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MAKING A DIFFERENCE:

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THE LIVED WORLD OF NURSING PRACTICE

IN AN ACUTE CARE SETTING

A thesis presented in partial fulfilment of the requirements
for the degree of Master of Arts in Nursing at Massey
University

Bronwyn Paterson

1989

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ABSTRACT

This study examines the practice world of twenty two registered nurses working in medical and surgical wards of an acute general hospital in New Zealand. It is argued that nursing practice is a complex, context-specific, activity and needs to be studied using methods that do not assume an objective, context-free reality.

The work of Patricia Benner (1984) guided this study which utilised a qualitative research approach to enter the lived world of nursing practice. Through descriptions of work days and a sharing of clinical exemplars, an understanding of the broader context of nursing practice was gained, areas of skilled performance in nursing emerged, and the meaning of making a difference for the nurses in the study examined. The central role of mutual advice and support in facilitating significant incidents in practice was apparent.

An examination of the types of experiences which challenge current practice and change it in some way provided insight into the importance of experience in developing clinical expertise and the vital role of local knowledge in facilitating practice. Nursing practice emerged as crucial to patient welfare and safety in the acute care setting.

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A research study of this nature and magnitude can never be completed in isolation and I would like to express my sincere thanks to all those people without whose contributions this thesis would never have become a reality.

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PART I

BACKGROUND TO THE STUDY

Part I of this thesis comprises chapters 1-3. Chapter 1 introduces the study, outlines the impetus for undertaking research into nursing practice and describes the purpose of the research. Chapter 2 reviews the literature relevant to the study and chapter 3 presents the methodology and structure of the study.

In writing this thesis an attempt is made not to use sexist language. At times this can become convoluted and for ease of reading the nurses in the study are referred to using feminine pronouns. This is because the majority of nurses working in acute care general hospitals in New Zealand are female and all but one of the nurse participants in the study are female.

The term 'patient' is used to describe hospitalised persons. It is realised that this term has connotations of passivity, and this is not intended. As it is the word in common usage in New Zealand hospitals and is the term used by the nurses participating in this study it has been adopted in the rest of the text.

CHAPTER ONE

INTRODUCTION

Background to the Study

Nursing students entering the practice world of hospital nursing in the early 1970's in New Zealand would have started with a brief period in Introductory School. At that time the student's perception of nursing was one of pan rounds, sputum cup rounds and toothmug rounds, bed making and bedbaths, sluice rooms and monometal. Very soon, however, the student would begin to supervise those even more junior than herself as they entered this world. The possibilities for care were not great, the level of expertise of those delivering care elementary and the focus was the task at hand. This was certainly my experience.

Many changes have taken place in the few years since then. Increasingly rapid changes in medical management have increased the possibilities for care and cure and led to the movement of sophisticated drugs, treatments and equipment, which in the past would have been reserved for Intensive Care Units, into general use within the wards. Major changes have taken place in nursing education, with a move from hospital based training to a broader education within tertiary educational institutions. Changes in practices and economic considerations have led to shorter patient stays, resulting in increasing acuity and dependency ratings of the average hospital patient. Consumers developed have greater expectations of the Health Service and have become more vocal regarding their rights.

I have a strong commitment to nursing practice and a belief in its value. In my interactions with patients, families and other nurses I know that my being there has made a difference. However, I also recognise that nursing practice is often undervalued and that my appreciation of its complexity is not always shared, even within the nursing community. Rigid formalisation of nursing procedures which was once mandatory for safe practice continues, along with a failure to recognise different levels of clinical expertise. Nurses are often treated as interchangeable units that can be slotted into any position as the need arises with no reduction in their effectiveness. The continued rigid adherence to rules and procedures has led to a failure to legitimise and value discretionary judgement. The fact that there is no clear definition of what nursing is, and what it is that nurses do that actually makes a difference, may be important reasons why this is so.

Organised attempts within the profession to strengthen clinical nursing practice have not been particularly successful. The development of a clinical career path for New Zealand nurses was proposed in the 1976 New Zealand Nurses Association (NZNA) policy statement *New Directions in Post-Basic Nursing Education*, where career structures in practice, management and education were outlined. No real progress was made and in 1984 the NZNA published another document *Nursing Education in New Zealand: A Review and Statement of Policy* which reaffirmed the Association's position and maintained that the establishment of a clinical career path was imperative. In the four years since then some isolated positions which focus on clinical practice have been advertised and filled and in line with movements in this direction the NZNA is currently setting up a committee to initiate the certification of Nurse Clinicians and Nurse Consultants. However, the reality is that apart from a few isolated instances, the positions for these clinicians still do not exist. The framework is not in place and individual employing bodies have had no incentive to take up the initiative. The need for these positions is still questioned, even in some nursing circles (NZNA, 1988).

Although on the surface there have been many changes to the practice world of nurses, the nature of the social relationships within that environment has not changed appreciably. These relationships have been referred to as being

'historically frozen' (Hickson, 1988). The North American situation would suggest that what nurses do has been heavily influenced by what hospitals permit and encourage (Packard & Ferrara, 1988) and that the conditions that exist in practice settings within hospitals have resulted in discouragement of the best prepared nurses to practice there (Jacox, 1982). These observations also fit well in the New Zealand setting. Despite professional policy statements espousing commitment to a clinical career structure in this country, positions still do not exist for suitably qualified nurses in clinical practice and there continues to be a movement of these nurses into management and teaching positions. The lack of senior clinical positions and the continuation of a structure which is no longer compatible with nursing's needs has played a crucial role in preventing nursing practice from becoming autonomous and self directed. It has also militated against the best possible quality of care being provided as more experienced clinical nurses are not willing to practice within this kind of environment.

Recent work published by Patricia Benner that has focused on clinical expertise has provided an insight into why nursing practice might be so undervalued as well as providing a much needed framework for identifying different levels of clinical expertise. Benner (1984) contends that nurses have failed to describe their practice and that a wealth of untapped knowledge lies embedded in the practices of expert nurses. Expert nurses practice in an holistic way and the procedural, incremental, context free methods used to describe practice are unable to "capture the essence and complexity of expert nursing" (Benner,1982 : 402).

If practice environments are to change, clinical career paths are to develop and clinical knowledge is to advance, then description of the practice of expert nurses and an understanding of the processes of clinical decision making are essential. The notion of practical knowledge (knowing-how) being different from theoretical knowledge (knowing-that) originally introduced by Polanyi in 1958 (cited Benner 1984), is outlined by Benner who considers that:

"knowledge development in an applied discipline consists of extending practical knowledge (know-how) through theory based scientific investigations and through the charting of existent know-how developed through clinical experience in the practice of that discipline" (p.3).

The development of practical knowledge, or know-how assumes a background of clinical experience. Experience in this sense is not related purely to passage of time, but rather to the turning around or refinement of preconceived notions and theory through encounters with real life situations (Benner, *ibid*). No systematic description of existing practical knowledge in nursing has been undertaken in New Zealand despite the fact that Benner's influential work has identified it as central to the development of nursing knowledge and advancement of clinical nursing practice. Christensen's (1988) study from which she develops a grounded theory of the Nursed Passage begins this task. Benner also suggests that the lag in description of clinical nursing expertise contributes to the lag in recognition and reward.

The impetus for this study comes from my personal experience and from my introduction to the work of Patricia Benner. As a clinical nurse for over a decade I have become increasingly aware of the limitations of existing descriptions of nursing practice and the inability of these descriptions to describe the lived world of nursing. Benner's (1984) study was exciting in that it provided an insight into the world of nursing practice that I had not been exposed to before. I also experienced caution in reading her work as it came from a different cultural setting and I felt there was a need for similar studies within New Zealand.

Purpose of the Study

The primary purpose of this research study is to begin the task of charting the practical knowledge of nurses in the New Zealand setting. By describing what it is that nurses do, the environment in which they work and the ways

in which they make a difference it is hoped that their contribution to patient care can be more clearly explicated and its value demonstrated.

Although research in this area has taken place in the United States (Benner, 1983, 1984 & 1989) it is vital that local research also be undertaken. Cultural, educational and health care system differences could well mean that different expressions of practical knowledge may be found in the New Zealand context, and from there, different domains of nursing practice may be identified. There are dangers in transposing a model from a different setting and developing clinical and other career structures such as has been done with Benner's work in Australia (Silver, 1986 a&b). Examples of what may arise when ideas and frameworks for practice are transported from another culture, were highlighted in papers presented by nurses from Japan at a recent international conference in Rotorua, New Zealand. The authors described, and provided critical evaluation of, attempts made to introduce primary nursing, clinical nurse specialists and Orem's self care model into health care settings where many of the values and assumptions underlying such practices were incompatible with the broader cultural values of Japanese society (Kodama & Koyama, 1987; Inoue, 1987). It is clear that the relevance and usefulness of research findings from another context needs to be established, before they can be adopted in another cultural setting.

More specifically, the aim of this study is to enter the practice world of a small group of registered nurses working in acute medical and surgical wards of a general city hospital in New Zealand and to explore the world of their clinical practice in order to:

- * describe the context within which these nurses work;
- * identify those areas where nurses make a difference;
- * identify the types of experiences which change nurses' practice.

In the process of the study, nurses were asked to describe the world of their practice, to identify and share clinical experiences where they made a difference and experiences which made a difference to their practice. The

study is guided by the work of Benner who undertook her research in the United States. A phenomenological orientation underlies the study and methods consistent with the phenomenological perspective are utilised. Chapter 3 of this thesis outlines the structure of the study and includes discussion of the theoretical orientation.

CHAPTER TWO

REVIEW OF THE RELEVANT LITERATURE

This thesis focuses on nursing practice and in particular on identifying where it is that nurses make a difference. The way in which nursing is viewed, the nature of clinical decision making and the development of clinical expertise are all related to this topic and current understanding of these areas will be examined in this chapter.

One's view of nursing and nurses varies depending on one's exposure to them. The media, for example, often offer a distorted view of the nurse such as that portrayed in many popular television series. Nurses tend to be seen in stereotypes, as young and sexy or older and domineering, sometimes helpful, but rarely called upon to make independent decisions – these remain the domain of the doctor. The role portrayed is one of doctor's helper.

Nursing texts offer a view of nursing aimed at capturing the nursing role and the essential role of caring. The holistic approach is emphasised. The reality is, however, that there is then a tendency to break down the person into parts – emotional, intellectual, social and physical – and to approach the person in variations of a biomedical, body systems approach (Luckmann & Sorensen, 1980; Phipps, Long and Woods, 1980; Smith & Germain, 1975). Identifiable nursing actions are emphasized. The experienced nurse can read such a text and gain helpful knowledge and understanding, but is well aware that it does not fully explain what nursing is. Partridge (1978) captured the dilemma when she wrote:

"Loving and caring can't be quantified or measured. They probably would not yield to demands for precision in questionnaires or scales. Can anyone, though deny their existence and the impact on each of our lives? We have all been touched by the serenity, even joy, of patients and their families who experienced nursing and health care delivered in warm, caring ways" (p.359).

The difficulty is that the essence of nursing cannot be readily described or quantified in the ways that have been traditionally valued (logical, empirical approach) and our nursing texts reflect that. They can describe some of the knowledge and teach some of the skills that gain safe entry into the nursing situation but they fall short of describing the essential nature of nursing. The essential nature of nursing is not tangible.

Bradley & Eisenberg (1986) offer a useful distinction between high visibility and low visibility nursing actions. High visibility actions are those which predominantly relate to the physiological needs of the patient, and involve psychomotor skills. These highly visible actions are those actions most people associate with nursing and that have been traditionally valued. Low visibility actions are those that are less easily seen by others and cannot be broken down into steps. They tend to require cognitive or affective skills rather than psychomotor skills and have not been traditionally valued or rewarded.

It can be argued that assessment of clinical competency focuses on the nurses' capacity to apply theoretical knowledge and their analytic ability. This grasp of theoretical knowledge and the ability to think analytically is seen to reflect an ability to make good decisions about care and therefore to reflect good practice. In line with this assumption, research into clinical decision making searches for a single underlying process which will explain how decisions are reached.

In reviewing the literature it is found that investigation into the nature of decision making and in particular making clinical judgements has predominantly focused on clinical judgement within medicine. Tanner (1983, 1987) has presented two overviews of research into clinical judgement. She defines clinical judgement in nursing, in terms of observation, diagnosis and management - decisions made by the nurse in interaction with the client regarding the type of observations to be made, the data observed and what it means, and the nursing action required. Three principal theoretical frameworks are identified by Tanner that have been used in studies on clinical judgement:

Decision Theory attempts to describe or prescribe how a course of action is chosen using mathematical models which weight cues to derive a diagnosis, or choose an action which has the highest probability of achieving the most valued outcome. These include Bayes Theorem, Utility Theory and the Lens Model.

Research has shown only modest support for these theories, tending to show that decisions are made in the direction predicted by the theory, but not to the degree anticipated.

Information Processing Theory - this theory is based on the assumption that there are limits to a persons capacity to process information and that their ability to problem solve is determined by their ability to adapt to these limitations. Problem solving is seen as an interaction between an information processing system, the problem solver, the task environment and the task at hand. An important tenet of this model is that of early hypothesis activation which is seen as a mechanism to 'chunk' information in short-term memory to increase its capacity to hold the large amounts of information required.

Research in this area has shown that early hypothesis generation and testing is consistently used in making clinical judgements.

Concept Attainment Theory - describes cognitive strategies used by persons to form concepts or categories when they are faced with a set of descriptors. Information is attended to selectively, hypotheses formed about ways information might be categorised and a strategy selected to test the hypothesis based on the amount and relevance of available information.

Studies using this model have not resolved whether the model can adequately describe the process of clinical diagnosis.

(Tanner, 1983, 1987)

Tanner(1987) observes that research relating to clinical judgement uses a variety of theoretical perspectives with little clear direction in replication, refinement or extension of previous work resulting in few conclusions being able to be made about the processes of clinical judgement. Most studies have searched for a single underlying process in making clinical judgements.

Approaches to clinical decision making that assume that it is possible for a single process to account for decision making fail to take into account the complex nature of a practice environment. Schön (1983), in discussing practice within helping professions, points to the inherently unstable nature of practice situations. He suggests that the unique nature of practice situations calls for an art of practice which "might be taught if it were constant and known, but it is not constant" (p.17).

Recent research in nursing using inductive approaches and focusing on areas such as novice - expert differences (Benner, 1984), rapid decision-making in critical care areas (Baumann & Bourbonnais,1982) and diagnosis and intervention in situations of elder abuse (Phillips and Rempusheski, 1985) also suggest that there may not be a single process involved. Benner (1984) and Benner & Wrubel (1982 a & b) identify differences in the way clinical situations are approached, depending on the level of expertise. The expert nurse is characterised by her ability to 'grasp the whole' which includes an ability to hone in on the accurate region of a problem without needing to

consider the full range of possible alternatives. Trumbull(1986) describes a similar ability with experienced teachers.

The Dreyfus model of skill acquisition, developed by Stuart Dreyfus (mathematician and system analyst) and Hubert Dreyfus (philosopher) and based on studies of airforce pilots and later chess players, outlines the development of expertise and less directly points to an understanding of decision making that changes as greater expertise is gained. This model has been applied to nursing by Benner (1984) and to teaching by Trumbull (1986). The model proposes that in the acquisition and development of a skill, a student is seen to pass through five possible levels of proficiency, beginning with novice and moving through advanced beginner, competent, proficient and expert. Differences in the way clinical situations are approached are identified within each level which in turn reflect differences in the way clinical decisions are made. If applied to nursing these levels of clinical proficiency are:

Novice - the beginner has no experience with situations in which she is expected to perform and to provide entry into these areas is taught skills in terms of objective attributes. She uses context free rules and is unable to use discretionary judgement.

Advanced Beginner - this nurse has had enough experience in real situations to be able to recognise recurrent meaningful situational components, but is still unable to take in the situation as a whole. She operates on general guidelines and achieves acceptable performance, but still needs help in setting priorities and support in the clinical situation.

Competent - the competent nurse is able to see actions in terms of long term goals and plans. She is efficient and organised, able to cope with many contingencies and plans by conscious, abstract, analytical contemplation of problems.

Proficient - the proficient nurse has an experience based ability to perceive situations as wholes. She is able to recognise when the normal is not present and is able to hone in on the accurate regions of a problem.

Expert – The expert has an extensive background of experience and is able to intuitively grasp a situation, zeroing in on the accurate region of a problem without wasteful consideration of a large range of unfruitful possible problem situations. The use of intuitive judgement is seen as a legitimate and essential part of expert clinical judgement and includes:

*pattern recognition – the ability to recognise relationships without prespecifying the components of a situation.

*similarity recognition – the capacity to recognise resemblances despite marked differences in objective features of past and present situations.

*commonsense understanding – a deep grasp of culture and language.

*skilled know-how – based on the concept of 'embodied intelligence' where the body takes over a skill.

*sense of salience – events stand out as more or less important.

*deliberative rationality – situations are viewed in terms of past situations. This is a way to clarify one's current perspective by considering how interpretation of the situation would change if one's perspective were changed.

(Based on Benner, 1984 and Benner & Tanner, 1987)

A recognition of the value of intuitive judgement in nursing is becoming apparent with an increasing number of papers being devoted to this topic (Agan, 1987; Rew, 1986, 1988 ; Rew & Barrow, 1987).

Each of the stages described above reflects a movement in three aspects of skilled performance. These are a movement from a reliance on abstract principles to the use of past concrete experiences as paradigms; the movement from seeing a situation as a compilation of equally relevant bits to seeing it more and more as a complete whole in which only certain parts are relevant; and the movement from being a detached observer to a skilled and involved performer (Benner, 1984).

Work in developing computer programs as diagnostic systems also highlights the importance of contextual and other variables in making a clinical decision. In looking at the area of medical diagnosis, Blois (1980, 1983) observes the hierarchical nature of medical knowledge and distinguishes between knowledge at low levels of the hierarchy (atomic and molecular levels) to that at high levels (the fully functioning human individual). Low level objects have fewer attributes and are free of ambiguity which makes them more amenable to the application of formalised methods such as algorithms and computer programs. At higher levels there is increasing amounts of ambiguity, vagueness and 'fuzziness', with meanings more dependent on context. Here computer programs are unable to compete with the human being who has a vast array of commonsense and local knowledge about the world which is inaccessible to the computer. This observation lends support to an understanding of clinical decision making as a process that is complex and multidimensional.

Polanyi's (1958, cited in Benner, 1984) differentiation between 'knowing - that' (theoretical knowledge) and 'knowing-how' (practical knowledge), introduced in the previous chapter, is also important here. Over the last few decades theoretical knowledge has been increasingly seen as paramount in nursing, as nurses have struggled to gain legitimacy within the health team which is comprised of disciplines (especially medicine) whose practice is more clearly defined. The importance of describing and owning practical knowledge in nursing so that the contribution nursing makes to patient care can be both developed and appreciated, has only recently been recognised (Benner, 1984).

