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**An Exploration of the Nature of Therapeutic Nursing in
a General Rehabilitation Team**

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

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1997

MASSEY UNIVERSITY



1061311638

Abstract

The role of the nurse in the rehabilitation specialty has been defined in terms of the tasks and functions which nurses perform. Whilst the therapeutic contribution of other disciplines is more clearly understood, the extent to which nursing activities are therapeutic is not clear. Therapy is defined as activity which brings about healing or an improved outcome for the customer and is arguably the *raison d'être* of the rehabilitation specialty.

The purpose of this study was to explore the concept of therapeutic nursing in a rehabilitation context from the perspective of the nurse and the customer. The purpose was not to explore **all** aspects of nursing activity. This was neither within the scope of the study nor necessarily consistent with the research question.

The aim was to make more transparent to nurses and to their colleagues just what constitutes the therapeutic work of nursing in rehabilitation, enabling nurses to focus specifically on activity which is of a therapeutic nature and consequently offer nursing which is specifically rehabilitative.

The investigator was the Team Leader of a General Rehabilitation Team in a rehabilitation unit located in a major city in New Zealand. The study design used the Focus Group method to collect data from nurse participants in the team. Thematic analysis applied to the data generated nurse-validated categories of therapeutic activity. Also, during the study discharged customer participants were invited to answer a questionnaire about their perceptions of the nature of therapeutic nursing activity. The responses facilitated a comparison between nurse and customer perceptions of therapeutic nursing. Major themes were extracted from the data and there was congruency between nurse and customer data. Together these themes created a profile of the nurse as a coach. This role constitutes a leadership role in the team, with the customer and with the family. Coaching activity supports the

customer through the rehabilitation programme, assists in overcoming barriers to progress and creates opportunities to develop independence.

A new model for rehabilitation nursing practice is proposed, and recommendations for practice, research and education are described.

Acknowledgements

This thesis was conducted under the academic supervision of

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Her continued guidance and support throughout the course of this research is gratefully acknowledged.

The author is indebted to the following people for their support and assistance in the conduction of this study:

- Dr. Rod Watts, Manager, Rehab Plus for his permission to conduct the study at Rehab Plus.
- Christine Clements, Clinical Nurse Advisor, Rehab Plus without whose support, energy and commitment in recruiting participants this study could not have been conducted.
- The study participants for their time, commitment and most importantly, their stories of practice.

This study is dedicated to my husband whose patience and love made the solitary business of study possible, and to nurses in the General Rehab Team who provide coaching, often in the face of many difficulties.

The Lord is my rock, my fortress and my deliverer;
my God is my rock, in whom I take refuge.
He is my shield and the horn of my salvation, my stronghold.

Psalm 18:6

Table of Contents

	Page Number
Abstract	ii-iii
Acknowledgements	iv
Table of Contents	v-vii
List of Tables and Figures	viii
Chapter One: Introduction	1-7
Chapter Two: Literature Review	8-31
Role of the nurse in rehabilitation	8-11
Defining therapeutics and healing	11-12
Conceptual models of therapeutic nursing	12-16
Primary nursing	16-18
Case management	19
Therapeutic relationships	19-21
Caring as therapy	21-23
Classification of therapeutic nursing practice	23-27
Testing nursing interventions and research-based practice	27-28
Therapeutic touch and non-traditional therapies in nursing	28-30
Chapter Three: Method and Study Design	32-61
Part One: Focus group method	32-51
Focus group method	32-35
Validity, reliability and trustworthiness in focus group method	35-37
Methodological strengths and limitations	38-39
Application of the method	39-44
Data recording	45

Data analysis	45-49
Comparison with other methods	49-51
Part Two: Focus group method and the therapeutic nursing study	53-62
The study	53-58
Data recording and transcription	58
Data analysis	58-59
Reporting the data	59-60
Customer feedback	60-61
Chapter Four: Data analysis	62-108
Part One: Focus group data	63-93
Coaching: face-to-face leadership with the team	66
Smooth Operations	67-69
Welcome to the team	70-72
Coaching: face-to-face leadership with the individual	73
Paying attention to people	74-80
Enabling others to act	80-84
Bringing out the best	85-90
Coaching: face-to-face leadership with the family	91
Making room for others to contribute	92-93
Sponsoring	93
Part Two: Customer data analysis	94-108
Coaching: face-to-face leadership with the team	96
Welcome to the team	96
Smooth Operations	96-98
Coaching: face-to-face leadership with the individual	99
Paying attention to people	100-102
Enabling others to act	103-104
Bringing out the best	104-105
Summary	106-108

Chapter Five: Discussion	109-148
Study design and method: strengths and limitations	110-112
Trustworthiness, validity and reliability	112-115
Discussion of findings	116-134
Coaching: face-to-face leadership with the team	
Teamwork	117-118
Nursing leadership	118-119
Collaboration	119-120
Coaching: face-to-face leadership with the individual	121-122
Trust, control, self-awareness and respect for the individual	122-130
Coaching: face-to-face leadership with the family	131-134
Summary	135-143
Leadership and management: the nurse: coach	136-139
Coaching in the sports context	139-140
Teaching: the nurse: coach	140-142
Relationship: the nurse:coach	142-143
Development of a model of therapeutic nursing practice in the rehabilitation specialty	144-148
Chapter Six: Study findings and conceptual models	149-154
Chapter Seven: Conclusion	155-158
Implications for practice, education and further research	157-158
Appendices	159-175
References	176-182

List of Tables

Table 1:1	Tasks and functions of the nurse in the rehabilitation setting	9
Table 1:2	Healing or caretaking - which will it be?	14-15
Table 4:1	Summary of categories from nursing focus group data	65
Table 4:2	Summary of categories from customer questionnaire data	95
Table 5:1	Coaching: face-to-face with the individual. Nurse and customer categories	121
Table 5:2	Family: nursing and customer categories	131
Table 5:3	Role of the coach in relation to performance and relationship	135
Table 5:4	Role of the coach in relation to performance and relationship (the study)	135

List of Figures

Figure 5:1	The Nurse:Coach Model: Face-to-face Leadership	145
Figure 5:2	Essential constituents of the nurse:coach role	146

Chapter One

INTRODUCTION

Background to the study

Nursing has been involved in the rehabilitation of people throughout its history. Focusing on **cure** as the optimal outcome of nursing, Florence Nightingale (in Taylor, 1992) described nursing as an activity focused on assisting the patient towards *full* recovery. More recently, Derstine (1992, p.4) described rehabilitation from the standpoint of **adaptation** to illness or disability as follows:

...an ongoing process that begins with prevention of further deterioration at the acute onset of a disability or illness, and continues as individuals adapt to their disabling conditions and ultimately reach their maximum potential...

This definition presented rehabilitation as a continuum, acute illness being at one end, and the achievement of maximum potential through adaptation at the other. Myco (1984) presents a similar definition, reiterating the concept of rehabilitation as a process of adaptation with the aim of maximising the potential of an individual.

Whether to achieve cure or adaptation to the illness or injury, therapy is central to the process of rehabilitation. Indeed it is argued that therapy is the *raison d'être* of rehabilitation. Whilst other disciplines such as physiotherapy, occupational therapy and speech/language therapy are by definition engaged in therapy, nursing is still developing indicators which will express its unique and therapeutic contribution to improving patient outcomes. It is important for improving patient outcomes in rehabilitation and for the evaluation of nursing practice that nurses develop therapeutic indicators, given that cost-benefit and patient outcome are central themes for health care agencies towards the year 2000 (Marwick, 1996).

Historically there has been an inherent assumption in the work of many nurse scholars that nursing activity is explicitly and inherently beneficial and therapeutic. Indeed, scholars might argue that the term 'therapeutic nursing' is an oxymoron. Hockey (1991, p.xiv) would go some way along this line of argument. With a long career in nursing spanning 50 years, she suggests that nursing activity over the past few decades has been demonstrated to have had a positive impact on patient health without the using the word therapeutic in roles or titles. She makes the following wry comment:

In the specific context of therapeutic nursing, the healing effect of many conventional nursing activities, such as information giving, has been demonstrated without necessitating the introduction of 'information therapist' (p.ix).

There is certainly merit in this argument. However, there is little room for complacency in the current health care environment, focused on gaining maximum benefit from the health care dollar. Discussed below are some of the constraints and imperatives that influence nursing practice in the health sector today. These present opportunities and challenges to focus specifically on the beneficial effects of nursing and the key role that nurses play in maintaining a healthy population.

Cost constraints

Health care organisations are restructuring and dismantling roles and replacing them with structures which cost less, sometimes presenting the public with compromised quality and quantity of care (Manchester, 1996). Nurses are responding in survival mode without always having a clear understanding of the benefits that their skills bring to patients.

Ethical imperatives

As the cost of health care increases with new technologies, improved survival following injury, and an ageing population, rationing of health care resources is a feature of the late twentieth century. Funding agencies are looking for cheaper and more effective ways of providing health care (English, 1997).

Addressing the tenets of traditional health care ethics, to 'do no harm' is not enough and the luxury of *assuming* that health care professionals do good is not a tenable position in today's health care environment. 'Doing good' is a social and governmental mandate and there is a need to make the good that one does transparent to consumers and to purchasers alike.

Maximising benefit

As Nightingale described, the role of the nurse in healing is not new. However, the means of demonstrating the impact of nursing on patient outcome is through applied research in the discipline, and this is a developing field for nurses. There is a need to identify and distil the therapeutic role of the nurse through research and education in order that nurses may focus on improving the outcome for patients. By failing to evaluate and reflect on practice, nurses risk practising nursing which is custodial rather than transformative, focusing on maintaining rather than transforming health status.

Evaluating nursing practice

Evidence-based practice and outcomes research are familiar concepts in the rhetoric of purchasers and providers of health care (National Advisory Committee, 1997). Nursing is no exception to this drive to demonstrate effectiveness and it is argued that nursing practice should be evaluated through assessing patient outcome. Outcome may be measured in a number of ways, for example, prevention of ill-health or injury, improved quality of life, reduced morbidity and mortality, shorter length of stay in hospital, earlier return to work, and increased independence rather than dependency on health care professionals. Without effective models to describe transformative nursing practice that are relevant and applicable to practice, it is impossible to develop evaluation tools. There is a need to demonstrate the benefits of rehabilitation nursing practice.

The Study

The therapeutic contribution of most disciplines in rehabilitation is clearly understood and recognised but the nursing role is less clearly understood. This is evident from the literature and from practice within the service. For example, therapists in the team collect measurable and specific information about their input into rehabilitation programmes. There is no such mechanism of recording nursing input. There is therefore a need to understand more about nursing as a therapeutic activity. When the therapeutic work of nursing in rehabilitation is made more transparent to nurses and to their colleagues, nurses are enabled to focus specifically on activity which is of a therapeutic nature and consequently offer nursing which is specifically rehabilitative.

The **aim** of the current study was to develop a transparency around nursing activity in the general rehabilitation sub-specialty which is specifically therapeutic, with a view to optimising the amount of therapeutic nursing activity which customers will receive in their rehabilitation programme. General rehabilitation is a new sub-specialty in New Zealand. Already there is a body of nursing knowledge related to the neurological sub-specialty, (particularly stroke and traumatic brain injury where patients' needs related particularly to cognitive deficit), but less in relation to the general area of rehabilitation where the needs are more general.

The **purpose** of the study was to enable nurse participants to recognise their therapeutic role and to practice in this role more often and more consistently. The purpose was not to explore *all* aspects of nursing activity. This was neither within the scope of the study, nor necessarily consistent with the central concept of the study, namely activity which is therapeutic.

About the study setting...

Individuals treated within the organisation are referred to as customers, the reason being that the service philosophy focuses on meeting the unique needs and expectations of the individual. The term is currently under review. The service is one year old and has been set up in what was a

residential/slow-stream rehabilitation environment. Approximately three-quarters of the nursing staff in the General Rehabilitation Team transferred from the previous service, and all of the remaining team members were employed at the start of the new service. The role of the keyworker, often taken by a nurse has an important organisational function. The keyworker chairs rehabilitation planning meetings and co-ordinates services, and provides the customer with the opportunity to actively participate in planning their own rehabilitation programme. The researcher was the team leader of the team with a keen interest firstly in researching within the sub-specialty of general rehabilitation (this immediately limited study setting options), and secondly in facilitating research in the team. The dual role of researcher and team leader presented ethical issues and these needed to be addressed (this will be discussed in more detail in Chapter Two).

The practice setting consists of three teams - two inpatient teams consisting of a General Rehabilitation Team (GRT) (participants for the study were recruited from this team) and a Neurological Rehabilitation Team, and a Community/Outpatient Team. The GRT has 16 beds and customers are admitted with a range of diagnoses including musculoskeletal injury, amputation, burns and some neurological conditions. The team includes 20 nursing staff and 12 therapy and support staff. Referrals for rehabilitation are retrieved from the acute tertiary environment and from the community.

About the Thesis...

Chapter One provides an introduction to the thesis. **Chapter Two** presents an overview of the literature which relates to the role of the rehabilitation nurse, the concepts of therapy and healing, and to models of therapeutic nursing practice. A number of conceptual models have been described in the literature which specifically present nursing as therapeutic and these are described. The American literature presents classifications of nursing diagnoses and therapeutic interventions. These are discussed, and followed by a description of experimental nursing practice in the area of patient

education and clinical practice that have been demonstrated to have a positive effect on patient outcome.

Chapter Three is presented in two parts for the sake of clarity. Part One examines aspects of the chosen research method, namely Focus Group Method. The historical background and definition of the method is described, and validity, reliability and trustworthiness issues are discussed. Importantly, the strengths and limitations of the method are presented in the context of other possible methods. Finally, data analysis approaches are described. Part Two applies the method to the current study and justifies its selection on the basis of its suitability to the research question and the study context. The ethical issues which were inherent in the selection of the method are discussed, as is the strategy which was adopted to address these issues. The proposed data collection and analysis approaches are presented.

A description of the data analysis is presented in **Chapter Four**. Thematic Analysis was selected as the analysis method, and quotes and exemplars from the data are presented in support of the author's interpretations. The principle theme that emerged was that of the nurse as coach. The data presented the nurse:coach as a leader in the team, and in the relationship with the individual and with the family of the individual. The nurse:coach role is one of face-to-face leadership with the team, the individual and the family and a number of sub-themes support this interpretation of the data. These are presented and discussed.

Findings from the customer data, albeit a small part of the data as a whole support the development of themes from the nurse participant data. These emerged spontaneously rather than by thematic sampling from the nursing data. There was strong correlation between both data sets.

Chapter Five presents a discussion of the strengths and limitations of the study design as well as a discussion of findings from the research. The choice of a coaching model is justified by reference to the coaching literature. The

emergence of the nurse:coach as a face-to-face leader in the team is supported by reference to the literature on aspects of teamwork. The main issues which emerge from the coaching relationship with the customer are trust, locus of control, self-awareness and respect for individuality. Some of these elements are also essential in the relationship between the family and the nurse:coach. Emerging strongly from the data was a demonstration of the interface between the nurse as a therapeutic agent, and the team, the individual, and the family. This led to the development of a new model for rehabilitation nursing. This is presented at the end of Chapter Five.

In **Chapter Six** the study findings are discussed in the light of the conceptual models described in Chapter One and, although there is some resonance with many, one in particular was noted to reflect the findings of the study.

Chapter Seven provides a conclusion to the study, including implications for practice, education and further research. Not surprisingly, a number of further research questions emerge from the findings.

Chapter Two

LITERATURE REVIEW

Introduction

The concept of nursing as therapy is the foundation of this study. The nature of nursing as it is currently understood in the rehabilitation literature will be described and the need to understand the therapeutic role of nurses in rehabilitation will also be discussed. Definitions of healing and therapy are presented. Conceptual models of therapeutic nursing will be described, as will classifications of nursing practice and an overview of research-based practice from traditional and non-traditional perspectives.

The Role of the Nurse in Rehabilitation

The role of the nurse in rehabilitation is seen by nurses and the interdisciplinary team as important but unclear. Tasks and functions of the nurse described in the literature are outlined in Table 1:1.

TABLE 1:1. Tasks and functions of the nurse in the rehabilitation setting

<i>TASK/FUNCTION</i>	<i>AUTHOR/DATE</i>
co-ordinator	Hahn (1988) O'Connor (1993) Benson & Ducanis (1995)
collaborator	Brillhart & Sills (1994) Benson & Ducanis (1995)
educator	Gillies (1987) Brillhart & Sills (1994) Benson & Ducanis (1995)
critical thinker	Benson & Ducanis (1995)
assistant to the client in developing to fullest potential	Myco (1984) Derstine (1992) Gibbon, Salter, Pierce & Govoni (1995)
rehabilitator par excellence	Henderson (1980)
assistant to the physician	Henderson (1980)
interviewing and assessment developing goals discharge planning	Brillhart & Sills (1994) Gillies (1987)
bowel and bladder management	Myco (1984) Gender (1989) O'Connor (1993)
communication	Gillies (1987)
counselling and support	Gillies (1987) O'Connor (1993)
physiotherapy assistant	Myco (1984)
prevention of pressure sores	Myco (1984)
understudy to other health workers in their absence	Waters (1986)
spiritual care	Davis (1994)

Although the tasks and functions of rehabilitation nurses have been outlined in the literature, little work has been done to demonstrate the extent to which these tasks and functions effect an improvement in health outcomes. One study however has begun to address this gap in the literature.

In a comprehensive study of 312 English-language articles investigating the role of the nurse in stroke rehabilitation, O'Connor (1993) described a managerial or understudy role for nurses that is therapeutically non-specific. The managerial aspect of the role essentially stems from the 24 hour responsibility of the nurse but includes discharge planning and social aspects of care. The understudy role on the other hand, is actively carried out in the absence of other health workers, for example physiotherapists and speech language therapist. O'Connor indicated that the nurses' role as an independent practitioner with a specific contribution to the rehabilitation team has still to be developed. Neither this study nor any other study found in the literature addresses the role of the nurse from the viewpoint of the patient.

O'Connor's study gives rise to several questions. For example, is it important that nurses in the rehabilitation team have a specific therapeutic role? If so, why? Is a co-ordination or understudy role any less significant to patient outcomes than a therapeutic role? Why do nurses need to be identified as independent practitioners in the team?

These are legitimate questions. In seeking to address them, several other questions need to be asked. For example, is it possible to say with confidence that a managerial or understudy function fully describes the role of the nurse in rehabilitation? If not, what other features of the role are important and why? What impact does this managerial or understudy role have on patient outcomes? What is significant to the patient about the role and functions of the nurse?

Until the nursing role is made more transparent, and the expectations of the patient of that role are more clearly understood, the answer to these

questions will elude all to whom it is important. The purpose of this current study is to provide some answers to these questions. A starting point is to begin by defining the terms 'therapeutic' and 'healing'. What is really meant by the terms and why are they important?

Defining therapeutics and healing

Therapy is described as a process of healing commonly associated with medicine and other health care disciplines (Hockey, 1991), and recognised to be involved in moving a patient towards independence and wellness. Therapeutics is a concept traditionally associated with medical practice, but is also an important part of the health practice of other disciplines. Hockey (1991, p.x) described therapeutics as a science and as 'curative' or 'of the healing art'. Buchanan (1994, p.190), quoting the Webster's New Riverside University Dictionary definition of therapeutics, described therapy as the 'administration of healing to treat illness or disability'.

The process of healing or curing often occurs in response to planned curative interventions by doctors and other health professionals, and healing is commonly understood in this sense. However, healing often also occurs as a result of the body's own natural resources and can be enhanced by appropriate interventions of health professionals. For example, prior to the advent of antibiotics, nurses were able to enhance the body's natural healing processes by using strategies designed to assist the physical, social and emotional body mobilise its own defences. These strategies included providing comfort, chest percussion, nourishment and postural drainage (McMahon, 1991, in McMahon & Pearson, 1991).

Taylor (1995) suggests that healing is not always the same as curing or enhancing of natural processes. Indeed, the process of healing may not even end in an outcome which is traditionally thought of as therapeutic. Instead, she describes healing generally as a positive experience in which an individual is moved towards health or a peaceful death. Ultimately, the person advances towards a fuller sense of self. According to Hockey (1991), healing

and health should be regarded in this broader sense - as multidimensional including physical, emotional, spiritual, mental and environmental aspects. This will include a range of outcomes, extending beyond the traditional interpretation of healing as cure.

If then, healing can be understood as a multidimensional approach to illness or disability, then therapeutic nursing is nursing which results in a movement towards health (Hockey, 1991) or, as McMahon (1991, p. 122) suggests, is 'nursing that *deliberately* has beneficial outcomes for patients'. In other words, healing is not simply a by-product of nursing care, but a specific goal of nursing activity. Healing may be facilitated in part through the experience of relating to the nurse as a human being, rather than as a distanced professional.

A number of authors have conceptualised nursing within a therapeutic framework and presented nursing as a unique activity from which patients will specifically benefit. These are discussed below.

Conceptual models of therapeutic nursing

The following conceptual models will be discussed:

- Professional nursing practice
- Primary nursing
- Case management
- Therapeutic relationship in nursing
- Caring as therapy

Lydia Hall: 'Professional Nursing Practice'

Over 30 years ago Lydia Hall wrote about nursing as a unique therapeutic activity. Hall (1964) was responsible for setting up a nurse-led rehabilitation unit, the Loeb Centre in New York, in 1963. She demonstrated a model of professional nursing care which describes the nurse as a facilitator of health. In the model, the nurse assisted in moving the patient towards self-awareness and autonomous decision-making during the rehabilitation phase of an illness

or injury. This was achieved via the process of intimate bodily caring, during which a transformative relationship was developed between patient and nurse. Such a transformative relationship was facilitated by transformative nursing practice which Alfano, a colleague of Hall's at the Centre some years later, described in more detail. Alfano (1971) developed the concept of the professional nurse expressed in terms of behavioural characteristics. Professional nursing, in sharp contrast to the behavioural characteristics of the task-oriented nurse, set the professional nurse apart as a therapeutic agent (see Table 1:2).

TABLE 1:2 (From Alfano J.G. (1971). Healing or caretaking - which will it be? Nursing Clinics of North America, 6 (2), 273-280)

Aspect of nursing practice	Task-oriented nurse	Professionally-oriented nurse
Intimate bodily caring	Technical measure to produce comfort	Opportunity for nurturing i.e. fostering growth, healing and learning.
Use of non-professional assistants	Substitute for nurses	Utilises nurse assistant while still working directly with patients
Role in interdisciplinary team	Nurse acts as scheduler. Little opportunity to incorporate suggestions of other therapists in nursing activities	Other therapists act as resource to nurses. Nurse acts as 'final effector'. Incorporates suggestions of other therapists in practice. Acts as team leader.
Recording of patient activity	Emphasises biophysical aspects and nursing tasks	Incorporates biophysical aspects in relation to patient feelings, activities and behaviours.
Location in time	Concerned with immediate treatment	Integration of past and future in current treatment planning.
Organising care	Task- and routine-oriented	Flexible routines in relation to requests and concerns of patient
Emphasis of care	Medicalised i.e. focus on medications, treatment and assisting physician	Patient-focused. Emphasis on concerns, goals and feelings of patient and family.
Preventative care	Focus on current disease process. Concerned with prevention of cross-infection, complications and recurrence.	Concerned with all of above, with emphasis on family wellness and prevention of new illness.
Role of family	Family regarded as a complicating dimension to nursing workload	Sees family as participants in care.
Addressing patient concerns	Sets limits on patient expression. Adopts a 'could have been worse' approach. Uses diversional tactics. Discourages expression of negative feelings.	Helps patient explore feelings and develop clarity about own personal limits and feelings.
Workload management	Workload divided by task.	Assumes responsibility for complete

	Hierarchical approach to workload assignment. Registered nurse handles more complex treatment for 8 hour shift.	care over 24 hours.
Environmental atmosphere	Pressured, hurried, depersonalising	Unhurried, patient-focused
Patient teaching	<ul style="list-style-type: none"> • minimum teaching of patient and family, often delivered by unskilled nurse assistants • focused on facts, and less conducive to learning • done at discretion of nurse • encourages conformity • emphasis on early discharge and safety 	<ul style="list-style-type: none"> • emphasises listening and reflecting. Includes evaluation and follow-up • facilitates use of patient's own ability, strength and knowledge • emphasis on patient's concept of self and safety
Relationship with doctors	Carries out doctor's orders	Acts as advocate for patient
Relationship with patient	<ul style="list-style-type: none"> • expectation that patient behaviour will be polite, courteous and co-operative • concerned to find out about patient; gathers data • sets goals for patient • fragmented approach to care • wears uniform • does not mask own feelings 	<ul style="list-style-type: none"> • allows patient to behave as he wishes, short of physically abusing self or others • concerned to facilitate patient finding out about nursing with less emphasis on nursing diagnoses or care plans • patient sets own goals • integrated approach to care • may or may not wear uniform • learns to vary behaviour through self-awareness and self-knowledge
Staffing	Concentration of staff during the day	Same number of staff assigned to evenings as to day
Organisational structure	Authoritarian	Liberating, democratic

The underlying assumption of Alfano's model of professional practice was that:

1. the patient was central to delivery of care rather than the mere recipient of nursing practice
2. professional nursing was therapeutic nursing

According to Alfano, task-oriented practice led to a type of care, described as caretaking, which safeguarded and maintained the health status of clients. Professional nursing, on the other hand led to healing and an active reversal of a process, in addition to the safeguarding aspects of care. Professional nursing was therefore described as a therapeutic or healing activity.

Primary Nursing

A more modern system of nursing described as Primary Nursing has as its core value the centrality of the patient. This system facilitates the nurse acting in a therapeutic or 'professional' way, rather than a task-oriented way, and embodies the principles of Hall's model of nursing practice. As Hockey (1991, p. xiii) suggests:

...primary nursing exploits the advantageous position of nurses in relation to their constancy, continuity and the confidence their patients give them. In itself, it does not guarantee therapeutic effects.

Primary nursing is a system or model of nursing care delivery, and operates on four principles (George, 1990). The primary nurse:

- has responsibility for the quality of care delivered to a patient at all times for the duration of his/her period in care
- is responsible for nursing decisions which are made
- delegates care to an associate in the absence of the primary nurse
- facilitates effective communication (Pearson, 1989)

The primary nurse approach ensures that an individual can identify one particular nurse who is responsible for the entire episode of nursing care. As a result, it increases the opportunity for the development of a therapeutic nurse-patient relationship.

