REFLECTIVE PRACTICE: Key to the Future of Nursing?

A comparative study of the nursing practice of graduate and non-graduate nurses

BARBARA. D. M. CREBER.

A thesis submitted in partial fulfilment of the requirements of London Metropolitan University for the degree of Doctor of Philosophy

January 2007

ABSTRACT

This is a qualitative research study of nursing practice. Using grounded theory, two groups of qualified nurses were compared, a graduate and non-graduate group. Nursing practice was analysed at an individual, team and professional level.

Data was collected using audio taped diaries, semi-structured interviews and observations of each nurse whilst engaged in direct patient care.

From the analysis of the data, (based on the work of Strauss and Corbin) differences between nurses were identified. A theoretical framework was developed which identified different types of nurses characterised by certain behaviours. Two main types of nurse, reflective and non-reflective emerged but this however was not necessarily related to whether the nurse was a graduate or not. Educating nurses to graduate level therefore did not necessarily produce a reflective practitioner.

The results of the research provide new insights into contemporary nursing practice and demonstrate differences in the way nurses tackle the demands and challenges of everyday nursing practice and perceive their role and professional development.

In conclusion, the research questioned whether the professionalisation of nursing has benefited nursing and more particularly patient care or whether indeed graduate status was more concerned with improving the standing of nursing as a profession when considered alongside other healthcare professions.

ACKNOWLEDGEMENTS

I would like to thank my supervisors, Brian Hall and David Kellegher for the help they have given me in the development of this research and construction of the thesis. Also, Geoff and Dougal for their support and patience.

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION & BACKGROUND

The question of whether nurses are suitably prepared for practice is constantly debated and whilst it is still not universally accepted within the profession that graduate status is the best way forward there are many who believe that an all graduate profession is the direction in which the profession is heading. But, do we know enough about the benefits of graduate status? And will an all-graduate profession meet better the needs of patients now and in the future? Is it possible to say whether a nurse who has achieved a degree is a better nurse than a non-graduate nurse? These are some of the questions I hope to explore further in this research.

As I have indicated my primary interest was to investigate the merits of educating nurses to graduate level. However, I also hoped that this research would reveal what it is like to be a nurse in the 21st century and shed light on the demands and pressures that contemporary nurses experience in everyday practice. Addressing questions such as, what do nurses do? , What do they think about? How do they relate to others? And what contribution do they make to a patient's experience of healthcare.

I, like many nursing educationalists became interested in this topic whilst working in a college of Nursing about to undergo a period of significant change as our College incorporated into the Higher Education Sector. Clearly, what interested me at this time was how well we were preparing future nurses for practice. Would an all graduate profession meet better the future challenges that the profession was facing in terms of improved patient care or was it more to do with improving the professional status of nursing when compared alongside doctors and other healthcare professionals?

When I began this research I was teaching Pre and Post-Graduate nurses at diploma, graduate and post graduate level.

History of Nursing, Nursing Practice & Education

Prior to the foundation of modern nursing, the family provided its own nursing services for family members, or employed experienced helpers for those who could afford it. For those without relatives care was often provided by nuns or the military. In the early Nineteenth Century there were neither skilled nursing nor trained nurses. As depicted by many writers of the day the nurse was not only ignorant but, dangerous to the sick. (Davis, 1980). Virtually all nurses were drawn from the domestic servant classes. At St Bartholomew Hospital Sir James Padget recalled that,

> " nurses of the 1830's were, dull, unobservant and untaught women; of the best it could only be said that they were kindly, and careful and attentive in doing what they were told to do" (Abel-Smith, 1960 p.6).

Nurses' of this period were often condemned by historians of the time as inefficient and immoral.

Reformers such as Florence Nightingale stated that,

> "Nursing was generally done by those, who were too old, too weak, too drunken, too dirty, too stolid or too bad to do anything else." (Davis, 1980, p.5).

However, it was not unusual for reformers to overstate the evils they were hoping to correct and it was certainly unfair to condemn all nurses of the time in this way. (Abel-Smith, 1960)

Elizabeth Fry was considered by many historians as the real pioneer of nursing reform in this country, recognising the need to provide more skilled and trustworthy attendants for the sick. (Davis, 1980) However, Florence Nightingale, an English nurse, writer and statistician who came to prominence during the Crimean War for her pioneering work in improving the conditions of injured soldiers is attributed with laying the foundations of the modern nursing profession. She set an example of compassion, commitment to patient care, and diligent and thoughtful hospital administration which she set out in her book, "Notes on Nursing". "Notes on Nursing", published in 1859 served as the cornerstone of the curriculum at the Nightingale School and other Nursing Schools subsequently introduced it. In the introduction to the 1974 edition, Joan Quixley of the Nightingale School claimed that the book was the first of its kind ever to be written at a time when the simple rules of health were only just beginning to be known, when its topics were of vital importance not only for the wellbeing and recovery of patients, at a time when hospitals were riddled with infection and when nurses were

still mainly ignorant, uneducated persons. (Nightingale, 1974 p.2). It is considered a classic. She was also responsible for establishing the first official training school, The Nightingale Training School at St Thomas' on July 9 1860. The mission of the school was to train nurses to work in hospitals, work with the poor and to teach. Her intention was to train nurses to a qualified level who would then work in hospitals posts across the UK and abroad. (Neeb, 2006). She spent the rest of her life promoting the establishment and development of the nursing profession and organising it into its modern form. She was an advocate for the improvement of care and conditions in the military and civilian hospitals in Britain. Among her popular publications were, "Notes on Hospitals", which deals with the correlation of sanitary techniques to medical facilities; "Notes on matters affecting the Health, Efficiency and Administration of the British Army". From 1857 onwards Nightingale was intermittently bedridden and suffered from depression. An alternative reason for her depression was that she had been mistaken about her reasons for the high death rate during the Crimean War. (Small, 1998). Although she suffered ill heath for the remainder of her life she continued her pioneering work in the field of social reform and hospital planning which was propagated across Britain and the World.

Mary Seacole, also worked in the Crimea but, was overshadowed by Florence Nightingale for many years. However, more recently there has been a resurgence of interest in her and efforts have been made to properly acknowledge her achievements and contribution to the nursing profession. (Robinson, 2004). Despite being rejected by Florence Nightingale to be included in a party of 38 nurses to travel to the Crimea to nurse war injured she borrowed money to make the 4000 mile journey herself. She distinguished herself by treating battlefield wounded; often nursing wounded soldiers from both sides whilst under fire. She was responsible for setting up and operating boarding houses in Panama and Crimea to treat the sick and war casualties, today she is noted for her bravery, knowledge of medical and tropical skills medicine and as women who succeeded despite the racial prejudice of influential sections of Victorian Society.

Once nursing schools were established the next major milestones in the development of nursing was the battle for Registration and the Nurses Registration Act of 1943 which officially recognised nursing as a profession and established criteria for entrance to the register

Today, the way in which nurses are educated and prepared for practice has undergone significant change since those early days following registration. Over the last couple of decades. Nursing and Midwifery Education in the U.K has had to embrace these changes, the most recent and perhaps, most significant being the incorporation of schools of nursing and midwifery within the Higher Education Sector.

However, the call for reform of nursing and midwifery education can be traced much further back, to The Athlone Report (1938), The Wood Report (1947) which made 40 recommendations, including student grants, a common foundation programme with later specialisation; The Platt report (1964) and The Briggs Report (1970). The introduction of Project 2000 was significant in terms of educational reform because it was the first real attempt to introduce supernumerary status for student nurses, a common foundation programme with later specialisation, allowing educational needs to be separated from service needs. These changes have paved the way for student nurses to be viewed in the same way as other university undergraduates whereby they are able to experience the benefits of being a full-time student of Higher Education and a member of the wider student community.

Professionalisation of nursing

The move to higher education and the resultant professionalisation of nursing and midwifery has not been achieved quickly or without disruption to students and educationalists alike. It has occurred over a somewhat lengthy and protracted period in the UK, which first saw mergers of Colleges of Nursing and Midwifery followed by the development of partnerships with Higher Education, culminating eventually in incorporation into the Higher Education sector. These changes for some Colleges of Nursing and Midwifery began in the late 1980's whilst others did not undertake incorporation into the university sector until much later, well into the 1990's. Whilst there were clearly some disadvantages to these changes not least the disruption to staff and students during the process of change, many people believe that the benefits have been the opportunity to utilize the facilities and expertise available in a University and of becoming part of a wider academic community (Quinn 1995). Other advantages were the management structure within Higher Education, which was flat and much less hierarchical when compared with nursing Colleges. Many writers at the time including Quinn believed that coping with

changes in curriculum or with internal management arrangements can be stressful for teaching staff, but these seem relatively minor when compared with the cultural upheaval consequent upon a merger with a university.

By comparison, the USA, Australia and New Zealand for example, underwent this process in the early 1980's. As Lawler (1995, p.3) stated, about nursing in Australia during this period, "the international nursing community were watching and waiting to see what would happen." In hindsight, nothing disastrous happened and the Australian experience was helpful as was The USA and New Zealand in encouraging the U.K to finally make the decision to move into the higher education system. Some of the concerns at the time were, and (to some extent still is) the question of whether nursing and nurses can embrace the intellectual challenges of academia. Whether nurses and nursing sit comfortably in higher education is still a topic for debate. As Lawler, put rather succinctly,

> "Our collective and universal history as nurses has been characterised by a struggle to be recognised as good thinkers and scholars. Indeed we are still distracted, from time to time by the remnants of anti-intellectualism and suspicion about those of us who seem too bright to be nurses or who enjoy the intellectual challenges of nursing." (Lawler, 1995, p.3)

Whether nursing can be considered a profession is subject to continuing debate. However, it is generally accepted that the move to Higher Education has significantly improved the standing of nursing as a profession when considered alongside other healthcare professions such as physiotherapy, radiography and speech and language therapy, particularly if one accepts Johnson's view that rather than identifying the criteria that constitutes a profession it is better to regard professionalism as an ideology and professionalisation as a process by which an occupation seeks to advance its status, (Johnson, 1972,1984). Higher education derives its authority from knowledge – getting a degree entry route validates the professions claim to a specialist knowledge base and hence to professional status.

Whatever view one holds about whether nursing can be defined in a theoretical sense, it is clear that this period in the development of nursing is significant because it allowed nurses to consolidate their position in academia and research.

Although, as Lawler has stated,

> "In the heat and pressure to find a place for nursing in higher education nurses at times paid less attention to scholarly activity and seemed rather too preoccupied with establishing a position in academia." (Lawler, 1995 p.3)

With the reform of nursing education in mind and within the overall context of the professionalization of nursing, I was interested to discover (when I began this research), whether educating nurses to graduate level was advantageous and if it was, what were the benefits for patients, patient care and the nursing profession as a whole? If graduate nurses do indeed make better nurses, what is it that makes them better nurses? Or was the move to higher education more to do with improving the status of nursing when compared alongside other health professions. Whilst, investigating the possible merits of educating nurses to graduate level was my primary interest I also hoped that this research would reveal what it is like to be a nurse in the 21st century and shed light on the demands and pressures that contemporary nurses experience in healthcare. I wanted to consider what nurses do; what they think about; how they relate to others and what contribution they make to a patient's experience of healthcare. In essence, the added value to healthcare.

Defining nursing

Nursing like many other disciplines has an ever-increasing number of concepts, perspectives, propositions and phenomena. Whilst, it is argued by many writers that Nursing cannot claim a unique theoretical body of knowledge specific to itself because as it has evolved, it has drawn upon other fields of study such as anatomy, physiology and pharmacology as well as sociology, anthropology and philosophy, a number of writers have attempted to distinguish nursing from other disciplines, especially the health-related professions such as medicine, social work, and physiotherapy. Writers such a Malmosten (1999) and Parse (1995) argue that basic care can be considered a core aspect of nursing that distinguishes it from other disciplines.

As already indicated, and further supported by numerous writers during the 1980s and 1990s nursing became somewhat preoccupied with trying to define nursing, its philosophical basis and the theories that underpin practice. The justification for this preoccupation was that theories and research are necessary components of professional education. (Fjelland and Gjengedal 1994 cited by Benner 1994). However, this has raised the question of whether nursing which is a practice based profession really

needs theories and whether attempting to define nursing in these terms only serves to create a gap between practice and theory. Because theory does not necessarily describe reality, but often speculates on what might be or what ought to be, as Timpson (1996) has suggested, nursing theory has a reputation for abstraction, even irrelevance in the minds of many practitioners.