Interest in research into practical knowledge in nursing was initiated by the important work of Benner (1982, 1983, 1984, 1987) and Benner & Wrubel (1988). Using the Dreyfus model of skill acquisition described earlier, Benner identified five levels of clinical proficiency, seven domains of nursing practice and thirty-one clinical competencies (see Appendix 1), based on descriptions and observations of actual practice situations. The identification of these domains of practice is vital because many of the competencies within these domains are examples of practice that is less visible and not currently documented. For example, one area of skilled performance identified was that of Effective Management of Rapidly Changing Situations. It is pointed out that the need for nurses to manage rapidly changing situations is often viewed as a break down in the system, but in fact it is completely unreasonable to pretend that a suitably qualified doctor will always be available when a patient's situation changes rapidly. There is a need for this area to be more fully explored so that it can be seen as a legitimate and valuable part of nursing practice rather than a simple 'holding' operation until a doctor can arrive, so that nurses can in turn be better prepared to function in these situations. Within this domain Benner identifies three clinical competencies, one of which is Identifying and Managing a Patient Crisis until Physician Assistance is Available. The example from Benner's research presented below illustrates the central role a nurse plays in facilitating a patient's safe passage through an emergency situation. It also demonstrates how the nurse's central role in a situation can be made so invisible - in this example her role would never be formally acknowledged as her actions would be written up in the doctor's notes and orders would be signed as if the doctor had initiated them.

Expert nurse: I had just admitted a new patient with the diagnosis of GI bleed. The doctor had given minimal orders as "he would be right over". Well the doctor's "right over" turned into a fair amount of time. The patient's blood pressure was in the 100's and the pulse in the 90's and he seemed fairly stable. He turned on his call light and stated he felt a little nauseated. He promptly had a huge emesis of dark brown burgundy. What skin colour he had drained almost instantaneously

away and the sweat popped out in beads in its place. I laid him back down, told one nurse to get a blood pressure, and another to start an I.V. of normal saline. I called the doctor but the exchange said he was "off-call". The on-call doctor was angry, saying he hadn't been told he was covering for this doctor, that he didn't know the patient, and refused to give orders. I told the exchange to put me through to the primary physician. They said he was in transit. I then ordered a packed cell volume and haemoglobin, three units packed cells and lab work to see if there was a coagulate deficiency. I then started a second I.V. and iced saline washes through a nasogastric tube. The doctor finally did show up. I told him what I had done and he said it was fine with him. I then asked him to be sure to sign off orders. (Benner, 1984: 118-119)

Benner's research clearly identifies the importance of studying the actual practice of nurses in the complexity of their context.

Leading on from Benner, Fenton (1985) undertook a study focusing on clinical nurse specialists which gave support to Benner's research and led to the identification of a new area of skilled performance and several new clinical competencies.

Other descriptions or expectations of nursing practice can be found in nursing care plans, job descriptions, standards for nursing practice, performance appraisals, quality assurance criteria, protocols and standing orders. These tend to be context free descriptions of what ought to be and to include only 'objective factors' such as specific tasks or skills. Programmes for evaluating or rewarding clinical competency, (Gaut, 1986; Jones, 1986; Lunde & Durbin-Lafferty, 1986; Townsend, 1988) also stress objective attributes, theoretical knowledge and even committee work and active professional involvement as the key elements in clinical competency. This approach assumes that theoretical knowledge and the ability to think analytically reflects the same skills as actual practice.

In a comparison study of models of clinical expertise in American nursing, Gordon (1986) compared the Dreyfuses model with a staff nurse clinical ladder based on job descriptions which spelled out progressive levels of clinical competence. These levels were based predominantly on theoretical knowledge and analytic ability. Gordon's study revealed that when a clinical ladder based on these job descriptions was used, awkward situations could arise when a highly qualified nurse with limited experience was placed on the highest position on the clinical ladder. Although an expert in science and theory, such a nurse could be surpassed in practical skill even in her own specialty, resulting in criticism from nursing and medical colleagues. An understanding of clinical expertise based primarily on theoretical knowledge and the articulation of formal models is clearly incomplete when it is unable to distinguish between different levels of expertise in actual practice. Gordon (ibid) puts forward the Dreyfuses' argument that :

" contrary to current academic understanding ... formal models and reasoning, which break down tasks into constituent elements and approach it through a set of rules or principles, most represents the early stages of skill acquisition where a backlog of experience is lacking" (p954).

Gordon concludes that whilst formal models and analytic practices are essential in moving the novice from the beginning to competent levels, they were less appropriate for the development, recognition and reward of higher levels of clinical expertise. This is in line with Benner's (1984) view that experts do not make decisions in an elemental procedural way and only if we look at the whole can the significance of the nurse's contribution to patient care be fully appreciated.

Research on making clinical judgements has used a variety of theoretical perspectives and predominantly focused on the search for a single underlying process. Current understandings of the development of clinical expertise have primarily focused on acquisition of theoretical knowledge and an ability to think analytically. However, the multidimensional nature

of decision making and the important role experience plays in developing clinical expertise is becoming increasingly apparent in more recent research using inductive approaches. Explanations of nursing practice which have focused on the performance of specific tasks and skills have been unable to adequately describe nursing practice and the contribution nurses makes to patient welfare. The use of approaches which also recognise practical knowledge and the vital role of context in understanding what nurses do are essential if nursing practice is to develop to its full potential and its contribution within the health service is to be fully appreciated.

CHAPTER 3

STUDY DESIGN AND METHODOLOGY

This study is a naturalistic, descriptive study of nursing practice which is directed toward a clearer understanding of nursing actions and the context in which they take place. A phenomenological method similar to that used by Benner (1984) is adopted for the current study, providing a focus for the investigation and defining the scope of the study. Phenomenology focuses on participants' lived experiences and attempts to examine such experiences within their particular context (Munhall & Oiler, 1986). It is therefore considered to provide a most suitable approach for the current study.

Selection of the Qualitative Approach

The question of which method to use in undertaking research is not merely a technical one. In the choice of methodology assumptions are being made about the way the world is viewed, the nature of knowledge and the definition of science. When related to nursing, it includes assumptions about the purpose of nursing practice - between nursing practice which attempts to understand and explain phenomena and that which hopes to predict and control them (Moccia, 1988).

In line with this view, it has been contended that differences in the basic beliefs about the phenomena of concern to nursing have led to two paradigms, or world views within the discipline (Parse, Coyne & Smith, 1985). A distinction is made between the 'totality' paradigm and the 'simultaneity' paradigm. The totality paradigm is grounded in the natural sciences and

within this view man is considered as a bio-psycho-social-spiritual being, an adaptive organism whose behaviour is measurable and predictable and can be changed through manipulation of the environment. The simultaneity paradigm, on the other hand, is grounded in the human sciences and here human beings are seen as "synergistic being(s) in open, mutual and simultaneous interaction with the environment" (Parse et. al., 1985:1).

According to Parse et al. (ibid), these views reflect different beliefs about people and require different research methods to uncover knowledge related to them. The totality paradigm, grounded in the natural sciences, uses quantitative methods consistent with the empirico-analytic tradition. Until recently, nursing research, as well as research within the broader scientific community, has been predominantly influenced by the empirico-analytic tradition, with its tenets often being assumed to be those of 'science' itself (Allen, Benner & Diekelmann, 1986). The place of qualitative research within this paradigm, if accepted at all, is limited to the testing of uncharted waters and is seen at best as a preliminary step to developing quantitative data.

The simultaneity paradigm, on the other hand, lends itself more comfortably to qualitative research methods, so that lived experience can be uncovered. Within this paradigm the thoughts, feelings and perceptions of persons about their lived experiences, which have no place in the totality paradigm, are valued. Although relatively few qualitative research studies have been published, there is increasing acceptance within the nursing community of qualitative research methods (Munhall & Oiler, 1986), evidenced by the increasing amount of nursing literature devoted to the topic (Parse et al, 1985; Allen et al., 1986; Chenitz & Swanson, 1986; Munhall & Oiler, 1986; Moccia, 1988).

Allen et al.(1986) outline three frameworks for nursing research - analytic empiricism, Heideggerian phenomenology and critical social theory. The contention is that each framework gives rise to different types of research, but that all three can produce research that is fruitful. It is not a matter of one or more being superceded by another. Their view is that it is not the technique itself but what is claimed for it that will differ if a

particular research technique is used within different frameworks. The point they make clear, however, is that even allowing for the usefulness of research methods emerging from different philosophies of science within a particular paradigm, the choice of method is not merely a technical one – it is not theory-neutral.

The Perspective of the Researcher

This researcher's beliefs about the world and the nature of people living within it are consistent with the simultaneity paradigm. Most of the literature related to clinical expertise and the nature of decision making, as discussed in Chapter 2, has assumed that these processes can be broken down into parts which can explain the whole. More recent work has challenged this assumption (Benner, 1984; Gordon, 1986; Benner & Wrubel, 1988) and it is this work which has offered the possibilities for a different and more productive approach to the study of nursing practice. While not unaware of the inherent limitations of Benner's work, it is her work which has influenced the current study and provided a framework for the research. If nursing is essentially a complex, context specific human activity, then it needs to be studied using methods which do not assume an objective, context free reality. Phenomenology provides one such method.

The Case for Phenomenology

In entering the world of nursing practice and exploring the lived experience of nursing, the use of a phenomenological perspective was seen to be the most appropriate. Phenomenological enquiry focuses on uncovering the meaning of experiences as they are humanly lived and has been claimed to best serve nursing's goal of understanding experience (Oiler, 1982). Within a phenomenological perspective, practices and skilled activities are valid subjects for enquiry.

Phenomenology as a movement embraces a diversity of philosophical thought, with phenomenologists unable to be placed within a single school or category. Martin Heidegger, a 20th century philosopher, brought together the works of Edmund Husserl and Soren Kirkegaard to create the philosophical science of existential phenomenology (Parse et. al., 1985). Within this view the Cartesian mind-body duality, assumed within the empirico-analytic tradition is rejected. The person is seen as an embodied intelligence who is brought up in a world of meaning and who has concerns, all of which connect the person to situations. Situations are in turn grasped in terms of meaning for the self. (Benner & Wrubel, 1988). If this interpretation of the person is accepted, it calls into question research methods that study human beings in the 'objective' way put forward within the empirico-analytic tradition, where there is no regard for the central nature of context and personal history in connecting the person to the world. In other words, Heidegger stresses that one cannot consider a human being, except as being in the midst of a world (Warnock, 1970).

A key concept introduced in the previous paragraph is *embodied intelligence*. Embodiment means that consciousness, used in the philosophical sense to include existence generally, is diffused throughout the body and finds expression through it (Munhall & Oiler, 1986). An understanding which first surfaced with Merleau-Ponty is used by Benner & Wrubel (ibid) who explain that over time people acquire a culturally skilled, habitual body which enables them to live in the world comfortably and easily, in a taken-for-granted way. Embodied intelligence, then, refers to the fact that the body itself is a knower and interpreter, and is involved in a wide range of activities which include recognition of familiar faces, recollection of past experiences, maintaining posture and culturally appropriate distances, and moving the body without consciously attending to it. It is also an integral part of any highly complex skill such as playing a musical instrument, flying an aeroplane or inserting an intravenous cannula. Embodied intelligence includes the notion of a mind-body unity as well as the capacity to be in a situation in a meaningful way and to respond to meaningful situations. Many intuitive responses related to nursing activities, such as giving an intramuscular injection or recording a person's pulse involve the culturally skilled body.

As a method of enquiry there is more general agreement regarding the phenomenological method. The phenomenological method explicitly takes into account a human being's participation in situations and draws on written or verbal descriptions of research participants as the text for analysis and understanding. The aim is to reveal the nature of the phenomenon under study and to understand the meaning of the experience as it is humanly lived (Parse et. al., 1985). Understanding, rather than prediction and control is the aim of nursing science within the simultaneity paradigm. This understanding is gained for the purpose of empowering and supporting others and is directed by a 'notion of good' (Benner & Wrubel, 1989).

The procedural steps used in this study will be outlined below in the description of the current study.

DESCRIPTION OF THE STUDY

The aim of this study was to enter the practice world of a small group of registered nurses working in acute medical and surgical wards of a general city hospital in New Zealand and to explore the world of their clinical practice in an effort to:

- * describe the context within which these nurses work
- * identify those areas where nurses make a difference
- * identify the types of experiences which change nurse's practice

and as a result, to gain a deeper understanding of the nature of nursing as experienced by those who practice it within the acute care setting.

Nurses who took part in the study were encouraged to share experiences of nursing as they were for them, experiences they perceived made a difference to the recipient of care and experiences which changed their nursing practice in some way. The critical incident technique was used to help study participants focus on their practice. *Guidelines for Recording Clinical*

Situations Where Nurses Made a Difference developed by Gordon & Benner (1984, see Appendix 2) was used to guide data collection. Minor wording changes were made to the guidelines for use in the New Zealand setting and the term 'significant incident' replaced 'critical incident'. This heeds Benner's observation that the term 'critical' tended to trigger thoughts of critically ill patients and crisis events in her own study.

Gaining Access to the Clinical Area

Permission was sought to undertake the study by submission of the research proposal to the Nursing Research Committee of the acute general hospital from which the participants for the study were recruited. Permission was granted through the Principal Nurse who circulated a memorandum to all ward areas that would be approached, formally introducing the researcher and indicating that she had permission to undertake the research within the hospital. It was made clear that any participation in the study was to be on a voluntary basis and undertaken in the study participants' own time. Formal written consent from study participants was not a requirement.

Identifying Study Participants

Study participants were nurses working in the acute medical and surgical wards of the hospital and were self selected. A random sample of participants is not considered essential in a qualitative study, rather, it is the representativeness of the data that is important (Sandelowski, 1986).

Criteria for inclusion in the study were :

1. That the nurse be a New Zealand registered general and obstetric nurse or registered comprehensive nurse.

2. That the nurse be currently practising as a staff nurse in an acute care area of the hospital used for the study.

3. That the nurse be willing to share his or her clinical experiences.

Study participants were self selected after discussions with nursing staff on the medical and surgical floors of the hospital. Group meetings were held, where the nature and purpose of the study and time commitment for participants was discussed. Staff who wished to take part in the study either indicated this after the session or notified the researcher at a later date. Consent was given verbally when the participants volunteered to take part and was confirmed by them when handing the written portion of the study guidelines to the researcher or keeping the appointment for the interview.

Twenty two nurses meeting the criteria volunteered to take part in the study. As a minimum number of 20 had been set, no further participants were sought after this number was reached.

Description of the Study Participants.

There were 21 female participants and one male participant. Ten were working in medical areas of the hospital (general medicine; oncology) and 12 were working in surgical areas (general surgery; urology; gynaecology; orthopaedics) at the time of the interviews. Ten participants held a general and obstetric nurse registration and 12 were registered comprehensive nurses. One nurse also held an Advanced Diploma in Nursing. All the nurses gained their nursing registration in New Zealand.

Length of experience since registration ranged from six months to 23 years with an average of 3.5 years. Excluding the one nurse with 23 years experience, the average time in practice since registration was 2.6 years. Nine of the participants were in their first year of practice, post registration.

Protection of the Rights of the Study Participants.

Study participants were self selected. The researcher undertook to protect their rights by explaining fully the nature of the study and the requirements of those who wished to participate as well as their right to withdraw from the study at any time. Participants were able to veto any information they shared with the researcher with regard to publication. The researcher assured participants that pseudonyms would be used in any material published and that their identity would not be revealed.

A cassette tape recorder was used to record interviews and all tapes were erased once verbatim transcription and checking was complete. Pseudonyms were used for the tape transcriptions and within the written descriptions.

A number of ethical considerations that had not been addressed by those giving permission for the research arose during the process of the study and created concern for the researcher. These included:

- * some of the information given by participants included sensitive items or described incidents which reflected poorly on their nursing colleagues and/or other health professionals, many of whom were known personally to the researcher. The people concerned would probably not have wished the researcher to have access to such information.

- * a number of the patients described in the exemplars were potentially identifiable and may not have wished such information to be revealed.

- * a number of the participants became distressed when they revealed information about themselves or others relating to an unpleasant incident or experience. The researcher then undertook to work through such situations with the participants before continuing the interview, so that the participant was not left with unresolved distress.

The researcher exercised particular care in using interview excerpts as exemplars in this report, in order to protect the identity not only of the 22 nurses who participated in the study, but also other people mentioned in the interviews.

These issues are explicated here, not because they affect the outcome of the research, but because the researcher wishes to make clear that she was aware of her responsibilities with regard to them, and to highlight to other researchers that their responsibilities may go beyond those formally laid down.

Data Collection

The data for this study were the written and verbal descriptions of the study participants nursing world, including exemplars of clinical situations where they made a difference or which made a difference to their practice in some way. Data collection was guided by *Guidelines for Recording Clinical Situations Where Nurses Made a Difference* (Gordon & Benner, 1984, see Appendix 2).

Data collection took place in three phases:

1. Phase 1: Written descriptions of a typical day at work and an unusual day at work and completion of the biographical section. This was accomplished through meetings with individual nurses who, after an explanation, provided written descriptions of typical and unusual days at work and completed the biographical section of the questionnaire.
2. Phase 2: Individual interviews with each participant focusing on at least one significant incident which made a difference to the recipient of care and one incident which made a difference to future practice. These interviews were conducted in a private area at the work place or at the researcher's home, and were recorded on tape recorder. These were scheduled at the convenience of the study participant and the interviews

lasted from between 20 minutes and 90 minutes.

3. Phase 3: Group interviews with 5-7 nurses after analysis of the individual interviews was completed to validate findings to date and to enable sharing of further insights and incidents. These were conducted in a private area at the work place and were recorded on tape recorder. These lasted approximately 90 minutes.

Data collection took place over a period of five months between May and September, 1988.

Data Analysis

There are seven essential activities that guide the treatment of data when using the phenomenological method which have been outlined by Spiegelberg (1976, cited Parse et al, 1985; Oiler 1986). These are:

1. Investigating the particular phenomena,
2. investigating general essences,
3. apprehending the essential relationships among essences,
4. watching modes of appearing,
5. watching the constitution of phenomena in consciousness,
6. suspending belief in the existence of the phenomena,
7. interpreting the meaning of the phenomena.

Within the current study these essential activities were included in the following procedural steps.

1. The participants descriptions of a typical day and an unusual day were read and reread to gain a feeling for them. This included the process of intuiting which involved looking at the experiences described whilst holding knowledge and theories at bay, in order to come to know the experience as described by the research participant.

2. Analysing the descriptions involved a tracing of elements and structure of the experiences revealed in the previous stage. The descriptions and exemplars were compared and contrasted and recurring elements identified.