Primary nursing was instituted in an experimental Nursing Development Unit (NDU) in 1981 in Oxfordshire (Pearson, 1989). The design of the experimental unit was based on the system used at the Loeb Centre and patients were admitted for nursing treatment to dedicated nursing beds. The unit was set up to test the hypothesis that primary nursing in a nursing unit would demonstrate therapeutic effects and improve patient outcomes. The underlying assumption about this therapeutic nursing practice was that the core therapeutic nursing roles were caring and nurturing (Griffiths, 1995). Results demonstrated that the unit was successful in promoting recovery, increasing quality and conserving costs (Pearson, 1989; Pearson, Durant & Punton, 1989). The findings of the experimental unit study supported the practice of primary nursing based on diagnosis as an indicator of suitability for admission, but was less specific about the nature of therapeutic nursing in relation to patient outcomes. It did not specifically test the assumption that therapeutic nursing was fundamentally about nurturing and caring. The extent to which the core therapeutic roles of caring and nurturing effected the improvement in patients was not explored.

Predicting the need for therapeutic nursing

The nature of therapeutic nursing within a Nursing Development Unit context was explored further in a more recent study (Griffiths, 1995). A Nursing Development Unit (NDU) was set up in 1993 at King's College Hospital in London. The underlying assumption of the King's College study was that health needs are not synonymous with medical needs, nor medical diagnosis necessarily a useful indicator of the need for nursing or admission to a nurse-led unit. Although there were large identifiable diagnostic groups amongst patients who were referred to the NDU (primarily diagnoses related to neuromuscular and musculoskeletal deficits, diabetes, wounds, infection and other secondary diagnoses including psychosocial or cognitive impairments), diagnostic information alone was thought to be of limited value in identifying suitable clients.

In the study, patients were admitted to the ward on the basis of their *nursing needs* rather than *medical diagnosis* (N.B. medical diagnosis was used as an admission indicator in the Pearson study). The definition of nursing needs were needs that required independent nursing intervention, or interventions under the co-ordination of the nurse. A nurse and a medical consultant screened patients in the acute care setting for admission to the nurse-led unit using a taxonomy for nursing need. The taxonomy of nursing needs had been developed from a pilot study using a survey of medical in-patients prior to the opening of the NDU.

The taxonomy of nursing needs included:

- education
- nurturing (non-specific caring to enhance natural recovery)
- nutrition/feeding
- psychological needs (disturbance of mood owing to hospitalisation or impairment which affects mood)
- rehabilitation (related to mobility)
- social problems
- symptom control
- TLC ('tender loving care' related to a terminal condition)
- wound care

The study revealed that 56% of patients were referred for rehabilitation alone by the referring consultant. The referring nurse however, identified rehabilitation in association with two or three other nursing needs in most cases. Referring nurses used the 'other needs' categories more frequently than did the consultant. It was argued that, were nursing needs rather than medical diagnosis used to identify suitable patients for the NDU, many more referrals would potentially be made to NDU's. The author argued that 'it may be that a measure of functional status would predict the need for therapeutic nursing better than diagnosis' (Griffiths, 1995, p.35).

Case Management

Primary nursing shares some of the characteristics of Case Management, an approach which has been developed within the managed health care environment of the 1990s. The Case Manager oversees or manages the entire episode of hospitalisation or treatment, including nursing and all other interventions. The case manager is often an advanced practitioner nurse (a nurse with knowledge, education and experience in a specialty), or may be another health care professional or administrative employee of a Health Maintenance Organisation (HMO). The principles of managing an individual patient's care are similar to Primary Nursing. However, Primary Nursing is fundamentally different in that it involves an experienced nurse managing only the nursing care component with the help of associate nurses.

Therapeutic Relationships in Nursing Practice

Another important contribution to the therapeutic nursing literature is the work of Taylor (1992, 1994, 1995) on therapeutic relationships in nursing. Taylor argues that the concept of therapeutics in nursing has taken on a disease-curing connotation, the perceived domain of medicine, leaving caring to nurses. Caring however, has been conceptualised within the psychoanalytic paradigm. In order to be therapeutic within this paradigm, there must be a 'professional' distance maintained in the relationship. The effect of distancing in the nurse-patient relationship, argued Taylor, has been to remove what is essentially therapeutic about nursing. In creating models founded on this approach, nurse scholars have 'tended to dispossess nurses of their essential humanness' and have created a polarity of human characteristics between nurses and patients (Taylor, 1992, p.65).

Instead, Taylor argued that nursing work requires a strong identification or affinity with people as human beings, rather than the distancing which is detectable in the work of nurse theorists. The very nature of therapeutic nursing rests in the quality of the nurse-patient relationship. A sense of shared affinity is a phenomenon in nursing which Taylor described as the 'ordinariness' of nursing, the characteristics of which describe the closeness

of a therapeutic nurse-patient relationship. Ordinariness in nursing is constituted by three qualities. These are **presencing**, **concern** and **authenticity** (Taylor, 1995, p.100).

- **Presencing** describes the process whereby a nurse makes him/herself available to the patient by a process of human relating, acknowledging the shared humanity of both individuals.
- **Concern** in the nurse-patient relationship brings attributes such as sensitivity, encouragement, endurance and empowerment to nurse-patient encounters.
- The nature of **Authenticity** is such that the nurse allows his/her own vulnerability to be revealed in the relationship, allowing in turn, the patient to reveal his/her vulnerability. The concept of a 'bedside manner' represents the antithesis of authenticity, and effectively shields the nurse from exposure to a therapeutic relationship, including the risks inherent in any self-disclosure.

Herzoff, Stoklosa and Tierney (1981) define therapeutic not only as the curing and healing of both physical and psychological wounds, but extend their definition to include the therapeutic possibilities inherent in the nurse-patient relationship, as does Taylor. A nurse-patient relationship in which the nurse relates to the patient as a human being can create feelings of acceptance, and acknowledgement for the patient. The nurse requires three skills, which are:

- self-awareness
- the use of therapeutic listening (bringing to the encounter the nurse's own interest and concern, combined with specific communication skills)
- a therapeutic milieu (a context which will facilitate the nurse's own self-awareness and development).

The importance of the quality of ordinariness, along with the skills which a nurse brings to the nurse-patient relationship are expressed succinctly by Wright (1991, p. 106):

Therapeutic nursing may include medico-technical or instrumental skills, but at its heart lies the expressive skills. It is the latter which the patient often sees as "real" nursing, and about which he or she complains most bitterly when it fails.

Wright (1991, p.107) goes on to suggest that:

The high touch skills of nursing - the comforting, supportive skills - in some cases have been delegated to support workers or auxiliaries, leaving the nurse to perform the high-tech skills. Yet without them, the patient may be treated but is not healed and feels alone and abandoned as a person... those acts often dismissed as basic, are actually complex, intricate and valuable elements in their own right.

These expressive or high touch skills of nursing can be understood to constitute the **ordinariness** of nursing or, as some authors would argue, the essentially **caring** nature of nursing (Watson, 1985; Leininger, 1988).

Caring as therapy

The concept of caring in nursing has been widely discussed by authors. Nurse scholars have argued that caring can be described as either an ethic or role virtue, a science or the essence of nursing (Radsma, 1994). Most authors would agree that caring for patients is likely to be beneficial. Curzer (1993) however, argued that, as a role virtue, health care professionals should *not* care, and that caring can ultimately harm the health professional and the patient. He suggested that instead, health care professionals should show benevolence and perform caring actions in much the same way that caring has already been discussed as a therapeutic activity in nursing (Griffiths, 1995). McMahon (1991) concurs with Curzer by suggesting that, instead of being a positive or transformative activity, caring can be passive and custodial in nature. Debate about the nature of caring in nursing still continues.

The concept of caring as a central theme of nursing has been expressed in an objective measure which has been used to examine the nature and impact of caring on patients [Parsons, Kee & Gray (1993); Cronin & Harrison,

(1988)]. Cronin & Harrison (1988) have argued that effective caring promotes health and a higher level of wellness and can help patients cope with stress more effectively. Defining caring, the authors describe a process by which a nurse relates to a patient as a unique individual. Caring behaviours are those behaviours which communicate caring to the patient, and may be either caring words or caring actions (Cronin & Harrison, 1988). The authors tested this premise using the Caring Behaviours Assessment instrument (CBA) based on Watson's ten 'Carative Factors' (Watson, 1985). These are:

1. formation of human-altruistic value system
2. instillation of faith and hope
3. cultivation of sensitivity to self and others
4. development of helping-trust relationships
5. expression of positive and negative feelings
6. creative problem-solving caring process
7. promotion of transpersonal teaching/learning
8. supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. assistance with human needs
10. allowance for existential-phenomenological-spiritual needs

The Cronin & Harrison (1988) study applied the CBA to identify those nursing behaviours perceived as indicators of caring by patients who had had a myocardial infarction. This group of patients were of special interest to the authors because they are particularly affected by the physiological responses to stress, responses which may be mitigated by the deliberate implementation of caring behaviours. Results of the study indicated that those behaviours perceived to be most indicative of caring were associated with monitoring of the patient's condition and demonstration of professional competence.

Parsons, Kee & Gray (1993) used the Cronin & Harrison (1988) study to compare the results of their own study of nursing caring behaviours described by post-operative patients, again using the Caring Behaviours Assessment instrument (CBA). Results revealed remarkable similarities between both

studies in that characteristics thought to be most important and those considered to be least important were very similar in both studies. The authors concluded that patients who perceive that they are 'cared for' may be better prepared to undergo the stress of surgery than those who do not experience caring behaviours on the part of nurses.

Classification of therapeutic nursing practice

Nursing diagnoses and nursing interventions

Expressing the independent and therapeutic effects of nursing remains a challenge which has been reflected in the move towards measurement of quality and impact of nursing care. Pressure to demonstrate positive outcomes has been driven by the public, and by reimbursement agencies (companies which fund health providers through insurance packages) in the USA (Brooten & Naylor, 1995). This pressure has been important for nursing in developing indicators for practice.

The development of nursing diagnosis in the 1970's was a major move towards a description of indicators for practice. A nursing diagnosis is 'a clinical diagnosis made by a professional nurse that describes actual or potential health problems which the nurse, by virtue of her education and experience is capable and licensed to treat' (Bulechek & McCloskey, 1985, p.1299).

Several studies have examined the frequency of use of certain nursing diagnoses in a rehabilitation setting, and suggest that nursing diagnoses assist in defining the unique nature of the specialty, facilitate the development of standards and guidelines (Sawin & Heard, 1992) and generate more systematic careplanning and further development of creative critical thinking in practice (Pierce, Rodrigues-Fisher, Buettner, Camp & Bourguignon, 1995).

Sawin & Heard (1992) conducted a study to identify the most frequently used nursing diagnoses in the rehabilitation specialty. A convenience sample of rehabilitation nurses attending a rehabilitation nurses conference was

compared with a randomly selected sample of 110 nurses from the Association of Rehabilitation Nurses. The same pattern of most frequently used diagnoses emerged from both convenience and randomly selected groups. Results indicated that 89% of nurses used nursing diagnoses in their practice. Diagnoses used most frequently by the largest percentage of nurses reflected physical care. The types of diagnoses reflected the practice settings and the stage of rehabilitation e.g. the first year following spinal cord injury (acute rehabilitation) versus subsequent years (community-based setting).

The 10 most frequently cited diagnoses were:

- impaired physical mobility
- self-care deficit
- alteration in urinary elimination pattern
- alteration in bowel elimination pattern
- impaired skin integrity
- potential for physical injury
- knowledge deficit
- impaired verbal communication
- decreased activity tolerance
- ineffective family coping

The next most frequently cited were:

- health management deficit
- impaired thought processes
- ineffective individual coping
- non-compliance
- alteration in nutrition: less than required
- body image disturbance
- uncompensated swallowing impairment
- alteration in comfort

The following are the less frequently used:

- sleep pattern disturbance
- fear/powerlessness

- independence/dependence conflict
- diversional activity deficit
- sexual dysfunction
- fluid volume deficit
- dysfunctional grieving
- altered sexuality pattern
- alteration in nutrition: more than required
- pain: self-management deficit
- spiritual distress
- fluid volume excess
- social isolation

Of the total participants in the study, 42% worked in hospital/medical centre rehabilitation units and 31% worked in free-standing rehabilitation facilities. Others included insurance company employees, private companies or practices, long-term care facilities, community, home health care agencies and educational institutions. Limitations to the study included missing or unusable data and a small response rate (35%) from the random group.

Pierce, Rodrigues-Fisher, Buettner, Camp & Bourguignon, (1995) conducted a retrospective study of the clinical record, of 100 patients who had had a stroke and were admitted to a large rehabilitation centre during a one year period. The mean age was 46 years. Of the 100 participants, 51 were male and 49 were female and the mean length of stay was 34 days. Nursing diagnoses most frequently used were

- impaired mobility
- self-care deficit
- potential for injury
- knowledge deficit
- ineffective individual coping
- alteration in nutrition

Other diagnoses used included:

- impaired communication
- urinary incontinence
- impaired skin integrity
- disturbance in self-caring
- alteration in bowel elimination
- ineffective airway clearance
- alteration in comfort: pain
- alteration in thought
- impaired gas exchange
- powerlessness
- sleep pattern disturbance

Often the same diagnoses were valid on both admission and on discharge.

Snyder (1992) has been involved in the development of independent nursing interventions which constitute an integral relationship with nursing diagnosis. She claims that a unique body of knowledge in the practice and therapeutics of nursing can be identified through the classification of independent nursing interventions. Indeed, Snyder has stated that, in the interests of remaining competitive in securing reimbursement from health care insurance companies, there is a need to identify and describe nursing interventions within a formal framework or classification.

The purpose of developing nursing interventions is to describe the work that nurses do, serving as a common language with which to communicate. The extent to which these interventions are therapeutic has been explored by nurse scholars who use nursing diagnoses and nursing intervention taxonomies as a basis for developing knowledge about therapeutic nursing. Buchanan (1994, p.190) describes therapeutic nursing interventions as

'nursing actions and interactions, executed as part of the nursing process, with or for individuals and families, that are directed at influencing a measurable change in health status and quality of life'.

Buchanan advocated the development of a unit of study in nursing education called Therapeutic Nursing Interventions. This type of course would focus on the development and critical analysis of knowledge relating to specific nursing diagnoses, models for research utilisation and methods for implementation.

Testing the hypothesis that nursing interventions are therapeutic

Research - based nursing practice and improved patient outcomes

Whether or not independent nursing interventions are articulated in a formal classification, other authors support the claim that nursing interventions can positively influence patient outcomes. For example, Heater, Becker and Olson (1988) conducted a meta-analysis of nurse-conducted, experimental studies on nursing interventions, and patient outcomes. Intervention was described in the areas of behaviour, knowledge, physiology and psychosocial issues. The authors concluded that research-based nursing practice could produce improved outcomes for patients. Brooten and Naylor (1995) present a review of patient outcomes resulting from the interventions of advanced practice nurses in specialist areas such as cardiology, home health care, and client education. The results demonstrate significant gains in patient outcome, including impact on morbidity and mortality.

Example 1: a study conducted by Lipman (1986) examined the effect of education by a Clinical Nurse Specialist on newly-diagnosed children with diabetes. The children in the experimental group were discharged home 2.2 days earlier than the children taught by non-specialist staff nurses.

Example 2: Another study supported the evidence for improving patient outcomes (Ramsay, McKenzie and Fish, 1982). Patients suffering from hypertension received care from either a doctor or a nurse practitioner. After 12 months the group cared for by nurse practitioners had reduced weight and blood pressure more significantly than those receiving care from physicians.

Teaching is described as one of the most important nursing functions (McMahon, 1991). In studies where patients have received education from a nurse there has been a reduction in anxiety, improvement in health outcomes and decreased length of stay [Cupples, (1991); Hill, (1982); Schmitt & Woolridge, (1973); Lindeman & Van Aernam,(1971)]. Devine & Cook (1983) conducted a meta-analysis of effects of psychoeducational interventions specifically on length of post-surgical hospital stay. The interventions were of 3 types:

- information about procedures and related sensations
- skills training
- psychosocial support

The authors concluded that information from two or more types was significantly more successful in reducing length of stay than information from one type only. Hathaway (1986) also conducted a meta-analysis of pre-operative instruction on post-operative outcomes. The study demonstrated that pre-operative instruction has a positive effect on post-operative outcome, and that patients with high levels of anxiety benefited more than those having medium or low levels of anxiety.

Therapeutic touch and non-traditional therapies in nursing

Touch is an integral part of nursing and is a means of communicating from person to person. Touch has been shown to enhance positive, non-verbal responses in critically ill patients and, used in conjunction with verbal requests, can increase verbal and non-verbal responses. Touch has been demonstrated to be very important to women in labour (Talton, 1995).

Two conceptual models of touch are described below.

Tutton (1991) describes 4 types of touch:

Instrumental touch is deliberate touch made during a procedure e.g. mobility assistance

Expressive touch is spontaneous and has an emotional component e.g. hugging a distressed patient

Therapeutic touch focuses on the transference of energy from one person to another with the intention of healing

Systematic touch, defined as a purposeful manipulation of soft tissue with the intention of enhancing well-being.

Talton (1995) presents a model which discriminates between **task touch** and **caring touch**. Task touch is touch which is performed during the course of procedures. Caring touch, on the other hand, is a deliberate expression of support and comfort, which, for example, has been shown to lower blood pressure and anxiety levels.

Formal touch therapies such as therapeutic touch or reflexology require specialist training but are being used by nurses in the course of practice (McMahon, 1991; Quinn, 1989). Touch therapy is described as a secular version of laying on of hands, and was first introduced into nursing by Kreiger (Keller & Bzdek, 1986). Therapeutic touch need not involve actual physical contact with the body, but always requires contact with the energy field of the client. The application of therapeutic touch into nursing has been advanced on the basis of Roger's theory of unitary man, based on the philosophy of holism (Keller & Bzdek, 1986). According to Quinn (1989) the Rogerian theory assumes that 'people are open systems of energy and that an exchange or energy is the underlying dynamic by which therapeutic touch has an effect' (p.79).

Several nursing studies described by Quinn (1989) have demonstrated the therapeutic benefits of therapeutic touch including

- an increase in haemoglobin level
- increase in physiological relaxation
- decrease in state anxiety

Keller & Bzdek (1986) investigated the effect of therapeutic touch on tension headache pain in comparison with a placebo simulation of therapeutic touch. One group of subjects were exposed to therapeutic touch and another group exposed to placebo touch. Therapeutic touch involves the researcher using

the process of centering herself into a quiet, meditative state with a conscious intent to help the subject. After passing her hand 6-12 inches from the subject without actually contacting the body, she then let her hands rest around, but not on, the head or solar plexus in areas of imbalance or deficit. She then redirected life energy to the subject. In the placebo group the researcher simulated the therapeutic touch process, but did not use centering or focus on helping the subject. The researcher instead concentrated on mentally subtracting from 100 by 7s. Using the McGill - Mdzack Pain Questionnaire before, during and after the application of therapeutic touch and placebo touch, 90% of the therapeutic touch group subjects experienced a sustained decrease in headache, twice the average pain reduction of the placebo subjects. Quinn (1989) tested the hypothesis that the positive effects of therapeutic touch was a result of energy exchange. In her study, she was unable to demonstrate positive effects/energy exchange in a study of patients awaiting cardiac surgery. She attributed the lack of supportive evidence to the confounding effects of cardiac medication and some limitations of the study design.

Nurses are exploring a range of other therapies including aromatherapy, meditation, imagery, acupuncture, reflexology, applied kinesiology, yoga, biofeedback, Alexander techniques, macrobiotic diet, hypnosis, irridology and others (Hockey, 1991).

Summary

Rehabilitation nursing has been described in the literature in terms of tasks and functions. The extent to which the role is therapeutic has received little attention, although a managerial or understudy role is emerging. In this chapter, a review of conceptual models of therapeutic nursing practice has been preceded by a clarification of the terms 'therapeutics' and 'healing'. A number of models have been outlined. This has progressed into a discussion of classifications of therapeutic practice and research-based practice, followed by a review of nursing practice in the area of non-traditional therapies.

The following chapter deals with the methodological approach which has been selected for the study.

Chapter Three

METHOD AND STUDY DESIGN

The current study is concerned to examine the nature of therapeutic nursing in a general rehabilitation team. The Focus Group method has been selected as an appropriate method to address the research question, namely:

'What are the features of nursing in a rehabilitation environment which are thought by nurses and customers to be helpful in moving the customer towards a state of independence and healing?'

The Focus Group approach has been selected for a number of reasons. Firstly, the method is useful for developing insights from subjective data into a phenomenon that is poorly understood. The method can be used to develop theory and constructs (Morgan, 1991). Secondly, the method compares favourably to other methods, namely individual interview and participant observation. Thirdly, it has been used successfully in the rehabilitation context on other occasions to examine phenomenon in the specialty.

Part One of this chapter presents an overview of the essential aspects of the focus group method. Further justification for the selection of the method will be discussed in this part. In Part Two, the way in which the method has been used in the current study is discussed. Included in this part is a review of the collection and analysis of data from customers.

Part One: Focus Group Method

An overview of the focus group method is provided as follows:

- historical background
- definition
- method
- validity and reliability
- methodological strengths and weaknesses
- methodological issues
- data recording
- data analysis
- comparison with other methods
- application in rehabilitation context

Historical Background

The concept of focus groups as a research method has its origins in sociology, although it is now used extensively in marketing research. The emergence of focus group as a method began as social scientists questioned the directive role of the researcher and the passive role of the participants in social science studies (Nyamathi & Shuler, 1990). Evidence from the business literature suggests that focus group method has been used to develop insight into consumer behaviour and motivations. These insights have assisted in planning business strategies, developing new products, and in retail (Stevens, 1996). One of the earliest work by Robert Merton and his colleagues using a focus group method in the 1940s and 1950s examined the persuasiveness of wartime propaganda (Morgan, 1991).

Developing the use of the focus group in health care, there is a recognition that the method is useful in investigating the health-related behaviours and perceptions of groups identified by their sexual orientation, gender and social class characteristics (Stevens, 1996). The method is gaining increasing attention from physiotherapists (Sim & Snell, 1996) and from nurses in primary and public health care settings. The method has been used to

examine drug use behaviour (Anderson, 1996; Kearney, 1996), behaviours associated with HIV infection (Sowell, Moneyham, Guillory, Seals, Cohan & Demi, 1997; Strebel, 1996) and beliefs and practices related to organ donation (Exley, Sim, Reid, Jackson & West, 1996; Peters, Kittur, McGaw, Roy & Nelson, 1996). The increasing popularity of the method is consistent with the need to plan and implement services from a consumer rather than a provider focus.

Definition of the Focus Group Method

Focus group method is a type of qualitative research. The hallmark of the method is 'the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group' (Morgan, 1991 p.12). According to Kreuger (1994) there are four important constituents of focus groups. These are:

- a group of people
- assembled in a number of groups
- possessing several shared characteristics
- providing data
- of a qualitative nature
- in a focused discussion

The goal of focus group work, essentially a type of group interview, is to generate conversation on a specific subject in order to develop a greater understanding of the participant's perspective based on his/her experiences - what they think and why they think the way they do (Morgan, 1991). The method is useful for several reasons - firstly for developing hypotheses around informants' insights, secondly for evaluating research sites and lastly, for developing schedules for interviews or questionnaires.

The data from focus groups can be used to develop constructs and theory from the expressed attitudes and opinions of group members. The focus group approach offers participants a feeling of security derived from being in a group situation rather than being exposed to an individual interview situation

(Stevens, 1996). This allows for individuals, especially those who represent oppressed or minority groups, to express ideas and opinions with impunity.

The Focus Group Method

The focus group method is a qualitative research design. As a stand-alone method it is useful in developing genuine understandings of human behaviour. Used in conjunction with a quantitative approach it can assist in combining the subjective data with experimental data to create a fuller picture of the phenomenon.

Nyamathi & Shuler (1990) describe 3 approaches to the focus group design:

exploratory approach uses focus group method to test operational aspects of quantitative research, or to develop hypotheses for future research.

clinical approach describes the application of the method to the investigation of phenomena which are analysed from a clinical perspective.

phenomenological approach is adopted when the aim of the investigation is to understand the subjective experience of an individual.

Data fall into two types: *emic* data arises from a natural or indigenous form with minimal researcher imposition, and *etic* data are characterised by a high researcher involvement and direction. Focus groups produce data which sit at the *etic* end of the continuum and are particularly appropriate to studies where the phenomenon are not well understood (Stewart & Shamdasani, 1990).

Validity and reliability in focus group method

Traditional research is concerned with issues of validity and reliability. The focus group method, being a type of qualitative research, arguably should not be considered within this paradigm when assessing its research merit. However, it is possible, if less appropriate to apply the concepts of validity

and reliability to this qualitative method and these are understood in the following terms:

Validity (the extent to which the tool or procedure measures what it is supposed to measure).

Face validity in focus group method is high, due to the credibility of comments from the group participants (Nyamathi & Shuler, 1990). External validity is threatened by the nature of the purposive sampling and the process of self-selection likely to occur. Groups may not be representative of the wider population. The method however, is generally selected because of its usefulness in exploratory research where generalisability is not the primary objective. Indeed, if generalisability is important, then an alternative methodology should be selected (Sim & Snell, 1996).

Reliability (the extent to which consistent administration of the instrument will provide the same data).

Reliability in focus group method is affected by many of the factors which also constitute the strengths of the method. For example, each focus group has a unique mix of participants, all of whom are united in their common interest or investment in the topic being explored. There may be a mix of sexes or some dominant personalities or individuals who represent a minority opinion in the group. This will vary from group to group. The degree of homogeneity in the group will influence the extent to which findings can be reproduced in another group.

All of these factors can be positively affected by the skills of the moderator and the implementation of a planned approach to the group process. However, the aim of focus groups is not necessarily to seek reproducibility. Rather, it may be to generate diversity in order to explore all possible views on a topic.

Authors McDaniel & Bach (1996) argue that the method should more appropriately be assessed within the qualitative paradigm by the criteria of

trustworthiness, indicated by the level of dependability, conformability and transferability.

Credibility can be enhanced by

- requesting feedback from participants about the author's interpretation
- peer debriefing - objective peer review reduces the risk of researcher bias
- negative case analysis - searching and accounting for disconfirming evidence

Dependability is assessed by the extent to which another researcher can follow the steps of the initial researcher. This can be enhanced by having two researchers examine the process and outcomes of the study.

