoritative resources (Giddens, 1981). Because resources are unequally distributed, they are the cause for power inequality. Those who control the resources control the sanctions, and hence have political power, although this does not equate to having total control over those without power. Even in a subordinate position, the powerless still have at least some control over their own course of action because people are capable of 'acting otherwise' and thereby making a difference. The powerless are thus capable of using their limited resources to influence or alter conditions because those who are considered to have significant power are still dependent on the powerless to achieve their goals. As the scope of control increases in order to achieve specific targets, so do the opportunities of the powerless to resist and/or undermine it. Domination is thus not perceived by Giddens (1984) to be something imposed on the powerless, but rather it is tacitly accepted and mutually reproduced in all aspects of day-to-day life. Giddens referred to this as the 'dialectic of control' and he proposed that those in subordinate positions might have a greater influence in the social reproduction of the inequalities of power than those who dominate. Giddens comes to this conclusion because not only has the subordinate group accepted its position, but they contribute to the reproduction of a social system that locks them firmly into this social system.

Structuration theory has some congruencies with Sense-Making theory developed by Dervin (1992). Sense-Making assumes that humans move cognitively from place to place by means of 'constructings' which bridge the gaps of existence from self to others, to situations, and to events across time and space. Sense-Making deliberately turns nouns into verbs, to remind us that making sense is always in progress and that it is the active involvement of the actor-in-the-world that creates personal sense. Similarly, Giddens (1979) referred to the 'structuring' properties providing the binding of space and time in social systems but that these have no existence by themselves. Structures, or should I say 'structurings', appear, disappear, and reappear through the ongoing course of system reproduction: "Social systems would plainly not exist without human agency. But it is not the case that actors create social systems: they reproduce or transform them, remaking what is already made in the continuity of praxis" (Giddens, 1984, p. 171).

As my research will demonstrate, nurses reflexively monitor their own place in the bigger picture of nursing practice and language played a key role in this process. Language is the medium for describing feelings and perceptions, and it enables nurses to make sense of the situation. Making sense in this context refers not only to knowing what other nurses say, but more importantly understanding what they mean. This 'shared' understanding creates a bond between nurses, a sense of 'mutual knowledge' or 'know how', needed to manage the routines of nursing practice. Mutual knowledge is unquestioned, mostly unarticulated and taken-for-granted, but constantly utilised and modified by members in their day-to-day interactions (Giddens, 1984). Mutual knowledge is displayed in routine behaviours and daily nursing practices which could be observed effectively in the clinical setting, but it was also demonstrated through communication where half a comment was enough for other nurses to understand the lay of the land.

Summary

In this chapter I have presented and discussed the research approach selected for the current study. Following a short discussion outlining key differences between quantitative and qualitative research methodology, ethnographic methods including fieldwork, observation, ethnographic interviewing and data analysis were introduced. Particular attention was paid to 'focused ethnography' which requires a well-defined research question and a researcher who can claim expertise in the

area of study. As the use of focused ethnography presupposes that the researcher has an intimate knowledge of the field, alterity rather than strangeness is part of the equation (Knoblauch, 2005). Alterity refers to differences between settings and situations, differences between participants and/or differences between what participants say they do and what they actually do. Focused ethnography is well-suited to situations where there are constraints in terms of time and scope but it demands that the researcher is thoroughly prepared before the research is commenced.

The role and the place of the researcher during the observations was discussed as well as the importance to suspend judgement. The etic perspective is the researcher's perception of the phenomenon under study, and is the outcome of a continuous moving between the social world under study, the clinical setting, and the abstract world of theory. The emic, or insider perspective, is what ethnography is all about. It is a combination of the emic perspective, what the participants say, what the researcher experiences, observes, and understands, and the abstract world of social theory which enables the application existing theoretical frameworks and social theories.

The concept of reflexivity was outlined. The reflexive process allows the researcher to deliberately and consciously examine their own taken-for-granted views and being-in-world, and how these may have influenced the research process, the participants, and the research findings. The concept of triangulation was disrobed as a tool to add rigor and increase the trustworthiness of qualitative research findings.

Finally, the chapter concluded with explanation how the initial research findings were re-evaluated and re-examined by overlaying it with the structuration theory lens to examine how nurses themselves produce and reproduce the very structures that limit autonomous nursing practice.

In the next chapter I will provide an account of the conduct of the research including ethical considerations, research protocol and an introduction to the research participants.

CHAPTER FOUR

Conduct of the research

Introduction

In this chapter I discuss the protocols that were followed to ensure that the research was carried out in an ethical and responsible way. The process to obtain research approval is outlined as is the sampling strategy used to select research participants. Particular attention is paid to informed consent and it is noted that this study fits in the category of 'partially covert' research. Fieldwork, interviews and patient documentation form the basis of my data collection and each of these strategies is discussed. Attention is paid to the analysis of the data and to the techniques utilised to increase the trustworthiness of the findings.

Research approval

In order to safeguard ethical standards an ethics application was submitted to the Massey University Human Ethics Committee. After obtaining the Committee's approval, the research proposal was discussed with the Director of Nursing at the District Health Board (DHB), as well as with representatives of the Maori Health Unit. I supported my research proposal with a summary of the literature review that explored the teaching and utilisation of health assessment practices in clinical settings, as well as the result of a questionnaire which surveyed utilisation of newly learned health assessment skills in the clinical setting. I gained approval from the Director of Nursing and the Maori Health Unit representatives, and their letters of support were enclosed with the ethics application seeking approval from the Regional Ethics Committee. The Committee approved in principle but required written clarification on a number of issues. After receiving these clarifications, the Committee granted approval for the duration of two years (Ethics Reference No: 04/03/007). Finally, official permission was sought and obtained from the DHB allowing the research to take place on their premises. The ethical approval process was repeated when it became clear that more data needed to be gathered after the two-year approval period had expired (Ethics Reference No: 09/02/03).

Research setting

As discussed in chapter two, New Zealand has gone through a series of health reforms which culminated in 2001 with the establishment of 21 District Health Boards (DHBs) which provide hospital and associated health services within a clearly defined region. The current research took place in the base hospital of one DHB. The fieldwork was carried out in medical and surgical wards only. Apart from one ward, all clinical ward areas are situated within the main tower blocks which were opened in the 1970s but have since undergone major refurbishments. The ward not situated in the main building was built in the late 1990s and its layout is quite different from the other wards. This ward has only single and double bedrooms and is significantly smaller in size.

Sampling strategies

The sampling technique for participants in a focused ethnography is rather different from that used in a traditional ethnographic study. In the latter situation the researcher enters the field as a naïve observer and 'hangs around', or the researcher may get introduced to the research area by an 'insider'. Being around and showing an interest in what is going on is likely to result in people coming forward and volunteering information or being helpful in answering questions. In time this may lead to some people becoming 'key informants'; people who have insider knowledge of the setting and who may, due to their position, expertise, or networking skills, facilitate access to other members of the group and smooth the way for the researcher.

In focused ethnography, the sampling of participants follows a different pattern as the field visits are relatively short. Focused on a very specific and narrowly defined area of interest, data collection is intense and requires the researcher to have expertise in the area of study (Knoblauch, 2005). As a registered nurse I have worked in a hospital environment for well over a decade in a variety of positions, hence I am very much aware of the ward structure, how the ward functions, and the responsibilities of the different health professionals who frequent the ward. I was thus able to step into the field and be focused on my research interests once I found participants who were willing to share their nursing practice with me.

Flyers explaining the research were personally distributed to the wards which enabled me to explain the details of the proposed study to the charge nurses and

seek their support (Appendix Two: 'Request for research volunteers'). The flyer indicated that the research involved observation of clinical practice for a limited number of days followed up with an interview, and asked registered nurses with two or more years of clinical experience, and employed not less than 20 hours per week, to consider taking part in the research. The rights of research participants were noted including the right to withdraw at any time during the study, and the flyer contained my contact details as well as contact details of the research supervisor. Only general medical and surgical wards catering for adult patients were targeted. Clinical areas such as the Emergency Department, Intensive Care Unit, Post Anaesthetic Care Unit, and Paediatric Ward were excluded from the research because of the highly specialised nature of nursing care provided in these settings, the intensive medical input, or the involvement of parents as first care providers. With the charge nurses' permission, the flyers were prominently displayed in the nurses' stations, offices, meeting rooms, and on notice boards. Additional information sheets were stapled to the back of each flyer (Appendix Three: 'Additional research information for ward nurses'). These sheets provided more in-depth information about the protocol for observing nursing practice, and the need to access written patient information such as progress reports. The information sheet also provided assurances concerning my commitment to maintain confidentiality of the research data gathered and reiterated the rights of the participants.

I asked the charge nurses to mention the research during ward meetings or report time, and to draw staff's attention to the research notices and information sheets to increase their awareness of the study. In two or three wards I was given the opportunity to talk to staff for a few minutes during the afternoon hand-over report.

Only three volunteers contacted me by phone in the weeks following the display of the flyers. My goal during this initial phone contact was to secure a date/time for a meeting to discuss the research face-to-face. During the meeting I asked the potential participants about their awareness that the study involved observational fieldwork as I assumed that this might be the most anxiety-producing aspect of the study, but all three participants were fully aware of this. I discussed the need for the analysis of written nursing communication, and an in-depth interview at the conclusion to explore the individual's nursing practice, workload issues, and clinical decision-making. I answered any questions and ensured that participants had a

clear understanding of the research and their role in it. At a later stage in the research project, some staff members felt that such an initial meeting was not required as they had obtained sufficient information from others or because they had already decided to take part anyway.

However, in the early stages responses were not coming in fast and I decided to revisit the clinical areas that had not responded. I became quickly aware that staff members in these wards were not aware of my request for research volunteers. Staff told me that they had not seen the flyers, and the research was not mentioned or discussed during report time or ward meeting. I looked for the flyers but was unable to locate these. I asked the charge nurses concerned what had happened to the flyers and written information. In some cases the material could be located buried under a pile of papers and in some cases it had disappeared altogether. I provided new flyers and information sheets and made myself available to attend a ward meeting. However, this second approach was not very successful in terms of getting more volunteers, and only one participant was recruited.

Becoming increasingly worried about the lack of volunteers, I decided to contact the clinical nurse educators (CNEs) who were allocated to the general medical and surgical wards. CNEs play a key role in professional development and clinical teaching and have regular contact with individual ward staff nurses. CNEs are in an excellent position to draw nurses' attention to the research and encourage participation. It proved to be a good strategy as I got quite a few more participants in a short space of time. I was either contacted by the CNE with contact details of a ward nurse who had expressed interest, or the potential participants contacted me directly after having spoken with a CNE. I followed the same strategy as before by trying to secure an initial meeting to explain face-to-face the research. Three potential applicants declined to take part in the research after contacting me, two of whom did so after the face-to-face meeting. In all three cases it appeared that the observational component of the study was the reason or at least a major contributing factor for their decline. All participants were provided with consent forms during the first meeting but discouraged from completing these at that stage (Appendix Four: 'Consent form ward nurses'). Rather, the signed consent form was collected on the commencement of the first field day. This allowed potential participants extra time to make an informed decision without feeling pressured.

While the research was in progress a number of additional participants were recruited as a result of snowballing. These participants either joined the research after talking to other participants or they approached me during one of the many field days. In both situations the key aspects of the research were explained i.e. the need for observation of clinical practice and interviews, and participant criteria reiterated i.e. being a registered nurse working no less than 20 hours per week. All participants were also provided with additional written information. All in all twelve participants were recruited for the first stage of the research.

Ethical considerations

The Rights of the Individual

To be true to the philosophical underpinnings of qualitative research, I respected and affirmed the rights of the participants as autonomous and self-determining individuals during all the stages of the research process. I ensured that all participants were provided with written information, emphasising that participation was entirely voluntary. Participants could withdraw from the research at any stage without personal repercussions. Any questions raised were answered to the best of my ability. Signing the consent form did not alter the participant's right to withdraw from the research, restrict clinical access for observation, retract statements made at any stage of the participation, or decide to not complete the interview without adverse consequences. This right to withdraw was mentioned again at the start of the first observation as well as prior to the commencement of the interviews.

Anonymity and confidentiality

The ability to discuss issues in clinical practice and to share personal opinions, beliefs and values are a critical component of any research. Participants need to know that their identity will not be revealed and that it cannot be extracted from the data gathered. The identity of all participants has been safeguarded by using codes and/or fictitious names throughout the data gathering process as well as during the writing-up stage, while the true identity remained only known to me as the researcher. All patient names used in this research are also fictitious and in some situations I have changed information deliberately to make the identification of the clinical area and thus the participants more difficult.

The transcriber was required to sign a confidentiality agreement, which included a clause that once the information was safely stored by the researcher, the transcriber was notified to destroy any back-up copies from the computer (see Appendix Five: 'Confidentiality form for transcriber').

Informed consent for participants

While in contemporary research great emphasis is placed on 'informed' consent, the concept is difficult and problematic, in particular in regard to research that is carried out in complex clinical settings such as nursing. In order to undertake this study I felt that I could not reveal all the details of my research, as doing so would potentially have influenced the way participants engaged in their nursing practice. I raised this issue with both ethics committees and sought their advice. The Committees agreed that full disclosure could jeopardise the observations and gave permission to inform participants 'broadly' about the research without going into too much detail. The committees were of the opinion that the information provided on the flyer and the additional information sheet (see Appendices Two and Three), was sufficient for participants to decide whether to take part in the research or decline.

Participants were informed that I was interested in bedside nursing practice, in particular how nurses manage their workload, how they prioritise care, and how they make clinical decisions. Information was also provided about the nature of ethnographic research, including the format and duration of observations. Furthermore, the requirement for at least one taped interview at the conclusion of field work was also noted. No mention was made of my focus on subjective and objective assessments, the utilisation of health assessment skills, and the influence of assessment findings on subsequent nursing interventions. Because of these omissions, this study can be labelled as 'partially covert' (Sarantakos, 1998) and hence it can be argued that any consent cannot be truly labelled as 'informed'.

However, even if I had provided detailed information regarding my research, informed consent remains an elusive ideal. When participants agree to take part in a study such as this, neither they nor I know what lies ahead and hence, the exact nature of what is to be observed is per definition unknown. Will the participant still accept being observed when a sudden crisis occurs? Does an agreement to observe nursing interventions also include observation of interactions with

colleagues and other members of the multi-disciplinary team? What if this interaction with colleagues concerns a disagreement with, or a criticism of, the participant? Does consent include listening-in on phone calls to medical staff or attending family meetings? What about the rights of these other people? Should they be asked for their consent to be observed? Does consent include hand-over report time when all patients, including those who were never asked for their consent, are being discussed?

As the research progressed, I developed my own rules and used my own judgement as to whether I observed an activity or temporarily ceased my observations. These types of decisions were largely intuitive and contextually driven. Several examples spring to mind here; a female patient required an indwelling urinary catheter. I felt that little was to be gained from a research point of view to observe that particular intervention and hence I did not. On another occasion a participant was summoned to the office of the Charge Nurse to discuss an event that had taken place the previous day. The tone of voice and the non-verbals displayed were indicative to me that I should not attend that meeting. Another situation involved a disagreement between two staff members about a particular incident that happened earlier in the day. As the argument heated up I withdrew from the situation and decided to check out some files of patients who had agreed to take part in the study.

Informed consent for patients

While nurse-participants had agreed to take part in the study, it was crucial to ensure that patients gave their consent too. In order to protect patients from undue pressure to oblige, I arranged for participants to make the initial contact and explain their involvement in the research project. I assumed that patients would feel more at ease to decline when first approached by their 'own' nurse. Patients were informed that their care would not be any different because of the research and that any care would be carried out in the usual way.

Once verbal permission was obtained by the nurse-participant, I followed up a few minutes later by introducing myself to the patient. I discussed the research in lay terms and checked whether the patient had any questions or concerns. I reiterated that if the patient declined to take part, they would still have the same nurse and receive the same care, except that I would not be there to observe the nursing

interventions. Patients, who agreed to take part, were provided with a written information summary sheet for future reference (see Appendix Eight: 'Research information sheet for patients'). The information was read out in those situations where patients had difficulties reading it themselves. Only after completing these steps, were patients asked for their consent. The patient consent form asked permission for two separate issues. The first part of the written consent form asked for the patient's permission for me to be present to observe nursing interventions. The second part of the consent form sought permission to access the patient's written records, referred to as the patient's file (Appendix Nine: 'Consent form for patients'). Access to patient records allowed me to view written daily progress notes, vital observation charts, medication charts, a variety of nursing assessment documents, referrals, nursing care plans and so on. A total of 136 patients gave their permission. One patient declined to participate in the research, this was respected and upheld. Whenever a patient record was photocopied, I made sure that any identifiers were removed or made unreadable. Over the course of the research no patients ever denied access to their notes, on the contrary, many felt rather special to be involved in the study and may even have been disappointed that they were not interviewed. Four patients were excluded because of their level of confusion which made it impossible to ascertain whether these patients understood the research and were able to give their informed consent.

The research participants

Twelve registered nurses volunteered to take part in the research. All participants were female, aged between 24 and 56. The age average was 35.5 years. At the time the research took place four participants worked full time (40 hours/week), while eight worked part time varying between 0.7 (28 hours/week) and 0.9 (36 hours/week). Three participants held overseas qualifications (Diploma of Nursing, United Kingdom) while all others had New Zealand qualifications. Of the latter group one participant held a Diploma in Comprehensive Nursing while the remaining participants all had a Bachelor of Nursing qualification. Two participants started their nursing career as enrolled nurses before gaining registered nurse qualifications. One participant was actively studying for a post graduate qualification. One participant resigned suddenly from her position and moved to

another city before the interview could be arranged. The data gathered during the field observation of the latter participant has been included in this study.

When I recommenced the research I was concerned that nursing practice had altered, rendering my original data invalid. Following renewed ethics approval, I re-approached the nurse-participants who were still working at the hospital and asked for a follow-up interview. The main objective of these interviews was to determine whether the data gathered previously were still useable. I assumed that the remaining participants would be able to tell me whether there had been any changes over this period of time in either their own nursing practice, the working conditions in the ward, or any other factors that had impacted upon their nursing practice since. The finding that 'nothing' had changed in nursing practice, that ward nursing was 'the same as it had always been' meant that data gathered previously were still usable. However, there was also a consistent message coming through that ward staffing levels had improved and because of this, workloads had become more manageable. This notion was significant in that participants in the first stage of the study had consistently indicated their desire to change nursing practice, to spend more time at the bedside, and to utilise their health assessment skills more frequently in order to be able to provide person-centred care. Participants had expressed their dissatisfaction with ward nursing, in particular the high stress levels, the chronic lack of time to care for patients, and the constant need to engage in non-nursing activities. Three years on, as I recommenced my research, participants reported that the allocation of patients had been reduced on average by one patient per shift due to additional nursing staff being employed. Yet, to my surprise, participants expressed the same concerns; heavy workloads, lack of time, being too busy to engage in more extensive health assessments, and a focus on tasks rather than patients. Why were nurses not engaging in the nursing activities that they themselves considered important; why was there this apparent stasis in nursing practice that resulted in nurses continuing with the same ward routines despite their expressed dissatisfaction with it and in spite of slightly improved staffing levels?

These findings raised major questions and resulted in a new research aim to explore the reasons for the status quo in nursing practice despite an influx of new staff and nurses' ability to take agency, to shape their own nursing practice as autonomous professionals. Data gathering was expanded by interviewing other

nurses, called stakeholders, who had close working relationships with the registered nurses in the wards. Because of their close working relationships, stakeholders were considered knowledgeable and capable of providing a differing perspective on ward nursing. The stakeholders were contacted either via phone or email and on each occasion I explained what the research was about and invited them for an interview (see Appendix Six: 'Request for volunteers (key stakeholders)', and Appendix Seven: 'Consent form (for stakeholders)'). Seven stakeholders volunteered: one charge nurse, three clinical nurse educators, and three clinical nurse specialists. All participants were female, ranging in age between 42 and the late 50s. The higher age range of these participants is partially a reflection of the required years of clinical experience before reaching that level of seniority, and partially because careers might have been put on hold during the child-bearing/rearing years. While not all these participants held a nursing degree, all of them either were or had in the past completed papers at post graduate level.

Patient involvement

As discussed under the heading 'Informed consent for patients', patients were involved in this research as my field work focused on 'bedside' nursing practice. I observed registered nurses engaged in actual day-to-day nursing practice which included the full range of nursing interventions such as admitting and discharging patients, taking vital signs, providing hygiene care, assisting with mobilisation and toileting, administering medication, supporting/comforting patients, engaging in patient education, and dealing with families and significant others.

I informed patients that I was a registered nurse, that I might assist the nurse with some of the interventions, but that I would not undertake any patient care on my own or at my own initiative (unless the situation was deemed to be an emergency in which case I had to act as is expected of any registered nurse). The nurse-participant remained in charge of, and responsible for, the quality of care delivered at all times. Patients were not asked any personal questions as part of the research prior to, during, or after the observational period. All research-related questions were answered by me to the best of my ability but all patient- or care-related questions were answered by the nurse-participants. Whenever required as part of the data analysis, patients will be identified as nursing 'cases' rather than

'persons', and sex and age have in some situations been altered to make identification of patients impossible.

Methods of data collection

Fieldwork

I spent 41 days in a variety of medical and surgical wards observing actual nursing practice. A time frame for the observations was arranged with each nurse-participant. The observations covered several 8-hour shifts with each participating nurse over a period of time (two to eight weeks). Participants were observed for a minimum of three full days while carrying out their day-to-day nursing activities. Preference was given to observing participants on week days and during the morning and early afternoon shifts as these tended to be the more busy times. Only on a few occasions were the observations on successive days. At the conclusion of the field days each participant was interviewed which was tape-recorded and verbatim transcribed. Although it was my intention to do all the transcribing myself, I decided after five interviews that it was better use of my time to engage an experienced transcriber. This person signed a confidentiality contract which also stipulated the process for dealing with the data. All transcripts were returned to the participants for checking and approval for release of information.

To blend in with the regular nursing staff, I wore the standard nursing uniform supplied by the DHB. In line with the Ethics Committee requirement, I had a name tag which clearly stated that I was a Nurse-Researcher. Despite wearing this, there were regular occasions when I needed to point out to ward staff and allied staff that I was not a regular member of staff. I regarded this as positive because it demonstrated that I had 'blended-in'. My presence in the ward was seen as a normal occurrence and ward staff felt able to get on with their usual duties.

Doing fieldwork is not as straight forward as it may seem. I needed to find my place and role in the field. I had to relinquish control of the situation and accept uncertainty as my ever present companion. Each day was different and there was no way of predicting what the day had in store, or how things would work out. As I commenced my observations the most important thing for me was to figure out what my role as observer would be. I did not aspire to be a 'complete' observer as this would make me stand-out. The question was; how much should I become

involved in the day-to-day nursing activities? The continuum between observer and participant slowly shifted from observer-participant towards participant-observer as I became more familiar with the setting and the routines. However, any shift on the continuum towards more participation was also determined by the clinical situation at hand and my rapport with individual participants.

Given that many nursing activities take place in a well-defined space, participants and their patients will be very much aware of being 'watched'. Such awareness may create feelings of artificiality and/or raise stress levels. While I took great care not to cause anxiety, it is very likely that participants have experienced variable levels of additional stress because of my presence. The nature of fieldwork, having somebody present and observing continuously, must be an uncomfortable and at times anxiety-provoking experience for participants. The feeling of being 'evaluated' or 'judged', even though it was emphasised that this was not the aim of the observations, can be very threatening. Being a participant in this type of research requires a mixture of bravery and confidence in one's professional performance. The fact that I am a nurse-educator and have worked with many of the staff in varying capacities, added another complexity to the relationship. I believe that for some it may have been the reason to participate in this research while for others it will have been the deciding factor not to partake.

Depending on the nurse-participant, the workload of the day, and the patients allocated to the participant, I assisted with hygiene cares, mobilisation of patients, checking and administering of medication, or taking routine observations such as blood pressure, temperature, cardiac and respiration rate. This enabled me to experience even more closely the realities of day-to-day nursing practice while it aided in my attempt to blend into the nursing workforce. Being in a clinical setting with a participant does not exclude a researcher from seeing and hearing things that are happening in the wider context. On the contrary; when undertaking observations in the field one is totally immersed in the environment and hence confronted with a whole range of impressions that are not necessarily restricted to the research participants and their activities. Indeed, I witnessed other nurses' nursing activities, overheard discussions with patients or family, or snippets of phone conversations with doctors or other members of the multi-disciplinary team. Other nurses freely expressed their opinions to others or to me personally. I was present during many informal conversations held over a cup of coffee over the

morning break or during lunch time. All the observations, impressions, opinions and discussions made in this wider context have influenced this research. The additional information influenced the type of questions I asked or the way I looked at, or valued a clinical situation, and hence these wider observations are included in the research findings as they too are inextricably linked with, and have always been part of the nursing locale.

Field notes

The primary purpose of field notes is to record one's observations in the field as well as one's personal understandings of events and actions (Emerson, Fretz, & Shaw, 2001). During my observations in the field I carried a pocket dictaphone as well as a small note book and either was used to note more or less in chronological order the events of the day. In particular I recorded what I perceived to be 'significant' events because they either appeared to be 'typical', like the set routines in the ward, or the 'atypical' events like interruptions, tension-creating situations, or parts of conversations with participants, other nurses, patients, or members of the multi-disciplinary team that raised noteworthy issues. I recorded general and specific observations, feelings and impressions, and all of this in no particular format. For me the field notes served as an 'information container' to be sorted out and expanded on at more convenient time. On most occasions this sorting out happened on the same day at home when I transferred the taped and written recordings onto my database adding additional information as I recalled it. Inputting this data provided me with the ideal opportunity to reflect on the day in terms of how the day had been, what I had learned from my observations, from my participants, from all the formal and informal conversations. It also allowed me to reflect on the next field day, the observations I needed to concentrate on, the questions to ask or follow-up on. Writing the full field notes was a crucial activity as it served not only to document information for safe-keeping but it also functioned as a preliminary analysis of the data gathered, raising as well as clarifying issues of importance.

Interviews

All participants were interviewed at the conclusion of the observational period. The only condition placed on the venue was that the interviews needed to be held in a quiet environment without disruptions or distractions. Typically, date, time, and

venue were set by the participants during the final day of field observations. All interviews were either held on hospital premises or at the residential address of the participant. At the start of the interview participants were reminded of their right to refuse to answer specific questions or stop the interview at any point. As an ice breaker participants were asked to start the interview off by providing personal demographic data as well as recalling their nursing background. A limited number of predetermined questions formed the basis for the interview. These included such topics as; the participant's philosophy of nursing; how they saw their role and responsibilities within the ward setting, the way the ward 'works'; how the daily workload is managed; how clinical decisions are made; the role of nursing reports; and the utilisation of nursing care plans.

Being a registered nurse undertaking this type of research has distinct advantages. My previous nursing experience and continued involvement with nursing ensured that I had good insights into contemporary nursing practice and a feel for the 'situation on the ground'. Insight is crucial for understanding the different angles from which my participants discussed their experiences. It enabled me to question specific aspects of nursing practice, to listen to what the participant was saying and what remained unsaid. It enabled me to discover taken-for-granted views as well as situations considered 'irresolvable'. Most importantly, being a nurse enabled me more easily to understand the meaning behind what was said.

Following the observations in the field, participants were formally interviewed. Twelve tape-recorded interviews were conducted as one participant was interviewed twice due to running out of time. The interviews lasted from 48 to 82 minutes and all took place after the completion of observational fieldwork. Care was taken not to interrupt the flow of the discussion and clarifying questions were asked during natural pauses. The interviews were verbatim transcribed and a copy was returned to the participant for checking. Participants could make changes to the transcript if they felt that what they had said did not truly reflect their intent. By doing this, I acknowledged not only the importance of the participant's input in the research but also that the meaning of what they wanted to say was more significant than what was actually said at the time of the interview. Apart from some minor comments and clarifications, no requests for changes to the transcripts were made.

Although I had a break from my study, it did not stop me from reflecting on the research and preliminary analysis. Thinking about my research aim to explore health assessment practices and the impact on ward nursing practice, I experienced varying levels of anxiety how I could precede given that observation in the field showed little utilisation of health assessment skills and participants indicated that it was most times not seen as a priority

Four of the original twelve participants took part in another interview when I recommenced the study three years later. In preparation for the interviews, participants were provided with the transcripts of their first interview. The intention of this second interview was to ascertain that the information provided three years earlier was still trustworthy, whether participants' views and opinions expressed in the first interview were still valid or whether changes in ward nursing practice had rendered the interviews out of date. This information was crucial in order to establish the ongoing usefulness and accuracy of previously collected data. This second interview also provided me with the opportunity to ask additional questions regarding the use of nursing documentation, the link between nursing assessments and care plans, and whether ward nursing practice had actually changed over the past three years.

I shared with the participants a description of a 'typical nursing day' in the ward (Appendix 1). This description was a summary of my observations, understandings, and experiences during my fieldwork. This was another approach to find out whether previously gathered observational data were still an accurate reflection of today's ward nursing practice. Furthermore, I planned to have two to three focus group meetings with staff nurses from the medical and surgical wards who had not previously been involved in the research. The main aim of the focus group meetings was to share the preliminary findings from the original data set with a wider audience and to seek feedback regarding the accuracy and relevance of these findings given the current clinical context. The second aim was to explore the nature of any changes in ward nursing practice over the past three years, or the potential existence of a status quo. Despite several visits to the wards explaining the research and asking for volunteers to take part in a one-off meeting, no volunteers came forward. Some of the feedback that I received at various stages was that it was too difficult to get a group of registered nurses together after work, even a small group, as everyone had different shifts and different

commitments after work. A second attempt for focus group meetings was made a short time later when I obtained permission from several wards that up to half the time required for the meeting could be duty time. This could be achieved by arranging for the meeting to start during the last 30 minutes of the duty while participating nurses would attend the remainder of the meeting time in their own time. Unfortunately it was not possible to reach an agreement amongst staff for a date/time that suited even a relatively small group, and furthermore, there was a degree of scepticism as to what difference the research would make to future nursing practice. Much to my disappointment I had to give up my efforts to gather additional data through focus groups and the meetings never took place.

Beside focus group meetings, I also planned to interview stakeholders such as charge nurses, clinical nurse specialists, and clinical nurse educators. I believed that interviews with these particular staff members would provide a broader picture of nursing practice in medical/surgical wards and provide, to some degree at least, a view located between the emic and etic perspectives. Stakeholders were personally approached by means of a visit, or via phone or email. In all cases I explained my research and asked for their willingness to participate. Some stakeholders were very forthcoming and readily agreed to take part while others avoided an answer, asked for time to think about it, or mentioned that they were too busy. In the final count seven stakeholders participated; one charge nurse, three clinical nurse educators, and three clinical nurse specialists. All stakeholders were individually interviewed and were presented with the same concise written description of what it is like to be a nurse in the ward. Stakeholders were asked whether they believed that the description of a 'typical nursing day' was an accurate reflection of contemporary nursing practice. Having analysed previous interviews, questions focused on the apparent lack of change, the status quo within the wards, the role of the charge nurses, and the ward nurses' ability to create change, to be in control of their own nursing practice. As with all previous interviews, discussions were tape-recorded, verbatim transcribed, and returned to the interviewees for their feedback and approval. All taped interviews were securely stored under lock and key.

Documentation

Patient documentation provided insight into health assessment practices and patient care, and as such it contributed additional data to my observations in the

field. Nurses spent a significant part of their day recording patients' vital signs and other observations, documenting progress, as well as the type of care provided over the duration of the duty. Primary records such as nursing assessment charts, TPR charts, nursing care plans, and clinical progress notes were examined in terms of health assessment skills utilisation and copied for analysis as entries in such documents ought to be an accurate reflection of what has happened to the patient on that particular day. Utilising a combination of documents containing key patient information, together with actual observations of the care delivered has the potential to create a more comprehensive 'picture' of the clinical field under study. Furthermore, it is assumed that those aspects of patient care and progress that nurses report on and document are reflective of the importance attached to it. Patient documentation was also utilised during the interviews to help guide questions in regards to clinical practice, the use of care plans and assessment activities. All copied patient documents were stored under lock and key.

Data analysis

Using an ethnographic approach, the process of data collection, coding and analysis occurs simultaneously (Fetterman, 2010; O'Reilly, 2009). Any data gathered, be this through observations, informal discussions with participants and others were recorded in my field notes as soon as possible in order to increase recall accuracy. Personal impressions of, and reflections on, situations and events were enriched with descriptions of the context. This, together with selected patient documentation such as progress reports, nursing care plans, referrals, various assessment documents and charts, as well as interview transcripts formed the basis of the research data which were analysed for commonly recurring themes and breakdowns. An example of a breakdown was the frequently mentioned notion that nurses ought to focus on patient needs and yet much of the care was standardised general care that did not necessarily take into account unique individual needs. As outlined in chapter three, Carspecken's (1996) 5-stage approach to research data gathering and analysis was utilised. However, these stages should not be seen as an organisational guide one has to adhere to in some sort of linear way. Rather, the stages serve to explain the components of research process 'in theory' more so than the actual research application. Ethnographic research is fluid and flexible which enables it to respond to changing

contexts. Often different stages of the research process were being utilised concurrently depending on the situation and the wider context.

This research typically commenced with fieldwork in which I observed nurse-participants during their 8-hr shift in the ward. My initial focus was on recording 'what was going on' in the clinical setting, but often, as the day progressed, my participation in nursing interventions tended to increase. This resulted in me becoming much more a part of the nursing team. Being in the midst of day-to-day ward activities, I was able to build up a primary etic record of nursing practices.

Maintaining field notes was an important tool as writing down the observations and describing events and situations from my own (etic) perspective helped not only the reflexive process, which I will describe shortly, but it also contributed to the preliminary analysis. Writing field notes enabled me to put things in some sort of order to make sense of it all. As I wrote, I tried to understand the actual role of the ward nurse, determine what nursing activities were considered important and/or what nurses saw as their responsibility. In particular, I examined how the ward environment enabled or constrained nursing activities related to health assessment. These preliminary analysis were influenced by my personal nursing experiences, my knowledge of the ward area and the nurses, as well as by my own assumptions and personal beliefs.

Besides the observations and the field notes, dialogue with participants was crucial. Rather than making assumptions about the participant's perception of an event, I needed to gain an understanding through collaboration and dialogue. Formal and informal discussions were the key strategies to create that understanding. Listening to what was going on, how participants felt about situations, or how they saw particular events. This ongoing dialogue and asking contextually-focused questions generated a wealth of emic data.

Common themes developed as I started to compare and contrast observational data obtained at different times and days, and involving one or more participants in the same ward, as well as different participants across a variety of ward settings. This approach enabled me to describe and analyse nursing practice within the broader hospital context. It was in particular at this stage of the research process that the theoretical concept of 'locale' came to the fore.

Research themes

As the research progressed a number of themes developed which increased in significance as more data were gathered. *TrendCare*, a computer-based workload measurement tool was one of the earliest themes. Participants argued that despite its inaccuracies *TrendCare* determined the amount of time nurses could spend on interventions based on standardised tasks, rather than patients' individual health needs. *Documentation* was another recurrent theme with participants expressing concerns about the steady growth of forms and charts and the exorbitant amount of time needed to comply with the administrative requirements. The use of *standardised nursing care plans* was seen as a task-focussed approach to nursing which effectively reduced the need for nurses to engage in comprehensive patient assessments and subsequent clinical decision-making. Participants' comments about not feeling in control of their own practice, of nursing being increasingly directed by document-based standardised protocols, contributed to the theme of *professional autonomy*.

Time, or more precisely the *erosion of nursing time*, was a major theme. Participants noted an increasing expectation for nurses to compensate for system failures by engaging in *non-nursing activities* to ensure smooth running of the ward. The *continuous flow of interruptions* to nursing practice also contributed to the erosion of nursing time. Not only impacted these interruptions by other health professionals and health managers on the amount of time nurses had available for nursing interventions, but it also impacted on how nurses valued nursing and how they saw themselves as health professionals. Related to this theme were staff relationships which covered such issues as nursing leadership, the role of the charge nurse, collegial support, feelings of disempowerment and horizontal violence. Ward structure and the existence of fixed ward routines were readily identified as both helping and hindering nursing practice.

The reflexive process

In chapter three I described reflexivity as a process of critical self-reflection, where the researcher clarifies and evaluates their own position, role, and responsibilities within the research process. Being reflexive is thus a tool for critical engagement with the 'self', an introspective gaze that enables the examination taken-for-granted views about ward nursing, professionalism, nursing values and beliefs, hospital structure and management. Although I started off with a separate log to document

my interpretation of this nursing world, once I commenced my observations I found myself writing reflective thoughts in my field notes, often woven into my descriptions of my experiences in clinical practice. I felt that this was much more effective as I could place my feelings and perceptions into the contextual situation from which they arose. Thus, when I became aware of my own discomfort in the clinical setting, I tried to explore through the reflective process to find answers. In particular at the start of my study I reflected on my role as researcher and observer. I thought about how I should behave in order to be unobtrusive. How did I know that I was observing nursing activities that participants would also have carried out had I not been present? I was unsure about my observational abilities as a researcher and at times I had doubts about my research aims. What if nurses do not engage in health assessment practices? Will I be able to pick up on the subtle signs that might indicate that the nurse is engaged in inspection as part of the health assessment? I became aware of my own discomfort in the clinical setting and tried to find answers for this feeling which was not helped by some comments made in the clinical setting.

Following the morning report I was asked by a care assistant why I was there. I said that I was doing research for my study and that I was observing nurse A for the day. She then asked some questions about the research which I answered. Two RNs who had listened in on the conversation commented to each other loud enough for me to hear, that hopefully I would examine workload issues. I replied to them that this was not really the focus of the study although it was possible that I might have to look into that as well. They looked at each other, shrug their shoulders, and while walking out of the office, they loudly proclaimed that there was nothing worth researching as far as nursing was concerned. (Field notes Amy)

This discussion early in the research project made me reflect on the challenges of fieldwork, in particular on the perceptions that some ward nurses might have towards research. It made me think about why some nurses were sceptical about the outcomes of research in terms of their impact to change nursing as a profession. Right from the start of my observations I had noticed the constant pressure nurses were under to get the work done on time, the business of the ward that required everything to be done in a rush, and the continuous noise levels of people coming and going and phones ringing. Their comments also increased my awareness of a sense of frustration that some nurses experienced with their conditions of work and how this can result in negative feelings towards the researcher and or the research itself. These nurses' comments might explain to

some extend the difficulties I experienced in getting nurses interested in participating in the study.

Throughout all stages of the research I engaged in continuous reflexive thinking by examining my role in the research, my presence in the field, and my perceptions, assumptions and beliefs concerning ward nursing. As I read the transcripts, I reflected on my interview technique, the questions I asked and the responsive I received. During the writing up phase I procrastinated for weeks as I struggled with the question how I was going to present the data in a way that showed my respect for the nurses who took part in the research. I reflected on the actions of individual ward nurses and their contribution to patient care as well as on the demands placed on nurses by changes in health care delivery and growing institutional demands to comply with requirements that are limiting patient contact at the bedside.

Triangulation strategies to increase trustworthiness

In research, triangulation refers to the use of multiple data sources and methods of data gathering to increase the trustworthiness of the research findings while providing rigour to the research process (Guba & Lincoln, 2005). Triangulation reduces the potential risk for researcher bias creeping into the research outcomes. The current research uses several strategies to increase trustworthiness. Discussions were held with participants as to what was observed and what it might mean. These discussions served to reduce the tendency of making assumptions and hence contributed to the trustworthiness of the data gathering. Participants were also asked to check and correct verbatim transcripts to increase trustworthiness.

Data triangulation was implemented which involved checking one particular set of data against another set. In this research, data gathered from observing one participant were compared and contrasted with the data gained from observations involving other participants. Data gathered from participants working on the same ward were analysed for congruencies and inconsistencies and in turn these were then compared for similarities and differences with the observations undertaken in other wards (environmental triangulation). Formal interviews and informal discussions were broken down into 'focus areas' such as ward nursing practice, ward routines, managing time, ward management, ward leadership, organisational

structure, and decision-making capacity and analysed in-depth to get a feel for, and a better understanding of, participants' role as a ward nurse. Again, the data obtained were compared and contrasted with the information received from the other participants.

Triangulation also involved using different data sources from the same participant to establish consistencies and/or incongruencies between the different sources, known as methodological triangulation. Observation information pertaining to an individual participant was cross-checked against information received through informal discussions when seeking clarification during the field observations or during the final interview. This data was subsequently compared with the participant's written patient reports as well as their verbal hand-over reports at the conclusion of the shift. All of this data was then compared and contrasted with that of the other participants working in the same ward and with data obtained from different wards. It is crucial to use multiple data sources and to actively search for patterns in the data that may challenge interim research findings, as well as converging patterns that support the findings (Lather, 2003). The main goal of triangulation is to check whether any inferences based on one set of data hold true when applied to a different set of data, or against data obtained at a different stage of the research (Hammersley & Atkinson, 2007). The finding that the research data were still considered accurate and reflective of current nursing practice despite a lengthy pause in the research strengthens the trustworthiness of this research. Data credibility was further enhanced through face validity; sharing data and aspects of the research findings with a sub-sample of participants. When participants can find themselves back in the description of the locale, the work routines of the ward, and the interim findings of the research, then data credibility is established.

Theoretical triangulation was achieved by involving stakeholders in the research. Not only did these stakeholders contribute to the research as the ward nurses had done, but they also commented on the interim findings from their perspective as senior nurses who are knowledgeable about the inner workings of the ward because of their position and clinical responsibilities. Indeed, each of the stakeholders contributed to the locale of ward nursing from a different perspective depending on their area of professional expertise and clinical role in the ward. Likewise, sharing my research findings with my supervisors and debating what it all

means and how the data might be interpreted was part of theoretical triangulation and contributed to further strengthen the trustworthiness of the research findings.

Trustworthiness is confirmed when the findings of this research are accepted and confirmed as a fair description of what clinical nursing practice is all about in these particular settings.

Summary

In this chapter I have outlined the research methods utilised to study nursing practices within medical and surgical wards in a middle-sized regional public hospital setting. Approval for the research was sought and obtained from university and regional ethics committees as well as the District Health Board which is responsible for the health services provided. Selection criteria and sampling strategies used to attract participants have been outlined. The procedure followed to obtain informed consent from both nurse-participants and patients has been discussed.

Particular attention was paid to the application of observational field work as one of the methods to gather data. Different ways in which observations can be carried out were outlined and the advantages and disadvantages were discussed. Observations occurred along a continuum between total participation and total observation, depending on participants and contextual factors. The use of interviews and the analysis of written patient records have been discussed as additional data-gathering strategies as well as methods to increase the trustworthiness of the findings. Twelve ward nurses took part in the research project. After a break of three years, four of the original participants were re-interviewed to establish whether previously collected data was still trustworthy and applicable to current ward nursing practices. These interviews also extended the data base by re-exploring specific aspects of participants' professional practices. In addition, seven stakeholders, one Charge Nurse, three Clinical Nurse Educators and three Nurse Specialists were interviewed to provide additional information and create a broader picture of ward nursing practice. Finally, this chapter outlined the preliminary data analysis that contributed to the major themes of this thesis and the strategies employed to increase research trustworthiness.

CHAPTER FIVE

Nursing practice within a ward setting

Introduction

In chapter two I provided an historical overview of the development of health care services in New Zealand, arguing that decisions made at the policy or macro level had a significant impact on nurses and nursing services. I noted that this impact was almost never considered in the decision-making processes. The environment for nursing service delivery in acute medical and surgical settings has undergone particularly substantial changes following the health sector restructurings in the 1990s and my data chapters now turn to explicating the impact of such changes. I will first examine the ward setting in more detail in order to understand how nurses are currently nursing within this altered environment.

Consistent with an ethnographic approach to research, a detailed description of the physical structures in which patients are nursed is provided. A discussion on the lay-out of the ward is important for this study in order to understand that the design of the ward contributes to, and influences the way nurses interact with patients and deliver nursing care. A detailed description of an 'ordinary' nursing day in a medical/surgical ward is then provided. This description is a distillation of all the field observations which took place over a period of more than one year in six different clinical areas.