What is Theory? Why is Nursing Theory Necessary?

When examining the literature, (of which there are vast amounts) it is interesting to note that different nursing theorists have argued from an array of perspectives and it is clear that different trends have gained popularity over time only to be quickly replaced by other viewpoints/ perspectives.

Theory can be broadly defined as an organised, coherent and systematic articulation of a set of statements related to significant questions in a discipline that are communicated in a meaningful whole (Meleis 1997). When applied to the discipline of nursing, it is argued that theory can describe phenomena, explain relationships between phenomena, predicting consequences or prescribing nursing care. However, the definition of nursing theory is somewhat problematic because there are several types of theory reported in the nursing literature, which is compounded by the use of unfamiliar terminology, which many nurses find difficult to understand and to relate to practice. Confusion has also been caused by exchanges in the nursing literature that have used concepts interchangeably with theory, such as conceptual framework, conceptual model, paradigm, met paradigm, theorem and perspective.

Nursing theories can be broadly classified depending on the generalisability of their principles, thus:

- Metatheory – identifies specific phenomena through abstract concepts.
- Grand Theory – provides a conceptual framework under which the key concepts and principles of the discipline can be identified.
- Middle range theory – is more precise and only analyses a particular situation with a limited number of variables.
- Practice theory – explores one particular situation found in nursing, identifies explicit goals and details how these goals might be achieved.

(Polit et al 2001)

Nursing theories can also be categorised by philosophical underpinnings thus:

- Needs theories – based around individuals fulfilling physical, psychological, sociological and spiritual needs. This approach has been criticised for relying too heavily on the medical model and placing the patient in an overtly dependent position.
- Interaction theories – These theories, described by Peplau (1988) revolve around the relationships nurses form with patients. These theories have been criticised for not addressing the patient's physical needs.
- Outcome theories – These theories described by (Roy 1990) describe the nurse as the changing force enabling individuals to adapt to or cope with ill health. These theories have been criticised for being too abstract and difficult to implement.

However, if a nurse can fathom some of the difficult language it is possible to see that nursing theory may help nurses to understand better the principles that underpin nursing practice, helping them to recognise the unique contribution nurses make to healthcare.

When examining the key writers of nursing theory and nursing knowledge between 1962 – 1980 it can be seen that this was a period of intense proliferation in the literature where nurses were debating the theory of nursing, attempting to define what nursing is the nature of nursing knowledge and the values and philosophies that underpin it.

Nursing theory during this time tended to focus on models, frameworks and concepts.

One of the difficulties of this period in the development of nursing theory was that many practitioners couldn't see the relevance to practice because theorists failed to engage enough with practicing nurses and as a result the gap between nursing theory and practice widened.

During 1990 –2000 a notable shift in thinking occurred amongst nursing theorists and it became popular for nursing to be described in terms of what nurses did in practice and practice knowledge development. Researching elements of practice became popular in order to examine and record contemporary practice. This increasing emphasis on researching what nurses did in practice, it was

argued, would remove the divide often made between theory and practice and help understand better the nature of practice and knowledge.

Writers such as Higgs and Titchen (1995); Benner (1990, et al) in focusing on the practice element of nursing began to argue that nursing does indeed have some unique aspects which are particular to nursing alone. Such as care and intuition. However, the claim that basic care is unique to nursing does have some flaws if one is claiming that basic care is performed only by nurses and by all nurses because not all nurses are engaged in basic care. Carper and Benner on the other hand prefer to argue that practical knowledge is central to nursing.

(Carper, 1978 p24) defines nursing thus,

> "Nursing thus depends on the scientific knowledge of human behaviour in health and illness, the aesthetic perception of significant human experiences, a personal understanding of the unique individuality of the self and the capacity to make choices within concrete situations involving particular moral judgements."

Whilst Benner (1984, p.3), describes five levels of practice ranging from novice to expert. Benner suggests that,

> "The novice operates on abstract principles and formal models and theories whereas the expert nurse, "perceives the situation as a whole, using past concrete situations as paradigms and moves to the accurate region of the problem without wasteful consideration of a large number of irrelevant options."

Nursing Knowledge: A Theoretical foundation for nursing as a science?

Perhaps, a useful way of addressing this question is first to ask why it is necessary to define nursing in terms of a theory/theories? Will it help define what good nursing is and when it exists? By describing elements of practice will it provide a better understanding of nursing? One of the dilemmas that the nursing profession faced when attempting to define nursing in terms of a theory (and to some extent still does), is whether it is possible to define nursing and what constitutes nursing knowledge in an all encompassing theory that defines all the different aspects of nursing. The other problem was whether it is really necessary to define nursing in these terms as many argue that nursing existed long before any attempts were made to define what it is, and continues to exist despite many nurses knowing little about nursing theory (Colley 2003)

Clearly, most people, patients and staff alike can recognise a "good nurse" from a "not so good nurse", but the dilemma is can it easily be determined whether this is due to lack of theory or lack of

experience? Herein, lies one of the difficulties nursing theorists is faced with, when attempting to define nursing in a theoretical sense, without considering the complexities of professional practice.

Art or Science?

A further, but related confusion surrounding nursing theory was the debate about whether nursing is an art or a science or perhaps some aspects of both. Whilst this question has probably been debated, since the inception of nursing (Le Vasseur 1999), it became a pressing issue when nursing education moved into higher education and had to align itself to one of the main schools of knowledge. (Rose and Parker 1994). Historically nursing has evolved alongside medicine or the scientific approach but, many writers of contemporary nursing theory have argued that for nursing to be taken seriously as a profession in its own right it was necessary to discover its own body of knowledge. It therefore became popular to argue that nursing science or practice was better aligned to the humanities.

Whilst this debate continued for some time, Carper's (1978) four ways of knowing in nursing - empirical, ethical, personal and aesthetical allowed nurses to move away from the medically dominated view of nursing and address their discipline in terms of artistry.

Forms of Practice knowledge

Schon (1987) referred to the field of professional practice as a swampy area, because he believed that decision-making is often uncertain, ambiguous or hidden. A number of writers have called for more research to be undertaken in practice in order that the complexities of professional practice can be understood better and as a means of bridging the theory practice gap. The knowledge that a practitioner brings to a clinical encounter it not always clearly understood, is complex and often related to the professional's experience. Higgs and Titchen (1995) suggest that the knowledge that a clinician brings to a clinical encounter takes three forms: -

- Propositional, theoretical or scientific knowledge – e.g. knowledge of pathology, physiology.
- Professional craft knowledge or knowing how to do something.

- Personal knowledge about oneself as a person and the relationships with others.

Whilst propositional knowledge is formal and explicit derived from research and scholarly activity, professional craft knowledge and personal knowledge may be tacit and embedded either in practice itself or in whom the person is (Cervero 1992). Herein lays the reason why many contemporary researchers are interested in examining the complexities of professional practice and decision-making, believing that scientific or theoretical knowledge is only part of a complex picture that explains the phenomena/knowledge distinctive of a professional group.

As far as nursing is concerned, Benner et al have argued that professional craft knowledge and personal knowledge, (who the nurse is as an individual) has an important bearing on what kind of professional she is. Benner and Wrubel stress this point, in their book, the primacy of caring *(1989, p.43)* when constructing a theory of nursing with the aim of improving practical nursing.

> "A theory is needed that describes, interprets, and explains not an imagined ideal of nursing but actual expert nursing as it is practiced day to day".

Benner & Wrubel constructed their theory of nursing not on the model of science but using a phenomenological approach inspired by Heidegger (1926/62) and Kierkegaard (1843/1885). Present day interpreters of this phenomenological approach include Dreyfus (1979); Taylor (1985) & Rubin (1984); Tanner (1993)

Research into Nursing Practice

Nursing practice has been studied from a variety of perspectives in the past in an attempt to define nursing and explain what is unique about nursing practice. Over the years a variety of views and perspectives have been proposed in an attempt to answer these fundamental questions and come up with a definitive framework that defines the core elements of nursing and nursing practice. Much has been learnt about role relationships and socialisation of nurses in practice but probably less about the knowledge embedded in clinical practice and how this knowledge accrues over time (Benner, 1984). Whilst, certain clinical specialisms such as intensive care have been subject to in-depth research, less attention has been directed towards the acute general areas.

Knowledge embedded in practice has largely been un-researched because the differences between practical and theoretical knowledge is poorly understood. According to Benner (1984) the fact that nurses in the past were not careful record keepers of their own learning and failed to record carefully enough practices and observations has deprived nursing of the uniqueness and richness of the knowledge embedded in expert practice. This research will evaluate whether graduate nurses make better nurses when compared with non-graduate nurses, in terms of impact on practice, the profession and professional development.

The future of nursing theory?

It is clear from the literature that defining what nursing is and what contribution nurses make to healthcare is neither a simple nor easily achieved task despite the fact that many theorists have attempted to do so. It is argued that this is because nursing roles are varied and very different, and it is never going to be possible to provide one theory that will explain the entire phenomenon of nursing. It is also important to ask whether defining nursing will contribute further to the articulation of nursing as a practice or whether it is better to accept that defining nursing in this way will only lead to generalisations rather than provide a rationalised systemic approach to nursing work, that brings about better care to patients and from which students can learn.

Researching clinical practice is key to understanding better nursing roles and should be undertaken jointly by academic and practicing nurses to reduce the practice/theory gap and to ensure that practice and academic skills are equally valued.

Understanding the contribution nurses make to care will help patients; managers and other health-care professionals appreciate the various nursing roles better and thus their contribution to healthcare. A useful approach to researching practice is the use of Phenomenology. Phenomenology, rooted in a philosophical tradition developed by Husserl and Heidegger, is an approach to thinking about what life experiences of people are like. The phenomenological researcher asks the question,

> "What is the essence of this phenomenon as experienced by these people?" (Polit & Hungler 1999, p.43.).

This approach attempts to capture the lived experience of the subject and attempts to understand the demands and challenges placed on the individual. It is this approach that I intend to use in this research in order to understand and explain nursing practice.

RESEARCH AIMS:

- Explore the process of professionalisation of nursing to evaluate whether graduate nurses make better nurses when compared with non-graduate nurses, in terms of impact on practice, the profession and professional development.
- Identify the benefits of educating nurses to graduate level
- Provide new insights into contemporary nursing practice.
- Understand better the demands nurses face in contemporary practice and to be able to recommend whether all nurses should be graduates.

The research is a qualitative study of nursing practice in acute adult nursing areas. Using a phenomenological approach, two groups of qualified nurses will be compared, a graduate and non-graduate group. Nursing practice will be analysed at three different levels:

- Individual – how the nurse perceives herself as a nurse.
- Team –how she perceives herself as a team member and how she relates to other team members.
- Professional level - perception of the nursing role and professional development.

Data will be collected by means of diaries (of their practice) provided by nurses, by observation whilst nurses are engaged in direct nursing care and by semi-structured interviews with these nurses.

Data will be analysed using Analytic-coding procedures based on the work of Strauss and Corbin (1990) whereby data is broken down, analysed, conceptualised and put back together in new ways. Theories will be built from the data.

THESIS OUTLINE

Chapter One: Introduction

Outlines the motivation for the research, defines the topic, the outcomes and indicates how the research will be progressed. Considers the overall context in which the study is based. This chapter discusses the professionalisation of nursing, nursing theory and the different forms of nursing knowledge.

ChapterTwo: Method

Identifies the research strategy and design and the reasons for selection.

ChapterThree: ANALYSIS: Pilot Analysis

Describes the pilot analysis and the coding procedures used to analyse the data. Identifies sub-categories, categories and themes that emerged from the data.

Chapter Four: ANALYSIS: Dialogues

Describes the analysis of dialogues in the data to identify differences amongst nurses.

Chapter Five: ANALYSIS: Differences between cases

Describes the analysis between cases

Chapter Six: The Reflective Scale

Describes the development of an analytic tool used to determine reflectiveness and the stages of reflection.