Confirmability is represented by a researcher producing an audit trail of activity which could be followed by an independent investigator, enhanced by:

- documentation of decisions regarding sample selection
- record of analytic decisions
- report of the data sources in analysis
- evidence of congruity between the data and interpretations drawn

Transferability refers to the extent to which findings from a study can be applicable to a study in a similar context, group or setting, enhanced by rich, detailed descriptions from the data supporting interpretations.

Trustworthiness generally is supported by a number of basic assumptions inherent in the focus group method:

- valuable information source is provided by the participants themselves
- participants are able to articulate their own thoughts and feelings
- the benefits of group interview outweigh the benefits of individual interview
- group interaction can generate valuable information
- by using focused questions, the moderator can assist participants to call to mind important and relevant information (McDaniel & Bach, 1996)

Methodological strengths and limitations of focus group

Strengths

- Data has high face validity. Results are believable and easily accessible.
- The synergy or interaction which result from focus group dialogue creates valuable insights. Group members share experiences, creating increased consciousness of subjective and collective elements, and reaching an awareness of areas of consensus and of disagreement (Stevens, 1996).
- There is security for members to express opinion or experiences of a sensitive nature where the group is homogenous. Quiet members may feel liberated to share experiences in the group because others are doing so.
- The researcher is able to probe for more detailed information whilst, at the same time documenting the process of group interaction - the way in which group exchanges and dialogue are conducted (Sim & Snell, 1996).
- The researcher, by virtue of being outnumbered in the group, is less conspicuous than he/she would be in an individual interview. In order to run a successful focus group, the moderator must take a facilitative rather than a directive role in the group.
- Data from focus groups can be used for description of phenomena, assessment of needs, planning for services or interventions, evaluation of either, development or design of services or strategies (Stevens, 1996).
- Although not applicable to the current study, focus groups are one of the few tools available to obtain data from children, individuals from underrepresented or disempowered groups, and individuals who are not particularly literate (Stewart & Shamdasani, 1990).

Limitations

- The skills of the moderator influence the extent to which all participants have an active voice in the group. Quiet members may be intimidated or inhibited by more loquacious group members.
- The risk of social posturing - conformity to preconceived notions of what is acceptable - is possible unless groundrules for the group are clear from the beginning.

- Lack of depth of data due to lack of time for individuals to express views in depth (Sim & Snell, 1996) is a weakness of focus group design.
- The small numbers of most groups and the convenience sampling used for recruitment limit the generalisability of the findings.
- The 'live' nature of the data can lead to an unwarrantable weight being awarded to the data (Stewart & Shamdasani, 1990).
- Data analysis can be difficult due to the open-ended nature of the data.

These limitations can be reported during analysis, and contribute to understanding of the phenomenon under review. It is useful to record in detail the characteristics and non-verbal communication taking place in order to analyse features of the group (Stevens, 1996).

The assumption that group interaction is superior to individual interview has aroused criticism of the method for several reasons. There is the possibility of group censoring of minority or unpopular opinion. Unanimity of opinion should not be assumed to represent consensus. Asking participants to complete a questionnaire prior to group discussion, or document their own beliefs or views prior to the group may help to reduce this effect (Sim & Snell, 1996).

Issues to consider in the application of the method

There are a number of issues which should be considered in using the focus group method. These will be discussed in this section as follows:

- selection of participants
- group size
- homogeneity
- selection bias
- role of the moderator
- running the group
- using an interview guide

Selection of participants

The important issue of homogeneity in participant selection will be discussed further on in this section. The issue of participant anonymity is debated in the literature and, while some authors argue that participants should be unknown

to each other (Sim & Snell, 1996; Stevens, 1996; Morgan, 1991), other such as Kreuger (1994) recognise that focus groups may be used in organisations where participants will be known to one another (see paragraph on Selection Bias).

Purposive and convenience sampling are appropriate methods of participant selection (McDaniel & Bach, 1996; Stewart & Shamdasani, 1990). Recruitment can be conducted by personal contact, telephone, advertising or word-of-mouth. Where group members are known to each other, special consideration should be given to non-verbal communication in the group, and to the interpretation of findings in the analysis phase (Kreuger, 1994).

A financial remuneration and transportation costs may be offered to increase recruitment (McDaniel & Bach, 1996). Incentives range from offering financial remuneration to the provision of food and a comfortable and easily accessible environment (Stewart & Shamdasani, 1990).

Group size

A moderate sized group consists of between 6 and 10 people (Morgan 1991). This limits the problems of larger groups such as underactive participants, difficulties of managing a large group discussion and the possibility of the larger group breaking into small discussion groups. It also limits the problems of smaller groups such as greater contribution being demanded from each participant and increased sensitivity to internal dynamics. The smallest number is recommended to be around 4 and the largest around 12 (Morgan, 1991).

Tang & Davis (1995) suggest that, when planning a group number, the following factors should be taken into account:

- the nature of the study
- sensitivity and complexity of the topic
- diversity, ability, expectations and needs of group members
- skills of the moderator

There is inconsistency in the literature about group size. The range of ideas generated in a group is dependant on human and situational factors, especially in unstructured focus groups, although it has been found that larger groups produce more ideas (Tang & Davis, 1995).

Focus group size can be determined by taking into account 4 critical factors:

- number of questions to be asked
- allotted time for each question
- format of the focus group session
- duration of the session

For the purposes of an exploratory study, group size should be smaller and less structured. For confirmatory purposes, a larger group is preferable (Tang & Davis, 1995). Focus groups can consist of 4-12 people with 8-12 members thought to be a suitable number (Sim & Snell, 1996). The number of groups held should be determined by the amount of new information being obtained (Nyamathi & Shuler, 1990).

Homogeneity

Authors generally advise a mix of participants who share certain characteristics such as:

- educational level, occupation, age, gender, or family characteristics (Kreuger, 1994)
- social class, sex and race (Morgan, 1991)
- shared common experiences, interests and understandings (Sim & Snell 1996)

However, the primary concern for the moderator and researcher are the differences which group members *perceive* amongst themselves. This determines their willingness to discuss a topic together more so than any *actual* differences. Some group mixes will not work well because of limited understandings of lifestyle or situation e.g. young working women mixed with homemaker women in their sixties who have never been in paid employment (Kreuger, 1994). In the interests of facilitating group cohesiveness, relative homogeneity is advised, the guiding principle being the extent to which group

characteristics will influence sharing. Participants should have something to say about the topic, and feel comfortable saying it in the group context but this does not imply homogeneity in attitude (Morgan, 1991).

Selection bias

Participants should be selected in a way which reduces the likelihood of selection bias. The aim of the selection process is to bring together a group which is an effective cross-section of those who are representative of the topic under discussion. Krueger (1994) cautions against participants being selected from the memory of the researcher or associates - suitable individuals may spring to mind but this can lead to a flawed selection process in view of the selectivity and fallibility of recall processes. He also warns against the selection of participants by a member of the organisation within which the study is to be done. There is the possibility that there may be agendas or biases inherent in this process e.g. participants are clones of the selecting supervisor, productive employees will not be released by the organisation to participate as readily as employees who are unproductive. Running focus groups with established groups, the moderator should be aware of some of the pre-existing formal and informal ways of communicating within the group. Avoiding the inclusion of participants of mixed status is important, as is the assurance of confidentiality. There is a strong case for randomisation of participants where there are sufficient numbers of potential participants who fulfil selection criteria. It should be born in mind however, that the intent of focus groups is not to generalise but to understand how people think about the topic.

An example of a successful study using a pre-existing group of participants with a mix of status is the study by Conrad, Balch, Reichelt, Muran and Kyoung (1994). In their study of musculoskeletal injuries in the fire service, they used a convenience sample of men from the fire service in suburban Illinois ranging from fire chiefs to firefighters. Results indicated the range and type of concerns amongst chiefs and firefighters. The likelihood of this group

of men knowing each other and having informal ways of communicating, including established friendships is probably high.

Role of the moderator

The moderator role is one of facilitation. The role is to ensure that discussion is inclusive of all participants, impartial, supportive and appreciative of all members, and able to unobtrusively guide discussion using a study guide or selection of open-ended questions (Sim & Snell, 1996). The moderator should listen carefully and engender a feeling of empathy without dominating the group (Sim & Snell, 1996; Nyamathi & Shuler, 1990). A high degree of preparation and concentration is required in order to moderate a group effectively. The moderator should also be aware of any personal bias toward the topic, and maintain neutrality in body language and verbal communication.

The moderator can adopt one of a variety of roles in the group in order to facilitate conversation and manage the group process. An example of this is the 'enlightened novice' - one who assumes the role of novice waiting to learn from the expert knowledge of the group members (Kreuger, 1994). The leadership style of the moderator has a determining influence on the course of group discussion. Stewart & Shamdasani (1990) describe four styles: supportive, directive, participative and achievement-oriented leadership.

Several authors suggest the use of an assistant to the moderator who will take notes during the group discussion and attend to the audiotape of the discussion (Kreuger, 1994; McDaniel & Bach, 1994; Nyamathi & Shuler, 1990).

Running the group

Comfortable, informal and private settings with light refreshments assist in creating a relaxed environment which is conducive to group discussion. It is important that group members are able to see one another, and that introductions and a review of the purpose of the group are made. 'Groundrules' for the group should be discussed, and participants encouraged

to speak with one another rather than with the moderator (McDaniel & Bach, 1996; Sim & Snell, 1996). Morgan (1991) recommends a session length of 1-2 hours.

The moderator should conclude the session by providing a summary of the discussion and thanking the participants. Following the discussion, the moderator should take time to debrief, summarising the content of the discussion, checking for audiotape functioning and making notes if there has been failure.

Using an interview guide

Kreuger (1994) suggests the inclusion of a number of question types. These are:

opening questions, the purpose of which is to identify characteristics which the group have in common

introductory questions which introduce the topic and foster conversation

transition questions move the conversation into the key questions

key questions drive the study (usually 2-5 questions). Questions beginning with 'why' should be avoided because they can appear interrogative.

ending questions bring closure to the group discussion

pre-summary question allows participants a final opportunity to make important statements which may have been missed in discussion

summary question occurs after the moderator has provided a short summary, and is designed to provide group confirmation of the summary

When developing questions for obtaining data the researcher should consider the following principles:

- a) questions should be ordered from the more general to the more specific
- b) questions should be ordered by their relative importance to the research agenda.

The moderator should try to predict the way in which the discussion is likely to go, and present the group with no more than 12 questions. Ideally the interview guide should be pre-tested (Stewart & Shamdasani, 1990).

Several techniques used during the discussion can assist in the analysis of the data. The moderator should listen for inconsistent and cryptic comments and probe for clarification. A diagram of the seating arrangement should be made as well as careful notes taken to capture the non-verbal communication of participants (Kreuger, 1994).

Data recording

Data should be audiotaped and specific consent sought (Sim & Snell, 1996). Bertrand, Brown & Ward (1992) outline 3 ways of recording discussions on paper.

- A complete verbatim transcription of the tapes can be made. The researcher's notes taken during the discussion serve as a means of clarifying conversation that might be unclear. A group lasting 2 hours is estimated to generate 40-50 pages of transcription (Sim & Snell, 1996).
- Expansion of the reporter's notes using the tapes. Where time and resources are scarce, this is a possible alternative method to transcription. However, the resulting data will necessarily be selective and biased.
- Reporter's notes only. This method is appropriate where time is short and the discussion very simple. Again, this method runs the risk of bias and selectivity.

Data analysis

Analysis must be systematic, verifiable, focused and have the appropriate level of interpretation. The process is time-consuming and should be done as close to the data collection date as possible. Analysis should attempt to

increase the level of understanding of the phenomenon. Such understandings can be incorporated into future focus groups for the purpose of confirmation or amplification (Kreuger, 1994).

The basis of the data analysis consists of the verbatim transcript, notes taken during the session as well as debriefing notes. Stevens (1996) recommends the researcher should pay close attention to group interaction and ask a range of analytic questions in relation to these interactions e.g. how closely did the group stay with the topic? What other issues arose - when, why and by whom? What issues provoked conflict? Bertrand, Brown & Ward (1992) suggest three approaches to focus group data analysis.

Inventory approach

Each question which was asked is written on a separate sheet of paper. Every time the subject is addressed in the transcription, the researcher records the main point under the appropriate question. The main point can be illustrated by a direct quote from the data.

Recall approach

The researcher outlines the main ideas that emerged on each topic from memory. The transcripts are re-read following this exercise, and any omissions or inaccuracies can be corrected. This approach produces a more spontaneous description of the process. McDaniel & Bach (1994) recommend that the data should be put away for two to three weeks and this process repeated with fresh copies of the transcript.

Margin coding

The researcher has a preliminary read through of the data and begins to identify emerging themes. Alternatively, the original questions are used as a guide. The researcher selects a code to identify the themes or questions and writes these in the margin as they occur, or selects a colour with which to highlight the theme or question. Any quotable passages are marked with an asterisk. Writing up the report involves the selection of a topic or theme, and

draws together and summarises all references in relation to the topic or theme. A cut and paste technique can be used to bring together all relevant references. Alternatively this can be done on a computer.

Content analysis

Content analysis is described as an analysis technique designed to make replicable and valid inferences from data. This type of analysis describes the 'location of a set of items that can be systematically counted' (Morgan 1991, p.66). Stewart & Shamdasani (1990) describe three types of content analysis:

pragmatic analysis seeks out causes and effects

semantic analysis classifies signs according to their meanings

sign-vehicle analysis counts the number of specific words or types of words used.

At all times in the analysis process, the researcher makes use of the notes taken during discussion and debriefing. Specific analytical techniques include:

- consideration of specific words used as well as their meaning
- awareness of voice inflection, animation, whether the words constituted a statement or question
- awareness of participants who have changed their opinions
- responses substantiated by personal experience or not
- having the data analysed by two or more people and reach agreement on categories
- documentation of each step to provide a clear audit/decision trail
- finding the 'big ideas' (Kreuger, 1994)

Some minor editing is possible in order to make the data more readable, providing that the meaning is not changed (Stewart & Shamdasani, 1990).

The final step involves data reduction - the identification of categories which can be subsumed into another category. This will be assisted by allowing a rest of 2-3 weeks between analysis episodes (McDaniel & Bach, 1996).

Computer software packages can be used to assist in automatic indexing of qualitative data.

Thematic Analysis

Using this method, analysis is done at two levels. The first level helps to summarise data, and the second level is a way of grouping or condensing these data segments into overarching themes. This process is described below.

Level 1

Level 1 involves the development of categories or codes from the data which relate to the research question or key concepts of the research. These help to create building blocks in the analysis. The process begins with a reading of the raw data. Miles & Huberman (1984) suggest the use of a start list of codes developed from the research questions or hypothesis. However, a more inductive approach can be used to allow the categories to emerge without any predetermination on the part of the researcher. Chenitz and Swanson (1986) describe the first step in this inductive process as the development of a 'laundry list' of categories or substantive codes. From here, categories can be clustered by identifying similarities and differences.

Just how detailed the coding should be is determined by what the researcher defines as a unit of analysis or a block of data, be it a clause, a sentence or a paragraph. In any event, the researcher is also looking for good explanatory exemplars to illustrate the category (Miles & Huberman, 1984).

It is helpful to have the coding procedure done by more than one person, particularly where the study has involved more than one researcher or where a researcher has worked alone. Reflective remarks made during the data collection should be used during the process of developing categories. At this point and before embarking on the next level, a process described as theoretical sampling may be used. For the sake of theoretical completeness, the categories may be tested on new participants to check for completeness or saturation (Chenitz & Swanson, 1986).

Level 2

The next step is to create pattern codes or higher level categories for the purpose of integrating and condensing findings. As Miles & Huberman (1984) suggest, 'the trick here is to work with loosely held chunks of meaning, to be ready to unfreeze and reconfigure them as the data shape up...' (p.68). Chenitz & Swanson (1986) describe this as the development of higher level categories. This can be done by arranging preliminary categories into coding families, of which there are a number of types.

- initial categories defining basic categories
- type families, for example behaviour types
- strategy families, for example the type of strategies that participants used to address a problem
- process families where participants used a particular process to deal with an issue or problem
- multiple process family where multiple processes were examined

The purpose of pattern codes is always to move to a higher level of abstraction (Miles & Huberman, 1984).

One way of presenting the final data using thematic analysis is the use of metaphor to dramatise, amplify or depict the data. Metaphor is richer than simple description. It also helps in data-reducing, pattern-making, provides a way of provoking attention from the reader or a way of connecting findings to theory. It also provides a way of moving the reader from simple appreciation of the facts, to understanding the significance of the facts. It is important to avoid developing a metaphor too soon in the data analysis, just as it is important not to overuse or attempt to squeeze too much from the metaphor (Miles & Huberman, 1984).

Focus group: comparisons with other methods

Two alternatives to the focus group method in the qualitative paradigm are **individual interview** and **participant observation**. However, neither of these methods are appropriate to the study question.

Although individual interviews may produce at least as many insights as a group approach (Morgan, 1991), offer the researcher more control over data and facilitate participant honesty, the method is researcher-focused (the researcher guides and directs the interview), time-consuming, expensive and does not capture ideas which a group will generate. Focus group method on the other hand allows the group to direct its own activity with low researcher input, requires less time and fewer resources, and generates useful data from the ideas and insights generated in a group situation.

Participant observation, it could be argued, may elicit more natural or spontaneous data, non-verbal as well as verbal observations, and a wider range of behaviours. The difficulty lies in the fact that participant observation may allow the observer to see **what** is happening but not **why** it is happening. Morgan (1991) argues that the spontaneity of data collected in participant observation in any event is limited in that the researcher may simply not be there to record crucial spontaneous moments. The strength of focus group work is that reflection on the event in the language of the participant is captured and understanding of the event increases. Whereas nurses are passive participants in the participant observation method, they are active contributors to the data gathering in focus group method. A further reason against the selection of the participant observation method is that the data collector in this study will be the researcher, whose role in the team could have compromised the validity of data collected if using participant observation.

Use of the Focus Group method in Rehabilitation

Focus Group method has been used in a variety of rehabilitation contexts, including needs analysis, programme planning and evaluation.

Needs Assessment

- Dickerson (1993) used the method to determine the support needs of spouses of cardiac patients enrolled in a cardiac rehabilitation programme.
- Three primary health care teams were involved in a focus group to discuss the health needs of adults with learning disabilities living in the community (Thornton, 1996).
- A focus group of firefighters was used by occupational health nurses to identify risk factors and preventative strategies in a worker rehabilitation context.
- Blake (1995) has used the method to explore the perception of social isolation and related needs amongst individuals who became quadriplegic as young adults.

Programme Planning

- Gitlin & Burgh (1995), both Occupational Therapists, carried out a focus group study in an elderly care rehabilitation setting to describe the process used by O.T.s to issue assistive devices to clients.

Programme Evaluation

- The views of women regarding cardiac rehabilitation programmes were explored by Moore (1996) using the method.
- Individuals using a vocational training programme were interviewed in a focus group discussion to ascertain their views of the programme (Packer, Race & Hotch, 1994).
- A focus group of employers and rehabilitation personnel was organised to evaluate the job placement process of a job placement programme (Fabian, Luecking & Tilson, 1995).

Summary

The focus group method has been widely used in the social sciences and marketing to gather opinions and perspectives from individuals with an interest in a particular topic. Consideration has been given to the strengths, weaknesses, methodological issues and implications of the method. Inherent

in the process of data recording and analysis are options from which the researcher may select the most appropriate. The focus group method has been used in the rehabilitation context as a means of gathering opinion about a variety of topics. Focus group method has been selected as the most appropriate method for the current study. Its application to the research question will be discussed in the following section.

Part two: The Study

Focus Group Method and the Therapeutic Nursing Study

Focus groups were conducted with groups of nurses in order to collect data which would develop transparency around nurses contribution in rehabilitation specialty. Data from customers constituted a small but significant backdrop to the nursing data, providing a means by which some preliminary comparisons could be made, thus increasing the validity of the data. Just how the focus group method has been applied to the current study will now be considered from the point of view of:

- selected approach
- selection of participants
- group size and homogeneity
- ethical considerations
- ground rules
- role of the moderator
- data recording and analysis

From there, the customer questionnaire will be discussed.

Selected approach

The study falls into the category of a clinical approach (Nyamathi & Shuler, 1990) in which the data is collected and analysed from a clinical perspective within the broad context of qualitative research. Practising nurses in the rehabilitation were invited to participate in a focus group to talk about their practice in rehabilitation. They were asked to think of a story or stories of practice in which they had been involved. The purpose of telling the story was to provide an illustration of nursing that was therapeutic, one that demonstrated a way in which nursing had contributed towards healing and recovery, or had put the customer in a position where healing could take place.

Selection of nursing participants

The General Rehabilitation specialty is very small and the General Rehabilitation Team is the first of its kind in New Zealand. This provided a

unique opportunity to study therapeutic nursing in the specialty in New Zealand. All nurses who had worked in the General Rehabilitation Team for a minimum of six months or more, including Enrolled and Registered Nurses were eligible to participate in the study. Of the total number of nurses in the team, six were Enrolled Nurses and 14 were Registered Nurses.

This method of convenience sampling was consistent with the sampling method proposed by McDaniel & Bach (1996) and Stewart & Shamdasani, (1990). The participants were known to each other through the unavoidable circumstances of being part of a somewhat unique team in New Zealand. The influence of this will be discussed in Chapter Four. No remuneration was provided to participants. Some of them joined the group in their own time and this time was returned to them in lieu. A random selection process had to be utilised so that the researcher, also the team leader, was kept ignorant of actual respondents (the process of random selection is described below). This meant that potential participants were lost in the selection process in order to protect team member anonymity. The final number of participants was eight which constituted over one-third of all potential participants. However, one volunteer was unable to join the group for personal reasons unrelated to the study.

Group size

Rather than run one group of seven where there might be less opportunity to talk and share stories, it was decided to run two separate groups. The nature of the topic required that there was time to ruminate freely about the subject without the pressure of having to wait in turn to speak. The small size of the groups facilitated this kind of discussion. The size of the groups also reduced the risk of underactive participants. Splitting the number of volunteers into two groups also made it much easier to bring together participants who worked on a roster basis. This was an important practical consideration.

Group homogeneity

Members of the groups shared a number of characteristics. They had all worked in the same team for a minimum of six months. All of the participants were staff nurses except for one enrolled nurse participant. The group was quite diverse in other characteristics. Almost half the group were studying for post-graduate awards. Four participants had had recent experience in the previous service. Both groups produced free-flowing conversation.

Gaining Ethics Committee approval

Academic and employer approval to conduct the study had to be given before the study could proceed. The proposal was submitted to the academic committee first and some changes had to be made. Of major concern to the committee was the way in which participants would be protected from a conflict of interest, the researcher also being the person to whom participants reported in their work. The process of participant selection had to ensure that staff members did not feel under pressure to participate.

The possibility of coercion was minimised with the assistance of the Clinical Nurse Advisor (C.N.A.) in the service who was a volunteer. She used the following process:

- 1) All potential participants (20 nurses) were sent an Information Sheet (see Appendix 1) by the C.N.A. describing the study, and indicating the process of participant selection and the reason for the process. Those who were interested in participating were asked to return the tear-off slip to the C.N.A.
- 2) The C.N.A. collected the tear-off slips with names of nurses. The C.N.A. was asked to present the researcher with an even number of names. Eight names were provided and the researcher was kept in ignorance of any other participants who may have completed the return slip. This ensured that the researcher did not know which nurses had declined to participate and therefore maintained the anonymity of the staff member.

- 3) This group of nurses were asked to sign a consent form (see Appendix 2) by the C.N.A. and this was returned to the researcher. (The opportunity to be interviewed individually was offered on the tear-off slip).
- 4) Each nurse was then sent a letter indicating the date and time of the Focus Group meeting (see Appendix 3).

The role of the researcher was made explicit at the beginning of each group as follows:

- the researcher was present in the group as a student, not as the team manager.
- however, if anything was exposed that placed either the team member, a colleague or a customer in danger, then the researcher had an obligation to discuss this with the team member concerned and take appropriate action.

Confidentiality was also a concern of the ethics committee and plans for storage of data had to be made very clear. Several other minor changes were requested by the academic committee. As a result of these changes, only minor changes were requested by the employer ethics committee and the proposal was accepted by both.

Running the group

The groups were both run in the Education Room in the organisation. Group members were positioned in comfortable chairs so that each person was able to see the others. Light refreshments were available on a small table in the centre of the group during the discussion. An audio recorder was positioned slightly outside the group to reduce any feelings of intrusion, but still in a position to pick up the conversation clearly. Each group lasted 1-1.5 hours.

Ground-rules

Ground-rules for the focus group were discussed at the beginning of each group and included the following:

- anything that was said in the group would not be discussed outside the group
- participants would respect the right of one another to speak in the group

- participants had the right to ask for the audio-tape to be turned off at any time during the group discussion
- there was no 'right' answer

Role of moderator

The researcher was the moderator who was also responsible for managing the audio-equipment and taking notes throughout the discussion. The moderator prepared thoroughly prior to the start of the group so that there were minimum distractions during the group discussion.

Participants had been asked to do some preparatory work before coming to the group. This took the form of reflection on instances where they believed that their practice was therapeutic, and why. Some wrote these down and chose to read them out during the discussion. Others simply recounted their stories from memory. This generated further discussions and stories of practice and facilitated participation from each person, including the less vocal members.

The researcher had low input into the group but used several open-ended questions to facilitate discussion initially, and then listened and provided prompts during the discussion in a supportive style of group leadership. A formal interview guide was not used, but the moderator had drafted several questions to use if the discussion began to falter. These were aimed at precipitating further accounts of practice, for example 'have you witnessed a colleague involved in a situation which you thought was especially helpful?'. During the process the moderator took a few notes, but was conscious of the possibility of creating a distraction or inhibiting conversation in such a small group.

Each participant took it in turn to share their story and the group discussed issues which arose from after each was recounted. Participants chose in which order they narrated their story and once this process was completed, the moderator provided a summary of the discussion and the group was

invited to add any closing comments. Following this, the moderator thanked the group and the discussion formally ended.

The moderator stopped the recording and, once the participants had left the room, checked the tapes to make sure that there had been no problems. Had there been, the moderator would have immediately proceeded to write notes from memory about the discussion. Notes that were taken during the group discussion were kept for analysis.