The hospital

The study context is a middle sized hospital of approximately 400 - 420 beds, and services a city of approximately 80,000 people and a regional population of about 160,000. The hospital provides for a wide range of medical and general surgical services, and acute trauma services and is a teaching hospital providing regional services in oncology, breast screening, haematology, and renal services. The hospital offers intensive care, neonatal and coronary care services. The majority of the in-patient wards are situated in the two tower blocks, with each block having four floors of wards. Additionally, a small number of wards are located in other

single and multi-storey buildings. An extensive network of corridors, staircases, and elevators ensures that all parts of the hospital are well-connected with each other.

The physical layout of the ward

The wards where I conducted the research are all but one situated in the main tower blocks and while there are minor differences in the lay-out, they are basically similar. A floor plan of one of the wards can be found in Appendix Ten. All the adult medical and surgical wards have a main corridor that runs in a straight line through the entire ward. The ward can only be accessed via this corridor which has lockable double doors on both ends. During the day these doors are usually left unlocked apart from a 60 to 90 minute period after lunch to provide a rest period for patients. For security reasons the doors are locked after evening visiting time and during the night. Once locked, entry can only be gained with electronic access cards. Visitors and non-staff members need to ring the bell and seek permission to be let in by a ward staff member.

On the left-hand side of the corridor there are a series of utility spaces as well as four single bedrooms. The first door on the left hand side is the interview room which is used for families and staff to meet and discuss patient issues. This room is also used for the hand-over report at the end of the day shift. Other rooms found on this side of the corridor are the Charge Nurse's office, and a patient treatment room (although in some wards the Charge Nurse's office is located outside the ward). Further along is the clean utility, a storage room for sterile consumables like dressings and dressing packs, irrigation fluids, urethral catheters, but also equipment such as dressing trolleys. The dirty utility is a space where bedpans, urinals, washing bowls and so on are cleaned after use and stored. This space also stores the equipment to test urine and faeces. Bags with dirty linen and ward rubbish are temporarily stored in the dirty utility room while awaiting collection. In a number of wards the ward kitchen, narrow and small, is halfway up the corridor. No food is prepared here apart from hot drinks such as tea and coffee. The kitchen has a fridge, mainly to store dairy products and a microwave oven for warming up the occasional meal when a patient's meal time is delayed. Half-way along the main corridor and close to the nurses' station, the first of four or five single patient rooms can be found while the last of the single rooms is at the far end of the ward

corridor. The corridor itself is wide and provides ample space which is required for the transfer of beds in and out of the ward. The floors of corridors and patient rooms are covered with linoleum while the walls are painted with an off-white colour. On several places in the corridor pictures, paintings or posters brighten up the walls. Although all the rooms have doors, these are almost always wide open, allowing passers-by to get a glimpse of the occupier and decor of the room.

There are six multi-bedded bay rooms situated on the far right side of the corridor which are intersected in the middle by the nurses' office and the medication room which split the ward in two halves, each containing three multi-bedded rooms that accommodate four or five beds. Each set of three multi-bedded bay rooms are interconnected via a secondary semi corridor that can be accessed from the nurses' station and from the far sides of the main corridor. Traffic flow in the secondary corridor is intensive at certain times of the day. Patients located in these rooms are exposed to significant noise levels. Situated between the secondary and main ward corridors are two service blocks containing male and female patients' bathroom and toilet facilities.

The open space in the middle of the ward between the two service blocks is taken up by the nursing station situated in front of the medication room and nurses' office. The nurses' station faces the main corridor while two corridors branch off the main corridor on both sides of the nursing station to provide access to the secondary corridors. The station itself has a U-shaped counter and serves as an information centre for patients and visitors. The area contains a number of chairs and writing spaces and is therefore frequently used by the nursing staff to read patient files or to write patient reports. The area is not suitable to discuss patients, firstly because it is a public area readily accessible to patients and visitors, and secondly because it is completely open and hence the sound of discussions travels well beyond the nurses' station. The ward clerk has a permanent space in the nurses' station and answers the ward phone on week days during 'office' hours (between 8am and 4:30PM). Some trolleys, weight scales, emergency trolley, electronic equipment for measurement of vital signs and a variety of other equipment can be found close to the nurses' station. There is a linen room on one side, and a storage room for stationary and other small items on the other side. At the far side of the ward is the last of the interconnecting corridors leading to the multi-bedded patient rooms.

The medication room is situated in the middle of the ward behind the nurses' station. Here all the ward medication is kept under lock and key. The room is also used as a storage facility for syringes, injection needles, and intravenous fluids. Ward nurses can enter the medication room with an electronic access card. Staff without such access arrangements can only enter if they are let in by any of the ward nurses who do have an access card. From inside the medication room the door can be opened without the need for such a card. While the security surrounding the storage of medication is considered standard protocol in contemporary ward nursing settings, it has placed a major strain on medication administration and contributed to increased disruption to the flow of nursing practice. The medication room has been fitted with a maximum of bench space which is important as this serves as a work area where nurses set out the prescribed medications for their patients. The size of the room allows for three to four nurses to comfortably work side by side without being in each others' way but as my observations showed, at peak times there were far too many nurses vying for the bench space resulting in chaotic scenes.

Although the physical lay-out of five of the six clinical areas was quite similar, each area was a unique entity in its own right. Factors that contributed to the uniqueness of the clinical area are the types of patients, the range of medical conditions, and the collegiality amongst the nursing staff. All areas used in the study catered for male and female patients. At the time of the observations patient acuity was high most of the time while the occupancy rate was often 100 percent.

Wagenaar, a leading architect in hospital designs, was critical of many hospital designs which he believed did not contribute to a healthy environment for patients or a good working environment for nurses (Wagenaar, 2005). A ward, designed with nursing in mind, needs to take into account what nurses do and how they work. Such a ward lay-out would ensure an easy overview of the ward from a central nurses' station, and a floor plan that would significantly reduce the walking time between patients and other facilities, enabling nurses to spend the maximum time with the patients. The common rectangular wards with long main corridors require nurses to walk significantly more than radially designed wards with the nurses' station in the centre (PricewaterhouseCoopers LLP, 2004).

When examined from the perspectives outlined above, the wards in which I carried out the observations were not particularly nurse-friendly. The size of the single and

the multi-bedded rooms was cramped and while the space between the beds of the multi-bedded bay rooms might have been sufficient two decades ago, in contemporary nursing practice the space is no longer adequate. The increase in acuity levels means that inpatients are much sicker and more dependent on nursing care. Risk management policies, as outlined in the hospital procedure/policy documents, require nurses to utilise technical aids when transferring patients or when assisting with their mobility. The space in the multi-bedded rooms was frequently insufficient to accommodate the bigger pieces of equipment. Even the larger-sized walking frames presented challenges in terms of safe use as the limited space was already clogged up by other equipment. The situation was no better in the single rooms where the transfer of a patient from a trolley or bed onto the ward bed required nurses to largely clear the room of furniture, and turn the bed 90 degrees in order to create sufficient space to align the beds side by side to allow for a safe patient transfer.

Having multi-bed bays without doors, combined with the nurses' habits of leaving most doors wide open, contributed to much unnecessary noise and movement, and reduced patients' level of privacy. None of the wards had a system that indicated in a central place such as the nurses' station and/or above the entrance to patient areas, whether there was a registered nurse in the area. The nurses' station, while located in the centre of the ward, was surrounded on three sides by the medication room, nurses' office, storage room and linen room, effectively blocking any view of the main nursing areas, the main corridor and the access doors on either side of the ward.

The stretched-out ward design was not nursing-friendly in that nurses had to walk considerable distances. More than 50% of the ward patients are located in a part of the ward that is the furthest distance from the clean and dirty utilities, two areas frequently used by the nurses. Access to both service blocks, containing patient toilets, showers and bathrooms, was only from the main corridor which was the furthest distance away from the multi-bedded rooms where the majority of patients were located. As a result nurses were not only required to walk around the block, but they were also physically much further separated from their other patients while using these facilities. Collecting bed linen, towels and other clean linen items presented similar issues. Clean linen was centrally stored in a walk-in cupboard next to the nurses' station. Its single location required nurses from all over the

ward to walk many times a day to this one place to collect the linen. Two smaller linen cupboards located closer to where the majority of the patients are situated would have reduced the amount of walking considerably. Hence it would make sense to consult with nurses when designing their work space in order to reduce unnecessary walking while improving the central oversight of nursing activities and visitors flow. However, despite existing research emphasising the need to involve nurses, they are rarely consulted regarding the lay-out and construction of their own workspaces such as hospital wards (PricewaterhouseCoopers LLP, 2004; Walenkamp, 2005).

In the next section I provide a detailed description of an 'ordinary' nursing day in a medical/surgical ward. The description is based on my observations and interpretations of what was going on, but also my increased understandings as a result of informal discussions with participants and other nurses at the time of my observations. Where appropriate I will include excerpts of field notes and also interview data to provide an emic perspective of an ordinary day on the ward.

An ordinary day in the ward

The hand-over report

I arrived in the ward at about 6:50am and waited in the nurses' office. There were already four nurses present, one of whom asked me whether I was an extra nurse. I explained that I would be observing nurse Elsie for the day and that this was part of a research project. No other questions were asked and while I waited more staff arrived for the morning shift. Elsie arrived and after initial greetings I asked her who her patients would be for the day. Elsie was not sure and answered that she hoped that it would be the same patients as yesterday. The nurse in charge of the night shift sat behind the computer and it took a short while before she announced that she had sorted out the allocation. She announced that most nurses would have five patients as a minimum while some would have six patients for the day. She placed a printed document on the table so that all the day shift nurses could have a look to see who their patients were for the day. They circled or tick the patients on their individual 'patient status report', a printed one-page document that contained the names of all the current patients in the ward, their location (room number) as well as the main diagnosis. On the flipside of this page most nurses tended to write the names of their allocated patients and drew lines so they could write down any important information as well as the timing when specific procedures needed to be done (this included the timing of medication administration). Now that all nurses knew who they would be caring for, the taped hand-over report was commenced (7:10 AM). The report was very quiet with nurses busily writing down the information given

to them. There was no verbal communication between the nurses while they listened, although there was the occasional laugh or head shaking. Sometimes there was only 'the look', a quick eye contact between two members of staff as if they disagreed with what was said on the tape. I noticed that most nurses made minimal notes concerning the patients who were not allocated to them. However, more extensive notes were made when the information concerned patients allocated to the nurse. Additional information pertaining to their patients was written on the blank flip side of the report sheet with nurses dividing the blank page into columns and writing their patients' names in the first column prior to the start of the report. The taped report took 15 minutes and finished at 7:25AM after which the nurses looked for, and collected their patients' files in order to read them. (Field notes Elsie)

The hand-over report was the first activity nurses engaged in at the start of their duty. For the day shift this means nurses coming together in the ward office at seven o'clock in the morning to listen to the taped patients' reports. The office is not overly large for the number of staff gathered and neither are there sufficient chairs which resulted in nurses having to stand during the report, while others were leaning against the wall or partially sitting on the window sill. Prior to seven o'clock each night nurse had recorded on tape the health status and condition of the patients they had cared for during the night as well as completed a written progress report in the patients' file. The sound quality of the tape was only moderate and required listeners' full concentration to hear what was being said. This was even more important when the nurse on the tape spoke with a strong accent. Some nurses took occasional notes while the report was in progress but the nurse allocated to the patient being discussed was the one taking the most extensive notes. Key points of the verbal handover were noted on the reverse of the patient status report. In particular information regarding treatments such as administration times of intravenous medication and fluids, appointment times for special investigations/tests, and various other tasks that had to be done were recorded after the patient's name and where possible in the column representing the correct time. As nurses kept these patient status reports with additional hand-written notes of tasks-to-be-done in their pockets, I will refer to this document from now on as 'pocket notes'.

The use of pocket notes for the documentation of the task aspects of the hand-over report was observed in all the clinical areas where fieldwork was conducted. By focusing on the tasks rather than patient's health status and assessed needs, workload planning and subsequent nursing interventions became very procedural

and task-oriented. This approach to nursing created the impression that the execution of the task was the focus of attention rather than the patient, resulting in a situation where nursing interventions are done to the patient rather than with the patient. And indeed, as I will demonstrate in my description of an ordinary working day, patients as persons did not feature highly on the pocket notes and this was also very pertinent in the nursing care plans that were in use at the time.

Generally the early morning hand-over reports took anywhere between 12 and 20 minutes, finishing between 07:15 and 07:30. The cramped conditions, the lack of chairs, and insufficient writing desk space made the physical environment in which the reports took place an unacceptable venue by most standards.

It was not uncommon for the hand-over report to be interrupted by a phlebotomist asking for laboratory request forms, or medical staff entering the office asking for one of the patient's files. At other times it might have been nursing staff arriving late for duty that caused the interruption. Although these disruptions frequently resulted in small segments of the taped report being missed due to the increased noise level, the tape was seldom stopped and/or rewound.

Mentioning the hand-over reports created a significant amount of dialogue with participating nurses, both during the observations in the field and also at the conclusion when I interviewed the nurses. Anouk, a very experienced nurse, had mixed feelings about the value of the hand-over reports and the way they are managed.

I don't find them [referring to the hand-over reports] particularly useful in the morning. I would much prefer to actually go and just read the notes and have a handover from the nurse who has been looking after my patients specifically. Ummm, I do realise that we do need an overview of the ward, ummm but it is usually done in such a way to make me blot out most of what is said because it is not said in a way that I find useful. So in effect I don't think handovers are very well managed these days. Some wards are better than others. (Anouk)

Anouk's biggest concern was the many interruptions that seemed to occur while the afternoon report was in progress.

...Like in Ward X, today was not particular good because you have got all the morning staff, all the afternoon staff, orderlies coming in and out, the ward clerk coming in and out, telephone ringing, ummm, family asking questions, doctors coming in and out, it goes on and on. (Anouk)

Other nurses also expressed concern. Some nurses felt that hand-over reports were a waste of time because the same information could be found in the written notes, while other nurses confirmed that they tended to focus on their own patients and 'switch off' when other patients were discussed. But not all participating nurses felt like this. Some felt that the report provided opportunities to gain information about all patients which could be useful in case one needed to assist those patients at some stage during the duty. The following segments of interviews reflect the diversity of opinions held by participants.

Kitty, an experienced nurse, felt that hand-over reports did not provide sufficient in-depth information and she pointed out the importance of talking to the nurse from the previous shift in order to gain more information.

For your own patients you just as well talk to the nurse or read the report, but if you are in charge of the ward obviously to have that bit of knowledge about each patient is always helpful. As far as your individual patients are concerned, all the information that you get handed over needs to be expanded and you do need to speak to either the nurse that has been looking after them on the previous shift or you really need to have a good look through their notes because not everything is communicated in our short reports. We do bedside handover now so that has been helpful but you don't know anything about the rest of the ward which I find a huge disadvantage. On the other hand, and I think of patient confidentiality, there is not a great deal of bedside handover either as you do have to be selective what you talk about at the bedside. It's good to have an overview of the ward but really for your own patients it's pretty useless. (Kitty)

Annika qualified more than a decade ago and has worked in several hospitals. Her comments reflect the task-focused care that was so prevalent in all the clinical areas where the research took place.

How useful the [taped] report is just depends on who is doing them. All you need to know is what needs doing immediately. You don't need to know their life history, just patient's name, room number, age, the doctor they are under, what they have had done and what needs doing now. That is all you need! And then what's supposed to happen is they listen to that, then they go and read the notes, and then they go and seek the nurse who has had them the morning before to find out what else has been done for them and... They don't do it with me now so much really, but it used to be terrible, you would spend hours messing about at report! I don't think that you should be doing it on tape – anybody could pick that tape up and find it. It has got people's personal details on and I am not quite sure how it stands, but hey, that is what we do, and they know my concerns. So that is why I try to keep everything to a minimum on the tape. (Annika)

Amy, another experienced nurse, regularly fulfils the role of acting charge nurse, when she is scheduled to work during weekends. Amy liked the taped reports because it was quick 'as nobody can ask questions'. However, she expressed concerns too as she felt that the tape-recorded reports were not always accurate or clear, and sometimes important data were missing. Amy's comment about accuracy and completeness of information is significant as at times nurses omitted to read the written reports thus missing out on what could potentially be vital information. Her other concern was that staff listening to the reports sometimes commented on what was said while the tape remained running, resulting in information gaps.

Sometimes they do, and yeah, sometimes people don't hand over things that are quite important. Sometimes lots of people talk. Like, there are some staff members that people are irritated by on the tape and people make jokes sometimes. Have you noticed that? Yeah, they make jokes where they sigh, they go, 'oh, come on!' (Amy)

Wendela is another experienced nurse who has mainly worked in a medical ward setting.

Some people go too in-depth because I go back and read the patient notes anyway. But in saying that, like if you have had three days off and you are given five patients and the handover person just said: 'Mister such and such had a good night', you sort of feel lost, but at least you can change your way of thinking or feeling as you are going to read those notes later and that is all I need to know right now. (Wendela)

Saskia mainly worked in an acute medical ward and despite her short time span in nursing, she was seen by many colleagues as the 'number two' in the ward.

We would go into handover, say pm shift would be sitting in handover waiting for the morning shift. We would go in at half past two, we would come out at half past three. We had a whole hour in that handover and often a lot of it was nonsense talking. We would all come out of there and a whole hour has been wasted sitting in handover. So with the sheet being developed, it gets read out in ten minutes, and if there is anything that needs to be taken to the bedside, that is what we do. It's both their jobs to find each other and go to that bed and check it, and with anything, like a salbutamol infusion, PEG feeds, what else.....oh yeah, underwater seal drains, we have to go to the beds and sign for any of those. (Saskia)

The views expressed by these six participants reflect the varying expectations and concerns registered nurses had regarding hand-over reports. Common themes were the disruptions that participants experienced while the report was in progress, the general expectation that reports needed to be short and concise, and

completed in a minimum of time. There was also a preference for reports to be focused on the tasks that needed to be performed. None of the participants expressed concerns about the physical environment, the cramped conditions, the lack of chairs and writing space. Nurses appeared to accept these conditions despite knowing that similar gatherings involving other health personnel were not held under such circumstances. For example, multi-disciplinary meetings with a similar number of attendees were held in physical spaces with an abundance of chairs and tables, and capable of accommodating twice the number of staff in comfort. I attended several such meetings where attendees were sitting around tables so they faced each other which encouraged dialogue. The discussion centred on the status of the patients, their needs, personal circumstances, social support networks, and potential to manage at home independently or with support. The focus was on the here and now as well as on the future needs of the patients as part of the discharge planning. Making decisions was a key aspect of any discussion and hence, these meetings radiated a degree of authority. Nursing hand-over reports were very different. Rather than focusing on the bigger picture by placing patients as persons at the centre of any discussion, nursing hand-over reports highlighted aspects of 'conditions' or segments of behaviour i.e. whether the patient had slept well, whether pain had been experienced, any interventions performed, and when medications or other interventions were due next. Hand-over report meetings were not an occasion for discussion of standards of care in general or patient care requirements in particular. Neither did the meeting present opportunities for nurses to discuss concerns about patient allocations and workloads, or to express personal concern and anxieties about a particular patient to alleviate their own stress levels and seek support from colleagues.

The bedside handover

Seeing the patient and noting physical appearance, body structure, behaviour, and mobility are critical components of surveillance (Jarvis, 2008). Surveillance is a key nursing activity to detect fluctuations in patients' health status by monitoring for appearances and/or behaviours that might be precursors to serious and sometimes life-threatening adverse events (Australian Commission on Safety and Quality Health Care, 2008; Considine & Botti, 2004; Odell, Victor, & Oliver, 2009). Surveillance relies on frequency and quality of direct patient contact; it relies on patient observations and communicating with patients in order to stay 'in touch', to

know how the patient feels and what is going on. There was a hospital policy that required nurses to see their patients immediately after the verbal hand-over report, but this policy was seldom followed by the ward staff.

At the time of the research only one participant had developed a set routine that involved such a ward round. This nurse visited all her patients immediately after the verbal report, greeted her patients and checked whether something needed to be attended to at that stage. She then informed her patients about her approximate plan for the day and the estimated time when she would attend to the patients' care. The usual practice routine was for nurses to read their patients' files immediately after the hand-over report was finished. There was one clinical area where the most senior nurse on duty consistently undertook a patient round on completion of the hand-over report while the other nurses read the patient reports. The early morning patient round lasted only a few minutes as both nurses quietly walked past the beds. As it was winter and still dark in the rooms at that time of the morning, the patients could hardly be seen. The night nurse held the torch as a pointer and shone the light on 'items of interest' such as the dripping chamber of the IV infusion to show the infusion rate, or the settings on the equipment, the urine collection bags hanging on the side of the bed, or the oxygen supply meter to show how many litres was being administered. While doing this, the night nurse provided a running commentary about the patients. Often commencing with the medical diagnosis, the remainder of the information focused mainly on the patients' sleeping/resting patterns, continence, need for analgesia or any other medication. The communications during these early morning ward rounds very much reflected the focus of the hand-over reports. Although many patients were awake at the time of the round, communication with patients was kept to a minimum with only a short greeting or just a hand wave. Only if the patient in the bed initiated the communication would the nurses reply as appropriate and/or acknowledge the patient. Within minutes of the ward round being finished the lights in the rooms were switched on, signalling that the day duty had commenced. I was intrigued by this and asked one of the nurses why the ward round was undertaken in the dark when patients could not be properly seen, while only minutes after completing the round all the lights were turned on. The nurse's response was that this was done to give patients some 'extra sleeping time' although I got a strong sense that the lights remained off to indicate to patients that it was still 'quiet time', enabling the nurses to do a quick ward round with minimal interruptions from patients.

Partial rounds involving a night and day-shift nurse occurred sporadically and if undertaken, concerned patients who were very sick or receiving special interventions such as patient-controlled analgesia. In one of the wards individual nurses collected the drug medication chart from the patients' bedsides after reading the progress reports, and this provided the first opportunity to check on, and talk with, the patients. Patients described as being in poor health tended to be seen first to get a better idea of their state of health. Generally nurses assessed these patients' level of comfort/presence of pain utilising a pain rating scale only. If pain was present, nurses seldom asked patients to describe the quality of pain, how long it had been present, where it was located, and what made the pain worse/better. If nurses felt it to be necessary, vital signs would be obtained. In the surgical wards nurses gave priority to patients who were scheduled for surgery by ensuring that all the pre-operative preparations had been attended to and the patient was ready for transfer to the operating theatre. The administration of early morning medication was often the first occasion of the day for nurses to have face-to-face contact with their patients, thus it could be almost 9am before a patient was seen for the first time by the allocated nurse. A time lapse of two hours for patients with high acuity represents a considerable risk of patients deteriorating without this being noticed by the nurse.

Reading the patients' files

Following the verbal handover report, nurses collected the files of the patients that were allocated to them. Finding a place to sit, either in the ward office or nurses' station, nurses would work their way through the patient progress reports and other associated documents, taking note of any specific procedures that needed to be completed on their shift. Although patient files were kept in a set location, it was not unusual for files to be mislaid or in use. Sometimes, an extraordinary amount of time was spent to locate a missing file. On occasions the disruptions to the work flow caused by the missing file was so great that the nurse gave up on the search, trusting that the 'lost' file would turn up eventually (and indeed they always turned up sooner or later). The following excerpt is from the general field notes during the early stage of the research. I thought that what I observed was something unique that ought to be recorded in my field notes. However, I realised soon after that what I had observed was not special at all. Participants saw this situation as quite

a normal way of working, maybe not ideal but nevertheless part of the usual ward routine.

Time and again I am struck by the amount of time it takes to locate patient information. There appears to be incredible amount of time connected with locating patients' files. On every field day thus far, I have noticed nurses searching for patient notes and sometimes their search might last for 10 to 15 minutes without the file being found in the end. Participants check the appropriate slot in the 'file trolley'. If it is not in the right place then it is possible that the file is placed in the wrong slot so the nurse checks out the remainder of the trolley. If it is not in the trolley then it could be somewhere in the nurses' office or the nurses' station, in the medication room, or in the patient's room. Another possibility is that another nurse has the patient file or a member of the multi-disciplinary team i.e. the physiotherapist, social worker, visiting nurse specialist, or doctor. On a number of occasions my participants have given up looking for the file and commenced nursing care without being able to check specific information. Going by my experiences thus far I estimate that nurses spent on average 30 to 60 minutes a day looking for files and other types of information. (General field notes)

Observations in the field revealed that ward nurses tended to read the nursing reports of the two previous shifts. Thus, nurses on the AM duty were most likely to read the reports from the previous evening as well as the night just finished. Nurses who returned from leave, or who had not cared for the allocated patient(s) before, were much more likely to read further back by including the previous day shift and/or the admission notes. While this took extra time, the additional reading provided nurses with a more comprehensive picture of the patient and with a better understanding of the trends, the patterns, of nursing care provided during the different times of the day. Besides reading nursing reports, entries made by medical staff, social workers, physiotherapists, and other health professionals were also likely to be checked. A number of participants commented that the latter entries often provided more useful information than the standard nursing progress reports. The non-nursing entries provided particular information about the patient's medical condition, assessment findings, changes in treatment, and details regarding discharge. The input from the physiotherapist might include information about the patient's balance, abilities when mobilising and degree of assistance required, or patient's lung function. Social workers provided information about the patient's home circumstances, abilities of family to assist, and other information that could be useful when planning for discharge.

Nurses tended to pay specific attention to the drug administration charts, noting the type of drugs charted and the administration times. While reading patient files,

nurses added further information to their 'pocket notes', often related to particular interventions that were considered important.

Drug administration

The administration of medication was considered an important aspect of nursing and a significant amount of time was absorbed by this single activity. It was usually around eight o'clock when nurses in the wards focused their attention on the administration of prescribed 'AM medications'. Medication administration required nurses to be completely focused on the activity to reduce the potential for mistakes. Beside the routine medication times of 8am, midday, six pm, and 10pm, medications were administered at other times as well. Whenever medications were due to be given, the nurse took the chart(s) into the medication room to set out the medications for one patient at a time. Once this was done, the medication was taken to the patient's bedside, where prior to the actual administration, the patient's identity was checked by asking the patient's name and date of birth. Usually, the patient's ID number on the drug chart was compared to the ID number on the patient's wristband, although the latter check was not always consistently carried out. The process as described here was repeated on each and every occasion when medication was administered to patients. Depending on the number of patients allocated, and the amount and type of medications required, the administration of medication could be rather time consuming. As 'once daily' medications were usually administered in the morning, the first medication round of the day was generally the most time-consuming, taking easily 30 to 60 minutes.

The administration of medication is not simply an activity of following doctors' orders. On the contrary, nurses are accountable for all medications administered (or not administered). Nurses checked as a matter of routine what was prescribed, the dosage, mode, and frequency, and when needed consulted medication compendiums to confirm that the prescription was indeed correct. It was not uncommon to come across prescriptions that were difficult to read, ambiguous in their instructions, or incorrect. Whenever any of these situations occurred, major disruptions to the flow of planned nursing care were the result. Rather than being able to focus on patient care, nurses needed to decide whether to administer or withhold the medication and to inform the prescribing doctor in order to discuss the concerns identified. If the prescription required correction, the administration was put on hold and the doctor notified. The nurses had to wait for the doctor to come

to the ward and correct the prescription before the administration of medication could be completed. Alternatively, in particular if the nurse felt that there was a degree of urgency for the medication, the nurse could phone the doctor and ask for a verbal order. Often when this path was chosen, the nurse discussed the issue with a colleague first before the doctor was called. The nurse-colleague, who was consulted, subsequently remained on stand-by during the telephone conversation as any verbal instructions to the nurse needed to be repeated to this second nurse for confirmation and sign-off of the verbal order before the actual medication could be administered. During my observations in the field it rapidly became clear that medication prescription issues were an almost daily occurrence, and even the smallest correction requiring follow up was disruptive to the flow of nursing care, and time-consuming. Nurses often spent 10 to 15 minutes to get the issue resolved. In the case of verbal orders such a disruption also affected a second nurse. According to the ward nurses, poorly charted or unavailable medications were a major cause of disruptions to work flow as illustrated in the following interview excerpt.

A lot of time is spent in the drug room organising the medications. When I started people were not on that many medications and having a medical patient on a surgical ward they don't have many tablets and stuff. Nowadays the medical patient could have 1 ½ - 2 drug charts. Because we are a surgical ward we don't normally have all the medications, so you are spending half your time ordering medication, borrowing from other wards, getting the house surgeon to chart it correctly or update it. (Elsie)

Although the administration of medication usually takes up to one hour, there were many factors that impacted on the actual time it took to complete the activity. For example, medications could be stored in different places and under different names and it could take considerable time to locate the required medications, in particular when it concerned infrequently prescribed medications. Likewise, if the nurse had several patients on complex multiple medications which required administration via different routes, significantly more time was taken up to complete the administration.

Early morning medication administration rounds were seldom restricted to just the administration of medication as illustrated in the field notes below.

While administering drugs, nurses tend to do all sorts of other nursing tasks/interventions as well i.e. taking observations such as T, P, R, help with arranging the food tray during meal times, assisting patients to get into

a more upright position so they can access their food tray more easily, opening or closing windows or curtains, looking for missing items like glasses, providing information and so on. For example, while giving Mr B his medication, the patient asked for assistance to get out of bed. As this patient has had a total hip joint replacement, getting the patient up is quite a slow process as the nurse at the same time needs to teach the patient what he can and cannot do. (Field notes Elsie)

Indeed, many times when nurses arrived at the bedside, the patient was neither waiting for, nor ready to take the medication. On the contrary, patients were still asleep or too drowsy, the bed was still in disarray with the patient hidden in a pile of blankets and pillows and needing to be repositioned. Sometimes there was no patient to be found, requiring the nurse to return the container with drugs to the medication room and try to administer them at a later time. Sometimes there was a smell of incontinence, signalling that hygiene care needed to be provided first. At other times patients requested to be taken to the toilet or required clarification of information provided previously. None of these activities were an actual part of medication administration and neither were they planned for, yet nurses needed to respond to such situations before the medication could be administered.

Because of the set times when medications were administered, nurses found themselves doing their medications at the same time as their colleagues. As a result, the medication room was crowded with nurses vying for some bench space to set out their medications. Queuing occurred regularly with some nurses either trying to get in slightly earlier, or delaying the administration, to avoid 'peak hour traffic' in the medication room. However, despite these strategies early morning medication remained the busiest time of the day in the medication room, when nurses set out medications in a physical space that was far too small for the number of nurses. During this peak hour, the medication room was a noisy place full of distractions and resembling a busy market place. Nurses were calling out the names of specific medications they could not find. These medications could be out of stock, were concurrently used by other nurses at the bench, or were accidentally misplaced when returned to the storage cabinet. There was constant movement as nurses walked from the bench to the storage cabinets to acquire the medication and back to the bench to deposit the right dose into a named receptacle. Also, nurses were constantly entering and leaving the medication room as they administered their medications, one patient at a time.

As an observer this spectacle did not just feel like chaos, it was chaos. Junior and less-experienced nurses asked questions, sought confirmation about generic versus trade names, or needed actual assistance. The more senior nurses frequently fulfilled a mentoring role by assisting junior staff while also doing their own medications. They answered questions, gave instructions where to look for specific medication, as well as checked and countersigned medications for junior registered staff and enrolled nurses. Interruptions and distractions can result in significant delays in the administration of medications and, more importantly, they can increase the potential risks for mistakes being made as noted by Lily, who confirmed the peak hour business with all its distractions, as well as the poor charting practices of medical staff.

We need a much bigger medication room. I think staggering the amount of nurses that are in there at any one time, concentration is just, it is really hard to concentrate at times when everyone is talking all at once and I am also guilty of that. You know, joking about different things, and there are a couple of nurses that spring to mind that drive me bananas in the drug room because they just prattle on about the most nonsensical stuff and yes, I confess to doing the same thing. I confess to having a bit of a laugh about different things, but I think that the medication room of ours really needs to be changed. The amount of nurses going in there needs to be staggered. The amount of oxygen in there must be depleted surely [laughs]. I think that I have made a couple of medication errors myself in the past and charting has a bit to do with that from time to time as well. I think nurses need to identify poor charting and poor medication charts. Like a medication chart that will have probably, the whole page is full, and yet only three medications perhaps that you are giving, and they have altered other ones and you are not sure whether you are suppose to be giving them because you are not sure whether they intended them to be stopped or what it is. I think that poor charting is quite huge and that concerns me a lot. And the writing, sometimes it is hard to distinguish as there are quite a few medications with similar names and if the doctors are not spelling the names right you can never be 100% sure you are giving the right drugs unless you double check. (Lily)

Lily and other nurses believed that there was an unspoken expectation on the part of doctors that nurses will apprehend any prescription mistakes and remedy the deficit.

Caring for patients

Nursing rhetoric frequently mentions the need to provide holistic care. Holistic care focuses on the health needs of the patient as a person and includes physical, social, psychological and spiritual care while also paying due respect to the

person's cultural background. Observations in the clinical setting revealed that care in these adult medical and surgical wards was focused more on the medical and physical aspects, than on social or psychological factors. Activities such as drug administration, monitoring/maintaining IV fluids administration, the measurement of vital signs, providing/assisting with hygiene care, wound dressings, and to a lesser degree mobilising patients or making the beds of immobile patients, appeared to be the main care activities during the AM duty.

As ward staff followed more or less the same routine, pressure on resources was a common occurrence. Just as there were peak times in the medication room, so too were there peak times for bathroom and shower utilisation which resulted in waiting times. On occasions, this led to nurses expressing frustrations, particularly when they perceived themselves to be very busy. Similarly, equipment used to mobilise patients, or to measure vital signs was more heavily utilised at certain times of the day than at others. During peak times nurses had to search for equipment that could be being used by their colleagues somewhere in the ward. Even when the equipment was located, it might not be available due to it being in use, or previously promised to another colleague.

Utilising time efficiently is a crucial skill to be mastered by any nurse. Observations revealed that during an 8-hour day duty, nurses spent at most around three hours a day at the actual bedside. This is surprisingly little given that this time needs to be shared between the allocated five or six patients who, due to the decreased average length of stay tend to be much sicker over their period of hospitalisation. One would expect that increased patient acuity would require nurses to spend more time at the patient's bedside, but in fact nurses spend no more time at the bedside than they did in the mid to late 1980s (Christensen, 1988).

Because ward nurses cared for five to six patients, planning care and making the best use of the time available were crucial skills. Being organised by doing things at the right time, having patients ready on time for tests or treatments, administering medications at the specific times prescribed, and dealing effectively with the many interruptions, was not only a crucial aspect of day-to-day nursing, but it was also considered a hallmark of good nursing practice, according to nurses' comments (general field notes).

For patients who were first on the surgical list, the preparations had already been started the day before or during the latter part of the night shift. One of the first things the morning shift nurse checked was that all pre-operative preparations were done, and that all required documentation had been attended to and signed off. While great care was taken to ensure that the documentation was completed and the patient physically prepared, much less time was spent on preparing the patient mentally. Often patients were only asked whether they had been informed about the impending treatment without checking patient's understanding. Neither was it standard practice to ask the patient whether they had any other questions or concerns. On the few occasions that I observed patient education in clinical practice, it was always an ad hoc event, with little actual time spent. Ensuring that patients were physically ready for transfer, that the 'paper work' was completed, and that the patient arrived on time for the appointment/treatment was clearly more important than providing psychological support for the patient. When time was at a premium and the nurse was slightly delayed, priority was given to the needs of the organisation rather than the needs of the patient. Thus, when preparatory interventions were behind schedule, patients did not always receive a full explanation, or the information was provided while the patient was already on the way to the treatment area.

Nurses escorted patients to the operating theatre and provided a verbal hand-over to the theatre reception staff. Once everything was re-checked and all documentation completed, the patient was handed over and the nurse returned to the ward. The procedure as described here may happen several times during a shift if the nurse had more than one patient requiring surgery. Furthermore, once the surgery was performed and the patient was stable and allowed to return to the ward, the nurse was contacted and informed to collect the patient. After the verbal handover and visual check of the area of surgery, the patient would be transferred back to the ward where the vital signs were checked on arrival. The patient might be given a partial wash, the theatre gown exchanged for regular attire, and the patient made comfortable. In the medical wards, nurses may engage in similar activities when preparing patients for medical tests or radiological examinations.

Breakfast time for the patients was between eight and nine in the morning. Staff, especially the health care assistants who were not involved in medication administration, assisted with the distribution of the breakfast trays. When needed,

patients were assisted into a more upright position and the bedside environment reorganised to enable the patient to eat independently. Sometimes patients required full assistance with the intake of food and fluids in which case the task was likely to be delegated by the registered nurse to care assistants or student nurses if available. If the nurse cared for a patient with diabetes, the blood glucose level needed to be checked and where applicable insulin administered 30 to 45 minutes prior to breakfast time.

Generally, around nine o'clock the breakfast trays had been cleared and the administration of medication was completed. According to ward routine, this is the time for nurses to commence hygiene care activities. Participants usually asked their patients whether they would like to have a shower, wash, or otherwise and observations in the field confirmed that this was a usual procedure followed by other nurses as well. Depending on the patient's abilities, full or partial assistance with hygiene care was provided. Participant-nurses encouraged patients to engage in self-care when possible given the potential slow-down effect of self-care. As patient acuity increased, patients needed more time to engage in self-care, which was more time consuming for the nurse providing limited assistance or supervision. Hence, if the nurses' workload was high, self-care was avoided or discouraged by nurses actively providing the required physical care.

Besides hygiene care and grooming, nurses attended to skin care, renewed dressings, checked intravenous cannula sites for signs of infection/inflammation, and assisted with mobilising their patients out of bed and/or to the toilet. Observations in the field suggest that physical care usually received priority over other aspects of care such as general skin care, grooming, comfort care, or providing psychological support. Explaining to patients their medical condition or treatment was most times done 'on-the-run', meaning while other activities were in progress. Setting aside a short time slot to engage in patient education was not observed during any of the field days.

Somewhere around 10:00 o'clock in the morning, a ten to fifteen minute break is scheduled for staff, although during my fieldwork I noted on several occasions that nurse-participants did not take a break because they were 'too busy' or 'behind schedule'. In some wards it was standard practice for nurses to remain in the clinical area for their break. These nurses made a drink in the ward and withdrew into the kitchen or meeting room that was not in use at the time. In other wards,

nurses were encouraged or expected to leave the clinical area altogether for a 'proper' break. Some wards indicated on the patient/nurse allocation board which nurses had to go on first or second morning break, while other wards arranged their breaks more on an ad-hoc basis. No matter what system was adhered to, care was taken to ensure that sufficient staff with appropriate skills mix remained behind on the ward.

When nurses left the clinical area for morning break or for lunch, their patients were handed over to the staff remaining on the ward. In most cases the hand-over was more symbolic and oriented towards the practical. The information provided centred on tasks such as the completion of hygiene care, any medications that were due, the progress of intravenous infusions, the location of the patient i.e. in bed or up in a chair, or information regarding the patient's physical state of readiness to undergo a planned test or treatment. The nurse accepting the patients was not necessarily taking over the actual care of the patients, or visually checking the patients in the absence of her nursing colleague. Rather, the hand-over of patients appeared to be a safety net in case the patient required assistance. I very rarely witnessed my participants reporting back to the nurse after returning to the ward. This occurred only when patients were expected to be taken to operating theatre during the nurse's absence from the ward, or when changes to medication prescription and infusion regimes were pending. More often than not no specific information was sought and the returning nurse re-assumed the responsibilities for patient care without seeking an update.

The lunch period was scheduled anywhere between 11:30 and 13.30 hours, a time when staffing was significantly reduced for a longer period as nurses took their 30-minute break. The patients' lunch trolley arrived around noon. Nurses helped the health care assistants and enrolled nurses with the distribution of the meal trays and assisted patients with their meals when required. This was also the time to administer the medications charted for noon. After lunch, once the meal trays were collected, nurses busied themselves, with or without the assistance of health care assistants, with repositioning patients, assisting patients with toileting, or returning patients back to bed for a rest period prior to visiting time. Occasionally this time was used to undertake nursing interventions that had not been done earlier in the duty due to lack of time, unexpected events in the ward, or at the patient's request. Dependent on workload, around two o'clock nurses commenced writing patient

progress reports. This also tended to be the time of day when nurses checked up on some or all of their patients, measuring vital signs, updating charts, and ensuring that all information had been entered as required. This final round was also used to check that patients were comfortable. Any information gained about the patient's condition or how the patient felt was often woven into the progress report.

While carrying out nursing care, nurse-participants frequently consulted their own written 'pocket notes' to ensure that no tasks, required to be completed at a certain time, were forgotten. This related in particular to the administration of drugs that were due outside the regular medication time slots. Medications such as intravenous antibiotics and analgesia are typical examples where administration times might follow a different pattern and hence great care was taken to ensure these were not overlooked. Often nurses added additional information to their pocket notes as the day progressed, and used the document as a reminder of the day's events when writing the patient progress reports.

From 2:15pm onwards, nursing staff scheduled for the PM shift started to arrive. As an observer this part of the day often felt chaotic. The day staff were rushing around and trying to finish their activities. Nurses were undertaking last minute checks on patients, completing unfinished nursing interventions, or asking patients specific questions to be noted in the progress report, or to be shared with the PM staff during hand-over report. It was also visiting time and hence nurses were frequently asked questions about the patients' health conditions, medical treatments, and discharge prospects by visiting relatives trying to obtain information. Sometimes relatives expressed concern about the apparent lack of progress or the patient's ability to cope at home should discharge be imminent.

The nurses commencing the evening shift used the pre-report time to find out about particular patients they might have been concerned about the evening before, checking out that patient/treatment requests from the previous evening had been carried out during the day shift. The office was buzzing with day staff looking for patient files to complete their written reports, while evening nurses searched through patient files to find out what had happened during the previous 16 hours, or tried to talk to the day nurse when the information could not be found. The feeling of 'chaos' eased a bit when the evening staff gathered in a separate room in order to receive the hand-over report. One by one the morning nurses met with the PM

staff to deliver their individual patient reports. Sometimes there were significant gaps between report presentations which led to one of the evening nurses going to look for the day nurse who had not as yet presented the reports. Sporadically a patient was overlooked and no verbal report was presented.

While the individual verbal face-to-face encounters may have provided an opportunity for broader dialogue about the actual implementation of the planned care, suggested changes, or other issues impacting on ward nursing, observations in the field revealed that this did not happen. In most cases verbal reports were a one-way communication stream from the day nurses to the evening staff. Furthermore, the content of the information presented was based on the written report and usually did not contain any additional information; hence each verbal report was finished within a few minutes. Very few questions were asked and I did not witness any discussion involving the care of a patient. Generally by about 3:15pm hand-over reports were completed, signalling the official end of the morning duty. However, it was not uncommon for day duty nurses to stay behind to finish specific care activities or to complete documentation requirements.

The complexities of care delivery

The above description of a day duty in an adult medical or surgical ward focused in particular on those activities that characterise nursing in these settings. The structure of an ordinary day in the ward was signified by a pattern of activities that were largely routinised. However, my description falls well short of capturing the inherent complexities of even the most fundamental of nursing activities. Using a patient shower as an example, I will illustrate the complexities involved and the skills needed to perform a nursing activity that is often considered so mundane that health managers increasingly argue that it can be left to unregulated health staff. Several nurses emphasised that the provision of hygiene care was an opportune moment to engage in surveillance and to undertake a more thorough physical health assessment i.e. assess patient's gross and fine motor skills, muscular strength, joint flexibility, ability to balance and multi-task, while it was also an ideal opportunity to inspect the patient's skin colour and condition. Being with the patient also enables assessment of patient's energy level, lung function, cognition, and mood. Providing hygiene care is thus much more as illustrated by Wendela's comments.