Chapter Seven: Differences between Nurses

This chapter considers each nurse in turn, identifying whether the nurse is reflective or not and to what degree.

Chapter Eight: The Theoretical Framework

Discusses the theoretical framework devised and describes how it can be used. Includes a literature review of reflection/ reflective practice.

Chapter Nine: Discussion

Discusses the research findings and the implications for future practice.

Chapter Ten: Conclusion

Summarises the main findings of the research, considers the contribution of the work to the field of study and suggests areas for further research.

CHAPTER TWO

METHOD

Aim and Context of the research

The aim of the research is to understand what are the demands and pressures that contemporary nurses experience in healthcare and to be able to recommend whether all nurses should be graduates.

With the reform of nursing education in mind and within the overall context of the professionalization of nursing, I was interested to discover whether educating nurses to graduate level was advantageous and if it was what were the benefits for patients, patient care and the nursing profession as a whole? If graduate nurses do indeed make better nurses, what is it that makes them better nurses? Whilst, investigating the possible merits of educating nurses to graduate level was my primary interest I also hoped that this research would reveal what it is like to be a nurse in the 21st century and shed light on the demands and pressures that contemporary nurses experience in healthcare. I wanted to consider what nurses do, what they think about, how they relate to others and what contribution they make to a patients experience of healthcare. In essence, the added value to healthcare.

I, like many nursing educationalists became interested in this topic whilst working in a college of Nursing about to undergo a period of significant change as our College incorporated into the Higher Education Sector. Clearly, what interested me at this time was how well we were preparing future nurses for practice. Would an all graduate profession meet better the future challenges that the profession was facing in terms of improved patient care or was it more to do with improving the professional status of nursing when compared alongside doctors and other healthcare professionals? When I began this research I was teaching Pre and Post-graduate nurses at diploma, graduate and post graduate level. Since the 1980s and following a number of educational directives (UKCC, 1986, 1993, 1994) all nursing courses lead to an academic award as well as a professional qualification. (Registered

General Nurse [RGN] and Diploma/Degree in Higher Education) Nurses can opt to undertake either a three-year degree or diploma programme. The majority of students in the UK undertake a diploma course. It has been estimated that approximately 80% of students qualify via the diploma route. Of the four countries of the UK, Wales is moving to an all degree entry whilst the other three continue to offer both routes. Within my own University students can study nursing at either diploma or degree level. The degree places greater emphasis on leadership and deeper study and research. Students can choose to follow child, adult or mental health branch, but will also share modules with students from different disciplines. Students are also able to work inter-professionally alongside students from other disciplines within the healthcare sector. Students begin with a one-year foundation programme, which provides them with a grounding in the general principles of nursing including applied biological sciences, sociology, psychology, ethics, personal development and research. In the second and third years students continue to study these subjects as well as learn about health and illness and the nursing needs of people of all ages and backgrounds. The third year is spent developing confidence and autonomy as a nurse. Academic study is combined with a range of branch-focused placements in different settings. Students will also gain insight into adult, child, learning disabilities, mental health and maternity practice with the option to change branch towards the end of the first year if desired.

Learning is facilitated through lectures, tutorials, group work, seminars and clinical practice. Progress is measured through a combination of simulated clinical exercises, practice based assessments, written assignments and examinations. Each student is required to keep a portfolio of evidence to chronicle their learning and professional development during their programme. All the research respondents who form part of this study have undergone a degree or diploma at this university.

The Diploma in Higher Education is generally regarded to be the equivalent to the first two years of a standard undergraduate degree, although the length of both diploma and degree courses in nursing is extended to three years in order to provide the opportunity for students to develop clinical practice skills. Many UK Universities offer diploma and degree programmes alongside each other with some shared learning. The assessment of the theoretical component is the distinguishing difference between the degree and the diploma course, differences in outcomes in terms of practical skills is less clear (Pleasance & Sweeny 1994). Although all pre-registration nursing courses, be they diploma or degree

level, are required to fulfil a common set of learning outcomes specified by the Nurses, Midwives and Health Visitors Act (Statutory Instrument 1989), there are no precise indicators of what the difference between a diplomat and a graduate should be. It is therefore left to individual educational institutions to interpret the statutory requirements in the context of a particular programme with which they are offering.

Focus and Design

An emergent qualitative design was selected as the most suitable approach to recording, understanding and explaining contemporary nursing practice. As noted by Lincoln and Guba (1985), an emergent design in qualitative studies is not the result of sloppiness or laziness on the part of the researcher, but rather a reflection of the researchers desire to have the enquiry based on the realities and viewpoints that are not known or understood at the outset of the study. Whilst a considerable amount of advanced planning was necessary to support an emergent design nevertheless unanticipated problems arose during the data collection process requiring adjustment to timescales and approaches. E.g. research respondents phoning in sick, unexpected ward emergencies, such as a cardiac arrest, when follow up interviews were scheduled. Other examples included the need to adjust the follow up interview schedules after listening to a reflective tape recording or following a period of observation of a nurse.

The approach to understanding and explaining contemporary nursing practice taken in this study is a combined approach using phenomenology and grounded theory. Phenomenology, rooted in a philosophical tradition developed by Husserl and Heidegger, is an approach to thinking about what life experiences of people are like. Present day interpreters of this approach include Dreyfus (1979) Taylor (1985 and Rubin (1984). The phenomenological researcher attempts to find out the essence of the phenomenon as experienced by people? (Polit & Hungler, 1999)

This approach attempts to capture the lived experience of the subject and is therefore, an appropriate method to use to discover what it is like to be a nurse in the 21st century and to identify the demands and challenges that the nurse faces in his/her everyday practice. The kinds of questions I will ask subjects are:

What is the life of a nurse?

What are the everyday challenges they face?

What do nurses do?

What do they think about?

How do they relate to others?

What contribution do they make to patients and healthcare overall?

The data gathered will allow me to build up an intermediate theory of contemporary nursing practice that will describe, interpret and explain nursing as it is practiced day by day.

Grounded theory studies social processes and structures. The focus is the development and evolution of the social experience. The primary focus is to generate comprehensive explanations of phenomena that are grounded in reality. Grounded theory was developed in the 1960s by two sociologists, Glaser and Strauss. Grounded theory methods constitute an entire approach to the conduct of field research and should not begin with a highly focused research problem, as the problem should emerge from the data. One of the fundamental features of the grounded theory approach is that data collection, data analysis and sampling of study participants occur simultaneously.

The research

This research is a comparative study of graduate and non-graduate nurses and attempts to provide new insights into how nurses make judgements in their everyday practice, how knowledge is used to inform practice and to identify any differences or similarities between graduate and non graduate nurses.

Method

Two groups of qualified nurses are compared. The graduate group is made up of nurses who qualified having undertaken a degree programme. The non-graduate group of nurses qualified by completing a diploma course. Both programmes were (and still are) three years in duration. A few diploma and

graduate programmes share learning at level two (in the second year) but, it is more common for the two programmes to be delivered separately.

Careful selection of nurses in each of the two groups was undertaken (graduate and non-graduates) to ensure that they were representative of the range of nurses in each type. This process is described by Glaser and Strauss (1967) as theoretical sampling. Purposeful sampling is necessary to ensure that data collection and analysis is continued until nothing new is revealed or unfolds. This was achieved when the nurses being interviewed no longer provided substantially different conceptions of their nursing role and professional development, i.e. theoretical saturation has been achieved (Hammersley & Atkinson, 1995)

Nursing practice was analysed and compared from three different aspects:

- Nursing care aspect – the nature and quality of nursing care (as perceived by the nurses and the researcher)
- Ward aspect – the way in which the nurse contributes to the delivery of care and relates to other team members (as perceived by the nurses and the researcher)
- The nursing profession as a whole – the nurse's perceptions of the nursing role and professional development in general.

Data was collected by a variety of means:

- Narrative descriptions provided by nurses of their nursing practice. (Benner 1996)
- Observation for two to four hours whilst the nurses were engaged in direct nursing care. (Benner, Tanner and Chesla 1996)
- Semi-structured interviews with these nurses.

All interviews and direct discussion during observation periods were audio-recorded and transcribed with the informed consent of the nurse. Narrative descriptions of the nurse's practice were obtained by asking each nurse participating in the study to complete a verbal reflective diary recorded on an audiotape.

Respondents included in the study possessed a Registered General Nurse qualification (Adult Nursing) having undertaken a Degree or Diploma Programme and had been qualified no less than six months and no greater than five years.

Objectivity and reducing bias

Some qualitative researchers deliberately avoid an in depth literature search before entering the field to circumvent having their enquiries constrained or biased by prior thought on the topic. (Polit & Hungler 1999). I was aware of Benner's domains of nursing before I began this research but knew that her research was exclusively undertaken in the intensive care nursing environment and therefore felt that this would not unduly influence me. The literature review that I undertook prior to entering the field predominately allowed me to generate ideas and find a suitable research methodology. I also visited The University of California and met Professor Benner and her team. I tended to focus upon the research process that Benner used rather than critiquing her research findings in any detailed sense. A conscious decision was made not to compare her findings with mine until I had completed the pilot analysis, when it would seem appropriate to compare similarities and differences.

There was a danger that objectivity and the behaviour of the nurses under observation could be affected by awareness of my position. It was therefore necessary for the researcher to be continually mindful of this weakness (inherent in any type of ethnographic research) applying reflective analysis (Hammersley, 1995). In order to counteract some of these weaknesses, triangulation was used. Triangulation combines different theoretical perspectives, different data sources, different investigators or different methods within a single study. (Murdaugh 1999) In this research it involved data drawn from reflective diaries, periods of observation and interviewing subjects.

As the study involved the observation of nurses whilst practicing the researcher also needed to be aware that some subjects might find being observed uncomfortable as judgements about their practice were being made. Difficult and stressful situations might also be encountered. In these circumstances the researcher would need to offer appropriate support to the nurse and if necessary to the patient.

A fundamental requirement of the research required nurses to reflect on their practice which some nurses might find challenging and sometimes stressful. The researcher needed to be prepared for any of these possible situations. On the other hand the potential benefits to the nurses agreeing to take part in the research were the opportunity to reflect on their practice, to consider aspects of care where the nurse made a difference or learnt something about an aspect of care or provided new insights into how they make judgements in their everyday practice

Sampling Rationale:

Convenience sampling was used. Qualified nurses working in medical and surgical areas that processed a diploma or degree in nursing and who had been qualified for at least 6 months and no longer than 5 years were selected randomly. I knew none of the subjects personally, nor have I taught them or had contact with them during their training.

Sample Size

12 subjects in total – 6 non-graduate nurses, 6 graduate nurses

Sample Characteristics

Age Range: 22 years – 28 years. Average Age: 24.8 years

Gender: 11 Female; 1 Male

Qualifications: All subjects hold an (Adult) Registered General Nursing Qualification,

6 with a degree; 6 with a Diploma in Higher Education.

Experience since qualification: range between 1year – five; average years of experience since qualification 3.3 years.

Ethical considerations when undertaking research.

Today many organisations have developed their own research guidelines and protocols to ensure that research involving human subjects is conducted ethically. All Health Authorities and the majority of Universities have ethics committees who are responsible for ensuring that any research proposals conform to approved principles and conditions.

Historically, codes of ethics were developed largely in response to past human rights violations, probably the most notable (in recent times) being the Nazi medical experiments of the 1930s. As a result, the first internationally recognised set of ethical standards was developed after the Nazi atrocities were made public in the Nuremberg Trials. Other internationally recognised codes have followed such as the Declaration of Helsinki, which was adopted in 1964 by the World Medical Assembly and later revised in 1975.

Most disciplines have now established their own code of ethics. Nursing research in Britain is guided by protocols laid down by the Department of Health in, "local Research Ethics Committees" (1991) and in 'Guidelines on the Practice of Ethics Committees in Medical Research Involving Human Subjects (1996).

Polit and Hungler (1997, p.24) define research ethics as,

> "A system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study of participants."

The over-riding principle being to make sure that research respondents involved in the research are protected and not subjected to human rights violations and that no harm is caused to them.

There are three main ethical principles incorporated into most ethical guidelines:

- **Beneficence** – encompassing the maxim, **above all, do no harm.** This principle involves the protection of participants from physical and psychological harm and protection of participants from exploitation.