Obtaining data/ data transcription

Data was recorded as previously outlined. Audiotapes from the group discussion were transcribed verbatim by a paid transcriber who signed a confidentiality statement (see Appendix 4). A transcription machine was used for ease of typing. Group members were identified in the written transcripts using headers, for example 'woman 1' and 'male'. During analysis, these headers were removed in order to avoid the distraction of identifying the statement with a participant. No coding of categories was done between the two groups which were only one week apart.

Data analysis - method

The researcher used a thematic analysis approach in analysing the data. Data analysis began with several readings of the transcripts. There were approximately 50 pages of data. The research question underpinned the data analysis only in as far as it had guided the discussion in the focus group and therefore the content of the transcript. No preconceived list of categories was used in the preliminary analysis. Therefore the process could be described as inductive.

Level 1 analysis

Margin notes were made against the transcription. Up to four notes were made against each paragraph of data, and approximately 300 summary statements or sub-categories were listed from these descriptive margin notes.

These sub-categories were examined for similarities and differences and the list was significantly reduced using the process of clustering.

Level 2 analysis

From this list it was possible to detect some emerging themes of which there were 13. This was done by reading and considering the statements and what they might represent. A coding family approach was not used but it was possible to identify the themes as essentially interpersonal or functional categories. These were reduced again until there were 9 themes. The next step was to use a coding system that would help to cluster the sub-categories under one theme. Coloured highlighting pens were used to highlight sub-categories. Once this was done, a computer table was constructed and columns were headed with the title of each theme. Each sub-category was placed under an appropriate heading and once again, the sub-categories were collapsed. At this point there were seven themes.

Thought turned once again to the complete transcript, and the same highlighting system was used to locate appropriate exemplars that related to the theme. Once this was done, a process of cutting and pasting took place. Statements or cameos from the transcripts which supported a theme were brought together by colour and placed in envelopes marked with the title of the theme. These were read in the light of the theme and were moved around between envelopes until the researcher was satisfied that they were correctly placed.

Reporting the data

The next step was to report the data. This was done by considering and reporting on each theme and using exemplars to illustrate the meaning. The author found the description of the coaching role from Peters and Austin's management text 'A Passion for Excellence' (1985) particularly inspiring, and chose to use some simple quotes from the book as a means of encapsulating all that the data from the current study presented.

A copy of the reported data was given to each nurse participant who was asked to review for appropriateness of interpretation. There was agreement with the researcher's interpretation of the data from all participants

Attention will now be directed to the customer questionnaire data.

Customer feedback and the Therapeutic Nursing Study

Customer Feedback

Because the aim of the study was to make more transparent the nursing activity which brings about healing or an improved outcome for the customer, it was important to understand something of the perspective, not only of the nurse, but also of the customer. However, this was a small part of the overall study (Developing a comprehensive understanding of the perspective of the customer constitutes a full study in itself). Although the data was less detailed - customer responses were written rather than sought using an indepth interview technique - nevertheless, responses facilitated a comparison between nurse and patient perceptions of therapeutic nursing in the specialty.

Collecting the data

During the study discharged customers were invited to answer a questionnaire about their perceptions of the nature of therapeutic nursing activity. The C.N.A. again became involved. Her role in this part of the study but also in the rest of the study was to provide an appropriate separation between potential participants and the researcher, and therefore reduce the risk of coercion. She gave all customers who were being discharged an Information Sheet (see Appendix 5) about the study up to one week prior to discharge. This provided the customer with the opportunity to ask questions before making a decision to participate. If the customer was willing to become a participant, the C.N.A. gave the customer a Customer Questionnaire (see Appendix 6) and provided him/her with instructions about either putting the completed questionnaire in the box as shown, or sending the questionnaire into the organisation. The questionnaire included open-ended questions to encourage feedback about experiences of nursing which were thought by

customers to be therapeutic. Customers were asked not to identify nurses by name or to use any other distinguishing features in their responses. This was part of the consent process.

The possible number of participants was initially thought to be in the region of 30-40 customers. However, the discharge rate was significantly less than was anticipated. The response rate from the 19 customers who were invited to participate and were given a questionnaire was 47.7% i.e. nine.

Data analysis

Customer data was analysed in a similar manner to the focus group data. Although it was less dense by virtue of being written rather than verbal data, 80-90 sub-categories were identified from margin notes on the customer response sheets. These sub-categories were examined for similarities and differences and a process of clustering took place. Coloured highlighting pens were used to highlight sub-categories. Once this was done, a computer table was constructed and headed with the title of each theme, and each sub-category was placed under the appropriate heading. Text from the questionnaires which would illustrate the categories was identified and a process of cutting and pasting took place. Sub-categories were arranged into envelopes marked with the title of themes and a data analysis report written which can be found in Chapter Four. The themes focused on the interpersonal nature of the rehabilitation experience and were found to be very similar to the themes identified from the nursing data. A comparison between the nursing and customer categories is found in Chapter Four.

Throughout the process of data analysis, the researcher's supervisor also reviewed nurse and customer data and developed preliminary categories and themes. These served both as a check on the researcher's academic analysis and also a form of cross-checking of codes.

An analysis of the data is presented in Chapter Four.

Chapter Four

DATA ANALYSIS

Introduction

This chapter is divided into two sections. In the first part of the chapter data will be presented from the nursing focus groups (Part One). In the second part of the chapter data will be presented from customer questionnaires (Part Two). Although some analysis and synthesis has been done in this chapter, the major analysis and synthesis of the two sets of data will be undertaken in Chapter Five. A nurse:coach model emerged from the data and this will also be presented in the following chapter.

The data is presented in two parts for several reasons. Firstly, the data sources are different and were collected using different methods. Nursing data was collected using the Focus Group method - a type of group interview - and data was verbal. Customer data was collected by questionnaire and was therefore written. It is important that this distinction is clearly made in order to avoid placing undue emphasis on findings, in particular on customer data which provides an important but smaller part in the overall findings. Secondly, it is arguably easier to proceed to a comparison of data if the data is initially set out in two parts.

Direct quotes from the transcripts are used in this chapter to justify the development of the category and then to illustrate the meaning of the category. This process has been described by Miles & Huberman (1984) within the context of thematic analysis.

Quotes are referenced by the use of numbers, of which there are two, in brackets following the quote. The quotes are coded in the following manner - the first number indicates whether the statement emerged from group one or group two, and the second number indicates on which page of the transcript the quote can be found. There were 47 pages of transcription. The transcript

of the first focus group was from pages 1-24 and the second group from pages 25-47.

Part One (focus group data)

A number of themes emerged clearly from the data. The therapeutic value of nursing in rehabilitation seemed to be highly focused on interpersonal aspects. The overarching theme throughout was that of the nurse as coach. The coach's main aim is to develop individuals to achieve their fullest potential no matter how limited the outcome may be. The coach role requires a passion for developing people to be the best they can be. Coaching itself takes time, commitment and consistency. Coaching involves dedicated, involved, enabling and enthusiastic leadership, aptly described by Peters & Austin (1985) as face-to-face leadership.

Coaches are leaders whose passion is to develop others to excel. Nurses in the rehabilitation team emerge as coaches - in other words, face-to-face leaders or nurse:coaches. Their aim is to develop individuals towards independence at the level which is possible for each person. A leadership model of the 'Nurse - Coach' is proposed from the data and this will be discussed in Chapter Five.

From the nursing focus group data, nurse participants appeared to be involved in three main groups of relationships. The first of these relationships occurred within the team between nurses and other colleagues (**Coaching: face-to-face leadership in the team**).

The relationship between nurse and customer began at the time of admission and, over time a trusting relationship was developed which facilitated participation in a rehabilitation programme (**Coaching: face-to-face leadership with the individual**). The function of the relationship was to facilitate independence and to do this, it required nurses to be enabling and to

develop the skills and strengths of the customer who, in turn was able to become increasingly more independent.

The other important relationships that nurse participants described were with family members (**Coaching: face-to-face leadership with family**). Nurses understood this relationship to be crucial, particularly where family members were likely to be primary support people.

The categories from the data are outlined in Table 4:1 below.

Summary of categories from focus group data.

Nurse as coach: face-to-face leadership

Table 4:1

Coaching: face-to-face leadership with the team	Coaching: face-to-face leadership with the individual	Coaching: face-to-face leadership with family
<p>Smooth operations</p> <ul style="list-style-type: none"> • leading the team • thinking beyond the discipline • learning from others <p>Welcome to the team</p> <ul style="list-style-type: none"> • where am I? • settling in • making the party go! 	<p>Paying attention to people</p> <ul style="list-style-type: none"> • taking time to build a personal relationship • looking in the mirror • doing unto others... • the awesome power of personal attention <p>Enabling others to act</p> <ul style="list-style-type: none"> • stepping up to responsibility • getting people to play • giving elbow room <p>Bringing out the best</p> <ul style="list-style-type: none"> • building on strengths • you can do it! • tough talk • developing a winning attitude 	<p>Making room for others to contribute</p> <ul style="list-style-type: none"> • taking time to build a personal relationship • sponsoring

Coaching is face-to-face leadership...

(Peters & Austin, 1985, p.325)

Coaching: face-to-face leadership in the team

A leadership and management role for nurses in creating integration in the team emerged from the focus group data. This was strongly linked to the role of coach. The consistent and integrated manner in which customers progressed through their rehabilitation programmes reflected the extent to which the team was working in a co-ordinated way, and nurses had an important role in making this happen (**Smooth Operations**). Nurses also facilitated the orientation of customers to the new environment (**Welcome to the team**), a necessary part of developing the relationship which would smooth the way into the hard work of rehabilitation. There was a sense in the data of interdependency and working together with colleagues in the interdisciplinary team.

These categories are discussed below.

The best coaches...find reasons everyday to underscore the point that 'we're all in this together'

(Peters & Austin, 1985, p.329)

Smooth Operations

Nurse participants articulated a leadership role in the team strongly connected with, and dependent on their coaching role with the customer. Exposure to the customer at all times of the day and night meant that they got to know the person more intimately and there was continuity in the relationships. They saw themselves as link people in the team - a team member who acted as liaison or co-ordinator within the team and between the team and family members. Exposure to customers over the 24-hour period, continuity of care, and co-ordination facilitated leadership (**leading the team**), with the ability to anticipate problems and needs by having some understanding of the work of other disciplines (**thinking beyond the discipline**). Nurse participants described how they respected the knowledge of their colleagues, and learned from them (**learning from one another**).

Leading the team

Nurse participants described the broad nature of their role, comparing it with the focused role of the therapist.

...the physios and the 'OTs' and that their roles are so specific...the physios get the people walking and things like that, but it's the nurses who get the person there or get the person motivated and reinforce what the physios have done...(1:18)

Because nurses saw the customer at all times of the day and night, the relationship was seen to be closer.

I think it's probably the nurses that they develop the closer relationship with rather than the therapy staff in general, because they are full on for one hour and it's specific...whereas with the nurses it's more open. (1:17)

This level of consistency and exposure to customers gave nurses a leadership role in the team.

...to have someone that consistently will stay with the person and doesn't give up, is very important...it's the leadership role within the team...(2:27)

The leadership role in the team included several management aspects. Therapy staff were able to refer issues or concerns to the nurse who would ensure that they were followed up.

And I think it's really good for the physio...having that key worker there...always that person there that you can go to if there is any issues or concerns or... things that need to be followed up. (1:18)

Nurse participants provided a lynch-pin for families, as well as ensuring that personnel who worked across teams were available when needed.

I think the nurses pick up on a lot of stuff and make things happen (1:19)

We almost act as link between everything(1:18)

I think that part of the rehabilitation is also to make sure that the follow up appointments are booked or whatever, so that they can get some positive feedback from medical side too (2:38)

I think also, we tend to see the families a lot more and they can identify with us probably a lot more(1:13)

There was also a sense of nurses managing the workload in a way which was supportive of their nurse colleagues. In one instance where several nurses were having difficulties with a customer, other nurses took over to give the others a break. Humour helped in coping in these difficult circumstances.

...if there's a problem happening like the other day - they were having trouble with her in the shower. Someone had to leave because they just couldn't cope any more...You go away and have a drink. It was okay - it wasn't as though they'd failed or anything like that...the nurses support each other quite well (1:6)

Thinking beyond the discipline

Nurses saw themselves as integrating their efforts with therapists by having a perspective beyond nursing. There was a sense in which nursing activities overlapped with and reinforced the efforts of the therapists, creating consistency and providing the opportunity to report on progress made during the times that therapists were not available.

...you need to have a perspective beyond just nursing... not that you are an 'OT' or a physio or whatever, but you actually need to be open to those sorts of things, because if you think something might be useful like a piece of equipment or something...(1:18)

I'm just thinking about two people at the moment who didn't realise that we could get the social worker in to organise that ...to reassure them they won't just be dumped out there (2:37,38)

Learning from one another

Nurses talked about the experience of working with colleagues in other disciplines and how helpful they found this.

You need that relationship too. With the physio...can you show me a better way to do this, to lift or whatever. It makes our job easier and better for the clients as well (1:17)

...talking to another staff member recommended doing a 24 hour nursing record of all her cares...sat down with the family and the social worker and discussed that (1:17)

I think it is good here because we have other disciplines like for example ...[neuropsychiatrist], if someone needs help in that area or...the social worker, not everybody needs these people ...there if they are needed, you know (2:37)

One nurse described the way in which the 'team within the team' (a sub-group of staff who were working with a specific customer providing input from all the disciplines) gave staff the opportunity to pool ideas together to develop an approach to working with a particular customer.

...the team that I was talking about in that instance was sort of like, the team, me as his key worker, the OT, the physio...not the whole team...he wasn't attending therapy, so we sort of tried to come up with some ideas about how to best encourage him to do that...how to make it interfere less in his life ...(2:24)

Welcome to the team

Customers arriving in the service in the first instance took some time to adjust to the new environment, and went through a period of settling in before they began to form relationships with the staff and other customers. Nurse participants saw themselves as facilitators of this process, from the initial adjustment ('**Where am I?**'), through a period of acclimatisation (**settling in**) until customers got to know others (**making the party go!**)

Where am I?

Customers arrived and nurses understood that they required time to adjust to the unfamiliar environment. Being greeted by a nurse who would be the keyworker - someone who will have consistent and regular contact with the customer throughout their stay - was thought to be very helpful in making the transition.

Like you walk into a strange place...It's scary, it's the unknown. To have someone there straight from the beginning when you step in the door I think is very good at developing that relationship. (1:9/10)

Settling in

The contrast of a rehabilitation environment with the acute care environment struck a loud chord for nurse participants. The physical situation of the customer was less acute, which allowed for time to grieve and make adjustments.

Nurse participants perceived that in the rehabilitation environment, they had the opportunity to develop a depth of relationship that could not occur in the acute setting.

...they don't get the chance to develop that level with the person but we do...(2:30)

People were not so sick, had more time to think, and they could take in information and appreciate humour in this different location.

...giving people knowledge - that can happen here whereas acute people are too sick...(1:8)

If someone is in a huge amount of pain they're not going to appreciate humour much are they?...(1:6)

The change of environment meant that customers could begin to grieve, and nurses could provide support during this time.

They never have time in the acute wards, to actually grieve there, and when they come here, it is usually when they start grieving, and just being able to be there and let them talk or cry, or whatever...(1:12)

'Making the party go'

After a period of settling in, relationships developed and bonding with others occurred. Small groups began to socialise together. Nurses saw that they had a role to play in facilitating this process.

...you had your little groups, and they've gone through and developed relationships, ...some of them, still see, keep in contact, once they've moved out. ...I mean we are part of that process, we make the environment. (1:14)

There was a sense in which nurses played host to the socialising of customers. They described this as 'making the party go..', a delicate arranging of individuals who might have something in common.

...trying not to mix people, you know, not, just being nice I suppose, but you wouldn't actually put people or you try to put people in where they're not going to fit ...(1:14)

Where there was a natural affiliation between a customer and a staff member, the team made adjustments to accommodate this in the interests of developing a helpful relationship.

I think that as a team it is really important that we find a way how we can individually work with a person...People will get on with someone, so we let people who get on with someone deal with that person (2:36)

Customers attending the outpatient department still called in to catch up with other customers and staff. Nurses took this as a kind of positive feedback about the team.

The data suggests a leadership role for the nurse within the interdisciplinary team. Facilitating the introduction of the customer to the team and

environment opened the way for the establishment of the coaching relationship to begin. These provide both the backdrop and the necessary preliminaries to the process of therapy and the development of a trusting relationship.

Coaching: face-to-face leadership with the individual

A coach could not lead an individual towards success unless the relationship was based on believing in and caring about the other, and becoming involved in their lives. This is the mark of one type of successful leader - that others follow because they are empowered to do so by a leader who cares about them as people.

Nurse participants described how they developed relationships with customers that were based on respect for the individual and getting to know the individual personally (**Paying attention to people**). Building a personal relationship also involved a level of self-disclosure and self-awareness on the part of the nurse.

Unless the coach was willing to relinquish control and power to the individual, the individual would never become a 'self-starter' but rather remain reliant on the vagaries of external forces. The coaching role of the nurse encouraged customers in this progression towards independence by first recognising that control needed to be transferred and customer choices honoured (**Enabling others to act**).

Finally, the nurse as coach was able to nurture performance in individuals by identifying barriers, building on strengths and occasionally by some tough talking (**Bringing out the best**).

Coaching at its heart involves caring enough about people to take the time to build a personal relationship with them.

(Peters & Austin, 1985, p.328)

Paying attention to people

Spending time to treat people as individuals gave nurses and customers opportunities for building trust and for sharing discoveries (**taking time to build a personal relationship**). Nurses often used their own personal skills and experiences to build the relationship. This involved some self-knowledge (**looking in the mirror**) and treating the customer as a valued human being (**doing unto others...**). The customer was able to make progress in their rehabilitation programme as a result of this trusting relationship (**the awesome power of personal attention**).

Taking time to build a personal relationship

Spending time with individuals was important in establishing trust in the relationship. Time spent with the person doing everyday things, or assisting with personal care helped to develop trust.

I think that it was a time thing. Not only was it the time, the rapport, but also the time spent with him. Doing these things, on an everyday kind of basis(2:28)

...the time spent in there, because she needed a lot of time umm, supervising in the shower, doing her dressings and supervising with the CAPD[... we talked in those times and we got to know each other a great deal (2:21)

Taking time to listen was often effective in that the nurse becomes aware of important issues in the lives of customers.

I guess just sitting down and relating to somebody person to person ... It's about allowing the relationship to develop...that information's never going to come out, and if you don't take that time to sit down and have some interest...(1:4)

Just listening to him like, one afternoon, he spent about three hours talking about the same thing, every single afternoonbut it was about things that were important to him (2:28).

Sometimes giving time meant giving 'time out'. The nurse in the following instance removed herself until an angry customer was calm enough to talk.

... before I even got in the door he was yelling and swearing because he obviously wasn't prepared to listen at that point. So I just left him alone for a while. And when I came back he was more prepared to talk (2:24)

Focusing on the whole person rather than on one aspect helped towards building trust.

Well, I've noticed that the focus was certainly on the customer...his wants and goals and I think he actually appreciated that (2:27)

So it's just moving beyond that immediate problem, I suppose, to try to see the person as a whole...(1:3)

That's what attracted me to working in a place like this. To start with you're not just doing the essentials of patching up, you've got time to develop those relationships (1:4)

As time was spent and trust developed in relationships, nurses began to make discoveries about individuals.

... he had a, yeah, a really nice side too. You know. Which he didn't show too many people...(2:26)

I discovered that she was quite an artist...(2:34)

In one particular case, a sign language interpreter was brought in to support a customer and nurses were surprised to learn much more about the customer.

I think our level of insight that came out through those talks with the interpreter was just amazing...it was a really good lesson on how she knew what was happening and what direction things could go in... quite amazing to see she had actually mapped out her life (2:23)

Disclosure of important issues sometimes happened. One woman in a rehabilitation planning meeting shared her plan to commit suicide in the acute hospital but she had decided against it when she began to make improvement.

...she told the group, including her husband, who didn't know, a vivid description that she had planned her suicide whilst she was in the acute hospital...She obviously

needed to be able to say it in the safety of that group ...The trust must have been established for her to feel comfortable with everyone (2:33)

Often customers also made discoveries about nurses in the team. Their perceptions of nurses in the acute setting were altered in the rehabilitation environment.

...they see us as normal people...(1:3)

There was a feeling that not wearing uniform helped to break down barriers and helped nurses to be seen as real people. It helped nurses share something of themselves.

I think the way we dress says a lot about people...Like when you're in uniform it's like a cover up...It's sharing bits of yourself too...Yes, you need to share something of yourself and it's part of caring as well (1:5).

...that's where mufti comes in as well, it really breaks down the barriers (1:11)

Looking in the mirror

Nurse participants, whether consciously or unconsciously, dug deep within themselves to use their own human and personal qualities, combining these with past experiences to create relationships. Stories illustrated this combination of sensitivity and perception as well as a knowledge of what had worked in the past.

I suppose I had... instinct or whatever from the very beginning of meeting her that I needed, that the important thing was going to be the relationship with her...But you could tell that this wasn't going to be simple...(2:31)

Often you get people who won't open up, and it's just being able to pick up cues or just sitting down with them and getting them to talk, asking them questions and just saying it's OK to talk (1:5)

...the doctor said something to this particular client about seizures and he just completely freaked out ... so I asked 'J' to just come and talk to him and be with him...she is just so appropriate and so tuned in to what she says...(1:15)

Another nurse participant described a situation where she did not immediately go and fetch pain relief when a customer was extremely distraught. She was aware that onlookers may have regarded this as a callous thing to do but

believed that her actions were necessary preliminaries to giving effective pain relief.

...I just worked through it calmly with the person got her to go back to bed, got her to relax and do things and then I dealt with the other things...the pain relief and everything (1:21)

The same nurse participant described how important it was to be aware of her own strengths and skills. She described her own personal strategy for developing trust.

...over a matter of time when you do the observing and how they react to things ...You do it by watching other people and how they interact and you do it from your knowledge of what are your best skills and how you can contribute... Emphasising your own skills (2:31)

Humour seemed to be quite a powerful agent in overcoming difficulties.

... one of my specialties is humour and I sort of tend to get through to some people with using humour and that sometimes breaks down the barrier (1:6)

Knowing when to hold back was very important in the relationship. The following two instances illustrate how nurses held back in a sensitive way. The first was following an incident where a customer had had a fall. The second came after the revelation that a customer had considered committing suicide a few weeks previously.

If I'd have then rushed in, I don't think she would have actually been in the right space. She needed some time just to settle, and just adjusting to hear that 'yes I've fallen but I'm OK'(1:3)

... she knew by my reaction that I wasn't going to rush off and get the psychiatrist and do all these things and create a big fuss. I acknowledged it as part of how she was at that time... (2:33)

Doing unto others...valuing the individual

Treating customers with respect, and behaving in a way that indicated that their lives were of value were seen to be important qualities in the relationship, and included:

Courtesy and loyalty...

...some of the niceties like traditional things about, courtesy and loyalty and stuff are a really important part ...(2:30)

Suspending judgement...

...her reputation actually preceded her...I don't like that, that reputations precede people. I always try to accept people the way I find them and I'll treat them the way I find them (2:33)

Finding common ground...

finding some common ground can be really good. Talking about gardening, orchids, and hobbies that she really liked doing. So I brought in books from the library about orchids (1:9)

... the only reason I think that I got our trust was that I was actually a foreigner because she was in an area where she was the only Maori ...she smoked and I smoked and she actually appreciated that. That I wasn't a professional or a nurse who didn't have any faults...had no vices. She actually liked that (2:34)

Finding a way to relate

most times when you communicate with a person who has a hearing impairment, you only do it to ask a question...People actually did have conversations with her (2:23)

The awesome power of personal attention

Trust in the relationship reaped its own rewards. Some customers seemed to have experienced disappointment in previous personal relationships. Trusting anyone was a quite a new experience and being able to depend on members of the team had a powerful impact.

I think part of it is knowing that you won't give up. That's a part of that trust...they have experience with people who have given up, not in the hospital situation, but probably in their social situation. So knowing that there are a core of people who are not going to give up is really important to them (2:25)

Taking time to build a personal relationship helped to foster communication.

The good rapport and trust meant what?... it presented communication...(2:34)

... if it was someone he didn't like he would just not communicate at all (2:27)

Spending time allowed customers and families to ask questions and helped to develop trust.

If they don't feel comfortable with you they're not going to say I don't understand or I don't know what you're saying because they're going to feel really stupid. It's better when they can say hey I don't understand and ask questions (1:7).

Gaining rapport was initially very important for me to have a working relationship with S... and her sister, and getting some trust (1:8)

Developing trust in one particular case allowed nurses to perform painful dressings.

I think that he required quite a great level of trust if you were going to work with him...it required you to have a good rapport with him...or else he would have refused all the time. But he didn't (2:25).

Consistency in the relationship also helped to relieve fears and build the relationship.

Being able to work for days with that person so they can relieve the fear and anxiety (1:10)

So you were consistently inconsistent?...We were, and it worked for us (2:34)

...it was little things but they meant a lot to her ...she knew that if I said I'd do something, I'd do it...(2:29)

In summary, part of the nurse:coaching role involved paying attention to the person by taking time to build a relationship, being aware of oneself, and valuing and respecting the individual. The effect was to build confidence in the individual and, in doing so, actively support the individual to move along the continuum towards independence.

Coaching is the process of enabling others to act, of building on their strengths. It's counting on other people to use their own special skill and competence, and then giving them enough room and enough time to do it.

(Peters & Austin, 1985, p.328)

Enabling others to act

The data revealed specific steps in the process of enabling the customer to make a recovery. Rehabilitation took place within the context of the nurse relinquishing control and the customer taking on responsibility (**stepping up to responsibility**). Sometimes there were physical or emotional barriers which prevented the customer being able to act autonomously and nurses described a number of ways in which they helped the customer overcome these (**getting people to play**). The process of relinquishing control meant that nurses felt that they needed to stand back and allow the customer to make choices, even when they did not seem to be ideal (**giving elbow room**).

Stepping up to responsibility

The transition from the acute environment to the rehabilitation setting appeared to mark a **shift in the locus of control**. The acute setting had the effect of encouraging passivity.

I think in acute hospitals it's very easy for them to just stop off (1:8).

So they don't have to think about what's happening. They don't have to think about that leg that's not doing anything (1:9).

In a rehabilitation setting, nurse participants indicated that control needed to be moved away from the nurse and back to the customer so that barriers could be broken down and goals met. This required a paradigm shift in the outlook of nurse.

It's quite a big shift in the way you view nursing, I think, isn't it? It seems to be more hands off and to let people explore some things (1:3).