When I'm showering somebody, you might just see me showering somebody, but I'm thinking how is this person able to walk? I'm thinking how short of breath are they? Is this a usual pattern? Is this something new, is this related? Then I'm usually asking them about what they used to do for a job. What they uhm..., who looks after them at home? Can they usually shower themselves? Can they usually get to the bathroom? Those sorts of things, those sorts of assessments. (Wendela)

Observations in the field suggested that of all the routine individual patient interventions that nurses undertake, the provision of hygiene care was by far the most time-consuming because of the preparatory work that needed to be undertaken first. Often, the preparation that nurses do prior to providing hygiene care was more time-consuming than the actual activity itself. Given that most patients requiring assistance were also elderly, time needed to be allowed so that patients were able to 'do it at their own pace'. This is how Lily described the provision of hygiene care:

Personal cares like showering takes the longest time. Actually no, not the actual showering itself but the preparation for the shower, and then after the shower, both of which take an enormous amounts of time. Finding their clothes, finding out what it is that they want to wear. Communication sometimes is a bit of an issue with some of the patients. Uhm, finding a bathroom. Ensuring that you have got the bathroom and keep the bathroom. Getting any equipment you need in that bathroom. They need the toilet and often we need the high toilet seats and that is not always in the bathroom you happen to have. Occasionally you have to actually clean the toilet before you can take a patient in there because a previous patient has been in there and has left a mess. So, the preparation can be quite time consuming at times, and it even depends on how organised the last shift were (laughs). So yeah, it can be very time consuming. Running off to get towels because you are running out of them, mmm. (Lily)

Lily's comments confirmed the observations made during the fieldwork that there is so much more to showering than just finding a shower and assisting the patient. The preparatory work sometimes involved activities that were not considered a nursing responsibility but which were nevertheless undertaken to reduce any slow-down effect i.e. cleaning the toilet or rinsing a hand basin before usage by the patient. Having to share equipment such as raised toilet seats or shower commodes meant that these pieces of equipment needed to be located and 'claimed' first before the patient could be toileted or showered. Lily's remarks about ensuring that you 'keep the bathroom', referred to situations where the shower was available but while the patient was on the toilet or in transfer, or while the nurse was gathering additional equipment, the shower facility was taken by another

nurse. To prevent this from happening, nurses 'claimed' the shower or bathroom by depositing some of the patient's belongings in those facilities in advance. This ritual signalled to colleagues that the shower or bathroom had already been taken. The impact of limited resources on workflow will be further addressed in chapter six.

The complexities of care delivery on a day shift are further illustrated in the following episode of observation in which two particular issues are identified that will be followed up in subsequent chapters. While most field days were scheduled on week days, some observations took place on Saturdays and Sundays. Few medical investigations and treatments were carried out during the weekend unless there was an urgent requirement and hence the weekends could potentially provide a different perspective on ward nursing than the week days. My first observation of Elsie's nursing practice happened to be on a Sunday. Elsie was in charge of the ward even though I was unaware of this at the start of my observations. Following the hand-over report all the staff left the office and dispersed. There was no discussion, no instructions, no other obvious signs that indicated who was in charge of the ward, and responsible for providing leadership to the team until a few minutes after the hand-over report was finished. Elsie had collected her patient files and was about to sit down to read the reports when the following situation unfolded.

Before Elsie could make a start with reading the written reports, the care assistant pointed out that a patient requiring IV drugs was allocated to a new graduate nurse. The care assistant went on to say that this should not happen and that the patient allocation needed to be changed. It was at this stage that I became aware that Elsie was officially 'in charge' of the ward. I was however quite astonished that it was not one of the registered nurses, or the new graduate nurse, who was bringing this allocation problem to the attention of Elsie; instead it was a care assistant. Elsie went to the new graduate and asked her to swap the patient who required IV medication with one of Elsie's patients who did not require such treatment. After this was sorted out and all the nurses' names were written on the patient allocation board, Elsie started to collect her patient files but then left these on a desk to first complete an 'alterations to the menu' form which had not been done by the night staff. As this form needed to be sent to the kitchen prior to the food trolley arriving in the ward, Elsie perceived this to be a priority. Unfortunately, as she faxed the completed form to the kitchen, the breakfast trolley arrived in the ward and so she needed to phone the kitchen and request that additional food was sent to the ward. (Field notes Elsie)

This excerpt illustrates two separate issues that have developed as recurring themes throughout this research; first, the lack of nurse leadership at ward level which resulted in a lack of role modelling professional nursing standards and keeping the team focused. In the situation described above, leadership was not only invisible but it was completely absent with individual nurses just being focused on their own patient list. Lack of leadership from charge nurses/nurses-in-charge, was observed frequently during the study, and was also regularly commented on by participants either informally during the duty or morning coffee, or in the formal tape-recorded interviews. In this particular situation Elsie turned out to be the nurse-in-charge as the most senior registered nurse on duty, yet she failed to demonstrate leadership and accountability to ensure the appropriate allocation of patients. It was of concern to me that a hospital care assistant had to draw the issue of incorrect patient allocation to the attention of the senior nurse, while five registered colleagues, including the junior nurse, said nothing. This raised not only questions about team functionality and cohesion, but also about the apparent lack of importance attached to ensuring that all patients are correctly allocated in the interest of patient safety and the nurse's level of competency. The issues of ward leadership and patient allocation are further examined in chapter eight.

The second issue concerned the continuous barrage of interruptions/disruptions that nurses encountered every day and which affected the flow of nursing care. The field notes concerning Elsie provided an example of the ripple effects that interruptions had on the flow of nursing care. Elsie was prevented from reading the patients' files because the first interruption required her to correct the staffing allocation. This was a priority as it concerned patient safety and the requirement to comply with hospital regulations. Attending to, and correcting the staffing arrangements resulted in Elsie being too late to respond in time to a second interruption which was caused by a diet sheet not being completed for one of her patients. By the time she had completed and faxed the form to the kitchen, the food trolley containing breakfast for the patients had already arrived in the ward. Elsie was thus too late and this caused the next interruption as Elsie now needed to contact the kitchen by phone to order the food required for her patient. All of these events were consuming not only valuable nursing time, but they also prevented Elsie from focusing on her patients and spending time where it matters most; at the bedside. Elsie expressed that she felt 'pushed' for time as it was past 8am and yet she had not read all of the reports or visited her patients. However, time was

pushing on and according to the ward routines, Elsie should now be engaging in the administration of regular AM medications.

By the time Elsie had finished reading her first report, one of the doctors came in to inform her that Mr "Tar" needed to be ready for transfer to the OT. This patient was admitted the night before with a laceration to his R thigh following an accident. Elsie had a quick read of Mr Tar's notes, collected his X-rays from the ward office and went to see the patient. She handed her patient special Op. Th. clothing and while she helped him putting this on, the orderly came to collect the patient. By now it was 8:30 and we were on our way to theatre with Mr Tar. Ten minutes later we were back and Elsie commenced her drug round. At that stage she had not read the files of her other patients. (Field notes Elsie)

Elsie accepted these disruptions as a normal part of nursing practice and she compensated for the 'lost' time by adjusting her activities. Because she was aware that by now she was 'behind schedule' by half an hour, Elsie reprioritised her workload and decided to limit any further delay in the administration of medications by not reading the files of the remaining patients. This strategy to save time can have serious repercussions for patient care as specific information could have been documented in the patient's file but which was (accidentally) omitted during the verbal hand-over report. By not reading the reports, Elsie might have potentially missed out on crucial patient information. Interruptions to nurses' work come from multiple sources and will be addressed in more detail in chapter six.

Summary

This chapter commenced with a short introduction to the hospital in which the study took place, followed by a detailed description of the physical lay-out of a hospital ward. It was noted that although there were minor differences in lay-out between wards, the design of the wards, and the location of, or the access to, various rooms and facilities were generally not designed to accommodate nursing service delivery. The remainder of the chapter provided a detailed account of what it is like to work as a registered nurse in a medical or surgical ward for adult patients in one public hospital in New Zealand. Using a chronological timeline and concentrating on the day shift, the most frequent and regular nursing activities were outlined. The structure of an ordinary day shift in the ward was signified by a pattern of activities that were largely routinised. There was a significant discrepancy between nurses' claimed desire to provide holistic care, and the task-focused, routinised nursing interventions that characterised contemporary ward nursing in this context. Lack of

time and interruption was claimed as the main contributing factor that prevented the provision of person-focused care.

In the next chapter I will explore in more detail the effects of such interruptions on the delivery of health care, but also the underlying hierarchy of power and control that influences nursing practice.

CHAPTER SIX

Nursing: The interruptible health profession

Introduction

Being a 24-hour service, nursing not only plays a key role in health care delivery, but nurses also coordinate the timely input of an expanding range of health care professionals. Indeed, when Thomas (1983) reflected on his observations as an in-hospital patient, he spoke of nurses being the 'glue' that held the health services together, describing nursing as a visible and vital component of hospital operations. However since the 1990s, the health sector has undergone significant change in the pursuit to increase efficiency and control costs. Under the dominant influence of generic management a leaner health system was created while the average length of stay was significantly reduced. A reduction in hospital beds saw bed occupancy rates increased while different medical specialties were required to share beds in one and the same ward. In this chapter I continue my interrogation of practice and the practice environment, focussing in particular on the issue of interruptions to nurses as they attempt to provide care. I will also examine how the need for nurses to increasingly mind the business of others, has impacted on nursing practice in medical and surgical wards.

Interruptions to nurses' practice

Given the acuity of the patient population it could be expected that interruptions to nurses' practice will be caused by nurses responding to patients' call bells. However, actual observations in the clinical setting revealed that patients used their call bell surprisingly little. From time to time patients commented that they felt sorry for the nurses as they always appeared to be so busy. Hence, whenever the situation allowed it, patients tended to wait until a nurse happened to come into the room before asking for a '*favour*'. The patients' limited use of the call bell reflected their awareness that nurses were busy. Interruptions in the flow of nursing practice were much more commonly caused by members of the multi-disciplinary team, nursing colleagues, visitors, phone calls, and lack of consumables or equipment.

Interruptions were in fact so common that one of the nurse-participants noted that nursing was 'the interruptible health profession'.

While participants noted that there was an official policy not to disturb nurses when they were engaged in drug administration, it nonetheless happened frequently. Interruptions due to phone calls had reduced significantly according to the participants, but disruptions caused by colleagues and other health personnel, including medical staff continued unabated. Often such interruptions concerned questions regarding patients' conditions, patients' whereabouts, or patient referrals. On several occasions nurses were unable to continue the administration of medication because the drug chart was required for the ward round and hence it was taken from the nurse. After several such interruptions I made the following entry in my field notes.

Today I again witnessed a situation where my participant is setting out medication for a patient and in the middle of this activity the doctor comes in and asks for the drug chart. The first time when this happened I thought that the doctor wanted to change one of the medications prescribed but as it turned out, that was not the case. He left the medication room with the chart. When I asked my participant why the chart was taken away, she answered that the doctors needed the chart for the ward round. She did not appear to be upset or surprised by it. Meanwhile the nurse was left in the middle of an activity which could not be completed without the drug chart. What does this say about the value of nurses' work? How does this unplanned interruption affect subsequent planned nursing interventions? It also raises questions about the way the multi-disciplinary team works together. Why are doctors undertaking ward rounds without the nurse being present to contribute to the consultation? (Field notes Amy)

The above field note is indicative of many other entries that were made over the duration of the study. Time and again, nurses were interrupted no matter what activities they were engaged in. Nurses were seen as an 'interruptible workforce'. As contemporary hospitals have become more open institutions with more liberal visiting times, the interruptions by concerned family members wanting information have increased. Frequent restructuring has altered the staff mix within the wards and nurses have to step up more often to support unregulated staff and supervise or check on their activities. Likewise, the growing number of multi-disciplinary health professionals involved in the care and treatment of hospitalised patients has increased traffic flows into the ward. Not surprisingly the rate of nurse-interruption has increased due to the need for information, guidance and/or assistance.

Observations in the clinical ward settings confirmed that amongst all the health professionals frequenting the ward, it is the nurse who is most likely interrupted when patient information is needed or assistance required. Nurses are interrupted while walking down the corridor, on entering or leaving a patient room, while administering medications, or writing reports and even whilst engaged in direct delivery of care to a patient.

The 'culture of interruptions' was so well-established that even hospital policies aimed at reducing such interruptions were completely ignored as illustrated by Saskia's comments.

It's a big issue because she'll [clerk] come and knock on the door and say: 'Please come and answer the phone, family members are ringing', or something like that. Well, you know, you could make an error while you're in the drug room. It's quite annoying at times ... uhm, getting you to come all the way out and answer the phone. You could be there for half an hour, you don't know, on the phone. It's time consuming, and it's risking a medication error. (Saskia)

[Researcher]: Are there lots of those types of interruptions when you work?

Yeah, there is. You could be at the bedside with the curtains drawn doing something with a patient, and she'll go up to the side of the bed: 'Saskia, there's a phone call for you!' If the curtains are closed you would [expect her to] say: 'I see you're busy Saskia, I'll tell that person to ring back', but she's kind of hoping that you're going to say: 'OK, I'll come now'. You're probably busy doing something quite important so, yeah, sort of like...the drug room is the one that annoys me more. That's the one that gets me.

Ward nurses believed that there were a number of contributing factors that led to an increase in interruptions. Increased staff turnover, in particular the loss of experienced staff, had resulted in an influx of junior nurses and new graduates who needed much more support and assistance. Alterations in skill mix and the employment of care assistants cause disruption due to the need to provide supervision and guidance. Increased patient acuity combined with 'no lift' policies also amplified the number of interruptions as nurses more often sought assistance.

Interruptions cause disruptions in the flow of work and were costly in time as Anouk explained in the following excerpt.

Look at drug charts, I don't know whether they [referred to the doctors] are too busy or lacking in insight or knowledge but lots of sometimes even silly charting mistakes are being made. Each time when you pick something like that up you need to take action and it costs time to get things sorted. It delays your medication administration uhhh, you need to keep an eye out

for the doctor, check that the mistake has been corrected, finish your drug administration and then go back to where you were in the first place. Can you see that these are all 'hold-ups', it doesn't come for free and somehow patients and nurses are paying the price. (Anouk)

Increased case mix was another factor frequently mentioned as a contributing factor to interruptions. As contemporary hospital wards catered for more medical specialties than ever before, there was a significant increase in multi-disciplinary staff, most notably medical, visiting the ward. As a senior nurse Kim ('stakeholder') spends a great deal of time on the wards and she has seen the effects of the health care reforms on ward nursing.

When I worked fulltime as a Staff Nurse, I knew that Doctor A came at 10am on Monday and Doctor B came at 1pm on Tuesday. You had your routines based a bit around that and you were available for the ward rounds. Uhm., we used to have dedicated wards around patient conditions and we don't have that now. A good example would be a ward that is gynaecology, urology, ENT, eyes and any medical overflow. We had 32 patients and 18 different consultants. So uhm., your scenario when the nurse was talking about consultants: "I don't go on Ward rounds because I don't know when consultants are coming", and they don't anymore! (Kim)

Kim's comments that increased case mix caused more interruptions due to the involvement of a much expanded multi-disciplinary health care team, was confirmed by observations in the field. However, the assertion that nurses did not attend ward rounds because they did not know when doctors were coming was only a partial explanation of the complexities surrounding case mix which I will explore in more depth in chapter eight.

Marije who works in a surgical ward noted the increase in doctors visiting the ward to see patients. However, she also noted that doctors do not seem to coordinate their visits, on the contrary; the house surgeon comes in to check that he/she has done everything okay and that their notes are up-to-date, and then the registrar comes to do the same in preparation for the consultant. Each of these visits represents a disruption for the nurses.

Some of the surgeons take quite a lot of time, and sometimes you get the house surgeon go round, then you get the registrar go round, and two hours later you get the consultant come around. So you could see three – you could be in there with three doctors because they don't seem to coordinate it. Yeah, like the days the consultant's coming round, the registrar would still go round and see them at eight, even though the

consultant may be coming round at ten, yeah. So that's time consuming.
(Marije)

Ward nurses believed that the reduced availability of the charge nurse was another important factor that needed to be considered. In particular those who had been nursing for a long time recalled the role charge nurses used to fulfil as senior clinical nurses; supporting and coaching junior nurses, and acting as a role model in clinical practice. As a senior clinician and team leader, charge nurses would provide a buffer for ward staff by being the first port of call for visiting multi-disciplinary health team members thus reducing the intensity of interruptions for ward nurses. Following the health sector reforms in the 1990s, charge nurses have a significant managerial role which takes them out of the ward much more frequently. As charge nurses have become less visible in the ward, and less accessible, ward nurses seeking advice, reassurance or assistance, tend to seek this more readily from their colleagues. Likewise, doctors and other visitors are now also more likely to interrupt ward nurses for information or assistance as illustrated by stakeholder Olga, a clinical nurse specialist.

I think we also interrupt nurses more than we ever did before. I think there are more people around to interrupt nurses in their day-to-day duty. Please don't get me wrong, I'm just trying to build a picture here. I think doctors, visitors and colleagues as well uhm.... interrupt one another, perhaps when they are doing a drug round. Interruptions from telephone calls at peak time are extraordinary. Uhm.. and there is an element of duplication I think as well. You know, I can come along and interrupt a nurse as well as my colleague who will come along. A physiotherapist might ask for an update on the patient of that same nurse. Yep, and then the occupational therapist will come along and perhaps have that dialogue. There is a lot of new roles that perhaps we did not have years ago that attribute to that business [of interrupting ward nurses]. (Olga)

The consequence of interruptions is not only the prolonged time required to complete nursing interventions but also, and more importantly, interference with the thinking processes that accompany skilled actions. Interruptions increased the potential for mistakes especially when nurses needed to concentrate on the activity at hand.

... it is that constant interruption to work-flow that impacts on all aspects of nursing. It was not, interruptions talked about in the context of getting out medications but it is in every single aspect of a nursing day. Whatever nurses are doing, they are perceived to be interruptible, and they quite often get no opportunity to have a clear run at whatever they are trying to do. (Jolanda, stakeholder)

The findings of this study are consistent with other studies reporting that in a health care environment characterised by time shortages and nurses being in a perpetual hurry, interruptions heightened nurses' stress and frustration levels due to frequent time delays, which contributed to lowered job satisfaction (Bowers, Luring, & Jacobson, 2001; Cornell, Herrin-Griffith, Keim, & Petschonek, 2010; Duffield et al., 2011). Of real concern was the finding by Westbrook et al., (2011) that 27% of all interruptions took place during medication procedures.

Underlying these interruptions is a hierarchy of power and control, signalling who or what is important and valued. Being able to interrupt requires a degree of power, based on seniority within the nursing ranks, or perception of higher status such as is held by medical staff. Nurses felt 'taken for granted' as they were expected to organise their work around the consultations and have their 'patients ready' for the ward rounds even though nurses never knew for certain what time consultations would take place.

There is a perception of whose time is valuable and there is a belief out there that whatever a nurse is doing is eminently interruptible because it is not as of great importance as what the doctor wants to do because the doctor has limited time, or what the physio wants to do because the physio has limited time or sometimes what the visitors want to do as well. It comes down to what I perceive as a lack of respect for what nursing is doing. (Jolanda)

Beside interruptions caused by people, nurses were also frequently stopped in their tracks by interruptions of a different nature such as running out of consumables or lack of equipment as the following field notes illustrate.

It was time to do Mr X's blood sugar levels as it was already 8:15am. Kitty looked for the equipment in the usual place and when she could not find it she widened her search and looked in the nursing station, on the trolleys in front of the office, and in a cupboard. I joined the search and started looking for the plastic container as well. We went around the ward, asked other staff until in the end we tracked the equipment down in one of the patient rooms where it was in use. We waited until it became available which was only a minute or so but as I waited I realised how amazing this situation was. Here we are, in a medical ward where even at the best of times there are always a number of diabetic patients and yet there was only one blood sugar testing kit in the entire ward. (Field notes Kitty)

I asked Kitty why her ward appeared to have only one blood sugar testing kit when it was rather obvious that the ward needed additional sets to be more effective and reduce unnecessary search/waiting times. According to Kitty the ward had three

kits but the device to take the blood was broken or lost in one kit and hence this kit was incomplete and could no longer be used. Kitty was unsure whether anything had been arranged to correct this situation. The second kit was complete but could not be found as it was not in its usual storage place. Kitty recalled that she could not find it the previous day either but she thought that it might have been left at the bedside in one of the rooms and that eventually it would turn up. However, as she still had the one remaining blood sugar testing kit she was not overly worried about the missing one despite having spent more than five minutes looking for it and interrupting several nurses while she searched for it.

A further example of the impact of lack of resources on Kitty's ability to manage her nursing work is illustrated in the field notes below.

The doctor had seen Mr Clark, a 29-year old patient with cerebral vasculitis and decided to do a lumbar puncture. Kitty ordered a LP set. When the set arrived it was realised that it did not have a 3-way tap. Kitty phoned Sterile Supplies but they were unable to assist and advised: "Try the Emergency Department (ED) or otherwise the Distribution Centre" (DC). Kitty phoned ED but they did not have the 3-way tap, leaving only the DC as the final option. Luckily, the DC did have one and Kitty arranged for a porter to collect it and take it to the ward. It took 20 minutes to organise the 3-way tap. It was by now 14:40 and Kitty had run out of time to write a hand-over report for the PM staff. [summarised version of Kitty's field notes]

For Kitty the procedure was not over yet. Having taken 20 minutes to get a single piece of equipment, she now had to locate the doctor. It took her several minutes to track him down in another ward and on the promise that he would be back in a few minutes, Kitty prepared the patient and the trolley and hovered around. Although she left the room on two occasions to do 'a quick job in between', her actual workflow was interrupted while she waited until the doctor returned 10 minutes later. Kitty assisted with the procedure and tidied up afterwards. By the time she had completed her written patient reports and handed over her patients at the end of her shift, she had done 45 minutes of overtime. Kitty's experiences are not unique. I observed on numerous other occasions nurses having to go to great length to obtain consumables or equipment required to continue nursing. The frequency of lack of consumables and equipment and the effects on nursing practice was researched by Kovner et al. (2007) who found that a quarter of the nurses reported to feel hampered in their job because of inadequate supplies.

Few nurses were able to sum up the discontent of ward nurses more succinctly than Sonja when I asked her; “If you can talk of ‘an average’ nursing day, what do you think takes up most of your time?” Her response provided much more than an answer to my question, it revealed the pent-up frustrations that I also sensed in other nurses.

Frustratingly ‘buggerising’ about. Trying to find equipment, trying to find stock, trying to track down doctors, trying to uhmm....get someone to help you with tasks that require two people. I don’t know what really does take my time each day, whether it is a perceptual thing, but I feel like I spend three hours doing my job and about five hours of my day doing things that shouldn’t really be required of me. Equipment that we need to provide care, we should just be able to walk to the appropriate place and get it. (Sonja)

Nursing work flow

Interruptions are disruptions to the nursing flow that impact on nursing far beyond the actual interruption itself. One nurse in the study compared interruptions to throwing a stone in the water; the ripples caused by the interruption go far beyond the original point of impact. Interruptions are typically not planned and hence when nurses are suddenly disrupted and required to focus on something else, they might not be able to switch back straight away. Vardaman, Cornell and Clancy (2012) explored nursing activities in medical and surgical wards and concluded that the nurses’ work flow showed all the characteristics of a complex adaptive system which is inherently unpredictable. Indeed, the unpredictability of nurses’ workload came to the fore on many field days. What began as a ‘manageable day’ could change rapidly to a day full of unexpected demands and even chaos at times. The following field notes reflect the unpredictable nature of nursing practice and are an excellent illustration of the non-existence of work ‘flow’. The field notes cover a period of less than two hours, but it is a period in which Helen is constantly required to make ad hoc decisions as she deals with one situation after the other, many of them unplanned and unforeseen. I start my observations a few minutes before 10am. The doctor saw one of Helen’s patients and decided that an operation was required. Given that the patient was confused and in no state to give consent for the operation, Helen notified the daughter by phone, explained the situation and invited the daughter to come to the hospital for a discussion with the registrar.

In anticipation of the patient’s daughter coming in, Helen checked all the patient’s notes and contacted haematology for ‘blood group and hold’. The

registrar had written a referral for an urgent echo cardiography and for Trop T levels to be done and hence Helen organised for this to happen a.s.a.p. The daughter arrived at 10:15; Helen contacted the doctor and invited him back to the ward and talk with the daughter to explain the situation. In between these activities Helen administered pain relief to one of her other patients, and ordered a new prescription for the PCA which was required for 2pm. Helen answered a couple of phone calls and notified the H/S after she discovered that the IV cannula from one of her other patients was blocked. The H/S came within a few minutes and a new cannula was inserted. Helen measured the patient's vital signs before arranging for a senior nurse to be present while she checked the PCA so it could be signed off as part of her competency assessment. In the mean time the doctors had done their ward round and inspected the dog bite wounds of another patient allocated to Helen. It was decided that this patient would undergo secondary wound closure in OT in the afternoon. The information was documented and relayed to Helen via the charge nurse. The time is 11:30 and Mrs X is ready to go home as her husband has arrived. Helen removes the IV cannula, checks that the patient has received her prescription and discharge letter. Patient walked out of the ward accompanied by her husband as Helen answered the phone. It is the MRI unit requesting pain relief for a patient who has refused to undergo the examination unless she has had pain relief. As this is not her patient, Helen promised to inform the nurse concerned. Helen checked the white board to see who the nurse was and looked for her to relay the message. Mrs Y rang the bell and asked for pain relief. Helen administers analgesia to Mrs Y and as this patient still needed a wash, Helen asked the health care assistant to assist her with this. (Field notes Helen)

Nurses practising in medical or surgical wards will not find the above scenario unusual. Rather, they will recognise and acknowledge that this is how their practice is on many days. While nurses 'plan' their day on paper or in their minds, in the reality of clinical practice it is the ever evolving and often unpredictable events that determine the nurses' day. As Vardaman et al. (2012) noted, the significance of complex adaptive systems is that small changes on the input side can result in large-scale changes on the output side.

Westbrook et al. (2010) researched the effects of interruptions on task completion of medical doctors and found that clinicians reduced the actual amount of time spent on tasks when they were interrupted. Frequent interruptions of complex tasks increased the risks for mistakes while about 18% of the doctors failed to return to complete the task. Although this research was conducted with doctors, similar responses were observed in the current study. Nurses hurried through the tasks to be done, knowing that an interruption was imminent. Nurses also forgot earlier commitments because of interruptions i.e. a patient was assisted to the toilet but forgotten for about 20 minutes due to a series of interruptions, or nurses

promising patients that they would be back in a few minutes which became a few hours because of interruptions. Nurses too will potentially be at risk of making more mistakes due to these interruptions (Cornell et al., 2010; Westbrook et al., 2010).

Cornell et al. (2010) researched workflow through direct observation of behavioural nursing activities. The authors found that 40% of the events lasted less than 10 seconds while 77% were of less than 30 seconds duration. Only 5% of the activities lasted longer than two minutes. The authors emphasised that these times did not indicate that the activity was finished but rather a reflection of the juggling nature of nursing and the frequent interruptions encountered. The research concluded that there was very little 'flow' in nurses' work due to constant interruptions. No conclusions could be drawn about the length of time nurses required to complete activities because nurses seldom completed activities without interruptions. This finding is significant in that it challenges the assumptions that underpin current workload calculation tools, which will be discussed in the next chapter.

Another study examined time utilisation with a 2-year interval to check for time utilisation changes following transfer from paper to electronic documentation and from individual patient allocation to team nursing (Westbrook et al., 2011). Their research found that on average nurses engaged every hour in 10 direct care activities with an average length of 80 seconds, confirming research that there is no work flow; nursing care delivery is fragmented with many stops and starts. Interruption not only disrupts the physical activity but also the thinking process that underpins the nursing intervention. Even routine activities such as assisting a patient out of bed require the nurse to engage in a cognitive process of assessing the patient's state of mind and physical capabilities. The nurse needs to undertake an environmental scan, assess safety issues/concerns, space availability and positioning of items on and around the bed, and estimate the amount of assistance required.

Nurses as 'gap fillers': Minding everyone else's business

Observations in the field and discussions with nurses confirmed that nurses spent an extraordinary amount of time on additional activities to assist and support other health professionals, or to rectify situations within the system that were problematic

or incorrect. Nurses engaged in a range of compensatory activities that were not their responsibility, yet nurses did so because they felt compelled, as indicated by the answers nurses gave; *'Well it needs doing and if I don't do it nobody else will'*. Nurses felt they spent an increasing amount of time *'picking up the pieces'*, and *'keeping the system ticking over'* (general field notes). Nurses expressed the view that there appeared to be a growing reliance on them to step in and do what was needed for the good of the patient and the greater benefit of the organisation. However, it was not only the hospital that relied on nurses. A report written by the Health and Disability Commissioner concerning an adverse event involving a junior doctor, the Commissioner also expected nurses to step in and mind the doctor's business (Health and Disability Commissioner, 2009, p. 13).

This case highlights the importance of good systems to support junior doctors, especially in specialties... where junior medical staff may have limited experience. There should be a safety net of vigilant senior nurses and readily available consultants.

It could thus be seen that the hospital as an organisation and the public of New Zealand are relying on nurses to go the extra distance. Nurses considered compensatory activities as major invisible time absorbers that prevented them from focusing on nursing activities and impacted on their ability to plan their day. One of the nurses put it very succinctly when she proclaimed: *"Our ward is like a circus, how can you ever plan anything when everyone comes and goes as they please and expect us to be there when it suits them?"* However, it was not only other people's expectations as nurses themselves also willingly offered their assistance. During my observations in clinical I noted that many nurses found saying 'no' difficult. Rather than declining a request, nurses avoided such potential situations by keeping themselves occupied elsewhere. However, in most cases nurses were generally eager to accommodate and to please even if afterwards they complained about the extra work or the lack of recognition. Nurses identified numerous system gaps which can be placed into two main categories; those caused by members of the multi-disciplinary team and those caused by a multitude of support services.

Minding doctors

In the context of multi-disciplinary input into patient care, nurses fulfilled the function of a safety net. While nurses used different terminology to describe their monitoring function, the meaning was the same. Some nurses talked about

'needing to keep an eye on things', while others talked about 'checking things out', or 'keeping tabs on ...' (general field notes). Medication prescriptions are a prime example of the monitoring function in which nurses engaged. Nurses routinely checked that doctors had correctly prescribed the medications and they did so for good reasons as noted by Wendela.

I have got a thing, like with some of the medical staff. They think that nurses should be there and run after them. I don't mind, you know, like helping them and things like that, uhm...I think there is a lot of stress put on nurses by... by....the fact that you have to, uhm.. say you have a new admission and their medication is not charted properly, or they are not admitted properly, or you have a transfer and you don't know who is looking after them, then you have to chase round, finding out who is looking after the patient. One medical staff will say: 'no, I am not looking after them, you try this one'. And then you do a big circle and uhm....yeah, I think there is quite a bit of stress put on us by medical staff. If things were done correctly in the first place you would not have to go back and do them again. (Wendela)

Discrepancies in drug prescriptions were so frequent that I cannot recall a field day when there was not a drug-related issue that required nurses to follow up with medical staff; medication needed to be altered or cancelled because it was charted incorrectly. On other occasions the charted medication was unreadable, or the medication was noted in the patient's file but not charted on the medication chart.

I don't believe that nurses should be trying to locate doctors, or find out why they are not responding to their pagers. I don't believe that we should have to chase medical staff to write prescriptions or discharge summaries for patients that they know are going home at a certain time. I believe that that is a huuuge waste of time but it reflects people's perception of how valuable your time is. (Sonja)

While most prescription problems could be resolved within a reasonable time frame, this was not always the case. The following extract from my field notes illustrates a problem that was from all perspectives a medical/pharmacy issue and yet, by disowning the problem, the doctor made it a nursing problem to be dealt with by the nurse who happened to be allocated to that patient.

A doctor had prescribed Prophane for a patient. The participant, Elsie, who was caring for the patient searched the medication room and, when she could not find it, consulted a pharmaceuticals book. When she could not find it in there either, she contacted the pharmacy. There was a lot of miscommunication over the phone and it resulted in the nurse giving up and terminating the conversation. The nurse went back to the prescribing doctor who interrupted her and said that he had nothing to do with this patient. When the nurse replied that he was the one who had prescribed

the drug, the doctor responded that he only wrote down what was in the referral notes and that this patient was no longer his responsibility as she was transferred to 'the other team'. He was unable (or more likely unwilling) to inform the nurse which doctor had taken over the treatment of this patient; "Whoever looks after her can sort that out", was his answer. By this time the nurse had spent more than 45 minutes on this one issue and felt that all was in vain. I offered to follow up with the pharmacist in the hope of resolving the problem. It took several phone calls and attempts to page the pharmacist before I got through. The person I spoke with was not sure about the drug and thought that it could be 'an old name' but she promised to sort it out and get back to me. Half an hour later I received her written response on my pager: "Hi. Cannot find no mention of Prophane, might be Protophane or Isophane". When I left the ward eight hours later at the end of the duty, the problem was still not sorted. (Field notes Elsie)

Duffield et al. (2005) also noted that following-up on medication prescriptions can take up an inordinate amount of time. Some nurses suggested that prescription mistakes might be due to doctors not receiving proper instructions regarding hospital charting protocols, and that new house surgeons 'were let loose in the wards' without the required knowledge, while others did not know, or believed that doctors were 'a bit casual' when it concerned medications (general field notes). Marije noted that although prescribing medication was a doctor's responsibility, it is the registered nurse's duty to ensure that all medications were prescribed correctly given that nurses were legally accountable for the correct administration of drugs. Marije maintained that because doctors relied on nurses to keep an eye on things, nurses were manoeuvred into a position where they functioned as the handmaiden to the medical staff.

....the doctor's writing is not legible, and their charting is not legible. I mean the medical charts are very clear, they just have to write in the gaps, but they score it everywhere. We cannot understand it, so therefore, even though they have charted it, if we're not sure it will come back on us, and we need to get it checked. I have to spend a lot of time following that up. Or they write antibiotics, five slash seven and it's already been day six, and they haven't come back and signed it off. I think we spend a lot of time babysitting them to do their job. I think the doctors just need to get smarter about checking their drug charts, because that is part of their role. (Marije)

While nurses were expected to complete incident reports when nurse colleagues made mistakes e.g. administering incorrect medication, incorrect dose or route, or not administering the drug(s) on time, there appeared to be no such requirement for nurses to complete an incident form when doctors made prescription mistakes. Instead, nurses would contact the doctor by phone or place a non-permanent note

in the patient's file reminding the doctor to correct the medication chart. The way nursing staff dealt with medication mistakes at ward level reflected the differences in perceived status between doctors and nurses, as well as passive acceptance by nurses of their lack of importance.

Minding activities went well beyond the monitoring of medications. Nurses not only needed to tell doctors how to do their job, but they also needed to keep an eye on them, or as Marije called it '*babysitting them*'. In particular in regards to new house surgeons, a significant amount of time and energy was invested to get doctors to understand their role within the ward setting, as well as the role and responsibilities of the ward nurses. Often new house surgeons lacked insight into their own role and the role of the ward nurse as they were not socialised into the ward setting. Marije noted that nurses, in particular the senior nurses, had developed their own strategies to sort out house surgeons and make sure that there would be an acceptable working relationship between nurses and doctors.

Sometimes they have a different way of treating nurses and I think with each group that comes through every three months, you have to work with them around that. Sometimes they're just...yeah, you can see how they respect you as a nurse, you have just got to work with them on that.
(Marije)

Minding other multi-disciplinary team members' business

Nurses were also minding the business of other multi-disciplinary team members, not by choice but because of historically-based expectations, or because not doing so would have repercussions for the nurse's own workflow. The replenishment of pharmaceuticals is a useful example to illustrate this. Under normal circumstances pharmacy staff monitor the levels of medications held in stock on the ward, check the expiry dates and replenish any medications that are running low. However, when the pharmacy is short-staffed, the wards are informed that the outreach services are cancelled, requesting that ward nurses check their patients' medication stock levels and re-order medications as required. When the re-ordered medications are delivered to the ward, ward nurses are responsible for checking the order and storing these in the medication room. There appears to be an unchallenged expectation that ward nurses have the time and opportunity to compensate for any unforeseen staffing gaps in the pharmacy department. However, nurses are not left any options as not checking medication stock levels

now means running out of medication later, the correction of which might be far more time consuming.

When the cancellation of the outreach services concern the replenishment of controlled drugs the effects on workflow is generally even more disruptive. With controlled drugs the registered nurse is required to fulfil the role of pharmacy staff, because hospital protocol prescribes that only pharmacists, medical staff, and registered nurses are allowed to handle controlled drugs. Hence, controlled drugs cannot be delivered to the ward using orderlies, but registered nurses are required to collect these drugs directly from the pharmacy which took a significant amount of nurses' time involving two nurses; one nurse to collect the medications, while the other nurse accepts responsibility for monitoring the patients while the former nurse is out of the ward. Prior to the nurse leaving the ward, patients needed to be handed-over involving either a verbal report or a hand-over at the patients' bedsides.

*As I said, I actually spent an hour on pharmacy. I was off the ward at least 40 minutes collecting narcotics and other drugs that we needed from the pharmacy, signing them off and checking them through. You know, when I have people in my care, the time to do what they need is my time best spent. Obtaining the things that the ward needs to run day-to-day is not. I find it really frustrating to have people come up with their little computer things on their wrists [refers to pharmacy staff checking and maintaining stock levels of medication] and yet we still are running out of things. That just amazes me quite considerably. Some days you don't appear to do a lot of those things because everything runs rather smoothly, but other days you feel like you literally spent all day trying to locate things and chasing people to do their job and you just think: "Gosh I wish somebody was watching here today and typing in a calculator how much time I spent doing that, compared to how much time I actually did spend on my work."
(Sonja)*

As illustrated in the above excerpt, a visit to the pharmacy can take the nurse away from the ward for prolonged period, adding pressure on the workloads of at least two nurses. This same scenario is repeated in any other wards that require medications from the pharmacy. Filling gaps in pharmacy services is routine practice, it might not happen very often but nevertheless when it does, nurses are expected to step in. When wards are short staffed the same rules do not apply, pharmacy staff are not expected to fill the nursing gaps taking over the administration of medication for example. Neither are doctors as prescribers expected to collect medications from the pharmacy. Rather it is the nurses whose job it is to fill the gaps in the system. This expectation is indicative of the

perception that what nurses do is either not important, or nurses are perceived to have enough time to fit in additional responsibilities. It is notable that nurses and nursing leadership appear largely complicit or seemingly powerless to address this.

Minding support services' business

Like the pharmacy services, support services such as catering, laundry, transport, cleaning and supply, all deliver services at ward level. Any changes in the function or staffing levels that impede their ability to function efficiently are likely to affect ward nurses. For example, a mistake made in the kitchen, a wrong meal or a meal that has not been delivered, all of these events impact on the workload of nurses who will have to step in and correct the situation. Likewise, problems in the laundry or the transport services may result in the ward running out of linen, towels or face cloths, which impacts on the delivery of nursing care at the bedside. Nurses were good at problem-solving and went to great length to develop alternative strategies to minimise these types of disruptions by circumventing the official channels. For example, in times of repeated shortages of certain consumables nurses will hide hoarded supplies which is both wasteful of time and counterproductive.

The bulk store and sterile supplies automatically replenish consumables and sterile items when ward stock is below predetermined levels. Despite this system that should see wards supplied with all the items needed, wards regularly ran out of stock requiring nurses to step in. As arranging additional orders from the bulk store is time consuming, nurses tended to check with neighbouring wards first to see whether they stocked the item. To save time, nurses frequently collected the required item from the other ward themselves rather than involve support staff who needed to be contacted, instructed as to what needed to be done, and waited upon for the arrival of the item. Not surprisingly, when the ward ran out of supplies it resulted in significant delays for the patient and caused disruptions in the nurses' activities.

To control expenses, hospital management determines which products are supplied on imprest and to what levels, and which products have to be ordered separately by the ward nurses on a case by case basis. Expensive consumables require additional approval from the charge nurse. The following field notes pertain to a situation where the item concerns an expensive wound dressing which required a special order. What originally should have taken a few minutes, setting

up a trolley in preparation for a wound dressing, turned into a major exercise that absorbed a large part of Elsie's time and energy.

It is just incredible how much time can be lost organising those things that one would consider to be fundamental nursing such as a wound dressing. In this particular case it concerned a patient who had been on a particular dressing for several weeks but the dressing was not on imprest due to its cost, hence it needed to be ordered separately. The nurse who uses the last dressing should order new stock but according to several nurses, this was a continuing problem. Either nurses were not aware of the requirement or they were so much in a rush to get everything done on time that they forgot that this particular dressing needed ordering. The time is 08:45 when Elsie noted that the special dressing was not in stock. She completed an order form and took it to the charge nurse for her signature after which she faxed the form to the store room with a request for the dressing to be delivered before 10 am. It was past 10 when Elsie checked if the dressing had arrived. As it had not, she made a number of phone calls to central supply to check what had happened to the dressing that had been ordered. Not only did this take more than 10 minutes to sort out, but it also involved at one stage the ward clerk and the charge nurse. In the end it was agreed that the dressing would be specially delivered to the ward. Meanwhile, Elsie prepared the dressing trolley in anticipation of the dressing arriving as indeed it did. Things seemed to work out well until Elsie noticed that the wrong dressing was sent. Again there was a 10-minute phone marathon which ended in confusion as it was not certain that the required dressing was in stock in the bulk store. Elsie decided therefore to leave the change of dressing for now and wait until things were sorted. By 12:15 the dressing had still not arrived. By 1:15 Elsie felt that she had waited long enough and she decided to proceed using the previously delivered, but slightly different, type of dressing. Once at the bedside she prepared her sterile field and placed the dressing to be used on the tray. About two minutes into the procedure the correct dressing arrived but it was too late as a \$120 dressing had just been opened. Elsie decided to use that rather than waste it. The change of wound dressing went smoothly and took approximately 10 minutes. (Field notes Elsie)

I recalled this event some time later and asked Elsie how she felt about it. Elsie responded that she had not given it much thought at all, rather, she saw it as '*one of those things that happen*'. There is a whole range of activities in which ward nurses engage and over time these have become part and parcel of nursing practice because no one has asked the question: "Why nurses?" I asked Elsie why nurses had to order the dressing.

... I don't know, it's so easy to forget when you are busy and there all these other demands as well. Yeah, why do nurses have to do it anyway [order the dressings], it could be done by the ward clerk cause it is still signed for by the charge nurse, is not it? At least if she does it there is just one person keeping tabs on things rather than all of us running in circles trying to do it in between all other things, but no it is left for us, yeah, like we have

nothing else to do. You know, nurses are continuously asked to do extra things that really could be and should be done by others but it is an easy way out you know: 'just get the nurse to do it!' (Elsie)

The requirement placed upon Elsie to order the dressing impacted on a large part of her day and affected her ability to focus on her other patients. Hospital management has created barriers to limit the use of expensive dressings thereby requiring nurses to jump over hurdles in order to provide appropriate care. However, focusing on jumping hurdles prevents nurses from focusing on patient care, on making effective use of their time and using their expertise where it counts most, at the bedside. It is interesting to note that doctors also use expensive disposable items, yet they are not required to complete special order forms signed off by a senior doctor for the purpose of being able to carry on 'doctoring'. There is an unspoken assumption that their clinical judgement supersedes issues of cost.

Other ward nurses too appeared to have accepted that nurses spend a large part of their time doing other things than nursing. As Sonja noted earlier, "*I feel like I spend three hours doing my job and about five hours of my day doing things that shouldn't really be required of me*". Anouk commented on subtle changes that had occurred over a number of years impacting on practice to such an extent that nursing was no longer '*just nursing*'.

Nursing has changed in that it is no longer just nursing. There is all that other stuff that used to be done by others but that seems to be left. Nobody does it and yet it is vital for the smooth running of the ward or for patient care, you know what I mean? Like the equipment is not there, or its broken or whatever. That used to be attended to but now I don't think that is happening anymore. Things are not maintained, rather they are used until it is broken. When I come across something like that it is me who has to fix the problem. I mean not repair it but I have to take action and that is nursing time. You need to take action and it costs time to get things sorted. Can you see that these are all 'hold-ups', it doesn't come for free and somehow patients and nurses are paying the price? (Anouk)

The drive to create a leaner and more cost-effective health care service has led to the development of gaps that have remained largely invisible because of nurses' willingness to accommodate system errors. Rather than venting the frustrations experienced when consumables run out, when equipment is not readily accessible, when equipment is broken or not maintained, when medications are out of stock, nurses look for solutions by trying to rectify the problems on their own.