- **Respect for human dignity and the right to self determination: -** This principle includes the right to expect that the researcher will fully describe what taking part in the research will involve and the freedom to volunteer to take part having first received a full and comprehensive explanation of the study.
- **Justice: -** This principle includes the right to expect fair treatment in the selection of participants and during the course of the study. It also, includes the right to **privacy.** Privacy being maintained through (anonymity) which includes ensuring that participant's **identity is not disclosed** and that formal confidentiality procedures **safeguard the information** that participants provide.

All three ethical principles were met in the research in the following ways:

Beneficence:

This was met by explaining in the invitation to participate in the research that I did not think that the research involved risks.

Respect for human dignity and the right to self-determination:

This principle was met by indicating that the benefits of taking part would allow subjects the opportunity to reflect on their practice and to consider aspects of care where they made a difference or learnt something about an aspect of care. Also, the research was fully explained in a leaflet, making it clear that to take part was entirely voluntary and if an individual had any queries or concerns what they should do.

Before agreeing to take part they were given some written information, which explained the purpose of the research, what participating would involve and how confidentiality would be protected. My contact details were included with this information should they require further information about the research or had questions to be addressed. Subjects who agreed to take part were asked to sign a written consent form, a copy of which was given to them and a copy retained for my records. Participants were also advised that they might withdraw from the study at any time. Permission would be sought to record audiotape interviews. Tapes would be destroyed following transcription. As researcher it was my responsibility to inform all relevant medical and nursing staff at each location where a volunteer was

employed. A written notice was displayed in the clinical area 24 hours prior to non-participant observation informing staff, patients and relatives of my visit.

Justice:

This ethical principle was met by ensuring that it was made clear the criteria for selection to take part in the research. Confidentiality was assured by ensuring that no-one apart from me would have access to the records pertaining to the research and that all tape recordings would be erased once the study was completed. It was also explained that my research supervisor would only have access to the anonomised typed transcripts. Assurance was given that the final written thesis would not contain any personal details or any information, which could be traced to any individual or place where the study was conducted. All records would be kept in a locked cabinet whilst the research was being undertaken.

Preparation of Research Subjects and the Field

It was explained to each nurse who volunteered to take part in the study that data would be collected using the following methods:

1. Verbal reflective diary to be completed by all nurses participating in the study.
2. Non-Participant observation to be undertaken by the researcher.
3. Follow-up interviews - all nurses to be interviewed by the researcher following the period of observation.

Observations of Nurses Engaged in Practice

Using a similar approach to (Benner et al 1996) I observed each nurse for a period of 2-4 hours in practice. The primary aim was to understand, rather than judge practice against a particular standard. I was interested to discover what the everyday challenges are that nurses face and how this impacts on patient care and the decisions they make.

The context of the practice, which may be largely invisible to the practising nurse because of its familiarity, stands out for the observer, particularly one who has not been fully assimilated into the

care environment. Context includes the physical environment, the resources available and the tempo and energy on the ward as well as the events that unfold prior to a particular incident in the nurse's practice.

At the start of the observation period I asked each nurse to brief me on the patients' they were caring for, their work priorities and what they hoped to achieve during the shift. Whilst I was observing the nurse I would ask questions about the nurse's work to seek clarification and understanding of the practice being observed. I would also talk to the patients' and other staff in the team. At the end of the observation period I would ask the nurse to comment on the shift in general, how they felt they had done, whether there were any surprises and whether anything had interfered with what they set out to achieve.

Reflective Diaries

The purpose of the reflective diaries was to provide me with a narrative of the day's events and their reflections of their practice.

Narrative accounts according to Benner,

> "Differ from questions about opinions, ideology or even what one does in general, because the speaker is engaged in remembering what occurred in the situation. Spoken accounts allow the speaker to give more details and include concerns and considerations that shape the persons experience and perception of the event. A story of an event is remembered in terms of the participants concerns and understanding of the situation. Therefore narrative accounts are meaningful accounts that point to what is perceived, worth noticing and what concerned the storyteller. Narrative accounts of actual situations give a closer access to practice and practical knowledge than questions about beliefs, ideology, theory, or general accounts of what people typically do in practice. Therefore narratives can be used to examine discontinuities between theories and practice." (Benner, 1994b, p. 110)

As, I was keen to encourage subjects to illustrate their practice encounters with the use of narrative accounts the most effective means of doing this was with the use of a tape-recorder. Data that describes what nurses' are doing in general to meet the demands and challenges of everyday practice was also important to include, as I required this information in order to record, understand and explain contemporary nursing practice.

Each respondent was asked to provide a verbal reflective diary recording of her practice covering a period of two weeks. After each shift worked the nurse was asked to spend about five minutes telling me about the shift. I was careful not to influence this process unduly and the only guidance I provided was that I was interested in building up a picture of what it's like to be a nurse in the 21st century and therefore required the nurse to tell me about the shift she had just worked. The data collection methods I have used were similar to methods used by (Benner, Tanner& Chesla 1996) with some important differences. Firstly, my approach did not involve asking subjects to provide written narrative descriptions of care nor, did I use group interviews whereby nurses' were invited to take turns presenting their narratives of care to a group of 5-6 nurses' selected by their supervisors as practicing at similar levels of skill. The main reasons for not asking subjects to provide written narratives of care and to attend group interviews was this approach would be difficult to implement given the demands on nurses' time in the clinical areas currently. Asking subjects to record into an audiotape seemed to be the most effective means of collecting the data I required. The other significant difference in approach was that unlike (Benner, Tanner and Chesla, 1996), I wished to collect data that included the nurse's opinions, perceptions and what they did in general in clinical practice as well narrative accounts of actual events encountered in practice.

Follow-up Interviews

Follow-up interviews were conducted once a respondent had completed the taped reflective diary recording and after I had listened to the tape, transcribed it and prepared an interview schedule. The primary purpose of the follow-up interview with each respondent was to seek clarification and illustration of elements included in the nurse's reflective diary or where there was a need to explore in more detail particular aspects mentioned in the tape recording. Often it was necessary to encourage the nurse to give examples of particular events and their perceptions. At the beginning of each interview I asked each subject the following questions?

1. What do you think about nursing?
2. How do you see yourself as a nurse, within the multiprofessional caring team and within the nursing profession as a whole?

3. Describe any memorable event (recent or in the past) where you learnt something or made a difference about an aspect of care or where you 'blew it', but learnt from the experience.

Piloting methods prior to the main study

All interviews and direct discussion during observation periods were audio recorded and transcribed. I spent the first year of the project finding a suitable methodology for my research. This included visiting The University of San Francisco, where I met Patricia Benner and her research Team. The main purpose of this visit was to discuss the research methods she and her team used and their individual experiences. I also undertook a study trip to Australia & New Zealand (sabbatical leave from my Employers) to investigate comparative data on Professionalization of Nursing, Nurse training and nursing.

Once I had decided on the methods I would use I undertook a pilot study using two nurses, one graduate, and one non-graduate. I sort feedback from these nurses on the process as well as determining whether the data generated provided the information I was seeking. (I.e. what is the life of a nurse? what are the everyday challenges they face? What do nurses do? What do they think about?; how do they relate to others? And what contribution do they make to patients' and healthcare overall?

I also evaluated the use of non-participant observation. Was it clarifying for me nursing activities; was I able to match nurse's perceptions/ observations with my own?

In the pilot study I also began to think about methods for processing the data. (I.e. possible categories, styles of behaviour, aspects of care that took up most of the nurses' time etc)

CHAPTER THREE

ANALYSIS: Pilot Analysis

The Process

The coding procedures that I used are based on the work of Strauss and Corbin. "Coding represents the operations by which data are broken down, conceptualised, and put back together in new ways. It is the central process by which theories are built from data." (Strauss and Corbin 1990.p57)

Pilot analysis

I initially analysed data from four research respondents (Both their reflective diaries and follow–up interviews.)

I began the process using transcribed reflective diaries of four subjects. (Two of the subjects were diploma nurses and two were graduate nurses). I selected these particular four subjects because they were the first complete sets of data that I had at this stage of the data-collecting phase. Before beginning the process of breaking the data down I removed from the transcripts any reference that would identify the nurses name, the ward where they worked and the qualification they possessed (e.g. their name, ward, whether they were a graduate or diploma nurse). I then labelled the transcript with a code (e.g. codeA, B, C, D) in order that at a later stage I could identify the subjects, but not be directly influenced by knowing the identity of the subject during the process of breaking the data down. I.e. whether they possessed a degree or a diploma.

However, as I became familiar with the data even though I had anomised the subjects I was still able to recognise them.

In order to integrate and make sense of the data I needed to develop a way of conceptualising it. I began by organising and coding the data. I took each transcribed tape and broke down the data by going through the text sentence by sentence in a systematic manner and placing similar behaviours,

discrete incidents, ideas or events together in a box on a piece of flip chart paper. (Without consciously, at this stage of the process giving a name to a behaviour or event). The use of flip chart paper I found allowed me to see at a glance all of the data that I was processing at the time, without having to sift through numerous different pieces of paper. Once I had completed this process and had taken apart the whole transcript, I then named each box that represented a phenomenon using 'a post it' label. (A subcategory) I then linked together subcategories to form categories. When naming sub-categories I used the nurse's own name/phrase for a particular behaviour where possible e.g. "happy with what I have done"

The process that I have described I undertook for each of the 4 subjects. Once I had completed breaking the data down in this manner and had named the sub-categories and categories for each of the four reflective diaries I looked at the results of this process to see if there were any common themes arising from the data that could be identified. I did this by reading and re-reading the data several times. I then transposed this information onto a summary sheet. (Sees page36-39)

Follow-up Interviews

I undertook the same process described above for the follow-up interviews, the final stage was the completion of a summary sheet that identified common themes arising from the four sets of data. (The four transcribed follow-up interviews)

(The emerging themes are discussed on 40)

TABLE 1

Summary: Codes A, B, C&D Reflective diaries	
Sub-category	**Category**
• Difficult communications	**COMMUNICATION**
• Doctor communications	
• Patient communications	
• Communication within the nursing team	
• Senior nurse communication	
• Communication with lead nurse	
• Sister communication	
• Communication with relatives	
• *Spent a lot of time	**TIME**
• *Took up a lot of time	
• Affects of lack of time	
DENOTES SUBJECTS OWN NAME OR PHRASE FOR BEHAVIOUR	

Table 1 continued SUMMARY: Codes A, B, C&D Reflective diaries	
Sub-Category	**Category**
• Negative statements about working with agency staff	**AGENCY STAFF**
• Experiences of working with agency staff	
• Positive statements about working with agency staff	
• Environmental conditions	**ENVIRONMENT**
• Stressful situations	**STRESS**
• Stressful/difficult day	
• Self doubt circumstances	
• Frustrations	
• Circumstances that reassure nurse or make nurse less stressed	
• *Annoyed me	
• *Other departments let you down	
• *Quite a stressful day	
• Positive statements about nursing	**MORALE**
• Good hyper mood (team morale)	
• *Love my job	
• *Dreading nights	
• *Don't know whether to leave or not	
• Learning experiences	**PROFESSIONAL DEVELOPMENT**
• Self assessment of competence	
• Professional development needs	
• Identification of learning experiences	
DENOTES SUBJECTS OWN PARAPHASE FOR BEHAVIOUR	

Table 2 SUMMARY:INTERVIEW CODES: A, B, C&D

SUB-CATEGORY	CATEGORY
• Experiences of working with agency nurses	**AGENCY**
• Good agency nurses	
• Bad agency nurses	
• Managers role- re: agency nurses	
• Type of patient aggression	**CHALLENGING PATIENTS**
• Causes of patient aggression	
• Student communication	**COMMUNICATION**
• *Happy with what I have done	**DESCRIPTION OF DAY**
• Bad day	
• *Confused patient wandered off ward	**DILEMMAS**
• *Doctors thought they knew	**DOCTORS**
• *Doctors don't understand the nursing role	
• Experiences of working with medical staff	
• Made a difference	**MEMORABLE EVENT**
• Reflection of memorable event	
• *Everybody is fed up	**MORALE**
• Causes of low morale	
• Low morale	
• What nursing ought to be	**NURSES VIEWS**
• Nursing expertise	**NURSING**

Table 2 continued SUB-CATEGORY	*CATEGORY*
• Care plans	
• Shortage of staff	***OFF DUTY ROTA***
• Short staffed	
• *Staffing is fundamental problem	
• *Patients soon form opinions about nurses	***PATIENT***
• Core essential care to maintain patient safety	***PRIORITY CARE***
• Role transition	***PROFESSIONAL DEVELOPMENT***
• Different role opportunities	
• Professional development interests	
• Being assertive	***QUALITIES OF A NURSE***
• Core attributes of a nurse	
• Advantages of having a degree	***REFERENCE TO PRE-REGISTRATION EDUCATION***
• *Stressful day	***STRESS***
• Effects of a stressful day on the nurse	
• Reasons for stressful day	
• Relaxation strategies following a stressful day	
• Stress relieving strategies	
• *Gets a bit much some days	
• *Feel vulnerable, frightened at times	
• *When sister is on everyone feels more comfortable	***SUPPORT***
• Supporting other nurses in the nursing team	
• *Senior nurses not supportive	
• Sister support	
• *Have to link everyone together	***THE MULTIDISCIPLINARY TEAM***

**DENOTES SUBJECTS OWN PARAPHRASE FOR BEHAVIOUR*

When examining the categories and sub-categories further a pattern appeared to emerge and it was possible to link them together to form themes. I will now show how the categories and sub-categories link to form themes with examples taken from the data.