...focusing on the customer's goals is paramount...For the nurses this often means shifting the balance of power or giving up the element of control that still exists in nursing (2:24).

I think that sometimes it's not being in that power role...it really breaks down the barriers (1:11)

It also required flexibility and surrender on the part of the nurse. One participant referred to an inflexible approach to work that was unhelpful in the rehabilitation environment.

I think probably to work here you've got to be reasonably flexible. And if you like to work in a down the line, organised it just wouldn't work (1:8)

...you let people voice their concerns rather than perhaps moving over them because you have other priorities (1:5)

Informing was part of returning control to the customer. Before choices could be made by the customer or family, a process of education or informing had to occur. One family was keen to take their relative home but the nursing staff were concerned that the family didn't fully understand what this would involve.

I had to respect this ... but I also felt that they didn't have all the knowledge and didn't know the reality... first thing was to sit down and do some education on hepatitis B...we talked about it and used the booklet ... going back to it and checking out to see they understood (1:7)

Nurses established boundaries by attempting to **clarify expectations** of customers, and by **setting limits**, particularly in terms of abusive behaviour.

It was important to establish with a customer what they could expect from the nurse, especially where the needs were very complex.

She needed someone that was clear about what they could do and what they couldn't do, step by step, from very beginning...(2:29)

Sometimes it was necessary to put limits on the behaviour of a customer. This

was possible in the context of a trusting relationship.

It is sort of like setting limits to what's acceptable to you...if you've got that sort of trust relationship with somebody, then it's OK to do that whereas if you haven't then you can get into sort of real difficulties (2:22)

It is just setting limits really. I'm not prepared to be yelled and sworn at...he said to me afterwards, oh, I wouldn't like to be sworn at that much either...it taught me a lot about setting limits...as long as I just went back afterwards(2:26,27)

It could have been a self preservation thing on both parts. One for him and two, removing oneself from him. Potentially a dangerous situation. (2:26)

The effect of clearly defined limits could be remarkable! One nurse described how she set limits by continuing to behave normally when a customer had suddenly become aggressive. This had the effect of defusing the behaviour.

...talking to me about ordinary things and be aggressive one minute ...if I managed to contain myself and concentrate on what I was doing she'd just switch... it was as if...she'd never started the situation (2:36)

Getting people to play

It was important to return control back to the individual because s/he needed to be making decisions prior to returning home. For some customers, accepting control and taking responsibility was not an issue. They appeared to be people who had a high level of motivation or whose recovery was unlikely to be complicated.

If somebody appears to be motivated ...they can set goals and they are quite clear on what they want to achieve, then you just need to support them to do that (2:32).

However, there appeared to be a connection between the complexity of the recovery and the level of motivation. Where needs were complex it could be difficult to find ways to encourage a person to move along towards independence. Complex physical needs could be compounded by issues such as reluctance, anger, communication problems, lack of knowledge, or feelings of powerlessness. The team deliberately developed strategies to facilitate return of control where there were such barriers.

A particular story of a woman who's condition necessitated regular catheterisation illustrated reluctance to take control.

...she didn't want to know about her condition... she had to have a catheterisation several times a day...she wasn't really interested...she would put it off, or, do anything...I would put limits, and say okay this is what we are going to do...it slowly turned around and she was taking a little bit of control...she was taking an interest in how much there was because she could see the progress ...(1:15-6)

The nurse was able to turn the reluctance into something like acceptance by a subtle blend of strategies: explanation, cajoling, consistency, recognising that there were other important issues going on for her, acknowledging progress, until the person began to accept responsibility.

One particular customer who had been very badly burned was acting in an angry way and verbally abusing staff.

...it became apparent that his anger was largely related to his feelings of loss of control of his body and his life. After consulting with other members of the team we decided to attempt to give J as much control of his life as possible (2:24)

Returning control meant negotiating a rehabilitation plan which helped to allow him to feel more in control. This included adjusting therapy times, going shopping for food and assisting him to prepare and cook it, and helping him plan weekends with his partner in a familiar environment. This strategy had a liberating effect.

I think it probably helped him to feel more in control, so he was more likely to participate, rather than just say no and refuse...empowered him to actually get on with his life (2:24)

Another customer was profoundly deaf and communicated using sign language. Returning control to her in the face of a language barrier presented difficulties which were overcome by spending time in a persistent and consistent manner.

I think that part of the therapeutic relationship with D... was with her communication difficulties, that you actually...spend a lot of time with her, you know, making sure she understood and re-explained things...I think that the input she got gave her more confidence too...she didn't become passive ...(2:24).

Lack of knowledge of the major issues involved in caring for one particular customer prevented the family from making an informed decision about where the customer should come home to live. This was overcome by bringing a family member in for a 24 hour period to participate in the daily care of the person and teaching her how to support and care for her dependant relative. Staff described the effect of this:

You were handing control over. They felt comfortable with you (1:8)

In another situation where the customer was highly dependant, returning control meant simply stopping and asking the customer what she wanted.

Just because she was in pain, it wasn't necessary to rush off. I just needed to say what did you want. What do you want, and quite often she could tell you what she wanted and it wasn't necessarily the medicine out of a bottle.....(2:31)

Giving elbow-room

Returning control and decision-making to the customer meant that staff had to accept the choices that individuals made for themselves. This wasn't always easy.

...his goals weren't our goals ... So, it came down to just accepting that it was his choice really (2:25).

Giving her control, choices.. I think it is the harder way to go (1:8).

Enabling the customer to become more independent meant a shift in the locus of control. Firstly, the nurse had to surrender control to the customer, and secondly, the customer had to be in a position to take control. Nurses used strategies to facilitate this process where there were barriers. Once the customer was in a position to take back control and make choices, nurses needed to step back and facilitate this freedom.

Coaching is tough-minded. It's nurturing and bringing out the best ...

(Peters & Austin, 1985, p.329)

Bringing out the best

Coaching the individual to reach maximum highest potential involves a flexible approach. What works with one does not work with another. However, there were some essential ingredients to include. It was important to acknowledge achievement, particularly in the face of difficulties (**building on strengths**). It was important to set goals and create and sustain motivation (**you can do it!**) and sometimes this necessitated tough talking in the context of the trusting relationship (**tough love**). The effort for both the customer and the nurse was rewarded by increasing self-confidence (**coaching a winning attitude**).

Building on strengths

Acknowledgement in the coaching role was vital in maintaining momentum in the effort of rehabilitation, particularly where there were major difficulties. Recognising that gains were difficult to achieve and that some individuals lose momentum or enthusiasm, the need to acknowledge progress and achievement was very important.

I could see his progress over the period of time he was here and I think it really helped him having someone acknowledge that and encouraging him all the time (1:10)

I think that one of the main things that people did with her, who worked with her, was emphasise how far she had come (2:21)

even the little things that might not seem as progress to customers, just pointing things out to them and saying that is really big progress, it is good and you've done well (1:9).

I think that just acknowledging that some people have better days than others and that just because they walk 5 metres, or 10 metres or 50 metres it may not be tomorrow, they may only be able to walk 1... you just need to acknowledge that it was really good today (2:36)

Acknowledgement in the face of difficulties. Sometimes acknowledgement and encouragement occurred in the face of almost overwhelming difficulties, and nurses had to face their own reaction to the negative outlook.

It was difficult when you were empathising with her and walking in her shoes not to just stay there, stay on what the difficulties were for her (2:21)

At times like this it was important to focus on what was possible, not on what was insurmountable. This was the nature of rehabilitation work.

...in terms of rehabilitation and wanting people to improve functionally...You'd be really disappointed and frustrated in the job if ...that's all you saw the job doing...we see lots of clients here where we've improved them and we've valued their lives for what they are, not focusing on their limitations (2:30).

One participant described a series of strategies which she had used in the very difficult situation described above. The customer was a young woman with a very poor neurological prognosis. Strategies included giving positive feedback about the coping mechanisms that she was using, reminding her how she was able to move by herself and how far she had progressed since she had been in the acute hospital. By acting in a calm manner and encouraging the use of relaxation techniques when the customer was particularly anxious, her anxiety level was decreased. Through all of this, a level of trust was developed in the relationship (2: 21)

Acknowledgement could be reciprocal. Nurses also experienced acknowledgement of their effort in various ways.

I think that feedback from the families, is a big one...Just seeing the person walk out of here...Or the first time they get up and walk on crutches...Seeing them smile and not cry...different behaviour, you notice behaviour changes sometimes in people (1:13)

You can do it...

Setting goals provided direction for customers and the team. Goal-setting was done in planning meetings and the customer was asked to actively participate in planning goals. This was sometimes a source of surprise and confusion to the customer.

I think most of the people expect us to make the goals... they don't realise it's their goals. I don't know whether we don't explain enough, or whether the other therapies don't explain enough...(2:37)

The difficulty that customers had setting their own goals was sometimes because they were distracted by other issues and participants thought that it was important that nurses recognised this.

There's lots of things that are going on for them that aren't easily understood and day by day interpreting what is going on for them is really important (2:36).

Keeping goals to a manageable size helped to maintain momentum.

always making sure that the goals are small enough so they get some positive feedback really quickly... Because if they're too big they are going to get that sense, they can't see it (2:32).

Motivation played a big part in achieving goals. There was a feeling that part of the nursing role was to find out what motivated individuals and help the customer deal with blockages to motivation, such as feelings of grief and loss.

Finding out what motivates, and assisting the individual to become motivated was thought to be a part of the nursing role.

I think it's about finding out what motivates people too... the tendency sometimes is to write someone off if say they're not motivated, that really irritates me 'cause I really see it as our job to get to know the person and find out there's always something that motivates the person...if they're not motivated there is always a reason for it(2:31)

One nurse described the discovery of just such a motivator. A customer was keen on art and the nurse was able to facilitate her interest in drawing.

Because I had found what she liked to do in her spare time... There was just so much negative stuff with her, that it was really....important... She got positive feedback from a whole variety of people. It was just the turning point actually(2:35-6)

When customers were less clear or less motivated, they needed more input. One nurse participant specifically described this as a coaching role.

Sort of need to be more encouraging...not likely to take the initiative so you need to be more you know...Be their coach or something...(2:32)

Motivation was sometimes a problem when an individual had to come to terms with loss and grief issues before they were able to actively participate in a rehabilitation programme.

I think that where the loss of motivation was, just the grieving and the fear of what was going to happen, "Am I going to walk again?" (1:12)

...a lot of people that come in, I mean, often it could be something dramatic like loss of limb, but I mean, usually it's marking something quite major in terms of... I mean that they are not going to be whole the way they were, are they, so it is a big grief thing (2:34)

Nurses listened and provided emotional support until the person was ready to participate..

She lost a husband...that first week..., physio and everything...she just couldn't do anything could she, because she was just grieving, crying the whole week virtually. It was just sitting there, being there with her, and I think that was a really big help for her and then she was able to sort of get moving and get motivated (1:13)

Sometimes nurses were caught in situations where spur-of-the-moment counselling was required.

I remember seeing him crying one night and I'd never seen that side of him before... asked him if everything was OK. He just said that he can't go home...I thought it was very sad...I actually didn't know what to say to him...I don't know what to say to you, I don't know what the answer is...(2:26)

Tough love

Sometimes a part of motivating was what could be described as tough love. One customer who seemed to be poorly motivated responded to a humorous and affectionately administered approach of **pushing and cajoling**, started with a preliminary wake-up call an hour before he needed to get up. It was clear to the nurse that he would not respond positively to a more heavy-handed approach.

He really needed a lot of pushing. He didn't have it naturally. It was just that constant pushing all the time, got him going... I got him up in the mornings and down to physio and was there with him while he was doing things in physio so I could see his progress ...I think it really helped him having someone acknowledge that and encouraging him all the time(1:10)

On some occasions a more **confrontational approach** was used. This seemed to be appropriate where there was a particular lack of motivation or non-compliance.

...you can challenge them if they are not doing it, like I mean, even ask them why not (2:31)

One such encounter was with a customer had set himself alight and sustained severe burns as a result. He had regularly expressed a feeling of blame towards members of his family and his partner.

I said to him one day, umm, he was doing the it's my girlfriends fault, and she did this to me and that's why I did it and I said to him well she didn't light the match and he went(expression of shock), like it was a real revelation to him. He couldn't believe it...it obviously had never crossed his mind that it could possibly be his fault. You know that he was in this situation (2:28).

At other times, tough love meant that nurses had to be part of **removing the dream**. For one woman, the hope of eventually going home was not fulfilled, and nurses were part of dismantling this dream.

even though I would have liked to have seen D... go home, it was hard for me to see ...that we were actually going to take that dream of reality away from her (2:21).

Another woman wanted to go home and look after her daughter who was living with her parents. However she was unable to be independent and, instead she reluctantly went to live at her parents home.

She wanted to be independent, which she knew she couldn't be...She didn't really want to go, in fact she didn't even say goodbye to me (2:34)

Coaching a winning attitude

One of the effects of coaching was developing personal strength and self-esteem.

...using her strengths, emphasising her strengths and I think that it did make a difference for her because it seemed like she did feel stronger and deal with things... see her able to deal with knockbacks to her physical condition much better by the time she left here (2:29)

Some of this personal development resulted from the accomplishment of a difficult task.

It was quite good to introduce a skill that was a bit more difficult to give her confidence as well... She was really keen and saying oh can I try that again. It went really well...(1:7)

The nurse as a coach began by building a personal relationship with the individual. During this relationship the customer was encouraged to take back control and was supported in doing so. The customer made progress with the support of nurses and was rewarded with renewed self-confidence.

Coaching: face-to-face leadership with family

Although a relatively small part of the data, nurse participants described the importance of developing a personal relationship with family members (**Making room for others to contribute**). The nurse as coach took steps to involve family members in the rehabilitation process.

It turns out that successful coaches instinctively vary their approaches to meet the needs of this person at this time, or that group at that time.

(Peters & Austin, 1985, p.328)

Making room for people to contribute

The customer was not viewed in isolation. Instead, the family or whanau members were important in the rehabilitation process and nurses recognised that the relationship, of necessity, extended beyond the one-on-one relationship. Developing a trusting relationship with family was essential (**taking time to build a personal relationship**), especially where family members were to become the source of community support for the customer. Family members were sometimes very involved in care and they became active participants in the rehabilitation programme which included education and training (**sponsoring**).

Taking time to build a personal relationship

The need to develop a trusting relationship with family members was thought to be very important. In the same way that the relationship with the customer required trust, so too did the relationship with the family members.

it could be to the detriment of the person, if you don't make an effort to get alongside the family members, see things from their point of view...develop the same level of trust as you do with the person (2:22).

One person talked about the concerns a mother had for her son, and another talked about the relationship of a mother and daughter. They both described how the relationship of trust with the nurse had helped to allay fears and provide support.

...his Mum was comfortable enough at the end of the week to go... She felt safe enough that she could go back home... It was all really about developing that relationship, a trusting relationship (1:10)

The mother obviously needed support too because she was having real difficulties dealing with the deterioration in her daughter's condition and giving the mother support, supported the person (2:30)

Trying to empathise with family members was not always easy, particularly where there was conflict but it was seen to be essential because of the social support which they provided for the customer.

I think it is very hard for nurses sometimes to see the other, the other, the family's point of view. And sometimes you have to do that. You have to walk in their shoes as well... they have got a valid viewpoint and if the bottom line is the person's social supports are the ones that are going to remain with them (2:22)

Sponsoring

One nurse participant described how she included, at their request, the family of a woman with quite profound disability. They wanted to take her home without necessarily understanding the full implications.

I brought the main caregiver, who is going to be her sister into work with me over an afternoon and then she stayed the night just so she could understand what the demands of the care were and took it as an opportunity to do some teaching with the sister (1.7)

Nurse as coach took steps to build relationships with family members and their involvement was recognised to be important, particularly when the family was providing the social support for the customer.

Part Two: Customer data analysis

Customer data was written and therefore less rich than the nursing data. This was due to the data collection method - questionnaire data collection rather than verbal group interview. The customer data was a small part of the overall study but provided the study with a method of validating findings from the nursing data. It also provided a consumer focus and a means of comparing perspectives.

Customer questionnaires were analysed using the same method as the focus group and sub-categories developed. During analysis of the themes that emerged, it became apparent that the issues could be grouped in a similar way as had been the nursing themes, with some minor differences (these will be discussed at the end of this section).

Customer participant responses were suggestive of the coaching:leadership role of nurses both in individual relationships (**Coaching: face-to-face leadership with the individual**) and within the team (**Coaching: face-to-face leadership with the team**). Some of the constituents of each major category varied, and these will be discussed. There were no references to the involvement of family members in the responses, probably because the questions focused on nurses.

An outline of the customer categories is provided in Table 4:2.

Table 4:2 Summary of Categories from customer questionnaires

Coaching: face-to-face leadership with the team	Coaching: face-to-face leadership with the individual
<p>Welcome to the team</p> <ul style="list-style-type: none"> • settling in <p>Smooth operations</p> <ul style="list-style-type: none"> • leading the team • we're all in this together 	<p>Paying attention to people</p> <ul style="list-style-type: none"> • taking time to build a personal relationship • going the extra mile • looking in the mirror • doing unto others...valuing the individual <p>Enabling others to act</p> <ul style="list-style-type: none"> • stepping up to responsibility • giving elbow-room <p>Bringing out the best</p> <ul style="list-style-type: none"> • building on strengths • you can do it! • coaching a winning attitude

Coaching: face-to-face leadership in the team

Customer responses included reference to the support they experienced in settling in (**Welcome to the team**) and in nurses' contribution to their integrated rehabilitation programme (**Smooth Operations**).

Welcome to the team

Support from nursing staff to adjust and settle into the environment was helpful for customers who arrived in the organisation (**settling in**).

Settling in

Included in this were aspects of initial welcoming and getting to know other customers and the team. Customer participants recognised that nurses facilitated this process of settling in, just as nurses themselves had identified.

The way they went all the way to see you fitted in.... (4b)

helped me settle in particularly over the first few days in adjusting to a new environment (8, 1)

Smooth operations

Customers recognised the managerial role that nurses held and which nurse participants also identified (**leading the team**). Customer participants appeared to derive comfort and security from what they described as nurses' professionalism. This could be attributed to a perception that nurses had training and knowledge that was unique to the discipline. Customers also appreciated the role of other team members in the functioning of the team (**we're all in this together**).

Leading the team

Professionalism was an aspect of the nurse-customer relationship which seemed to provide a feeling of comfort and support. Monitoring of health issues which was mentioned on several occasions may have been part of this

global professionalism. It was not recorded by nurse participants as such, but may allude in general to the trust which was created in the relationship.

...I knew I was dealing with professional nursing staff, trained in rehabilitation. (3, 1)

Customers described how nurses monitored their medical conditions such as blood pressure and diabetes.

Regular Blood Pressures taken especially in the mornings, plus medication. (2, 1)

...monitored my health issues...diabetes...(6, 2b)

One person mentioned medical supervision on several occasions as helpful, but did not specify which aspects in particular (4,1,2a)

The managerial role that nurse participants themselves identified was reflected in customer comments.

...organisation of my days...(4, 1)

...another very helpful thing was when my nurse on the day shift would keep me up to date with appointments...(8, 2c)

...advise you of extra services they think you may like to use e.g. family counsellor, social worker etc...(1, 2c)

...have offered me help - arranging for counselling (6,2c)

We're all in this together

The importance of others in the team was highlighted. Just as nurse participants respected the unique knowledge of their colleagues, so did customer participants. Several customers mentioned the importance of physiotherapists in their rehabilitation.

I did enjoy the P. Therapy....(2,2a)

physiotherapist

-encouragement

-help

-asking my opinions (5,2a)

The unique contribution to the team of service assistants was also mentioned.

...kitchen-helpers - helping assist with light kitchen duties as you got used to doing them yourself....(5,2c)

Customers recognised that nurses worked co-operatively with other disciplines, an aspect of their practice that nurse participants themselves identified.

...the physio was the making of me...I attempted things that had been beyond me...the after-hours encouragement the nurses and staff gave me allowed me to achieve these goals...(4, 2c)

Coaching: face-to-face leadership with the individual

Introduction

The concept of the nurse as a coach was reflected in the customer responses. Customers indicated that they had been involved in a personal relationship in which they were respected and valued as individuals (**Paying attention to people**). They appreciated the way in which nurses provided a hands-off support whilst they were testing their independence and felt able to make choices (**Enabling others to act**). Customer responses indicated that they were encouraged and supported to achieve goals and were rewarded with increased confidence (**Bringing out the best**).

Paying attention to people

A trusted relationship was developed over time (**Taking time to build a personal relationship**). Customer participants perceived that nurses sometimes went beyond the call of duty (**going the extra mile**). Nurses were seen to have personal qualities that were appreciated (**looking in the mirror**). Respecting the things that meant a lot to customers - dignity and modesty - was mentioned several times in responses (**doing unto others...valuing the individual**)

Taking time to build a personal relationship

Nurses were appreciated for the time they spent with customers.

...able to give that extra time...(3,2c)

...time taken to do this (treat as an individual)...(1, 2a)

Some customers expressed appreciation that they had been treated as an individual, with individual needs.

...ability of the nursing staff to treat you as an individual with individual needs...(1,2a)

...talking and understanding your needs...(1,2b)

...pain problem was well looked after and indeed contained: quite often before I was fully aware of it myself...I appreciated their awareness of my problems with chronic pain. (3, 2a)

The role of the keyworker was mentioned on several occasions in relation to a helping and support role.

My care-worker the one-on-one relationship...when the going got rough or the tears came the one-on-one came into its on...(4,1)

Key-nurse...encouragement + care (5, 2b)

One customer expressed how helpful it was to know which nurse had been assigned to him/her on each day.

It was helpful to know the nurse who was assigned to you on each shift...nice touch for them to identify themselves to you. (8,2b)

Going the extra mile

Customers seemed to appreciate the wholehearted commitment to their welfare (This did not emerge as a category in the nursing data).

Nothing was too much trouble...(9,1a)

...do the little extras for you, such as messages, arrange personal interviews, accompany you...(4,2b)

...nothing was spared to return me to a normal or near normal life.(4,1)

Looking in the mirror

Customers appreciated the personal qualities which nurses brought to the relationship. A caring attitude, sometimes expressed in other words, was significant. Customers also appreciated the quality of humour.

...helpful and considerate...(9,2a)

...without the professionalism and compassion my rehab will be a lot more difficult + maybe not fully completed. (6, 1)

...very great care...very kind...thoughtful...(7, 2a,b,c)

Some found that humour helped them to stay on track.

...without the care and humour of these nurses I would have lost sight of my goals. (6,1)

... cheerfulness...(4,1)

Doing unto others...valuing the individual

Customers described how nurses had been respectful of their modesty and this helped to ensure a feeling of privacy (nurses did not address this particular aspect of respecting the individual in the focus group data).

...the dignity that I was allowed to maintain. I am a large person but was never ever embarrassed or made to feel inadequate. (4,2a)

...helping me to preserve my dignity in all situations. This was very important to me as I am a fairly private person and the situation that I am in caused stress in this area...(6, 2a)

...the way they allow you to preserve your dignity and modesty. (1,2c)

Enabling others to act

There was evidence from customer responses that the locus of control had shifted during the rehabilitation programme and that nurses were part of this occurring (**stepping up to responsibility**). Customers described how they had been given choice in several ways (**giving elbow-room**).

Stepping up to responsibility

Customer participants described how nursing staff had helped them to take back control of their lives through providing information, maintaining self-confidence whilst they were testing their independence, and by providing emotional support and counselling

It was clear that nurses were seen as **providers of information**. This provided a means by which customers could take back control for their own independence.

Once you have been assessed and taught safety they allow you to get on with showering dressing etc...(1,2c)

Good initial education about bed to chair transfers...allowed me to manage these manoeuvres myself and maintain a degree of independence (4,2a)

I was given hints to improve or handle daily chores. (4,1)

...nurses explain medication and treatments...(1,2b)

Customers could test their independence with a feeling of confidence because nurses were **available and supportive** while they were doing so.

...knowing they are close at hand on hearing the bell. This also most importantly boosts your confidence which is a big part of your rehab.(1,2c)

The nurses were still attentive and helpful but allowed me that degree of independence. (8, 2a)

... Help to get around but not too much caring etc. so they became a pain. (5, 2b)

Several customers expressed their feelings of **emotional support**. This helped to overcome difficulties that may have prevented further progress, including home issues, sharing problems, and stress.

...observations the nursing staff has made re my home issues - my general mental attitude to my treatment length of time & diagnosis they have talked and listened...(6,2c)

...excellent skills & were helpful in any problems..."a problem shared is a problem solved"... time to devote to a customers physical, & spiritual, well-being.(3,2b)

...Everyone is cool and calm, so there was no undue stress put on me. (2, 1)

Giving elbow-room

Customers thought that they were free to make choices about their own lives. One person particularly addressed appreciation that s/he was asked by nurses for...

...my input of progress - where I wanted to be...(5,2b)

Another person appreciated that s/he felt under less pressure to eat.

...and not like the hospital, there was no pressure on having to eat everything put in front of you. (2,2b)

Bringing out the best

Customers described how nurses supported them in everyday activities, which helped in the journey towards independence (**building on strengths**). When motivation or energy flagged, nurses provided encouragement to keep going (**You can do it!**) and the customer was rewarded with the sense of achievement that followed (**coaching a winning attitude**).

Building on strengths

Customers discussed the effect of nurses being available to help, assist, supervise and support them in their activities.

...helping and assisting me to become more mobile and able to do a lot more for myself...showering feeding ... made my disabilities so much easier to cope with(9, 2a, b))

...the thing that particularly stood out for me was the nurses' willingness to help with basic everyday hygiene needs. (8,1)

...as I was self-medicating, check with me regarding drug requirements (8,2c)

These nurses have supported me fully in my attempt to rehabilitate as completely as I can. (6, 1)

You can do it!

Customers described feelings of encouragement and acknowledgement of their progress. This provided motivation to take the next step.

...I was always encouraged to take that next step forward...(4,1)

... after-hours encouragementallowed me to achieve these goals...(4,2c)

Encouraging me to keep up with physio out of the gym. (6, 2c)

Without the care + humour of these nurses I would have lost sight of my goals. (6,1)

Coaching a winning attitude

Several customers referred to the way in which nurses had assisted in building self-confidence.

They did everything they could to return to me my confidence, pride, privacy and sense of accomplishment...(4,2c)

One person spoke highly of the rehabilitation service in general as a liberating experience where s/he...