3. Recurring elements were organised in an effort to allow for the emergence of theme clusters, leading to identifying common themes.

4. Describing the data involved focusing attention on the major themes revealed in the previous stages, culminating in an elaboration of the meaning of the elements and structure of the experiences. The descriptions drew on examples from the data to highlight significant aspects of the experiences.

5. The descriptions and exemplars of situations where nurses made a difference and situations which changed the way nurses practiced were analysed in the same way as the typical and atypical day.

(Based on Riemen, 1986; Parse et al., 1986)

Description of Findings

The following three chapters constitute Part II of this thesis and provide the description of the findings.

PART II

DESCRIPTION OF THE STUDY FINDINGS

Description of the findings constitutes Part II of this thesis. Chapter 4 will outline the findings related to the context of nursing practice, chapter 5 describes situations where nurses made a difference and chapter 6 presents situations which changed the way nurses in the study practice.

In order to facilitate reading of the verbatim descriptions the following conventions have been used.

Key to transcripts

()	Researcher comments to provide clarity or explanation
..	Pause
..//..	Material edited out
Names	All names used in the text are pseudonyms
*	Abbreviations or colloquialisms explained in the glossary (Appendix 3)

CHAPTER FOUR

THE CONTEXT OF NURSING PRACTICE

The importance of context to qualitative research approaches was outlined in the previous chapter. In setting the scene for what is to come, this chapter explores the broader clinical environment in an effort to gain a feeling for the context in which the majority of clinical exemplars are set. Chapter 5 will then examine clinical situations where nurses made a difference and Chapter 6 will examine clinical situations which resulted in a nurse changing her practice in some way.

An understanding of the context of clinical practice for the participants in this study was elicited through their descriptions of a typical day at work and an unusual day at work, as well as from their exemplars. These descriptions of typical and unusual days were provided in writing by most of the participants, although two participants described their days at interview. A number of exemplars were not set within the current work environment of the participant, having occurred in another hospital, another ward and/ or another time. This does not undermine their value as it is the personal significance of the exemplars that is important.

Background

Some general background regarding the hospital at which these nurses work may be useful in placing the more specific descriptions. The hospital is an acute general hospital providing specialist services for a large catchment area. Acute medical, surgical, maternal/child and psychiatric services are all

housed within the hospital which is also the base for outpatient services within these areas. The Hospital Board (now Area Health Board) of which this hospital is a part is also heavily involved in both education and research activities and has considerable responsibility in these areas.

The nurses who participated in this study were drawn from acute adult medical and surgical areas. Medical areas represented include oncology and general medicine with general medicine including some medical specialty areas such as rheumatology, endocrinology, gastro-enterology, dermatology and infectious diseases. Surgical areas represented include orthopaedics, gynaecology, urology and general surgery. Most wards receive a range of patients and might include one or more specialty areas.

Nurses working within the hospital are attached to one ward and stay in that ward until they request and/or negotiate a change. Some shifting of nurses does take place on a day to day basis if wards are short due to sickness or rostering problems, or a ward is particularly quiet for one of a number of reasons. The wards are staffed with both registered and enrolled nurses in a variety of mixes, from almost all registered staff on the general surgical floor to a significant proportion of enrolled nurses on the orthopaedic floor. Orderlies assist with some patient care, such as showering and lifting on the general medical and orthopaedic floors. Nursing care modality varies greatly between wards and at times within wards, and includes primary nursing, team nursing and daily patient assignment. Within these modalities, wards are more or less patient or task oriented. Care modality is strongly influenced by individual ward charge nurses.

A TYPICAL DAY AT WORK

The nurses in the study were asked to describe a typical day at work. They were asked to think of a day that had been typical and to describe that day, including any thoughts or feelings they may have had related to that day. In looking at their descriptions of a typical day one is struck by the variation. There is no typical day for a nurse in an acute care area. Many nurses

expressed that even within their areas there are a number of typical days - a typical operation day, a typical acute admitting day, a typical ward round day. The essential structure of each day may be similar in a particular ward in terms of usual tasks that will be completed, no matter what else happens, but the very nature of 'acute' care nursing in this environment means there is a constant reshuffling of priorities, a need to be constantly thinking ahead and frequent interruptions. For example, the nurses comments included:

- .. you've got to keep that in the back of your mind
- .. like any day this schedule is interrupted
- .. fitting around ward rounds and morning tea
- .. you seem to be constantly doing things for other people which takes you away from the time you have with your patients
- .. my mind is constantly racing ahead
- .. it's like walking a tightrope

Many aspects of the nurse's role can only be partly planned for, if at all, such as, when a patient will return from the operating theatre, when an acute admission will arrive on the ward, when an impromptu ward round will take place or when an emergency will arise. Of all the disciplines working in the hospital setting the nurse's role is probably the least predictable and the nurse tends to be the one who has to work around the others to the greatest extent. It is also clearly apparent that direct patient care is not all that is required - organising diet sheets, assisting a colleague with a procedure or giving advice, calculating patient categories for the supervisor, paging a doctor to chart fluids or medication, teaching a student nurse, or guiding a relief nurse who has come to help out for the day are all an integral part of the nurse's day. The nurse may have her specific patient load but needs to be aware of how her workmates are coping with theirs, assist as required and adjust when the anticipated load changes. It is a complex and multidimensional role.

Within each ward, then, there are a number of routine activities which provide a skeletal structure for the shift - meals, medication administration, bedbaths and showering - but the extent to which any ward can be considered to have a routine is limited. The unexpected is typical. Organisation of any work day will depend on a number of factors, such as day of the week, care modality, shift, workload, number of staff on duty, how experienced they are and how well the individual staff members work together. For example, a nurse who works in an area purported to practice primary nursing explains that the extent to which she can take care of the total needs of her patients will depend on the staff on duty.

Depending on how many staff there are and who they are, I have to decide if we are going to do our own patients obs* or go around in a task oriented way. I always wish that I was able to do my own patients as it gives me a chance to see everyone before breakfast.
(Nan, written description)

The descriptions of typical days at work provided by the nurses in the study revealed three broad phases to their day. These are described as Settling In, Working Through and Handing Over.

. Settling In

All shifts appear to have a settling in period where nurses take stock of the day and anticipate how it is likely to progress. This may commence before the nurse reaches the ward and tends to be completed around the end of the shift report. Many factors will be taken into account as the nurse prepares for the day ahead and anticipates its likely progress - these will include day of the week, ward workload, individual case load, who else is on duty and whether anyone will be sent away to work in another area. The shift report provides an overview of the whole ward and occurs in all areas. Even in areas where primary nursing is practiced, a shift report with all staff present is seen as

important in gaining an overview of the ward and a general understanding of the status of all the patients.

A staff nurse prepares for morning duty, anticipating one possible outcome if she finds herself in charge.

.. rush into the locker room, scramble into my uniform. Thinking to myself, or more like hoping I won't be the only staff nurse on as Saturday mornings are always busy and its hard for me to organise myself around the doctors as I still don't know what time they're usually around. And here's hoping I don't do something stupid or potentially fatal today (Clare, written description).

The next passage illustrates what occurs when the nurse arrives on the ward and finds she is indeed in charge. Her telescoped writing pattern communicates clearly how busy this time of the day can be and the many competing bits of information confronting her.

0700 - scribble down names of patients .. full ward. Hopefully about six discharges though... have report* from night nurse ... Gulp.. I'm the only staff nurse on. At least the two enrolled nurses are experienced. Give report. Patient allocation - I'm not going to overload myself as I've got to run around after the doctors. Three I.V's* though so I'd better look after them. Luckily two are in the same room (Clare, written description).

Another nurse prepares herself for an afternoon shift.

.. I arrive at work at 2.30pm to find the usual cloud of people hovering around the nurses' station. Four or five medical staff pondering over lab reports and x-rays, the charge nurse, district nurse and social worker, a mixture of student and registered nurses and maybe relatives of patients. A quick look at the patients' name board tells me who's gone home and maybe who's died since I was last here. I jot down the names of the patients and then it's time for a chat to find out how people's weekends have been and anything interesting that's happened on the ward.

My expectations of how the duty will go depend a lot at this time on who I'm working with. I'm pleased to find that this particular duty I enjoy working with the three others rostered on - two senior staff nurses and an enrolled nurse (Olive, written description).

The settling in phase of the nurses' shift involves much more than 'receiving instructions' for the day. It involves familiarisation with a considerable number of patients, other staff members' activities and plans; absorbing a large amount of information within a short period of time; an orientation to individual responsibilities and priorities for the day; a cognitive-emotional orientation to the other staff members working that shift, and an assessment of the likely frustrations, problems and satisfactions that can be expected in the course of the day.

Working Through

After settling into the ward the day begins. Typical days are characterised by being familiar, busy, and yet manageable. In some areas there is a feeling that even though the day is manageable not quite everything has been achieved. It is a blend of the controllable and the uncontrollable - routine tasks, the individualised, personalised interactions with patients, families and staff members, the acute admission or unstable patient who disrupts an already busy schedule and a myriad of little tasks such as answering the phone, advising a colleague or ringing a plumber to fix a blocked toilet.

Study participants' descriptions of a typical day were varied and included task focused descriptions, descriptions that focused on patients and those that included both. Task focused descriptions most closely follow the signposts that provide a degree of predictability to the day and include those highly visible tasks most frequently included in job descriptions. For example one nurse describes a morning duty in a task oriented way.

0655 - Arrive at work, answer a bell, write out patient names in rooms.

0705 - Other staff arrive, get night nurses handover - this takes until 0715.

0720 - All staff present, we start reading reports punctuated by patients ringing for pans, wet beds, sit ups for breakfast. Meal trolley arrives mid report.

0735 - Report over, help get breakfast for patients, check I.V's*, do BP's* & TPR's* after breakfast because cups of tea tend to increase temps. Total fluid charts*, empty drains* and catheter bags*. Ring doctors to get fluids charted*.

0820 - Give patients medications - some can be checked with the patient others with another nurse e.g. IV antibiotics, subcut* injections etc. Help another nurse get a patient on and off a pan. Say hello to other patients and assist them if their nurse is not available.

0845 - Attend doctors rounds to offer information from the nursing side of things and ask for future planning for particular patients.

0920 - check my patients IV's and comfort, then I can get to my own patients needs individually after answering calls from relatives, administering IM* analgesia and helping with lifts to other patients.

FROM THIS TIME UNTIL LUNCH TIME MY TIME IS SPENT ON PATIENT CARE (nurse's emphasis) - washing, walking, panning, weighing, wound dressing and seeing to their comfort.

Between 1200-1300, lunch time medications are given out, blood sugars* (tested) and insulin given.

About 1300 I will have my own lunch.

1330 - check and write up what my patients had to drink during the morning and at lunch time. Admit patients that have arrived before lunch.

1420 - Give any drugs e.g. antibiotics, ranitidine, captopril. Write reports and update care plans as time allows.

1500 - hand over to pm staff, check drips* and go home after afternoon report which can take until 1540.

(Dale, written description)

This description could reasonably give the impression that the nurse's role is a set of clearly defined activities, but this same nurse's descriptions of care given and exemplars from practice belie this impression. Nurses are expected to complete certain tasks within the shift so that the ward runs smoothly. The way in which they are evaluated is also strongly influenced by their ability to be organised and complete their work. Those nurses that described their day in this way verified that the activities described presented a skeletal structure only and that the important work of nursing took part within that. Their interactions with the researcher at interview also validated that, with only one exception, each nurse had a strongly personalised and individualised approach to her work. That some of the nurses presented their day in this way could also have been a function of the way in which this section of the data was collected. To write out the myriad of activities, interactions, interruptions and so on from a typical day turned out to be a very difficult undertaking. Other nurses did attempt a fuller description with what they considered to be only moderate success. For example, at the end of one description a nurse commented:

I don't know whether this is typical day - first time I've ever analysed a day's work - many miles clocked up and I've missed out heaps* (E11, written description).

Two nurses shared their descriptions with the researcher at the time of the interview and were able to provide richer descriptions than were achieved with a written document. Such verbal descriptions resulted in a greater understanding of the multiple contingencies placed on the nurse.

More complete descriptions of a typical day are provided below, with one example each from a medical and a surgical ward, to help illustrate the complex nature of the nurses work in acute care areas.

The first description comes from a staff nurse in a combined general surgery and urology ward and describes a typical Monday morning duty. Her lengthy description illustrates the complex nature of her role. It also demonstrates the multiple ways in which her work is increased by factors out of her control- the doctor has to be reminded to chart medication, the pharmacy and

solutions imprests are not up to date, departments schedule appointments in the middle of meal times and she has responsibility for a student, a role she does not cherish. The nurse is expected to do her work completely and thoroughly, but this is clearly not an expectation of all other actors in the system. The nurse facilitates the work of others but there is no one to facilitate her work. That this nurse focuses on the tasks and describes the frustrations is not surprising. A number of comments do attest to her individualised, concerned, approach however - allocating extra time to a newly admitted patient, going to the trouble of checking if there is another appointment time when a patient is called for an electrocardiogram at meal time, and going to extra lengths to ensure rapid delivery of solutions so a patient's intravenous site will not clot. Note again the importance of the beginning of the day in assessing what sort of day is likely to be in store for her.

Monday morning duty is one of the busiest days of the week in our ward as its a major surgery day. First we have report in the Charge Nurse's office - a time for waking and taking stock of the day. On hearing report and realising staff numbers plus the fact that we will have students arriving any moment to guide and teach I think about the end of the day and wish it was nearer. I get very frustrated having to work with someone else, especially a student as I can organise my workload better and more efficiently if its only myself I have to worry about. My mind is constantly racing ahead, filling various jobs or chores that need doing into various times. Of course like any day this schedule is interrupted by doctors rounds, patient demands and various other reasons. I ensure the patients who are more self caring have towels etc and know where the bath or shower is. If any other task needs to be done for them I will allot a time and hope I remember through the bussle of the day - usually instruct them to remind me if I overlook something. Between 0730 -0800 I do my routine obs on patients - i.e. BP's, TPR'S, tallying up fluid sheets* and ensure everyone is comfortable and ready for breakfast, as well as giving them their morning medications - almost not a morning goes by when there's not something missing - to be traced after the round. Wind on another half hour or so waiting for hospital departments to open. I look at the theatre list and see which patients need to be ready at what time and what pre-meds* are due - these are usually due or called for at the most inopportune times - such is life.

Finally everyone is sprucey clean ready for their day. Theatre calls - take patient up - // - back to ward for morning tea. Someone is ready for a dressing - done. Midmorning making beds, answering queries, chatting to patients - where does the time go - pain relief here - vomiting there - all sorted out and its time for lunch - midday obs and meds round*. Patients lunch arrives - found I have a new admit*. Do admission procedure - lots of time spent to ask and answer questions - reassurance +++ only to find as she commences her lunch she's needed for ECG* - only appointment available - thank goodness for microwaves.

Midafternoon start writing reports - a long process with lots of interruptions - wondering when my post-ops* will arrive in the ward - probably around changeover. Organise for discharge of patient the next day - referral to district nurses - written - more report writing - phone call regarding patient - make an outpatient appointment. Speak to pharmacist regarding special needs for same patient and notice afternoon staff arriving. Quickly finish writing reports. Introduce afternoon nurse to (our) patients - she's been on holiday and doesn't know anyone - more reassurances on round and wouldn't you know it my first post-op arrives back. Receive her into the ward - post-op BP and pulse done - round the corner and there's another post-op - same routine. I hear an IV pump* alarming - more fluid needed for an IV heparin infusion and as usual none charted - call doctor to chart - find base fluids* supply has run out - so I ring solutions* to send up urgently - only way seemingly to get them within the hour. They arrive 1/2 an hour later - IV site* not clotted thank goodness - only due to heparin being the additive. Find someone to check the dose and put up new fluids. 3.15 and time to go home (Eli, written description).

The next description comes from a nurse who works on a medical ward. She describes the day she has just completed. This nurse's description is very patient focused and demonstrates how even casual remarks made in the course of completing the highly visible tasks lead her into wide ranging areas - an intimate discussion with a patient regarding the meaning his colostomy has for him, exploring a young boys social situation which could lead to a referral to a social worker at a later date, an ethical dilemma when a very sick patient asks her to place a bet on the horses. This nurse must focus on all aspects of her patients' lives - physical, social, emotional, ethical. They are seen as integral and inseparable. Note the way in which tasks which can seem quite routine for the observer looking in, such as the bed bath, can take on new meaning when the fuller context is described. On this day the nurse has eight

patients to care for. After arriving a little late and having a verbal report with the rest of the staff her day begins.

.. there was a young boy in .. he's quite often in because he has a diabetic state that fluctuates .. he's 16 .. and his blood sugar was up really high so I saw to that and got the insulin .. it's just what we normally do up there ... then we did the pills* .. and I was the only one on .. which quite often happens .. in our team .. because there's often one girl that might help with 2 teams .. say team 3 might have 2 people and team 1 and 2 will sort of have a runner* that floats* between the 2 .. so that was fairly typical too.. and it wasn't so bad because I had a lot of men and the orderly does the showers ..

.. everyone's so cheerful .. buzzing around .. the patients all behaved themselves .. at breakfast time I made sure everyone was sitting up .. one man .. I forgot to put in the nursing care plan he's got to be fed .. he's got to be assisted .. because they leave him food .. hot tea and things .. it's a shame he's only 56 too .. and anyway after that I put out the medications .. Sally helped me .. there's always two ..

.. and then we start the washes and oh my nice man on bedrest .. they thought he had a pulmonary embolism but he's got a DVT* .. // .. and on those awful mattresses .. they're so hard .. so I remembered there were a couple of sheepskins that weren't terrific but they'd been put up on another shelf in the linen room so I whipped down and got those ..and you would've thought you'd given him a gold clock getting these two old sheepskins .. because it was better than nothing .. so I helped him with his wash and he had a colostomy and we talked about that a bit .. I said is it better than having the colitis .. and he said well yes .. I wouldn't be alive now if I'd stuck with that .. having this colostomy has probably saved my life .. but he said it's not easy to live with .. you see they find it hard to adjust to those things .. and he was a really nice man so I got him sorted all out and then this wee boy .. Harry Wilson .. this lad .. I went along and he said look I'm really hungry .. I usually have more than that for breakfast .. and I feel really hungry .. and he'd had these fluctuating blood sugars and we were trying to get it right .. so I said could you just hang on and perhaps stay with what you've eaten in the meantime because your blood sugar was 28 .. and you've had those 14 units* but lets just see how that works first and I'll get the dietician up and you can discuss the food with her .. because I don't know enough about it and of course he said .. well that's okay we'll do that ..

and then he started talking to me .. now here's this lad .. it's the first time I've actually looked after him .. he's been in perhaps 4 times over the last year .. he's 16 .. he's working in a bakery .. I thought he'd still be at school .. his mother and father are separated and he lived with his mother before but he was telling me .. now this is just his side of the story .. but he was telling me how he said .. well my mother didn't want me anymore .. well your heart just goes out to him when he says that .. so I said well Harry where are you living and he said with my sister and her fiancee in a flat .. and I said do you like that .. and he said well not really.. no .. he said my sister's had a breakdown and she's recovered from that but she's really nervy and I just hate it .. I just hate living there .. he also said his mother hasn't got a house any longer .. that she now flats with a friend of hers .. I gathered it was a lady friend like as if two of them // had gone into this house .. and I thought here's this kid, he's 16 .. and he's at risk because he's a diabetic and emotionally .. you know .. just terrible .. so I said to him.. well Harry.. I'll try to get back to you but I've got to see to someone in the meantime .. and he said that's fine .. thanks very much .. //.. anyway I didn't really get a chance to get back to him because he was down in the TV lounge once the TV came on .. and also there's other demands put on you .. the frustration is that sometimes you can't .. so you leave things in the air .. so this is fairly typical .. sometimes I do get back but it has to be after duty .. of course there's things that you just have to do and that's all there is about it .. so I did my washes..