SELF

This theme links together categories and sub-categories that are to do with nurse's thoughts about stress, morale, self doubts and being assertive.

[I have highlighted aspects of the quote/s that I particularly want to emphasise]

Thoughts about stress/morale – (see page 36)

"It made me **feel angry** because I needed her on that shift and I felt let down

"Quite **frightening** and you do feel vulnerable"

"**Felt emotionally drained, quite a depressing speciality,** emotionally you are thinking about those 2-3 days, maybe a week later."

"Depending on how I'm feeling, I either **get a real buzz when it's all going well,** bouncing about the ward, getting everything done. I love that; it's my favourite bit. When I'm **over tired or feel a bit ill or just plain knackered and I just get sick of constantly being busy."**

"**Morale** is quite low on the ward at the moment, quite a few staff is thinking of leaving."

All of these quotes seem to suggest that these nurses can clearly articulate when they feel stressed and the causes of their stress.

About self doubts –

"Just kept wondering whether **I will make an E Grade."**

"I'll never be able to cope on my own tonight."

"I'm really having a problem today. **I just feel incompetent. I just didn't have a clue what to do and I feel I should have picked up on it before.** I didn't think to do any stats on him or anything. I just hate people bailing me out. ……**I just feel I can't cope with it. I'm so frustrated with my own limitations, my own inabilities."**

These quotes highlight that nurses have self-doubts concerned with their competence and their abilities to perform when under pressure.

Good feelings about nursing –

"Good days, **you enjoy your work and think this is what you want to do."**

"Love my job, love caring for really sick patients, love looking after the terminally ill."

"Nursing is a very demanding but, also a very rewarding career."

Thoughts about being assertive:

(About a terminally ill patient that the doctors wanted to keep in hospital over a holiday weekend)

"I just thought if I hadn't have said anything they would probably have kept him in hospital all weekend and is all he wanted to do was sit in his garden. I felt really pleased with myself. I was so desperate that his man should get out of hospital. .... I went home that evening and thought **nursing is really good.** I had a good day and **felt very positive** about it."

(About [a not for resuscitation] order)

"I pushed and pushed to have that decision reversed because I felt it was inappropriate given his history and I didn't feel we had ruled out every possibility with him. It was reversed the next day and **I felt it was a point of pride. One of my proudest moments,** since I qualified."

Nurses do appear to feel it is their responsibility to ensure patients in their care receive the right care and will advocate on their behalf if and when they feel it is necessary.

ROLE

This theme links together categories and sub-categories that are to do with nurses thoughts about how they spend their time when on duty; about the different types of patients they are dealing with and their individual problems, about their working conditions, how they organise their work, make decisions and their thoughts about the nursing role in general.

Thoughts about time – (see Table 1 page 35)

"I basically **had to spend a lot of time with a particular gentleman.** Not because he was very sick but, because he was very upset. He was told quite a bad diagnosis today."

"Oh, what a nightmare, **I've spent the whole day following an agency nurse around correcting her mistakes and basically doing the work for her.**"

"I've **had enough time to do things,** have **met everyone's needs** and have had time to talk to patients."

"My lady who had decreased mobility was found a bed for rehabilitation. They rang up at 10 O'clock and said can you have her ready by 11 0'clock – so, I had about 20 minutes literally to get her ready and inform the doctor of the transfer. And when I rang the doctor and told her that the patient's mobility had got even worse and she could hardly get out of bed, the doctor said she was going to the right place for rehab. Then I got a phone call saying that the patient would have to come back to us, under the neurologist because a lump had been found near her thigh. This made me feel terrible because I had rushed her transfer. I called the doctor who said, 'Oh, I forgot to do her neuro examination. **I just felt this had been a whole waste of time.**"

"The **majority of my time is spent going with doctors** and then **just tasks, things you've got to do.** You've got to get your drugs done, **got to get your IV's done, got to make sure the staff are on, book staff for the next day, answering phones, enquiries, chasing up doctors.**"

"There are **so many other influences on your time.** All your time is spent organising, chasing up tests, chasing up doctors."

"I was working with a nurse who had recently completed his training, he was very good but I had to **take a lot of time** explaining things so that he could help me."

"I felt that I **hadn't done things properly** because I **didn't have enough time** to spend on individual things."

"I found that **quite a lot of my time was taken up during that night shift looking after this one patient.**"

"I **actually had time to potter around** and do pulses and blood pressures."

"I **just wanted to spend some time with them** but it didn't really happen."

"I was quite annoyed really because I **took quite a lot of time organising** and they promised it to me. There you go, other departments let you down."

Nurses appear to be very conscious about how they spend their time, understand the importance of using their time well and because they are often short of time, don't like to waste it on unimportant things.

Thoughts about dealing with patients and different types of patient problems:

"The clinical practice **wasn't particularly stressful, we didn't have a lot of complications or post surgical patients, and they were more or less self caring."**

"No post-op surgery as the list hasn't started this week yet. **Getting ready patients for theatre on Tuesday. Ordering beds, ordering supplies. Getting bowel preps ready for people who are going for bowel surgery on Tuesday and Wednesday lists."**

"I feel that **nursing is a very changeable environment**. Gone are the days when I felt I could spend all my time at the patient's bedside caring for them in a holistic manner. Now I find myself **dealing more and more with patients' and their relatives' anxieties, dealing with questions about their loved ones,** who are going to theatre, why has their operation been cancelled, explaining that this is a busy hospital trauma unit. I just feel myself **making excuses for the constraints of current day environment and the demands are more and more evident as a whole."**

"Had a very abusive patient who tried to slap a member of staff and then she tried to slap me. This situation arose due to shortage of staff really. We had a gentleman pass away, we were busy with this gentleman in the side room and this lady wanted some analgesia. Obviously she couldn't find a member of staff to speak to and basically lost her temper when she did find someone."

"One patient in particular seemed to take up a lot of time **because he was paraplegic and couldn't do anything for himself.** So, we had to turn him and the trachy was very productive so, we had to suction that regularly."

"The last couple of weeks there have been **a very sick man with an aggressive brain tumour."**

"We had one incident – a young chap, he was only 18. **He died a horrible death, it was very sad.** A very sad family background as well and because we had been so heavily involved in his care for that length of time and knew him so well. ..... Bleed in ITU and **never regained consciousness."**

"We had one lady who was **seriously ill; she had an emergency laparotomy because she went into sub-acute bowel obstruction."**

"Spent most of the morning trying to **sort out one of our patient's pain control."**

"Had an elderly gentleman admitted with a **GI bleed and basically he was the sickest patient I had ever looked after."**

"And I had **a patient with a trachy in the side room who needed specialing and another 27 patients to care for.** A patient on the board **waiting to come round from A &E, a schizophrenic with sepsis,** and **none of us had any tracheostomy experience at all."**

"Too many ill people."

"We have **just had an arrest on me and we got him back."**

"After I had given her, her medication I said to her, 'would it help if I stayed and held your hand?' She said, yes it would help.'and I stayed with her for about 20 minutes until the intensity of the pain had eased and she seemed more comfortable and was able to rest."

"I was doing the drug round with a student and went to give her, her medication and she was just in floods of tears."

I went to get some blood and it happened to be the wrong blood and even though all the protocols for checking were followed it managed to get through to the patient."

"The only surprise was we had been **a gentleman who was unfortunately very ill, not for resus, died on our shift."**

These quotes highlight the variety of activities and demands nurses' face on a daily basis from dealing with very sick patients with very demanding needs to dealing with routine, repetitive aspects. Points for emphasis are highlighted.

Thoughts about **working conditions –**

"On privacy and dignity, I'm afraid that is **sadly lacking due to just the facilities that we have here."**

"This lady has quite a long history and **her boyfriend is banging on the ward door at 4 O'clock in the morning it is quite frightening and you do feel vulnerable as a nurse."**

"There's **not the spaces between the beds, especially if you've got an arrest, there's clutter everywhere all the while,** and **our toilets are awful** for anyone who is permently in a wheelchair. We have a lady on the ward at the moment who is very confused; she's actually in the side room at the end of the ward near the doors and **you just have to get extra staff to sit with her because it's difficult to keep an eye on her."**

The above quotes highlight some of the concerns nurse have about the working conditions and how this affects the working environment as a whole.

The following quotes about how work is organised suggests that there are issues of shortage of staff and lack of senior nurse support:

"I don't feel there is **any support for us."**

"I just think **their needs to be more staff on at times."**

"We basically **have to link everyone together in the team and make sure the patients are getting the care from everyone."**

Thoughts about **decision-making:**

I pushed and pushed to have the decision reversed because I felt it was inappropriate given his history and I didn't feel we had ruled out every possibility with him."

"I've noticed about myself I'm much happier since I became an E grade. I think it's something to do with my personality type. **If I'm in charge, the decision maker, I will be quick and decisive whereas if I'm not in charge I tend to fanny around a lot."**

"I just failed to notice or failed to consider that they needed a special for today. I don't take full responsibility for it because the night staff could have checked as well. I should have considered it really."

"Came on to find that they had an admission during the day. A 63-year-old lady with query, perforated bowel or bowel obstruction. She was quite unwell and was on the emergency theatre list for that night. She was on hourly observations and hourly urines. When I came on **my main priority was to get her ready for theatre."**

Thoughts about the **nursing role:**

"Emotionally I find nursing very challenging."

"I do feel that **we are undervalued** in our contribution both by the public and by some other groups of healthcare workers."

"It's just a bit **daunting at times** because you don't know everything. People, relatives all expect so much of you; it's a bit much sometimes."

"The actual job if you are left to do your bits is fine. **The hard bit about nursing is when you are left to do paperwork and all the political stuff. Like booking agency staff and all that.** But, the actual nursing is what attracted me to nursing in the first place. **I didn't think it was going to be like this,** now is all I do is chase up doctors. I don't feel I nurse patients' anymore, I feel I'm running a ward, an organisation."

"Generally, **it needs to be more academic to cope with the change in pace.** I think there is such a disparity between nurses. Some are academic and some are clearly not so and that's the problem."

"It's very, very busy and you don't always have the staff to support you."

From the above quotes it is clear that nurses feel that their role can be adversely affected by lack of appropriate support, demanding workloads and feeling disillusioned because the role is different from their expectations of how the role ought to be.

COLLEAGUES

This theme links together categories and sub-categories that are to do with communications with doctors, nurses and other healthcare professionals, with agency nurses. It is clear from the following quotes that nurses' communication with medical staff is variable, some circumstances seem to suggest that doctors are supportive and at other times are not only unsupportive but, fail to appreciate the nursing role well enough or seem unable to accept a nurse's judgement or knowledge when it is greater than their own.