I would say that nursing is busier and faster, and we have got fewer resources. There is less time to give to care and there are more frustrations as it doesn't flow as easily as it did. We don't have access to the equipment in the same way we used to. We go to the drug cupboard and drugs aren't there so then you have to go to a fax machine, find a form, fill it out and send it off and then wait for it to come. We get told that there is not equipment. Some of our dressing products, when we send down to get them, they say: "well, we haven't got any, we're out of stock". So then we have to ring around the wards. Here is a good example: we could not get an ECG machine a couple of weekends ago for a patient. So we were 20 minutes ringing around the wards trying to get an ECG machine. In the end the nurse and the patient had to go with an orderly to ED and the nurse did the ECG in ED then came back to the ward 45 minutes later. So those are the frustrations. That probably might be the time she would have spent with the patient. So she would say: "I had no time", because her time is used in other ways. (Kim)

Many ward nurses are likely to recognise the above scenario as part of their ordinary nursing practice, yet this is not supporting the effective delivery of nursing services. The medical profession would not put up with repeated situations where access to equipment of consumables was blocked or required a significant amount of time and energy, so why are nurses so tolerant? Lack of equipment or consumables was identified as a very common problem and research conducted elsewhere suggests that more than 25% of the nurses felt hampered in their nursing practice at least once a week (Kovner et al., 2007)

The value of nursing

The findings of this research thus far are that interruptions in work flow and "minding other people's business" were a major part of medical and surgical ward nursing although it remained largely invisible. There are no permanent written records that document the activities performed for others, just as there are no records about the number of times that nurses prevent medication errors from happening because they inform the doctor about medication charting mistakes. The amount of time absorbed by minding other people's business was not accounted for yet, if we talk about nurses being the glue that keeps things together to make it work, then it may be this almost invisible 'minding'. The invisibility of what nurses actually do adds to the perception that nursing as a profession does not make a significant contribution to health care and hence health care agencies do not value nursing for its input (Campbell, 2000; Fagin, 2001; Ministerial Taskforce on Nursing, 1998).

Health care environments are largely dominated by medicine or hegemonic medical thinking (Baggot, 1994) and this was reflected in nursing documents such as care plans and nursing progress notes, both of which were medically-focused and contained significant amounts of medical jargon (Hyde et al., 2005). It is also an environment in which the nursing perspective was not well-represented by nurses who felt unable to assert themselves as reflected by such comments as: *'nobody listens anyway'* and *'everybody can have their little say but nothing happens'*. This perception of not being heard, of not being able to make a valuable contribution had permeated ward nursing to the point where nurses did not seek or provide input. Nurses were much more likely to avoid ward rounds than take part in them even if they had the opportunity. Likewise, nurses seemingly joined multi-disciplinary team meetings more as observers than as full partners. The following excerpt illustrates this point as Lily discussed multi-disciplinary team (MDT) meetings.

Those MDT meetings, if you want to have your say about a patient, if you disagree with something that is going on with the patient, that is a really good time to do it. Everybody is there and everybody has input. There have been occasions when I have walked out of those disgusted really, because the nurses were more verbal behind the scenes [meaning outside of the meeting] than they are when it really comes down to it. (Lily)

Lily's assertion that nurses had opinions on issues but that they were not prepared to share these during the meeting was confirmed by my own observations. I attended several MDT meetings to observe proceedings and listen to the ward nurses' input. The following is an excerpt from my observations.

MDT meetings are held at regular times and involve staff from a variety of disciplines who are involved in the treatment and care of patients residing in the ward. Meetings took place in an oversized room in which several tables had been pushed together to provide ample room. On this particular occasion nine people attended the meeting as well as a number of ward nurses who only attended that part of the meeting when their patients were being discussed. Sitting around the table were the consultant, the registrar, a house surgeon, two physiotherapists, a student physiotherapist, one social worker, one occupational therapist, and the charge nurse. There were still two empty chairs at the table. Ward nurses were rotating in and out of the meeting when their patients were being discussed. The ward nurse would bring in the patients' files and placed these on the table near the consultant who would introduce the patient. Often, but not always, the registrar would open the file and read out some additional details before a discussion would take place. Medical notes, and to a lesser extent MDT members entries, were read out. Nursing reports were seldom referred to. The most verbal input was provided by the consultant

and the house surgeon while the registrar had less input. The occupational- and the physio-therapists also took part in the discussion, be it to a lesser extent. The student physiotherapist had more input than the qualified physiotherapists. The charge nurse made occasional comments, while the social worker did not have any input in the general meeting although she did have some 'side-talks' with one of the physiotherapists. Of the five nurses who attended parts of the meeting none of them took actively part in the meeting. On the contrary, it was telling that they often positioned themselves away from the meeting table, by sitting on the chairs that were arranged along the walls of the room, a distance of about three metres to the meeting table. Except for occasional nodding and agreeing with one of the speakers around the table, there was no verbal input from the ward nurses. (general field notes)

The above field notes suggest a great deal about ward nurses' perception about their own role in health care. Choosing to sit on the chair against the wall instead of at the table illustrates where these nurses saw themselves in terms of the value they can add to these gatherings. I contend that the tendency to remain on the 'outside' reflected the low self-worth of these nurses, their perception that what nurses do does not make a real difference and is of lesser value than the contribution of other health professionals. In chapter eight I will explore the factors that contribute to this perception in more depth.

Doctors enjoyed a privileged position within the medical and surgical wards as reflected in the way nurses handled errors in medication charting. I noted before that charting/prescribing errors were a common occurrence and although they posed a considerable risk to the nurses' professional careers should mistakes not be noted in a timely manner, nurses were never observed completing official incident forms implicating doctors. Rather, nurses informed the doctor and withheld the medication until the error had been corrected. This role of being the 'good helper' reflects the competing discourses in which nursing was subservient not only towards medicine but also towards the employing agency. Nurses willingly sacrificed their nursing expertise, time and energy to prop up system failures such as lack of resources and lack of equipment. Nursing also willingly adapted their nursing standards to comply with agency demands.

Tucker and Edmondson (2002, 2003) researched nurses' responses to system failures which appear to be an integral part of frontline health care delivery. Their research findings suggested that every nurse spent more than 30 minutes a day sorting out problems as a result of system failure. Tucker and Edmondson

stressed the importance and influence of the work environment on nurses' responses to system failures. The authors maintained that if nurses do not feel safe, if they perceive that there are considerable personal risks to speaking up and rectifying the problem at a higher level, or if the perceived benefits are smaller than the personal costs, nurses are unlikely to take actions to resolve the problem at that higher (managerial) level. The finding of this current research that nurses tended to deal with the problems themselves raises therefore serious questions about the working environment of nurses.

Summary

A phenomenon thus identified by all participants and stakeholders related to the continuous stream of interruptions that severely interfered with the flow of nursing practice. Nurses were interrupted by members of the multi-disciplinary team, nursing colleagues, visitors, phone calls, and/or lack of consumables or equipment such that nursing was described as the interruptible health profession. Contributing factors to the high level of interruptions included loss of experienced staff, increased patient acuity, high patient turn-over, and reduced availability of the charge nurse. Interruptions were described as disruptions to the nurse's work flow resulting in frequent stop-start situations. Ward nurses expressed frustration with the unrelenting stream of interruptions which made it almost impossible to pay focused attention to patients' needs and contributed to the high stress levels associated with ward nursing. The ad hoc nature of nursing and the inability to plan in advance contributed to a lack of job satisfaction.

Nurses increasingly engaged in a range of compensatory activities that were not their responsibility, but not doing so would have had repercussions for the patients' well-being or nurses' ability to keep delivering nursing care. There is widespread awareness amongst nurses themselves, nurse leaders and probably generic management positions that all is not well in the study setting. In the next chapter I turn attention to a number of the responses implemented in recent years with multiple aims including risk reduction, improving efficiency and safe staffing levels. This will show that the responses embrace a particular world view of nursing and may thus be counterproductive.

CHAPTER SEVEN

Capturing nurses' work

Introduction

In chapter five I described the physical environment of the medical and surgical wards and captured a typical working day for nurses in that setting. In chapter six I explored nurses' concerns about being constantly interrupted and their need to increasingly mind other people's business to the point where it affected the provision of nursing care. Nurses believed that the changes effecting contemporary nursing practice were still the aftermath of the health sector restructurings of the 1990s which were driven by a desire to establish a cost-effective competitive health care system. Guided by a doctrine of market demand and generic management, the quality of health services was assumed to remain unaffected (Arthur Andersen & Co, 1987; Ashton, 2002; Easton, 1999; Gibbs et al., 1988; Stent, 1998). By changing health care policies and funding, and introducing a competitive model of health care, the emphasis of the reforms was in particular on developing managerial structures that would control cost, to monitor input and output, and to allow productivity to be measured. While the main focus was on the macro structures of health care, far less attention was paid to the effects on service delivery at the individual (micro) level (Ashton, 2002; Devlin et al., 2001).

In this chapter I will explore in greater depth a number of developments which I have come to understand as residual impacts from the generic management decisions commenced in the 1990s. After discussing the effects of shorter hospital stays and increased patient turn-over ('churn') on nurses' workload, I will explore TrendCare, a patient classification system that is utilised to manage nurse staffing levels, as well as the effects of standardised care plans on nursing practice. I contend that despite the change of focus in 2000, which sought to reverse some aspects of the previous reforms, the influence of generic management has not only persisted, but has shaped hospital services, the way nurses perceive nursing, and the way nurses engage in nursing practice.

Shorter hospital stays and increased patient acuity

The trend to decrease the length of hospital stay was a worldwide phenomenon and can be traced back to the 1980s (Ashton, 2002; Reinhart, 1996). In New Zealand this led to the health sector reforms of the 1990s with its emphasis on cost control and the implementation of generic management principles as described in chapter two. Statistical data gathering became an important tool to objectify the complexities of health care in an attempt to justify the change (Easton, 2002; Fagin, 2001; Rankin & Campbell, 2006). Hospital managers and administrators started to focus on admissions, discharges, and transfers to monitor bed utilisation, average length of stay and re-admission data. Results were not only used for comparisons in performance between hospitals, regions and even countries, but were in particular used to highlight where further savings could be made. In the United States the average length of hospital stay decreased by 40% between 1980 and 1995 (Reinhart, 1996). In New Zealand too the average length of time spent in hospital has declined significantly. According to the 2005 annual report (Ministry of Health, 2005) the average length of stay declined by 50% between 1988 and 2003. The drive to improve productivity is ongoing with the Ministry of Health setting targets for DHBs to achieve and publishing the outcomes in annual and public reports. Subsequent reports show that the average length of stay has continued to shorten which was attributed to less invasive surgical treatments, effective drug treatments, improved community (follow-up) care, and more effective hospital administration including bed management (Ministry of Health, 2010), and it is this latter aspect in particular that has a significant impact on ward nursing practice.

Bed management

Bed management refers to the management of admissions, discharges and transfers. Effective bed management is crucial for avoiding underutilisation and in ensuring that resources are used efficiently (Ministry of Health, 2010). Although limited prediction can be made about acute and unplanned admissions, for patients already in hospital, bed utilisation can be managed through the use of clinical pathways which serve as maps or care tracks that identify patient outcomes and expected treatment times (Forkner, 1996). Clinical pathways also referred to as critical pathways, care pathways, care map, and integrated pathways, direct and record key interventions, allowing for early detection of variance while at the same time setting milestones and goals to ensure timely discharge of the patient. The

ability of clinical pathways to contain health care cost by reducing length of stay and making better use of available resources has been a strong incentive for its utilisation as a managerial tool (Aspling & Lagoe, 1996; Gordon, 2005; Rankin & Campbell, 2006).

Clinical pathways are an objectified tool based on a virtual patient with a medical diagnosis or undergoing a specific treatment. It charts the trajectory from admission through till discharge (Gordon, 2005; Hunter & Segrott, 2008). The pathway is virtual and hence does not take into account the effects of any existing co-morbidities or personal circumstances that a real patient may have, but it sets clear indicators for treatment schedules and expects nurses and other health professionals to work accordingly to ensure timely discharge (Rankin & Campbell, 2006). Clinical pathways thus signal a change in orientation from hospitals being analogous to 'railway' stations, or places of rest, to hospitals being 'trains' where patients hop on for a scheduled length of time to receive a predetermined length of treatment before being required to hop off again.

During my observations in the field, several charge nurses referred to the tensions that exist between the needs of the patients for individualised nursing care and the institutional expectations to increase patient turn-over and efficiency. That patient turn-over is an important responsibility was evident as charge nurses attended special meetings, the so called '*bed meetings*' to discuss admission and discharge figures, look at and compare statistics, and obtain an overview of how the hospital and/or the wards were performing. Absorbed by admissions and discharges and the management of the 'here and now', charge nurses are in a difficult position. On the one hand, as the most senior nurse leader in the ward, charge nurses ought to support, guide and motivate staff, give clinical advice, and create the conditions where nurses are able to work as individuals and within a team to deliver professional nursing care. On the other hand, as ward managers, charge nurses are accountable towards hospital managers and administrators for efficiency gains, for achieving admission and discharge targets, for managing allocated ward staff, and for remaining within budget. One of the charge nurses described her role as 'challenging' due to balancing her role as clinician and manager. This excerpt was selected because it best demonstrated the pressures placed on charge nurses to keep patient turning over:

I feel as a Charge Nurse a bit like the meat in the sandwich. You have got this constant pressure. The biggest pressure in the day is to get patients discharged and to get new patients in. That is a constant, from the minute you get to work. The first thing I do in the day: "Who are the discharges? Who are we going to get out? Who are we getting in?" Then you move on and you look at roster: "How many nurses have I got? Who is off sick"? And then you just move on through the day. (Linda, stakeholder)

Patient 'churn'

Contemporary hospitals focus on efficiency of services and bed management. Patient 'churn' refers to the constant movement of patients, both through admissions and discharges as well as between wards and treatment areas (Duffield et al., 2007). Two decades ago most patients would not be discharged home until they had recuperated from their illness or treatment. Nurses were caring for patients along a wider scale on the ill-health – wellness continuum, from newly admitted acutely ill patients to patients who required only minimal input while awaiting discharge. Because of the spread of patients along this continuum, nurses' workloads were not as heavy and appeared to be better manageable. However, the drive for efficiency and increased productivity, which was at the centre of the 1990s health sector reform, has resulted in significant changes in the way hospitals are run and the way nurses are required to manage their work (Aiken, Clarke, & Sloane, 2000; Dingwall & Allen, 2001; Parker, 2004; Rankin & Campbell, 2006; Weinberg, 2003).

Nurses frequently mentioned the impact of patient churn on work flow. Nurses were much busier as they had to arrange for patient transfers to and from other wards, taking patients to or collecting patients from treatment departments, as well as all the 'waiting around' that accompanied such activities. The effects of patient churn on nursing workloads, including admissions and discharges, is considerable and should not be underestimated (McWilliam & Wong, 1994; Unruh & Fottler, 2006). Present day hospitalised patients are sicker while the shortened length of their stay has increased the nurses' workload (Norrish & Rundall, 2001; Unruh, 2003). The increased complexity of care and the increased use of technical equipment has resulted in today's medical/surgical patients being the equivalent of the ICU patients in the 1970s (Benner et al., 2010). Gordon referred to this increased intensity of nursing as 'heightened patient acuity' as more needed to be accomplished over a shorter period of time (2005, p. 258).

Patient churn also increases the workload in less obvious ways. For example, the patient allocation board might indicate at seven o'clock in the morning that nurse X has been allocated five patients for the day. By ten o'clock two patients are discharged while two new patients are admitted early in the afternoon. The board still indicates that nurse X has five patients yet the true accumulative workload is seven patients which is not reflected in the workload. Unruh and Fottler's (2006) research demonstrated that workload calculations based on nurse - patient ratios are inaccurate by underestimating the true workload of nursing staff.

In this study senior nurses Jolanda, Madeleine and Kim, with long professional careers in hospital nursing, expressed concerns that nurses spent less time at the bedside even though patients were sicker than in the past. They noted that patient care had become much more focussed on performing tasks such as administering medication, measuring vital signs, or providing physical care while virtually no time was spent attending to patients' psychological, social, or cultural needs. Nurses in this study reported feeling under constant pressure to free up beds for new admissions. Their concerns were also confirmed in a passing comment by one of the nurses with whom I went to morning coffee; *"It becomes a rare phenomenon to see a nurse sit at the bedside. To be honest, I cannot remember when I last saw that"*.

Olga, a registered nurse of 15 years has worked in a variety of wards as staff nurse and charge nurse. Being a clinical nurse specialist for a number of years, she too has noted the effects of high patient turn-over. Olga maintained that contemporary nursing is characterised by high intensity and a less personal approach to patient care.

I think the throughput of patients is so much more rapid. We are constantly up to full capacity so there is not that downtime, if you see what I mean. Patients are acutely ill uhm.., and gone are the days when they could stay in for another week to rest before they went home. So there doesn't seem to be that let up of capacity and patient condition. Uhm.. so I think that has an impact on the way we work. Everything is always in a rush these days cause there is not the time and I guess the personal touch is not there as much as it used to be uhm.... (Olga, stakeholder)

Routinisation of care

Olga's notion that the personal touch has been lost was confirmed by my own observations in the field which showed nurses being in perpetual hurry, running from one activity to the next with very little time left to care in a more holistic way for patients. The combination of high patient turn-over and the influence of clinical pathways contributed to the routinisation of nursing care. I became aware of this at the early stages of my research when I intended to explore the role of health assessment in clinical decision-making. Participants maintained that the workload was too hectic and that there were not enough hours in the day to be able to assess patients. Quite a few nurses labelled the observations of vital signs as the main assessment activity and argued that there was little need for additional assessments as that would cross into medicine. There was a belief that patients were over-assessed as many members of the multi-disciplinary health team would routinely ask similar questions to complete the required standardised documentation; *'patients must get sick of all the questions repeated time and again'*.

While observing clinical practice I noticed that the nursing assessment document was seldom completed fully. It was not uncommon for parts of the assessment form to be completed by the nurse in the office without the patient being consulted. On such occasions the nurse gained the data from other notes without confirming the accuracy of it with the patient. Generally the nursing assessment documentation was filed in the patient's notes, and hardly ever re-looked at. I mentioned my findings to Kim and asked her for a response.

That comment made me smile, that it is just filed and we don't go back to it. I have heard that comment from a lot of people. So I am sort of quite bemused that they say they file it. I guess, they have no ownership of it or find it of no value. I find it bizarre that nurses sit in an office and do it, because traditionally that is the one bit of paper you take to the patient and do it with the patient. With the majority of nurses there is no connection from a nursing assessment to a nursing care plan, to the progress notes. I think in some nurses' minds there is a sort of linear perception, that you start at this point and your end point is that. (Kim)

As it was difficult to find out more about nursing assessment activities while observing nursing practice, I focused my questions around 'decision-making' on the assumption that this would lead me back to assessment but it did not. Nurses felt that care delivery was very much standardised and that it required mainly 'routine

decisions' based on protocols. Indeed, it can be argued that when nursing decisions are based on set routines and protocols rather than individual patient needs, patient assessment loses its value.

Quite a lot of them are routine decisions. Here in this hospital, as you know yourself, there are many protocols and usually if you're having some trouble making a decision, there'll be a protocol to tell you what you should be doing anyway. I think on a day to day, we make fairly basic and routine decisions that we are well-trained to do. (Kitty)

In the hospital environment they are very much routine decisions. Cause usually it is pretty much, you know routine. Whether they are gonna have a shower (laughs), do they need blood sugar levels, it is stuff, it is the same stuff different day. (Sonja)

The above comments highlight the effects of high patient turn-over and clinical pathways which led to a type of care best described as 'conveyer belt' health care nursing where set routines mark expected patient progress. Although nurses did not mention so much the concept of clinical pathways, their replies very much indicated that patient care followed a strict trajectory with most if not all nursing interventions being routine practice. The voice of medicine was strongly represented as any discussions concerning the patient's care were framed in medical jargon and centred on medical diagnoses.

Reviewing my data, I gained the impression that nursing interventions considered most important concerned the administration of medications and monitoring infusions while the bulk of the remaining tasks mainly related to physical care which needed to be done as a matter of course. While nurses sometimes referred to the concept of holistic nursing, they often did so in terms of emphasising the discrepancy between the 'ideal situation', what they would like to do and what was actually done. The patient as a person was rarely mentioned apart from the aim to achieve discharge by a certain day. Nurses followed protocols and talked about what happens to patients on 'Day One', 'Day Two' and so on. As Sonja noted nursing is routine, decision-making is routine. Nurses do *'the same stuff'* as yesterday, today, every day, *'the same stuff'* just a different day or different patient. By following the routine nursing practices, Sonja and her colleague nurses contribute to the structures of the ward even though they may not have had any part in establishing these routines in the first place. Giddens (1987) concept of the duality of structure is applicable here; as routinisation becomes more and more

normalised it becomes less likely that any individual nurse will find the discursive space in which to imagine practice differently.

While in the vast majority of cases clinical pathways worked well in terms of achieving early discharge, observations in the field also provided several situations where adhering to clinical pathways resulted in inappropriate discharge. One such situation concerned an elderly woman who lived by herself and was admitted following a fall in which she sustained a fractured left wrist and right elbow. With both arms in plaster casts she was substantially incapacitated yet she was prepared for discharge that day. The patient was anxious and expressed concern about her ability to manage. During the two days that she had been in hospital she required assistance at meal times and with hygiene care and she wondered how she was going to cope on her own. The nurse felt anxious too that the patient was perhaps not ready for discharge but did not share her concerns with the patient. She continued the planned discharge, reassuring the patient that she would be alright. However, later that morning she did go into the office and shared her concerns about the patient's ability to manage at home on her own, with three nurses who happened to be there. However, her concerns were put aside by her colleagues who responded that *'there is no longer a medical reason for keeping her in'*.

The above scenario is indicative of a change in nurses' thinking in that focusing on patient need has been subsumed by other agendas. Once a medical situation has been resolved, even if the patient still requires care, nurses no longer see any justification for keeping the patient in hospital. The nurse was persuaded that it was *'no problem'* and that the district nurses *'can look after her'* (general field notes). I observed other situations too where patients were discharged while not ready; an elderly overweight man with right-sided hemiplegia who required a great deal of physical care. Although his wife felt he was much too heavy for her to cope with, the patient was discharged as *'things would be sorted out'*. I also observed a frail-looking elderly woman suffering from a chronic respiratory disorder who was rather short of breath and extremely anxious. Care delivery was very slow as the patient needed breaks to regain her strength. At the time of discharge the patient indicated that she was not ready but her concerns were ignored. This patient was readmitted the following day.

Where was the nurse's voice in these situations and why were nurses not sufficiently concerned to intervene effectively? Any situation where care requirements may or may not be manageable by the patients themselves or their families should be a nursing concern (Davidson-Baer, Fagin, & Gordon, 1996; Fagin, 2001; Gordon, 2005). Rankin and Campbell (2006) observed similar situations and noted that nurses tended to fulfil their role as 'hospital agents', representing the interests of the hospital or health agency rather than the interests of the patients and their well being. Indeed, in the cases that I observed it appeared that nurses conformed to a philosophy that placed more emphasis on the management of beds than the care of patients. If we take the analogy of the train a little further then it almost looks like the nurses have become the train conductors whose responsibility it is to ensure that patient-passengers leave the train according to schedule.

Patient classification systems and their effects on nursing

The hospital where the research took place utilised TrendCare, a computer-based patient classification system (PCS) which calculates nursing workload on the 'estimated' time needed by nurses to care for an 'average' patient, focusing in particular on physical activities. TrendCare, which operates in particular in Australia and New Zealand, claims that their system:

"... provides nurse managers with the necessary information to identify and manage patient risks, monitor patient outcomes and variances to clinical pathways, develop realistic nurse patient ratios, HPPD targets and budgets, distribute fair workloads to clinical staff, retain an adequate skill mix, monitor staffing costs and develop accurate nursing cost weights for specific DRGs or patient types" (Trend Care Systems, 2010)

TrendCare claims that the success of the system is based on its reliability to allocate fair and equitable workloads to staff and that its use will save hundreds of thousands of dollars while improving patient care (Trend Care Systems, 2010).

According to Perroca and Ek (2007) patient classification systems PCSs have been in use since the 1960s when it was a tool to support the charge nurse in the decision-making process to allocate or withhold additional resources for the provision of patient care. Since its initial introduction PCSs have undergone many changes as a result of the health care reforms. Malloch (1999) identified the first significant change during the 1980s with the introduction of managed care and diagnosis-related groups (DRGs). Previously fluctuating staffing needs were dealt

with through overstaffing, the second generation PCSs became a tool for health care organisations to improve productivity in an effort to contain health care cost and introduce greater flexibility in the health care workforce. The third generation PCSs were developed from the 1990s and focused on macro-level management, coinciding with the introduction of generic management principles, market forces, and health as a business. Based on DRGs, time and motion studies, as well as estimations by expert nurses, a complex system was developed aiming to calculate, amongst other things, the exact amount of time a nurse requires to complete a specific task.

In New Zealand a project team examined the benefits of PCS and came to the conclusion that the workload data only provided one part of a much broader picture and that 'without attention to the total context of acute care in which nurses work and without understanding nursing resources available to the clinical unit, acuity information is open to misinterpretation' (District Health Boards New Zealand, Nurse Executives of New Zealand, & MidCentral District Health Board, 2001, p. 1). The report noted that the current tool did not account for patient turn-over and intra-ward transfers, both of which were significant issues in contemporary hospital settings. The PCS also did not adequately reflect work patterns in very acute wards, did not allow for any weighting of staff mix and skills mix, nor did it reflect the non-nursing activities that nurses engage in. All of these shortcomings were seen as important factors when calculating workloads, and these findings have been confirmed by other researchers since (Fagin, 2001; Rankin & Campbell, 2006). Despite the known shortcomings the project team felt that with the right modifications, functionality of the system could be improved (District Health Boards New Zealand et al., 2001).

The thoroughness of the report is evidence that TrendCare was implemented with all the good intentions of having an objective tool that would assist nurse managers to justify their staffing arrangements/requirements. However, without the fine-tuning and the necessary adaptations TrendCare can only calculate staffing requirements based on average patients with standard needs requiring standardised nursing interventions, while actual staffing requirements should be based on unique individual patient needs and the multiple realities of nursing practice. During the data collection period many nurses expressed scepticism

about the current utilisation of TrendCare which was frequently perceived as a tool manipulated by managers with no real benefits for nursing.

TrendCare is not a true reflection of what you actually do for your patients. It's done so that it reflects how much time we are spending with our patients and things like that. But I think it's also done to manipulate where staff are sent, or if they are kept on the wards. I don't know [pause], I think the statistics are manipulated for the company's own gain, certainly not for the nurses' gain. It's just another ten minutes spent at a computer. I really don't see the benefit to nurses. (Annika)

Like Annika, Elsie and Marije firmly believed that TrendCare was used by hospital management to keep staffing levels to a minimum. Both recalled situations where the workload was well over eight hours but no extra help was provided.

No matter how hectic you are on the ward, I personally don't feel TrendCare can actually show that. And even if you are four hours over [meaning that TrendCare has calculated the workload to be 12 hours], there's really nothing that they can do to help you with on that shift, does that make sense? Yeah, requesting for more staff when you're already really full but when you don't get it, it's just a bit sad. I think it is used for setting maximum staffing levels ['maximum' meaning that no additional staff is allocated despite a calculated higher workload]. (Elsie)

When TrendCare shows spare capacity they'll remove someone, but when you are, you know, say twenty hours over, so you need another two and a half worth of staff members for their hours, you don't get them. So it never works to your advantage. (Marije):

The nurses' comments are supported by research literature confirming that administrators do not utilise patient classification systems to estimate the number of staff required, and respond accordingly by ensuring in advance that sufficient staff are employed (Perroca & Ek, 2007). The only way for nurses to exercise some influence in the decision making regarding staffing levels, is by inputting the real time requirements for care rather than the allocated time spans provided under the TrendCare guidelines.

I have been accused of manipulating the hours, but you know, you're not. I find that quite disheartening as well, because that's saying you don't know your patients, and no one's trying to fiddle the TrendCare system, it's just we're trying to say, well, you know, this is actually what this patient takes, but you don't get the extra staffing for them. (Marije)

A charge nurse showed me how TrendCare 'really' worked by inventing a fictitious patient called Mr Brown, a medical patient with a diagnosis of COPD. Mr Brown needed total assistance as he was immobile. He required full assistance with

hygiene care, was independent with nutrition etcetera. The actual hours of care required totalled up to 2.25. Mr Brown's medical diagnosis was subsequently extended by adding the diagnosis 'unstable post-operative bowel surgery'. While all Mr Brown's needs remained the same as before, the care now included ½ to 1-hourly observations of more than two types of vital signs. His medication was also significantly increased yet the total hours of care calculated by TrendCare remained 2.25 hours. Not only was this a demonstration to show that the system did not work as claimed, but it also demonstrated more than before the 'standardisation' of patients as 'units of time'.

Campbell (2000) maintained that the implementation of a patient classification system has pervaded nurses' thinking about their work in different ways; in terms of direct and indirect care, and managing the scarcity of time. There are two crucial points to be made here. Firstly, standardisation ignores the complexities that are inherent in any social interaction, especially when these involve vulnerable patient populations. Standardisation of interventions simplifies nursing to a set of distinct tasks for the purpose of enabling managers to allocate set times for task completion. Secondly, categorisation of nursing activities enables labels to be attached in terms of essential, less essential and non-essential interventions, which will be discussed under the subheading 'justification of care given or care missed'. In the restructured health care environment characterised by clinical pathways dictating the essential treatment/care activities, lean staffing arrangements, and a chronic shortage of time, nurses have no other option but to alter their nursing practice by providing the care deemed essential to meet set targets within shrinking time frames.

Time pressure made nurses become task-focused by taking over activities of daily living that the patients were quite capable of doing themselves. While taking over from a patient speeds up the process of 'getting the job done', it reduced the patient to an object to whom nursing was done.

It is an older population which impacts on your ability to get through your workload. You are supposed to enable people to do as much as for themselves as possible, but when they are very frail, multiple co-morbidities, you cannot rush those people and that is not accounted for. That is probably one of the things that TrendCare doesn't capture.... In the medical setting it [patient load] is never less than 5, and you know that the average age is going to be about 80. You cannot make an 80 year old

patient move fast so you know what happens, nurses are going to take it over to hurry it along, aren't they? (Jolanda)

Staffing decisions are increasingly based on economic decisions and depend both "... upon the way that 'needs' are constructed through patient classification, and upon how those data are manipulated with budget information" (Rankin & Campbell, 2006, p. 38). The health reforms of the 1990s emphasised efficiency and cost containment, but also sought to secure greater influence and control over the nursing workforce by reducing nurses' influence in decision-making (Gibbs et al., 1988; Norrish & Rundall, 2001; Rankin & Campbell, 2006; Weinberg, 2003). While the original intention of PCSs might have been to develop an objective tool to justify nursing staffing levels, generic health care managers have captured the tool to define and standardise patients' needs to limit the amount of care that will be provided by regulating staffing levels.

Prior to the introduction of TrendCare nurses determined the time individual patients required. Nurses were in control of nursing matters, assessed patients' needs, developed plans of care, and made changes to these based on continuous evaluation; nurses managed their own workload (Rankin & Campbell, 2006; Weinberg, 2003). Based on the prolonged period of data gathering in this study, I argue that the introduction of clinical pathways and PCSs have had a significant effect on nursing practice to the extent that it has eroded nurses' professional autonomy.

Rather than being able to concentrate on nursing practice, nurses had to continuously balance perceived, required care with officially sanctioned care, which is care that can be legitimately 'claimed' under TrendCare. Nurses dealt with this in a combination of ways such as manipulating input data for nursing activities that were not accounted for in TrendCare or by limiting the actual care provided to patients. Marije's excerpt illustrates how the focus of nursing has shifted from patients as unique individuals to viewing patients in terms of 'units of time investment', what each patient is 'worth'. Marije's still resists to a certain extent the influence of TrendCare by manipulating the input of data.

TrendCare is not an accurate system. It doesn't reflect everything you do for a patient. You know, if you have spent an hour with a patient on a transfer, you cannot record it there. So you try and make up for it in other parts and then, yes, you are altering TrendCare and making it inaccurate, but it's not really inaccurate if you look at the time and that is really the

main issue. With our TrendCare system, I don't think it properly reflects what each patient is worth. (Marije)

Marije's excerpt reveals how big the influence of TrendCare is on the nurses; everything revolves around time and perceived workloads, and it demonstrates the control managers have over nursing practice through the use of TrendCare and other similar tools. Many nurses rightly or wrongly manipulated the input data to the extent that question marks should be placed over the usefulness of the information submitted for the purpose of determining staffing levels. If ward nurses are over-estimating the time requirements because either the allocated time is too lean, or they try and safeguard their staffing levels, and if hospital management assumes that this is happening and hence do not respond as indicated in Marije's interview, then this whole process has turned into a 'hollow paper exercise' only. Over-estimations and discrepancies in the amount of time required to deliver nursing care, sometimes referred to as 'acuity creep' appeared to be common and have been reported in the nursing literature for many years (M. Hughes, 1999; Malloch, 1999; Norrish & Rundall, 2001; Perroca & Ek, 2007).

Not providing individualised care and focusing on limited standardised care was a common response of nurses to deal with the constant struggle to fit required nursing interventions in a shrinking time allocation. By doing so, nurses were giving in to the dominant discourse that values efficiency and cost containment over individualised holistic care. Giddens (1991 p. 211) argued that it is not only that people diminish their personal beliefs and ideas "in favour of the increasingly persuasive influence of impersonally organised systems; rather, what occurs is a genuine transformation of the nature of the personal self". While nurses might resent in the first instance the way nursing is practiced, over time they might not only accept it but make it fully their own; this is what nursing is.

Lots of people think that it [refers to TrendCare] provides no time for rehabilitation. Like, if you want to walk a person, or your patients might take an hour, yeah, lots of people think that it doesn't allow for that. (Amy)

[Researcher] How do you deal with that?

I tend to do the most important things to the least important things.

[Researcher] What are the most important things?

Uhm, giving medications. You know like if people are on uhm they are on morphine pump or anything like that, I go and check those things. I prioritise blood sugar levels you know, those sorts of things and like I leave

washes and that to the last. I guess I don't appease people as much, do you know what I mean?

[Researcher] No, no you tell me.

You know sometimes I used to give washes and that to make people feel good but now I tend to focus on nursing things more yeah... its all more hectic now, I feel... yeah..

[Researcher] When you say you tend now to focus more on nursing things, what are those things?

Uhm like uhm they're like, you know, giving medication. You know, in the assessments, doing medication, rather than the... I don't know, than the patient cares as such. The more acute things than the ... yeah, does that make sense?

Amy's dialogue illustrates how nurses have reconstructed their own views on nursing to make it fit within the dominant discourse and how it subsequently affects actual nursing practice. In contemporary ward nursing PCSs like TrendCare, rather than nurses, increasingly validate and control what counts as important and how much nursing time should be allocated. In doing so these programmes undermine and diminish the professional autonomy of the nurse. Having been in use for well over a decade, there is a significant cohort of nurses for whom TrendCare has become what nursing is all about. By adapting nursing practice to reflect the values inherent in TrendCare, nurses have created a structure of routines that become self-perpetuating to the point where nurses as contributors to the structure also become dictated by that very same structure.

Nursing workloads

One of the most recurrent themes raised by participants was nursing workloads. Nurses frequently expressed concern about their inability to provide care due to the multiple demands on their time. I can readily recall a number of occasions where nurses did not go to morning coffee or even lunch because of the busyness of the ward. However, many discussions about workload quickly turned into confusion as there was no shared understanding of what should be included in 'workload', which is understandable given the multiple definitions of nursing (see also chapter two). Some nurses saw all forms of documentation as part of nursing while others did not perceive this to be the case, describing documentation as a waste of time. Some nurses maintained that hygiene care was an important part of nursing, providing opportunities for patient assessment, while other nurses felt that this was much

better done by health care assistants so that nurses could do the more complex nursing interventions such as cannulisation and intravenous therapy.

The topic of nursing workload in the literature illustrates the complexities. Myny et al. (2011) conducted a literature review and found that of the 30 publications selected, only five defined what they meant by workload. Needham (1997) maintained that any definition of workload needed to be preceded with a definition of nursing, although he subsequently used an existing workload definition: workload is 'the totality of the need for nursing time from all work that must be carried out over a defined period of time' (Mersey Regional Health Authority, 1991), but added that such a definition needed to include direct and indirect nursing care as well as non-patient related work. Despite his own insistence that a workload definition needed to include these aspects, he pointed out that this represented a problem as it might suggest that the nurse subsequently becomes responsible for non-nursing work. Similar concerns were expressed in this study too, in particular in regards to medication prescription errors created by doctors. Nurses have taken it upon themselves to constantly check for mistakes but does this mean that they are now responsible for that?

I contend that nurses have historically always undertaken additional tasks; nurses used to clean the top of patient lockers and over-bed tables, tended patients' flowers, tidied up clean and dirty utility rooms, and in the distant past washed patients' laundry, and cleaned, checked, and repacked syringes and needles for reuse after sterilisation. What nurses do and what nurses see as their responsibility is for a large part determined by the contextual setting. Nursing roles differ significantly when comparing primary health care with secondary health care settings. Given that in many situations nurses are employees and have job descriptions which include a range of responsibilities, care has to be taken that the allocation of additional tasks is not at the detriment of patient care provisions.

According to NZNO, nursing workloads are steadily increasing since the change of Government in 2009 (Walker, 2011). The nurses' organisation reported a worrying trend of increased job dissatisfaction and increased stress levels, as ongoing restructuring in the secondary health care sector has resulted in further job losses, reductions in support staff, and higher patient to staff ratios. The NZNO survey revealed that only 42 percent of the nurses felt that there were enough nurses

employed while more than a quarter of the respondents employed by the DHBs felt that care was compromised on most shifts.

Observations in the field showed that nurses had developed a range of strategies to manage their workload. Nurses streamlined activities by keeping to strict routines and used an hour-by-hour time schedule to monitor their timing and ensure that all important interventions were carried out. The use of a written time schedule, which I referred to in chapter five as 'pocket notes', appears to be commonly used in ward settings (Bowers et al., 2001). As discussed, the use of pocket notes helped nurses to structure their day but it also contributed to task-focused nursing. The way some nurses utilised these notes reminded me of a grocery shopping list; pocket notes provided structure but at the same time also shaped the way nurses have come to see nursing practice as illustrated by the comments from one of the senior nurses.

So someone devised this little sheet [refers to pocket notes] where we could put little reminders in for ourselves. But what I have noticed is that nurses use that as: "this is my nursing!" Nurses write on their pieces of paper that they keep, and on this piece of paper they tend to list tasks, it's not about the patient. The bit that they used to write about the patient's history, what had happened when they had their operation, anything of note around the patient is now a tiny little column and the rest is filled up with the tasks they need to do over eight hours. (Kim)

Another strategy to manage workloads was by reprioritising nursing activities and eliminating interventions determined as non essential; this is what I will turn to next.

Justification of care given or care missed

Observations in the ward and discussions with nurses revealed the impact of higher workloads. Not only was care highly routinised and dictated by the clock, but increasingly nursing interventions focused on medically-related activities such as medications, infusions, vital sign measurements and charting. Nursing interventions such as talking to and comforting patients, ambulation, turning patients on bedrest, assistance with nutritional intake, oral care and patient teaching were frequently omitted, not because they were overlooked but because they had been prioritised out of the workload due to a lack of time (Bowers et al., 2001; Duffield et al., 2011; Gravlin & Bittner, 2010; Kalisch, Landstrom, & Williams, 2009; Rankin & Campbell, 2006).

Even though I am an experienced nurse, as an observer I became much more aware of the sheer pace of contemporary ward nursing, the continuous 'running around', the constant responding to a myriad of different situations flashing past, and in between all of this there is the provision of care albeit fragmented with numerous starts and stops. I also became aware of the many occasions when nurses struggled to cope or were stressed because they felt that they could not meet the care requirements of their patients. How do nurses cope and how do they decide what nursing intervention to undertake?

[Researcher]: How do you manage your workload?

I guess we prioritise, and stay late! [laughs] Yeah, and....I don't know, you just... just manage... just time management...or lack of time management sometimes! [laughs] (Helen)

[Researcher]: Earlier on you talked about prioritising care and not doing all the cares. Can you talk a little bit more about that?

Unfortunately, when you prioritise, a lot of the things that are dropped are the washes and the basic patient cares, like turning. If you've got a really ill patient, you need to be doing the medications and assessing them, and then they [referred to washes and basic cares] would be the things that would be dropped. I don't see it as any more important in a way, but in the bigger scheme of things, of keeping people alive, sometimes that's what you have to do, and because, you know, you've got the doctors chasing you up, asking you to give this and this and this. And you have to just...yeah.

Anouk is one of the most experienced nurses taking part in the research and the following excerpt illustrates how she managed her workload and how she made her decisions.

I try and get the things that I consider I want done at the top of my list. And sometimes that means that you can only do the basic things. Q: Basic things? Well medication would be sort of the top of the list and any IVs. Whether a patient gets up and has a shower or not, to me that is not important. If you haven't got time to get a patient up and showered they are not going to die of that. With our new beds, you can change positions and set them up. They don't need to get up in a chair for a change of position, you don't actually have to mobilise them. If mobilising is a priority, that is something that has to go sometimes. It takes a considerable amount of efforts to get someone out of bed, put their slippers on, walk to the toilet. Well that would go. Uhhh, education I guess is a thing that goes when you are pushed for time. TrendCare, leave that out, just minimise a lot of things, just minimise your patient contact too. You cut everything back, little snippets here and there so you can manage everything together. (Anouk)

To manage her workload, Anouk was constantly adjusting her plan according to how the day developed and the amount of time left. If one patient's nursing interventions took longer than expected then another patient's care would be cut back. In a way, patients have become competitors for a steadily shrinking resource of nurses' time. Little 'snippets' Anouk called it, but for patients it meant receiving less or even sub-standard care. Observations in the clinical setting suggest that nurses have come to accept that nursing's goal posts have steadily been shifting.

If you cannot do what you have to do, you don't do it. I prioritise what I need to do. If the workload is that hectic and there is not any more staff available then uhmm.. you follow your safe staffing protocol and do your medication job and observations and that's about it. (Wendela)

[Researcher]: You mention 'protocol' so is it all prescribed by the hospital what you need to do?

Yeah, there is a flow chart so you escalate to the next level and then you escalate next level, ...yeah and then so like at that level you notify, say if you know that you are absolutely hectic you notify the supervisor and then they notify the director of nursing. I think that's what goes on, I have to go back to it and have a look.

[Researcher]: Have you ever had that situation?

Yeah, a few times. It doesn't guarantee you extra help because if there is no help there is no help, but at least it is been documented so if things operate safely then that's okay.

Three nurses and three ways of explaining how care was reduced in response to heavy workloads. Nurses have reluctantly come to accept that contrary to the official rhetoric, contemporary nursing practice was no longer about holistic care and maintaining standards. Rather, ward nursing is all about managing a high workload by rationing care. When patients complained of not having had a wash for two days, or not having been out of bed, it was not because these interventions were forgotten. Missing out on cares was seldom an accidental event, and hence was not synonymous with 'missed' cares. Cares were not overlooked, but cancelled because in the bigger picture of 'keeping patients alive' the missed cares were classified as 'non-essential' care i.e.: oral hygiene, assistance with nutritional intake, mobilising/exercises, patient teaching, and providing emotional support (Duffield et al., 2011; Kalisch et al., 2009). Elsie's comments below illustrate how this rationing of care has become an ordinary part of day-to-day nursing practice with nurses making sure to explain why certain cares might not be done because of the high workload.

Yeah... I would definitely change a dressing if it needs to be, or remove a redivac if it needs to be, and my observations [referred to doing vital signs measurements]. Yeah... like if I had time I would sit down and rub their feet, and turn them over and rub their back if they were, you know, in quite a lot of back pain and stuff, and just spend time with them. But it is just the lack of time, that it's just the.. it's not just the basic stuff, it's just the.. yeah... I would definitely explain it to the patient, as to why I was doing it, so that they don't feel neglected. (Elsie)

[Researcher]: On average, how often do you think you are able to do these extra bits of care, like rubbing people's feet and massaging their backs, would that be every day, every other day, once a week, once a month?

Yeah. I'd probably say once a week.