...would not be where I am to-day - returning to normal living and the work-force. (4,2c)

Summary

Part One of this chapter has provided an analysis of data retrieved from the nurse focus groups. Themes emerged clearly from the nursing data. The therapeutic value of nursing in rehabilitation seemed to be highly focused on interpersonal aspects, and the overarching theme throughout was that of the nurse as coach, focused on assisting the customer to progress towards independence. Nurses were, in other words, face-to-face leaders or nurse:coaches.

Because the aim of the nurse is to maximise the independence of the individual, s/he develops relationships within the team as well as with the individual customer and with family members. Three distinct relationship formations have been described in which nurses have a coach:leadership role, namely **coach: leadership with the team**, **coach:leadership with the individual**, and **coach:leadership with the family**.

Aspects of the **coach:leadership role within the team** have centred on facilitating the integration and co-ordination of individual rehabilitation programmes, and on welcoming the customer to the team. The **coach:leadership role with the individual** has three important components. Firstly, the development of a trusting or therapeutic relationship facilitates progression towards independence by fostering good communication, by sharing information, and relieving fear and anxiety. Secondly, within the context of a trusting relationship, the customer is enabled to begin to take back responsibility for the future and the nurse has an intrinsic role in reducing barriers to this, and then standing back as individuals make choices for themselves. Finally, within the trusting or therapeutic relationship the customer is encouraged, acknowledged, supported and motivated to move along the continuum of independence. Sometimes this requires tough love with the aim of increasing the person's self-confidence or being realistic about the future. The **coach:leadership role with the family** centres around the development of a trusting relationship in which the family is supported to be involved to the extent that is decided by the individual and his or her family.

In Part Two an analysis of customer questionnaire data has been presented. Although small, it is an important component of the study. There were strong parallels with the nursing data. Customer responses also clearly reflected the coaching role of the nurse. This was predominantly within the context of the personal relationship that was developed between the nurse and the customer. Customers expressed ways in which they felt valued and enabled to progress towards independence. Customers described the professionalism and the monitoring of health issues that nurses performed. It is not clear what was meant by this. However, it suggests that customers perceived that nurses had knowledge and experience that gave them a discreet professional identity.

Several customers described nurses in terms of going the extra mile, and of protecting privacy and modesty. These were not mentioned specifically by nurses but could be considered as part of valuing the customer. There was no reference by customers to the aspect of the coaching relationship described as 'tough love'. This may reflect an exclusively nursing perspective of the relationship.

Customer participants expressed their appreciation of the nurses' role within the team which facilitated both integration of their rehabilitation programmes, and their welcome into the team. Customers appreciated the input from other team members, namely physiotherapists and service assistants, and recognised that nurses supported the work of other therapists 'after hours'. The internal team issues which were described in categories such as 'learning from others' or 'thinking beyond the discipline' were not apparent in the customer data. This is not surprising in that the inner-workings of a team are not always visible even to those who are intimately connected with it.

There were no references to the relationship with the family in customer responses.

The data will be discussed further in the following chapter. The central themes from the data will be reviewed in the light of the relevant literature and the conceptual models of therapeutic nursing which were outlined in the introductory chapter. The emerging model of nurse:coach will be described and discussed.

Chapter Five

DISCUSSION

This chapter presents a discussion of both the methodological strengths and limitations of the current study, and issues related to the trustworthiness, validity and reliability of the findings. The interpretation of the data is discussed within the context of the current literature relating to coaching. Finally, a model for rehabilitation nursing is presented.

Study design and method

Strengths and limitations

A major strength of the study design was the way in which the focus group method encouraged participants to talk about their practice in a relaxed environment with limited researcher input. Effort was directed towards creating a conducive environment for discussion. The groups were run on two consecutive Sunday afternoons, Sunday often being a quieter day of the week for rostered nurses. A spacious room overlooking a rose garden was set up with chairs and a coffee table and refreshments were provided.

Other design strengths were:

- Both groups of participants in the nursing focus groups, in spite of the small size of the groups, interacted with one another to expand on and produce further ideas.
- All nurse participants in each focus group participated in the discussion. The small size of each group was advantageous in that it was less daunting for participants to contribute than it may have been in a larger group. Participants appeared to feel free to express an opinion without inhibition. Some group members spoke less than others but no participant spoke at the expense of another or dominated the discussion.
- Each member told their own story of practice. (Having to do so may have helped the more reticent members to feel comfortable about speaking in the group). Thinking of stories of practice had two benefits, firstly the obvious benefit of providing credible data for the study and secondly, for participants who could use the stories of practice in their professional portfolios.
- Nurse participants appeared to find the group process enjoyable and made some informal comments about the importance of such a study in

illuminating their input into the teams and the specialty. Participants were sufficiently motivated by the topic to join the group in their own time, which for one participant meant coming into work on her day off, and for several others meant coming two hours ahead of the official start of their shift.

- There was diversity amongst participants. Some members had been in the service for 7-8 months and others had joined from the previous service. There was a mixture of length and range of experience and this helped to create different points of view. Although participants were known to one another this did not seem to inhibit the flow or range of conversation.
- The study was enhanced by the inclusion of customer data for the following reasons:
 - a) the consumer aspect was a necessary inclusion in a study which examined the service of nursing in rehabilitation. When asking the question 'what is helpful or therapeutic about nursing', findings would have been incomplete without asking recipients about their experiences of the phenomenon. Indeed, this aspect of the study would constitute an important study in its own right.
 - b) it served as a comparison with the nursing data and, as it happened, actually provided verification of findings (see below)
 - c) it shed light on the process of rehabilitation from the point of view of the nurse-customer relationship and gave some indication of outcome in relation to nursing endeavour in the relationship.

There were only a small number of limitations in the study.

- Organising the roster to bring together the two groups of volunteer participants proved to be quite challenging, taking into consideration the fact that participant selection itself took a period of one month to complete and rosters are done one month in advance. Nurses were also heavily committed in their work and other work-related activities, and almost half of

the group came in their own time. For both these reasons, there were limits to opportunities to run further groups.

- No theoretical sampling was done during the time between running the focus groups. The study approach was inductive and it was the choice of the researcher to obtain data in the second focus group which was not predetermined by theoretical sampling from the first focus group. Although some new sub-categories did emerge in the second group, these served to enhance the main themes, which clearly marked both groups. The design of the study incorporated sampling from the coaching literature in the areas of management, sports and education. However, it would be useful to further test the categories by using the theoretical sampling technique from this current study in a further study.
- The data-yield from customer data was less rich than that of the nursing data because of the method of collection - written rather than interview. It would be useful in a further study to apply the focus group method with customer groups in order to gain richer data about their experience of nursing.

Trustworthiness, validity and reliability

Data collection and analysis were carried out, as previously described, using the focus group method and thematic analysis. Authors discussing the focus group method generally argue for its place within the qualitative paradigm [McDaniel & Bach, (1996); Sim & Snell, (1996)]. Consequently, the criteria for assessing the merit of the study findings, collectively described as trustworthiness, are presented. Validity and reliability issues are also discussed in relation to certain aspects of the study design, namely the incorporation of customer data, the role of the researcher, and some aspects of the focus group method.

Assessing the trustworthiness of the study, it is important to review the findings from the perspective of credibility, dependability, confirmability and transferability as follows:

Credibility and Dependability

Copies of the data analysis were returned to all nurse participants for review. No participant disagreed with the interpretation of the data. The research supervisor also provided feedback on the development, interpretation and analysis of categories.

Confirmability

An audit trail has already been described in Chapter Three where the process of participant selection, data collection and analysis have been discussed in detail. Nursing and customer data are also presented in Chapter Four and the two sets of data were examined for commonalities and outlie material. Congruence was found between the two.

Transferability

Because the study size was relatively small, ideally it should be replicated in another context in order to begin to build up a fuller picture of the nature of nursing in the general rehabilitation specialty. The size of the specialty in New Zealand would limit opportunities for further study without going overseas. The study design could be applied readily in another study context.

Validity

- Customer data served as a method of checking the validity and level of saturation of the nurse data. Had customer data yielded significantly different categories, a second round of nursing data collection, either individual interviewing or group discussion, would have been necessary to ensure that all categories of practice had been made transparent. If there had still been incongruity between nursing and customer data, this would have suggested that customers were experiencing a different kind of nursing than that which nurses believed they were delivering. This did not

appear to be so. In fact, customer data strongly reflected the categories from the nursing data. The strong concurrence suggests that customers do experience the same benefits that nurses believe that they deliver. It would be of interest in a further study to use a theoretical sampling technique to further explore the themes and sub-themes developed from the study. It would also be useful to investigate both the positive and therapeutic aspects of practice and the unhelpful and negative aspects.

- Data from focus groups had high face validity because as Nyamathi & Shuler (1990) point out, comments from participants are credible. The stories told by nurse participants were records of actual events in their practice. These were exposed to group discussion, and meanings were derived by the narrator and other group participants.
- The small size of the groups was likely to have produced more ideas because, as Fern (1982) has pointed out, eight-member groups do not produce twice as many ideas as four-member groups and more information may be obtained from two four-member groups than from one eight-member group.

Reliability

Issues relating to reliability are as follows:

- The researcher's role in focus group method increases the reliability of the findings by reducing researcher bias compared, for example, with the role in face-to-face interviewing. The researcher is relatively passive in the process of data collection. The researcher facilitates discussion in a focus group rather than solicits responses in an individual interview setting. In the study, the researcher input was low-key, achieved by allowing the discussion to occur spontaneously with the minimum of intervention, and only using prompts to encourage elaboration or probe deeper. The backup questions that were devised to be used if conversation stopped were not required. In one particular case, a participant almost became an informal

interviewer to others in the group, encouraging elaboration on some topics. This was done in a non-intrusive manner and seemed to be quite acceptable to participants.

- Without comparing findings from a group run by a moderator who was not the team leader, it would be impossible to know if the researcher's role in the team influenced the collection of data. However, the focus group method does have the effect of minimising the influence of the moderator compared with the role of the interviewer and the nature of the discussion in the focus groups was limited to therapeutic activity about which participants were encouraged to speak freely.
- Findings could only be said to be representative of the study environment itself as has been discussed in relation to transferability. The groups were a convenience sample of a small and new specialty in New Zealand and findings could not be generalised to a larger population without further investigation and testing of the categories in other sites. The number of nurse participants was limited by the number of potential participants (20), this being the total number of nurses in what is a small specialty throughout New Zealand. The total number of nurse volunteers was 40% of possible participants. The customer discharge rate in rehabilitation is significantly slower than in an acute service. This places some limitations on the total number of potential participants over the period of customer data collection (1/8/97 - 2/12/97). Of a possible 19 customers who accepted a questionnaire, a total of 9 questionnaires were completed.

The purpose of the study was exploratory and as such, the purpose was not to generalise but to explore the phenomenon and this was achieved.

Discussion of findings

The role of the nurse in rehabilitation is complex and multi-dimensional. The role contains elements of **leadership, management** and **teaching**, and it is always about **relationship**. From the interpretation of the findings in this study, it is suggested that the combination of these elements makes the role essentially one of coaching.

At the heart of the coaching relationship lies the determination of the coach to assist the individual in developing to his or her fullest potential. From the data this appears to be the nature of nursing practice in rehabilitation and constitutes what is therapeutic about the role. The role and attributes of the nurse:coach together help the customer towards healing and restoration through the relationship and also by

- providing a fertile environment
- leading the individual towards achievement
- managing the process of rehabilitation
- educating and supporting the individual

The coach cannot lead, manage or teach without first having effective relationships with individuals and with the team. From the data, the nurse:coach engages in three relationship groupings. These are:

- Coaching: face-to-face leadership in the team
- Coaching: face-to-face leadership with the individual
- Coaching: face-to-face leadership with the family

Within each of these groupings there are key elements which support the role of the nurse:coach. These elements are discussed below and supported by reference to literature.

Coaching: face-to-face leadership in the team

What is the role of the coach in the team? What attributes does the nurse:coach bring to the team?

Evidence from the study suggests that the development of a supportive and personal relationship with the customer took place within the context of established team relationships. Nurse participants described the use of a team approach - two way communication, team goals and developing new ideas together (**thinking beyond the discipline and learning from one another**). This team approach depended on

- effective teamwork
- collaboration
- leadership

Teamwork

The nurse:coach is a team player...

The term 'team' is traditionally used in a sporting context but has gained popularity in a range of business and service environments, including the health care setting. Effective teams are 'not merely a collection of individuals but a group of people united together by shared values and commitment to achieve agreed objectives' (Barr, 1993). The degree of success of working together in teams depends on a number of factors:

- clear team goals
- members using their skills and knowledge to achieve goals
- two-way communication
- team member responsibility and accountability for tasks
- conflict regarded as opportunity for growth
- innovation
- taking risks (Barr, 1993)

There was evidence in the data that nurses engaged in establishing goals with customers and colleagues, using effective communication to achieve these.

Nurses drew on their relationships within the team, accessing the knowledge and skills of colleagues. The concept of collaboration and collegiality are important components of teamwork.

Collaboration

The nurse:coach collaborates...

Appropriate structures can facilitate teamwork but in no way guarantee that effective teamwork will ensue. An example of this is provided by Cartlidge, Bond & Gregson (1987) who studied five aspects of the working relationships between district nurses and GPs, and health visitors and GPs. Participants in their study were working in structured situations which had been created to maximise teamwork, such as health centres and attachments. One significant finding was that collaboration between GPs, nurses and health visitors was functioning at a low level. The authors suggested that structural arrangements alone were not sufficient to promote effective collaboration. Of equal importance was the need to foster a positive attitude towards co-operative working including commitment from both managers and health service professionals.

Similarly, collegiality is an important component in a team. Collegiality is a concept explored by Beck & Utz (1996). Defined as the support and advancement of a profession by the sharing of knowledge and expertise, the authors describe the process of networking as a means to promote collegiality. Groups also develop collegiality within their discipline by networking, sharing resources, exchanging views, obtaining peer support, collaborating and problem-solving.

There was evidence of collaboration and collegiality from the nurse participant data. An example of this co-operative working together is described in the following quote from a nurse participant:

...the team, me as his key worker, the OT, the physio...not the whole team...he wasn't attending therapy, so we...tried to come up with some ideas about how to best encourage him (2:24)

A nurse participant in the study described how she had utilised the idea of a nurse colleague to teach a family member about the intricacies of caring for her relative by inviting her to participate in a 24 hour period of care.

Leadership

The nurse:coach leads...

An essential aspect of the coaching role is the ability to lead others. Nurse participants described themselves as a central link in the team because they:

- provided a 24-hour service
- they had consistent contact with family members
- pulled together various strands of information and were a central resource point for other team members
- had the breadth of knowledge of the customer that helped to develop innovative strategies in managing complex customer problems.
- often took the keyworker and were responsible to meet, greet and orientate the customer to the area. Keyworkers and nurses generally also helped customers during the settling in period to adjust to major changes in their lives. This role was recognised and appreciated by customer participants, although it was variously described by them as 'care-worker' and 'key nurse'.

An example of this leadership/co-ordination role of nurses comes from the rehabilitation literature. Discussing a team approach to the rehabilitation of children with head injury, Appleton (1994) describes the nursing staff as pivotal members of the team, providing a link throughout each stage of recovery and rehabilitation, being responsible for the co-ordination and

organisation of the rehabilitation programme, and involving parents in care as much as possible.

In the current study, as well as a co-ordination role there also seemed to be a leadership role in what customer participants described as nurse 'professionalism'. It was not clear what was meant by this, but it suggested a discreet nursing role supported by education and training. Customers wrote that they felt supported by nurses in the management of clinical issues such as diabetes, self-medication and blood pressure. Nurse participants also talked about their management of issues such as pain relief and management of peritoneal dialysis or diabetes in the context of the coaching relationship with the customer. The skills to manage these problems were necessary to the coaching role and provided the appropriate backup to the interpersonal aspects of the nurse:coach relationship.

Coaching: face-to-face leadership with the individual

Evidence from both the nurse and customer data suggests that nurses developed personal relationships with customers characterised by a level of trust and a shift in the locus of control that supported the individual towards independence. Similar aspects of the interpersonal relationship described by nurse participants were also reflected in the customer responses. This is demonstrated in Table 5:1.

Table 5.1: Coaching:face-to-face with the individual: nurse and customer categories

Nurse categories	Customer categories
<p>Paying attention to people</p> <ul style="list-style-type: none"> • taking time to build a personal relationship • looking in the mirror • doing unto others...valuing the individual • the awesome power of personal attention <p>Enabling others to act</p> <ul style="list-style-type: none"> • stepping up to responsibility • getting people to play • giving elbowroom <p>Bringing out the best</p> <ul style="list-style-type: none"> • building on strengths • you can do it! • tough talk • coaching a winning attitude 	<p>Paying attention to people</p> <ul style="list-style-type: none"> • taking time to build a personal relationship • going the extra mile • looking in the mirror • doing unto others...valuing the individual <p>Enabling others to act</p> <ul style="list-style-type: none"> • stepping up to responsibility • giving elbowroom <p>Bringing out the best</p> <ul style="list-style-type: none"> • building on strengths • you can do it! • coaching a winner

The key elements in this relationship with the customer revolve around several important issues. The nurse:coach develops:

- trust
- shifts the locus of control back to the customer
- is self-aware

- has respect for the individual.

These are described in more detail below.

Trust, control, self-awareness and respecting the individual

Building trust

Nurse participants spoke of taking time to build a personal relationship with the customer (**paying attention to people**). The trust that developed enabled customers to make progress with their rehabilitation. Customers wrote about the way that nurses encouraged them to keep going, and the supportive role of nurses in facilitating independence (**bringing out the best**). The relationship with nurses was therapeutic in that it provided physical and emotional support and education as customers progressed through their rehabilitation.

Nurse participants described specific, practical ways in which they developed trust in the relationship with customers. These included spending time in listening, talking and teaching and encouraging, respecting and valuing the individual. Both nurse and customer participants in the study described personal qualities that nurses brought to the relationship. These included such qualities as courtesy, loyalty and dependability, all of which helped to form the basis of a trusting relationship.

Trust and the investment of personal qualities are not always characteristic of health care relationships. Traditionally relationships between health care professionals and patients tend to be rather guarded and impersonal. Taylor (1994) somewhat cynically describes these types of relationships as follows:

While professional competence and politeness is standard behaviour for most people-oriented professions, it seems somewhat standard practice also that professionals forget, dismiss, or otherwise reject, their everyday genuineness as humans, when they engage in their professional contexts. Leaving their personal identities at home, health workers sally forth to their practice places each day to interact as

masked professionals with the hapless inmates of the health care system (p. 234).

The following study from the literature illustrates the importance of trust in the nurse-patient relationship.

The durability and workability of relationships between patient and health care professional are particularly tested during the experience of chronic illness where both parties are committed to an ongoing relationship. Using a grounded theory method, Thorne & Robinson (1988) conducted an exploration of patients' perceptions of their relationships with health care professionals in the context of chronic illness. This qualitative study involved interviews with 77 'expert witnesses', including family members, who had been intimately involved in the experience of chronic illness and health care management. Most importantly and paradoxically the authors found that 'trust from health care professionals fosters trust in health care professionals' (p.786). Being trusted by one's health professional was both affirming and validating, and as a result, increased the patient's feelings of confidence and self-esteem. The authors Thorne & Robinson (1988) argue that trust in the context of chronic illness facilitates collaboration and co-operation in illness management. They recommend that, since trust is an important therapeutic element, health professionals should continue to cultivate reciprocal trust by developing listening skills, suspending judgement, seeking the opinions of the patient and providing ongoing information and explanation.

Taylor's (1994) description stands in stark contrast to the role of the nurse:coach in the current study. Instead of being distanced and impersonal the nurse:coach seeks to engender trust and control through self-awareness and respect for the individual. These aspects transformed the nurse-customer relationship from a traditionally 'professional' one into a relationship of personal connection.

There was evidence in the current study to suggest that customers appreciated the trusting support that nurses provided, facilitating independence without overprotecting whilst still being available when necessary.

...knowing they are close at hand on hearing the bell. This also most importantly boosts your confidence which is a big part of your rehab.(1,2c)

The nurses were still attentive and helpful but allowed me that degree of independence (8, 2a)

The nature of the trusting relationship meant that nurses could also safely set limits, something which they inferred would be difficult in a relationship where trust had not first been established.

setting limits to what's acceptable to you...if you've got that sort of trust relationship with somebody, then it's OK to do that whereas if you haven't then you can get into sort of real difficulties (2:22)

At the heart of trust lies the issue of control. Trust shifts the weighting of power or the locus of control, particularly where there has been an imbalance of power. The locus of control in relationships between health care professionals and patients has historically resided with the professional. Particularly in a rehabilitation context it is important to shift this balance because trust has the effect of empowering the individual to determine his or her own future.

Locus of Control

If individuals believe that they have control over their own lives, they are more likely to take responsibility for their own learning and success. Generally speaking, people who attribute success or failure to forces beyond themselves, such as luck or other more powerful people are described as having an external locus of control. Those who believe that success or failure is within their own power to influence are described as having an internal locus of control (Martens, 1987). Locus of control is linked to motivation and a sense of responsibility.

A sports coach will encourage athletes to develop an internal locus of control, just as a coach:manager or coach:teacher will concentrate on empowering the employee or student. That way, the athlete, employee or student will be more achievement-oriented, and more able to adapt to success and failure in a productive way (Martens, 1987).

Returning control in the context of a health care relationship is important if patients are to be active rather than passive participants in their health management. Historically, the influence of paternalistic attitudes in medical practice has created a belief amongst health care practitioners that patients are not accustomed to formal decision-making processes, choose short-term benefit over long-term benefit and that physicians are more capable of objectivity when decisions about patient welfare need to be made than are the patients themselves (Thorne & Robinson, 1988). This casts patients in the role of passive, non-participative individuals who disavow their right to influence their destiny. Paternalistic attitudes therefore serve to shift the personal locus of control of patients towards the external.

However, patients may have more influence than is often recognised and the 'interactional processes of mutual negotiation and micropolitics' that signify actual relationships in healthcare (Lowenberg, 1995, p.299) should not be overlooked. Thorne & Robinson (1988) argue that patients are not completely passive in most health care settings. In fact, patients have developed a wide variety of strategies to negotiate situations to their best advantage. 'Compliance and adherence studies show how illusory care provider 'control' actually is' (Thorne & Robinson, p.299). Sully (1996) agrees that both parties in healthcare relationships exert power - health care professionals by using knowledge and language to have power over patients, and patients by making demands on resources.

Genuinely shifting the locus of control back to the individual is a necessary prerequisite to gaining and maintaining trust. Discussing strategies that will achieve this in the relationship between nurses and the parents of sick

children, Farrell (1995) indicates that **information-sharing, listening, resolving preconceptions, seeking family perspectives and validating parental conclusions**, are all important ways of developing trust and a sense of control.

Nurse participants in the current study recognised that the locus of control tended to sit with the health care professional and that it was important to shift this back to the customer in the interests of a more balanced relationship and a return to independence. In order to do this they shared information with customers, used strategies to return control where there were barriers, accepted the choices that customers made, and clarified for customers what they could expect from themselves as nurses and where the limitations in the relationship were. Nurse participants recognised that it was important to share something of themselves in the relationship, to disclose a little of themselves to the customers about whom they knew so much. For example, nurses felt that not wearing a uniform served to remove some barriers to relationship. Another nurse who was a smoker felt that smoking a cigarette with a customer helped to create relationship with the customer. She described it as helping to remove the mystique of the professional and served to demonstrate that nurses are real people.

Nurse participants described a number of situations where they were constantly challenged to find individualised ways of shifting control.

Customer responses bear out the success of nurses' attempts to return control. Customers appreciated the fact that they were given choices and were supported in returning to independence.

The nurses were still attentive and helpful but allowed me that degree of independence. (8, 2a)

Exploiting Trust

The link between trust and control has been described and it is clear that health care professionals are in a position to influence the extent to which patient vulnerability is respected and patient control is maximised. There is

opportunity to exploit trust by misusing the power of the professional role and there is therefore a need for health care professionals to be aware of their own personal needs and boundaries.

Take, for instance, the opportunity for sexual abuse of patients by health professionals. 'Nurses in a wide range of specialties have to engage in intimate interactions with their patients every day and consequently must consider themselves at risk' (Briant, 1997, p.23). The risk of being accused of, or actually exploiting the relationship is high. As a result, both the American Psychological and the American Psychiatric Associations have outlawed sexual relationships between professional and patient on the basis that such relationships are likely to 'exploit emotions deriving from treatment' (Briant, 1997, p.24).

For health care professionals to develop safe therapeutic relationships with patients, it is important that they practice self-awareness.

Self-awareness in therapeutic relationships

Jerome & Ferraro-McDuffie (1992) define a therapeutic relationship as an:

...interpersonal process that uses the nurse (as self) to move a patient to desire healing and healthier behaviors. The nurse does this by providing information, empathy, non-directive listening, respect, and feedback as an actual treatment modality (p.153).

In the nurse-patient relationship there is a need to establish boundaries which differentiate the self from the other. Jerome & Ferraro-McDuffie (1992) describe how, when a nurse has not learned to do this in personal relationships, the professional relationship can become a dependant or abusive one. Nurses can become over-involved with patients, or be unable to safely use themselves in a therapeutic way.

The authors describe several strategies which nurses can use to maximise their self-awareness and contribute to the development of healthy therapeutic

relationships. These include identifying a 'safe' person or trusted colleague who will provide honest feedback, using scheduled meetings for discussion about therapeutic relationship issues in a non-threatening environment, and sometimes there is a need for professional assistance to explore personal boundary issues.

Nurse participants in the study discussed the need to clarify expectations in their relationships with customers.

She needed someone that was clear about what they could do and what they couldn't do, step by step, from very beginning...(2:29)

That way, there was less likely to be confusion or dependency in the relationship. Nurse participants did not discuss specific strategies that they used to develop self-awareness although they did describe using colleagues in the team to generate ideas for managing certain customer behaviours. It is an important implication for practice that, particularly with regard to the management of customers with complex needs or behaviours there is a supportive system in place to ensure that nurses are provided with an outlet or objective person with whom to discuss issues.

The issue of respecting the individuality of the patient is important in developing therapeutic relationships. Both nurses and patients bring their own unique identity to the relationship and this will influence the planning, progression and outcome of the relationship. There has been a growing recognition in the education and practice of nursing that people retain a unique identity by virtue of their essential humanness when they enter a hospital or seek the services of a health care professional. This has resulted in a reformation in the language and practice of nursing. The words holism, individual care and therapeutic relationship have been introduced into a new vocabulary of practice. Nurses have now added communication skills - listening, talking and counselling - to their requirements for practice (May, 1992).