Thoughts about **doctors:**

> **"Didn't get a lot of support** from the orthopaedic doctors."
>
> **"The doctors all agreed with me that the resuscitation orders in the notes were extremely small."**
>
> "I don't think, especially from the doctors that **they fully understand how difficult it is on the ward, managing the patients' when they come back from theatre.** You're very busy trying to recover them, make sure everything is alright and they seem to think **it's a very easy job** from what I can gather."
>
> "The doctor who was on **was really good.** I totally agreed with everything she decided."
>
> "I've seen it time and time again through experience and yet every 6 months **new house officers come along that doubts you time and time again."**
>
> "So, I thought that was **quite nice for medical staff to be concerned about how the patients' treat us."**

Concerning nurses' communication with other nurses, the following extracts show that it can often be supportive and constructive:

> **"I had kept my eye on my junior D grade,** she's basically still settling in, very unsure of herself although she's an excellent nurse."
>
> "I had my appraisal with my ward manager **which was very promising. It was constructive** and I know where I am heading with my career."
>
> "Had a health care assistant (HCA) working with me and **a sister on who spent most of her time doing management in the office."**

"Sister who was feeling unwell **decided to go home at half past eight, not even coming on to the ward."**

"Then I turned to Sarah and said, 'Oh, my God, I just would not know what to do. **She said yes, you would and she explained the logical steps to take** and I thought, yes, I probably would have done this in this situation.

Concerning communication with other **healthcare professionals,** some nurses believe that they have a co-ordinating role within the inter-professional healthcare team whilst other nurses feel that they are used as a convenient information source thus:

> "When I'm out on the ward, and you've got doctors rounds and you've got OT's and physio's **they all seem to come to you. I don't know whether they communicate with themselves or not."**

> "As a ward nurse I think you are quite often **used as a point of information for other members of the inter-professional team,** such as doctors', physios', social workers' and so on."

> "As part of the multi-professional team I suppose **I see myself as the nurse in a sort of co-ordination role linking medicine, nursing and those professions' allied to medicine."**

Thoughts about **Agency nurses**

> **"Quite difficult** with the Agency staff, **just to keep an eye on what they are doing."**

> **"It is hard work with staff who does not know the ward.** Agency staff is **not familiar with the techniques and the routines."**

> "It's really difficult because we have a lot of agency staff who **don't know the ward and it takes longer to get things done and you have a lot of pressure to do things still and just haven't got the support."**

On the whole nurses feel that agency nurses can make things more difficult rather than reduce the pressure at busy times, because they are often unfamiliar with the ward routines.

LEARNING

This theme links together categories and sub-categories that are to do with learning experiences; professional development needs and self-assessment of competence.

Thoughts about **learning experiences –**

> "I've **learnt a lot more about discharges, complicated discharges.**"
>
> "It makes me **feel that I can manage things, sort things out on my own.**"
>
> "But, **I learnt so much from being on duty last night watching another staff nurse performing all these tasks.** It just made me realise if it happens to me I need to think logically, I need to be calm and hopefully, now after seeing all that I could manage to do it myself if it ever happened to me on duty."
>
> "Well, there have been so many different things I have learnt as a staff nurse in the last two years but, **one of the worse things that really made me learn. I learnt the hard way was a blood incident when things were just so busy.**"
>
> "I have recently completed the gynae-oncology course **which has taught me a lot more about the speciality and has given me a lot more knowledge.**"
>
> "I know that **I've helped with somebody's professional development and learnt from them as well.**"

From the above quotes it is clear that nurses' are able to identify learning experiences in practice.

Thoughts about **professional development needs:**

> "In order to facilitate my preceptor course I aim to commence a preparation for mentorship course in October hoping it will provide me with a broader understanding of effective assessment and teaching strategies, improving my role of preceptor for other members of staff."
>
> (About a cardiac arrest) "It was good to see that I could actually put the skills that I had learnt in College and so on into practice on the ward. After the event it was quite good to have time to identify what needs I still had and what areas I need to develop."

Thoughts about **self-assessment of competence –**

> "I felt that **I was able to use my skills tonight,** especially skills I learnt in the ambulance service."

(About a cardiac arrest) "I took part in some life support training and I **was able to identify how I could have possibly done a few things differently** and also, **how I could have prepared myself better** for the same situation in future."

"I don't know whether it's because I have a degree of not or whether I have more experience and **am able to judge clinical situations differently. I look critically** at other people's care plans. Some people's care plans are very inadequate and I always think if you are going to do a care plan you might as well do a thorough and a proper one. Whereas they are very scanty and don't pick up on a point."

SUMMARY

When examining the categories and the sub-categories further a pattern appeared to emerge and it was possible to link them together to form themes. The themes that I have identified are nurses' thoughts about:

- Self
- Role
- Colleagues
- Learning

The tables 3, 4, 5 & 6 on pages 51-55 show how the four themes that I have identified link with the categories and sub-categories.

TABLE 3: THEME: SELF

Sub-category	Category	Theme
• Stressful situations	STRESS	ABOUT SELF
• *Stressful/difficult day		
• Self doubt circumstances		
• Frustrations		
• Circumstances that reassure nurse or make nurse less stressed		
• *Annoyed me		
• *Other departments let you down		
• *Quite a stressful day		
• Effects of a stressful day on the nurse		
• Reasons for a stressful day		
• Relaxation strategies following a stressful day		
• *Gets a bit much some days		
• *Feel vulnerable frightened at times		
• Positive statements about nursing	MORALE	
• *Good hyper mood		
• *Love my job		
• *Dreading nights		
• *Don't know whether to leave or not		
• *Everybody is fed up		
• Causes of low morale		
• Low morale		
• Difficult communications	COMMUNICATION	
• Doctor communications		

Table 3 con't Reflective diaries & Interviews – emerging themes linking sub-categories and categories together		
SUB-CATEGORY	**CATEGORY**	**THEME**
• Patient communications		**ABOUT COLLEAGUES**
• Communications with the nursing team		
• Communications with the lead nurse		
• Sister communications		
• Communication with students'		
• *Spent a lot of time	**TIME**	
• *Took up a lot of time		
• Effects of lack of time		
• Environmental conditions	**ENVIRONMENT**	
• *When sister is on everyone feels more comfortable	**SUPPORT**	
• Supporting other nurses in the team		
• Support after an incident		
• *Senior nurses' not supportive		
• Sister support		
• Being assertive	**QUALITIES OF A NURSE**	
• Core attributes of a nurse		
• What nursing ought to be	**NURSES VIEWS**	

TABLE4: THEME: COLLEAGUES

• Negative statements about working with agency staff	**AGENCY STAFF**	**ABOUT COLLEAGUES**
• Experiences of working with agency staff		
• Positive statements about working with agency staff		
• Good agency nurse		
• Bad agency nurse		
• *Doctors thought they knew	**DOCTORS'**	
• *Doctors don't understand the nursing role		
• Experiences of working with medical staff		
• *Have to link everybody together	**THE MULTIDISCIPLINARY TEAM**	

TABLE 5: THEME: ROLE

• Type of patient aggression	**CHALLENGING PATIENTS'**	**ABOUT ROLE**
• Causes of patient aggression		
• *Happy with what I have done	**DESCRIPTION OF DAY**	
• Bad day		
• *Confused patient wandered off the ward	**DILEMMAS**	
• Made a difference	**MEMORABLE EVENT**	
• Reflection of memorable event		
• Making a difference		
• Nursing expertise	**NURSING**	
• Care plans		
• Shortage of staff	**OFF DUTY ROTA**	
• Short staffed		
• *Staffing is fundamental problem		
• *Patients' soon form opinions	**PATIENT**	
• Core attributes of a nurse	**QUALITIES OF NURSE**	

TABLE 6: THEME: LEARNING

• Learning experiences	**PROFESSIONAL DEVELOPMENT**	**ABOUT LEARNING**
• Self-assessment of competence		
• Professional development needs		
• Identification of learning experiences		
• Role transition		
• Different role opportunities		

CHAPTER FOUR

ANALYSIS: DIALOGUES

In chapter four I identified common themes that emerged from the data. These themes were concerned with nurse's thoughts about self, role, colleagues and learning and are conveyed in the data in the form of conversations or dialogues the nurse is having with her, with me, (the researcher) and with different inter-professional colleagues. It would seem appropriate at this stage of the analysis to look in more detail at these various dialogues to see if it is possible to identify any differences amongst the nurses I am studying. In particular differences in the way they think and feel about their role, how they communicate with others and the degree of self-awareness that they demonstrate.

[I have highlighted aspects of the quote/s that I particularly want to emphasise]

Dialogues about self

When examining the data for examples of self-dialogue it is firstly important to distinguish what I mean by self-dialogues. It is how the nurse feels about an event rather than an expressed opinion about a situation. For example I am not interested in a nurse who states, "I think there should be more staff", but, I am interested in the nurse that expresses how she is feeling with a comment such as, "it does upset me" or "I do feel vulnerable" These latter comments will allow me to determine to what extent the nurse is able to demonstrate an awareness of self.

I found a number of examples in the reflective diary where nurses' expressed how they felt about events, which were both positive and negative. Some examples of positive thoughts being:

"I did **feel it was one of my best nights**, last night."

"I do **enjoy** this part of nursing"

"I'm **quite happy** at the moment"

"I **love** my job"

"I do **enjoy being a nurse.**"

And negative thoughts:

"When you can't fulfil your care **it does upset me"**

"I do feel quite vulnerable"

"I feel absolutely shattered, run ragged the whole day"

From the above examples it can be seen that the nurses expressed a range of thoughts about how they were feeling, from being upset or vulnerable to feeling happy and enjoying the nursing role. From the data it could be seen that all the nurses have good days and bad days and I was unable to determine any individuals who just expressed negative feelings about their role. All subjects experienced both positive and negative feelings overall.

The following examples (taken from one particular nurse's reflective diary) highlights further this point demonstrating both positive and negative thoughts. She talked about feeling stressed, about feeling irritated, about feeling good about achievements or learning and about whether she was competent or not.

"I actually **felt proud to cope with all that was going on, on my own,** everything was in order, and all the ob's were done and ready for the night staff. And well, **I thought this has been good for me in a way and maybe I will be able to do my E Grade after all."**

"I stood there thinking, Oh, my God what would I do if this was one of my patient's and this happened to me! **I really don't know what I would have done."**

"Already this had annoyed me so, at half past eight I was already stressed out."

"Very stressful being left on my own."

The next examples taken (from a different nurse's diary), talked about the sort of days she liked and also, how she felt when she challenged a doctor's decision and acted as a patient's advocate.

The following quote expressed anxiety but, also enjoyment:

"Stressful at times but, **enjoyable."**

"I didn't feel completely on my own as I sometimes feel."

Both the above comments show that this particular nurse even when feeling stressed is still able to look at a situation and see aspects that are positive as well as negative. Whilst the former comment described the situation as being stressful she also said it had been enjoyable. The latter comment highlights perhaps, that it is not unusual for her to feel on her own but, on this occasion she didn't feel completely alone. Therefore this was a situation whilst not ideal, was a good deal better than is sometimes the case.

Conversely, in the next quotes (which describe two different events) clearly show that there are no aspects that are positive or can be viewed in a positive light or as a learning experience. In the former quote the nurse clearly feels that this was an experience that was horrible, where she felt stressed and very alone and was extremely relieved to finish the shift and get home and in the latter, the psychological effects of stressful situations:

> "Today's shift was **particularly horrible. It was extremely stressful, I felt very alone** although there were people there to ask, they weren't immediately available. So I had to find time to find them. The patients were all very poorly in the HDU (High Dependency Unit) today and **when the shift finished I must say I was extremely relieved to get home. I feel demoralised and extremely fed up."**

> **"You** felt emotionally drained as well as physically. **I think physically you can cope with it but emotionally you can't get rid of that. Physically you can go home, have a bath and get into bed but, emotionally you are thinking about that two or three days, maybe a week later, recently with that chap. And if you haven't got any support, anyone to go to, to chat with."**

On the other hand, the following quote although positive also contained feelings of frustration because then nurse was unable (due to time constraints) to meet her own personal standards:

> **"The sort of days I like.** However, having said that, **today I felt that I hadn't done things properly because I didn't have enough time to spend on individual things."**

Similarly, in the next quote the nurse expressed feelings of disillusion about the clinical environment yet still could describe the situation as enjoyable:

> "I think I came into the clinical environment with **a very idealistic expectation** of how I wanted nursing to be and it wasn't how I felt it ought to be and **I felt very disillusioned.** Although I enjoyed it, I felt that it just wasn't right."