The Ministerial Taskforce on Nursing (1998, pp. 21-22) stated that: "Research has demonstrated the process by which some nurse graduates relinquish their theoretical preparation in order to comply with the dominant ethos of the practice setting". This research suggests that relinquishing theoretical preparation was not restricted to some nurse graduates but rather that all nurses, even those with many years of clinical experience had relinquished their professional beliefs and practices in order to function within the dominant ethos of clinical practice. Campbell (2000, p. 187) argued "The current restructuring of caring work imposes the 'superior' world of rationality, objectivity, and impersonality into the experientially diverse world of nursing as if the former accounts for and supersedes the latter". Indeed, by accommodating managerial demands for efficiency and the willingness to adapt and alter caring practices, nurses have unwittingly contributed to and reinforced the current standards and prevailing work patterns which have become the routines that structure everyday contemporary nursing practices in medical and surgical ward settings. Asking about the future, none of the participating nurses expected their work to be better; on the contrary, the general feeling was that nursing was getting heavier and even more demanding in the future, confirming the findings of the NZNO survey results (Walker, 2011).

I think the ward I work on is a very busy ward so it's not just that people don't want to be supportive, but it's often hard because everybody has a difficult workload and the expectation seems to be getting higher and higher I think, of what us nurses should be able to do or what we should be doing on a day to day basis. So yeah, I think it's just the everyday demands on everybody that makes it hard to follow through on that. (Kitty)

Planning nursing care

Lydia Hall, a nursing theorist, appears to have introduced the 'nursing process', a systematic problem solving approach, into professional nursing during a lecture in 1955 (De la Cuesta, 1983). The original aims of the tool were in part ideological as it symbolised professional practice and nurses' autonomy to make decisions, and in part practical namely to improve nursing practice (De la Cuesta, 1983). The nursing process has ever since been utilised and further developed by scores of nurse theorists, in particular as a teaching tool in higher education (D. Allen, 1998; De la Cuesta, 1983; Dingwall, Rafferty, & Webster, 1988).

The current health care environment based on generic management principles and standardised processes that focus on maximising efficiencies and cost containment, appears to be at odds with nursing's philosophy which emphasises individualised care. In the United States where the nursing process was first introduced, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) decided in the mid-1970s to make NCPs a mandatory requirement for clinical agencies to gain accreditation in the hope that it would contain the continuously rising cost of health care (De la Cuesta, 1983). Dingwall, Rafferty and Webster (1988) argued that De la Cuesta did not emphasise the significance of the Joint Commission's decision to use the nursing process for something completely different than its original intention and that it demonstrated how easily such a tool could be appropriated for different purposes.

The nursing process is claimed to be at the heart of any nursing care plan (NCP) and consists of several distinctive steps; a thorough nursing assessment to identify patient problems or areas of concern; a statement of goals to be achieved within certain time limits, a set of instructions for nursing interventions, and lastly a regular review to evaluate the effectiveness of interventions and progress towards the goals set. Based on continuous assessments and focused on actual patients, these NCPs are 'living' documents that reflect the patient's journey through the health care facility towards the desired goal (Carpenito-Moyet, 2008; Gulanick & Myers, 2011). Despite nursing textbooks and a variety of journal publications claiming that NCPs contributed to more personalised goal-focused care, there is significant nursing research that questioned these benefits and noted nurses' ambivalence towards NCPs (D. Allen, 1998; Greenwood, 1996; Henry, Holzeimer,

& Reilly, 1994; Jansson, Pilhammar-Andersson, & Forsberg, 2009; McCrae, 1993; Waters & Easton, 1999).

NCPs have been in use in New Zealand for over thirty years. The original NCP were hand-written and from personal experience I recall that developing a NCP required between 30 and 45 minutes, while updating and maintaining care plans could take five to ten minutes per patient per day. Before the health sector reforms of the 1990s the length of hospitalisation was more than double and hence there was a more stable patient population with less admissions and discharges. Having an average allocation of about four patients (the period 1981-1989), there was sufficient time in the day to update NCPs each day even though this did not always happen. Of all the documentation that nurses undertook, the NCP used to be the only document developed and maintained solely by nurses for nurses. Learning how to assess patients and how to write NCPs with patient-focused problems and nursing interventions remain key skills that nurses, enrolled in Bachelor of Nursing programmes, continue to acquire to this day.

The restructuring of the health service, the multi-disciplinary approach, and the introduction of information technology have contributed to an increasing amount of documentation to be completed by nurses (Duffield, Gardener, & Catling-Paull, 2008; Fitzgerald, Pearson, Walsh, Long, & Heinrich, 2003; Gugerty et al., 2007; Pelletier, Duffield, & Donoghue, 2005). However, these authors' research findings showed large discrepancies with results ranging from as low as 12% to more than 50% of the nurse's time being spent on documentation. Nurses involved in this current study confirmed that they had noted an increase in documentation requirements which was impacting on overall workloads. In an effort to assist nurses to reduce the amount of time spent on documentation, senior nurse-leaders had, as in many other hospitals, enabled the introduction of pre-printed 'standardised' NCPs. Based on a range of medical diagnoses, nurses were able to select a plan that fitted best the patient's condition from a set of pre-printed NCPs. While these NCPs were worded in such a way that they were able to be utilised for a wide range of patients (see below), limited space was provided to tailor the plan to individual patient's needs.

Standardised NCP surgical ward

Risk of complications (e.g. Haemorrhage, infection) related to surgical procedure.
Risk of pain related to surgery.
Alteration in nutritional/hydration status secondary to surgery/injury/nausea & vomiting
Self-care/mobility deficit related to injury / surgery
Risk of anxiety/fear secondary to surgery & lack of knowledge of illness
Risk of altered sleep pattern r/t hospitalisation, surgery, delirium
IV Access

Standardised NCP medical ward

Abdominal pain r/t inflammation, oedema, abdominal distension or peritoneal irritation.
Potential for fluid volume deficit r/t fever, diaphoresis, vomiting or reduced fluid intake.
Potential for ineffective breathing patterns r/t pain, abdominal distension, or ascitis.
Potential for complications (eg sepsis, hypovolaemia) r/t body fluids shift and metabolic changes
Risk of anxiety due to unknown outcome of condition and hospitalisation.
Risk of altered sleep pattern r/t hospitalisation, surgery
Self care deficit r/t fatigue, pain, and weakness
(r/t = related to)

Table 1: Example of actual NCP from surgical and medical ward. Please note: only patient problems are provided while interventions have been omitted.

Kim, one of the senior nurses could remember the development of standardised NCPs.

When they started auditing notes there were quite a few patients that did not have nursing care plans. So the standardised care plans were brought in, sort of as a risk management. At least there was a sort of a care plan, it might not be a good one, but at least there was one. Argued about it a lot over the years, because to me, if you pull out a standardised nursing care plan, nature is that that will do. (Kim)

Nurses' opinions regarding the usefulness of standardised NCPs varied but were largely negative. Nurses interviewed indicated that the pre-printed NCPs were not helpful in providing clear instructions related to care requirements, blaming each other and the hospital for the poor quality of NCPs which were described as 'a waste of time'. Although nurses could add or alter nursing interventions this was only sparingly done. Nurses did not trust the information as frequently it was incomplete or out of date i.e. the NCP indicated that the patient was on an intravenous infusion while the actual treatment was stopped two days earlier. Kitty's comments exemplified my observations that many NCPs were not based on any patient assessment or that the plan was not adjusted to the individual's needs

When ED phone up and give us a diagnosis, say they said this person is a CVA so we just print off a care plan to do with CVA. You do obviously get one that relates to the serious CVAs, where they've got a dense hemiparesis. But [if] you get a CVA [patient] that, you know, they seem quite normal apart from a slight facial droop and then you've got this huge care plan telling you how to position them but really they are quite independent with mobility so that does happen quite often. (Kitty)

It is tempting to link JCAHO's strategy to use the nursing process to contain the rising cost of health care to the current use of pre-printed NCPs, and claim that this too is a management strategy to influence and control nursing practice, or undermine nurses' ideal of providing holistic person-centred care. However, I believe that such a link would be incorrect and too simplistic. Hospital managers might indeed not value emotional work or understand holistic caring, as after all the managers' main role is to focus on raising efficiency and containing costs (Dingwall & Allen, 2001; Gordon, 2005; Norrish & Rundall, 2001; Rankin & Campbell, 2006). However, the pre-printed NCPs were never intended to be an end product as noted by Kim, but rather they were to be a template for nurses to complete. NCPs are a nursing tool and therefore the full responsibility of how these are used rests with the nursing profession and the individual nurse.

The challenges related to the utilisation and usefulness of NCP is complex, in particular in clinical settings where the reduced length of stay typifies the majority of patients. It is questionable whether the existing format of NCPs is the most suitable tool for contemporary medical and surgical ward settings that are per definition multifaceted, dynamic, and fast moving. It may well be argued that the amount of time and energy required to develop and maintain a truly holistic care plan for only 24 to 48-hours is not the best use of nursing time and resources. Likewise, patients might not be very interested or willing to provide personal details for a 'small routine' procedure that sees them out of hospital within 24 hours. Nurses may want to consider a different approach in these situations with a much more focused assessment covering the treatment and after-care.

Observations in the field showed that the current pre-printed NCPs were a source of confusion and undermined professional nursing practice. Nurses claimed to have no time to personalise NCPs to the specific needs of patients thus resulting in standardised task-focused interventions. Elsie's comments illustrated how her views of the NCP have changed as she gained more clinical experience.

Care plans are based on the [medical] condition. We have 'ready-made' care plans that are yeah....I personally don't think that care plans are made specific enough on our ward. Even crossing out bits and pieces that are not needed, just dating them and signing them, just little things like that aren't done by the nurses. If I was new, and I was looking at the care plan, I'd just assume all these cares were meant to be done. Not all of them are done, so you don't know whether or not you're meant to implement them on your patient. I started off my nursing career relying a lot on nursing care plans but now I don't, simply because I cannot rely on the nursing care plan. (Elsie)

Indeed, I noted that the utilisation of NCPs was very inconsistent, ranging from nurses who did not read and check care plans to nurses who used them as a matter of routine. Ward nurses explained that the use of NCP had also changed in an attempt to reduce the amount of documentation. To assist nurses, dated columns had been added to the NCPs for nurses to tick off the nursing interventions provided, eliminating the need for these to be documented in the progress notes. Like the pre-printed NCPs, the intention of the change was an attempt by senior nurse leaders to manage risk by improving the quality of documented information in a way that did not increase the time requirement for documentation. Despite good intentions, the addition of columns changed the original function of NCPs even further as observed in clinical practice. The requirement to sign off interventions became the focus and resulted in nurses perceiving the NCP as 'must do' intervention in which the signing off was perceived to be most important. Thus, I regularly observed nurses at the start of their duty signing off all sorts of interventions in advance and before they had seen their patients. Others signed off interventions at the completion of the shift, even though some of those interventions had not been carried out. For some nurses the need to sign off care was described as just another task to satisfy bureaucratic requirements, rather than a tool to communicate what cares had been provided. Others felt that it was part of quality control because of the fact that it was used for auditing purposes. This strengthened the perception that NCPs 'dictated' care requirements. The ambivalence towards NCPs which has been noted in the nursing literature over many years was certainly present in clinical practice. Pre-printed NCPs were either largely ignored or readily accepted without any individualisation of nursing interventions to reflect assessed patient's needs.

Some people will sign things that haven't even been done, you know.they just sign, sign, sign, sign and in reality they should stop and ask: 'did I actually do that?'. Quite often at the bottom there is the patient

information, the uhmm.. discussing things with the family, and people sign the whole lot yet, they [the nurses] have not spoken to the family member at all. You don't know what has been discussed so it is not really, you know. I just find them....but then we need to have care plans even though the plans are not based on actual patient needs. (Lily)

Lily's comments, which were confirmed by other nurses, as well as by my own observations in the field, raise many concerns. NCPs are a compulsory requirement and yet they do not indicate actual patient needs. There is no direct link between patient assessment and NCP. The information is task-focused but cannot be trusted as a signature is no guarantee that the intervention was carried out, while no signature is not a guarantee that the intervention was not carried out. The information contained in the NCPs favours physical/medical concerns while ignoring other aspects of patients' health care requirements, which leave patients experiencing a health system that values the documentation more than the actual care provided at the bedside.

Nurses shared their frustrations during informal discussions and the interviews and expressed feelings of being disempowered and lacking control over things nursing. I asked why they continued to use NCPs when at the same time they maintained that NCPs had no connection with the real patient. Nurses claimed to have spoken to charge nurses and higher management about the lack of time, the stresses and strains due to high workloads, and their concerns that patient care was suffering as a result of it. Nurses maintained that they were told to work smarter and to think in new and more flexible ways because this is a new world, which appears to be a universal response in contemporary health care settings across the world (Davidson-Baer et al., 1996; Gordon, 2005; Rankin & Campbell, 2006). Although nurses felt unable to change the situation they were in, they still blame nursing and themselves for their situation as illustrated in the following excerpt.

I don't think we're oppressed anymore, but I feel that as with so many things, when we do try and have our say that we're just squashed. Like about our stress levels and everything, and I think that comes into this, we don't feel as though we're able to have a say, that, you know, that the care plans aren't working for us and we aren't going to do it. I mean, that would be, you know, probably seen as obstructive, and performance managed. In the last interview you asked, would it be better if we had to write it in ourselves, yeah, and that would be a better system, but it is time consuming. I mean, at the moment we come in and we just go and pick a care plan out of the vertical file, that is, that could be used for another twenty patients on the ward. So, I mean, we fall down automatically ... (Marije)

Despite the continuing ambivalence displayed by nurses towards NCPs, at the end of the day nurses still used the pre-printed plan. Discussions with nurses revealed that they felt that there was no other option but to use these NCPs. I suggested to bring it up during a ward meeting and even though responses varied, the general reply was that this would make no difference and that the charge nurse was not able to change this. Indeed my discussion with one of the charge nurses about TrendCare revealed that although she disagreed with it, she was unable to change it as these decisions are made external to the ward. This apparent lack of authority to determine what happens in the ward raises questions about leadership at ward level. What is the purpose of maintaining nursing records that are known to be inaccurate but have the ticks in the right place for audit purposes?

Nursing documentation

Nursing documentation represents a written account of the patient's health status, the findings of observations and assessments undertaken, a plan of care, as well as a record of the actual interventions implemented and their effects/outcomes. Nursing documentation serves as an important means of communication between nurses, and between nurses and other members of the multi-disciplinary health team. With fewer ward nurses working full time, and a growing input from the multi-disciplinary team, documentation as a means of communication has increasingly taken centre stage in contemporary health care management (Duffield et al., 2008).

While nurses noted the importance of documentation as a critical factor for safe nursing care, observations in the field revealed that patient progress notes often contained little specific patient information that would be helpful in guiding nursing practice. This finding is in line with other studies (J. Allen & Englebright, 2000; Smith, Smith, Krugman, & Oman, 2005; Törnvall & Wilhelmsson, 2008). Beside the two key documents, the nursing progress notes and the NCP, participants noted that there were well over 50 other specific documents and charts in regular use for specific patient information. All nursing documentation has a legal status and can be used in a court of law to defend the quality of care provided (D. Allen, 1998; Jefferies, Johnson, & Griffiths, 2010). This is of concern given that I have pointed out the inaccuracies that can be found in standardised NCP with interventions being signed off that may or may not have been provided. The notion that documentation can be unreliable and may not reflect actual care provided has also

been supported by other research (De Marines et al., 2010; Taylor, 2003; Waters & Easton, 1999), and explains Elsie's comment why she could no longer '*rely on the nursing care plan*'.

Most nurses felt that they spent 'hours and hours' on documentation. My observations in the field suggested that nurses were likely to spend an estimated two hours a day on documentation, which is congruent with other research findings (Duffield et al., 2008; Korst, Eusebio-Angeja, Chamorro, Aydin, & Gregory, 2003). Reading reports and checking various documents at the start and during the duty required on average 45 and 60 minutes a day, while nurses spent around an hour, which was about 10 minutes per patient, writing the daily progress notes and maintaining the charts. Projected onto a standard 8-hour shift nurses spend about a quarter of their time on documentation which is indeed a significant amount of time.

Also paperwork, which I think a lot of people don't expect from a nursing job. People on the outside [of nursing], would not think of that as a huge part of our job. Paperwork takes up an immense amount of time. (Kitty)

Nurses expressed their concern about the growth of documentation because it was seen as a '*waste of time*' impacting on available time for bedside nursing. Arguably, if nurses believed that the required documentation facilitated nursing practice they would have judged the time spent on it differently. In particular duplication of written information was frequently mentioned as time-consuming and a bone of contention.

I think that some aspects of the documentation are important but I think that we are being asked to reiterate it too much. We may be asked to record a Falls Risk on the observation chart, on the Falls Risk chart above the patient's bed, and on the nursing assessment. So we are repeating ourselves and it takes a lot of time. I think we need to get people to decide, the documentation needs to get smarter and combine it together. (Marije)

Although nurses acknowledged the importance of documentation, many documents and charts were revealed to have missing/incomplete data. For example, fluid balance charts were poorly maintained, TPR charts were only partially completed or missed dates/times when observations were taken. Health assessment documents of newly admitted patients were frequently incomplete due to the admitting nurse claiming not to have had sufficient time. Sometimes the health assessment document was left for the next shift to complete. In the latter situation

more often than not it remained uncompleted as nurses saw it either as the responsibility of the admitting nurse or they too lacked the time.

Incomplete documentation contributed to a significant loss of time when nurses searched in vain for missing data in patients' files. When data could not be found other nurses were interrupted, phone calls made, or extra trips to the bedside undertaken in an attempt to gain the required information. Because missing data was frequently not added to the notes once it was obtained, other nurses on other shifts had to repeat the same exercise contributing to a continuous erosion of nursing time.

Jolanda is involved in the auditing of clinical notes and she suggested that gaps in documentation might be the result of ward nurses not understanding the importance of documentation.

There seems to be a lack of understanding across the board that all of our documentation are actually legal notes.... I think one of the problems that we have with the documentation is it is seen as a nuisance and a waste of time because they are taking me as the nurse away from the bedside. They are not seen as an integral part of the nursing practice and part of patient care. (Jolanda)

While nursing managers expected nurses to attend to all required documentation, nurses on the floor believed that there was too much documentation and too much duplication. Ward nurses regularly expressed views that anyone not working as a nurse at the bedside would lack the understanding of 'what really goes on'. Nursing managers were held responsible for requiring more and more paperwork from the ward staff. Ward nurses argued that managers were quick to tighten documentation and/or introduce new documents to deal with clinical concerns 'without proper consultation'. Lack of consultation and communication resulted in ward nurses displaying a degree of resistance and negativity towards these changes.

I guess it's the division between what you see with the nurse managers, and the on-the-floor staff. I guess sometimes you think that there's all these policies and protocols being implemented but whoever is implementing them, doesn't work on the ward, and don't know what it's like, and I think sometimes you feel like, well here's another piece of documentation that we have to do, so that they can say they're meeting this quality control or audit. But whereas, like, we just literally you don't have the time to do all these things and I think sometimes, you know, it

needs to be a bit more realistic about what we are trying to achieve.
(Marije)

At the time of the research the hospital was in the middle of introducing a new format for writing patient progress reports. Although 'SOAPIE'¹ had been in use for many years, and was successfully used by the multi-disciplinary team, ward nurses did not utilise it correctly as important patient information was either omitted or could not be found easily, hence it was decided to introduce 'focused charting'. The way focused charting documents patient concerns means that the nurse does not need to read through the entire report as concerns stand out in a separate column and are therefore less likely to be overlooked. However, both reporting formats are 'problem-based' with the only difference being the way it is documented.

The change in the documentation it is because of risk. It is a risk management change. Simplify it, I mean if you look at it, the brass tacks off it, it is because things weren't being done in a way that was legally prudent. So it is one of those, I mean .. focus charting is no different to SOAPIE. It is SOAPIE wearing a different colour jacket and SOAPIE and ADPIE wearing a different colour jacket. (Madeleine)

Madeleine's comments illustrated that the reason for the introduction of focused charting was an attempt to change nursing practice. There was an assumption that nurses might not be aware of the importance of documenting the patient's health status even though this is in fact a professional responsibility and expected competency by the Nursing Council of New Zealand. If nurses were not using SOAPIE correctly, which was described as a different colour jacket, it would make sense to re-evaluate why this was the case and address any of the identified issues in cooperation with the ward nurses. Instead, it was believed that using a different format for report writing would eliminate the concerns and ensure problem identification at an earlier stage so that action can be taken and potential risks averted. This approach assumes that nurses were aware of patient deterioration but were unable to document it properly. I contend that nurses were not documenting patient deterioration because they were not aware of it, because of the limited time available to engage in surveillance, and the low priority given to

¹ SOAPIE is an acronym of Subjective, Objective, Assessment, Plan, Intervention and Evaluation and is used as a structure for writing patient notes

patient assessment in the first place, an issue that will be discussed more extensively in chapter nine.

If it is not documented it is not done

In observing the utilisation of documentation by ward nurses, there was little evidence that documentation served as a tool to communicate information about patients to others. As noted before, the ward nurses were critical about the quality of the NCPs which contained little specific information. NCPs were seldom personalised and/or updated. Additionally, there was doubt amongst the nurses whether members of the multi-disciplinary team were even aware of the existence of NCPs. The nursing progress reports contained little information about patients in terms of their subjective illness experience and their current state of health. Progress reports generally did not provide information about care requirements for the next 8 to 16 hours, but tended to be a summing up of tasks completed.

Duplication of information was perceived to be '*a waste of time*', although nurses themselves frequently documented information in more than one place i.e. documenting vital signs measurements in progress notes when the same information was also documented on the TPR chart, as can be seen in the first of the two verbatim transcripts below (surgical ward first, medical ward second).

Written report at end of duty:

- S Pt very tired this morning as not much sleep for the last 3/7 days.
- O Pt is of the thought that abcess decreased, still cellulite markings on face, slight redness. T: 35.4, Pain 0/10, PR: 60 bpm.
- A Pt condition is stable.
- P Cont IV Abs as charted. Offer Panadol. Enc rest for pt.
- I IV Abs given. Pt r/f Panadol. Pt up and about ward. Nsg ass not done due to insufficient nsg time. Will attempt past notes.
- E Pt condition remains the same with slight improvement according to pt.

Written nursing report at end of duty:

- S 'Don't feel any better than yesterday'. Anxious about three recent deaths that have occurred in his room since admission.
- O SpO₂ 84% on RA, peak flow 110 @ 10am after taking inhalers. Other obs as charted.
- A Altered gas exchange r/t COPD
- P Continuing on RA, encouraging independence prior to discharge. Aim for discharge Friday if stable.
- I Pt offered shower & declined. Appears exhausted & anxious. Meds as charted. Seen by social worker.
- E Pt comfortable @ rest, SOBOE.

Though ward nurses were dissatisfied about the amount of documentation and sceptical about the need for more documentation which was *'just filed and never looked at'*, hospital managers were insisting on more documentation. In contemporary health care, documentation served a new purpose, something that was well understood by Marije when she commented on documentation being used for quality control and auditing. Indeed, one could argue that restructured health care services have transformed contemporary nursing from a practice-based profession based on assessed patient's needs and individualised nursing interventions, to a document-based profession. The implementation of clinical pathways and standardised NCPs has effectively eliminated the unique patient by turning all interventions into clinical procedures and protocols based on medical labels. Nurses are expected to utilise these documents which serve as 'instruction manuals' for providing nursing interventions. Nurses are told that if interventions are not documented or signed off, they are assumed not to have been carried out; the latter can ultimately result in disciplinary action against the nurse.

I contend that the actual utilisation of documents reflects a significant disparity between the cultures of nursing and management. Nursing acknowledges the validity of the subjective experience and the uniqueness of patients as individuals. Nurses ought to focus on patients' needs and ensure that interventions are needs-driven as reflected in the importance of health assessment as the first step in the nursing process. Documentation should serve to capture these unique assessment findings and communicate required nursing interventions to other health care providers to ensure consistency of care. Indeed, observation in the field and discussions with nurses clearly indicated that nursing documentation was foremost seen as a tool for communication even though that is not how it was implemented in the realities of clinical practice.

While nurses should focus on patients' needs, managers fulfil a different role. Health care managers manage resources and are budget-driven rather than patient needs driven. Managers have finite means and hence seek control over resources in order to achieve set outcomes/targets (White, 2004). Managers utilise nursing documentation to monitor the business of nursing. High levels of standardisation of documents and classification of patients, is required to enable computerised data input that will predict care requirements and resource utilisation. Managers scrutinise patient care processes by means of extensive document auditing. Every

time documents are audited, managers gain more insight into the business of nursing; the role of the nurse in the caring process, what nurses do, and how nurses work. Campbell (1988, p. 33) argued that: "... documentary processes of corporate management provide the means by which nurses' actions are coordinated in such a way as to bring them into line with state policy, itself oriented to capitalist interests". Indeed, what Campbell was arguing here is that nursing is ruled by a new master; contemporary nursing has become subordinate to generic management principles which controls nursing through documentation practices that prescribe nursing responses in ways that meet the organisational goals and objectives i.e. deliver health care services within budgetary restraints, rather than take account of actual patients' needs.

Nursing, as objectified and documented in clinical pathways and NCPs, has become standardised, predictable, and above all measurable. Nursing is 'imprisoned' in the written discourse and turned into a virtual world where actions are determined without contextual considerations and independently from nurses' experiences and intellect. Braverman (1974) argued that when tasks and actions can be routinised and separated from the knower the right conditions are created for it to be managed externally. What we see happening in medical and surgical wards is exactly that; the complexity of nursing has been deconstructed and reconstructed into a set of highly routinised (mainly) physical interventions of which the exact duration can be calculated through virtual levels of patient dependency. Not only have nursing actions and intervention been separated from the 'knowing' nurse, but far worse, it has been removed from the 'experiencing patient' who in the process has become little more than an object requiring certain interventions. Rankin (2009) noted an irony in contemporary health care where nurses' expertise and knowledge is systematically being subordinated to managerial management principles and yet health care settings continue to rely on nursing expertise and judgement as the foundation of acceptable health care.

Nurses have reported a lack of control over their own nursing practice and believed that their input was not valued and their expertise not recognised (Bowers et al., 2001; Parker, 2004; Walker, 2011). Lack of control was also evidenced by the fact that ward nurses were not consulted or involved in decision-making even if the consequences of the decisions impacted directly on their work or the ward. A further example of this process can be seen in the implementation of ALERT (acute

life-threatening event recognition and treatment) a risk aversion tool. This was implemented at the time of the research and nurses saw this as evidence of lack of trust in their own clinical judgement.

And then we've got uhm...X just came yesterday with a new sheet. I think that's been added to the observation sheet with a scoring system to an alert system so that if that person is becoming more unwell, its got a flowchart of what to do, when to ring 777. (Wendela)

[Researcher]: So it is really more for emergencies then?

No it's for everybody.

[Researcher]: Yes but if somebody develops a fever you would not ring 777, would you?

No but it's like when you write your observations so if their systolic falls below 90 it comes into a 3. And if their temperature goes above 36.5 then it comes into a 3. And then those sorts of things, if their GCS falls then it comes into it. So when you've got just this certain score, then you follow the flowchart of whether to notify the medical staff or what you do next.

[Researcher]: So why is that?

I don't know but I said to X: "it's a shame you know, whatever happened to the nurses' assessment and judgement, clinical judgement?" That's just the way it is these days

[Researcher]: Let me clarify this, you follow a tick box and you fill in a 3 and a 2 and a 4 and you add it up and it comes above a certain number you need to phone the Doctor.

Mmmm.

[Researcher]: It looks to me that this form takes away the thinking behind assessment.

It does, it does.

Wendela was not alone in her claim to have had no input in or even an awareness of ALERT. Several other nurses also maintained not to be aware of ALERT prior to its implementation and were sceptical about the need for change, and suspicious about the underlying reasons.

Like the pre-printed NCPs, ALERT standardises patients/situations as it provides nurses with an authoritative instruction manual outlining what to do when a set of vital signs or measurements are outside the limits of what is considered desirable for that patient. In doing so, it marginalises nurses' expertise and undermines professional judgement as noted by Wendela. Replacing the 'knowing nurse' with

a set of instructions or a set of tick boxes contributes to the deskilling of professional nursing practice as the virtual world becomes 'the standard' by which things are measured and actions are taken. ALERT not only marginalised nurses' knowledge and clinical experience but it also sowed doubt in the minds of nurses that their nursing knowledge and practical expertise was inferior to a set of documented instructions: '*Maybe it's because nurses haven't been making good clinical judgements...*' (interview Wendela).

Summary

In this chapter I have explored why nursing is the way it is in the acute hospital setting and how changes implemented at the macro level of the health sector filtered through to impact on contemporary day-to-day nursing practice in medical and surgical hospital wards. In New Zealand the average length of stay was halved in the period between 1988 and 2003 and has continued to drop every year since. According to the Ministry of Health (2010), the four most important factors that have contributed to the continued downward trend are changes in surgical treatment, in particular 'key hole' surgical techniques that are less invasive, the availability of more effective drug treatments, improved follow-up care and support in the community, and more effective management of the available hospital beds. More effective bed management was achieved by a two-prong approach namely clinical pathways and patient classification.

The introduction of clinical pathways provided for a clear patient trajectory from the day of admission till the day of discharge and has transformed the health sector into an industrialised model of depersonalised health care controlled by hospital managers and administrators. The introduction of a patient classifications system enabled hospital managers to measure the amount of nursing time required to carry out interventions. The resulting virtual workload calculations were subsequently used to determine nurse-staffing levels despite nurses' claims that the system was flawed and did not incorporate many of the activities in which nurses were frequently engaged.

The implementation and use of both clinical pathways, standardised care plans and tools such as ALERT may or may not have raised the efficiency of nursing care delivery, but it has also provided generic management with the tools to increase its control over nursing practice. Nursing now relies less on knowledge of a patient's

actual health status and more on clinical pathways, protocols, and ward routines. This reliance has altered nursing practice and significantly reduced the autonomy of the nurse over nursing matters. In the next chapter I will explore how these changes have affected the nurses' role and the way nurses see themselves.

CHAPTER EIGHT

Nursing identity

Introduction

In the previous three chapters I presented my analysis of the situation in medical and surgical wards settings based on ethnographic observations in the field and discussions with nurses. In chapter six I discussed how the continuing dominance of medicine visibly impacted on all aspects of nursing. This included the requirement for nurses to assist and 'look after' doctors, medically-focused interventions taking frequent precedence over patient-focused care, the strong presence of medical discourses in nursing documentation, i.e. NCPs based around the medical diagnosis and the need for nurses to accommodate physicians' needs ahead of patients' needs.

In chapter seven I discussed how the health reforms of the 1990s and the introduction of generic management has added its particular form of domination to the shape and nature of health care services in medical and surgical wards. Major hospital restructurings have focused on cutting cost by reducing bed numbers and average length of hospital stays. The implementation of clinical pathways, outsourcing of certain services, tighter control over resources such as consumables, a re-definition of the charge nurse's role, and changes in staffing levels and skill mix have all had a major influence on the provision of nursing care. In this chapter I explore how the continuing impact of medical dominance and the persistence of generic management have impacted on nursing practice in medical and surgical ward settings to the point where the personal self-concept of individual nurses and nursing's disciplinary identity and authority has begun to change. Key areas where this can be seen to impact include processes for leadership, patient allocation to staff and skill mix. First I address what it is that nurses consider to be a nursing approach to patient care.

Developing a nursing identity

Contrary to popular belief, nurses are not born as nurses, but rather they gain the required knowledge and competence through studying nursing and associated subjects as well as gaining practical experience in a range of clinical settings. As part of the application process for entry into the bachelor of nursing programme candidates are asked to provide information about why they want to become a nurse and what personal qualities they bring to nursing. This information provides some insight into the prior perceptions of people who apply for nursing. As a nurse educator, I deal with hundreds upon hundreds of applications each year and have done so for many years. Although applicants differ in age, sex, social background and nationality, they tend to share certain beliefs, values, and attitudes that are perceived to be characteristic of the nursing profession. For example, many applicants portray themselves as being socially sensitive, of having an awareness of social needs and suffering within society. Many write compassionately about their wish to work with people, to make a difference in someone's life, while others mention their liking of fellow humans, their desire to care for the sick, the newborn, and/or the elderly. Applicants write about their own health, and their understanding of healthy living, of being physically active and mentally well-adjusted. They write about their desire 'to do good', to assist individuals with achieving higher levels of health. Many applicants emphasise that 'now' is the right time in their life to commence nursing and that they feel motivated and committed to make themselves available to provide support and to help those in need. Having an appreciation for cultural differences and an ability to communicate and relate well to others is also frequently noted. For some applicants it is their own experiences as a child-patient being cared for by a nurse that has left an indelible impression. What the application information highlights is that all applicants have a prior perception of the role of the nurse, what nurses do, and what nursing is all about and it is this perception on which applicants build over the duration of the bachelor of nursing programme.

Over a three year period students are taught the knowledge, values and attitudes that underpin the nursing profession. Guided by the Nursing Council competencies (2007), students are required to demonstrate knowledge of professional, legal, ethical and cultural issues and act in a way that maximises patient safety, independence, and quality of life. Students learn to assess patients and be

responsive to identified patients' needs. Interpersonal and therapeutic communication with clients is emphasised, as is inter-professional communication and documentation. Furthermore, students are required to demonstrate that they are capable of evaluating the effectiveness of the care provided and their ability to promote a nursing perspective within the inter-professional activities of the health team. Nurses develop a wide range of 'knowledges' ranging from the natural sciences (anatomy & physiology), social sciences (human development, sociology & psychology), nursing knowledge (theories of care), nursing skills (technical skills/dexterity to perform interventions), organisational (time management, role & responsibilities of multi-disciplinary team, and community support networks), to experiential knowledge.

Hence at the end of their 3-year educational programme new graduates have a strong sense of professional identity in terms of the focus of nursing and the role they will play as a qualified nurse. Personal professional identity will be strongly linked to the knowledge related to making clinical judgements based on careful assessment of individual needs and a plan of action to meet those needs. Professional identity is also based on the knowledge that qualified nurses make decisions about nursing care and are accountable for those decisions as well as the care delivered or delegated. Finally, professional identity is reconfirmed when a nurse through a therapeutic relationship is able to make a difference that contributes to the well-being of the patient.

An important component of professional identity is constructed and sustained by the ability of a professional group to ensure the nature and quality of its practice. In the current acute hospital setting there is a residual tension between the maintenance of a nursing leadership structure from bedside to directorate level and the goals of generic management positions which remain especially focused on fiscal constraints. In some instances, especially at middle management level, positions are required to embody both goals with resulting tension for successful accomplishment of seemingly opposing goals. For many nurses both in these positions and those watching the contribution of these positions their notion of the nature and value of nursing is constantly challenged, perhaps nowhere more profoundly than at ward level. Charge nurses can be seen as the pivotal point where clinical leadership is vital but generic management makes significant demands on the role to address their own goals.

Ward leadership

Hospitals depend on nursing leadership to achieve efficiency and effectiveness (K. Hughes & Carryer, 2011), and within this structure charge nurses fulfil a key function as frontline managers (Sawbridge & Hewison, 2011; Squires, Tourangeau, Laschinger, & Doran, 2010; Walker, 2010; Wong & Laschinger, 2010) Although there will be differences in employment conditions, it is fair to say that charge nurses will be responsible for upholding the professional nursing standards and ensuring the delivery of safe and effective care. Furthermore, charge nurses are responsible for the day to day management of the ward which includes supporting the nursing team, coaching individual staff members, and matching staffing levels with workload demands.

As noted in chapter two, the health sector reforms of the 1990s saw major changes in career pathways and a loss of leadership structure (Buchan & North, 2008) which impacted in particular on the charge nurses. Although subsequent restructurings have partially undone the reforms, the effects still linger on and impact on contemporary ward management.

Nursing leadership is essential for providing the environmental (ward) conditions and infrastructure to ensure that nurses are supported and empowered to provide high standard quality care (Laschinger & Leiter, 2006; Sawbridge & Hewison, 2011; Squires et al., 2010). In the study setting, nurse leadership within the ward was usually provided by a small team consisting of the charge nurse, associate charge nurse and the more senior staff nurses. Within this team only the charge nurse did not have a patient assignment and hence was able to focus more fully on the functioning of the ward. As the observations for this research took place in six wards, I was able to compare and contrast the prevailing roles of the charge nurses, the way staff interrelated and communicated with each other, and the standard of nursing care provided.

In the two wards where the charge nurses provided active clinical leadership, the ward nurses were much more team-oriented, more supportive towards each other, and seemed to cope better even when the ward was busy. There was a sense of unity and shared responsibility. Nurses in these wards tended to have a more positive outlook on nursing. Nursing practice seemed to happen more smoothly with staff being more open and willing to share their opinions, skills, and

knowledge. Lily works in an area where the charge nurse provides clinical leadership and is highly visible.

I think the CN is a real leader. She is the type of person that would not accept things for the way they are because that is the way they are. If she can see that it is affecting the nurses in the ward she will get right behind it and push it to the limit. She'll get in there and shakes everything up. She shakes the nurses up, the medical staff, she just uhmmm.... Without our charge nurse the ward would be very different, very very different. She is one of us, but she is also a leader. She makes you feel comfortable. You always know where you stand with her if you are doing something wrong because she will tell you. She is a real role model. (Lily)

Nurses working in these wards had a role model on which to mirror their own practice and in doing so they had the opportunity to further develop their professional identity, knowledge and skills. Annika works in a ward where the charge nurse does not provide leadership but instead gets involved in the actual bedside nursing care.

She takes on a workload which is fantastic, she helps everybody out, but in doing that, she compromises her position. She is supposed to be the one that the new grads go to for assistance, apart from the preceptors. Uhmm...we need advice from her, and yet she has got her own workload. She cannot cope with that. She cannot cope with running a ward and she cannot cope with delegating tasks to other people. You [she is] are the boss, but I don't feel that she is the boss on this ward. (Annika)

Being 'one of us' as Lily called it is clearly different from what Annika's charge nurse was doing. Being in the midst of nursing, being where the action is and leading the team, is not the same as taking a patient workload and losing the overview of the ward. Indeed, the role of the charge nurse in ensuring a well-functioning ward was acknowledged and emphasised by every nurse who participated in this research. Nurses from wards with poor clinical leadership were markedly more disgruntled about their working environment and more likely to complain about awkward collegial relationships, poor nursing standards and low staff morality. Ward nurses argued that charge nurses needed to be much more visible in the clinical area as well as engaged in clinical decision-making.

Observations on the wards revealed that charge nurses were increasingly taken away from the actual clinical area. The demands of the role required ever increasing amounts of time to be allocated to administrative matters including attending meetings on and off the ward. Spending little time on the floor combined with the high turn-over of patients meant charge nurses struggled to maintain

oversight of the standard of care provided as well as staff competencies. There was a shared concern, expressed over and over again, that the clinical role of the charge nurse was being neglected or worse, that it had disappeared all together.

I think the charge nurses are removed from the ward by administration and management things and I think they need to be having more of a role in the ward. I would like to see the charge nurse more clinically involved, more involved in decision making in the ward on a daily basis. I would like them to be more visible. I would like them to be supportive of especially new people in the area.I could say quite a bit about that. (Wendela)

Ward nurses had clear expectation and were single-minded about the role of the charge nurse, but staff external to the ward had different ideas. As a senior nurse, Madeleine was well aware of all the changes that had occurred as a result of the restructuring of the health sector and the effects this had on the role of the charge nurses. Back in the 1990s the introduction of generic management resulted in virtual elimination of the charge nurse role. Subsequent restructuring saw different models of leadership re-introduced into the wards, but it is clear that generic management requirements remain deeply embedded in the charge nurse role as it has been re-established. As illustrated in the excerpt below, Madeleine acknowledges the importance of the clinical role and yet she also stresses the importance of management as reflected in her comments that charge nurses need to manage staff, including performance management, and that there was a 40-60% time split in favour of management.

They need to be managing people but I don't know that many of them have the management skills to performance-manage people.... I mean a charge nurse's role is very confusing, is not it? Because they were the clinical specialist [prior to the health sector reforms], then they were in management and some sort of bizarre hybrid, a cross between a CN and a manager. Some of them seem to struggle with this. I think charge nurses were quite disadvantaged by having their roles disestablished and not being charge nurses for that period [is referring to the 1990s]. I think their role was quite clear before that, and then the role was taken away and they were called something else weren't they? When they turned them back into charge nurses, I don't think the role solidified again. They do spend a lot of time going to meetings and they really are a management role whereas I think the old charge nurse was more of the clinical nurse specialist, role-modelling good nursing practice. Now the charge nurse is not actually necessarily doing that. A certain percentage of their time is supposed to be clinical. I cannot remember what the breakdown is, but it might be 40% clinical 60% admin or something like that. (Madeleine)

Going by this scenario charge nurses are in a no-win situation as contemporary ward nursing is busier than ever before with high patient turn-over, fragmented health care services, and more part-time nurses boosting overall staffing numbers. How can charge nurses role-model clinical practice and be more visible, when at the same time they are expected to performance-manage increasing numbers of staff and attend more meetings. It is not so much that the charge nurse's role 'is confusing' but rather that charge nurses are expected to perform the job of two people; it simply cannot be done. In addition, there was evidence that charge nurses did not always understand the authority or leadership inherent in their role.

Ward nurses expressed the view that clinical leadership and role-modelling of professional practice and behaviour were no longer seen as a critical aspect of the charge nurse's role. Rather charge nurses had become 'managers', in particular managers of resources or as one nurse noted 'bed managers' with the emphasis on 'beds'. The role of the charge nurse had changed from a patient-care-focus to ensuring that patients remained in hospital for the shortest possible time. This emphasis on managerial aspects was perceived by many ward nurses as a negative development for ward nursing.

Some CNs [charge nurse] will do a mixture of everything, other CNs will only be really interested in how quickly you can get patients to the transfer lounge or home, and free up an empty bed because there is a big turn-over of patients. Some CNs you don't actually see a huge amount of what they are actually doing, but they are obviously doing something, not so much to help you. (Anouk)

I guess the role of the charge nurse now is to coordinate the patient care, so to coordinate between the doctors and the physios and dieticians and make sure that patients are progressing smoothly. I guess a lot of their focus now has to be on discharges with the way the hospital is with bed shortages. So they are always being asked to consult with the consultants and get people out for discharge and that. I think their role probably has, like a few years ago when I started, the charge nurse was always on the ward and would help you out and support you, but with them all going to meetings all the time now they just don't seem to be here. I think their role has sort of evolved over the years, and they are now not out on the ward as much as they used to be. I think it is probably a change for the worse, but I guess someone needs to be going to these meetings to ensure there's quality improvement, and continual improvement and yeah, I guess perhaps the charge nurse is in the most prime position to be doing that. (Marije):

The role of the charge nurse was described as 'tough' and 'lonely' (general field notes). Ward nurses noted that charge nurses were in a difficult no-win situation as they tried to manage the ward with insufficient resources while not having full control. The powerlessness of the charge nurses came to the fore in situations concerning workload and staff management. Charge nurses generally had no ability to decline a new admission even if it was felt that the ward was not coping with the workload. Neither did charge nurses have control over their own staffing as nurses could be taken out of the ward and directed to work in other clinical areas. Being a charge nurse was not perceived as an enviable position and none of the nurses involved in this research expressed an aspiration to pursue a career in ward management.

One charge nurse was seen by nurses as being especially clinically focused. She said:

I try and limit the meetings. So I tend to sort of prioritise. I have backed out of a lot of meetings. I used to go to everyone because, again as a new charge nurse, you feel that you need to be there. I don't do that now. I know that I will get the information somehow. If it is important it will come to me, otherwise I just choose the meetings I go to.... I think in a way you have to maintain what I believe clinical excellence, and you set the standard and it is not the lowest common denominator. You make it as high as you can and you encourage and role model behaviour. You keep an eye on whether the nurses are achieving that. So it is little things like you walk into a room and you see a patient probably not positioned in the bed correctly. So you call the nurse and assist them to reposition, or you reposition and tell the nurse what you have done. I always have an open door, the nurses can come and ask me questions about anything; I assist them with any complex things. If I see there is a problem, I act on it as soon as I can. If not, I make sure that the next shift that nurse is available, to do that. So it is about having an overview and about keeping tabs on where everyone is at. (Linda)

Linda described exactly what the ward nurses were talking about as the key role of the charge nurse; providing clinical leadership, setting and enforcing practice standards, coaching staff and being accessible. How difficult and challenging this is can only be fully appreciated when one gets an overview of 'an ordinary week in the life of a charge nurse'. Linda described her week to me, keeping in mind that this overview does not include the meetings that she declined to attend.