The influence of 'individualised care' on patients and nurses

May (1992) is critical of the process which has attempted to reintegrate the concept of patient individuality into the practice of nursing, demonstrated in the emerging use of the terms 'holistic, individual and personal care. Historically, the pervasive model of health care described as the 'medical model' rendered patients as identifiable by their disease or disability. Professionals in health care acquired what has been described by the late French philosopher Foucault as a 'clinical gaze' (May, 1992). The clinical gaze was a powerful agent in retaining professional control over, and detachment from, the patient as an autonomous human being. May suggests that nurses, in attempting to individualise care, have instead developed what he describes as a 'therapeutic gaze...through which the nurse attempts to reveal the underlying reality of the patient's experience and authentic disposition' (p.594). The formal interventions of individualised care - talking, listening, counselling and cultivating a relationship with the patient - create a language of holism which May describes as a 'rhetoric of the individual' (p.592). By a process of formalisation into the organisation and structure of nursing work, those spontaneous moments previously enjoyed between patients and nurses where true sharing took place are rendered 'plastic and informal interactions that have the paradoxical effect of *routinising* personal encounters' (p.594). They are no longer the beginnings of a therapeutic relationship but are nothing more than a crude intrusion into the patient's private life. Another effect of such routinised encounters is to marginalise and minimise the role of those who truly know the patient - either family members or other significant people. Where patients give permission to nurses to enter into their 'social selves' (May, 1992), there is the risk of exploiting such trust, creating compliancy within the environment over which professionals still retain control.

However, although s/he has no control over a physical invasion May argues that the patient ultimately retains control over this social invasion. Where clinical investigations reveal all that can be known about the physical body, there are no such devices to examine the personality and thoughts. As May

suggests, 'patients are able to resist this new field of labour by the simple means of remaining silent' (p.593). Control in this area remains with the individual.

Nurse relationships with customers in the current study seemed to have been marked by genuine responses to the individual. There was emphasis on respecting and valuing the individual and on seeing the whole person, not just a sum of parts. Respecting what was personally important to them was appreciated by customers. One nurse described the relationship with a customer as 'almost like a friendship' (1:12). Such 'friendships' were occasionally marked by spontaneous disclosures by some customers, a sign of the level of intimacy in the relationship. Customers on several occasions described the way in which nurses went beyond their expectations in seeking ways to meet needs.

Evidence from the study suggested that the personhood of both the nurse and the customer was respected and, in this sense, the care could be described as 'individualised'. For example, there was evidence in the data that nurse - customer partnerships were sometimes changed in order to facilitate a good relationship. (The potential for a customer to ask for care to be provided to them by another staff member was not discussed). Nurse participants talked about treating customers with respect, and valuing their individuality. Customer respondents described how they had felt that their privacy and dignity had been maintained and how they had been treated as an individual. It must be said that the remit of the current study would not have captured ways in which customer behaviour might have been normalised to the environment. This would be an important aspect to investigate in further research.

Key characteristics of the nurse:coach role are the building of trust, returning control in the relationship, the nurse being aware of self and personal needs, and respect for the individual. These elements were demonstrated in the study and are reflected in the coaching literature.

Coaching: face-to-face leadership with the family

The philosophy of the rehabilitation organisation is family-focused. This is important because the domestic and family roles of the customer have often been altered by virtue of the accident, injury or illness which has caused them to require rehabilitation. The individual may have moved from an independent state to one of dependency on a parent or other family member and there are often needs related to the adjustments that must be made by family members in such situations.

Table 5:2 illustrates the categories which emerged from focus group and customer data relating to family.

Table 5.2: Family: nursing and customer categories

Nursing categories	Customer categories
Making room for others to contribute <ul style="list-style-type: none">• taking time to build a personal relationship	not mentioned

A key element in the relationship between the nurse and the family is the awareness of the

- family as a partner in the rehabilitation experience.

Nurse participants in the study described ways in which they aimed to apply the philosophy of the organisation to practice. Again, this was a leadership:coaching role characterised by the same elements of education, power-sharing and trust as were developed with the individual and included building rapport and using personal qualities in a therapeutic way. Nurses described how they effectively established trust and were empathetic towards family members. This was thought to be an important and fundamental part of rehabilitation, although less important for those whose disability was less severe and who were consequently less dependent. An appreciation and awareness of family dynamics helped nurses to be sensitive to ongoing

needs of the customer, even if they did not become directly involved in resolving issues. When they were aware of problematic issues, they adopted a co-ordinating role by letting the customer know that there were other professionals available who might be able to help.

One practical reason for developing a relationship with family members was because they were often the people who would provide support for the customer on discharge. A nurse participant in the study described a strategy whereby she had arranged for a family member to become actively involved in learning how to care for her sister. Other nurses in their descriptions focused on the need to develop relationships with family members.

Customers did not mention the concept of family in their responses. This was noteworthy, given the emphasis placed by nurse participants on this aspect of their practice. Suggested reasons for lack of reference to family in customer responses are described below:

- a) some customers live in socially isolated situations with no family involvement
- b) customers may not recognise a relationship between nurses and family members as central to the recovery process, although nurse participants perceived this to be important
- c) customers may see themselves as the primary agent in their own recovery and family members as external or peripheral to their recovery - family members being more passive in the rehabilitation process
- d) families were not an integral part of the process
- e) one nurse participant, after reading the data suggested that this may be because families are involved as a matter of course and were therefore not mentioned in the data.

The role of family in the rehabilitation context has parallels with the relationship of parents with nurses in a paediatric setting. The parent's role is profoundly altered when the child is hospitalised. There is evidence in the

paediatric nursing literature that the family, in this case the parent, is an inextricable but ambiguous partner in the health care relationship with the patient. Rowe (1996) describes the phenomenon of 'public parenting' (p.102). By this she refers to the manner in which an intimate relationship is made public by being conducted under the watchful gaze of strangers. She argues that there is tension between 'the understandings of nurses and those of parents regarding parental involvement and responsibility' (p.102). Nurses' practice is also public but the environment is one in which they are familiar and therefore powerful and knowledgeable. Although nurses embrace the rhetoric of parents as integral partners and participants in care, parents are often viewed in a different light in practice. Nurses see parents as able to 'help out' rather than as partners in caring for the child. Parents are displaced from their normal role of responsibility. Rowe (1996) suggests that this paradox of the visitor as centrally responsible for care needs to become a focus for further research. It requires nurses to examine their own rhetoric in the interests of finding congruency between theory and practice. Not only so but there is a social mandate to 'walk the talk'. As Thorne & Robinson (1988) suggest, 'professionals are obliged to address health care relationships as significant social processes rather than mere inconsequential niceties'.

It is difficult to draw conclusions about family involvement without specifically having included family members in the study. The data however has suggested that nurses actively developed relationship with family members and were practising and applying the family-centred philosophy of the organisation. A focus for further research in rehabilitation nursing would be the concept of 'public' caring and the family as a key member of the rehabilitation team.

To summarise, there is evidence in the study that nurses engaged in three relationship groupings. These are fundamental to the role and activity of the nurse:coach in supporting the customer through the process of rehabilitation.

Summary

On the basis of an effective, trusting relationship within the team, with the individual and with his/her family, the coach can effectively **lead, manage** and **teach** within these relationships.

Table 5:3 provides a summary of the main functions and attributes of the coach from the literature (Chen, 1993; Haas, 1992; Mott, 1992; Spink, 1986; Peters & Austin, 1985; Smoyak, 1978). Table 5:4 outlines the constituents of the data from the current study which, together describe the nurse:coach role from the perspective of the nurse participants.

Table 5.3 Role of the coach in relation to performance and relationship

performance	relationship
<ul style="list-style-type: none"> • observe and analyse performance • communicate expectations • provide feedback • reward effort not outcome • provide information to enhance performance • reflection on action • help create new ideas • create context of fun • be visible 	<ul style="list-style-type: none"> • know and respect the individual • develop self-confidence and self-motivation • set limits • shape values and provide guidance • train and extend skills • develop trust • provide praise and reassurance • discipline • reinforce • counsel • sponsor • confront • educate

Table 5.4: Role of the nurse:coach in relation to performance and relationship (the study)

performance	relationship
<ul style="list-style-type: none"> • acknowledge achievement • facilitate independence • return control • provide education and information • consultation • orientation • set goals • evaluate goals • reward effort not outcome 	<ul style="list-style-type: none"> • self-awareness • confront and challenge • motivate • set limits • value and respect individual • use of humour • flexibility • self-disclosure • trust • listen and counsel

1. Leadership and management: the nurse-coach

Part of the role of the coach is to lead others. Nurse participants in the study described leadership attributes which they brought to the relationship such as **consistency, dependability, courtesy and loyalty, suspending judgement, humour, flexibility, sensitivity and perception**. In the context of teamwork, nurses used leadership skills to achieve the best outcome for the customer. Evidence from the study suggests that the relationship between the nurse and the customer was seen as significant to both. Nurses spent time **listening** and **getting to know** the customer and this involved treating

the customer with **respect**. Nurses used their own personal attributes, such as **humour and perception** in the relationship. Their current relationships were informed by other experiences in nursing. The relationship also involved some **self-disclosure** on the part of the nurse. Nurse participants identified that when they or others felt that they were not able to develop a good relationship with a customer, they negotiated with other nurses to work with the person.

The coach also has a role in managing performance. This aspect is linked to the ability to **motivate** the individual and to foster self-motivation. Nurses in the study saw it as their responsibility to find out what motivated customers and to facilitate the development of customer control and responsibility. There were illustrations in the study of nurses using strategies to facilitate motivation where there were barriers of grief, anger and feelings of powerlessness. Nurses described occasions when they **confronted and challenged** the customer. Nurses would communicate about the acceptability of certain behaviours and **set limits** where this was necessary.

Nurse participants talked of **acknowledging progress** even in the face of almost insurmountable health problems. Rather than focus on functional gain only, which in some cases was very slight, nurses saw the need to understand gain in terms of other achievements as well. As a participant in the study commented, the focus of rehabilitation nursing was not totally on functional improvement but on the effort put into an activity by a customer. This may signify an improvement in the level of confidence and motivation. Customers reported that they appreciated the way in which nurses **facilitated their independence** by being available for support without intervening unnecessarily.

There was noted to be a strong link in the study between the level of **trust** and **locus of control** in the relationship. Nurse participants described the need to facilitate the return of control and responsibility to the individual. They

also described the need to be **self-aware** in order to avoid exploiting the relationship or creating dependency.

Both the leadership and management functions of the coach are demonstrated in the disciplines of management and sports.

Coaching in the management context

For organisations adopting a Total Quality Management (TQM) approach to management, the use of coaching as a tool to improve performance is fundamental. Employees are required to work in teams and deliver a high standard of performance and therefore need support to develop team skills and achieve goals.

In their book entitled 'A Passion for Excellence', Peters and Austin (1985) devote an entire chapter to a discussion on coaching. Coaching, they maintain is about personal leadership, 'about really paying attention to people - really believing them, really caring about them, really involving them' (p.326). 'Coaching is tough-minded. It's nurturing and bringing out the best...enabling others to act, of building on their strengths' (p.328-9). The coach is **visible, listens, sets limits, shapes values and stretches skills**. The coach achieves **trust** in relationships by being **consistent, flexible** and having **integrity**. The coach treats **employees as individuals** - what works with one employee does not work with another, and to coach well, the manager may need to **counsel, sponsor, confront or educate** employees to bring out the best performance.

'Coaches stretch you to your limit, a limit often beyond what you thought possible. Great coaches stretch you exactly to that previously unknown limit, but no further...you achieve some stretch and lots of success (p.362).

The purpose of coaching is always the same - to maximise the person's ability to achieve. This is the same for the rehabilitation nurses. The process of

coaching includes practical, day-by-day support to achieve specific goals in a climate of **empathy** and **respect** for the individual where the coach uses skills of **observation, analysis and feedback** (Orth, Wilkinson & Benfari, 1990). The fourfold process of **goal-attainment** involves the coach and trainee engaging in the clarification of expectations, evaluation of current performance, development of goals, and implementation and evaluation of the goals (Haas, 1992).

The coach:leader/manager then is someone who gets behind the individual and develops a personal relationship, bringing attributes such as integrity, trust, listening skills, assertiveness and empathy to the role. The coach: leader/manager helps to set goals and uses a feedback process to develop the individual to achieve success. There are clear parallels with the role and attributes of nurses in the study.

Coaching in the sports context

'Just as a gardener does not grow plants but creates an environment in which the plants can grow, likewise the coach provides the environment in which the athlete can develop' (Chen, 1993).

The success of a coach is not only measured in the number of wins or losses of the team or individual athlete, but on the qualities and skills that the coach brings to the relationship. These again include leadership and management skills - understanding and sensitivity, humour, ability to listen, consistency, and receptivity. The coach also needs to know the athlete, observe and analyse performance and provide feedback (Chen, 1993).

Kevin Spink, a lecturer and researcher in sports psychology has discussed the important relationship between the coach and the junior athlete in his book entitled 'Coaching for Sporting Excellence' (1986). When developing potential in the young athlete, it is important to **communicate expectations** clearly and consistently. The coach should **listen** empathetically, actively and reflectively and provide clear explanations. Athletes are likely to perform to

the standard expected of them by the coach. It is important that the coach is able to **provide balanced feedback** and **reward effort rather than outcome**. This is important in **developing self-confidence** in the athlete. Fear of failure may prevent individuals from participating in the activity or expecting success. Coaches should therefore encourage athletes to take risks and reward the effort involved, even when the result is failure. That way, the individual will be prepared to risk failure in the future, consequently increasing the opportunity for success. In order to encourage responsibility, the coach should involve the athlete in **setting personal goals**, and **provide information to improve performance** where it is necessary to give negative feedback. Motivation is an important ingredient in the relationship. The coach should begin to understand what it is that is meaningful to the individual about participating in the sport. The focus needs to be on **self-motivation** rather than on the coach providing the motivation. This approach has the effect of returning control over to the athlete and away from the coach. The process of coaching requires **discipline** but also needs to be **fun**. Where lack of discipline is affecting performance, the coach needs to take steps to turn this around to co-operation and involvement.

The sports coach is someone who creates a fertile environment for development. The coach aims to develop a confident and motivated performer, using a process of goal-setting and feedback. Again, the rehabilitation nurse role has strong parallels with the coaching role.

A second important element in the coaching role is the aspect of teaching.

2. Teaching: the nurse-coach

Nurse participants in the study provided **education and information** to facilitate independence. For example, relaxation skills were taught where anxiety was impeding progress. There was evidence of **consultation** with customers and their families. Customers appreciated the fact that nurses provided information and explanation because this had the effect of increasing their self-confidence.

There was evidence of nurses leading and being involved in a distinct process of rehabilitation. This began with initial orientation and assessment of the customer, followed by goal-setting and evaluation, and the re-establishment of goals.

The process of goal-setting and evaluation that nurses helped to lead is similar to the coaching role in education described by Mott (1992) as 'peer cognitive coaching'. By peer discussion and reflection on teaching practice, teachers analyse the teaching/learning experience and encourage innovative teaching practice. A safe environment is provided with a means of reflecting more critically on their work and practice. Coaching in this context is described as a cyclical process involving analysis, study, hypothesis-forming, critiquing and testing. The process of coaching helps teachers to reorganise materials, create new ideas and apply new teaching skills in order to benefit students.

An important consideration for the teacher and the coach is the mechanism of learning a process or activity. When asked to explain how s/he would behave under certain circumstances in the real-time environment of the practitioner, an individual may describe an espoused theory. However, the theory which actually governs his/her practice is a theory -in-use (Argyris & Schon, 1987, Schon, 1987). Schon (1987) argued that the way in which individuals developed their theories-in-use was through reflection on action and this can be learned through the coaching process. He identified three types of coaching. 'Joint Experimentation' involves a process whereby the coach and student work together in order to facilitate learning by discussion and thinking aloud. The 'Follow Me' coaching approach encourages the student to learn by exactly copying the practice of the coach. This provides insight into the construction of the action. 'Hall of Mirrors' approach is appropriate in the context of teaching and learning psychotherapy whereby the student in a learning situation replicates the actual practice of the coach, enabling the student to deconstruct the action and understand the practice (Schon, 1987).

The teacher:coach engages in a process of practice and evaluation with the student, creating a safe environment where experimentation can occur. The teacher:coach encourages the use of appropriate theories-in-action and uses his/her own skills and experience to model effective practice.

As in the teaching role, nurses created a supportive environment for experimentation, providing backup without overprotecting the customer. The nurse:coaching process in rehabilitation is most akin to the coaching type described as 'Joint Experimentation'. Here the customer engages with the nurse in adjusting and amending an activity to best suit the individual and the environment.

Benner (1984) discusses the teaching role of nurses in the context of coaching. In her book 'From Novice to Expert' she discusses how, through the domain of The Coaching Function, nurses can assist a patient to navigate his/her way through the pain and isolation of illness and the possibility of death. The nurse is enabled to do this through a personal process of education and experience.

3. Relationship: the nurse: coach

In every aspect of functioning, the interpersonal relationship is fundamental to all that the coach and individual hope to achieve. The interpersonal process of coaching that involves mutual trust, empowerment and respect underpins all that the coach and individual aim to achieve and this is demonstrated in the role of the coach in leadership/management, sports and education as previously discussed. This has been demonstrated in the elaboration of the categories in the current study during the course of this chapter.

Only one reference in the rehabilitation specialty literature to the nurse as coach has been found. The concept of the nurse:coach has been described by Bell (1996). He outlines an innovative approach to head injury rehabilitation in the UK which used a coaching system as a model of rehabilitation for adults with traumatic brain injury. The unit was founded on

some of the principles of Conductive Education, originally described by Peto, founder of the Institute of Conductive Education in Budapest in 1945 (Cotton, 1974). The nurse works within a multidisciplinary team and is responsible for facilitating the rehabilitation programme for an individual patient. The coaching model is based on three approaches: the transdisciplinary team, behaviour modification, and skills transfer (Bell, 1996). The approach means that therapeutic interventions are delivered in a consistent, responsive and adaptable manner. The coach provides scheduled interventions, feedback, guidance and training related to patient goals with the aim of extending the patient's skills rather than eliminate the problem behaviours. In view of the 24 hour cover provided by nursing staff, nurses are the most appropriate discipline to fulfil this function. Success in the programmes however depends on maximum consistency, effective teamwork and communication.

Development of a model of therapeutic nursing practice in the rehabilitation specialty

Nurses often capture the moments that other team members do not - the after hours moments of celebration, sadness, reflection and frustrations. Nurses share customers' moments of intense vulnerability - during the deeply intimate activities of personal hygiene and painful wound dressings. Nurses have the opportunity to help the customer dismantle barriers to progress that come about through fear, grief and loss, changing roles, handicap and disability. Nurses do not have an exclusive claim to this intimacy. However, of all the members of the team, nurses have the privilege of being uniquely placed to develop deep relationships with customers, relationships that facilitate progress and enable development. The articulation of the role of nurse:coach provides an opportunity for nurses to focus on this key role and develop it in the interests of effective nursing and improved outcomes for customers.

A model for rehabilitation nursing practice has emerged from the data and is illustrated below. The model illustrates the centrality of the individual in relationship with members of the whole team, and with family. The nurse:coach as a face-to-face leader has a pivotal role in developing a relationship with the individual and the family, and within the team. This role underpins the whole rehabilitation programme. The nurse:coach expresses leadership aspects without being the sole leader in the interdisciplinary team. The leadership comes from exposure to, and knowledge of the customer and his or her family members. This places the nurse:coach in a unique role and offers the opportunity to provide guidance and direction to the whole team.

The leadership/management, educational and interpersonal elements of the coaching role are strongly reflected in the coaching literature. The outcome of coaching is to achieve the maximum potential of the individual and this is facilitated by the relationship between the coach and the individual. The

concept of the coaching relationship is applied to the nurse-customer relationship in rehabilitation and the role of the nurse is described as a nurse:coach.

The Nurse-Coach Model



Face-to-face Leadership

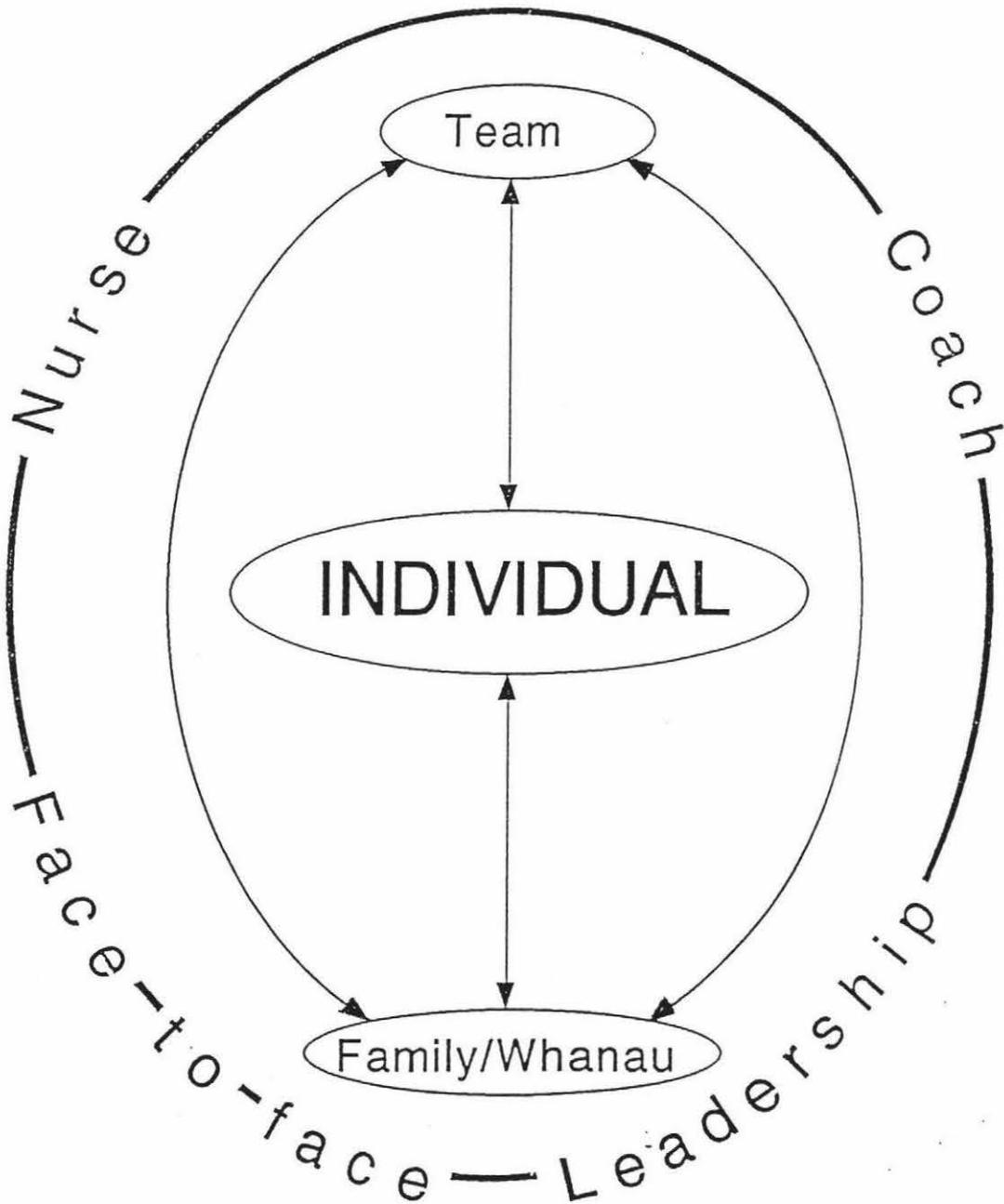


Figure 5:1 The nurse:coach model: face-to-face leadership

The essential constituents of the nurse:coach role are:

- leadership and management
- education
- relationship

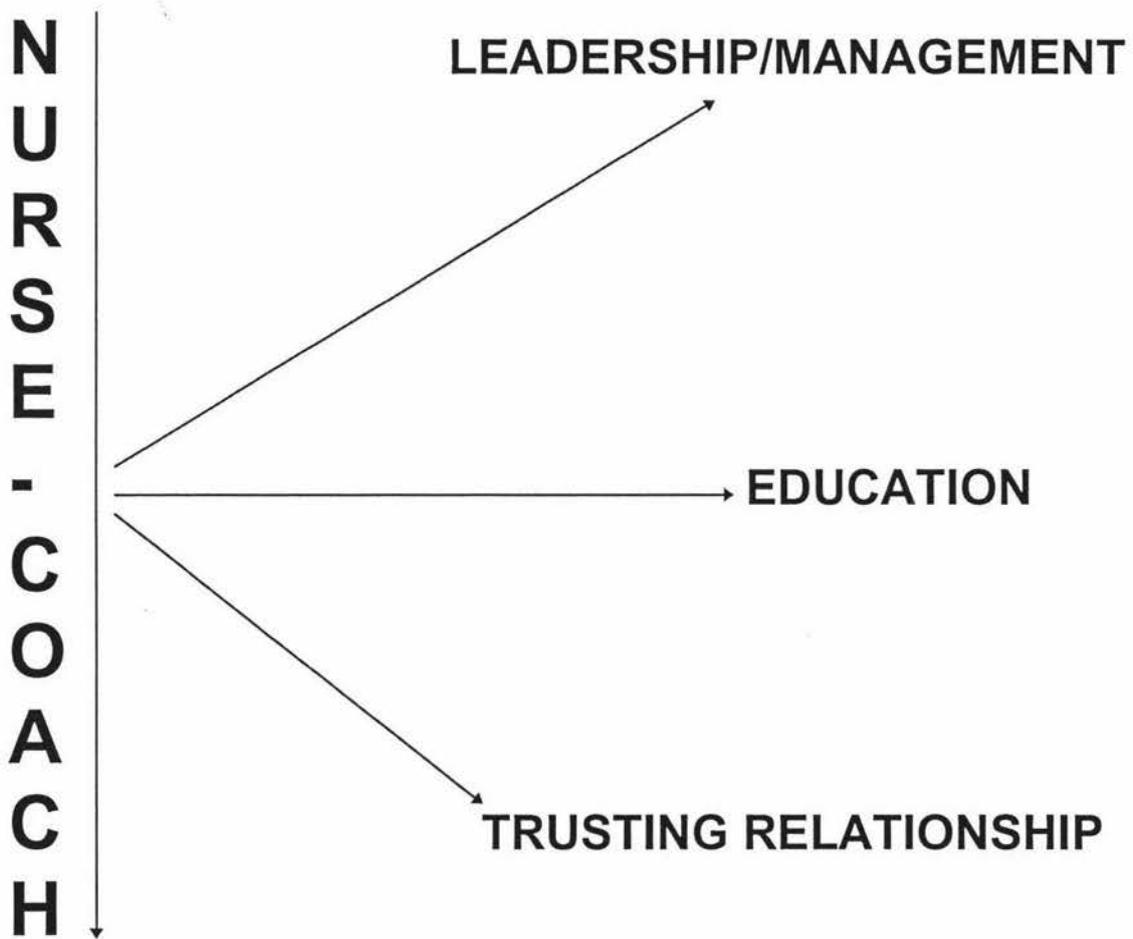


Fig: 5:2 Essential constituents of the nurse:coach role.