Some nurses described situations where a clinical decision was challenged for the benefit of the patient.

The following quote describes how satisfying this can feel for a nurse when the outcome is positive:

> "I **felt pleased with myself.** I was so desperate that this man should get out of hospital. And when I went home that evening **I thought nursing is really good. I had a good day and felt very positive about it."**

Dialogues about the nursing role

When examining the data it was possible to identify differences in the way nurses viewed their work. Some appeared to be patient focused whilst others described care in terms of a condition, a type of surgery or a technical procedure or a task to be completed and very rarely referred to a particular patient. The following examples taken from reflective diaries highlight these differences; the former I think demonstrates that the nurse is more concerned with technical care, whereas the latter appears to be much more concerned with ensuring that the patient is cared for in a holistic way.

> **"Getting ready patients for theatre on Tuesday, Ordering** beds and ordering supplies.
> Getting bowel preps ready **for people who are going for bowel surgery on Tuesday and Wednesday lists"**

The same nurse on another occasion described care as a list of jobs to be done:

> **"....** Lots of IV fluids, maintaining fluid balance charts, pain management, managing patient's nausea and vomiting. **.... Had a lot of patients with pyrexia's."**

And again, on a different occasion she grouped her patients together describing them as 'post op' patients rather than referring to them as individuals. Also, the measure of how busy she was appeared to be gauged by whether there were admissions or by the number of postoperative patients.

> "Didn't have any admissions, **didn't have any empty beds. Had** a number of post op patients."

All the above examples I think suggest that this nurse's descriptions of events during an average shift, gives the impression that her work consists of a series of tasks to be completed and one doesn't get the

impression from reading her diary entries that there is any empathy or any real concern or feeling for her patients. Her descriptions when compared with the next example on the other hand, give one a very different impression of nursing work. This nurse I think demonstrates that she cares about the people she is looking after and that there is a connection or rapport with the patients.

> "I had to spend quite a lot of time with one particular gentleman. Not because he was very sick but, **because he was very upset.** He was told quite a bad diagnosis today at work. They offered him to take part in a trial, whether to have his chemotherapy first then have surgery or to have the surgery and then the chemotherapy afterwards. **The man was quite worried about the results but, was also in turmoil about what to do.** He was quite intent on helping them with their research (for other people) he said, not for himself. It was quite a difficult dilemma for him, deciding what he should do. Trying not to push your own views and listening to what the man wanted. He did actually come to a decision this morning before I went off duty but, **it was nice to sit and chat to this man** especially, as he had been told his results but, the day staff hadn't had time throughout the day to talk to him about what the results meant and what to do. **I do enjoy this part of nursing and think it's the most important part of nursing, sitting and finding out with your patients what's wrong with them."**

This nurse has not only emphasised the importance of sitting and talking to a patient who is very upset but, also has indicated that she enjoys this aspect of nursing and considers it to be the most important.

On another occasion this nurse commented:

> "Had a very abusive patient who tried to slap a member of staff and then tried to slap me. This situation arose due to shortage of staff really. We had a gentleman pass away in the side room and this lady wanted some analgesia, obviously she couldn't find a member of staff to speak to and basically lost her temper when she did find someone. **The whole situation affected me really because the man who passed away, I couldn't give him enough time and enough care when these events arose which I found quite upsetting really. When someone passes away I like to give a bit of respect and a bit of dignity when dealing with them before and when the family arrive, and this was all rushed. I'm quite upset about it this morning."**

Both these examples describe different feelings, the former a feeling of satisfaction when she has helped a patient think through a difficult dilemma, resulting in a satisfactory conclusion and the latter, feeling upset when it has not been possible to spend enough time with a deceased patient due to other events on the ward interrupting her.

The next example is another nurse who talked about technical procedures to be undertaken but, also, appeared to have a connection with her patients, demonstrating a caring perspective to her work.

> **"The most demanding patient was in bed 4, who was on regular pethidine every 2-3 hours and wanted it on the spot. Had two discharges during the day, which were no problem and an admission from A&E.** The admission from A&E was a very confused old lady who didn't know where she was, didn't know why she was in hospital, and was very difficult to cope with. **Also had** one transfer from ward, young lady who was really annoyed as it was her third transfer. I had to reassure her that this would be the last transfer as she was under one of the Consultant's on our ward and she wouldn't be moved again. So, spent about half an hour with her. **Other than that the shift went really well with no major difficulties to deal with. The agency was really good working with patients in beds 10-11; there was no problem with him."**

Whilst, this nurse described technical procedures to be completed she, talked in particular about two patients in her care, both requiring different kinds of support, a confused elderly lady that she stated was 'difficult to cope with', because she didn't know where she was, requiring help to understand that she was in hospital and a distressed lady who had been transferred for a third time requiring the need for reassurance that she wouldn't be moved again. In the descriptions of both these patients one was given the impression that effective communication was a necessary factor in the care the nurse provided.

A further example of holistic approach to caring, can be seen with the following examples. In this nurse's diary descriptions of day-to-day nursing activities was discussed with an emphasis on patient care rather than activities to be done and tasks to be completed. When technical care was discussed this was done in relation to patient safety, physical and psychological comfort of the patients. She talked about "patients" when discussing nursing care rather than talking about conditions, IVI's or post op's, such as:

> "One of **our patient's** was acutely ill who had come in overnight and had subsequently died."

> **"One patient** in particular seemed to take up a lot of time because they were paraplegic and couldn't do anything for themselves."

> **"Patients** were all very poorly in the high dependency unit today."

> **"All the patients** seemed to be quite dependent. Had a post op lady and a person who couldn't do anything for themselves and four people who needed constant pain relief so, I was rushing around trying to sort them out."

This patient focused approach is further confirmed by the following extract taken from the follow-up interview in response to the question, when describing a memorable event:

> **"The last couple of weeks there has been a very sick man with a very aggressive brain tumour and I don't know,** some patients you get more attached to and this particular patient has a lovely family, with lots of small grandchildren and I went home and felt very upset **that this man up until six months ago was an active man with his own business. Now he can't stand up, can't see and because he is on very high doses of steroids his blood sugar is very erratic, and the doctors didn't want him to go home for the weekend. It was the bank holiday weekend and it was his birthday on the Monday and he wanted to go home on the Saturday but the doctors said his blood sugar was too erratic.**
>
> **So, I said this is palliative care we are doing for this man and he doesn't need to be in hospital. He has been diabetic for 25 years and he and his wife are probably much more able to deal with it than we are. And I said to the doctors I think he should go home. He is miserable and he doesn't want to get out of bed. So, he said O.K. he can go home. I said to his wife when she came in, if there are any problems give us a ring and we will see what it is. And initially they wanted him to come back in the evening and he was able to stay home all weekend and for his birthday on the Monday.** I just thought if I hadn't said anything they would probably have kept him in hospital all weekend and is all he wanted to do was sit in his garden. I felt really pleased with myself. I was so desperate that this man should get out of hospital."

This description suggests that this nurse had developed a special empathy with this particular patient and his family to the extent that she stated, 'some patients' you get more attached to'. Because of the special relationship that she had developed with this particular patient and his family she clearly felt the need to try and make his life more bearable when circumstances were clearly difficult.

Dialogues about colleagues

I found in the data thoughts about poor communication, lack of appreciation of roles, poor support and differences of opinions concerning patient care.

Most nurses commented about other staff they were working with. The following quote is an example of a nurse who only once commented about other nurses in her team.

> "I've **got quite a lot of good staff** on today, quite a lot of support, everybody knows their job, **and didn't have to pull rank at all**, which you don't need to do anyway. Everybody worked well."

Yet, this same nurse made several comments in her reflective diary about her communications with medical staff thus,

> **"Didn't get a lot of support from the orthopaedic doctors."**

> "We **had quite a lot of support from the duty manager and the orthopaedic registrar,** who we bleeped so, we had support for the juniors' of the team."

> "A busy day, **lots of doctors' rounds,** teams reviewing Monday morning, seeing what's happening over the week end and reviewing which patients' are to go home. Lots of doctors' rounds, couldn't keep up, too many all coming at once. I can't split myself into three!"

I wondered whether this perhaps suggests that she considers communication with medical staff to be more important than communication with her own nursing colleagues and that perhaps she considered communication with medical staff improved her status.

On the other hand, the following quotes taken from another nurse's diary entries refer to other staff quite often, particularly thoughts concerning communication with nursing colleagues. She commented about senior nurse support, her experiences working with agency staff, and her role as a member of the multi-professional team. Very little reference was made specifically to working with doctors. The following comment highlights her concern about lack of senior nursing support.

> "I just don't think there is any support for us. The lead nurse and the ward sister know about the situation, **nothing seems to happen and it is quite scary." (Referring to a violent patient.)**

On another occasion, this nurse when referring to agency nurses made the following comment, indicating that her experience of working with agency nurses was not very positive; that they are not familiar with the ward routines and treatments and that often it is better to do the work yourself to ensure it is done competently:

> **"Quite difficult with the agency staff,** just to keep an eye on what they are doing. They don't know the secrets of the ward; you know when you do drugs, when you do this and that. I seem to end up doing it anyway."

> **"Oh, what a nightmare, I've spent the whole day following** an agency around correcting her mistakes and basically doing the work for her."

When considering the inter-professional team and in response to the question,

"How do you see yourself within the professional team?" the following response was made:

> **"I see myself very much as** part of the team. **We basically have to** link everyone together in the team **and make sure the patients are getting the care from everyone. It is** a co-ordinating role, **linking everyone together."**

From the response to this question it is clear that this nurse sees herself as a co-ordinator of care and as a link between the various inter-professional staff.

The next quotes taken from a different nurse's diary referred to communications with sister, agency staff, and other nurses within the team. This particular nurse unlike the previous nurse appeared to have some positive experiences of working with agency staff but like the previous nurse also expressed concern with their work and motivation:

> "The Agency was really good; **there were no problem with him."**

> "Had an Agency working with me who did not do anything so, I felt I was on my own. **The agency was more concerned with finding a shift for the next night, spent most of the night on the phone ringing friends whatever and spent the morning on the phone to the agency."**

> **"Had to ask her to do things, had to make sure things were done in her bay."**

> **"If you know the agency nurse from working on the ward before usually you feel that they know the ward and the kind of patients they are looking after. If it's new agency staff they don't know the ward, the routine, and the type of surgery.** Usually they are o.k. If they know the ward. Sometimes you find they are very good and into role but, some can be lazy and sometimes it's really hard to tell them what to do. **I just find it's quicker to do it myself sometimes. You're running around doing the washes for example, whilst she is sitting down and you can't be bothered sometimes.** If you know they are lazy I just can't be bothered with them and I just get up and do it myself."

She talked about communications with doctors and of senior nurse support. The majority of dialogue concerned her relationship with sisters on the ward and revealed communication difficulties and lack of support. Typical comments were:

> "Had a HCA working with me and **a sister who spent most of her time doing management in the office."**
>
> **"Sister who was feeling unwell in the office** decided to go home at half past eight, not even coming on to the ward."
>
> **"Sister spent a lot of time in the office"**
>
> **"At 1.30 the sister** informed me that she had to go to a meeting. **The other sister was due on to cover the first sister going off but, as she came on duty the senior sister cornered her and brought her to this meeting as well.** I was really annoyed."

Clearly, from the above comments this nurse feels that the ward sisters' are not always supportive. It is also clear that she believes that sisters should be more visible on the ward and spend less time in the office.

The next comment in contrast to this nurse's less than positive views about sister support shows how a staff nurse can be supportive in helping to boost an inexperienced nurse's confidence.

> **"Sarah asked me to get a few things for her and I did. Then I turned to Sarah and said, my God, I just would not know what to do. She said,** yes, you would and she explained the logical steps to take **and I thought yes, that's right I probably would have done that in this situation."**

When discussing the nursing team as a whole she said,

> "They're a great bunch of girls and we get on really well. **It's just that there aren't enough of us there really. Especially with the amount of work we have on the ward, most of the patients are quite ill."**

This indicates that she feels part of a team where the other nurses work cohesively together.