.. then .. oh then Mr Young down the end .. he's a character* .. I saw him talking to the male nurse from another ward and I thought what's he doing .. and I said .. excuse me do you want something Mr Young .. he said I'm speaking to him it's very personal .. and I thought something personal .. can't he tell me .. but the male enrolled nurse .. said no that's your nurse you tell her .. and so we persuaded him to tell me .. what he wanted was to get me to put 50 bucks in the TAB* for him .. on his telephone account because .. he was a sick man too and he just wanted a little bit of a dabble* .. he loves the horses.. loves his races .. and I don't think he gets a lot of joy in life so I said why don't you get your wife to do it and he said she'd go right up through the roof .. doesn't even know I have a bet .. I said I bet she does .. he said she doesn't .. so I said I don't know.. I'll think about it .. 50 dollars is a lot of money.

.. then there's dear Mrs Marks who has secondaries .. metastases of the bone .. and she's a lovely person .. they're controlling her (pain) with Morphine .. that long acting MST* .. but it wasn't holding her and thank goodness we got this lovely registrar ://.. she said I don't want her to be in any pain at all .. we'll redo it

and she came with me and we went in and redid it all .. works together with you .. great like that

..and the rest of them .. they all needed things but some of them .. when a person's self caring they're pretty good .. Mr Green, he's not self caring but you've just got to keep an eye on him .. he's a bit confused .. you've just got to make sure he doesn't (wander)..

oh and then I had that other man .. that 56 year old man .. I have to feed .. and you take him to have a ciggy .. he likes a ciggy* .. and I took him down to the lounge there .. he drops the cigarette and forgets he's got it .. .

I believe if you did the bare minimum you could get away with it and not be busy all day .. but I reckon* that most days you're fairly steady and most of that time there's always something .. a bed to make .. someone wants to have a bit of a yarn* for 10 minutes .. there's always something to do .. you can't tell me that with a job like this there's ever a time to stand around because there's nothing to do .. but that's just me.

(Vicki, Individual Interview)

Given the many activities packed into the nurse's work day, it is not surprising that the end of the duty is eagerly awaited. This is true, not only when the day has been a demanding one, but also when the nurse feels satisfied that she has done 'a good day's work'.

Handing Over

The third phase is the handing over of patient responsibility to the oncoming shift. How this is achieved varies greatly between the different wards, is influenced by care modality and also depends on the shift. A written report on each patient at the end of the shift is universal. In areas where the commitment to primary nursing is high the oncoming nurse will receive a formal handover from the her outgoing colleague. The handover will involve a round of their patients and include a review of significant aspects of each patient's care, introductions between a new patient and unfamiliar nurse and informing the patient (and family if present) that the morning nurse is now

going home and the afternoon nurse will be taking over their care. In other areas the hand over will take place at the shift report which will be given either by the morning nurse responsible for each group of patients, or the charge nurse. As there is only one nurse in most areas at night, the night nurse is given a verbal report from each of the afternoon nurses and then one of those nurses will go around the patients with her to check all is well before leaving. The night nurse will normally give the nurse in charge of the morning shift a condensed verbal report when she arrives and will only go to the bedside of a patient whose condition is cause for concern or who has been admitted acutely during the night. Differences between shifts relate to the time set aside for handover -this is much greater in the middle of the day - and the fact that the patients are normally asleep at the beginning of the night and morning shifts.

The handover, then, may include a written report, an interaction between the oncoming and outgoing nurses (which may include the patient and/or family), and a shift report. The nurse completing her shift can then go home with a feeling of completeness, assured that the nurse now responsible for her patients is fully aware of each aspect of the patients care. One nurse relates this very well:

At 2pm when I was writing my reports I started to feel good because that is the time you review your day. I feel satisfied writing my reports if I have done everything I can for the patient in the day. I always think about the afternoon staff and if they will have any questions for me and will I be able to answer them. It can be a busy time because I can run around trying to find out things and doing last minute jobs that have to be done (Nan, written description).

These descriptions of typical days illustrate clearly the multidimensional nature of the nurses work. The 'typical day' is typical only to the extent that it progresses through the three phases described above and is made manageable by a variety of tasks which are attended to, whatever else happens. The unexpected and new is an integral part of a typical day. The limited degree to which any day can be considered typical attests to the

constant need for the nurse to adapt, reset priorities and shift her attention to different foci within very short time frames.

AN UNUSUAL DAY AT WORK

Unusual days at work are characterised by extremes and on the whole appear to be quantitatively rather than qualitatively different. All but one study participant described their unusual day as either extremely quiet and organised or extremely busy. The other study participant described a day where she was sent to another ward to relieve for the shift - her day was unfamiliar.

The quiet day is one where the nurse can care for her patients in the way she would always like to, things go smoothly, and there is no need to race against the clock. For example:

.. being able to talk to patients seriously and quietly about their prognosis without being disturbed.

.. all routine morning tasks are completed by 9.30am.

Sometimes these days are used to hold teaching sessions or the opportunity taken to go with a patient to watch and/or support them during a diagnostic or surgical procedure.

Others participants commented that on very quiet days staff could tend to get a little lax and chores that were done on a normal day could be forgotten. Such days tended to be more common at week-ends.

.. sitting around the office waiting for duty to be over. Wandering around the ward periodically seeing if anything's doing* (Nan, written description).

Unusual days , however, were most commonly reported at the other extreme, with either a greater than normal workload or made busy by the need to focus around an overwhelming event or seriously ill patient. One nurse commented that an unusual day "stays in your mind for a while". Sometimes an unusual day turns into an unusual few days or week if workload increases beyond its normal limits or there is a spate of staff sickness. Two nurses describe such days and illustrate the frustration nurses can feel when they are expected to cope in situations which reach the stage of feeling out of control.

A day that is unusual for me is when I have been so busy that I don't get to see my patients. I have had several afternoon shifts like that and one that I remember is when I was the only staff nurse and someone from (intensive care) came to help. Most of the duty consisted of working with IV's and doing 2 drug rounds. There were lots of people with IV additives and people who were very sick as well as a couple of acutes. I was having to deal with still being new, having to organise people and have responsibility for what was going on in the ward. I found that I didn't get any satisfaction and for the whole duty there was quite a tense atmosphere. Even though we got through the evening, after not leaving the ward till 11.45pm, I came away extremely wound up and wondering what I had done wrong and what I had forgotten. It was a horrible feeling and I had about 4 or 5 of those days in a row. They were not normal days, but I learnt a little bit more about stress and pressure and could relate to nurses suffering from burnout if it was like this most of the time. I felt feelings of anger, guilt, dissatisfaction, fear and worthlessness. I didn't even feel pleased with myself that we'd coped (Nan, written description).

The next example is similar. It also identifies how when the handover from one shift to another is rushed this can lead on to difficulties in settling in for the oncoming shift.

It had been a busy week really .. It was just really frantic .. we'd had acutes every day .. and it was just one of those horrible weeks I just never wish to have again. But that Wednesday was a really horrendous duty .. I came on .. the morning had been really busy .. so we had a busy handover ..it wasn't settled .. and so we

went on from there. We had admissions and we had people with GI bleeds on blood transfusions and there was a young diabetic on an insulin infusion and the pump went wrong and .. getting too much insulin and his blood sugar came down too quickly .. well as it happened it didn't make any difference but we would have preferred it to have come down more slowly than it did .. and then this lady arrived in and she'd collapsed at home and she was unconscious and she was taken down for a CT scan .. and when she came back from the scan she just roused and started rolling around the bed and screaming and we didn't have enough people to stay with her .. bedsides were absolutely useless .. and if it hadn't been for her family who stayed .. her nephew in particular, I don't know what we would have done with that lady .. she would've been out of bed .. venflons were getting bent because her arms were like this .. and we splinted them and she was pulling the splint out the end of the bandage .. oh it was unbelievable .. I've never spent an afternoon like it .. we were still there at midnight .. we hadn't written reports at 11 o'clock (Toni, individual interview).

Not all situations which are taxing will result in feelings of distress by nurses. At times such situations can be very fulfilling if the nurse feels she has worked through it and coped well. Another nurse describes a night duty where a seriously ill patient was admitted. The rest of the ward was settled which meant that the nurse was able to devote her attention to this man, without sacrificing the care of her other patients, resulting in a positive outcome.

I came on this night and everyone was up in arms in a panic and they'd just had this man arrive about half past ten at night with a cerebral bleed .. and I suppose it was a really acute situation .. lines were put up and he was having different lots of fluids going through .. he was unconscious .. neuro- obs (and so on) .. so I was having to have this handed over to me right at the start of my night and I thought oh my god .. here we go .. this will be a real test.

.. I was practically specialising this man all night .. doing lots of things .. IV's, therapies, half hourly observations .. I felt I really coped well .. I was really pleased by the end of the night that I'd got through it and I felt really good about it .. and the next day some feedback came up to me that made me feel even better .. he got transferred down to neurosurgery .. and the message came back that whoever looked after him the

night before did a wonderful job .. and I thought, "wow!" (Helen, individual interview).

Whilst none of the nurses described their typical day as a night shift, a number of unusual days were set at this time. Nurses are on their own at night in most of the wards with one or occasionally two less experienced staff working between three wards. This means that there is very little leeway in terms of staff availability if something goes wrong, with the result that there is greater potential for a situation to get out of hand.

Summary

The context of nursing practice for this group of registered nurses is usually a busy, and sometimes an extremely busy series of activities which call for the nurse to be constantly alert and to anticipate and sort changing priorities. Routine tasks must be completed and the inevitable extra demands attended to. These nurses deal with multiple contingencies throughout their day and can at times expend all their available energy just making it through their work day. That patient care can be individualised, sensitive caring interactions take place and patient safety maintained in such an environment seems barely achievable. That nurses can also make a difference to their patients, families and other nurses and that a great deal of experiential learning can take place within this environment is attested to in these descriptions and the ones that follow.

CHAPTER 5

EXPLORING SITUATIONS WHERE NURSES MAKE A DIFFERENCE

Having outlined the contextual reality of the nurses' practice and their everyday experience of meeting a multiplicity of demands, one can focus on nursing practice as it is directed to individual patients and families. This chapter looks at specific descriptions of nursing practice where nurses perceive they have made a difference in some way. Making a difference in nursing involves making a contribution to patient welfare that can be identified as uniquely nursing. Domains of nursing practice, which identify areas of skilled performance in nursing and which emerged within the context of this study are described, and the meaning of making a difference to the nurses in the study is explored.

DOMAINS OF NURSING PRACTICE

All the domains of nursing practice and most of the competencies identified by Benner in her 1984 publication (see Appendix 1) were revealed in the data drawn from the descriptions of practice and exemplars of the study participants. It is not intended to detail each domain and the competencies within those domains. This study is not a replication of Benner's work, nor is it an exhaustive study where redundancy in the data leading to closure of themes is a realistic expectation. Only the four domains which emerged strongly from the data will be discussed in this chapter. The reader is referred to Benner's study for a full description of the domains of practice which she identified in her research, and to chapter 7 of this thesis for a more detailed comparison of the findings of this study with that of Benner's.

The principal domains of practice to emerge within the study are identified as Monitoring and Ensuring the Quality of Health Care Practices, The Teaching/Coaching Function, The Diagnostic and Monitoring Role and Organizational and Work-Role Competencies. During the analysis, the domains of practice identified by Benner (1984) were held at bay in an effort to allow the themes to emerge unimpeded by knowledge of a previous categorization. Once the analysis was completed, however, reference to the domains identified by Benner was made. This was in order to maintain consistency if emerged themes fell comfortably within Benner's existing framework. No new domains were identified, but two new competencies were identified. Coaching Through a Situation Bit by Bit was identified within the Teaching/Coaching Function and Advising and Supporting Other Nurses was a newly identified competency within the domain of Organizational and Work-Role Competencies. The way in which nursing action makes a difference to patient and family welfare emerges from the descriptions of areas of skilled performance.

Monitoring and Ensuring the Quality of Health Care Practices.

Providing a Back-Up System to Ensure The Delivery of Safe Medical and Nursing Care was the principal competency to emerge in this domain. It includes the concept of patient advocacy which is the term used by the study participants. The aim of advocacy is to ensure safe or appropriate medical or nursing care and examples emerging from this study ranged from the ordinary to the dramatic. The clinical situations described focus on the nurse stepping in on behalf of the patient, or supporting the decision of the patient, when care being given is unsafe or inappropriate, or if the nurse considers the patient needs further assessment.

The need to act as an advocate is seen by the nurse as a breakdown in the system, especially when it involves challenging a doctor or another nurse over an unsafe practice. It is not perceived as a position of power. The role of patient advocate emerges as a difficult one for most nurses and often results in considerable cost to the nurse. For example, discomfort or fear may be

experienced or the nurse may risk altering meaningful established relationships in her work environment . This is particularly evident when the situation involves challenging the practice or questioning the orders of one of the medical staff. Less experienced nurses, particularly students or those in their first year of practice after graduation, experience considerable ambivalence and fear in entering this role and in some cases achieve their end by passing the responsibility on to a more experienced nurse. If not, they may still require assistance from another nurse to completely resolve the situation.

In the following exemplar, a nurse in her first year of practice describes her feelings when she challenges a medical registrar and refuses to allow him to perform a pleural aspiration on her patient when he attempts to carry out the procedure in an unsterile manner and without the appropriate equipment. The doctor leaves the room after the discussion with the nurse:

.. and I was just left floundering around thinking good lord .. I can't believe this is happening .. I didn't quite know what to do next .. I felt really horrible .. I felt really horrible that a registrar could .. be so stupid as to do something like that and not know how to attempt to do a pleural tap* which I'd .. seen a few before .. it was getting later on in the year .. later in my first year .. and I'd seen a few pleural taps done and knew enough to know they had to be done sterilely.. they had to be done in the treatment room with packs from CSSD (central sterile supply department) .. the doctor was gowned and gloved and masked ... I was just totally dumbstruck .. and by this time it was getting on to change over time and I'd just kept an eye on this patient .. he'd left this so called equipment in the room so I'd just kept an eye on this patient to make sure he hadn't come back and done it behind my back. (Andrea, individual interview)

This nurse acted to prevent harm to her patient but did not have the skills or composure to work towards resolution of this problem on her own. The outcome was that when she handed over her patient at the change of shift, she explained her dilemma to the experienced nurse who was to take over from her. This nurse arranged for the appropriate equipment to be delivered and supervised the doctor to ensure the procedure was carried out safely.

The way in which nurses approach advocacy situations varies. The factors involved include the nature of the situation, the nurses' experience, the support they have, their confidence, and their position within the ward hierarchy. The persistence of some of the nurses in pursuing a situation, even when the nurses responsible for the patient feel they have done what they could, is remarkable. For example, one busy evening on the medical floor a woman had a gastro-intestinal bleed, vomiting about 500mls of frank blood and passing a melæna stool. The nurses paged the doctor on call who came and examined the patient and then left after charting her an anti-emetic. The nurse relating the story commented:

well that's just not on .. he's just being unsafe .. but (the other nurses) were so wiped out they just sat there .. and I thought well this just isn't on, I've got to do something even though she isn't my patient ..
(Pat, individual interview)

The nurse had assessed that the patient's condition warranted greater concern and that a blood transfusion would also be in order. She then contacted another doctor and explained both the situation and her dilemma, eventually resulting in the patient being further assessed by a registrar and appropriate treatment instituted. There was a possibility of diffusion of responsibility in this situation which could have resulted in no action being taken, and this emerged in several descriptions. The nurse/s may initiate action but if that action is inadequate or inappropriate there is a sense of "we did what we could". The exemplars from practice often identify those situations where one nurse persists when her colleagues are not prepared to do so.

Diffusion of responsibility also occurs frequently when the nurse points out a situation to a member of the medical staff. Because there are a number of levels of medical staff from trainee interns to consultant physicians or surgeons, and this number in turn increases during periods of on-call coverage, a problem situation may keep being passed along with the result that nothing comes of it. In one of the group interviews this was discussed:

You have to take a risk to say something but quite often no-one is prepared to take responsibility for what you've pointed out. . that's a tough one .. when you've had the courage to do it but no one will say yeah, you're right .. we'll do this and this and this about it ..//.. but no-one's prepared to .. they don't want to know (Group Interview 1).

One can only surmise that many times the situation which calls for a stance to be taken does not reach fruition resulting in a less than positive outcome for the patient.

A previous experience of successful advocacy and a climate which encourages advocacy lead to greater confidence in being an advocate when the situation requires it. Experience of successful advocacy may also result in the nurse persisting in a matter she thinks is important but that would not result in harm to the patient if it was not pursued. An experienced nurse working in oncology gave such an example at one of the group interviews where advocacy was being discussed. She shared that when she first graduated she did not challenge the medical staff in situations where she would not hesitate to challenge them now because of the mistaken belief that their knowledge was superior to hers and that they would always be right. Discussion and challenging of care was, however, an everyday occurrence in the oncology ward where she now worked and within a climate which encouraged and supported this aspect of the nurse's role she had gained considerable confidence.