At times the nurses say to me: "oh you're always at meetings". I don't know, I uhm... I have to say, Tuesdays and Thursdays I am present in the ward because of full ward rounds. I have the multi-disciplinary team meeting and I have other meetings. The perception of the nurses might be

then that I am absent in terms of the fact that I am involved. They all know a ward round day, you know, that is kind of a real busy day for me. So I am not present in the fact that I can be as available to them for things. Friday is a fairly heavy ward meeting day. I have a 9am management meeting followed by a 9.30 bed meeting, uhm... we have a lunchtime reconfiguration meeting. I have my hour charge nurse meeting with the team leader, and so that tends to mean Friday pretty much meetings all day. Monday is my day in the ward. I don't book any meetings for a Monday if I can help it. So I have one full day in there. I work 0.9 so every other Wednesday I try and have as a day off. So again, they would think I am not there on a Wednesday. I am not really there on a Tuesday or a Thursday. I am really not there on a Friday, but I try and make myself as available as I can. (Linda)

(please note that certain details have been altered to protect the participant)

Linda acknowledged that the biggest challenge she faces as a ward manager was dealing with under-performing staff but she regarded herself 'lucky' that she did not have many problems in this area. Talking to Linda, listening how she juggles her time to increase her clinical presence in the ward, and seeing her interact with the nurses, there may be an explanation for this. Linda has set some clear goals for herself and the ward and she has elected to prioritised her clinical leadership role despite all the stresses and strains of ward management. Linda is out there providing leadership, role-modelling professional practice and coaching ward nurses. She corrects staff, follows up on issues, and works alongside them when needed She has set clear standards and has opted for raising staff performance rather than performance-manage it.

Allocation of patients

In principle an important component of nursing identity is the recognition that clinical judgement is based on education and experience and that nurses' decision-making is critical to patient safety and outcomes. Patient allocation to a chosen nurse is a point at which decisions should be made to match the complexity of patient need with the capability of the relevant staff member. This study surfaced an apparent loss of recognition of the connection between education, experience and competence.

Assigning nurses to patients requires knowledge of the patient's state of health, medical treatment regime, and insight into nursing care requirements, as well as knowledge of the nurse's skill level and clinical experience. Ensuring that the right nurse is allocated to the right patient not only increases the quality of health service

provided but it also makes sense in an era of dwindling resources and where the emphasis is on efficiency. Furthermore, patient allocation best takes into account consistency of care by reassigning the same nurse for several days to the same cohort of patients. Last but not least, patient allocation needs to accommodate the learning needs of junior registered nurses to safely enable role development and professional growth.

Given the complexities involved in patient-to-staff allocation, one would expect this allocation to be undertaken by the most senior nurse in the clinical setting, the charge nurse/nurse-in-charge. However, in wards where charge nurses spent little time in the clinical area, this could present a problem as the charge nurse might only have limited knowledge of patients' conditions (due to high turn-over rates) and of nurses' competencies. Maybe it is for this reason that patient allocation was frequently undertaken by other staff including the night nurses who may or may not have been in the best position to make such decisions.

On a number of occasions patient allocation was not done or needed to be corrected, and this provided me with a glimpse of the criteria, if any, that were used for making patient allocation decisions. The following field notes described a situation where the night staff had either overlooked patient allocation or had been so busy that they had had no time. Either way, the patient allocation had to be done prior to the commencement of the morning report.

There did not seem to be leader, or a 'nurse-in-charge' to start things off and the office felt like chaos. Nobody was taking the lead and I wondered where to from here? Patient allocations hadn't been done and one nurse started to make some changes to the board. This did not seem to be going well so a second nurse started to help while a third nurse, who remained sitting in her chair, every now and then commented loudly on what should be changed. While names were added, wiped, and changed, the other nurses said nothing as if it did not concern them. The three nurses deliberated over the heaviness of some patients as they tried to ensure that, at least on the white board, the workload was evenly divided. The other nurses meanwhile just stared at the board, looked at each other, and at the clock. Some nurses had been there five to ten minutes prior to the commencement of the duty and it was now already 7:10. Finally the work allocations appeared to be done; the time was almost 7:15 when the handover report could begin. (Field notes Anouk)

The above field notes reflected the lack of importance that was attached to patient allocation which appeared to be undertaken without any systematic approach other than a loosely applied 'fairness' principle which was explained to me as meaning

that the 'nursing load' should be evenly divided amongst the nurses. The adding and deleting of names demonstrated that decisions were very much made in an ad hoc fashion rather than careful consideration of patients' needs versus nurses' competencies and expertise.

There are several reasons why patient allocations may be made in the manner described. Because patient care is in effect based on medical diagnosis rather than nursing assessment of need, little can be known about the real competencies required. Further evidence for this approach was the fact that on one occasion there had been two new admissions the evening before. At the time of allocating the patients next to nothing was known about these two patients apart from their medical diagnosis, yet this made no difference in terms of allocating nurses. In terms of nursing needs it was very much a case of 'a patient is a patient is a patient' and hence the same routine cares were likely to be delivered to all by whoever seemed most available.

Patient allocation issues were also highlighted in workload-based transfers of staff. Beside the fact that nurses 'hated' being transferred to other wards because they did not know those wards very well, they also noted that they were sometimes given the more challenging patients; *'Sometimes... people offload their patients that they are not keen to have again onto you unsuspectedly, some places do that'*. (Anouk)

The current allocation patterns of patients did not reflect the presumed principles of consistency of care and allocations were more likely based on workload considerations. Although consistency of care was already compromised due to the high number of part time employed nurses, subsequent frequent changes in allocation of patients to manage workloads magnified discontinuity of care. The allocation of patients previously not cared for by the nurse resulted in loss of nursing time and increased stress levels due to not knowing the patient. How long it takes for some nurses to feel confident about the care requirements of their patients became clear when I interviewed Saskia.

I think when you have the patient on the first day, you try and be as thorough as you can but if you've had that person three or four days, you just basically read the plan from the day before. You have got some good grounding of that person and you can go on that. So the first day back is scary cause you've got to learn them all [referred to the patients], and their

bits and pieces, and then by the fourth shift you should have some good grasp of them. (Saskia)

Given that patients' average length of stay in medical and surgical ward settings is now only 4.15 days (Ministry of Health, 2011), and the majority of nurses worked part time (Walker, 2011), patient allocation presents real challenges that require due consideration not in the least to provide consistency of care for patients, and to lower the stress levels of nursing staff. It is difficult for nurses to see value in their education and experience when neither appears to make much difference to the processes by which their services are matched with the needs of patients. This is nowhere more apparent than in the issue of skill mix or the deployment of two levels of nurse and the utilisation of the non regulated care assistant workforce.

A nurse is a nurse is a nurse

The standardisation of nursing interventions for the purpose of raising efficiencies in health care has also standardised the nurse as the provider of care. Gordon (2005) and Duffield and O'Brien (2003) noted the lack of respect for nurses' work that frequently resulted in nurses being seen as 'a nurse is a nurse is a nurse'. Quality of care is assumed on the basis of simply having any nurse present. This approach to nursing turns nurses into a 'one size fits all' type of worker, which devalues the professional knowledge and expertise that individual nurses bring to their nursing practice. Head counting is thus not an appropriate approach to determine whether a ward is sufficiently staffed as it ignores the individual nurse's qualities. I have already discussed the impact of clinical leadership on the functioning of the ward as a whole and the quality of care provided by the nurses in particular. I will now explore the impact of skill mix on clinical nursing practice.

Skill Mix

Skill mix as used here refers to both, the different levels of expertise of ward nurses, and the availability of different levels of personnel employed in patient wards. Skill mix decreased after the major health reforms as registered nurses were substituted with less expensive staff to meet leaner budgetary requirements (Carrier et al., 2010). Contemporary medical and surgical wards employ a range of staff from registered nurses (RNs) and enrolled nurses (ENs), to non-regulated staff such as hospital care assistants (HCAs). Despite the fact that there are significant differences between the roles, competencies, and accountabilities of

these staff members, they are commonly referred to as 'nurse'. Both ENs and HCAs are not allowed to practice independently and require direction and supervision by registered nurses (Nursing Council of New Zealand, 2011a, 2011b). Directing and delegating of nursing interventions is a complex process which requires considerable people skills and contextual knowledge on the part of the registered nurses, and this is even more pertinent in a clinical environment characterised by high acuity and high patient turn-over. The registered nurse requires up-to-date knowledge of the health condition of the patient in order to determine care requirements and to decide which part of the required care can be delegated. They also need to be well aware of the capabilities of the staff member who will be directed to provide the care to ensure that the delegation is appropriate. Finally the care needs to be evaluated to make sure that the delegated activity was carried out appropriately, providing feedback as needed. Given the above requirements the partial substitution of registered nurses by ENs and HCAs has increased the burden on, and the workload of, registered nurses as fewer staff with the required skills and expertise are responsible for the well-being of high acuity patients who are admitted for the shortest possible time, and whose health can deteriorate suddenly and rapidly when not monitored properly.

Delegation of care

Delegation of care becomes increasingly important as hospitals employ different levels of health care workers in an attempt to lower health care costs. Delegation of care has been directly linked to patient outcomes (Gravlin & Bittner, 2010; Hansten, 2008; Kalisch, 2006; Kalisch et al., 2009) and hence it is crucial that such delegation is undertaken with due care to maintain the quality and standards of care. ENs are legally only allowed to work under the direction and delegation of registered nurses, (although in certain situations other health professionals may also delegate to ENs) (Nursing Council of New Zealand, 2011b). The Nursing Council has also outlined the registered nurses' responsibilities concerning the delegation of care to health care assistants (HCAs) (2011a). Given the stated requirements and the potential ramifications for registered nurses who do not comply, nurses require knowledge and understanding of their own role and responsibilities in matters of direction and delegation. Effective delegation requires excellent communication skills and authority to ensure that direction and delegation messages are clear and not misunderstood. Nurses need to have sound clinical

knowledge and expertise to think through potential and emerging complex clinical situations to make critical decisions concerning the delegation of any care. Furthermore, no two ENs or HCAs have the same skill and experience and hence it is essential that the nurse has good knowledge of the abilities and limitations of ENs and HCAs so that delegation of care is appropriate.

Observation in the field revealed that there were significant variations between wards in what ENs and HCAs were allowed to do and how much direction and delegation was provided by the registered nurses which in itself is a concern given the fluidity of staffing arrangements. Although nurses are made aware of the Nursing Council guidelines, and are taught the theory and skills related to delegation as part of their educational preparation, there is a vast difference between knowing about delegation and being able to delegate. Effective delegation as a component of managing people requires a completely different set of skills than those required to 'manage' patient care (Hall, 1998).

At the time of the study there were only limited numbers of ENs employed by the hospital and many had been in the same ward for many years. Most nurses spoke highly about the ENs who were well respected for their experience and input. Indeed, as an observer it was sometimes difficult to tell from the observed nursing activities who was the EN or the RN. ENs tended to take on a patient load without any obvious signs of direction and/or delegation. Although ENs were allocated to a RN in the realities of daily nursing practice this meant that if the EN needed support i.e. administering medications, the 'allocated' RN would assist with the task but otherwise both staff would work independently from each other. ENs were not necessarily allocated the less ill patients, rather they were involved in the care of patients affected by a wide range of medical conditions. I asked one of the nurses how the allocation was arranged as different models are possible.

The night shift do our allocations, whoever is on night shift. Sometimes it comes down to a case of what sort of staff you've got on. Like if you've only...yeah...., say, officially they're not allowed to be with new grads, so you have to put them with more senior staff. Sometimes they [refers to the EN] have got people [patients] with ... IV antibiotics, so therefore they would have to be with someone [RN] with second levels, and not everyone's got second level. So sometimes the person that ends up with them hasn't got the greatest load. (Amy)

There appeared to be few 'rules' when it came to allocating ENs to RN. Amy was aware that ENs were not allowed to be allocated to new graduate nurses who were

still on the NETP programme. Directing can be direct, when the RN and EN work together, or indirect when the RN 'overlooks' the care provided by the EN. The latter form of directing was much more common, and in practice this meant that the EN worked independently, informing the RN if there was a 'problem'. Interestingly, while new graduate nurses were not allowed to be allocated to patients who required intravenous medication (see field notes Elsie in chapter five), ENs did not have those restrictions, as long as there was a RN with second level IV skills overseeing them. This suggests that ENs were capable of looking after patients with more complex needs than new graduates despite the latter group having received education and practical instructions concerning the monitoring of IV fluids and medication.

Conflict was never far away in relation to directing and delegation and was directly related to the ward nurses' perceived or actual lack of professional authority. Ward nurses repeatedly mentioned the need to maintain tricky relationships in order to '*stay on the right side*' of ENs but also HCAs could make life miserable for the ward nurses by being rude, going slow, or refusing to do certain tasks claiming that it was outside their scope of practice. In day to day nursing practice 'good' delegation depended more on the quality of the relationship, than on the fact that the ward nurse had the professional and legal authority to delegate specific nursing activities. The lack of authority led to the most comical situations had such situations not been happening in the actual clinical setting involving real patients.

Giddens's theory about power applies here; even HCAs and ENs who do not control any resources and are perceived to be powerless are able to exert power because the resource they control is their own labour which can be used to manipulate their immediate environment. Based on my own observation, I contend that the HCAs and ENs are assisted in their actions by the ward nurses' lack of professional identity and authority in not managing such behaviours effectively (general field notes).

Discussions with ward nurses revealed that many saw ENs and HCAs as the workers with whom they could share responsibilities and reduce their workload. Amy for example expected ENs to 'pay back' the time that she spent doing things for them. This reflects not only the task-focused nature of contemporary ward nursing but also the embedded belief that delegation is a 'mutual service' to please and help each other. However, that is not what delegation is all about. The ward

nurse should delegate only those activities that can be carried out safely and are within the scope of the person's practice.

I don't really feel that they help you when you help them. I don't really think they think that's their job. They think that....yeah..., do you get what I mean? Like, I think that if you give a lot of IV antibiotics, then someone should go and do a set of obs for you, I've always thought like that, and when...(Amy)

[Researcher]: Do you mean another staff nurse?

No, the enrolled nurse. Like, if I went and did a job for her, she should do a job for me? It used to happen in ward X, when I worked in ward X, but it doesn't in this ward.

The discrepancies in what ENs were allowed to do lead me to ask ward nurses what their understanding was of the role differences between RNs and ENs. These informal discussions, held during coffee breaks and lunch times, frequently ended in utter confusion when nurses indicated that they were not 100% sure any longer, or where ward nurses maintained that there was no 'real' difference between RNs and ENs apart from the salary and the fact that ENs were not allowed to undertake medications on their own. Clinical experience appeared to compensate for the difference in education, closing the gap between RNs and ENs. Elsie was one of the nurses who believed that EN were very capable and over the years she has come to rely on them more than on the support of her registered colleagues.

If they're sick, sick people, and if you're allocating, you should know that the enrolled nurses are able to actually take care of them, but because they are under the title 'Enrolled Nurse', they cannot. Whereas the sick, sick patients are given to us, and we're more or less new, and we don't know what to do. We don't have enough experience to know what to do – whereas...(Elsie)

[Researcher]: Are you saying that the enrolled nurses would be more capable because they have a lot more experience in years?

Yeah.

[Researcher]: How many years since you graduated?

I've got...this is my third year.

[Researcher]: Your third year, but you still see yourself as having less experience than some of these enrolled nurses?

Yeah.

[Researcher]: When do you think: 'now I have sufficient experience?' How many years should you work here?

Probably about four or five, yeah. Simply because, like, we get the occasional XX patients and when they come, they're never given to us. Like, the new ones that have been there for about three years, we hardly ever get the XX patients, it's always given to the most senior nurse on the shift... and I just think it's a bit unfair cause it's depriving me of my learning. Whereas if they could give me the patient, and buddy me up with the senior nurse. Yeah, that would be really good....

[Researcher]: Have you ever mentioned it?

Yes.

[Researcher]: What was the answer?

Uhm, you can buddy up with that person, but even when you do buddy up with that person, they get so involved with it, they forget that they're actually....that they've been asked to answer questions for you and show you what they're doing and stuff. And it's understandable because you have your own patient load, and you cannot always be there to learn what you really want to learn.... But in saying that, in the last couple of months, I have taken care of a couple of XX patients, yeah, under the supervision of an enrolled nurse, yeah.

[Researcher]: Under the supervision of an enrolled nurse?

Oh, like, directly, I've gone up to enrolled nurses and asked them, because they have more of an idea, then...because like I've been on a couple of shifts where I am seen as a senior nurse because of my registration, and I've been working with two other enrolled nurses plus two other registered nurses. However, they haven't worked in the country for over a year. They're new registered nurses to the country, and they don't know themselves about XX patients, so I tend to go and ask the enrolled nurses.

Elsie's comments appeared extraordinary at first but in the reality of clinical practice they were not. The fact that RNs were able to rely on ENs for clinical advice and support, and my own finding that it was hard to distinguish between the ward nurses and ENs on the grounds of displayed activities, was indicative of the level at which ward nurses practice in medical and surgical ward settings and demonstrated that the current organisational hospital/ward structures restrain professional practice and prevent nurses from reaching their full potential.

Case mix

The placement of patients with different medical conditions into one ward is known by the term 'case mix' (Diers & Potter, 1997; Fagin, 2001; Gordon, 2005; Rankin & Campbell, 2006). Prior to the restructuring of the health sector in the 1990s, most hospitals had dedicated wards to cater for specific medical specialties. Because nurses working in these wards would care consistently for patients affected by the

same type of conditions and receiving similar treatments, nurses built up significant clinical expertise. Following the restructuring of the health sector, hospitals reduced bed numbers and closed wards (see chapter two). To increase efficient use of the remaining beds, medical specialties which had until then been located in separate wards/units, were put together and expected to share beds often spread over several wards. Increased flexibility of bed use resulted in increased case mix. Hence, nurses needed to develop new skills and gain new and sometimes highly specialised knowledge. However, the spread of patients over different wards means that nurses do not care consistently for sufficient numbers of patients to build up the same level of experience as they could in the past. Lack of frequent exposure makes it more difficult for a nurse to see whether a patient follows the expected trajectory towards recovery or whether there are early warning signs of complications.

Like doctors, nurses also specialise, for example in paediatric or gerontologic nursing, in cardiology, or in specific medical or surgical nursing conditions/treatments. Hence there is no such thing as 'a nurse is a nurse is a nurse'. To ensure the best quality and highest standard of care, it is important that nurses are able to utilise their knowledge and skills to the full potential. With the current focus on efficient bed management, rather than patient management, nurses do not get the number of patients with the same medical conditions to develop the expertise that is required to prevent adverse events in a more timely manner.

In an effort to contain cost, patients with different medical conditions but whose treatment is reasonably similar in level of expertise and resourcing are put together in specific diagnosis-related groups (DRGs). An assumption has been made that caring for all these different patients will make no difference in terms of workload and yet it does (Czaplinski & Diers, 1998). Diers and Potter (1997) studied the effect of a changing case mix on the nurses' workload during a hospital renovation project. The authors focused on one particular ward which was considered 'badly' managed in terms of cost overrun and use of nursing resources. The ward had 'overflow' beds meaning that a variety of medical specialties could use these beds as they became available. This approach to efficient bed use extended the range of DRGs admitted to the ward. Following a major renovation project and changes in staff mix, the ward moved back into their refurbished ward with a decreased

variety of DRGs. According to Diers and Potter the reduction in DRGs had a positive effect on the ward's performance with its average length of stay dropping by 1.27 days which was twice the rate of the general trend in the hospital. Reduced DRGs resulted in nursing staff having to deal with fewer medical specialists while gaining more opportunities to build up the required expertise to care more effectively.

The decision to mix DRGs in any one ward is indicative of the failure to recognise that nurses do indeed have specific forms of expertise. Moreover this specific expertise contributes fairly directly to patient safety through improving the quality of surveillance provided to anticipate complications. I now argue that the combined impact of the issues explored (leadership, patient allocation, skill mix) has had far reaching effects on nursing's sense of identity and value.

A crisis in identity

Formal and informal discussions in the field revealed a strong dissonance between nurses' long-held beliefs about nursing, their educational preparation to become qualified as a nurse, and the actual nursing practice in medical and surgical ward settings. Nurses increasingly found themselves in situations where there was no opportunity to work in harmony with their own beliefs about nursing, about '*wanting to make a difference*' and '*wanting to do good*'. Sonja expressed the view that nursing was constantly changing and that theoretical nursing knowledge could not necessarily be applied in clinical practice because the realities of nursing practice were rather different. When I asked Sonja why she felt that way, she noted that there were constant changes and that nurses needed to adapt to the changing clinical environment. However, while she talked about going with the 'flow', she was also concerned that nursing might become something else, that what is considered uniquely nursing will get lost in the change.

I can only hope that people within themselves have their own line of where nursing ends and medicine begins and ensuring that what we do is nursing.... Who is there noticing when the skin is breaking down? Who is there noticing when the IV cannula is tissing? Who is really hearing what this poor little person in the bed is trying to say, and if that is the care assistant it is scary, it is really scary and I have to admit it sometimes worries me with nursing that we remember what our goals are. (Sonja)

In my general field notes I have documented many comments that nurses have shared with me regarding their perceptions of nursing and their work in the ward.

Nurses talked about what they felt they needed to do, and what they actually managed to do. The discrepancy between the two frequently resulted in a sense of inner tension and disappointment with themselves. Nurses expressed a wish to spend more time with patients and feel less rushed but they were also realistic that it was not likely to happen. As one experienced nurse noted when she discussed the demands of ordinary nursing practice: *'I don't know whether anybody can prepare themselves for the realities of nursing practice, cause you don't know what you don't know until it hits you with a sledgehammer'* (general field notes).

A recent NZNO employment survey (Walker, 2011) found that more than half the nurses felt that there were not enough nurses to meet patients' needs, and almost 27% of respondents employed by DHB in-patient services felt that patient care was compromised on most shifts. The effects of a mismatch between personally held beliefs about nursing and the realities of clinical practice have been described for more than 35 years as 'reality shock' (Kramer, 1974). While Kramer applied this phenomenon in particular to graduate nurses, the symptoms of burnout such as guilt, anxiety, disappointment with self, negativity, and fatigue were also present in some of the more experienced staff who expressed their cynicism about 'the ideals of nursing'. Over the last decade there have been numerous publications that have linked poor working conditions, high workloads, inadequate staffing levels, and lack of perceived support with high work stress and job dissatisfaction. See for example Adams and Bonds (2000), Aiken et al. (2001), Halfer and Graf (2006), Scott, Engelke and Swanson (2008), and Shader, Broome, Broome, West and Nash (2001).

In chapter seven I noted the introduction of ALERT (Acute Life-threatening Event Recognition and Treatment), a document-based tool designed to avert risks through early recognition of patient deterioration. This can be seen as an example where nursing identity is significantly challenged because of the assumptions implicit in its function. Nurses saw the implementation of ALERT as an infringement on their skills and a devaluing of their expertise; *'...whatever happened to the nurses' assessment and judgement, clinical judgement?'* Nurses spoke in negative terms about ALERT; that it could not possibly take into account all the contextual factors that impinged on people's health and that the implementation meant that nurses' experience had to give way to a document-based process.

Each vital sign has a score depending on how significant it is, like what's not normal and it is all added up, like in your temperature, your pulse, respiratory rate, urine output, uhm what else...your blood pressure sorry. They all have a score, so and it is rated between 0 and 3. So if a patient scored 1 ... or 2, you would liaise with the shift leader and put the patient on hourly observations. If the patient had scored greater than three you would contact the house surgeon, or the doctor on call, and the patient would have to be reviewed within 20 minutes, and if the doctor had not returned your call, or was unable to review your patient in 20 minutes, you would have to contact the registrar. It is just a way of, I guess, getting the attention that the patients need to detect things prior to things happening. It is just I guess patient safety. But however it does not override clinical judgment. If your patient looks unwell but their blood pressure is stable and things along those lines, you know you would not let your patient, well you would get your patient reviewed, that's what I'm trying to say (Elsie)

[Researcher]: How does this impact on your decision making as a professional nurse?

Uhhh... I don't know, does it? I mean you just follow the EW [early warning] score instructions and that makes the decision for you, that's what I am trying to say.

Elsie felt that the procedure was confusing and complex, and could easily result in procedural mistakes which could then be attributed to the nurse. Indeed, procedural mistakes and miscommunication have been singled out as important factors contributing to failure-to-rescue (Kohn, Corrigan, & Donaldson, 2000; Thomson, Luettel, Healey, & Scobie, 2007). Like other nurses, Elsie expressed concern that independent patient-focused clinical decision-making by nurses was replaced by a de-contextualised document-based programme such as ALERT. Discussions with other ward nurses resulted in similar views with nurses feeling that their knowledge and expertise was being by-passed and devalued. ALERT was seen by many nurses as a management-initiated protocol to tick off an identified gap in health care.

As a senior nurse (and as someone involved in its introduction), Madeleine saw it quite differently. She believed that ALERT and the study day were really positive. Madeleine said the aim of the programme was to refocus nurses and to make them aware that 'basic' assessments are crucial in day-to-day nursing practice.

It just is really basic. It goes through: "What do you do with a blue patient? You know? "If you noticed someone cyanosed, what should you do? What should you assess? How do you approach them? How do you manage that? You know? "You give them 10 litres of oxygen, 15 litres of oxygen and see if they pink up". You know, things that you or I would think, was

really very basic obvious stuff. But basic obviously is not happening.
(Madeleine)

According to Madeleine the ALERT study day focused on the teaching of fundamental assessment skills. As a nurse-educator the content of the programme came as a shock to me and immediately raised questions as to why registered nurses had to be re-educated at such an elementary level as recognising and responding to obvious signs of deterioration such as cyanosis. If it is indeed a flaw in nursing education in New Zealand, that student nurses do not receive the education they require to work effectively in an acute clinical environment, then why do other countries like Britain, Australia, the United States and elsewhere experience similar phenomena (Kohn et al., 2000; Rankin, 2009; Rural and Regional Health and Aged Care Services Division, 2006; Sawbridge & Hewison, 2011; Thomson et al., 2007)? Is it that nurses in all these different countries have similar knowledge deficits or could it be that there are other factors impacting on the nurses' ability to carry out these so called 'basic assessments'?

Although a whole range of factors have been identified, from communication problems and poor documentation designs through to organisational systems and technology failure, there appears to be a greater emphasis on educational programmes for nurses rather than to examine the preconditions that contribute to failure-to-rescue. Key publications such as 'To err is human'; 'Recognising and responding to clinical deterioration'; and 'Safer care for the acutely ill patient', mention nurse staffing levels and/or high workloads, but omit this from the discussion. For example the Australian Commission on Safety and Quality in Health Care (2008, p. 7) noted that high workloads and busyness decreased the time 'to think about the implications of the vital signs observed', yet in the summary which listed the unresolved issues, no mention was made of high workloads. Clarke (2004, p. 68) warned against creating situations where nurses think it is their fault as there is a risk: "... that nurses may take on the psychological burden of responsibility for poor patient outcomes unnecessarily or inappropriately". The way some nurses have expressed their understanding for the introduction of ALERT suggested that this has indeed happened; nurses see it as their fault even though the problems related to failure-to-rescue can be traced back to organisational features, hospital downsizing, budgetary pressures, high workloads, staffing ratios, undue time pressure and staff turnover (Clarke, 2004; Kohn et al., 2000).

Shortly after the introduction of ALERT I became aware of a 'new' nursing practice that was occurring quietly in the background. Nobody talked about it openly but it was clear that vital signs were not always recorded at the time they were taken. During informal discussions some nurses shared with me that they were aware that sometimes measurements were 'manipulated' to ensure the results remained within the margins on the grounds that ALERT did not take into account all the patient factors. It was felt that given the full health history of the patient certain abnormal measurements could be quite acceptable. Other nurses noted that altering the measurements would buy them a bit more time before they had to call in the doctor. This time would be used to either collect more data or, to allow things 'to cool down' as often things would settle and come right again. Unless the early warning score was seriously amiss, the doctor's instructions were likely to be to 'keep an eye on the patient and repeat the vital signs again in 30 or 60 minutes time'. What I observed during the field work is apparently not extraordinary as other research has also reported inaccuracies with the documentation of early warning signs (Odell et al., 2009).

A climate of silence

Nurses were reluctant to talk about what really happened with the documentation for ALERT and in a sense it was no different than for example the documentation for NCPs, the vital signs charts or fluid balance charts. Nurses were knowingly maintaining and/or contributing to inaccurate documentation, or were aware of others doing so, and yet nothing was ever said or done about it. Elsie was one of the few nurses who spoke openly about this phenomenon with me, but when I asked her whether she had brought it up at a ward meeting she shook her head and indicated that that was not a good idea. She suggested the problem was well known and nothing new, bringing it up would only mean that she would be given 'a hard time' by some of her colleagues.

You're meant to sign it as well as date it when you commence the nursing care plan. A lot of that is not even done. Also I have noticed, I have seen nurses sign off things at the start of their duty, I have seen nurses sign off things that I know for a fact they haven't done for their patients and I just don't find it reliable. Therefore, I don't use nursing care plans. (Elsie)

Giddens (1984) argued that all social actors possess power albeit at varying degrees. For Giddens the concept of power has no meaning unless it related to 'transformative power', the capability to make a difference. Power is exercised

through controlling resources which are unequally distributed in society. However, even those who do not control any of these resources, those who perceive themselves to be in a subordinate position, still have power by means of a range of actions that they can take or refrain from i.e. ward nurses can cooperate with a newly introduced procedure and contribute to its successful implementation or they can not cooperate which contributes to its ineffective implementation and potential downfall. Giddens referred to this as the 'dialectic of control'; the power that the less powerful have to exert at least some control over those who have the power.

Maintaining nursing-centred practice

Registered nurses are required to be capable assessors and decision makers with knowledge of professional, legal, ethical and cultural issues and expected to act in a way that maximises patient safety and independence while contributing to the patient's quality of life (Nursing Council of New Zealand, 2007). Nursing theory has provided nurses with the conceptual tools to provide professional care. The nursing process provides structure to the systematic assessment of patient needs which enables nurses to set goals and implement nursing interventions and evaluate the effectiveness. Yet contemporary ward nurses find themselves caught in a health care environment that is focused on increasing efficiency by reducing length of stay, increasing patient turn-over, and containing costs (Fagin, 2001; Gordon, 2005; Ministry of Health, 2011; Rankin, 2009). In this setting nursing is no longer based on individual patient needs, but on the use of standardised pre-printed care plans. Lack of time has all but eliminated patient assessments apart from document-based risk aversion tools such as Braden score, numeric pain rating scales, ALERT and many other documents. Hence, nursing expertise and authority has been marginalised to the point where nurses have lost control over their practice and see assessment no longer as an essential part of their responsibility.

First of all, the new nurses don't see health assessment being role modelled by the established nurses. The established nurses have been off and been to the health assessment course, but deep down inside, where it really counts, for a lot of them they don't perceive it as part of their role. There is this split between my role as a nurse and what the doctor should be doing. It is the doctor's job to be listening to the lungs and checking out the pulses and doing the abdominal assessment. They don't realise that it is actually an integral part of their nursing role or they don't want to realise it. I think also there is a significant lack of confidence amongst staff in using it and there is also the undermining that goes on by uhm.. medical

and nursing colleagues uh.. things like: “oh what are you doing, listening to that chest?” or: “why were you doing the abdominal examination?”, and the disbelief when a nurse has done it and found something. So when you have got younger nurses that have got those skills, they have got to feel confident and safe to use them. The environment currently is not one where they do feel safe, or if they do use them, that peer pressure from within nursing and medicine to not to, you know almost like you are getting too big for your boots, when you are doing that sort of thing, and uhm.. there is also a perceived time factor. There are nurses who feel that they do not have the time to actually do an assessment as part of their nursing because they are pressured to do this, that, and the other, and the other... (Jolanda)

While there is a provision to individualise the medically-focused care plans according to nursing assessment findings, there was insufficient time to engage in health assessment. Knowing that nursing interventions ought to be delivered in a much more personal and holistic approach but not having the means and resources to do so has to be a distressing situation for any qualified nurse who is aware of nursing's potential. Knowing that any additional time spent with one patient meant that another patient was 'short-changed' creates a moral dilemma for the nurse. Given the high acuity of patients in contemporary hospital ward settings how can nurses make these decisions day after day without doing any harm to their professional and personal identity and to their soul?

On the medical ward you have really complicated family issues, health issues, uhm, social issues, discharge issues, uhm, bed status issues are huge within the hospital, where they were constantly trying to move patients out to move patients in. The workload, it varies hugely depending on what is required. Nurses are uh, we are so good at uh, when something is not being done that should have been done we go and do it.... I am told I am good at managing my time. I generally think if I have missed something, it is because I really haven't noticed that it's there, or I genuinely haven't been able to do it rather than I don't pull my weight or don't manage things effectively. Often it is a matter of deciding what's going to fall off the end. That person can do without me for the shift to that capacity and so that is what you do. You kind of prioritise I guess. (Sonja)

[Researcher]: How do you feel about that, not being able to spend sufficient time with one of your patients?

... I guess I sometimes feel stink about it

One of the nurses I observed made it a habit to visit all her patients apologising in advance for the fact that she was very busy. She reassured her patients that she would do her best but that she could not promise to attend to all their needs. Chronic shortage of time had resulted in nursing being restructured into 'must do'

interventions only, as observed during the field days. For example, hand-over reports needed to be short and succinct, focused on tasks completed or still to be done, rather than on evaluation and effectiveness of nursing care provided. Notes taken during the report generally only contained the timing when interventions needed to be performed. Communication between nurses, which is vital for the continuity of care as well as the efficient functioning of the team was non-existent. *'Heads down, bums up'* was a common expression amongst nurses which I interpreted to mean 'get the work done and stay out of trouble'. Observing the ward nurses in their day-to-day practice left me with the impression that nursing had become an obstacle course run against the clock.

Nursing output has been harnessed in the interest of the health care provider rather than the interest of the individual patient's needs and well being. Standardised care has altered the foundations of nursing by substituting nursing knowledge with document-based protocols and procedures, limiting the nurses' role in patient care, and therefore altering the way nurses see themselves and their professional accountabilities. Standardised and decontextualised care has made it possible to provide nursing interventions without patient assessment and without 'knowing' the patient.

Nursing understands patient education as integral to nursing practice. In practice nursing interventions that require a patient-focused approach are being in effect outsourced. For example ward nurses were frequently observed to write a referral requesting the clinical nurse specialist's (CNS) assistance in providing education. Alternatively, patient education was diminished to a ritual of handing out an information pamphlet without much dialogue. In doing so, valuable interaction between patient and nurse was missed, leaving patients with potential knowledge gaps.

Complex individualised care does not really sit well in an environment where routines determined the nursing rhythm. The next scenario illustrates the discomfort and role confusion when ward nurses were confronted with patient needs that did not fit within the usual routines of the ward. A senior nurse (not a clinical nurse specialist in wound care) wanted to teach ward nurses how to undertake a complex dressing on one of their patients. According to this senior nurse, ward nurses no longer saw any work that was of a slightly more complex nature as being their responsibility. Their strategy to avoid getting involved in the

wound dressing was by not attending the dressing demonstration which is another example of silent resistance.

It was not a straight forward dressing and I was involved in her care because of the complexity, and because the wound service could not be there all the time. So, I used to go in everyday to do this woman's dressing and it was almost impossible to get the nurse caring for that woman, to come in and learn how to do her dressing so that they could actually do it. And I mean this was from Staff Nurses right through to Associate Charge Nurses and the Charge Nurse. The resistance was absolutely incredible. You know, you just could not get people to see that it was actually part of their role and part of their caring for this woman. There is like this abrogation of responsibility: "right someone else is here, I can leave them to do that and do something else because I am busy"!.... They just see their role and the nurse specialist role is actually quite separate. "Oh, you know, the nurse specialist is in teaching Mr Jones about his diabetes, well I don't have to do any teaching because she will be back tomorrow and she will teach again tomorrow", and so on and so on.... (Jolanda, CNS)

The following scenario is a summarised description of one particular patient to illustrate the care provided according to the nurse's own patient progress report. The scenario highlights the hurdles Helen faces; the gaps in verbal and written information, the minding of other peoples' business (radiology department), and the effect of standardised NCPs on the care provided. What is clearly illustrated in this scenario is the context and circumstances in which this nursing takes place, the focus of the nurse on a whole range of organisational aspects, and the severe limitations placed on nursing's potential by standardised NCPs which are typically not based on patient assessment and therefore do not reflect true patient needs. As demonstrated in this scenario, the result is that the patient's experience, the patient's voice is being lost. The nurse's attention was focused on getting things organised, attending to the essential needs as documented in the care plan and ticking off the boxes of tasks completed, yet the real care requirements of the patient were not attended to. This scenario could have been allocated to any of the nurses who participated in this research. What makes this special and the reason why it was selected was because of the second report that was written by the CNS about 30 minutes after Helen had completed her report. The CNS spent less than half an hour at the bedside and afterwards documented her findings immediately underneath Helen's report. Both reports have been presented verbatim after introducing the patient, Mrs N and her nursing care plan.

Mrs N is an 84 year old woman admitted a few days ago with severe back pain. The patient has multiple medical problems including a past history of CVA eight

years ago, breast cancer with (R) mastectomy four years ago, and severe lymph oedema R arm. She is currently on chemotherapy. The back pain experienced is thought to be due to bone metastasis and hence the patient is to undergo a CT scan. The nursing assessment document contained the patient's name label but no further information concerning the date or reason for admission, associated medical conditions, or the name of the nurse who admitted the patient. Although the medical notes stated that the patient is no longer coping at home requiring assistance with mobilising, the nursing notes indicated that patient was fully independent. Large sections of the assessment form were not completed, for example there was no information on activity-exercise pattern, risk assessment, respiratory and cardiovascular assessment. Medical records noted that the patient suffered from constipation but the nursing assessment stated 'usually every day'. The referral and discharge plan was not completed.

The pre-printed NCP selected for Mrs N noted thoracic/lumbar spine fracture as the official medical diagnosis to reflect the back pain that the patient was experiencing. The cover sheet contained the patient's name label and the hand-written diagnosis stated '?sciatica'. Because the NCP is pre-printed it does not address the actual concerns of the patient who is experiencing increasing levels of severe nausea since admission, constipation and voiding difficulties, and anxiety about her current pain relief regime. Mrs N is so much troubled by the lymphoedema in her R arm that she is no longer able to use her arm. No mention of either of these issues can be found in the NCP except that the BP should be taken on her L arm without providing a rationale. The following major NCP headings concerned 'identified problems and desired outcomes' which were to guide nursing practice (only the identified problems and the signed off interventions have been verbatim listed below). As can be seen, the discrepancies between the patient's actual health history and assessment finding and the stated patient problems in the standardised care plan are significant.

- Risk of complications (e.g. incontinence, constipation, urinary retention) related to injury.
Interventions: TPR, BP, SpO₂ monitored daily
Medications administered as charted
BP taken on L arm only (hand-written intervention)
- Potential of pain related to injury.
Interventions: Pain assessment done routinely with obs
Analgesia administered as charted

Alternative methods or relief used – e.g. COP
APS referral sent X-X-XX (hand-written intervention)

- Altered nutrition/hydration needs related to positioning/bedrest secondary to injury.
Interventions: Usual diet encouraged
- Self-care/mobility deficit related to injury.
Interventions: Bedrest maintained
Assisted with shower
Mobilised with partial assistance
Up in chair (hand-written intervention)
- Risk of anxiety secondary to injury/surgery and lack of knowledge of illness.
Interventions: All treatments & procedures explained to pt
Restriction of activities discussed with patient
- Risk of altered sleep pattern related to hospitalisation, injury, surgery.
Interventions: Comfort cares prior to settling
Regular physical checks overnight completed

The standardised intervention provided insufficient and sometimes contradictory information regarding the required care i.e. bedrest and mobilise with assistance. Helen needed to spend a considerable amount of time looking through the patient file to get a more complete picture. She discovered that the medications for Mrs N needed to be checked as the chemotherapy drugs were only given once although it had been prescribed since the day of admission (now day 6). Once the medication was sorted, Helen needed to phone radiology to clarify which of the two appointment times set for the CT scan was correct. Major confusion resulted when the radiology department noted that the patient was not on the list. This led to numerous phone calls and discussions with the charge nurse and house surgeon taking more than 30 minutes. While all these issues related only to one patient, Helen had four more patients to care for and hence it turned out to be a rather hectic day running from patient to patient trying to complete all the tasks on time. At the end of the shift Helen made the following entry in Mrs N's progress notes.

Written report at end of day duty:

S Patient state fed up with situation

O Mobile with frame and assistance, showered, hair washed needing assistance in shower. HNPUed, BNO, oedema remains in right arm. Nauseous at times ? Morphine.

A Comfortable

P CT scan 13:30hrs, regular antiemetics, analgesia, reassurance.

I Showered ✓, antiemetics ✓, analgesia ✓, R/V of medication ✓, S/B palliative Nurse, declined PR.

E Awaiting CT

Helen's day, illustrated through the care and organisational requirements of only one of her five patients, provides an insight into the complexities of nursing practice and the variety of contextual factors that impinge on nursing practice. Helen's day in the ward was not unique; rather it typified nursing practice in medical and surgical ward settings. The standardised NCP for Mrs N was by no means unusual; it was no better or worse than many other NCPs that I have seen in use.

Helen's report reflects a lack of connection with the patient as a person. There is an absence of surveillance and subjective health assessment. When the patient mentioned that she was 'fed up with the situation', Helen did not explore why she made that comment hence the patient's voice is missing from the written report. Helen noted that the patient had not passed urine all duty but there was no indication why this was so, whether fluids were encouraged and the patient placed on a fluid balance chart. The patient was described as 'comfortable', but the lymphoedema in Mrs N's R arm was so severe that she was unable to use her arm which affected her self-care capabilities. The report only noted the oedema in R arm. No mention was made about the missed chemotherapy. Mrs N was very anxious for the upcoming CT scan and it would have made a big difference if arrangements had been made for a nurse to accompany the patient during the CT scan. Yet Helen is by no means an uncaring nurse. From my own observations, and from the way Helen spoke of her patients, I know that she was genuinely concerned about their welfare. When the ward was busy, Helen would not go to morning coffee but instead she would remain in the ward and continue her cares. She juggled her time, prioritised and reprioritised her workload in order to ensure that all patients got what she called 'a fair share of her time'. As a nursing lecturer I read many applications of students hoping to be admitted to the bachelor of nursing programme. Most applicants write about their wish to become a nurse, to focus on patients' needs and to do good. Many applicants also write about their desire to make a difference but in the realities of nursing practice which is marked by standardised care and a race against the clock, this might not be so easy to achieve as illustrated by this scenario.

Mrs N was also seen by the CNS who spent about 25 minutes at the patient's bedside before writing the following report directly below Helen's report.

Report written by clinical nurse specialist

- S Feeling rotten. Vomited back tablet this morning, feeling nauseated; comes in waves. Level of nausea has been increasing over the past 3-4 days. Was not nauseated pre admission. Pain is much improved, only sore when moving now. Is sleeping better. Feels tired and sleepy. Bowels: loose x2 on Friday. Not moved since. Feels she needs to go but cannot. Having difficulties in passing urine.
- O Having regular Metoclopramide with x2 doses of Nozinan since last Friday. BNO x 5 days. Bowel movement Friday, nil since. Difficulties in voiding, nil reflux or indigestion present. Calcium normal on 5/9.
- A Nausea ?related to opioids. ?constipated
- P * Stat dose of Nozinan 6.25mg (aware this makes her drowsy, needs to review effectiveness. If this is helpful Rx nocte regularly with an extra dose mane prn if required.
* Medical review re bladder/bowels, ?constipated. May need abdo X-ray to rule out any faecal loading. ?PR required.
- I D/W Dr X and S/N
- E Nausea: response to Nozinan, Bowels: check for constipation, PCT will review tomorrow.