In this chapter a discussion of the study design and method, including strengths and limitations, and trustworthiness, validity and reliability issues has been presented. The coaching role has been discussed as an appropriate interpretation of the data from the current study and substantiated from the coaching literature. Finally, a new model of rehabilitation nursing practice has emerged from the data and this has been diagrammatically represented.

Chapter Six

Study findings and conceptual models

The study has demonstrated that the coaching role in the context of a trusting relationship is central to the therapeutic role of the nurse in the study environment. The nurse-patient relationship evolves within the framework of a team in which the nurse provides a co-ordination role. The nurse also helps to create a comfortable and welcoming environment for the customer. Developing a relationship with family members is important in the process of rehabilitation.

These findings provide answers to earlier questions asked in Chapter One. These were:

- 1. Is it possible to say with confidence that a managerial or understudy function fully describes the therapeutic role of the nurse in rehabilitation?**

The rehabilitation literature described tasks and functions of the nurse (see Table 1.1, p.9) in rehabilitation where it has been suggested that the managerial or understudy role encapsulates the therapeutic role of nurses in the specialty. The current study however clearly indicates that a managerial or understudy role is not a complete description of the nurses therapeutic role in rehabilitation.

- 2. If not, what other features of the role are important and why?**

The managerial or co-ordination role in the team, and understudy roles are evident in the current study findings, but appeared to be less important than the role of coach and partner in a trusting relationship. Active as a coach in a trusting relationship, the nurse facilitates rehabilitation by enabling the person to participate, helping to remove barriers which might hinder progress towards independence. It is argued that, without the support and encouragement of nurses in the team through adjustment to illness and injury, engagement in

the rehabilitation programme, and maintenance of motivation, the customer would often be unable to maintain the momentum required to achieve goals.

3. What is significant to the patient about the role of the nurse?

Albeit a small component of the data collected in the study, the categories developed from customer responses strongly suggests that the characteristics of an interpersonal relationship - trust, encouragement, preservation of dignity, support, motivation, humour - were identified as helpful and assistive in the customer making progress in rehabilitation.

It is important to consider the findings of the current study in the light of the conceptual models of therapeutic nursing that were presented in Chapter Two.

Conceptual models

The conceptual models of therapeutic nursing practice that were reviewed in Chapter One were as follows:

1. professional nursing practice
2. primary nursing
3. case management
4. therapeutic relationship
5. caring as a therapy

1. Professional Nursing Practice

The conceptual model of Professional Practice originally described by Lydia Hall (1964) and developed by Alfano (1971) places the patient firmly at the centre of nursing care delivery and in the context of his/her social role within a family or community. The model describes the patient as a person with many dimensions including the physical/material dimension. It is facilitative of the patient using personal strengths to regain health and emotional wellbeing, and emphasises communication skills and an advocacy role for nursing.

The study findings support the model up to a point. However, the professional practice model describes nursing within a psychoanalytic paradigm, with the nurse maintaining a professional distance from the patient in the context of the relationship. It does not as succinctly reflect the components of the Coaching role, nor does it deal comprehensively with the matter of control.

2 & 3. Primary Nursing and Case Management

Primary Nursing and Case Management share some of the principles of the keyworker role which are reflected in the study. This would include the aspects of creating the environment, co-ordination of the rehabilitation programme and monitoring health issues. The theory of both primary nursing and case management include many aspects of the formation of a trusting relationship in so far as both seek to facilitate effective communication. However, both models essentially focus on the effective organisation and administrative of nursing. Neither seem to have a particular focus on a coaching or power-sharing role in nurse-patient relationships.

4. Therapeutic Relationship

Taylor's model of therapeutic relationship (1992, 1995) strongly reflects the interpersonal aspects of the coaching role. Her concept of 'ordinariness in nursing' is constituted by the three interpersonal qualities of presencing, concern and authenticity which Taylor believes encapsulate the essence of therapeutic nursing. The study findings have resonance with model in the area of trusting relationship.

Data from the current study suggest that the humanity of the nurse is brought into the relationship with the customer (presencing).

...they see us as normal people...(1:3)

Yes, you need to share something of yourself and it's part of caring as well (1:5).

The nurse brings personal attributes such as sensitivity and encouragement to encounters with the patient (concern). There are a number of examples of this in the study.

I think that just acknowledging that some people have better days than others and that just because they walk 5 metres, or 10 metres or 50 metres it may not be tomorrow, they may only be able to walk 1... you just need to acknowledge that it was really good today(2:36)

The nurse allows his/her vulnerability to be revealed in the relationship (authenticity). There were moments described in the study that revealed this aspect of the relationship.

I remember seeing him crying one night and I'd never seen that side of him before... asked him if everything was OK. He just said that he can't go home...I thought it was very sad...I actually didn't know what to say to him...I don't know what to say to you, I don't know what the answer is...(2:26)

The nurse shares his/her humanity in the relationship and, in doing so, creates a sense of shared affinity. The patient may find that this alleviates feelings of isolation or loneliness and enables him/her to engage in the process of being coached, not as a 'patient' but as a person. Taylor (1992) goes as far as to say that it is 'the quality of the nurse-patient relationship and how this relationship mobilises healing responses in individuals' that constitutes therapeutic nursing (p.23).

5. Caring

The study reflected many aspects of the carative factors described by Watson (1985). The word 'caring' was used by customers on several occasions as one aspect of therapeutic nursing. Other issues such as being treated as an individual and preservation of dignity were mentioned more frequently. As a therapeutic nursing model, the caring model seems to be more appropriate to acute settings where patients are likely to be more highly dependant. In a rehabilitation setting where the focus is to empower individuals to become independent, the caring model has limitations. Caring can also be regarded as passive and custodial (McMahon, 1991). The model does not appear to address the issue of control as a central focus. The data in this study is more highly suggestive of a coaching model than a caring model.

Other aspects of nursing practice that were originally thought to be pertinent to the role of the nurse in rehabilitation included nursing diagnoses and nursing interventions, and researched-based practice and outcomes.

Nursing diagnoses and nursing interventions

The focus of nursing diagnoses and interventions in the rehabilitation literature tends to be functional and psychosocial with an emphasis on tasks and functions rather than on the interpersonal focus of the current study. This approach to the nursing role was therefore not strongly supported by the study.

Research - based nursing practice and improved patient outcomes

The study supported research-based evidence that education and information are helpful, supportive to patients and influence outcomes. Informing and educating were recorded by both nurse and customer participants as being helpful and an important component of the trusting relationship.

There was no indication that non-traditional therapies such as therapeutic touch were being practised by nurses in the study.

Summary

Most of the conceptual models of therapeutic nursing practice reflected some aspects of the nurse:coach role in the study. For example, Primary Nursing and Case Management demonstrated aspects of the interpersonal relationship between the nurse and the customer. The Taylor model of therapeutic relationship seemed to encapsulate the qualities of trusting relationship most succinctly. It also demonstrated aspects of power-sharing in the nurse-patient relationship, emphasising the vulnerability and the humanity of the professional as well as patient. However, Taylor's model has limitations in describing the therapeutic role of nurses in rehabilitation. Focusing as it does on the interpersonal relationship between patient and nurse, it does not contextualise that relationship within the team or with the family.

Apart from the work of Benner (1984), mentioned in Chapter Five in relation to the coaching role of the nurse with regard to education of the patient, none of the models specifically discussed a coaching role for nurses. The teaching function of the nurse as a therapeutic activity was supported in the study.

The current study proposes answers to the questions posed in Chapter One. The findings from the study are considered in the light of the conceptual models presented in Chapter One. Each model provides some substantiation for the current study findings but none addresses all the aspects presented by the study. As a result, the model for rehabilitation nursing practice offers a new way of understanding rehabilitation nursing practice.

Chapter Seven

CONCLUSION

The concept of nursing as a therapeutic activity has been the foundation of this study. The tasks and functions of the rehabilitation nurse are described in the literature (see Table 1:1) but the extent to which these are therapeutic has not clearly been defined in the rehabilitation nursing literature. The aim of the study has been to develop clarity with regard to rehabilitation nursing activity which is beneficial and which maximises the potential of the individual. The purpose of the study has been to enable nurses to recognise their therapeutic role and to practice in this role with more consistency. As a result, customers will receive nursing that is specifically therapeutic and rehabilitative.

Emerging from the data has been the role of the nurse:coach. Consistent with the role of the coach as described in the management, sports and education literature, this nurse:coach role is about relationships - within the team, with the individual and with the family. The overriding purpose of the nurse:coach role is to enable the individual to reach his or her maximum potential and this is achieved through the multiple dimensions of the role. The main constituents of the coaching role are leadership/management, education and the development of trusting relationships.

In the context of the interdisciplinary team the nurse:coach provides leadership, not only because of the personal relationship with the customer but by virtue of creating a facilitative environment for rehabilitation. He or she has a co-ordination function as well as working in a collegial and collaborative way with team colleagues.

In relationship with the individual the nurse:coach seeks to build a personal relationship which is characterised by a power shift in the direction of the customer and away from the nurse. The nurse:coach enables the customer to achieve goals by motivating and supporting the individual to participate, and

then supporting the customer in developing independence. There are features of a therapeutic relationship in the coaching role - the nurse uses personal qualities to bring about healing and restoration for the customer.

The relationship with family has a focus on involving family members in the process of rehabilitation, and the nurse:coach does so by cultivating a trusting relationship with family members.

The emergent role of the nurse:coach in rehabilitation nursing has provided direction for practice, education and further research.

Implications for practice, education and further research

The study presents a range of implications for nursing practice, education and further research which are discussed below.

Practice

The study has demonstrated a new role for nurses in the field of general rehabilitation. The coaching role is therapeutic in that it supports and facilitates the individual during the rehabilitation programme. This provides a framework for:

- consolidation of the role of the nurse:coach in practice with a view to extending the rehabilitation programme and consolidating the therapeutic content.
- development of documentation that reflects the therapeutic input of the nurse:coach.
- informing the debate and discussion about the role of the nurse with therapy colleagues.
- informing discussion in the broader practice arena with nurses from other settings when they are presented in a conference and seminar setting.

Education

Understanding more about the therapeutic aspects of nursing practice may provide a framework for a rehabilitation nursing course curriculum. This is currently being set up in the service. Suggestions for inclusion in such a curriculum would be:

- therapeutic relationship as a treatment modality
- activities which are anti-therapeutic and help to create a 'therapeutic gaze'
- strategies to avoid exploitation in therapeutic relationships
- integrating family into the rehabilitation team

Research

As previously indicated, it would be useful to conduct some theoretical sampling of categories. It would also be of interest to conduct focus groups with customers to gain richer data than that which was collected in the study. There are a number of research questions that have emerged from the findings of the current study.

- To what extent are customer expectations 'normalised' during the rehabilitation experience by the powerful influence of nursing culture and the experience of disability?
- What meaning do customers attach to the experience of nursing in rehabilitation?
- What do nurses and customers consider to be anti-therapeutic about the practice of nursing and would there be congruency between the two views?
- What do family members regard as helpful about rehabilitation nursing practice?
- How should the concept of the 'visitor as centrally responsible' be incorporated into the practice of rehabilitation nursing? Is there a gap between the espoused theory of family-centred rehabilitation programmes and the theories-in-action? What strategies can nurses employ to empower family and whanau to be part of the rehabilitation team?

The study may have raised more questions than it has answered but, as with any inductive research, the indicators for further research are a valuable product of the research and provide opportunity to further develop the body of nursing knowledge in the specialty.

Appendices

	Page Number
Appendix 1: Information sheet for nurse participants	159-163
Appendix 2: Nurse participant consent form	164
Appendix 3: Nurse participant explanation sheet	165
Appendix 4: Declaration of confidentiality	166
Appendix 5: Information sheet for customers	167-170
Appendix 6: Customer participant questionnaire	171-172
Appendix 7: Massey University Human Ethics Committee proposal approval.	173
Appendix 8: North Health Ethics Committee proposal approval	174

It should be noted that some identifying features have been removed from the forms which appear in the appendices in order to protect the anonymity of individuals concerned.

Appendix 1

Therapeutic Nursing Study

INFORMATION SHEET FOR NURSE PARTICIPANTS

My name is Eileen Price. Along with my role at Rehab Plus, I am a Masters student in the Department of Nursing and Midwifery at Massey University. My thesis supervisor is Dr. Gillian White. I am looking for volunteer nurses from the General Rehabilitation Team to participate in a research study as part of my degree. You are invited to become a nurse participant in this study.

The aim of the study is to understand the role of General Rehabilitation Team nurses in helping customers move towards health and independence. In the study this role will be described as Therapeutic Nursing - nursing that has a healing effect on customers.

The purpose of the study is to help nurses, their therapy colleagues, managers and customers better understand how nurses are therapeutic agents in this healing process.

Why General Rehabilitation Team?

This team is the first of its kind in New Zealand and offers a unique opportunity to study therapeutic nursing in the specialty in New Zealand. Your role in the team however, puts you under no obligation to participate in the study.

Therapeutic Nursing Study: Eileen Price

How can I participate?

It is important that you do not feel pressured to participate in the study and that your anonymity is maintained. Because of this, the selection process is as follows:

- 1) if you are interested to participate and have worked in the team for a minimum of 6 months, please complete the tear-off slip and return it to the Clinical Nurse Advisor.
- 2) The Clinical Nurse Advisor will collect the tear-off slips with names of all nurses who are interested in participating. By a process of random selection, the C.N.A. will select up to 12 participants. This will ensure that the researcher will not know which nurses do not want to participate and will therefore maintain the anonymity of each staff member.
- 3) This group of nurses will be asked to sign a consent form by the C.N.A. which will then be returned to the researcher.
- 4) Each nurse will then be sent a letter indicating the date and time of the Focus Group.

What is involved in the Focus Group?

- firstly, you will be asked to think of a situation(s) in which you believe that you helped a customer move towards independence/health and why. It may be helpful to write down these thoughts.
- you will then be invited to be part of a small discussion group of nurses (4-6) led by myself which will meet once or twice for a period of two hours at Rehab Plus during work time.
- During the group you will be invited to share the thoughts which you have written down (If you would prefer to be interviewed individually this can be arranged).

I will ask the group several questions during the session. You will be invited to participate in the discussion which will follow. The group discussion will be tape-recorded. The conversations will be typed by a

Therapeutic Nursing Study: Eileen Price

transcriber who will sign a confidentiality statement. The transcriptions will be seen by myself, my research supervisor and the transcriber only, along with any notes which I take during the group.

- you will be invited to review the transcripts for errors or omissions which will then be rectified.
- categories of nursing activities will be drawn from the transcriptions and presented back to you along with other categories from the literature, in the form of a questionnaire. You will be asked to prioritise the importance of these categories, then return your questionnaire to me. This process will be repeated once more and a final selection of categories will be reached. This will require a time commitment of approximately two hours.
- during the study, customers who are being discharged from the General Rehabilitation Team will be invited to respond to a Customer Questionnaire in which they will be asked to describe instances where they received nursing care which helped in their progress towards independence and health. As part of the consent to participate, they will be asked not to use names or any other distinguishing feature of specific nurses in the team.
- at the end of the study, nurse and customer responses will be analysed for similarities and agreement.

Respect for your choice....

You are under no obligation to participate in this study. Your right not to participate will be respected. There will be no repercussions should you wish not to participate or should you wish to withdraw at any time during the study.

During the study.....

- I will be the only person who will know your identity. Your name will be removed from the transcripts of the audiotapes
- you may withdraw at any time.

Therapeutic Nursing Study: Eileen Price

- you have the right to ask for the tape recorder to be turned off at any time during the group discussion if there is something you wish to say which you do not want to be recorded.
- your right not to answer questions will be respected.
- you will be free to ask any questions at any time during the study.
- tapes, transcripts and notes will be kept in my home in a locked drawer apart from occasions when these will be reviewed by myself and my supervisor.

After the study.....

Tapes of the discussion groups or interviews will be destroyed after they have been transcribed. The data will be stored for a period of 10 years in total.

The procedure for storage is as follows:

- All information relating to the research will be stored by the Faculty of Social Sciences at Massey University as directed by the Massey University Human Ethics Committee.
- Following this period the data will be returned to the researcher and stored in the researcher's own home in a locked filing cabinet for the duration of the 10 year period.
- During the course of the study, audio tapes and written material will be kept in a locked cupboard with access only to the researcher and the research supervisor.

The research findings will be presented as a Masters Thesis for marking and may be used for publication and/or public presentation. A copy of a shortened version of the report will be available on request.

Therapeutic Nursing Study: Eileen Price

Compensation.....

If you suffer **physical** injury as a result of your participation in this clinical trial, you may be covered by ARCIC. You should note, however, that eligibility for *cover* is not automatic.

Your claim for *cover* may be accepted by Accident Rehabilitation and Compensation Insurance Corporation (ARCIC) but your *entitlement* to compensation will depend on a number of factors such as whether you are an earner or a non-earner. You should note that in most cases ARCIC provides only partial reimbursement of costs and expenses and there is no lump sum compensation payable under the current ARCIC legislation.

If you have suffered only mental injury, there will be no ARCIC compensation available.

You should also be aware that if you have cover under the ARCIC legislation your right to sue the researcher(s) or anyone else involved in the clinical trial is extremely limited.

If you have any questions about cover or entitlements under the ARCIC scheme you should contact your nearest ARCIC branch office for further information before you consent to participate in this trial.

tear

off

slip

.....

Please complete and return to, Clinical Nurse Advisor by (date)...

NAME:

I do/ do not wish to participate in the study (Please circle your choice)

I am willing to join a focus group: Yes/No (Please circle your choice)

I would prefer to be interviewed individually: Yes/No (Please circle your choice)

THERAPEUTIC NURSING STUDY

Nurse Participant Consent Form

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I understand that I may/will chose to use a false name and that my participation will be confidential. (*The information will be used only for this research and publications arising from this research project*).

I agree/do not agree to the group discussion being audio-taped.

I also understand that I have the right to ask for the audio-tape to be turned off at any time during the group discussion.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date:

Appendix 3

Therapeutic Nursing Study

NURSE PARTICIPANT EXPLANATION SHEET

Date:.....

Dear.....

Thank you for agreeing to participate in the Therapeutic Nursing Study.

The first Focus Group meets on

.....at.....

During the group you will be invited to share a story about a time when you made a difference in the recovery of one (or more) customer(s). I want you to reflect on what you as a nurse did that made a difference.

It would be helpful if you could take time before the group to consider some of these stories and write them down.

Thank you for your participation!

Therapeutic Nursing Study

Declaration of Confidentiality

The purpose of the research has been made clear to me and I understand the need to maintain strict confidentiality with regard to all of the information I will be asked to transcribe from audio-tapes.

Itherefore declare that I will not disclose any details of the identity of the research participants, or the content of the tapes I receive to transcribe.

I will keep the tapes and the transcripts in a safe place while they are in my possession.

I understand that any disclosure of information pertaining to this research by me will be in breach of the Privacy Act.

Signature:.....

Date:.....

Therapeutic Nursing Study

Information Sheet for Customers

My name is Eileen Price. Along with my role at Rehab Plus as Team Leader of the General Rehabilitation Team, I am a Masters student in the Department of Nursing and Midwifery at Massey University. My supervisor is Dr. Gillian White. I am looking for customer volunteers who have been involved in rehabilitation in the General Rehabilitation Team to participate in a research study as part of my degree. You are invited to become a customer participant.

The aim of the study is understand the role of nurses in the General Rehabilitation Team in helping customers move towards health and independence. In the study this role will be described as Therapeutic Nursing - nursing that has a healing or beneficial effect on customers.

The purpose of the study is to help nurses, their therapy colleagues, managers and customers better understand how nurses are therapeutic agents in this healing process.

Why General Rehabilitation Team?

This team is the first of its kind in New Zealand and therefore the only opportunity to study therapeutic nursing in the specialty in New Zealand.

Therapeutic Nursing Study: Eileen Price

What is involved?

You will be asked to read this information sheet and, if you decide that you would like to participate, a questionnaire will be given to you by the Clinical Nurse Advisor. Once you have completed this, you will be asked to post this in the box as directed, or return it in the stamp-addressed envelope to Rehab Plus.

What will happen to the information I provide?

Your answers will be used to develop categories of therapeutic nursing. These will be compared with categories which will be developed from the nursing literature and from nurses themselves.

Respect for your choice....

You are under no obligation to participate in this study. Your right not to participate will be respected. There will be no repercussions should you wish not to participate.

During the study.....

- you will be asked to fill in a questionnaire.
- your right not to answer questions will be respected.
- you will be free to ask any questions at any time during the study.
- your answers, along with other documents from the study will be kept in my home in a locked drawer apart from occasions when these will be reviewed by myself and my supervisor.
- you will not be asked to provide any information which will reveal your identity on the questionnaire. Whilst every step will be taken to protect your confidentiality, you should be aware that it may be possible to identify you from the information you provide.

Therapeutic Nursing Study: Eileen Price

After the study.....

The research findings will be presented as a Masters Thesis for marking and may be used for publication and/or public presentation. A copy of a shortened version of the report will be available on request. Tapes of the discussion groups or interviews will be destroyed after they have been transcribed. The data will be stored for a period of 10 years in total. The procedure for storage is as follows:

- All information relating to the research will be stored by the Faculty of Social Sciences at Massey University as directed by the Massey University Human Ethics Committee.
- Following this period the data will be returned to the researcher and stored in the researcher's own home in a locked filing cabinet for the duration of the 10 year period. Such information will be destroyed electronically and/or shredded after this time.
- During the course of the study, audio tapes and written material will be kept in a locked cupboard with access only to the researcher and the research supervisor.

Compensation.....

If you suffer **physical** injury as a result of your participation in this clinical trial, you may be covered by ARCIC. You should note, however, that eligibility for *cover* is not automatic.

Your claim for *cover* may be accepted by Accident Rehabilitation and Compensation Insurance Corporation (ARCIC) but your *entitlement* to compensation will depend on a number of factors such as whether you are an earner or a non-earner. You should note that in most cases ARCIC provides only partial reimbursement of costs and expenses and there is no lump sum compensation payable under the current ARCIC legislation.

If you have suffered only mental injury, there will be no ARCIC compensation available.

Therapeutic Nursing Study: Eileen Price

You should also be aware that if you have cover under the ARCIC legislation your right to sue the researcher(s) or anyone else involved in the clinical trial is extremely limited.

If you have any questions about cover or entitlements under the ARCIC scheme you should contact your nearest ARCIC branch office for further information before you consent to participate in this trial.

How to participate in the study.....

I will assume that you have chosen to give your consent to participate in the study if you return the completed questionnaire in the envelope provided.

This study has received ethical approval from the
Massey University Human Ethics Committee
North Health Ethics Committee

For any further information study is

contact:

Eileen Price
Team Leader
General Rehabilitation Team
Rehab Plus
54 Carrington Road
Point Chevalier
Auckland

The research supervisor for this

Dr. Gillian White, PhD. MA(Hons), B. Ed.
DipSocSc(Psych) RM, MTD.
Senior Lecturer
Department of Nursing and Midwifery
Massey University
Albany
Phone: 443-9373

For independent advice/support during this study, contact:
(names deleted)

If you have any queries or concerns about your rights as a participant in this study you may wish to the Health Advocates Trust, telephone 623 5799.

Therapeutic Nursing Study

CUSTOMER PARTICIPANT QUESTIONNAIRE

Thank you for agreeing to participate in this study. You have been invited to participate because you have recently had experience of nursing care in the General Rehabilitation Team at Rehab Plus. Anything you say will be treated as confidential by the researcher.

The purpose of the study is to understand what it is that nurses do in rehabilitation that is helpful. We are interested to hear how nurses assisted you during your experience at Rehab Plus. Please do not use real names of nurses in the team.

Please answer the following questions.

1. What particularly stands out in your mind about the nursing care you received that assisted you in getting better?

Therapeutic Nursing Study: Eileen Price

2. Describe three things which are most helpful about the nursing care you received in the General Rehabilitation Team. (Please attach further sheets if you wish).

a.

b.

c.

Thank you for your participation!

Appendix 7



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**FACULTY OF
BUSINESS STUDIES**

**DEPARTMENT OF
HUMAN
RESOURCE
MANAGEMENT**

18th July 1997

Eileen Price
Department of Nursing and Midwifery
MASSEY UNIVERSITY

Dear Eileen

Thank you for your amended information sheets and consent forms.

The amendments you have made now meet the requirements of the Human Ethics Committee and the ethics of your proposal are approved.

Yours sincerely

Professor Philip Dewe
Chairperson
Human Ethics Committee



Appendix 8

14 July 1997

Ms Eileen Price
Rehab Plus
PO Box 44037
Pt Chevalier
Auckland 1002

Dear Ms Price

97/119 AN EXPLORATION OF THE NATURE OF THERAPEUTIC NURSING IN A GENERAL REHABILITATION TEAM

Thank you for the revised application incorporating the changes requested by Ethics Committee Y at the meeting on 9 July 1997.

I am pleased to inform you that the study is approved until 14 July 1998. It is certified as not being conducted principally for the benefit of a manufacturer and will be considered for coverage under ACC.

Please note that the Committee grants ethical approval only. If management approval from the institution/organisation is required, it is your responsibility to obtain this.

We wish you every success with the study.

Yours sincerely

Ann Howard
Secretary
Ethics Committees

APPROVED by the

NORTH HEALTH
ETHICS COMMITTEE

until 14/7/98
Secretary A Howard
Date 14/7/97

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