It's not always big things but I always do it. I know sometimes if I went along with (the doctors) I could have a real cruisy duty and everyone would like me but I go for gold if it's something I believe in. Sometimes it's quite minor things .. like we had this 38 year old leukaemic lady .. the house surgeon had said to give frusemide (a diuretic) after blood .. she wasn't in heart failure or anything like that .. and he said 'you always give it' .. he wanted to give this frusemide and I said .. 'the patient's obs are fine .. she's young' .. it was 10 o'clock at night .. I didn't want her weeing all night.. she needed the sleep .. and the housesurgeon said 'yes but we always give it' .. and I said 'well always' .. and he said 'yes' .. so I said 'if I have a car accident down the street and I come into A&E* and need blood then you'll give me frusemide' .. and he said 'well that's different' .. and I said 'yes this is different' .. and it

turned out the reason (he was insistent) was that the registrar had charted it .. he said 'you have to give it' .. and I said to him 'I'm refusing to give it' .. and he came round and he spent about half an hour in with the patient .. her obs were fine .. and she didn't want it .. she'd never had it before .. she didn't think it was appropriate either and especially at that time of night.. and he assessed her condition and said 'no you don't have to give it'. It would've been a lot easier if I'd just done it but I had to stick up for my patient .. that's what my patient wanted and that's what I thought too.. we do that a lot on our ward. (Group Interview 2)

Although many of the incidents described related to unsafe or inappropriate medical practice, nurses also intervene when the practice of one or more of their nursing colleagues is found wanting. Again the manner in which this is approached will be influenced by a number of factors. Relative position in the ward hierarchy emerges as one of those factors. Student, part-time, or new graduate nurses may use a more subtle approach in ensuring appropriate nursing care so that their working relationships are not threatened. One nurse describes such a situation where she had a sense of possibility for a patient which the other ward staff did not recognise:

This incident happened about a year ago .. we had a patient...//.. in for faecal impaction .. she was 46 years of age .. she was an insulin dependent diabetic .. she had poor eye sight .. she had query TIA's* as well...// .. now this woman was not in my team but she was an object of loathing because she would finger paint with faeces and she was just a mess. But what I noticed was when she came to sit down to eat her food she ate very nicely .. she seemed to be able to concentrate and pick up the things and use all the utensils properly .. could actually say 'where's the pepper and salt' .. so I observed that.. and because I don't work every day of the week .. I work 3 mornings a week .. so sometimes there is a gap between when I work and when I come back .. I could see a difference (where perhaps the other staff couldn't) .. now what was happening was this woman got to the stage where she would hardly speak .. she just wanted to sleep all the time .. the girls would get her up , shower her, put her in a chair for a while, put her back to bed , leave her, she'd pooh herself, they'd clean her up and the whole process would go on .. and I noticed she was more and more sleeping .. and one day I went in and it just got to me .. I thought she's going to die.. that woman is 46 years of age and she's going to die .. and I just thought it was terrible .. so I didn't know what to do because she

wasn't my patient so I started to talk to her and ask her things and I'd take her for walks and .. //.. without standing on anyone's toes .. because as I said she wasn't my patient .. just took a bit of an interest in her .. now I thought either one of two things is going to happen .. they're going to say ..she's a mug she wants to work on something that's absolutely hopeless .. we'll let her .. or .. they're going to see that she's not a dead loss .. an automaton .. you see one person can change the way things are done .. and ..//..I'd say things in report like 'I noticed Doris Isn't going to bed as much .. If we all talk to her a bit and made her feel a little more like a human being I think you'd find a lot of the symptoms that aggravate you mightn't be so gross' .. and anyway it worked. She ended up being the star turn of the ward ..//.. the (nurses) in the ward started communicating with her .. her hair was very sparse .. her hair started to grow .. she could hold a conversation .. that woman went from being a vegetable to actually functioning as well as she ever would I reckon .. and in the end .. after about a year she went to (a nursing home) .. (Vicki, individual interview)

The role of Monitoring and Ensuring the Quality of Health Care Practices emerged as one of the principal domains of practice for the participants in this study. It was identified in the practice of inexperienced and experienced nurses, although nurses experienced in this role were able to approach such situations with greater confidence and skill. Inexperienced nurses clearly felt the need for support in this role and a ward climate which fosters its development.

The Teaching-Coaching Function

The teaching- coaching function also emerges strongly from the data. Many different competencies are identified under this domain and include formal teaching of new skills, providing information regarding health practices or in preparation for surgery or procedures. However, much of the teaching and coaching is done on a less formal basis in everyday interactions and may not be recognised as such by the nurse at the time. Working with patients or families to get them through new and often frightening periods is done with great skill. This may involve working with a family towards gradual acceptance of the loss of a loved one or acting as interpreter, for example,

when the doctor has attempted an explanation in medical jargon and the patient's language is conversational English. Another situation of interpreting occurred for a nurse who was working with a deaf person for the first time.

The idea of interpreting brings to mind a man I looked after who was deaf .. and I'd never really looked after anyone in that situation. He could lip read really well so I made an effort to speak really clearly and look at him when I spoke..//.. but a lot of the other staff weren't taking as much time with it as they could have .. especially the doctors.. they'd just talk as usual and often be talking to each other and not looking at the patient .. I really ended up being an interpreter for this man. It was developing a sensitivity .. you know .. oh yes he can lip read ... but you have to be looking directly at the person for them to be able to read your lips (Group interview 2).

Being a coach is encompassed in the ideas of supporting, confirming, encouraging, interpreting - getting someone through a situation bit by bit. Examples of this type of Coaching Through a Situation Bit by Bit, are seen in situations where the patient is living through a frightening procedure or a rapidly changing situation. Coaching in such situations enables patients/families to live through such situations maintaining control and poise. An experienced nurse provides an example of working with a patient whilst a doctor inserted a central venous line. She explains that the patient, who had had a protracted post-operative period with multiple complications after a femoral-popliteal bypass was extremely fearful of the procedure. The nurse's support during the procedure resulted in it being completed quickly and without undue distress to the patient.

I feel that if I can get onto the level of the patient .. like get into their position and feel what they are feeling about something like that .. I mean it's fairly major .. I feel I can get down on their level and relate to them that way .. although I've never experienced anything like that.. //.. (I say) things like 'you're doing really well' and 'we're almost there' .. or I try to take their mind off it in terms of getting them to focus on something else apart from what the doctor's doing (E11, individual interview).

Working this way with patients having invasive procedures in the ward or X-ray department is an every day occurrence for many nurses and the nurse develops considerable skill. Not only is the patient able to maintain control and poise in such situations, it can also enable the person doing the procedure to progress more quickly and cause less trauma than if the patient is agitated and distressed. Coaching Through a Situation Bit by Bit is a new competency identified within the Teaching/Coaching Domain.

The Diagnostic and Monitoring Function

The diagnostic and monitoring function of the nurse is often the central reason for the patient's hospitalization. The nurse monitors patients after anaesthesia and invasive procedures, monitors their response to drug therapies and in many other ways that relate to medical intervention. The nurse monitors recovery to assess readiness for discharge. The nurse monitors every aspect of the patient to pick up cues which will tell her there is cause for concern.

One vital ingredient to emerge from many cases of successful monitoring is continued interaction with the same patient over time. An in depth knowledge of a particular individual allows for the picking up of cues that would go unnoticed if the patient is not known on a personal basis. One nurse describes how she identified that all was not well with a woman she was caring for after gynaecological surgery. This woman had been in the ward for nearly two weeks and was to be discharged the following day.

.. just after I'd done the pills I saw Mary in her room and she was just sitting there .. not doing anything ..which wasn't like her because she'd been in so long and was really friendly with the nurses and other patients .. she was usually up walking around talking to people .. so I sat down with her just to have a wee chat .. and she told me that her husband had told her that the marriage was basically over ..(Clare, individual interview).

The importance of continuity of care to successful nursing management was illustrated time and again by the study participants. This not only includes working with the same patients throughout their stay, but also to caring for the whole person. Monitoring, especially the taking of 'routine' or formal observations is often done in a task oriented manner and not by the nurse who has overall responsibility for the patient. This in practice divorces the person from the observation and a potentially significant recording can lose its impact. An experienced nurse identifies what occurred when another nurse took an observation on her patient.

We normally have our own patients but the first thing in the morning everyone rushes around doing the obs .. and I had a frustrating situation the other day when someone did all the obs and one of my ladies had a raised pulse. I didn't look at the chart and the nurse didn't tell me and it wasn't until later when I didn't think she was looking well that I checked the chart and her pulse again and realised she was having a bleed. I was annoyed with myself and the other nurse because I know I would've picked it up earlier if I had seen the rise in pulse (Group interview 1).

Anticipating Breakdown and Deterioration Prior to Confirming Diagnostic Signs is evident in the practice of more experienced nurses. These nurses are also more open to alternative explanations of deterioration in their patient's condition and will pursue alternatives if they consider there has been premature closure on diagnosis. For example, an experienced nurse identifies cues at the shift report which make her uneasy when a patient's confusion is put down to an anaesthetic two days previously. These feelings may be difficult to explicate for the nurse. This nurse notes early in the sharing of her exemplar:

This incident occurred on an afternoon shift in an acute orthopaedic ward. I'd looked after this lady the previous day .. she was 60 years old and had had a traumatic fractured neck of femur for which she'd had a total hip replacement.. she was second day post-op. The afternoon report said the patient had been confused all day .. the previous day she had been quite orientated. She had an intraoperative history of a queried bundle branch block or some sort of cardiac irregularity (Leslie, individual interview).

Although this woman's confusion was put down to post anaesthesia confusion, a common occurrence with elderly patients with a similar diagnosis, this nurse was already identifying factors that didn't quite fit (she had not been confused on the first day after surgery) and other possible contributing factors (an intra-operative cardiac irregularity). On taking the patient's pulse after report, the nurse is immediately alerted by a tachycardia of 160 beats per minute which results in a rapid reassessment and transfer to the coronary care unit for monitoring and treatment. On reflecting back on the situation the nurse muses:

I was concerned about her confusion because she was young .. she had no previous indications for going off* quite the way she did .. but apart from taking the pulse that was my first clinical sign (Leslie, individual interview).

Nurses constantly monitor all aspects of the patients' care and their environment. This domain of practice is most closely related to the assessment and diagnostic phases of care outlined in the nursing process. It is clear, however, that monitoring occurs continually throughout the patient's stay and although documentation may reflect a linear approach to care this does not mirror actual practice.

Work-Role Competencies.

Many work-role competencies emerged during the study. The need to Coordinate, Order and Meet Multiple Patient Needs and Requests and Setting Priorities is clearly reflected in the nurses accounts of typical and unusual days at work. The other main competencies to emerge related to Building and Maintaining a Therapeutic Team to Ensure Optimal Therapy and to Advising and Supporting Other Nurses.

The need to work as a team was clearly identified by the study participants and is particularly evident for them when it does not occur. This relates to nurses working together, nurses working with other members of the health

team and is also seen as important within other disciplines. For example, if a medical team does not work well together this is identified as cause for concern by the nurse as it can increase her workload and result in an increase in the number of instances where patient care is inappropriate or unsafe. The extent to which working with a 'good team' can colour the nurse's perceptions of how her work day would progress is also identified in the previous chapter (see p.36 and p.38).

Nurses understand the need for teamwork, even in situations where they have discrete case loads. In sharing an incident where she made a difference, one nurse describes a day on an orthopaedic ward. This nurse identified that she made a difference to the care of her colleagues' patients by recognizing that they weren't coping with their workload. This ward divided the workload by allocating a side of the ward to each of two pairs of nurses. On exploring how she knew the nurses on the other side were not coping with their case load the nurse states:

Well you hear the buzzers going all the time .. people ringing all the time for pans, to have their pillows fixed up .. things like that .. that should have been done .. and (at) half past ten at night .. usually we're finished by a quarter to ten and writing notes.. (Karen, individual interview).

This is an example of local knowledge the nurse had gained during her time in the ward. After being alerted to the fact that her colleagues were not coping the nurse goes over to the other side of the ward and finds a patient who had been incontinent and left unattended. The other nurses are aware of the situation but are too busy working on higher priority tasks. The nurse then makes the patient clean and comfortable herself.

The competency of Advising and Supporting Other Nurses is another principal theme to emerge from the study. This is not the same as team work, but is seen as a more individual type of support. In a group interview an experienced nurse summarises her perceptions:

I think there's a difference between a team spirit and providing support in a clinical situation .. I mean if you have a team on a shift that work well together you can cope on a very busy day when you might not if the team doesn't work well and so that's important for the smooth running of things. It's also good to have someone to bounce ideas off or say .. 'I think I want to do this here .. what do you think' .. that sort of thing .. especially if you're not sure. That's a more specific type of support (Group interview 1).

Advising and Supporting Other Nurses often only indirectly affects the care of the patient, but is an integral part of the experienced nurse's role within the acute care setting. It is an example of nurses caring for each other or respecting and valuing the knowledge of a colleague. Experienced nurses revealed examples of providing this type of support in their descriptions of the context of their practice, in their exemplars and in the group interviews. It is evident that many inexperienced nurses seek and find support in their work environment from those with more experience and greater expertise. Experienced nurses will seek support, advice and confirmation from respected nurse colleagues.

The study participants gave many examples of advising and supporting each other. These included giving advice that has been sought by another nurse, coaching a new graduate through a new, distressing or rapidly changing situation, and acting for another nurse. A number of nurses felt they had made a difference by helping another nurse.

Inexperienced nurses identified that experience was required to gain expertise and this involved both practical skill in caring for patients and knowledge of the work environment. A new graduate shared an experience from her final year as a student on elective in a surgical ward. Her patient, who was recovering after a femoral-popliteal bypass graft presented with a haemorrhage from her leg at the beginning of a morning shift, resulting from a breakdown of the graft. Emerging from this incident is the recognition of the support and encouragement provided by the registered nurse who guided the student as they worked rapidly with the medical team to stabilise the patient and transfer her to the operating theatre for repair of the graft. This exemplar also identifies clearly that it was not the lack of theoretical

knowledge which made the student feel inexperienced in this situation but the lack of local knowledge (such as where things were kept), a skilled body (putting up an intravenous line in a hurry), and familiarity with the sights and smells (the smell of all that blood).

This incident happened when I was on my six week elective at the end of my third year as a student nurse .. I spent the whole time in a surgical ward ..I came on duty one morning and we were having report .. it was quarter past seven in the morning .. and one of the patient's (Mrs Love) who I'd known quite well .. I'd been looking after her during my time there ..she'd had a redo of a fem-pop* bypass and she was two days post -op .. she rang the bell and I went and answered it .. she felt she was bleeding in the lower end of her fem -pop wound in her right leg .. and it seemed to be bleeding a wee bit .. but not much so I wasn't too worried .. I got her to press on it ... she had a facecloth there and I got her to press over the existing guaze and I went away to get some more guaze and combine (thick, absorbant) dressings and told the staff on the way .. and Helen, one of the staff nurses came back with me .. and when I went back there was a lot more blood and it was .. almost gushing everywhere and so I pressed on that while Helen organised things .. she rang the doctor .. and got things organised .. the doctor came ...we swapped roles .. like we pressed for a while whiist the other was taking her obs ... and elevated her legs and feet . .. during the time I was thinking .. about her going into shock and she'd actually had blood two nights (ago) and the night before .. and I was quite glad we'd organised that the night before .. she didn't go into shock at all .. her obs were stable .. and the doctors were getting a line into her ..//.. and she had bad veins* and he had a lot of trouble .. and I felt really stupid .. what I did was I pierced one of the bags as I was putting the soluset* into it ..and the doctor actually did this with one .. she pierced it as well .. and the third time I got it .. that made me feel more nervous .. I was a bit nervous as it was .. //.. because I'd never seen anything like that .. and the smell .. I remember particularly the smell of a lot of blood .. I hadn't smelt that before. My role was sort of reassuring Mrs Love and taking the obs more than pressing which Helen was doing ... when it was all over we actually went to theatre with her .. we ended up both pressing on her leg because the bleeding became more extensive along the wound .. and we actually went into the intubation room and right into theatre with her ... and afterwards I think I felt good because Helen said that I'd acted quite well during it and that she was pleased with what I'd been doing and I was okay .. and I was quite pleased that Mrs Love wasn't too anxious

about it all ..I think I was also pleased because I'd learnt a lot and I felt during the time that I was really looking forward to being registered and hoping I'd pass my exams ... and I was looking forward to being more experienced. The most demanding thing during the time was when Helen happened to be pressing on her wound and I was being asked to get things .. like SPPS* and I didn't know where it was kept .. and I had to ask other staff on the way .. (Jane, individual interview).

Other nurses identified situations where they had made a difference to a colleague. An experienced nurse described a situation where she worked with a patient and his family on the afternoon of his death. Interwoven with this story was another relating to the nurse for whom the experienced nurse was a preceptor:

. and the other thing that was important was it was my buddy, Jo's, first death and I think with comprehensive (nurses) it just hits them really hard when somebody they've looked after and nursed (dies) .. and talking to her about why we were doing things... she did really well .. she wouldn't just follow me .. she took her own initiative to go and speak to the family or if somebody was upset.... she was really great (Ray, individual interview).

Looking back on the day the nurse reflects:

I think it really touched me because I came home that night feeling I had done lots for that family .. and that I had helped Jo through this first death and she was really good (Ray, individual interview).

The importance of working as part of an overall team and the importance of team cohesion in facilitating situations where nurses make a difference to patients is identified. More specific advice, support and encouragement from individual nurses is also vital and is seen as a separate competency. It includes teaching specific skills, pointing out exceptions, guiding through new experiences and teaching new nurses local knowledge and culture. What is taught or advised may make a difference to patient care at the time or in the future.

MAKING A DIFFERENCE.

Making a difference for participants in the study took many forms, some of which have given illustration to the principal domains that emerged and which are outlined above. Making a difference is strongly related to the less visible role of the nurse and is expressed through the art of nursing or the successful integration of art and science. The nurse identifies that a situation matters and in an effort to make a difference works to facilitate successful resolution of a situation or intervenes to turn it around. The 'notion of good', which is an expression of the benevolent intent central to the work of the nurse is identified in situations where the nurse makes a difference.

The 'notion of good' which is inherent in the practice of nursing results in the nurse looking at a person as an individual and prevents her from being too strongly influenced by other health professionals' perceptions of appropriate treatment. For example, nurses are often faced with situations where treatment is offered to a patient which has the possibility of resolving their condition, but is more often less than effective. The nurse working in a surgical area recognises this with frail elderly patients facing a major surgical procedure, knowing that although the possibility of cure or palliation is there, the procedure itself can result in overwhelming complications or hardship. In the oncology ward the nurse recognises that at times continuation with chemotherapy is no longer in the best interests of the patient. The nurse has insight into her patient as a person now. Total acceptance of the patients' perspective, even when at odds with the view of other members of the health team is legitimate. That such a grasp of an individual's reality and an acceptance of it can occur with even inexperienced nurses gives insight into the notion of good pervading nursing practice. One nurse related an incident which had occurred two years previously when she was still a student nurse.