The second report provided much more in-depth information and while the focus was also on the medical condition, the patient's voice is clearly present. I asked Helen why the CNS was able to provide more in-depth information over a relative short period of time, while she had been on duty for the whole shift. Helen expressed the view that she did not have the time to find 'all those things out' as she also had other patients to attend to. She also noted that she knew that the CNS was coming and she felt that it was the CNS's responsibility to sort things out and let her know. Helen's comments are reflective of the way many ward nurses see their role; ward nurses are responsible for the day-to-day care requirements which are largely routinised and they expect CNS and other members of the multi-disciplinary team to attend to the special (individual) needs of the patient. Ward-based nurses have thus relinquished part of what used to be their responsibility to 'others'.

I asked the CNS who assessed Mrs N why her report contained so much more information than the report from the ward nurse.

I think some of the contact [between patient and nurse] has been lost, you know. The focus is on the tasks and perhaps not on the patient you know. When you spend some time with the patient you can observe a lot. The fifth vital sign [referred to pain assessment] can be observed by looking at how a patient is breathing, it is that kind of thing. It is very difficult to articulate you know. (CNS)

Observations in the field confirmed that nurses did not undertake subjective health assessments as evident in the content of the daily progress reports which mainly focused on physical care aspects. High workloads, interruptions, reduced time at the bedside, and lack of equipment were frequently mentioned as factors affecting health assessment activities. Interestingly, few nurses linked it to managed care which had transformed ward nursing. I contend that in this new environment of prescribed standardised care based on diagnosis-related groups (DRGs) the role and importance of health assessment has diminished as was illustrated in the following anecdote.

As part of the research I arranged to conduct an interview in one of the wards. While waiting for the nurse, two second-year nursing students started talking to me as they were curious about my presence. I told them that I was researching health assessment to which I received the instant response: "Oh, they don't do that here". I asked them why not, but the students were unable to answer that question and repeated that no one did the assessments that they had learned in the classroom. I then asked: "What about you, are you applying your assessment skills?" The students responded totally surprised: "What, us, are we supposed to?" These students' responses were indicative of clinical practice as mediated through their preceptors. Students were not applying the assessment skills they had studied and practiced in the simulation suite because their clinical role models did not use those skills. The influence of preceptors on the professional socialisation process of student nurses is considerable, even if the clinical practice role-modelled was negative or against the standards taught in theory (Carlson, Pilhammar, & Wann-Hansson, 2010; Henderson, 2002; Mackintosh, 2006). Ward nursing practices were extensively discussed during the interviews when nurses shared their perceptions of what was happening. Participants were aware of the task-focused nature of ward nursing and they mentioned the routinisation of care and it being limited to the essentials. Nurses noted that this is what ward nursing was all about. While many expressed in varying ways their discomfort, frustration or even angst with the current situation, the way ward nursing was practised was so ingrained in the structures and routines of the ward that nurses felt unable to change it.

Clinical nurse specialists (CNSs) are senior nurses who are specialised in a well-defined area of nursing practice often related to specific medical conditions. CNSs frequently hold or are working towards advanced qualifications such as a master's

degree or PhD. The CNSs who took part in this research all had had significant experience as ward nurses prior to their current role and hence they had an appreciation of what ward nursing was all about. They acknowledged the high workloads ward nurses faced and noted the gradual transition to task-focused nursing. This is how Marjan, a CNS, described the care provided by ward nurses.

It happens incredibly commonly that uhm, the patient is left out of the whole decision making process. Uhm people [nurses] assume the role that if they [patients] are sick, they [the nurses] need to take everything away from that patient and do it for them rather than you know... The patient loses their voice essentially. From our point of view when we're going in, we utilize that patient knowledge to the nth degree. However, as for a staff nurse on the ward, ... my perception is that they don't look at that holistic view. They don't see the patient as an expert perhaps. They are just, perhaps, uhm... task orientated in terms of: 'okay I've got to do this, this and this, and I need to do it, rather than actually asking the patient to become involved in that whole process and carry on the care they have actually managed quite well in the community. But, because they are an in-patient in that bed then they need to be looked after so all that self management gets taken off them. I don't know why that happens, but it does, continuously. (Marjan)

In talking about what happened in the ward, Marjan is also emphasising what nursing is all about. Marjan stressed the need to include the patient, of making sure that the patient's voice is never lost because ward nursing is all about the person experiencing ill-health and for the nurse to make the difference. Nursing is thus about supporting and empowering the patient, having a holistic approach, and using the patient's strength and expertise. In her daily practice this is what Marjan is doing, she provides person-focused care and that sets her apart from the ward nurses more so than her expertise as a CNS. Marjan is the nurse who makes the difference and this is also illustrated in the report written by a fellow CNS concerning Mrs N's health needs.

When Marjan talked about her dual role of working with patients and at the same time teaching ward nurses so they can support patients better, she also describes unintentionally the barriers that ward nurses face by working in an environment that constraints the potential of nursing practice because of its lack of resources. Marjan used to make appointments prior to her visit but she gave up doing so because the realities of daily practice meant that mostly ward nurses had no time to join the CNS in assessing the patient. Marjan now goes to the ward 'just as it comes'. Referring to her role of teaching ward staff, I asked Marjan whether it was

not essential to arrange a time that suited the ward nurses as this would enable them to join the consultation and learn more about the patient.

No uhm it's incredibly hard to get the nurse to come with you because they don't have the time.... I generally go and see the patient by myself because the nurse is busy tending to somebody else. Uhm, if there is any changes to happen, I'll go and find that nurse to say: "I've put this is my plan, it's in the notes, this is going to change, that is going to change". That's how we try and work, I mean, it doesn't always work. (Marjan)

[Researcher]: Does the nurse ask questions to gain more insight into what led to your decisions and...?

Sometimes, but generally no. It's just like: 'oh, yep okay, that's cool'. There's no, they're not seeking rationale. But, generally, if I'm telling somebody that I've changed something. I'll say I've changed it because of this. So I mean, perhaps I've given them enough information and that's why they haven't asked the question.

Marjan's experience was shared by many other CNS and indeed my own observations in the field showed that nurses seldom attended with the CNS during their consultations.

High workloads, having no time, and being busy, all different expressions that signal the same problem that has become the hall mark of ward nursing and the reason given for providing task-focused essential patient care, and for not attending consultations or medical ward rounds that are vital in a health environment that relies on multi-disciplinary input for effective patient care. What I witnessed when I observed ward nurses in clinical practice was the rejection of patients as unique individuals. By this I mean to say that ward nurses' focus of attention was no longer on the patients or on the patients' needs, but almost exclusively on the routine activities that were considered much more important; making sure that the medication has been administered, that vital sign measurements had been completed, and that all the boxes on the varying nursing documents had been ticked. Having in depth knowledge of the patient, how the patient was affected by the medical condition, and how the patient was coping was not a priority as reflected in the written referrals. These referrals are treated as just another documentation chore, the boxes are ticked but patient-focused information is lacking.

If the nurse is available I'll say: "I have had this referral, what are your particular issues with the person?" Nine times out of ten it is: "This is the first time I have ever looked after this person, I don't know". Or: "I did not

know they had been referred” might quite possibly be the response. Sometimes you get: “Oh, the doctor wanted me to refer, I don’t know why”. (Marjan)

Christa frequently received referral forms with little information and she attributes this to the ward nurses’ lack of knowledge of the patients. Christa suggested that it was important to find out why nursing is the way it is.

As nurses we know we have always been busy, that’s the nature of the job. To me, it seems that it’s a task that needs to be done: ‘oh condition X, send a referral!’ They think their job is done, because they’ve sent the referral... This is the perception, this happens quite a lot... We’re talking about having conversations and actually asking the patient how they feel. Is it that the registered nurse is not truly at the bedside a lot these days? There are IV medications to be given, there’s uh.., observations and everything. I’m sure that you can ask these questions at any time but maybe that has an impact I’m not sure, but we need to know why that’s just the way nursing is now. (Christa)

Given that ward nurses spent a considerable amount of time in the ward one would assume that nurses are in the ideal position to be in touch with patients, knowing *where* the patient is at. As contemporary health care is all about multi-disciplinary input and cooperation, one would expect ward nurses to be in a pivotal position, acting as information sources and being the ‘glue’ that binds the services, but this is not what I observed in clinical practice. On the contrary, when one works in a system, in an environment, that does not value an individualised approach to health care delivery, where patients are standardised, and where nursing expertise is not acknowledged or valued, it is inevitable that personal views of what nursing is are going to change. Indeed, nurses have been so bogged down in complying with institutional expectations, with ticking boxes, filling gaps, and minding other people’s business that they have lost sight of nursing and of their own identity as a registered nurse and this is evident in the ‘choices’ nurses make when they give meaning to nursing over the course of their working day.

The CNS who assessed Mrs N believed that she was able to assess her patients because of her position: *‘I realise nursing has become very busy, and I am in a privileged position to be able to sit at the bedside and observe, or make these assessments’*. I would argue that the privileged position does not so much relate to being able to sit at the bedside and observe the patient. Rather this privilege is achieved by not being constrained by the same working conditions as the ward nurses. A report in the late 1990s noted that there was a: ‘... gap between what

nursing is in its intent and theoretical foundation, and the degree to which that potential is lost because many practice settings are powerfully influenced by medical definitions and outcomes' (Ministerial Taskforce on Nursing, 1998, p. 21). This research shows that not much has changed since then. Nursing remains influenced by medicine but it is also powerfully impacted upon by generic management decisions made at the macro level. CNSs are 'only' privileged because they retained the values inherent to nursing; to focus on patients' needs, make independent decisions in the best interest of the patient, and without the constraints placed on the shoulders of ward nurses. The difference in nursing practice between ward nurses and CNS shows the full impact of the health sector reforms. Ward nursing is constrained by the way resources are allocated, the changes in skill mix, the increase in case mix, the high turn-over of patients, and the high patient acuity, all of which has culminated in ward nurses not having the opportunity or the time to gain sufficient experience to develop their expertise to provide patient-focused care.

The CNSs do not work under the same constraints and are able to utilise the full gamut of nursing knowledge and skills for the benefit of the individual patient. CNSs are not dominated by generic management decisions in the same way as ward nurses and hence do not need to ration nursing time to the point that only essential medically-focused standardised care can be provided. CNSs do not work under the same degree of scrutiny by management who have established elaborate documentation processes, including professionally sanctioned clinical pathways and standardised care plans, to control nursing practice in medical and surgical ward settings. Within this tightly controlled and highly structured ward environment there is no 'space' left for nursing to reach its full potential and nurses will not be able to make a difference and provide care that is individualistic and geared towards the assessed needs of the patient. As Sonja noted:

It is not always necessarily what the person [patient] might want, or the way you might do things but this is the way we do things here. For example, pills are given out at certain times, washes are done certain times. If you try and step outside that, you are very quickly brought back to: "This is the way things are done here!" There just is not the room [to deviate from it], so I guess the systems for it are in place and there is a plan for the day. Certainly in our organization you just do well to follow that. There are protocols, policies, procedures, those kinds of things. Our organization is very big on that, and we have a lot of people employed for keeping those in place and updating them to ensure that nursing practice is

in line with it. I learned that very quickly. It makes it very rigid but it keeps order I guess. (Sonja)

Sonja's comments related to the ward and the hospital as a system and organisation that is tightly structured. However it is not only generic management requirements that control what goes on within the wards. Rather, nurses themselves continuously monitor the ongoing flow of social actions in a process that Giddens (1984, p. 3) labelled 'reflexivity'. Reflexivity can be seen as a circular activity by knowledgeable agents over time and space in which they develop mutual knowledge about the actions. Reflexivity contributes to 'taken-for-granted' situations; where actors no longer question consciously why things are the way they are. Hence, reflexivity contributes to stability and continuity of practice. Thus, while changes at the macro level influence health care services generally, it is the nurse leaders' and the ward nurses' responses to these changes, the way they deal with the challenges, that gives shape to contemporary ward nursing practices. By de-emphasising patient assessment and introducing pre-printed NCP, by emphasising medically-focused nursing interventions and rationing cares to 'essentials' only, ward nurses created the structures of standardised task-focused nursing which have been incorporated into the ward routines and reinforced each time a nurse engages in them. On the other hand CNS positions are able as shown above to function quite differently.

Because CNSs came into the ward as consultants they were able to function under a different set of rules and conditions. Although firmly connected to a medical specialty, CNSs did not focus on the medical condition only. On the contrary, being able to give the patients their full and uninterrupted attention, CNSs were able to focus on the patients and the effects the medical condition had on the patients (see for example Mrs N's report). CNSs were not required to use standardised plans of care that ignored the individual needs of patients nor were they required to keep to the routines and practices that structured and limited nursing practice and nurses' authority in the ward. Rather, CNS were able to focus on the individual person's needs, engage in a subjective health assessment and involve the patient and wider family in the treatment of the patient, restoring the patient's health or minimising the impact of ill health. That this was seen as a 'privileged' position rather than a standard way of nursing demonstrates how much ward nursing has changed and how much it has become removed from what many nursing applicants would see

as the identity of the nurse as the person who makes a difference in someone's life at a time of need.

Nurses' authority

Nursing authority is inherent in the 'Registered Nurse Scope of Practice' (Nursing Council of New Zealand, 2010b) as well as the Nursing Council competencies for registered nurses (2007). The Nursing Council stipulates in these documents the expectation that nurses utilise their knowledge and professional judgement to assess the health needs of their patients and provide the identified care, advice and support. Nurses practise independently as well as interdependently with other members of the multi-disciplinary team and are accountable to the Nursing Council and under legislation for their actions.

The authority of professional nurses is undermined in situations where their knowledge and expertise is not utilised or acknowledged as was the case with the implementation of various new procedures and protocols at the time of the fieldwork. Nursing authority was undermined when nursing knowledge had to give way to standardised care provisions that focused on the completion of tasks and did not take into account the patient's actual needs. Nursing authority was also undermined when clinical experience was devalued and contextual factors ignored, through reorganisation of the health sector based on objectified generic management principles.

In chapter two I provided a historical overview of the development of health services in New Zealand going back a hundred years or so. I noted the absent voice of nursing in all the important decisions, even decisions that focused on nursing education and the work nurses do. This research suggests that not much has changed since then. Decisions made at the macro level are rarely examined for their impact at the micro level and nurses within institutional settings such as hospitals are seldom seen as true partners in decision-making. Research covering more than 700 hospitals in five different countries found that only 34 percent of the nurses surveyed felt that they had an opportunity to participate in policy decisions (Aiken et al., 2001). However by not involving nurses in decision-making concerning nursing matters, the collective professional wisdom is cast away and with it the nurses as the owners of that nursing knowledge.

While I do not want to dwell on uncivilised or ‘bullying’ behaviour, it warrants at least some attention as it has been linked to power differentials between people and oppressed group behaviour (Hutchinson, Vickers, Jackson, & Wilkes, 2006; Roberts, 1983; Stokowski, 2010). Whether one considers nursing to be oppressed or not, the facts as set out in chapters five to eight clearly indicate that following the health sector restructurings of the 1990s, nursing knowledge and expertise has been marginalised and devalued. Nurses have and currently still are experiencing role ambiguity while the high workload has meant that nurses are unable to meet professional standards as they have to ration nursing interventions. Without clinical leadership and good role models, and without the hope that the work environment will improve, disappointments have turned to frustrations and anger to the point where some nurses have turned to behaving in an uncivilised fashion.

Bullying in the work place

The topic of bullying has received a lot of attention in the nursing literature where the first publication appeared almost three decades ago (Roberts, 1983). Bullying is known under a range of different terminologies including ‘relational aggression’ (Dellasega, 2009), ‘lateral violence’ (Griffin, 2004), ‘horizontal violence’ (Jacoba, 2005), and ‘oppressed group behaviour’ (Roberts, 2000; Roberts, Demarco, & Griffin, 2009). Although there are many different definitions of bullying there are a number of key concepts that appear to be used commonly to describe it; often there is a degree of verbal or non-verbal violence involved, an act of aggression or intimidation against someone perceived to be weaker. Bullying directly effects the level of job satisfaction experienced and according to the NZNO nurses perceived bullying to be getting worse (Walker, 2011). I do not think it necessary to discuss in great detail the prevalence of bullying as it will not contribute to, but rather distract from the current discussion. However, I will discuss one type of bullying that has been made possible through the use of contemporary documentation practices and which I have labelled ‘bullying by stealth’.

On a number of occasions ward nurses used officially sanctioned procedures for the purpose of getting colleagues into trouble. Incident reports are used for a wide variety of situations where staff actions or in-actions have resulted in (potentially) risky situations for patients, staff or other parties, where damage or loss of property has occurred, or any other event that can be interpreted as unprofessional or unbecoming of health personnel. The intention of incident reporting is to follow up

on the event and to learn from it. However, in practice it became very quickly obvious that whether an incident report was completed or not did not so much depend on the incident but rather on who was involved. To the best of my knowledge, none of all the medication prescription mistakes made by doctors were documented on an incident report clearly reflecting the dominance of medicine over nursing. However, the reporting of medication administration incidents involving nurses depended clearly on who was involved. Furthermore, inconsistent use of incident reporting appeared to be more common in wards that lacked effective leadership and where bullying behaviour was condoned. The following three excerpts all related to the use of incident reporting and are illustrative of its use as a bullying tool.

Incident reports are wrongly used in this hospital, wrongly used! They are used to get people into trouble, I honestly do believe that. I mean, for example, XY, she's made more mistakes than I have picked up, and I have said to her: 'look, you have done this'. I know for a fact that she cannot wait to fill in an incident form for other people. It makes me think, 'ooh, should I write one about her?' But that's is not how they're meant, I mean you have to do it if it's a serious thing, but, you know, I think they are used as part of a tool for bullying, I really do, absolutely. And yet, they are not used for serious things, like, you know, if we are short staffed and if anything happened. (Annika)

Quite often too they're a bit scared of those [bullying] people because they put incident forms in. Like there was a new graduate on our ward who got an incident form put in against her because the IV fluids ran through too quick. It amazes me that this person put an incident form in and never even bothered to tell the new graduate that she could use a burette if there were no infusion pumps available. I thought the idea was making someone's performance better. I was quite alarmed that no one had told her and yet they had sort of disciplined her, but they hadn't actually improved her performance. (Amy)

Yes, uh.. there are some people out there that use the incident reporting process as a way of trying to get at another nurse. I have actually had it happen to me. Uhm people won't talk to you about something but they think: "aha, I have got her" if you make a small error or something like that because there are some people who actually want to try and bring you down. Bullying is alive and well out there in the workplace, and some staff do get targeted. It is not nice. And you will often find that the ones that are targeted are the nurses that are trying to do a good job. (Jolanda)

Bullying has been linked to oppressed group behaviour with members feeling inferior and unable of taking control over their own destiny (Hutchinson et al., 2006; Roberts, 1983, 2000). Nurses in this study felt frustrated about the situation they found themselves in time and time again. Their identity as a professional nurse,

capable of making independent decisions for the health and well being of patients, has been affected by the structural constraints that have been instituted in contemporary medical and surgical ward settings.

Summary

In this chapter I have described how nurses gain a nursing identity through study and practical experience. Many graduate nurses commence their career in medical and surgical hospital wards. It is within these settings that the nurse theoretically strengthens their professional identity, or as shown in this research, loses sight of the role of nursing within the health care setting.

Strong clinical leadership by the charge nurse, or the lack thereof, has been identified as a significant contributing factor to nurse identity. Ward nurses expressed the view that the role of the charge nurse was confusing. Charge nurses were once responsible for upholding professional nursing standards and ensuring safe and effective delivery of care. Now charge nurses have become managers of resources, ensuring that hospital targets are met by making certain that patients remain in the hospital for the shortest possible time. As a result of this role change ward nurses felt often unsupported and disillusioned as there was no opportunity to work in harmony with their own beliefs about nursing.

I have identified that beside the historical domination by medicine, ward nursing practice has been significantly influenced by generic management decisions in its pursuit to reduce cost and raise efficiency. It has resulted in ward nurses losing control over nursing practice as they try and cope with the constraints placed upon them. Increased case mix has not only marginalised the requirement of having nursing knowledge and expertise, but it has also hindered nurses from developing it further due to the dispersion of patients with similar medical conditions, the increased turn-over of patients, the decreased length of stay and a shortage of nurses to care. In this study contemporary nursing practice in medical and surgical ward was characterised by rationing nursing interventions and keeping people alive which has limited the potential of nursing and affected ward nurses' personal and professional identity. This was in sharp contrast to CNSs who did not work under the same institutional constraints and who were able to focus on the patient, identify individual needs, and respond to those needs. CNSs were able to use their

knowledge and expertise to 'make a difference' in the patients' experience of ill-health. These nurses had a strong professional identity and continued to develop nursing expertise which energised their motivation.

Within the ward environment, I observed the existence of a climate of silence whereby nurses held the perception that speaking up would not make a difference and that those who do might get into trouble for that. This climate of silence impacted significantly on the ward nurses' professional attitude and behaviour. I have highlighted how dissatisfaction with the nursing role can have far-reaching consequences, from increased stress levels and pent up frustrations to losing motivation, manipulating the documentation, and engaging in bullying behaviour.

CHAPTER NINE

Discussion

This thesis began with my curiosity about why, despite repeated attention to nurses' health assessment skills (at undergraduate and professional development level), it remained an under-utilised skill. My awareness of this phenomenon was derived from a year spent in a DHB hospital specifically attempting to increase the utilisation of nursing assessment skills in clinical practice. The degree of under-utilisation was very apparent in the study environment and confirmed as a broader issue in the literature (Edmonds, Ward, & Barnes, 2010; Secret, Norwood, & duMont, 2005; West, 2006; Wheeldon, 2005). Interim research findings and time away from my study made me realise that my research aims to explore health assessment utilisation and their effects on subsequent nursing practice were too narrow, and that I needed to examine bedside practice in acute wards from a much broader perspective. I have thus completed a focused ethnography of bedside practice in a set of acute medical and surgical wards in one District Health Board hospital.

My engagement in the field led me to consider the many forces at play in determining the significant changes that have occurred in the day-to-day life of an acute ward. The 1990s shift to generic management of hospitals and the increasing drive for cost efficiencies has led to a range of changes in the operations of hospital processes. In particular these include the rapid reduction in the average length of hospital stay, increased patient acuity, increased patient churn and bed occupancy rates, increased case mix, and altered skill mix.

Much recent quantitative research has revealed a number of concerning findings about reduced time nurses spend at the bedside, the complexity of nursing work flow and the increase in interruptions (Cornell et al., 2010; Hendrich, Chow, Skierczynski, & Lu, 2008; Vardaman et al., 2012; Westbrook et al., 2010; Westbrook et al., 2011), missed nursing care (Kalisch et al., 2009), and the vital role of nurses in preventing many adverse events and preventing unexpected death (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Clarke, 2004; Clarke & Aiken,

2003; McCloskey & Diers, 2005; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Rafferty et al., 2007).

The research outlined in this thesis has added a rich and in-depth qualitative examination of the micro-environment of acute medical surgical wards exposing the impact and consequences of the last 15 years of change on nurses' ability to provide nursing care. As such the thesis goes some way to explaining why there has been growing disquiet expressed nationally and internationally (Braithwaite, Westbrook, Hindle, Iedema, & Black, 2006; Davidson-Baer et al., 1996; Fagin, 2001; Ministerial Taskforce on Nursing, 1998; Norrish & Rundall, 2001), about the quality of nursing care now provided.

In response to the disquiet expressed it is often suggested or implied by external stakeholders (Australian Commission on Safety and Quality Health Care, 2008; KPMG Consulting, 2001; Patient Safety Observatory, 2007) that nursing education is at fault for the deterioration in the quality of in-patient care. Anecdotally older or retired nurses continue to lament the lack of "hospital training" and see it as a means for restoring levels of care.

In this thesis I now argue that the nature of nursing education is not the source of any change in the quality of patient experience in acute medical or surgical wards. Rather, I have shown that the ward environment and the conduct of an average day involving high turnover of very sick patients and the attendant multi-disciplinary team along with other key changes, has markedly reduced a nurse's ability to provide patient care in the manner always intended by nursing as a discipline. Other changes raised in the findings have combined to cumulatively reduce an individual nurse's ability to focus on patients. I shall now briefly revisit those findings before moving to discuss them more critically.

In chapter five I commenced my exploration of the micro-environment by describing the physical structures in which patients are nursed in the research setting. An examination of a day on the ward revealed a chaotic and frenetic world in which nurses are required to cope with a broad range of minute-by-minute demands for their physical and intellectual attention. This surfaced the impact on daily nursing practice of decisions made for reasons of fiscal restraint or risk aversion, and the

impact of an increased number of personnel attempting to attend to sick patients in the very short time frame now available.

Chapter six focused on the impact of frequent interruptions to nurses' attention both from the demands of other members of the multi-disciplinary team, and because nurses constantly compensated for failures in the conduct of others, such as poor availability of essential supplies, unreliable drug charting, or doctors not taking responsibility for completing their own tasks. In settings characterised by time shortages and where nurses are in a perpetual hurry, interruptions heightened nurses' stress and frustration levels due to frequent time delays, factors which are known to reduce job satisfaction (Bowers et al., 2001; Cornell et al., 2010; Duffield et al., 2011).

The research showed that nurses spent considerable time on additional activities to assist and support other health professionals, or to rectify situations within the system that were problematic or incorrect. Nurses engaged in a range of compensatory activities that were not their direct responsibility, yet nurses did so because they felt compelled to ensure that matters ran smoothly for patient welfare and additionally they noted that such compensatory activity had come to be expected. Minding the business of others was thus a major part of medical and surgical ward nursing although it remained largely invisible. The amount of time absorbed by minding other people's business was not in any manner accounted for formally.

In chapter seven I explored the impact of changes made to try and improve both organisational efficiency and patient safety. The impact of changes such as TrendCare, standardised nursing care plans to better accommodate clinical pathways, and the escalation of documentation requirements, can be seen as a site of tension between conflicting agendas. Generic management is focused on cost efficiency and the inherent risk aversion culture of the contemporary hospital. Professional nursing leadership responses aimed to balance those goals whilst protecting the quality of nursing practice. Thus, to reduce time spent on documentation, nurse leaders implemented nursing assessment forms that require minimal writing through the use of tick boxes, documentation by exception which meant that only variances were to be noted, and a switch from SOAPIE to 'focused charting' so health concerns would stand out without the nurse having to scrutinise the entire report. Likewise, the introduction of pre-printed nursing care plans

provided a framework for standard nursing interventions which served concurrently as a checklist of tasks performed. However, the result of these changes was the eradication of the link between nursing assessment and a nursing care plan. Nursing care became task-focused and nursing documentation and hand-over reports generally contained little information about the patient's experience or the nurse's assessment-based knowledge about the patient.

In chapter eight I explored the degree of incongruence between nurses' expectations of what it means to nurse and the day-to-day realities of trying to deliver nursing care. The decrease in patients' length of stay, the constant patient churn, and the knowledge of being able to attend only to essential nursing care has impacted on nurses' sense of identity and the value of nursing care. There is notable role confusion inherent particularly in the charge nurse role as a further site of tension between the demands of generic management and professional practice leadership. Issues of skill mix, the processes of patient allocation, supervision and delegation and case mix distribution were also found to be significantly at odds with the notion of nurses as knowledge workers whose service is contingent upon education and specific expertise. I now argue that over time, in these settings at least, this has eroded nurse's individual and collective sense of the value of their espoused goals as nurses.

When Thomas (1983) spoke of nursing as the glue in hospitals he described a visible and vital component of hospital operations, in effect holding the patient at the centre of operations. At the simplest level it could now be argued that just as glue is invisible when functioning so has the service of nursing been similarly invisible. I argue that the health sector changes occurring in the last ten to twenty years have not factored in nursing. The invisibility of what nurses actually do adds to the perception that nursing as a profession does not make a significant contribution to health care and hence health care agencies do not value nursing for its input (Campbell, 2000; Fagin, 2001; Ministerial Taskforce on Nursing, 1998). Health care environments remain dominated by medicine and this was reflected in nursing documents such as care plans, nursing progress notes and nursing referrals, all of which were medically-focused and contained significant amounts of medical jargon at the expense of a genuine nursing approach to care.

Since the period of "health reform" in the 1990s the actions taken and the events occurring have effectively reduced the space for the metaphorical glue which is

nursing. Nursing is not currently accommodated or accounted for in the planning, preparation, costing and design of a range of hospital structures in New Zealand. The physical ward environment is not designed with nursing in mind (Wagenaar, 2005). The poor ward lay-out requires nurses to walk unnecessary long distances between service areas and patient areas, the nurses' office is too small, providing insufficient chairs and writing spaces for nurses. Likewise, the medication room is too small and offers insufficient working space for nurses to set out medications without being distracted. Increased patient turn-over has increased administrative requirements yet wards had the same administrative support as they had prior to the reforms. Patient to nurse ratios have increased as has the skill mix despite increased patient acuity and nursing intensity.

None of this is perhaps surprising as my examination of the history showed that the voices and views of other players or stakeholders were often louder and consistently dominated the discourse of health policy, politics, funding and planning. The historical development of the NZ health services bears witness to the battles fought between successive Labour Governments and the medical profession (Hanson, 1980; Sutch, 1966), and the continuation of a dual system of public and private services shows how influential the medical profession is when it comes to defending their financial interests in health care (Gauld, 2008). Carpenter (1971) noted that nurses were not working to their full potential and that nurses were used to fill the gaps in the health care system. The report by the 1.6 Committee (1972), which was to consider the development of colleges of health sciences, illustrated in a powerful way how political manoeuvring ensured that nursing, despite being the largest group of health professionals, was shut out of any decision-making concerning their own education. Nursing aspirations were silenced as their educational preparation was made to serve the interests of the polytechnic institutions. The Ministerial Taskforce on Nursing (1998, p. 29), noted 27 years later that nurses did not contribute as full members of the multi-disciplinary health team but were viewed as "...providers of the necessary hotel, hygiene and basic-care requirements of patients". As numerous other commentators have attested (Gordon, 2005; Norrish & Rundall, 2001; Rankin & Campbell, 2006), nursing, despite its numerical predominance, is either silent or ignored in major health sector decisions

At the hospital level there is an apparent view that nursing is an invisible component of housekeeping or hotel services (District Health Boards New Zealand et al., 2001), or as an adjunct to medical care (Campbell, 2000; Lupton, 2000) and it is therefore rarely factored in the calculations or considerations of planned changes. Reviewing the data, surfaced through an examination of day-to-day practice, it reveals that the interests of dominant actors in health are served without recourse to consideration of their impacts on nursing practice.

There is compelling evidence that fiscal demands have increasingly taken priority in the provision of hospital services (Davidson-Baer et al., 1996; Fagin, 2001; Ministry of Health, 2010). There is an almost exclusive focus on the cost of health care, on managing the budget, standardising treatment and care, and reducing length of stay. There appears to be an unsubstantiated conviction at the macro level that decreasing the length of stay is a worthwhile goal. Yet, no thought appears to have been given regarding the consequences of early discharge, the stresses and strains placed on patients, relatives, friends and neighbours, who are obliged to provide the after-care without having the necessary expertise or time to do so (Fagin, 2001; Weinberg, 2003).

Nursing is rarely seriously factored in to the fiscal equation except as a cost (Aiken et al., 2000) yet, for more than a decade, there is convincing evidence of a relationship between higher registered nurse staffing levels and a reduction in adverse events that are potentially sensitive to nursing such as urinary tract infections, pneumonia, upper gastrointestinal bleeding as well as lower rates of failure to rescue (Carryer et al., 2010; Kovner & Gergen, 1998; Needleman et al., 2002). Lower registered nurse staffing levels have been linked to increased mortality rates and failure to rescue (Aiken et al., 2002; Needleman et al., 2011).

Contemporary nursing practice can thus be seen as the response to the health sector restructurings of the 1990s. Driven by the need to establish a cost-effective health care system and guided by the principles of market demands, competition, and generic management, it was believed that the quality of health services would remain unaffected (Arthur Andersen & Co, 1987; Ashton, 2002; Easton, 1999; Gibbs et al., 1988; Stent, 1998). Thus, health reforms focused on the macro structures of funding, introducing a competitive model of health care, and especially developing managerial structures that would control cost, monitor input and output, and measure productivity. Far less attention was paid to the effects on service

delivery at the individual (micro) level (Ashton, 2002; Devlin et al., 2001). Furthermore, not even those authors who have commented on the failure to address the micro level have specifically addressed the consequences for nursing practice delivery.

As White (2004) commented nurses and managers fulfil different roles. While nurses ought to focus on patients' needs, health care managers manage resources and are budget-driven rather than patient needs driven. Managers have finite means and hence seek control over resources in order to achieve set outcomes/targets. Managers utilise nursing documentation to monitor the business of nursing. High levels of standardisation of documents and classification of patients is required to enable computerised data input that will predict care requirements and resource utilisation. Managers scrutinise patient care processes by means of extensive document auditing. Every time documents are audited, managers gain more insight into the business of nursing; the role of the nurse in the caring process, what nurses do, and how nurses work. Campbell (1988, p. 33) argued that: "... documentary processes of corporate management provide the means by which nurses' actions are coordinated in such a way as to bring them into line with state policy, itself oriented to capitalist interests". Indeed, what Campbell was arguing here is that nursing is ruled by a new master; contemporary nursing has become subordinate to generic management principles which controls nursing through documentation practices that prescribe nursing responses in ways that meet the organisational goals and objectives, i.e. deliver health care services within budgetary restraints rather than take account of actual patients' needs.

Nurses in the study setting appear to have reluctantly accepted that, contrary to the official rhetoric, contemporary nursing practice is no longer about holistic care and maintaining standards for patient comfort and safety. Much of their anguish is turned inwards rather than articulated effectively through the use of power and an alignment with consumer needs. There is significant research published concerning the effects on nurses when they work in an environment where they feel unsupported and not listened to (Hutchinson et al., 2006; Parker, 2004; Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010; Roberts et al., 2009).

Observations in the clinical setting revealed that nurses have accepted ward nursing for what it is and in doing so they have inadvertently contributed to the very structures that maintain the status quo of contemporary, acute ward nursing

practice. As Giddens (1984) has argued, the longer certain social (nursing) practices are endured and the more widely such practices are accepted, the more entrenched they become as structures that make up what nursing is all about. Nursing practice should not be seen as a collection of isolated single acts that are performed 'out there', but rather nursing practice in this context needs to be a complex and nuanced relationship between nurse and patient, Nurses 'nurser', and in doing so they collectively develop their own 'system' which is maintained and reinforced every time a nurse engages in such action. In this study the utilisation of the 'pocket notes' served to illustrate how nurses managed perceived lack of time by collecting and documenting only the minimum of task-focused information which subsequently determined the nature of their practice.

Nurses described themselves to be in a powerless position as they had little to no input in changes that affected the delivery of nursing care on the wards. They also noted that management would not listen and that expressed concerns remained unaddressed. Yet nurses had consistently removed themselves from situations that provided opportunities to take control over their situation i.e. nurses did not utilise hand-over reports to discuss and evaluate the quality of care provided. Nurses did not attend ward rounds to ensure the presence of a nursing voice, and neither did nurses utilise ward meetings as a forum to discuss openly their concerns about the contextual setting in which nursing care was to be provided. Nurses did not recognise that they too have power because they control to a large extent their own course of action; they have, as Giddens (1981) noted, the power to 'act otherwise'. He went on to say that those who perceive themselves to be in a subordinate position have a big influence in the reproduction of such inequalities because they not only accept their position, but contribute to it in all aspects of daily nursing practice: the 'dialectic of control'. An example of this is the constant interruptions to which nurses are exposed. Although nurses complained about this intrusion on their clinical practice, they did nothing to stop it and worse still, they readily offered their time and energy to assist doctors by looking for patient files, preparing equipment for intravenous cannulation, or phoning family on the doctor's behalf.

So what does this research offer for future consideration? I argue that nurses' autonomy in the study setting is significantly eroded (especially by the presence of standardised nursing care plans), but this is in effect a microcosm of the failure to

take nursing seriously at all levels of health service decision-making. I maintain that nursing's ability to provide essential surveillance as a key source of patient safety is compromised by the way in which nurses in acute wards are now working. I note the persistent strain between operational and professional leadership as a source of tension and the process by which nursing's disciplinary autonomy is eroded.

I further argue that even current efforts to address the situation such as the 'releasing time to care' project in NZ, and the current United Kingdom discourse about the same problems, are already colonised by managerial agendas and an overriding concern for fiscal restraint. This continues to silence competing voices and any real recognition of the value of nursing attention to patient care.

Nurses as autonomous practitioners

Rankin and Campbell (2006) conducted an institutional ethnography to explore nurses' management of patient discharge in the post-health reform environment in Canada. They concluded that there is an expectation that nurses will be alongside patients conducting professional observations and responding accordingly. But they argued that current conditions constrain nurses from that very activity because the weight of institutional authority is directed towards objectified decision-making which consistently overrides nurses' professional knowledge and judgment.

As noted in chapter seven, the introduction of the nursing process and the development of NCPs heralded a new way of providing nursing care in a systematic way. NCPs were originally developed by The Centre for Nursing Case Management in the United States as a tool to assist nurses in the planning of care. The potential for it to be used for other purposes was very quickly realised by the medical insurance industry in the U.S. which made it a compulsory requirement for health care institutions to apply across all health professionals in the form of clinical pathways (M. Berg, 1997; Dingwall & Allen, 2001; Dingwall et al., 1988; Pearson, Goulart-Fisher, & Lee, 1995). In NZ clinical pathways (CPWs) were viewed by the Ministry of Health and health care managers as a tool contributing to improvements in patient turn-over and cost containment thus embedding both medical and generic management requirements in the one tool. At the micro level, the implementation of CWP and NCPs has had a significant impact on professional nursing practice in

medical and surgical wards. Put simply, the impact has been a reduction in the autonomy of nurses to determine the nature of care.

The autonomy of nurses refers to their right and responsibility to make decisions at an individual level regarding the provision of nursing care when these decisions are within the nurse's scope of practice. The findings of this research indicated that nurses, employed in medical and surgical ward settings, had reduced autonomy over the provision of nursing care as the very nature of their clinical practice was regulated by hospital procedures and policies, in particular those related to the standardisation of patient care, as well as the hegemonic allegiance to medical priorities.

I see autonomy not as something that nurses have, meaning autonomy as a noun, but rather autonomy as a verb, something to be used as an enabling tool. Nurses use their autonomy if they take initiative, if they do their own observations and assessments and make decisions based on their findings. Clinical pathways and related behaviours have 'industrialised' health care by standardising procedures in order to increase efficiency and ostensibly to ensure a smooth trajectory for patients coming in and out of the institution. However, the effect of clinical pathway protocols and the use of standardised NCPs have had a profound effect on the ethos of ward nursing. Standardised procedures contribute to the perception that there is only one single answer or solution in a given situation when in reality there are many other options to choose from.

The expectation that nurses utilise standardised plans impacted directly on the nurses' level of autonomy as standardisation removed the need to engage in patient health assessment or to think independently about the patient as an individual. I observed nurses "going through the motion" of completing the written nursing assessment but the findings generally had no bearing on subsequent nursing interventions. Although most nurses had either studied and practised health assessment as part of their professional preparation, or undertaken a short course programme, none of the nurses observed applied these skills extensively and/or consistently. Patient assessment was largely restricted to the measurement of vital signs and a general survey while being with the patient.

Autonomy includes the authority to make decisions that contribute to 'making a difference' by focusing on the patient's individual needs. Decision-making in

medical and surgical ward settings was generally limited to making 'routine' decisions such as whether and when patients would have their bath or shower and for how long the patient was sitting up in a chair. The compulsory use of pre-printed NCPs discouraged an individualistic approach to patients and strengthened the routinisation of nursing care. By denying the embodied experience of the patient it was possible to reduce complex clinical realities into a simple set of written instructions related mainly to medical/physical tasks while leaving the patient out of the picture altogether.

In this study it became clear that a shift had taken place in the function of standardised NCPs. What began as a guideline to support nurses by providing a framework had gained a virtual existence within the structure of nursing practice. Nursing care plans are not highly individualised, on the contrary they are standardised to the level of providing a structure for essential care only. While structures are both enabling and restraining (Giddens, 1984) in relation to ward nursing practice, NCPs restrained nursing interventions to the point where nurses delivered highly routinised care mainly focused on a limited range of physical needs. Pre-printed NCPs are firmly embedded in contemporary ward nursing practice despite nurses not believing that the plans reflect the complexity of patient care requirements. The absence of individualised plans and the compulsory requirement to utilise NCPs not only weaken holistic nursing practices because patients' needs are not addressed, but it also undermines nurses' level of autonomy as all nursing interventions are structured around the standardised plan.

The value of surveillance

In chapter five, I noted the importance of surveillance is a key nursing activity to detect alterations in patients' health status at an early stage in order to prevent serious and potentially life-threatening events. Surveillance is much more than vital signs measurements as it provides objective parameters about the whole person such as physical appearance, behaviour and mental status, mobility and body structure. Properly carried out, surveillance takes time as it requires nurses to establish frequent direct patient contact. My observations in the field revealed that nurses frequently did not see one or more of their patients for periods of two to three hours due to the business of the ward and the high workload. Given the increased level of acuity, such a time span of non-attendance represents an

inherent safety risk to patients as their condition can deteriorate without being noticed in a timely manner. During my observations I noted that more often than not problems were picked up because patients themselves or fellow patients sounded the alarm. On other occasions abnormal routine vital signs measurements triggered off a follow-up assessment. Some nurses described intuition as playing a role although this appeared to be more related to decision-making after deterioration was detected following vital sign measurements. Nurses did not engage in deliberate surveillance rounds and only one nurse saw all her patients immediately after morning hand-over report (see chapter five).

During my observations in the field I estimated that nurses spent less than three hours in direct patient contact which spread over five or more patients amounted to only 30 minutes of actual time per patient over an 8-hour shift. This estimation might be generous as other studies, specifically focused on time and motion, found that nurses spent considerably less time in direct patient care (Hendrich et al., 2008; Westbrook et al., 2011). When taken into account the research finding that contemporary nursing care was signified by rapidly changing task-focused interventions (Cornell et al., 2010; Westbrook et al., 2011), the time spent at the bedside is neither used, nor conducive, for surveillance. A significant body of literature published over the last two decades has emphasised excessive workloads, inexperience, and lack of skills as the main causes for nurses not detecting patient deterioration or not following up and seeking assistance. Health care providers have developed a range of 'rapid response systems' such as ALERT (see chapter seven) to ensure that patient deterioration is detected at an early stage and appropriately responded to.

Nurses in this research expressed the view that they were spending less time with patients who, due to their level of ill-health, required more care. The reduced amount of time spent at the bedside was perceived to be a safety and quality of care concern. There is significant evidence that nurse staffing levels play a major role in patient outcomes in terms of reducing adverse events and mortality rates. Kovner and Gergen (1998) studied the relationship between RN staffing levels and the occurrence of complications considered nurse-sensitive and found that thrombosis, urinary tract infection, and pneumonia post surgery were inversely related. Aiken et al. (2002) analysed the data from more than 10,000 nurses with more than 230,000 surgical patients over a period of 18 months and found that

hospitals with higher patient-to-nurse ratios experienced higher failure-to-rescue and mortality rates. The authors calculated that for every additional patient on top of an average nurse's workload the odds of mortality increased by 7%. Other large scale studies have found similar results (Needleman et al., 2002; Rafferty et al., 2007).

Failure-to-rescue

There is a phenomenon described in the literature as 'failure-to-rescue' (Clarke, 2004; Clarke & Aiken, 2003), 'adverse event'; unintentional injuries or complications resulting from health care (mis)management (Considine & Botti, 2004), or 'suboptimal care' (McQuillan et al., 1998). In essence it refers to hospital-based deaths which cannot be attributed to reasonable physiological cause.

Factors including a lack of staff, high workloads and time pressure have been repeatedly singled out as predisposing factors for decision-making mistakes. Thompson et al. (2008) researched the effects of time pressure on risk assessment using 50 clinical scenarios on 245 nurses in four different countries. All scenarios were randomly mixed, 26 had time limits placed on them while 24 did not. The research findings showed conclusively that increased time pressure more than doubled failure-to-rescue in simulated practice (from 14% to 32%). Observation in the clinical setting showed that most nurses were continuously making decisions under time pressure (Thompson, McCaughan, Callum, Sheldon, & Rayner, 2005). High workloads, staff shortages, and increased patient acuity resulted in nurses feeling stressed to '*get through the workload*'. The constant stream of interruptions, the need to fill gaps in services, and the minding of other people's business contributed to the stress, as well as further increased the erosion of nurses' time at the bedside.