I was in my second year of nursing and (working) in a general ward .. mainly Urology I think .. I came on about 1 o'clock and found the staff nurse I was buddied with

and she said 'we've got a little old lady who's 88 who came in with a bowel obstruction, would you like to go down and see how she's doing' .. so I went down to see her and she had a naso-gastric tube down which was draining faeces basically .. she'd had it put down because she was vomiting faeces .. and an I.V. and she seemed really distressed .. she seemed really tight in the bed .. so I asked her and she was in no pain .. so I sat down beside her and asked her what the matter was and she said that we were stopping her from dying and that she wanted to die.. so I asked her why this was and she said 'well, you've got this tube down my nose and this line into my arm and all these doctors keep hassling* me .. all they want is to operate and save me .. and I don't want to be operated on .. I'm 88 and I'm ready to die' .. and so I sat down and told her what the function of the naso-gastric tube was .. I said 'it's better that its down otherwise you'd be vomiting faeces and that wouldn't be very nice for you .. and the I.V.'s just keeping you hydrated .. its better to be hydrated than to die of dehydration .. which you're going to if you keep vomiting faeces' .. and she said 'and you're sure that won't stop me from dying' .. and I said no 'there's no way it'll stop you from dying'. Then I asked her if she'd like to see the minister and she said 'yes that would be really nice' .. so I went back and organised for the minister to come up and he sat down with her and she was quite peaceful after that .. and she was having a wee bit of pain but nothing really bad .. I saw her about 1.30 and she died about 10 to 8 that night (Sam, individual interview).

This nurse was able to hone in very quickly on what was concerning this woman and resolve her distress, enabling her to die peacefully, maintaining her dignity.

This study identifies many examples of good nursing practice given by nurse students or nurses in their first year of practice post registration. This chapter illustrates that being a proficient or expert nurse is not a prerequisite for good practice, although expertise clearly increases the possibilities for care. Experienced nurses also approach clinical situations with greater ease and confidence, often achieving more immediate results.

Facilitating factors which enable the nurse to make a difference to her patient or another nurse include working in a supportive environment with a cohesive team, continuity of patient care and caring for the whole patient. The opportunity to apply, confirm or expand knowledge in practice is evident in

such situations. Isolation, task orientation and non supportive ward environments are barriers to nurses making a difference, although they do not preclude the possibility for good practice.

Nurses in this study perceive making a difference as doing something positive, which often means moving beyond the nurse's normal expectations of care. The role of experience in developing and expanding clinical expertise is also identified in these situations where nurses make a difference. Situations which are significant in changing some aspect of the nurse's practice also result in the development and expansion of knowledge and help move the nurse towards a more proficient level of expertise. These situations are identified in the following chapter.

CHAPTER 6

MAKING A DIFFERENCE TO NURSING PRACTICE

Nursing knowledge develops through research and other scholarly activities. For the nurse in clinical practice breakthroughs in perspective and understanding also occur as a result of personal experiences and the nurse's reflection on the meaning and significance of such experiences. Participants in the study were asked to describe significant clinical incidents which changed their practice in some way. Explication of an incident where the nurse identifies the need to change some aspect of her nursing care is an example of expansion of practical knowledge through having preconceived ideas turned around or developed - that is, through experience. Benner (1984) refers to such knowledge as *clinically embedded* and stresses its importance in the understanding of nursing as a skilled discipline.

The clinical incidents which changed the practice of the nurses in the study were examples of discontinuity in practice which resulted in the nurses stepping back and re-examining their practice and making a conscious decision to change it in some way. Some nurses described a series of small incidents which made them aware of changes that were needed in their practice, other incidents reflected a greater understanding of the practice of environment and how to function within it, still others related to overwhelming events which had a profound effect on the nurse and her practice.

Gaining Knowledge from Everyday Incidents in Practice

Everyday incidents in practice can lead to a nurse modifying her practice. The nurse learns to adapt situations when the rules don't fit and to apply general rules in a flexible way with individual patients. Nurses new to practice gradually learn to integrate what they know into a cohesive whole. For example, in the beginning, charts and forms can be filled out religiously without a full recognition of their significance – the filling in of a fluid balance chart is a task, the taking of a nursing history is a task and it may not be until something is missed that the nurse identifies why she does this each day. The nurse asks about drug reactions or sensitivity in her nursing history, but it may not be until a patient receives an inappropriate drug that there is a realization that the information is only of benefit if it is used. A new graduate explains how she gained an understanding of the importance of fluid balance observation:

Another thing was when I came down to the (surgical floor) .. charting and things like that .. observation charts, fluid balance charts .. sometimes you fill them in and you don't think much about it .. and you forget that they're there for a reason ..they're there so you can assess the patient .. and this unit nurse was working with me one day and she was looking at the fluid balance chart with me you see .. this patient had a naso-gastric, catheter and fluids in and he was putting out a lot more than he was having in and she said to me 'I think this man might be a wee bit dehydrated' .. I just felt really stupid and foolish .. because I'd been writing on this piece of paper and not really taking any notice of what I was writing down and realising that from this I could assess what was required .. //.. that really opened my eyes .. the charts that we fill in have a purpose .. to assess (Andrea, individual interview).

Nurses learn that the knowledge gained in the classroom is a guide for practice and that there are individual differences in patient responses as well as in a the ward environment's tolerance for different points of view. Pain management is one area which has changed considerably in acute care nursing and nurses can find their ideas about pain management being turned around

when they work in an area where good pain management is a priority. A nurse who moved from an orthopaedic ward to a surgical ward explains this transition.

..on the surgical floor there are a lot more narcotic infusions .. beforehand I'd had no real experience with pain relief infusions and giving IV narcotics ... I think I'd given IV Morphine once on the orthopaedic floor and apart from that it'd been IM. And in (orthopaedics) it was given fairly rigidly 4 hourly .. you didn't really question it .. it was basically rigid .. and when I first started (in surgery) there were all these pumps and things and it took me a while before I was confident with them .. so I set a few up and finally got all the connections right .. on the whole it was pretty new and I was worried about the possibility of giving overdoses .. I didn't have any experience to go by as far as how much a person can take .. what's the difference between 2mls per hour, 3 mls per hour, 4mls per hour .. what level should it be put on postoperatively .. I'd never had abdominal surgery .. so I didn't know how painful it was .. so it took me a while to realise that peoples' pain tolerances differ and so gradually over my time in surgery I've had experience of abdominal surgery patients .. seeing what they're like .. knowing the signs of pain .. apart from what they tell you .. heart rates and blood pressures and things .. and feeling happy about giving more than the infusion rate if its required.. (Bobby, individual interview).

The nurse explained that she has developed increasing confidence and this has changed both her management of her patients and her understanding that her role extends beyond the giving and monitoring of pain relief, to initiating reassessment if the pain relief charted is inadequate or inappropriate.

.. now I feel more confident .. even about discussing it with the doctors if I feel that what's charted isn't holding them .. keeping their pain level down .. adding in voltaren .. getting boluses charted if they aren't already charted .. (Bobby, individual interview).

The Work Environment

Nurses identify factors in their work environment that affect their practice or their ability to practice as they wish. When the nurse enters practice her perception of other actors in the system is coloured by social expectations and taken-for-granted role expectations. Some nurses will have those expectations turned around as they enter the practice world. For example, nurses express the expectation that when they enter nursing they will carry out the work of nursing and the doctor will attend to the medical care. Their perception is that doctors have superior knowledge and that they will always be right. The fallibility of their medical colleagues both surprises and concerns them. This is also identified in looking at patient advocacy in the previous chapter (see p.54-56). The nurse gains an understanding that her greater knowledge of the individual who is the patient can put her in an excellent position to identify inappropriate suggestions or notice when something has been overlooked. It enables her to see patterns that may not be otherwise identified. The doctor may chart an inappropriate dose of a drug and if the nurse is working with that drug every day in practice she will immediately identify it as a mistake or at least question the doctor to ensure the dosage is the correct one. She also identifies that her knowledge of the medical management of patients with particular health problems may be greater than that of junior medical staff or those who have focused on a specialty area when the patient has multiple problems. One nurse explained how she had moved from an area specialising in endocrinology before coming to work on the surgical floor and was surprised to find that both doctors and other nurses were not as conversant with the management of diabetic patients as she was. Her previous experience puts her in a position to ensure appropriate care is given to diabetic patients facing surgical intervention.

.. It helps me to change some management of diabetics who come into the surgical ward .. It helps me perhaps make a difference in their care if I can say 'well that's an outdated way of doing it .. the new thing that's happening now with diabetes is this' .. and I'll say this to the doctors and they'll say 'oh yes .. I didn't realise that'.. Then perhaps getting them to change it or at least consult the diabetic people to get it changed. So that's helped me .. given me some nursing knowledge of diabetes which I learnt from the medical floor and then coming down here and having almost special knowledge

which I didn't realise I had until I came here (Fay, Individual Interview).

Nurses also learn about their nursing colleagues. To work successfully in a team situation the nurse must know her colleagues and be able to trust them. Gaining an understanding of a colleague who cannot be trusted is also important and nurses will identify this in situations where they are not supported or in situations where they are faced with a colleague who acts without integrity. When a nurse does not write an incident report when she makes a mistake it is a sign to her workmates that she is not prepared to take responsibility for her actions. Similarly when a nurse denies any responsibility for an incident and leaves a colleague to stand alone she is not trusted in the future. One nurse described an incident where a nurse had put a drug through an intravenous pump too rapidly and although the doctor was notified it was not documented in the medical notes or on an incident form. In fact, the ward staff were unfamiliar with the pump and there was some confusion as to how to set the rate properly. The nurse's failure to bring the incident to broader attention resulted in the same error occurring a few days later with another nurse. The nurse relating the incident said that she had learnt two things from this incident. One was to take greater care with pumps and to check them frequently to ensure the rate is set properly - the other is that she cannot trust this particular nurse to take responsibility for her actions and that this will affect her future relationship with her.

Being supported through a stressful event can affect working relationships in a positive way. A single incident can result in a nurse being deeply grateful to one of her colleagues and knowing that she can be relied on when the need arises. The way in which nurses are treated by other staff members has a profound effect on them. If they are treated fairly and supported through difficult or stressful events there is the possibility they will see the event as a very positive learning experience (see also chapter 5).

Considerable distress can occur when nurses are treated poorly by each other. Being put to the test by a charge nurse can be trying indeed and take great courage to overcome. In describing an incident which changed her practice, one nurse highlights how difficult it can be to make a difference to patient

care when the charge nurse is obstructing rather than advising and supporting in a manner appropriate to the time and situation.

Two of my patients that day had to have central lines* put in .. now I'd never seen central lines before .. (so).. I said to that Charge Nurse .. 'now look, they're going to put a central line in Mrs Morris' .. I said 'what sort of things do you set up for this' .. the (doctors) were waiting to do it you see .. and she said 'well what do think you need for it' .. and I said 'well I'd seen a cut down (years ago) but surely something must have happened since then because it's all gone to disposable stuff' .. and she said 'well if you don't know you'd better find out' .. and I said 'yes, that's why I'm asking' .. and she said 'where do you think you might find out' .. and I said 'you mean what we used to call the bible .. the book of procedures' .. she said 'that's right' .. and I said 'have I got time to hunt through that right at this moment' .. and she said 'well I don't know' .. and I thought hells bells what do I do .. I didn't even know where the damn book was (Vicki, individual interview).

The rest of this nurse's day continued in a similar vein until she was so stressed and felt so intimidated she could not concentrate to write her reports at the end of the day. She eventually resolved the situation for herself once she was out of the situation and able to think more clearly. Her practice has changed significantly as a result of this day. She now faces her work environment with confidence, is able to be assertive with the charge nurse, and no longer feels intimidated by her.

I was told that I'd put too high a demand on myself .. I was putting all these pressures on myself .. why did I do it to myself .. and I wanted to say why did you do that to me .. but I didn't .. // .. but it got sort of resolved in hindsight ..//..I got home and I was just a mess.. but I also learned something .. once I'd sort of worked it all out I said I'd never allow ..//.. it to happen again (Vicki, individual interview).

- Learning about the personalities working in a ward environment is an example of the local knowledge that nurses need to acquire in order to work comfortably and effectively. Knowledge of personalities and systems also provides a know-how for nurses to work around the system to achieve their own ends or those of their patients, when required.

Overwhelming Experiences

A single overwhelming experience has the potential to change a nurse's practice in an immediate and dramatic way. This type of experience can be remembered in detail even years after the event and influence practice profoundly. The making of a potentially fatal error, inflicting unnecessary distress on a patient, or having a distressing personal experience of hospitalization are examples of the types of incidents which can have a profound effect on future practice.

One nurse relates an experience which occurred several years before. This incident clearly demonstrates the encompassing nature of such an experience and the effect of the incident on future practice.

An incident which changed the way I look at people .. care for people .. was when I was a (second year student nurse) ..//.. and I was working in the burns unit ..//.. anyway we had this fellow come in after an accident on his farm .. //.. with about 70 per cent burns .. it's not very nice to look at .. let alone look after .. and it's definitely painful .. and my story involves pain relief .. I always had a bit of an apprehension for burns .. I still have in a way .. probably from this incident .. he was burnt badly on this face, chest, back and to his legs .. both sides .. and he required dressings q.i.d. and those dressings were very painful for him .. and for some reason I had to do this dressing .. I suppose the staff nurse was doing something else .. I was more than happy to do it .. with help .. but I wasn't really fully understanding of what this patient was feeling .. and I don't think the staff nurse was either because he hadn't had any pain relief before his dressing .. and I was due to change his leg dressings and I had the chux* off and the Silvazine (burns cream) off and was putting the new bandages on

with tubigrip* .. (I had) a wire cage to apply the tubigrip .. and it was so tight on this fellow that he was crying out in pain .. I honestly can't think why we carried on .. why we didn't stop and fix it up .. get some pain relief .. we carried on anyway .. it was so long ago I can't remember exactly why .. but the room was hot for a start .. because he'd be susceptible to the cold .. and it was hard work putting on these dressings .. putting this tubigrip on .. and I was sweating like anything .. I came out of that room drenched .. not only from the exertion of putting on the dressings but from the psychological exertion of knowing this fellow was in pain and knowing he was having to grit his teeth to finish the dressing off .. and virtually from that day on I've been .. //.. I wouldn't say more careful about my pain relief .. but more inclined to give it than not .. some people probably think I'm a bit generous in the way I give pain relief .. but I think that that has definitely stamped an impression on my brain .. not only with pain but also with burns. I recently had to overcome that feeling .. that disturbing feeling .. we had a burns patient admitted to the ward last year .. I was very apprehensive about looking after a burns patient .. I'd said to myself one day I'll have to look after one and here's one so I'll take him as my primary patient .. and that's six or seven years later .. and so I actively went out and did everything I expected to do .. gave pain relief .. it made me feel a lot better in my work. I've also had quite a few instances where I've given pain relief when other nurses haven't .. and its made a difference to (the patient's) state of mind at the time.

.. at the time it wasn't my responsibility to make sure he had the pain relief with the dressing .. now it is my responsibility and I actively set out to do it .. to make sure its done .. and it made me feel a lot better about looking after burns patients.. so I definitely learned from it .. not only burns patients but also in surgical patients .. (Dale, individual interview).

The possibility of making recompense for past wrongs is evident in this exemplar and emerged in a number of others. The examples in this category also convey the distress of the nurse when the 'notion of good' is not realized.

Several nurses shared incidents where errors had been made in drug administration or intravenous therapy. The potentially fatal nature of such errors can be overwhelming for the nurse who sees how easily the patient

could have died. The potential loss of registration and career are added fears. A nurse who shared an incident of this type also identifies in her reconstruction of the event the importance of a supportive supervisor and the loss of confidence in a colleague which occurs when she was left to stand alone.

This incident occurred on a general surgical ward .. it had been quite a busy day actually .. an afternoon .. and we'd had quite a few patients back from surgery ..//.. (and the patient) was a lady who had had her gall bladder out. She was a real honey of a lady .. someone you got to know really well .. someone I loved looking after .. and she was on a morphine infusion which we'd only been doing for a while ..they're really common now ..//..and I'd checked it out with the nurse from the next ward .. we'd been that busy that she'd had to come and check it out with me .. and it was 50mg of morphine in the syringe .. and that was to go up in 1-2mls per hour .. I checked it with the other girl and she went back to her ward .. and I went to put it up on my own .. without thinking I couldn't do it like that .. and there was a large air bubble at the end of the tubing so I turned it up to clear it before I connected it to her .. it was a hassle to get the syringe out of those pumps .. it was one of the older syringe pumps .. so I turned it up .. stopped it .. connected it all up .. started it again and forgot to check the rate. I checked on her a couple of times .. she was okay .. and kept on going .. and then the next thing I heard was the syringe beeping .. and I thought .. thats funny .. something's wrong .. I went through and I looked .. and it was empty .. and I thought it can't be. I've just put it up .. and I turned it off .. it can't be ..I thought this can't be happening to me .. this is a big mistake .. and my first instinct was just to run and let someone else find it .. I just didn't want to know about it .. I didn't want to admit what a mistake I'd made.

I went to go out of the room .. and thought no what's she like and so I checked her and did her obs very quickly .. and she was fine .. her resps* were down to about 9 or 10 .. so they were slow but I wasn't concerned and her pulse was okay .. and she was asleep but roused .. if I called her name she woke up and answered me .. so I took off .. I thought I'd better get someone to check this with me .. before I called the doctor .. I didn't know the doctor well and I still wasn't comfortable calling doctors at that stage .. it takes me a while to get comfortable with doctors and feel happy about calling them .. and the doctor who was on .. I didn't have a good rapport with him and couldn't just talk to him and know he knew exactly what I'd said .. and I knew Sally Green (supervisor) had been through not long before and I've always got on well with Sally .. and so I just ran down the ward .. she hadn't long

been with us so I knew she had to be in one of the other two wards .. and another supervisor was on but .. I didn't know how she would react .. so I pretended I didn't see her and kept on going and found Sally .. and Sally came back with me and checked the patients obs as well .. and they were okay ..and thats when I called the doctor. . and I went to get the narcaïn .. but his first reaction was .. 'oh she'll be okay .. I'll pop up later' ..and I was really shocked because to him it didn't really seem to matter .. and it wasn't until later that I realised that people do get large amounts of drugs .. but it was still a shock to me and far more than she should have had .. and his reaction was so blasé that it made me even more determined that she was going to be okay. The doctor wasn't in any rush to come and see her .. so I went back and Sally was still there .. she'd stayed around .. and I did keep doing this womans obs every 10 minutes or so .. //.. and she actually came through fine. But I was really shaken .. and I just kept thinking the whole night .. it could've been so bad .. it could've been so bad .. and I told her that night what I'd done .. the patient .. and she said its alright dear .. you're only human .. I'm all right aren't I .. that really helped me a lot .. she was so accepting .. and was saying she was okay .. and that's what mattered .. //.. I filled out an incident report .. and I went to the other nurse and told her what I had done ..I hadn't put her name on the incident report because I knew it was my mistake .. but in the drug book she had signed that she had checked the drug out with me .. and so I thought she should know what was going on ..and she said .. well its nothing to do with me .. I checked the drug out with you .. that's all I had to do .. I felt terrified .. I thought well if anything had happened she was never going to back me up .. and I knew it was her mistake too because she should have checked the rate when I put it up on the patient .. but I do know that quite often we don't do that .. and I actually won't check drugs again with that girl now ..I'd go out of my way to check them with someone else before I would check them with her .. because I don't trust her to back me up if there's ever another mistake ..//.. I've got no faith in her anymore as a nurse.

When I went home that night Steve (husband) picked me up .. and I was just in tears .. I burst into tears when I got in the car .. and he said what's the matter ..and I told him .. and he said 'but she's okay isn't she .. look .. what's the worst thing that could've happened' .. expecting me to say 'well she would've had a good night's sleep' ..but I said 'the worst that could've happened could've been that she could've died .. I said I could've been dragged up in a court of law .. I could've been charged with manslaughter .. I would've never nursed again .. never allowed to work in a hospital again' ..he didn't know what to say to me .. he didn't know how bad it could've been. I didn't sleep all night ..

and I couldn't wait to get to work the next morning to see how she was .. she was fine .. and I asked her if she realised what had happened .. she said 'yes you told me' .. so it was really good .. she'd been a lot more aware than I actually realised .. but since then I just won't put up anything like that unless someone else checks the rate .. and I do a double check of the rate myself before someone even checks it .. and I'm just so much more careful in checking out any drugs like that .. I mean I always checked things like basic calculations .. but now its always that one step further where you check connecting it up to the patient .. I just check it so much more carefully .. and when other people say 'oh thats okay I'll just go and connect it up' .. I say 'no I want to come and check that with you' .. and you get one or two people looking at you funny .. but its too risky .. I mean if that lady had been a thinner person .. or had had a heart condition .. I mean it could so easily have gone the other way ..//.. I was just really lucky .. I can see that. I'm just so careful with drugs .. I don't take any risks (Gaby, individual interview).

An understanding of the need for constant vigilance is gained by nurses who have made or almost made errors which actually or potentially endangered the patient/s. This understanding is shared by a nurse who administered the incorrect solution during intravenous therapy.

..the main change that that's made is to make me really cautious about IV therapy, IV additives, drugs, the whole works .. I feel I'm much more careful about what I do .. I know you do go on automatic pilot .. I've stopped myself even recently .. you know .. thinking that its something and not checking it properly .. so I still have to stop myself every now and then and just make sure its really what I'm looking at ..and I've got much more careful about taking the charting down with me and checking labels and things like that. I don't think I was very unsafe beforehand ..this certainly has made me much safer (Meg, individual interview).

Summary

The main situations to emerge from the study which resulted in a nurse changing her practice in some way related to incidents where there was a

break down or discontinuity of some sort. Each incident shared involved recognition that the current situation was not working, or not working as well as it could. When this occurs, the notion of good which pervades nursing and is central to nursing practice is not realized. There is a need to step back and look at the situation and learn from it. If such experiential learning results from a conscious examination of practice then it is not surprising that the situations shared by study participants were of this nature. The incidents are remembered because they caused discomfort.

Clinical situations where nurses make a difference also have the potential to result in changes in practice as seen in some of the exemplars from the previous chapter. The change in practice is perhaps more subtle, however, and knowledge has been extended or expanded rather than directly challenged.

The last three chapters have presented the results of analysis of data collected from the participants in the study. The broad context within which these nurses practice has been described, situations where nurses make a difference have been identified and situations which result in changes to practice have been explored. It is clear from the data presented that the practice world of nurses participating in this study is a complex and multidimensional one. Each day is a mixture of the predictable and the unpredictable, which in different configurations passes through three broad phases identified as Settling In, Working Through and Handing Over. At times safety is all that can be achieved. The ability of nurses to make a difference despite the nature of the practice environment is evident from the exemplars provided by the study participants. Making a difference occurs in a variety of ways in the acute care setting and is aimed at both patients/families and other nurses. These situations reflect the use of knowledge and exercise of clinical judgement, and may also involve an extension and/or expansion of knowledge. Situations which nurses identify as changing the way they practice result from some sort of breakdown or discontinuity in practice. In these situations there is a challenge to previous knowledge, understandings or practices and future practice is often changed in important ways. These descriptions and exemplars identify the valuable place that gaining of practical knowledge plays in the development of clinical expertise.

PART III

THE SIGNIFICANCE AND IMPLICATIONS OF THE STUDY

Part III of this thesis comprises chapters 7 and 8 which discuss the significance of the findings revealed in this study and their implications for nursing in New Zealand. Chapter 7 provides a comparison of the findings with work in related areas, in particular the work of Patricia Benner, and places the findings within the context of current understanding. New understandings that emerged from this study are then presented. Chapter 8 concludes the discussion by examining the limitations of this study and the implications it has for practice, education, research and hospital management.

CHAPTER 7

DISCUSSION OF THE FINDINGS

This study confirms the intuitive understanding of many experienced nurses and the researcher has confidence that its findings will 'ring true' to those familiar with acute care nursing practice in New Zealand. The study makes clear that nursing practice takes place within an environment typified by the unexpected, a world that hums with activity. It is a hazardous place where patients are often more vulnerable than at any other time of their lives and where they may have no option but to place their faith in strangers. Nursing practice takes place within this environment and it is here that nurses become the caretakers of this faith. Nursing practice clearly moves beyond the delivery of physical care and adherence to medical plans of care, which are the most visible and identifiable aspects of nursing practice. Nursing is a unique and quietly powerful discipline pervaded by a 'notion of good'.

This study is important in that it begins the task of charting the practical knowledge of nurses in an acute care setting in a New Zealand hospital. The importance of experience in clinical practice to the development of clinical expertise is identified and supports the work of others (Benner, 1982, 1983, 1984, 1985, Benner & Tanner, 1987; Benner & Wrubel, 1982a & b; Gordon, 1986). A number of factors within the work environment are also identified in this study as facilitating the nurse in making a significant contribution to patient care. These are continuity of patient care and a climate within the work environment which supports responsibility, caring, and supportive working relationships.

The importance of gaining practical knowledge in the clinical setting and its central role in the development of clinical expertise is identified throughout this study and emerges in both the descriptions and exemplars. This provides further evidence in support of the growing number of authors (Benner, 1982, 1983, 1984, 1985; Benner & Tanner, 1987; Benner & Wrubel, 1982a & b; Gordon, 1986) who have applied the Dreyfus model of skill acquisition and contend that practical experience is mandatory for gaining proficiency in the practice of nursing. It also provides indirect support for an understanding of clinical decision making that includes multiple processes.

Also identified within this study is the central role nursing practice plays in patient care. This type of study, which examines actual practice rather than what practice should be, elucidates the invisible aspects which characterize so much of nursing. The portrayal of nursing through the media and through nursing texts has concentrated predominantly on the visible aspects of nursing practice and has contributed to a distorted view of the nurse's contribution to patient care. The use of a phenomenological approach in examining the lived world of nursing in the acute care setting has resulted in an understanding of practice that is not achievable with quantitative research methods, and has enabled a fuller expression of the less visible aspects of nursing practice.

The importance of making an appropriate choice of method in examining nursing practice is highlighted in the current study. To gain access to the lived world, where meanings and personal understandings shape an individual's perceptions of and experience within that world, researchers must make themselves amenable to those meanings and understandings. The lived world of practice, which is characterized by complexity, uncertainty, instability, uniqueness and value-conflict (Schön, 1983) is not easily categorised or even described in writing when linguistic rules tend to stifle the full expression of feelings and understandings in a situation. An open, non directive approach, and the dialogue style of interviews, which are a feature of phenomenological research, allowed for richer data to emerge. This approach has enabled a fuller description of the lived experience of nursing practice.

The Relationship of this Study to the Work of Benner

Although not a replication of the seminal study undertaken by Benner which culminated in the publication of *From Novice to Expert : Excellence and Power in Clinical Nursing Practice* in 1984, some comparison of the findings presented in the previous chapters with those of Benner is valid. The guidelines for recording critical incidents where nurses made a difference were essentially the same as those developed by Gordon and Benner(1984, see Appendix 2) and provided a framework for data collection for the study.

This study provides support for the relevance of the work of Benner and her associates for the New Zealand setting. It clearly identifies four of the domains of nursing practice presented in her study. The other domains and competencies are not precluded, but rather, did not emerge as strongly. This is not unexpected given the more limited nature and scope of the current study. Benner acknowledges that the domains and competencies emerging from her study provided a beginning point and makes a plea for them not to be seen as providing closure on areas of skilled performance in nursing practice. It was therefore probable that new areas of skilled performance would arise from this study and their identification supports the need for continued research in different settings.

Differences arising from this study are partly differences in emphasis. The current study gives greater emphasis to the broader context within which the nurses in the study practice. The practice context is a complex one and this study identifies that nurses often make a difference despite the context rather than because of it. On the other hand, certain contextual factors are facilitative and these are important to identify.

A knowledge of contextual factors which facilitate practice can enable nurse managers to assist in providing an environment where excellence in practice is the focus of nursing services. For example, supportive nurse colleagues and a care modality that provides for continuity and totality of patient care were identified as enabling to nursing practice and these factors can be

facilitated. Kramer and Schmalenberg (1988a & b) point to the powerful role of the organization in creating conditions crucial to practice in their analysis of Magnet Hospitals in the United States. Magnet hospitals are hospitals that have been shown to consistently attract and retain staff and have been identified as creating a 'culture of excellence'. Whilst the ability of nurses to make a difference in less than ideal work environments is not disputed, it is clear that there is a relationship between the quality of the work environment and the quality of care provided. For example, this was demonstrated in the importance nurses in the study placed on who their workmates were on a particular day (pp. 34-36) or when nurses identified the difficulties they had in attaining a full understanding of their patients when ward routine or the preferences of other staff dictated that certain aspects of care would be carried out in a task oriented manner (p.34).

A deeper exploration of the context of nursing practice in this study, revealed a very loose framework for the typical day in the wards where the nurses participating in the study practiced. During the phases of Settling In, Working Through and Handing Over nurses engage in a multitude of planned and unplanned activities. The highly visible tasks which nurses undertake each day provide a certain amount of structure to this framework and this, to some extent, appears to provide a feeling of control and manageability within an environment which is by nature complex and changing. The nurse's experience of her day is one that is busy and varied. It is little wonder that nurses first entering this world find it confusing and difficult to manage after a relatively sheltered experience during their nursing education. The new nurse experiences a difference between the 'ideal' and the 'real' that can lead to disillusionment if a simplistic view of nursing practice is adhered to. The very nature of the nursing world means it cannot be totally controlled and there is no one best answer or solution to each problem. The experienced nurse who has developed discretionary judgement based on experience and local knowledge is more able to function within this type of setting. An ability to function within the environment is essential if the knowledge and skills that nurses come into practice with are to be effectively utilised. This does not mean that it is the responsibility of nursing education to prepare nurses to conform so they can work within the system. The system must also change dramatically if nurses are to be facilitated in their efforts to provide

excellent care. The complex nature of the acute care environment does, however, need to be recognised and nurses better prepared for it. An understanding of the mandatory need for practical experience, and the requirement for local knowledge in the development of clinical proficiency in a particular setting, can lead to a more realistic expectation of beginning practitioners.

Nursing education, and to some degree practice have moved towards an understanding of nursing care that is an integration of task oriented and person oriented care. Attempts to implement more professional models of care, with care modalities such as primary nursing, have been partially successful in introducing a more balanced approach. Vestiges of a task orientation, however, do continue to exert their influence even within areas that have been relatively successful in changing their emphasis. For example, some technical aspects of care such as patient observation and medication administration may still be carried out in a task oriented way, resulting in the nurse's understanding of the significance of an observation or the effect of a medication being seen in isolation from the patient. Such an approach does not allow for the integration of those less visible aspects of patient observation or medication administration which include watching for subtle changes in colour or demeanour or evaluating a patient's understanding of a new medication. In putting up barriers to this integration the potential value of the care provided through that action is diminished.

An understanding of the changing nursing role by the general public, other health professionals, and at times nurses, has made little move towards incorporating a view of nursing which reflects an integration of art and science. This is likely to affect patients' perceptions of the care given as well as their understanding of the experience and is an area which requires investigation. An understanding of the nursing role by other health professionals also lags behind. A diminished view of nursing by other health professionals may reinforce taken-for-granted patterns of relationships, but ultimately is to no-one's advantage. There is a need to portray an image of nursing as "nursing science applied within a highly compassionate art" (Peplau, 1988), thus placing value and legitimacy on both aspects of nursing practice.

As one progresses through the reading of *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, the role individual nurses have in making a difference to individual patients and families is clearly identified. This is also identified in the current study. What emerges more strongly from the current study, however, is the value of nurses working together to provide care and the importance of this, as well as other contextual factors, in facilitating or inhibiting nursing practice. Benner certainly identifies in her study that they have a role to play and outlines such factors in her discussion of the domain of Work-Role Competencies. This aspect arose so forcefully from the current study, however, that it requires a more prominent place in the discussion of the development of practical knowledge and clinical expertise. For example, the competencies of Building and Maintaining a Therapeutic Team to Provide Optimal Therapy and Advising and Supporting Other Nurses were found to significantly influence the nurses participating in this study. The importance of these competencies was felt in each area examined. In descriptions of the work context the nurses identified that the other nurses who were working with them on a particular day influenced their perceptions of how well they would cope with their own workload and how their day was likely to progress. In clinical situations where nurses made a difference the role of other nurses in advising, supporting and confirming was evident. In clinical situations which changed the way nurses practice, the need for local knowledge, which included knowledge about those staff who had integrity and could be relied upon to support them in a difficult situation was seen.

While a small, single study cannot provide unequivocal support, it may well be that the greater focus on collegial and team activities, evident in this New Zealand study, is culturally based. It may be that this emphasis is a reflection of the strong values of community in a small country such as New Zealand which also places less emphasis on individualism and competition evident in the American setting in which Benner's study took place.

There is very little literature that more than alludes to the added impact nurses working well together in the hospital environment can have on the quality of care. There have been major changes in the mix of nursing staff

within hospitals over the last two decades in New Zealand. The move from hospital based nurse training programmes to nurse education within tertiary institutions has resulted in a major change in nursing staff mix and a change in the types of relationships these nurses have with each other. When nurses trained in hospitals they also lived out their daily lives in close contact with each other in nurse's homes and so their knowledge of each other as people was more intimate. Wards were organized along military lines and the legacy of the Nightengale ethos of endurance, forbearance and obedience (Rodgers, 1986) was felt until recent times. This ethos is no longer helpful within acute care settings where a predominantly qualified nursing staff are attempting to practice on a collegial basis, but it does need to be replaced with something that enables the staff to work together effectively. Also, many of the staff no longer interact outside the hospital and so the relationships they build with each other are qualitatively and quantitatively different than they have been in the past. Although some changes in work organisation have occurred to accommodate new staffing patterns these changes have not been complete. For example, the vestiges of the task oriented organization of ward activities and the demand for unquestioning adherence to orders and protocols are seen in situations where nurses in senior positions struggle to retain relationships of power more appropriate to a military setting. What the current study demonstrates is that team building activities are seen as important by nurses in clinical practice and they are identified as important facilitators of practice. When team cohesion is not present it results in a detrimental effect on practice.

Benner's (1984) study focuses on the best of nursing practice and she adequately justifies her concentration on the outstanding in nursing. In addition to identifying the best of nursing practice - the current study also gives focus to the factors which influence such practice - those factors which facilitate it and those which do not. Descriptions of typical and unusual days and examples of situations where nurses learned something from their practice provide examples of less than adequate care. The real world of nursing practice contains the good and the bad and an understanding of those factors which influence both the best of practice and the worst of practice are important. Examples of poor care can increase the disillusionment of those already disillusioned with hospital nursing practice, but what this

study clearly shows is that experiences of making a mistake or providing less than adequate care can have beneficial results. Experiences of this type can act as catalysts that change a nurse's perspective on her practice and stimulate progress towards a more expert level of care.

In her 1984 study Benner suggested that within the Teaching/Coaching Function of nursing practice, many more competencies were likely to be identified. A new competency of Coaching Through a Situation Bit by Bit was identified in the current study. This competency focuses on a special relationship between the nurse and the patient, usually during an unpleasant or frightening procedure or during a rapidly changing situation. When comparing nurse teachers with athletic coaches Smoyak (1978) notes that coaches are masters at ignoring undesirable behaviour and deliver 'yes' messages with great enthusiasm close to the act. This is similar to the close relationship between nurse and patient in Coaching Through a Situation Bit by Bit. The nurse connects with and guides the patient who is being propelled through an unpleasant or confusing situation. She provides information as well as enthusiastic support and encouragement for the smallest positive signs exhibited by the patient, thus assisting the patient to live through the situation maintaining dignity and composure.

Benner & Wrubel (1988) allude to the 'notion of good' inherent in nursing practice. This notion of good relates to the benevolent intent in the practice of nursing and pervades the exemplars where nurses make a difference - exemplars which reveal the essence of nursing practice. On the other hand, clinical situations which challenged the nurses' practice in some way are examples of situations where the 'notion of good' was not realized. In these situations actual or potential harm was caused to a patient or their family, nurses denied responsibility for their actions, or preventable oversights were made. This may go some way to explaining why these situations which nurses identified as having changed their practice in some way often had such an impact. The nurse steps back and examines her actions when the 'notion of good', which nurses expect to characterise their practice, is not realized. This can be within her own practice or the practice of a colleague. After an experience of this kind, practice will normally incorporate the new insights or understandings gained. In some cases the nurse experiences a

renewed sense of compassion. This is poignantly illustrated by the nurse who describes the situation of redressing the wounds of a patient with burns without giving adequate pain relief (see pp.73-74). The incident is remembered in vivid detail many years later and is acknowledged by the nurse to have had a profound effect on future practice, not only in caring for patients with burns, but in any situation where another human being is experiencing pain.

The hazardous nature of the hospital and the nurse's role in preventing harm is evident in this study. Situations requiring an advocacy stance by the nurse, such as when the practice of another health worker needs to be challenged or harm prevented, illustrate this. The nurse's deeper understanding of the person who is the patient, especially in situations where she has been able to provide care on a continuous basis, also puts her in an ideal position to identify errors of omission or inappropriate suggestions. Lack of knowledge and skill are quickly identified by the nurse who is familiar with a specific clinical area. This role may be seen as one that nurses should not have to undertake, as in a perfect world where each person does their job properly, care would be ideal. That perfect world does not exist and in an environment where the unexpected is typical and large numbers of actors come and go each day these situations are inevitable. The nurse's role in preventing harm is an important and legitimate one, but one that has gone largely unrecognised and therefore not valued.