A New Zealand wide study researched the effects of health reform periods on adverse patient outcomes (in 12 million patient discharges) known to be potentially sensitive to nursing care. The study explored three distinct time periods between 1989 to 2006 (Carryer et al., 2010). The results showed a marked increase in the rate of adverse outcomes for 16 of the 20 nurse-sensitive events following the 1990 health reforms and a levelling off although no real decrease between 2000 and 2006 when some of the health reforms were reversed. Although the authors warned that results needed to be interpreted with due care, they pointed out that

despite marked increases in adverse events there had been a decrease in hospital mortality. The authors suggested that the latter might be due to technological innovations or because nurses prioritised life-saving activities. In reviewing the findings of this study I now argue that the concluding suggestions from that significant volume of quantitative data in Carryer et al. are borne out by this study. Nurses quite specifically mentioned the need, in the face of overwhelming demand, to prioritise and focus on life threatening issues rather than the broader provision of comprehensive nursing care.

In discussing the findings of this research I return now to my earlier assertion that there is a tendency to look within nursing itself and to nursing education for the source of problems, rather than critically examining the contexts in which nurses attempt to provide high quality care. In chapter seven I noted that hospital nurse managers had responded to the reduced quality of nursing surveillance by selecting an educational strategy through the use of the ALERT tool. This was despite knowing that the hospital had already been actively teaching comprehensive short courses in health assessments for a number of years. Research conducted previously in the setting found that nurses did not conduct health assessments despite having successfully completed a 12-week educational programme specifically focused on assessment (Stillwell, Teekman, & Budge, 2002). By opting for ALERT and the associated one-day study programme, senior nursing leaders are ignoring the fact that previous teaching did not lead to the expected outcome and that other factors might be preventing nurses from detecting deterioration at an earlier stage.

The implementation of ALERT may be another example of the inherent tension experienced by nurse leaders who attempt to bridge nursing and generic management agendas. It is easier to challenge and change what you can influence and much more difficult to address that over which you have little influence. It may then be a feature of the relatively defined or constrained degree of control nurse leadership has over the domain in which nursing is delivered. The business leadership or generic management positions theoretically work in partnership but unless nurse leaders have complete budgetary control over nursing units they are in effect powerless to determine how the operations of the ward unit are managed. More often it is difficult to make a distinction between professional and operational accountability as argued by Hughes and Carryer (2011, pp. 42-43)

The area of splitting accountability between professional and service or line reporting is fraught with tension and raises many questions. Current reporting is often a dual reporting situation with nursing staff reporting professionally to the DON and operationally through to the service manager or group manager dependent on their position. Professional reporting is around the ability to maintain their annual practicing requirements, updating their professional development recognition portfolio (PDRP), ensuring they have met their practicing requirements and educational requirements within New Zealand Nursing Council requirements. Operational reporting requirements are organizational reporting requirements that cover risk management, patient safety, budget expenditure, resourcing for their service or area. The first question is around the registered nurse and the ability to clearly demarcate between this artificial “professional” accountability and “operational” accountability. At what point is a registered nurse operationally accountable on a shift and not professionally accountable and vice versa?

It can thus be argued that there is a legacy from the generic management implemented as a key feature of the 1990 reforms in New Zealand. As Hughes and Carryer noted there is a persistent tension and significant lack of role clarity across all New Zealand DHB hospitals. The degree to which nursing is able to control its own practice quality remains significantly diminished. As fiscal constraints increase, it seems likely that this situation will persist and that recourse to managerial solutions will increase.

The politics of health care

This study has been conducted in a New Zealand hospital but it seems important at this point to recognise that international parallels exist in terms of disquiet about the quality of nursing practice and similar failures to recognise the source (see e.g. Rankin & Campbell, 2006 above). The National Health Service in Britain experiences the same difficulties as many other Western countries including New Zealand. In a recent article in the Guardian newspaper (Topping, 2012) the British Prime Minister David Cameron gave a somewhat complex message to the nursing profession. On the one hand Cameron noted that:

‘Somewhere in the last decade the health system has conspired to undermine one of this country’s greatest professions.... Nursing needs to be about patients not paperwork. So we are going to get rid of a whole load of bureaucracy that stops nurses from doing what they do best’.... ‘It is the stifling bureaucracy’. ‘The lack of consequence for failing to treat people with dignity’. ‘...the pursuit of cost-cutting or management targets without sufficient regard for quality of care’.

On the other hand the Prime Minister noted that care was not consistent:

'While we know that the vast majority do a brilliant job, there is clearly a problem in some hospitals, in some settings, where we are not getting the standards of care the nation expects. I think politicians frankly have done nurses a bit of a disservice by not talking about this. Such is our respect for nursing that we've hidden away concerns about this'.

Cameron then said that he expected all nurses to engage in hourly ward rounds to 'systematically and routinely check that patients are comfortable, are properly fed and hydrated' (Topping, 2012).

This is a fascinating quote on a number of levels. Firstly it suggests that this politician has been well briefed about the changes in the British NHS clearly mirroring the micro-level changes found in this New Zealand-based study. The referral to the *'stifling bureaucracy'* is a deep irony as it reflects the normal right wing resistance to bureaucratic expansion but ignores the fact that these changes have occurred as a result of managerial expansionism resulting in New Zealand at least from the period of right wing Government in the 1990s.

Cameron argued that the dominance of managerialism, the effects of cost-cutting and the pursuit of management targets had stifled the provision of person-centred care and had turned nurses into paperwork managers rather than patient carers. Nurses in this study would agree with Cameron's comments; they too mentioned the stifling influence of management on the provision of nursing care and the ever growing need for more and more documentation. Cameron noted that *'most nurses did a brilliant job but that there were some hospitals, some settings, where health care was below standard'*. Cameron's response however, focuses on nursing itself by 'ordering' all nurses to undertake hourly ward rounds to ensure that patients are well-looked after. The notion that politicians had hidden their concerns, because of their respect for the nursing profession, was an interesting comment given that nurses have expressed their concerns to policy developers ever since the health restructuring started.

Cameron blamed *bureaucracy*, he noted *cost cutting*, and he mentioned *management targets*. What he did not mention was that the health sector restructuring was put in place by politicians; that budget decisions are made at Government level and led to cost-cutting in health care delivery resulting in altered staffing levels and skill mix at the bedside. Cameron also failed to mention the political choice to implement 'managed care' as a strategy to control health budgets, which has effected person-centred nursing as well as reduce nursing

autonomy. Ordering nurses to engage in hourly ward rounds without understanding the context of health care suggests that nothing has actually changed; indeed his comments are reminiscent of Reverby's (1987b) comment that nurses have been ordered to care in an environment that does not support or value caring.

It would be short sighted to criticise the fact that decisions are made on the basis of the need to contain hospital budgets. As populations age, technology escalates and chronicity increases (Institute of Medicine, 2001; Weinberg, 2003) all Western countries are attempting to manage health expenditure. It is however more reasonable to argue that decisions made have been based on assumptions about nursing that have only served to reduce nursing's capacity to contribute to the same goal. Instead of seeing nursing as an asset that contributes to the reduction of re-admissions, costly adverse events, reduction in complaints and general process efficiency, nursing has been more regarded as a cost to be pruned or trimmed and above all to be managed by others.

Releasing time to care

In New Zealand several District Health Boards have recently implemented a British initiative, called 'Releasing Time to Care' (RTC) that aims to enable nurses to spend more time at the bedside. Nurses involved with the implementation at some DHBs were recently invited by other DHBs to present their experiences during workshops and to share the programme's successes with colleagues who have not as yet undertaken the RTC journey. The NZ Ministry of Health also engaged in this initiative by sending a representative. Because of the direct relevance of the project to my thesis findings which were being written up at the time, I attended the workshop to observe.

Language is important if the aim is to get as many nurses positive about this new programme. Given that the intent of RTC is to improve the nursing environment so that nurses will be able to spend more time at the bedside, nurses ought to be positive and keen. The following are verbatim quotes from slides presented. The first referred to the reason why a particular DHB was passionate about RTC while the second referred to their vision.

'To provide optimal care for patients and whanau in a multicultural, holistic environment to obtain the best outcome for all'.

'Provide safe & friendly environment while working in Partnership with patients & staff to em-Power & Promote independence while Protecting their dignity & individuality'.

These slides speak directly to nursing through the use of terminology central to the nursing endeavour; optimal care, multicultural, holistic, dignity, and individuality, all concepts that are at the heart of nursing practice. However, the slides that share the success story do not measure any of these concepts.

Instead, these slides show graphs and statistics based in managerial discourse such as standards, action plans, compliance and links to organisational key performance indicators (KPIs). At the workshop there were speeches about what healthcare looks like from the outside, Government waste and private sector efficiency, and why New Zealand will lead the world in healthcare reform. Presenters discussed strategies to reduce time wastage i.e. 'PSAG' boards (patient status at a glance boards), so nurses know in a few seconds the most important things about the patients, 'WOW' (well-organised wards) to speed things up i.e. use of linen trolleys, visitors information notices to reduce interruptions and so on. The message at the workshop was seemingly clear; management has understood that nurses are not happy and that things need to change.

Presenters referred to time and motion studies to improve hospital services that impact on, what in this thesis I have called, compensatory services provided by nursing staff. Indeed, efficiency was to be improved by the hospital services freeing nurses to "mind their own business" of caring for patients. However, as stories of success were revealed, it became apparent that this project too has been captured by the agenda of cost efficiency rather than a commitment to improve the provision of nursing care.

It was noted at the seminar that working more efficiently saved 715 hours per annum or the equivalent of 89 shifts per ward which multiplied by the number of wards resulted in a cost saving of \$583,000 per year for the hospital concerned. But if 89 shifts per ward were to be saved through RTC, caring time for patients was not increased. On the contrary, the equivalent of 89 shifts were saved by management but lost to nursing. All subsequent examples shared during the presentation were also evaluated in terms of money saved and no process of

evaluating increased time to care was described. Examples of raised efficiencies included the setting up of a 'meal module' team undertaking time and motion studies to explore processes that will speed up meal deliveries and the successes already booked i.e. streamline linen distribution and reduce access to linen cupboard reported as saving \$800 - \$1000 in the first month alone. RTC was also predicted to reduce agency staff costs and contribute to a reduction in stock, linen and food costs.

The RTC programme claims to provide nurses with the tools to take control and make changes in their work processes and physical environment resulting in more safety, efficiency and well-being (National Forum Day RTC, 2011). Implementation of RTC is said to improve direct patient care time by up to 41.6% (NHS Institute for Innovation and Improvement, 2011). Despite all the rhetoric the underlying discourse remained the same as demonstrated by the slides presented at the seminar. While there is nothing wrong with the principles of 'working smarter' and minimising waste, if the project is truly about releasing 'time to care' then the financial savings should be translated into extra hours at the bedside and better nurse – patient ratios rather than presented as dollars saved.

The marketing strategy of RTC is to reduce resistance and dissent by involving nurses and creating the appearance that they are in control and that the programme will benefit them and their patients. However, nurses have no real influence as the programme's modules are fixed and neither can nurses decline their participation once hospital management has decided to implement it, as can be concluded from the presentation where one ward was told to implement it even though the staff did not want to. Clearly, the power of the 'uncooperative' nurses was reflected in the poor outcomes of that ward; nurses withheld their labour needed to make it work. Giddens (1979) maintained that power is in the hands of those who control resources but that those who find themselves in a subordinate position have power too as they control their own input and involvement. The more importance the dominant group attaches to achieving a certain goal, the more dependent they become on the subordinates to make it happen and hence the more power subordinates get albeit only for the duration of the implementation. Those having control over resources still dependent on the cooperation of the ward nurses. Giddens (1984) argued that a fine balance of power between the ruler and the ruled contributes to the chronic reproduction of the inequalities in power

relations and the asymmetrical distribution of resources. Domination is thus not perceived to be something imposed by the powerful on the powerless, but rather it is tacitly accepted and mutually reproduced in all aspects of day-to-day life. Giddens referred to this as the 'dialectic of control' and he proposed that those in subordinate positions might have a greater influence in the social reproduction of the inequalities of power than those who dominate because not only has the subordinate group accepted its position, but they contribute to the reproduction of a social system that locks them firmly into this social system.

At the macro level the situation is not much different. While the Ministerial Taskforce on Nursing (1998, p. 40) noted that the "... undervaluing (and consequently under-utilisation) of the professional expertise of nursing was a recurring theme in many of the submissions that we received", little appears to have changed since. Current health strategies continue to pursue policies that increase nurses' workloads through higher patient acuity despite a perceived lack of experienced staff (Walker, 2011). Restructuring in the health sector is ongoing in the name of efficiency and cost containment and there are reports of worsening staff to patient ratios despite a significant body of research suggesting that adequate staffing levels with qualified nurses reduce the rates of preventable complications such as urinary tract infections, pneumonia and deep vein thrombosis and failure-to-rescue (Aiken et al., 2002; Duffield et al., 2011; Kovner & Gergen, 1998; McCloskey & Diers, 2005; Needleman et al., 2002).

Rankin (2009, p. 283) referred to "the ever expanding technologies of the new public management" and the manner in which they have come "to dominate nurses' knowing". The challenge for nurses now is to make visible what Rankin referred to as "oppositional knowledge" in order to challenge the invisibility of patient and nurse experiences in the relentless drive to cost efficiency

Limitations of the study

Any research has its limitations and this study is no exception. Some limitations are caused by the deliberate choices that have been made in terms of the selected research areas. Although I contemplated at the preliminary stage to conduct the study in two hospitals in different towns, by the time the proposal was written for the Ethics Committee a decision was made to limit the research to one hospital only. The main rationale for this decision was that the use of an additional hospital was

unlikely to reveal vastly different nursing practices, and the objective of the research was to do an in depth exploration of health assessment in the same hospital where the survey had taken place. The objective of the research was to create a unique understanding of what was going on here, rather than generalise the outcomes to other settings which is also one of the most important limitations of the study.

Within this one hospital, field observations were limited to general medical, surgical, and rehabilitation wards catering for adult patients only. Specialty areas such as ICU, ED, or paediatric wards were not included because the original study focused on health assessment practices and clinical decision making. It was envisaged that nursing practices could be significantly different in specialty areas where patient to nurse ratios could be as low as 1:1. It was also likely that patients in these areas were monitored electronically as a standard precaution or, as in the case with paediatric patients, that parents were actively involved in the assessment of their children. In all these situations the role of the nurse in assessing patients could be markedly different. Although the research focus was changed for the second stage of the research, the same clinical areas were utilised. This was deliberately done to ascertain whether nursing practice had or had not changed in the intervening years. Furthermore, staying in the same clinical areas contributed to a degree of consistency in terms of other known and unknown factors potentially impacting on nursing practice.

Another limiting factor was the decision that only nurses with a minimum of two years experience could take part in the study. This was done to ensure that nurses had sufficient clinical experience in nursing and assessment practices and would not be unduly distracted by the presence of an observer. Given the change of focus of the research it is possible that the inclusion of newly registered nurses would have accentuated the differences between those new to the system and those who are firmly entrenched in the routines of the ward and the standardisation of nursing care.

With the benefit of hindsight, it could be argued that not including patients has limited the study and indeed I believe it has. During the first stage of the research observations in the field focused on health assessments which assumed by definition a patient-focused approach. The lack of observed patient assessments resulted in a change in research direction with an increased focus on patient-

focused versus task-focused nursing. Had the field studies been repeated the inclusion of the patient should have been seriously considered in order to establish how patients feel about the care they received.

The original plan was to include two or three focus group meetings as a strategy to gather additional data. Several attempts were made to set this up without success. While some nurses indicated their willingness to take part in these meetings, it proved impossible to find a date and time that suited a number of staff.

While the findings of qualitative research cannot be generalised, it is important to point out that the findings of this research appear to be congruent with a range of research publications that have examined aspects of contemporary nursing practices in hospital settings lending strength to these current research findings.

Recommendations for further research

This research identified a number of factors impacting on ordinary day-to-day ward nursing practice which requires further investigations. The charge nurses role was identified as a crucial factor for the development of nursing identity as well as raising ward nurses' professional performance and the standards of ward nursing practice. Further investigations in the area of nursing leadership are therefore warranted; in particular research focused on the visibility and accessibility of charge nurses as clinical leaders, and the potential for their active input into nursing practice by means of role modelling and mutual clinical decision making.

Clinical pathways, pre-printed NCPs and other highly prescribed and standardised health care practices have been in use for a significant length of time, yet little has been written about their impact on actual ward nursing practice. While this research suggested that some forms of standardised care planning might be appropriate for highly routinised medical treatments requiring only short-term admissions, the use of standardised NCPs for patients with complex health problems has been challenged. Research to explore the effects of this latter category of NCPs is warranted in particular in regard to the potential effects on health assessment practices, clinical decision making, and the impact on nurses' authority and their level of autonomy.

Benner (1984) maintained that nursing practice is marked by many non-routine situations that are at least partly indeterminate, asserting that the development of

clinical expertise can only be captured by pattern recognition and interpretive descriptions of actual nursing practices. This current study found that ward nurses engaged minimally in patient health assessments due to the highly standardised routines of ward nursing. The lack of assessment, combined with the increased case mix and patient churn, contributes to ward nurses missing out on developing the skills and know-how to recognise patterns at an early stage as reflected in the literature concerning failure to rescue. While there is considerable research undertaken in regard to the latter phenomenon, it is suggested here that further research is undertaken to assess the effects of highly standardised care on the development of nursing expertise in clinical practice.

Concluding statement

During 2010 and 2011 a series of 'consensus' meetings were held to discuss a vision for nursing in New Zealand for 2020 and beyond. These meetings were hosted by the NZ Nursing Organisation and were attended by nurse leaders, nurse managers, nurse educators, practising nurses and student nurses from across New Zealand. Discussion topics included undergraduate nursing education, collaborative partnerships between education and clinical providers, a national graduate profile, first year of practice provisions (NETP) and interdisciplinary education. The need to teach student nurses the 'realities of clinical practice' was frequently heard and emphasised. These current 'realities', that are part of the nursing locale include, as has been shown in this thesis, a tough and stressful clinical environment in which nurses are struggling to provide the most basic of care.

Rather than examining the factors that contribute to these 'realities' of clinical practice and emphasising the need and commitment to improve the current working conditions of nurses, health care providers and nurse educators discussed and explored how nursing curricula can be adjusted, what theoretical content needs to be added, and how clinical experiences can be enhanced in order to ensure that graduates are better prepared for the realities of clinical practice.

I conclude this thesis by noting that we will gain nothing for the quality and safety of patient care in this setting if we look to nursing education as the solution. We have spent many years discussing the need to produce nurses who will rigorously challenge the current context of practice and we have seen that it does not happen.

More responsibly I suggest the solution may lie in addressing exactly what constitutes the role of the registered nurse in an acute ward and through bolstering their sense that they hold the primary relationship with the patient in terms of determining care and delegating authoritatively. Perhaps this means relinquishing physical hygiene and related care but regaining assessment and decision making through individualised planning; at the very least the conversations need to begin.

APPENDIX ONE

An ordinary day in the ward

My day starts with listening to the taped night report. I take particular note of the patients allocated to me and write down brief comments on the back of the Patient Status Report (PSR). I dot down what needs to be done i.e. tests/treatments but also drug administration times and the likes. After report I look for my patients' files and check the written progress reports from the previous evening as well as the night report just completed. I also check any medical entries. Any new information that is important to remember, especially things that I need to do, I add to my 'planner' on the back of the PSR. If I have patients with an intravenous infusion I tend to go and see them just to make sure that the drip is patent and running on time. If I have blood sugar levels to check then this is the time when I will do it. Following this, I collect the medication charts and start setting out and administering the medication, patient by patient. Breakfast is being served and depending on the staffing levels I might have to assist with that. Sometimes I also assist patients with their meal but when caregivers are on duty, I delegate this to them. Doing the AM medications often takes me to anywhere between 8:30 and 9:00am after which I start with patient cares. Of course, if I come across a patient who is incontinent or needs assistance with toileting, I would attend to that client before continuing with the medication round.

As a staff nurse I am likely to have between four and six patients for the day and that will keep me pretty busy in terms of assisting with hygiene cares, doing a range of vital observations such as BP, P,T,R and pain assessment, mobilising patients, and other regular nursing tasks. Furthermore, I am kept busy with administering additional medications such as IV antibiotics, arranging for and writing referrals, notifying medical staff when medications are not correctly charted, clarifying/sorting out issues, checking the files for additional instructions, and answering telephone inquiries. We all have our own patient load that we are responsible for and I can say that it keeps me busy for the full eight hours of the shift. Generally speaking I look after my own patient but that doesn't mean that I don't help a colleague when asked. Often we check each other's drugs, co-sign for narcotics or assist when patients need two nurses for mobilisation. Morning coffee and lunch is arranged in such a way that sufficient staff remain behind to ensure that all patients are cared for following verbal hand-over. I absolutely love my job but I also have a number of issues that I would like to raise with you to see whether I am the only one who has problems with this:

- I wish that I could get on with nursing. I like to care for my patients but I feel that quite a bit of my time is taken up by things that are non-nursing;

- Every day I 'waste' about 30 minutes trying to sort out things that should have been done by medical staff or colleagues i.e. medications not correctly prescribed or not ordered by previous duty nurse;
- Medication is a real concern anyway as charting is frequently inconsistent (trade names versus generic names) and the medication room is not organised in a way that aids finding drugs easily;
- Medications should be set out in a quiet environment without interruptions but at times the room is likely a market place, that's how busy it is. Sometimes I get called away because there is a phone call or the doctor needs my drug chart;
- I feel that there is a lot of doubling up when it comes to documentation. As a result I estimate that I spent at least 1 hour a day writing but possibly even more;
- I waste time looking for my patients' files which are not strictly kept in one place;
- Having patients across the ward means that I spend a significant amount of time walking from room to room;
- I get frequently interrupted while walking between rooms and this slows down my cares;
- Time is of essence and so it is frustrating when you have to wait, search, or sort out things as it is valuable time taken away from care;
- I do not attend the Dr's round. I never know when they come in and it takes a lot of time. I rather read the communication book or patient file to see what has been decided;
- SOAPIE is generally used but not viewed to be very user friendly, quite a few nurses are not even sure how to use it correctly;
- The nursing assessment document is most times done although often only partially. Generally, once completed it is filed and not further consulted/used/updated;
- The NCP are all standardised with an occasional additional comment. I mainly use it to sign off what I have done;
- I still complete TrendCare as required although I maintain that it does not reflect my true workload;
- Generally speaking my assessment of the patient is based on what I see and the results of vital signs. Assisting a patient with a shower is also an ideal time to do an assessment;
- I think intuition plays a part in assessment as well

Overall, when I am on AM duty, the morning is spent on verbal report, reading the patient files, doing the medications, and patient care. In between these activities I also complete TrendCare so I know what my workload is. Most of these things are what I call 'routine'. It will take me to lunch time. After lunch I undertake a round just checking my patients are okay. I might return a patient back to bed for a rest, do some vital sign measurements, check that documentation is up to date and then finally I write my progress notes and prepare for the handover report. I aim to finish on time but every now and then I do run a bit late and might leave the ward 15 – 30 minutes late. I guess this is for me more or less an ordinary day in the ward.

APPENDIX TWO

Request for research volunteers

My name is Bert Teekman and as part of my PhD study at Massey University in Palmerston North, I am researching actual bedside nursing practice. In particular, I am interested in the 'normal' (routine) day-to-day nursing activities. I would like to explore how you cope with your workload, and how you make decisions concerning the care that you are providing for your clients.

Ethical approval to carry out the study has been gained from the Human Ethics Committee at Massey University, and the Regional Ethics Committee. Approval for the study has also been obtained from the DHB.

I am seeking registered nurses who are employed by the DHB on either full time or part time basis (not less than 20 hours per week average) and who are willing to share their professional nursing practice with me. If you agree to participate in this study I would like to:

- Be a participant-observer for a couple of days so I get insight into your nursing practice
- Explore with you workload issues and how you make decisions in clinical practice
- Access the progress notes that you have entered in the patient's file (with patient consent)

If you are a registered nurse employed in a medical/surgical ward, I would like to invite you to consider participating in this study. Please do know that participation in the research is entirely voluntary, and written informed consent will be sought prior to your involvement in the study. All participants have the right to:

- Refuse to answer any particular question or to withdraw from the study at any time.
- Ask the researcher or the research supervisor any questions about the study at any time.
- Expect confidentiality regarding the information you provide.
- Gain access to a summary of the findings when the study is concluded.
- Participate in this study under the conditions as set out on this, as well as the Additional Information Sheet.

My research supervisor is Professor Julie Boddy, School of Health Sciences, Massey University, Palmerston North. If you consider taking part in this research, or would like to hear more about it, please do not hesitate to contact me at:

Massey University: Ph (06) 356 9099 ext 7384 during day time hours or in the evenings at home Ph. (06) 326 9044.

You may also contact my supervisor, during office hours, concerning any aspects of this research:

Dr Julie Boddy
School of Health Sciences, Massey University
Ph. (06) 350 5799 ext 2541, FAX (06) 350 5668

For more information concerning this research please refer to the accompanying 'Additional Information sheet' or contact me personally. Thank you for taking the time to read this and for considering your participation in this study.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 03/141. If you have any concerns about the conduct of this research, please contact Professor Sylvia V. Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone (06) 350 5249 or email: humenthicspn@massey.ac.nz

Bert Teekman

APPENDIX THREE

Additional research information for ward nurses

This page contains additional information for registered nurses about the research that is being conducted by Bert Teekman and should be read in conjunction with the 'Request for Volunteers' document.

Aim of the study

While it may be true that a lot is known about nursing 'in general', very little research has been done in the area of actual bedside nursing practice in New Zealand. The focus of this research is not on 'special' or 'exceptional' nursing situations but rather it concentrates on the 'ordinary' nursing activities that you as a registered nurse undertake on a day-to-day basis in order to care for your patients. The study intends to explore the type of activities you engage in, and how you manage your 'normal' nursing workload.

Why study nursing in the practical setting?

Nursing is a science and an art; nursing is a practice profession. Nursing does not occur in isolation but is at all times context bound, meaning that the act of nursing involves beside the nurse also a client, a client's family, input from other health care providers and the physical environment in which nursing takes place. It makes sense therefore that, if we would like to know more about nursing and about what nurses do as part of day-to-day nursing practice, we should not just rely on anecdotes and narratives but we should observe nurses at the bedside where nursing actually happens. A review of the nursing literature revealed a very limited number of observational field studies, with most of the research being based on questionnaires examining some particular aspect of nursing practice. There appears to be no publications of observational studies in New Zealand about the type of activities that nurses carry out in their ordinary day-to-day nursing practice.

Can I be a participant and what is my role in the study?

If you are a registered nurse working at least 50% (average of 20 hours/week) you are an eligible participant. You are not required to have special interests in, or possess advanced knowledge of clinical nursing practice as the study focuses on 'normal routine' day-to-day nursing activities. The research itself consists of gathering observational data by the nurse-researcher followed by an audio-taped interview in which we discuss and explore together 'what was going on', how you managed your workload and how you made the necessary decisions. The observational part takes place as you care for your patients. It is envisaged that you will approach the patient first in order to ask for their consent to be involved in the research. Information sheets as well as patient consent forms will be provided for. The interview will be conducted at a mutually agreed time and place after work. I estimate that the duration of the interview is between one and two hours. All data collected as part of the research is strictly confidential and no other staff will have access to any information given to me. You will have access to your own interview data; in fact, I will ask you to check the transcripts to make sure it is accurate and recorded in the way you intended it to be.

What about confidentiality?

Code-names will be used in the write-up to ensure anonymity, and the nurse-researcher, as well as the research supervisor, are bound by a confidentiality clause. All tapes and transcripts will be kept under lock and key and destroyed after a set time following the completion of the study in line with Massey University research protocols. Please note that the focus of the research is to learn and understand what goes on in 'ordinary' clinical practice. At no time does the researcher judge your skills or knowledge and neither does the researcher criticise your nursing practice.

Temporary exclusion from the study

If you are currently enrolled in any study in which the researcher is involved as the primary lecturer you are unable to take part in the research until such time that you have completed your study. This exclusion is in place to ensure that there will be no grounds for conflict of interest.

What do I get out of participating and what happens if I change my mind?

The exciting thing about research is that we do not always know what will come out of it but one thing is sure; we will learn and understand the research topic better at the end of our 'journey'. If you come with me on this journey, you are sitting in a front seat and as such we will be learning together in partnership. Your participation in the research might result in you re-evaluating your own practice, in extending your own knowledge and understanding of nursing practice.

What are my rights?

Your participation in this research is entirely voluntary and you can withdraw at any time without any personal consequences. You have the right to:

- Ask any questions about the study at any time.
- Refuse to answer any particular question.
- Ask for the tape to be turned off at any time during the interview.
- Expect confidentiality regarding the information you provide.
- Gain access to a summary of the findings when the study is concluded.
- Participate in this study under the conditions as set out on this, as well as the Request for Volunteers sheet.

What about agency protocols and guidelines?

At any time during your participation in this project all DHB protocols and guidelines need to be upheld by both participants and nurse-researcher. In the unlikely event that I observe inappropriate practice I will discuss my concerns with your Charge Nurse.

Where to from here?

If you have any questions or require further information don't hesitate to contact me as indicated below. If you have made up your mind and you have decided that you would like to take part in this research I would like to meet with you to discuss the research with you before you sign the Informed Consent Form. You can contact me at home by phoning (06) 326 9044.

Thank you for taking the time to read this and for considering your participation in this study.

Bert Teekman

APPENDIX FOUR

Consent form (ward nurses)

I, _____, have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my full satisfaction, and I understand that I may ask further questions, if I wish to do so, at any time.

I agree to participate in this study on a voluntary basis. I have the right to withdraw completely or partially from the study at any time, and I have the right to decline to answer any particular questions.

I am aware that part of the study will involve fieldwork and that the nurse-researcher will participate-observe alongside me in clinical practice.

I agree to provide information to the nurse-researcher on the understanding that my name will not be used without my permission.

I understand that all information obtained will be used only for this research and for publications, seminars and research forums arising from this research project.

I agree to the interview being audio-taped but I do understand that I also have the right to ask for the audiotape to be temporarily turned off at any time during the interview.

I agree to participate in this study under the terms and conditions as outlined in this form as well as the Additional Information Sheet.

Signed: _____

Name: _____

Date: _____

APPENDIX FIVE

Confidentiality form for interview transcriber

An ethnography of bedside nursing practice

I, _____ will keep confidential all the information that comes to me in my function as transcriber for the above named research study.

I will ensure that all data received will be stored safely and securely so that no third party can get access to it either accidentally or deliberately.

I will not keep any copies of the research data, be this taped, written, digital, or in any other form, after I have handed over the information to the researcher.

All digital information will be deleted from my computer and associated disks after the researcher has confirmed successful transfer of data onto the research computer.

Signature: _____

Date: _____

Full name printed: _____

APPENDIX SIX

Request for volunteers (key stakeholders)

A focused ethnography of bedside nursing practice

My name is Bert Teekman and as part of my PhD study at Massey University Palmerston North, I am researching actual bedside nursing practice. In particular, I am interested in the 'normal' (routine) day-to-day nursing activities. Ethical approval to carry out the study has been obtained from the Human Ethics Committee at Massey University, and the Regional Ethics Committee. Approval for the study has also been gained from the DHB.

During the first stage of data gathering (2006 and 2007) fieldwork was undertaken in the form of 'bed-side' observations and interviews with individual nurses. During the second stage I am organising Focus Group meetings with ward staff nurses to share the initial fieldwork observations/findings (while safeguarding confidentiality of those who contributed to the study) and ask for their comments.

However, I am also interested in the perceptions of Charge Nurses, Clinical Nurse Specialists, and Clinical Nurse Educators connected to the adult medical and surgical wards. I would like to interview stakeholders individually, share key aspects of the study and ask for your comments in terms of the accurateness of the observations in the field (do you recognise the descriptions as a realistic reflection). I would like to listen to your perceptions and your clinical experiences. The interview/conversations will be tape-recorded while written notes may be taken by the researcher.

Participation in this research is entirely voluntary and written informed consent will be sought from all participants prior to involvement in the study. The written consent to take part in the study places the following rights and obligations upon all participants. You can:

- Refuse to answer any particular question or to withdraw from the study at any time.
- Ask any questions about the study at any time.
- Expect absolute confidentiality regarding the information you provide.
- Gain access to a summary of the findings when the study is concluded.
- Participate in this study under the conditions as set out on this, as well as the Additional Information Sheet.

My research supervisors are Professors Julie Boddy and Jenny Carryer, School of Health and Social Services, Massey University, Palmerston North. You may contact my supervisors during office hours concerning any aspects of this research:

Dr Julie Boddy
School of Health and Social Services,
Massey University
Ph. (06) 356 9099 ext 2541

Dr Jenny Carryer
School of Health and Social Services,
Massey University
Ph. (06) 356 9099 ext 7719

For more information concerning this research please refer to the accompanying 'Additional Information sheet'. If you consider taking part in this research, or would like to know more about it, please do not hesitate to contact me on 027-280 2986 or 06-326 9044. Thank you for taking the time to read this and for considering your participation in this study.

Bert Teekman

APPENDIX SEVEN

Consent form (for stakeholders)

A focused ethnography of bedside nursing practice

I, _____, have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my full satisfaction, and I understand that I may ask further questions, if I wish to do so, at any time.

I agree to participate in this study on a voluntary basis. I have the right to withdraw completely or partially from the study at any time, and I have the right to decline to answer any particular questions.

I agree to provide information to the nurse-researcher on the understanding that my name will not be used without my permission.

I understand that all information obtained will be used only for this research and for publications, seminars and research forums arising from this research project.

I agree for the interview to be audio-taped and I understand that the researcher may take additional written notes during the interview.

I agree to participate in this study under the terms and conditions as outlined in this form as well as the Additional Information Sheet.

Signed: _____

Name: _____

Date: _____

APPENDIX EIGHT

Research information sheet for patients

My name is Bert Teekman. I am researching bedside nursing practice as part of my study at Massey University in Palmerston North. I am a Registered Nurse and interested in the 'normal' (routine) day-to-day nursing activities, how nurses cope with their workload, and how they make decisions about the care that they provide for their patients. In order to do this study I will observe nurses in the midst of their daily nursing practice. Ethical approval to carry out this study has been gained from the Human Ethics Committee at Massey University, PN Protocol 03/141 and the Regional Ethics Committee. Approval for the study has also been obtained from the DHB. As this study involves observing nurses, it is possible for patients to become part of the study but this will only happen if you agree to do so. The following information is intended to explain to you what happens when you participate so you can make an informed decision as to whether you would like to take part in it.

Do I have to take part in the study if my nurse is doing it?

No, you don't have to take part in the study as participation is entirely on a voluntary basis. Your nurse cares for more patients and I (the researcher) can still observe the nurse interactions and activities when (s)he cares for these other patients. Your refusal to take part in this study does therefore not disadvantage your nurse or the quality of care that the nurse provides to you.

What happens exactly if I agree to take part in the study?

I will be present during the provision of care and observe how the nurse cares for you. While the focus of the observations is on the nurse and not on you, you are the key person in the nursing situation and you need to agree with me being present. It is possible that I make some notes during my observations but this will be kept to a minimum.

What if I change my mind later and don't want to take part in it anymore?

If, at a later stage you decide that you prefer not to take part in the study you have to tell your nurse and I, the researcher, will no longer observe your nurse while (s)he cares for you. Your care will be unaffected and the nurse will remain committed to providing you with the best possible care.

Is there anything else that happens and that I should know?

Yes, I would also like to see what the nurse writes in your report (patient file). For this I need to have your written permission (your written consent). If you don't want me to read your file you can still participate in the study and you can indicate this on the consent form by crossing out that you give me permission to view your file.

How is my care affected by the study?

Whether you take part in the study or not, the care you receive from the nurse should be the same. At all times the nurse should be committed to provide appropriate quality care no matter whether you volunteer to take part in the study or not.

What if I have questions or concerns about the study?

If you have questions or concerns you may ask your nurse or ask me and I am happy to explain the details of the study. You can also contact Professor Julie Boddy, who is the research supervisor (School of Health Sciences, Massey University, phone (06) 350 5799 ext 2541).

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 03/141. If you have any concerns about the conduct of this research, please contact Professor Sylvia V. Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone (06) 350 5249 or email: humenthicspn@massey.ac.nz

Thank you for taking the time to read this and for considering your participation in this study.

Bert Teekman
Nurse-Researcher

APPENDIX NINE

Consent form for patients

(THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS)

I have read the Information Sheet and I have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

I give* / do not give* permission to the researcher to access my patient file.

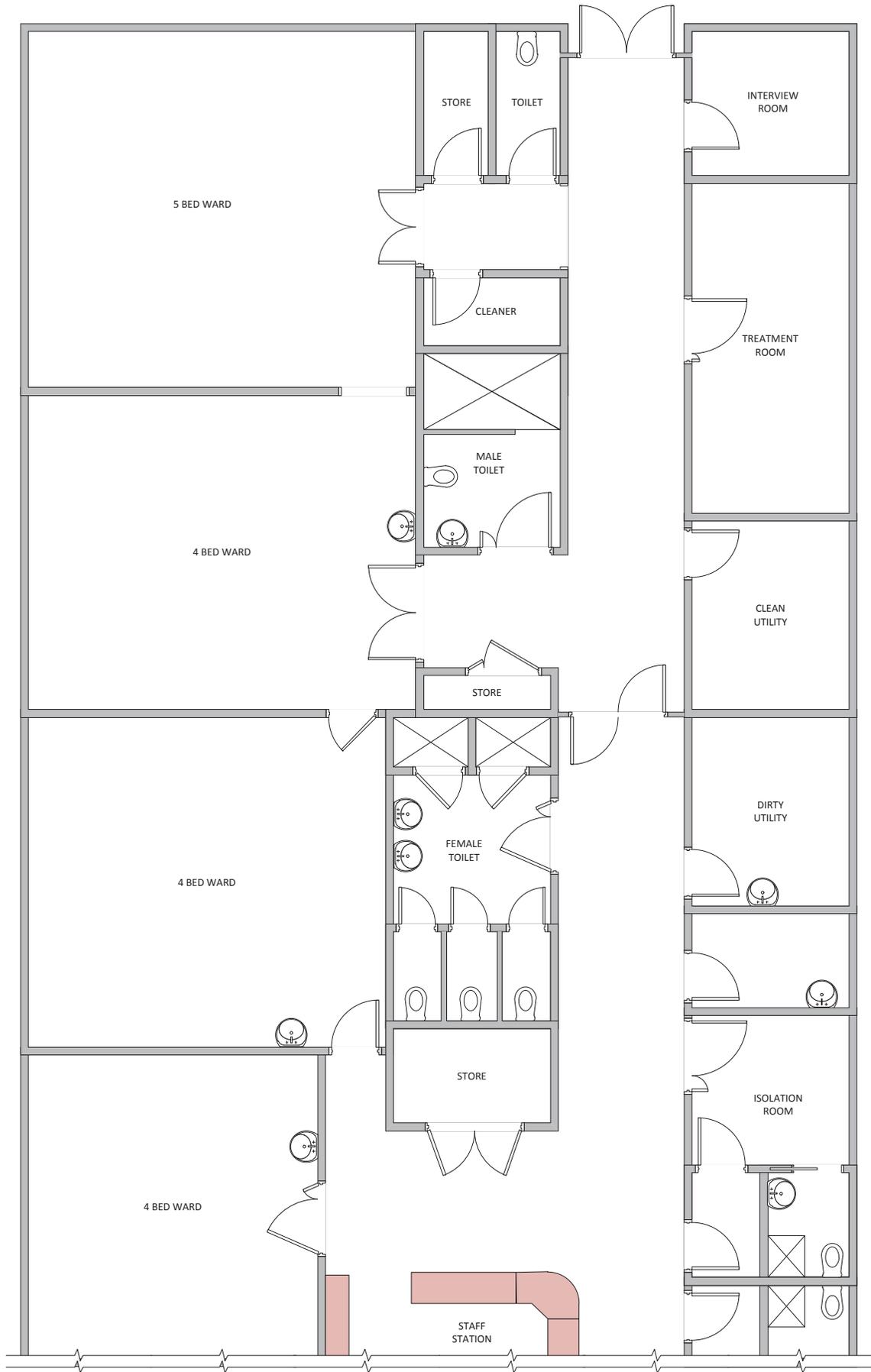
(* please cross out what is not applicable)

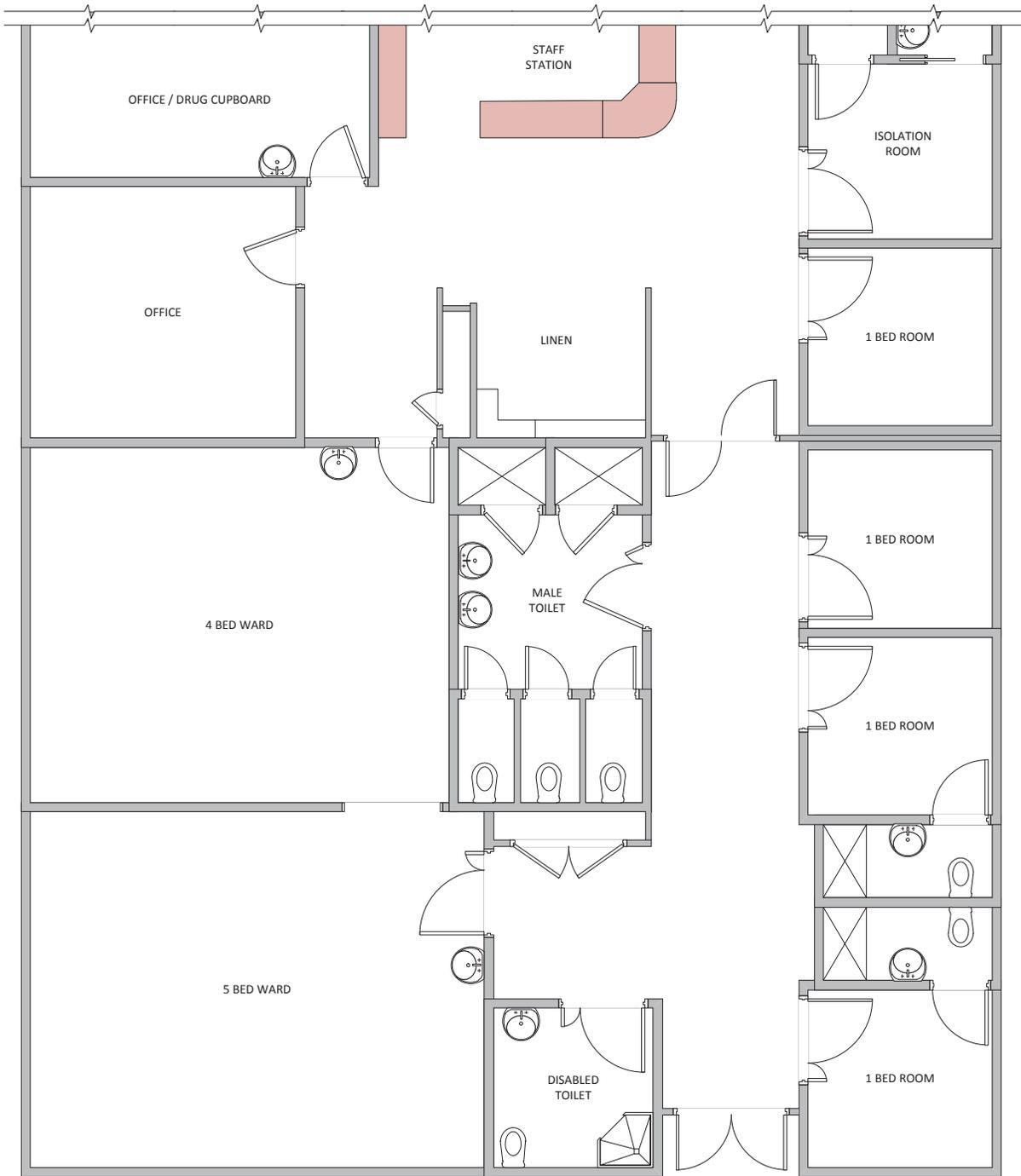
Signature: _____ **Date:** _____

Full Name (printed): _____

APPENDIX TEN

Ward floor plan





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