New Understandings

This study is the first of its kind in New Zealand to examine the world of nursing practice within the acute care hospital environment. The phenomenological approach used in this study has enabled the richness and complexity of the the context of nursing practice to emerge. The best of practice and the worst of practice have been revealed. Even for the researcher, familiar with acute care nursing practice, the understanding of the complexity of the environment in which many nurses practice, has in itself led to a greater appreciation of the contribution nurses make to patient

welfare within hospital settings.

The vital role of nurses working together to enhance their own practice and that of their colleagues has been one of the most significant findings to emerge from this study and one which requires more thorough investigation. This contrasts with the greater emphasis on individual nurse's performance presented in Benner's research. Other structural and contextual factors also play a vital role in facilitating or inhibiting practice. The current emphasis on improving the quality of patient care through the personal growth of individual nurses will not be adequate. Structural factors must also be investigated and nurses and others in positions of power must be prepared to examine the effect of their own agendas on nursing practice.

CHAPTER EIGHT

CONCLUSIONS

This study has described the practice world of a small group of registered nurses working in an acute care setting in a New Zealand hospital. The context of their practice was presented and exemplars provided to enable the reader to gain some appreciation of the lived experience of nursing practice as it is for these nurses.

Limitations of the Study

As this study focuses on the practice world of a small number of nurses working within an acute care setting, caution needs to be exercised in generalizing the findings. The practice area of the study participants is limited to the acute care setting and the small number of participants further narrows the study setting to general medical and surgical wards. The number of domains of practice to emerge significantly from the data also reflects the limited scope of the study and supports the need for similar studies to be undertaken in a variety of settings throughout New Zealand if a more complete picture of nursing practice in this country is to emerge.

The investigation of a patient perspective in identifying where nursing practice has made a difference is also required if we are to truly understand the impact nursing practice can have on people's lives, and its lack is clearly a limitation within this study. This could well be a perspective to be investigated in conjunction with nurses' understandings of where they have made a difference, and again needs to be undertaken within a variety of health care settings.

Implications for Practice

As could be expected with any study which focuses on the nursing practice, many implications for nursing practice emerged from this study. The need for nurses to continue to explicate the knowledge embedded in clinical practice is mandatory if the significance of nursing practice is to be fully appreciated and continually developed. This is even more urgent at a time when the health service in New Zealand is in a period of rapid change and is becoming increasingly driven by economic rather than humanitarian considerations. Our qualified nursing workforce is being placed under threat. Although the true significance of nursing practice to patient welfare is not easily (and never totally) amenable to quantification, an understanding of it is important to the continued survival of nursing practice. The use of clinical exemplars to illustrate the role played by nurses is one way of explicating the important role of nursing practice to patient welfare. Another possible use of clinical exemplars is within staff development and performance appraisal systems so that nurses can acknowledge, and share in, the significant impact they clearly have on patients' welfare.

The importance of nurses working well together, in team building and supportive activities, is clearly identified in this study and the central role of these activities to patient care and patient safety cannot be understated. Fostering the development of a ward environment which nurtures the new nurse and facilitates respectful and supportive collegial relationships amongst more experienced staff is vital. Ward charge nurses are in an ideal position to foster a climate where this is facilitated and it needs to be seen as one of their central roles. It is yet to be seen whether the current restructuring of the New Zealand health service, with its emphasis on general management, will provide support to charge nurses so that they can create a ward climate conducive to team work and mutual support.

Continuity and totality of patient care emerge as factors which facilitate the nurse in her effort to make a difference to her patients. These are affected by ward structures and care modality and again the charge nurse is well placed to encourage the development of care modalities consistent with professional

models of care that stress continuity and individual accountability. Charge nurses need to look to their own role if they are to facilitate this, as the current care modality in their area may reinforce their power position and increase their reluctance to change it. Nurse managers are in a position to ensure that staff allocation and rostering systems that minimise the shifting of staff to provide adequate staff coverage are in place and that such practices are not an every day, taken-for-granted occurrence. There is a need to recognise that nurses are not interchangeable units that can be slotted into any position within the system at will. Nurse managers can also support charge nurses who are struggling to change the care modality in their area and assist them to carve out new roles effectively. They also have an important role to play in creating a 'culture of excellence' within their institutions which acknowledges and promotes excellence in clinical practice.

Opportunities to share exemplars with colleagues will enhance nursing practice by encouraging nurses to acknowledge and value their contribution to patient care. Nurses themselves need to own the best of their practice.

Implications for Education

The importance of experience to the development of clinical expertise has been supported in this study and has a number of implications for nursing education. Expectations of practice within the acute care hospital tend to focus on the competent level of practice, as evidenced by an emphasis on task completion and the expectation that nurses will practice efficiently within well defined rules and protocols. This has contributed to unrealistic expectations of beginning practitioners in New Zealand, who are expected to be able to function at a competent level as soon as they enter the workforce. An understanding of the mandatory need for experience in the development of clinical proficiency places the practice of the new graduate in perspective. For experienced nurses, the need to move beyond the level of competence is not recognised, and may be actively discouraged, when it causes discomfort or challenges taken-for-granted expectations or practices. This may result in many nurses not moving beyond it. Rigid adherence to rules, protocols and

procedures, even when they do not fit, does not foster the development of discretionary judgement and an awareness of alternative possibilities.

The way in which nurses at different levels of clinical proficiency approach clinical situations has implications for the choice of preceptor for both new graduates and experienced nurses as they enter a new institution. For example, a novice or advanced beginner will find a competent nurse a more appropriate preceptor than an expert nurse who looks at complete wholes and may have difficulty explaining aspects of her practice. In line with this, an understanding of the levels of clinical proficiency and the nature of intuitive judgement can provide a framework for inexperienced nurses to gain a better understanding of the behaviour of more experienced nurses which may appear to them as slipshod or even mystical (Dolan, 1984).

The important role of local knowledge in facilitating practice emerges in this study. Many aspects of local knowledge can be actively taught and this can be incorporated in the preparation of preceptors, if its importance is recognised. Today, new graduates from technical institutes have considerable theoretical knowledge but it needs to be acknowledged that there are limits to the preparation that can be undertaken outside of the practice setting. These nurses are being prepared to practice in a variety of community and institutional settings and not just for practice within a specific institution. In the past, graduates from hospital based nursing programmes had already learned much of the local knowledge required to function within the particular institution and so it is little wonder that they appeared more proficient by the time they graduated. All nurses can support each other by sharing new understandings related to their work environment.

Implications for Research

As with any research study, more questions are inevitably raised than are answered. As noted earlier, despite the legitimacy of the current study it is of limited scope and similar studies need to be undertaken to build on this work. Studies covering a variety of settings in different areas of New Zealand

are required to build a picture of nursing practice in this country. Studies which focus on, or include, patient and family perceptions of significant encounters with nurses and nursing practice will provide another perspective and will be important in providing a more complete picture of the contribution nurses make to the health care of New Zealanders. Patient perceptions may require nurses to re-define some aspects of their care. A cross-cultural perspective is also missing within this study and patients from different cultural life experiences may define the need for nursing in different ways. In a multi-cultural society this cannot be ignored. Studies within different geographical settings in New Zealand will increase the understandings in this area.

Research examining the influence of different contexts, care modalities and organisational factors in facilitating or restraining practice are required so that positive personal and structural influences can be enhanced. Further examination of the influence nurses have on the practice of their colleagues may help identify those nurses with special skills in enhancing the possibilities for care of others and provide insights that will help prepare nurses for this role. Research within psychiatric and community health care settings may provide new insights. The nature of the acute care environment may result in a need for cohesive team relationships which may not be as necessary, nor as important, in other settings.

The participants in this study were predominantly women. The nature of caring and making a difference in nursing practice may be defined differently by men in nursing and is another area of possible fruitful investigation. Nurses bring to their practice their life experience and with the increasing numbers of men entering nursing it cannot be assumed that their definitions of caring, making a difference, working within a team, or responding to contextual realities will be similar to those of women. New insights and understandings could be gained in adding a male perspective on nursing.

The composition and focus of ethics committees within hospitals in New Zealand have been medically dominated. The understanding of research is predominantly quantitative and heavily grounded within the empirico-analytic tradition. Nursing research, using qualitative approaches, is

gaining momentum in New Zealand, but there is a considerable lack of understanding regarding such approaches within the broader nursing community and within the medical profession. If qualitative research is to be facilitated, then hospital ethics committees need to be fully aware of all possible implications of such research. The composition of ethics committees also requires serious attention, with broader representation from within the health professions as well as significant community representation being mandatory.

Implications for Hospital Management

The hazardous nature of the hospital environment and the important role nurses play in preventing harm to patients is an area which needs to be acknowledged and explored more thoroughly. Current questioning of the need for a qualified nursing workforce in New Zealand, in undertaking what is considered by many to be 'routine' care has major implications for patient safety. The movement of most of the control of hospitals in this country into the hands of general managers is of grave concern if a simplistic view of nursing practice is adopted by these managers. If the use of unqualified staff is seen as an answer to the high cost of a qualified nursing workforce, the implications for patient care could be serious indeed. It is vital for nurse managers as well as non nurse managers to identify the savings in both human and economic terms of this important role. The wholesale removal of senior nursing positions in some newly formed Area Health Boards points to the urgency of this task.

Concluding Statement

This study has examined the practice world of twenty two registered nurses working in medical and surgical wards of an acute general hospital in New Zealand. The aim was to provide an understanding of the lived world of nursing practice through descriptions of work days and to gain an

understanding of where nurses make a difference, through the sharing of clinical exemplars. An understanding of the broader context of nursing practice was gained, areas of skilled performance in nursing emerged and the meaning of making a difference for the nurses in the study examined. The central role of mutual advice and support in facilitating significant incidents in practice was apparent. An examination of the types of experiences which challenge current practice and change it in some way provided insight into the importance of experience in developing clinical expertise and the vital role of local knowledge. Nursing practice emerged as crucial to patient welfare and safety in the acute care setting.

While the study did not specifically set out to do this, it clearly demonstrates the difference that nursing makes to patients' welfare. It is hoped that nurses reading this study will have their understanding of themselves as caring, skilled, and knowledgeable professionals confirmed, and their vision of nursing's possibilities expanded. It is also hoped that other readers will have their perceptions of nursing challenged and will be helped to see nursing as it is experienced in the lived-world of nursing practice.

APPENDIX 1

Domains of Practice and Clinical Competencies Identified By Patricia Benner (1984)

THE HELPING ROLE

The Healing Relationship: Creating a Climate for and Establishing a Commitment to Healing

Providing Comfort Measures and Preserving Personhood in the Face of Pain and Extreme Breakdown

Presencing: Being With a Patient

Maximising the Patient's Participation and Control in His or Her Own Recovery

Interpreting Kinds of Pain and Selecting Appropriate Strategies for Pain Management and Control

Providing Comfort and Communication Through Touch

Providing Emotional and Informational Support to Patients' Families

Guiding a Patient Through Emotional and Developmental Change:
Providing New Options, Closing Off Old Ones: Channeling Teaching,
Mediating

Acting as a psychological and cultural mediator

Using goals therapeutically

Working to build and maintain a therapeutic community

EFFECTIVE MANAGEMENT OF RAPIDLY CHANGING SITUATIONS

Skilled Performance in Extreme Life-Threatening Emergencies :
Rapid Grasp of a Problem

Contingency Management : Rapid Matching of Demands and Resources
in Emergency Situations

Identifying and Managing a Patient Crisis Until Physician Assistance is
Available

THE TEACHING-COACHING FUNCTION

Timing: Capturing a Patient's Readiness to Learn

Assisting Patients to Integrate the Implications of Illness and Recovery into Their Lifestyles

Eliciting and Understanding the Patient's Interpretation of His or Her Illness

Providing an Interpretation of the Patient's Condition and Giving a Rationale for Procedures

The Coaching Function: Making Culturally Avoided Aspects of an Illness Approachable and Understandable

THE DIAGNOSTIC AND PATIENT-MONITORING FUNCTION

Detection and Documentation of Significant Changes in a Patient's Condition

Providing an Early Warning Signal:

Anticipating Breakdown and Deterioration Prior to Explicit Confirming Diagnostic Signs

Anticipating Problems: Future Think

Understanding Particular Demands and Experiences of Illness: Anticipating Patient Care Needs

Assessing the Patient's Potential for Wellness and for Responding to Various Treatment Strategies

MONITORING AND ENSURING QUALITY OF HEALTH CARE PRACTICES

Providing a Backup System to Ensure Safe Medical and Nursing Care

Assessing What Can Be Safely Omitted from or Added to Medical Orders

Getting Appropriate and Timely Responses from Physicians

ADMINISTERING AND MONITORING OF THERAPEUTIC INTERVENTIONS AND REGIMENS

Starting and Maintaining Intravenous Therapy with Minimal Risks and Complications

Administering Medications Accurately and Safely: Monitoring Untoward Effects, Reactions, Therapeutic Responses, Toxicity, and Incompatibilities

Combating the Hazards of Immobility: Preventing and Intervening with Skin Breakdown, Ambulating and Exercising Patients to Maximise Mobility and Rehabilitation, Preventing Respiratory Complications

Creating a Wound Management Strategy that Fosters Healing, Comfort, and Appropriate Drainage

ORGANIZATIONAL AND WORK-ROLE COMPETENCIES

Coordinating, Ordering, and Meeting Multiple Patient Needs and Requests: Setting Priorities

Building and Maintaining a Therapeutic Team To Provide Optimal Therapy

Coping With Staff Shortages And High Turnover:

- Contingency planning

- Anticipating and preventing periods of extreme workload

- Using and maintaining team spirit; gaining social support from other nurses

- Maintaining a caring attitude toward patients even in absence of close and frequent contact

- Maintaining a flexible stance toward patients, technology, and bureaucracy

APPENDIX 2

RECORDING CLINICAL SITUATIONS
WHERE NURSES MADE A DIFFERENCE

Questionnaire Developed by
Gordon, D. & Benner, P. (1984).

GUIDELINES FOR RECORDING CLINICAL INCIDENTS WHERE YOU MADE A DIFFERENCE.

You are being asked to describe incidents from your clinical practice where you made a difference. Please describe the situation in story or narrative form, avoiding a cryptic, "shift report" style. Fill in as much detail as you consider necessary for someone else to understand your intentions, fears, feelings and hopes as the situation unfolded. It helps to recount how you were thinking and feeling before the outcomes of the situation were clear, since this is the most accurate way of accounting for the uncertainty that exists in any unfolding clinical situation. Include any significant details about the patient and family involved in the clinical situation.

The type of situation you describe could be any of the following:

- * An incident in which you feel your intervention really made a difference in patient outcome, either directly or indirectly (by helping other staff members)

- * An incident that went unusually well

- * An incident where things did not go as planned

- * An incident that is very ordinary and typical

- * An incident that you think captures the essence of what nursing is all about

- * An incident that was particularly demanding

- * An incident you have recently experienced that stands out in your mind for some reason or other

I. Personal Data:

NAME: (Optional)

DATE:

TITLE:

INSTITUTION:

CURRENT UNIT:

AMOUNT OF TIME IN NURSING PRACTICE:

UNIT WHERE INCIDENT TOOK PLACE:

QUALIFICATIONS:

II. WHAT TO INCLUDE IN YOUR DESCRIPTION OF A PATIENT CARE SITUATION WHERE YOU MADE A DIFFERENCE:

- * The context of the incident, e.g. shift, time of day, staff resources
- * A detailed description of what happened including as much dialogue as possible
- * Why the incident is "significant" to you
- * What were your concerns at the time
- * What were you thinking of as it was taking place
- * What were you feeling during and after the incident
- * What, if anything, you found most demanding about the situation
- * What you found most satisfying about the situation

Example A:

Recording Clinical Situations Where You Made A Difference

You will be asked to share this example in an interview session addressing the questions outlined above. You should think about an incident before the interview session and may wish to jot down some notes in the space below.

Example B:

Recording Clinical Situations Where You Made a Difference

Please use the space below to jot down some notes about a clinical situation from your nursing practice that changed the way you go about your nursing care in preparation for your interview session.

- * In what way was this incident significant
- * What were your concerns at the time
- * What were you thinking about as it was taking place
- * What were your feelings during and after the incident
- * What, if anything, did you find particularly demanding about the incident
- * What did you find particularly satisfying about the incident

Example C: A TYPICAL DAY AT WORK

In the space below, please describe a typical day you have had recently at your work in an acute hospital setting.

Example D: AN UNUSUAL DAY AT WORK

In the space below, please describe a day at your work that was unusual in some significant way.

Appendix 3

Glossary of Abbreviations and Colloquialisms

A & E	Accident and Emergency Department
Additives	Drugs added to intravenous fluids
Anything's doing	Anything is happening
Bad veins	Veins that are difficult to cannulate
Base fluids	Intravenous fluids to which electrolytes or drugs will be added
A Bit of a yarn	A friendly conversation
Blood sugars tested	Testing of blood glucose levels using chemical indicators
B.P.	Blood pressure
Catheter bags	Bags collecting drainage from urinary catheters
Central line	An intravenous cannula inserted into a major blood vessel
Character	An interesting person, often viewed as having eccentric qualities
Chux	An absorbant cloth
Ciggy	Cigarette
Cruisy	Easy
Dabble	Gamble for fun
Did the pills	Medication round
Drips	Intravenous infusions
D.V.T.	Deep vein thrombosis
E.C.G.	Electrocardiograph
Empty drains	Measurement and disposal of drainage from bodily cavities

Fem-pop	Femoral-popliteal
Float	A nurse who is not assigned to particular patients on a given day but assigned to assist other nurses with their case load
Fluid charts	Forms used to record patients' fluid intake and output
Fluids charted	Medical prescriptions for parenteral fluids
Go for gold	Persist
Going off	Deteriorating
Hassle/hassling	To bother or annoy, bothering
Heaps	A large amount
I.M.	Intramuscular
I reckon	I believe, I would think
I.V.	Intravenous
I.V. pump	Mechanical device used to control rate of intravenous infusion
I.V. site	The area where an intravenous cannula is inserted
Meds round	Routine administration of drugs to a group of patients
M.S.T.	Morphine sulphate - long acting oral morphine
New admit	A patient who is newly admitted to the ward
Obs	Observations (commonly include recordings of blood pressure, pulse, temperature and respirations)
Pleural tap	Aspiration of fluid from the pleural cavity
Post-ops	Post-operative patients
Premeds	Premedications ie. medication given prior to patient going for surgery or other procedure.
Report	Written and/or oral communication describing patient status, care etc.

Runner	A nurse who is not attached to a single ward area but working between a number of wards on a particular day
Soluset	An administration set for intravenous fluid
Solutions	Sterile solutions department
S.P.P.S.	Stable Plasma Protein Solution
Subcut	Subcutaneous
T.A.B.	Totaliser Agency Board- a betting agency
Temps	Temperatures
T.I.A.	Transient Ischaemic Attack.
T.P.R.	Temperature, pulse and respirations
Tubigrip	A tubular bandage
Wiped out	Exhausted

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