Whilst her contemporaries (that make up her immediate team) were clearly supportive her views about whether senior nurses' are supportive were quite different,

> "No, not on this ward. No. **We've got one off on maternity leave so we have an acting F Grade. She's been gone about a month and we've just had another acting for her. But, the two senior F Grades and the G Grade,** they just spend most of the time in the office with paperwork. I

> **find that** when they are on the ward they don't want to be there and I wouldn't go to them with any of my problems. I don't feel I could talk to them. **I talk to the acting F Grade, at the moment but, not the more seniors."**

In response to the question, **"How do you see yourself within the multi-professional team?"**

responded,

> "I feel that you're the one in the middle. They come to tell you things but they don't seem to communicate with each other. **You've got the OT's coming to ask when the patient's going to be discharged, what's going on with the patient, you've got the doctors telling you where they are going with the patient and what needs doing to the patient and you are running around sorting out what they have asked you to do. Things they need to know. If you've got a ward round going on they are telling you what to do all the time. So, you are running around doing what they have asked you to do, chasing up what they have asked you to do, same with the OT's and physio's**

Clearly, this comment seems to suggest that this nurse feels that she doesn't always feel there are many advantages to communication with other inter-professional staff and that perhaps the communication is often for the benefit of others who see the nurse as a good source of information that they could perhaps get for themselves elsewhere without bothering her.

When discussing senior nurse support following her first cardiac arrest she commented,

> "Afterwards the duty manager ran through things with me so, things are much clearer."

This suggests that the duty manager was supportive.

Concerning communication with doctors this nurse seemed to find them supportive, highlighted in the following comment:

> (About medical staff) "Medical staff is alright at the moment, especially the batch that came out at the end of last year. Even though they are new they are very supportive. **One patient in particular on the ward was very aggressive and wanted painkillers and was getting very aggressive with me saying, call the doctor. I rang the house officer and explained the situation to him and he said, 'well is there anything you want me to say about the way he spoke to you?' So,** I thought that was quite nice for medical staff to be concerned about how patients treat us. **But, generally the bunch on the ward now are fine. They don't ever get stroppy with you. I've never had a problem with them.**

The next examples from a different nurses' diary and interview transcripts describe this nurse's communication with others and her thoughts about events involving a broad spectrum of staff including nurses, doctors, agency and health care support workers. When examining the data it was interesting to note that when discussing experiences she used the term 'we' rather than 'I', which seemed to suggest that she saw her role as a member of a team and considered the team working important. When being interviewed and asked what she thought about nursing she emphasised the importance of teamwork

thus,

> **"Now that I have left and I'm doing the midwifery course** I feel I miss certain aspects of it, especially the team work that you get with nursing. **I miss that because in Midwifery you are very much on your own."**

When asked,

> **'How do you see yourself within the multi-professional team?'** She

replied,

> **As an important** member of the team. **I think** as a nurse you are the one that for example gets occupational and physiotherapy going. **Although the doctors refer for physiotherapy you're the one that says, well actually I think they are fit enough to get up today, they've had a good night's sleep and they're not tired and their blood pressure is o.k."**

This nurse is clear that the role of the nurse within the interprofessional team is an important one. Whilst, other nurses that I have discussed previously have emphasised the nurse's role in the co-ordination of care this nurse feels that she also has a role in influencing the doctor's decision-making. She made some interesting comments about medical staff communications and her thoughts about relationships with medical staff, which seemed to indicate at times a lack of collaboration and poor understanding of individual roles. The following comment perhaps highlights this lack of understanding of individual roles.

> "I don't think, especially from **doctors that they fully understand how difficult it is on the ward managing patients, when they have come back from theatre.** You're very busy trying to recover them, making sure

> everything is all right and they seem to think it's a very easy job from what I can gather. It's very, very busy, stressful and you don't always have the staff to support you. **In that respect I think it's very misunderstood."**

Apart from this apparent lack of understanding of individual roles I also, found the nurses that I studied often commented about medical staff being reluctant to accept nurse's advice and knowledge when it was greater than their own. The following comment is typical of this.

> "I think from my experience on the ward, because we only have senior house officers **it was difficult for them to understand that they couldn't just come into a new environment having no previous neuro experience.** They came into an environment where **they felt they knew an awful lot more than they actually did and were making unsound decisions.** That was very stressful for the nurses. Because there were a lot of nurses with neuro experience who really did know their stuff and yet they were telling the doctors what was the matter with the patients and **they would dismiss it.** In the end the nurses were proved right. **So, that was always difficult and a battle of wills with them."**

Whilst it is sometimes acknowledged that the nurse-doctor relationship can be troubled and the partnership often unequal, I found examples in the data that describe situations where nurses' have challenged a doctor's decision and acted as advocate for the patient. The following example is typical of numerous accounts in the data that demonstrate how nurses were able to convince a doctor to rethink a decision he/she has made for the benefit of a patient.

> "The last couple of weeks there have been a very sick man with a very aggressive brain tumour and I don't know, some patients you get more attached to than others and this particular patient has a lovely family, with lots of small grandchildren. And I went home that night and felt very upset that this man up until 6 months ago was an active man with a small business. Now he can't stand up, can't see and because he is on high doses of steroids and is diabetic his blood sugar levels are very erratic. And the doctor's didn't want him to go home for the weekend. It was the bank holiday weekend and it was his birthday on the Monday and he wanted to go home on the Saturday but, the doctors said no because his blood sugar was too erratic.
>
> **So, I said this is palliative care we are doing for this man and he doesn't need to be in hospital. He has been a diabetic for 25 years and he and his wife are probably much more able to deal with it than we are. And I said to the doctors I think he should go home. He is miserable and he doesn't want to get out of bed. So, he said o.k. He can go home.** I said to his wife when she came in, if there is any problems give us a ring and we will see what it is. And initially they wanted him to come back in the

evening and he was able to stay home all weekend and for his birthday on the Monday. **I just thought if I hadn't have said anything they would have kept him in hospital all weekend and is all he wanted to do was sit in his garden. I felt really pleased with myself. I was so desperate that this man should get out of hospital.** I saw him last week and he has detoriated so much he probably has only got a couple of weeks left and yet they wanted to keep him in hospital for his last few days. He was so grateful and his family were grateful. And **I went home that evening and thought nursing is really good, I had a good day and felt very positive about it."**

This nurse often talked about staffing levels and senior nurse support available for the team.

> "A bad day is when **you don't have any support,** not just support from senior staff but, no support in the team. You haven't got anybody to say, can you help me with this?"

On another occasion she commented,

> "So, that day I had a good day. The sister was on if I remember correctly, I could remember **she was very good and very supportive and just knowing that she was there.** Working alongside her, I might have been up the high dependency end. **I just knew she was there and if there were any problems I could just go and ask her instead of waiting for half an hour for the manager** because she might be sorting out beds for example. So, **I think when the sister is on everybody feels a lot more comfortable with the situation."**

Clearly, this nurse feels that adequate support from sister is vital and makes all the difference to how the nurse feels about herself and her role.

Regarding **senior nurse support** she commented,

> "I can only say **that our manager was very good. She was very supportive.** Any problems **she would move everything to sort it out for us,** so in that respect **she was very fair and reasonable."**

Similarly, she also feels that good senior nurse support is an important factor in ensuring that the working environment is fair and responsive to the needs of staff.

She often discussed the general morale of the nursing team and described situations that had contributed to the general working atmosphere of the ward. How the nursing team interacted with one another and addressed difficult situations together. The following is a typical example of this and highlights I think, **team working and effective communication.**

"We had one incident, a young chap, he was only 18. I was a student nurse before I qualified and I was with him. I always seemed to be put the end where he was and I guess I was with him for the first 6 months of qualifying. He died a horrible death, it was really sad. A very sad family background as well and because we had all been heavily involved with his care for that length of time and knew him so well. And I knew him pre-op when he was just a normal 'jack the lad', 18 year old and came back after a holiday after I had qualified, and he bleed in ITU and never regained consciousness. He died and **all the staff felt we needed a debriefing. Everybody was really upset and things had happened that other staff didn't agree with and the sister was very uncaring at this point in time.** Maybe that was her way of dealing with it. **We all thought he was dealt with very badly and we were all affected badly by it.** One particular thing was, he was on a monitor and it was nearing the end and the family became fixated by this monitor. We said we think we should turn off the monitor and then they can focus on him. We were on nights, me and a girl I trained with. Sister came on in the morning and turned the monitor straight back on. And three hours later he died. I think it was awful, the last three hours of the poor boy's life the mother was staring at the monitor. It was un-necessary. Well she didn't see our point of view and **our ward manager said I really think we need a de-briefing and a critical incident analysis.** Everybody was very, angry, very upset. That's the only time that we ever had a de-briefing.

"And did it help?"

It helped because we could say we didn't think it was done right. She didn't like it at all. She was the sort of person that was always right. But, even the ward manager supported us and said look I'm not saying who was right or wrong but if this happens again and someone is nearing the end I don't think it's right to have monitors on. She was o.k. Then, the point accepted. From our point of view it was good to get it out in the open because it would have simmered for a long of time and we would have probably felt very bitter towards her forever. But, no, **after we got it all out the working relationship was fine from then on,** which is important, you don't want to bear grudges on the ward do you? Yeh, that was very helpful."

Dialogues about **learning**

In the data I found a number of **dialogues about learning and professional development.** They included discussions about knowledge or lack of knowledge/competence and identification of learning experiences.

Whilst many nurses in the study made reference to competence and knowledge, one nurse in particular stands out because she made no reference to her own professional development needs or situations

where her skills or knowledge was inadequate giving one the impression perhaps, that she no longer felt the need to develop her skills.

> "Nothing too worrying or stressful. **Nothing that I didn't know** or was unable to get help with such as prescription drugs or antibiotics".

However, in contrast the following nurse made reference to her skills and her future development needs thus:

> "I felt **I was able to use my skills tonight,** especially skills I had learnt in the ambulance service".

She also discussed her future career development plans and I got the impression that she had given some thought to her ongoing development needs.

> **"I'm very interested in oncology nursing** and being a general surgical ward we do get quite a lot of oncology nursing. I have actually got to take up a link role on the ward and I am going to suggest to Sister that I do palliative care as I do find that very interesting".

> "I've also been talking about my E Grade role and it's starting on Monday. I'm quite pleased about that too. .....**I'm looking forward to teaching students. I've got my 998 Teaching and Assessing course starting in July".**

The following nurse however, tended to focus on her learning opportunities as well as areas of competence thus,

> "Had to pass two nasogastric tubes. This took me ages as **I'm not brilliant at passing NG Tubes".**
>
> **"But I learnt so much from being on duty last night,** watching another staff nurse performing all these tasks. It just made me realise if it happens to me I need to think logically. I need to be calm and hopefully now **after seeing that, I could manage to do it myself if it ever happened to me on duty."**

The last quote suggests to me that this particular nurse looks at learning opportunities broadly and sees learning occurring through experience in the clinical area as important as learning that results from undertaking a course or being shown how to do something.

The next example however, is a nurse who made no reference to professional development or opportunities for learning needs apart from discussing her personal reasons for undertaking a degree programme and how this may assist her when applying for senior posts in the future.

> "I don't know I look at my training. I had a very good training and really enjoyed my degree. ……**Initially it hasn't benefited me in nursing but, then again when I go for senior posts I might be really glad I've got it."**

Summary

One of the aims of the research is to identify differences amongst the nurses I am studying. I looked for differences amongst nurses by analysing the different dialogues found in the data. These dialogues were broadly categorised into the following areas:

- Self
- Role
- Colleagues
- Learning

Self Dialogues

Some nurses were able to demonstrate self-awareness by verbalising how they felt about a particular event or situation whereas others could not. Those nurses who lacked an appreciation of self seemed to be pre-occupied with getting the work done and focusing on technical care. Having established this difference I will need to consider what effect this has on how the nurse performs her role. I.e. is the self- aware nurse a better nurse? If so, what differences are demonstrated in everyday practice?

Role Dialogues

Those nurses that I have described as caring and "patient focused" appear to consciously spend time thinking about what they are doing, how they are communicating with their patients, thinking about their practice in a thoughtful and reflective way. Whereas, those nurses who were more concerned with technical care, completing tasks and getting the work done tended to spend little or no time reviewing actions or events.

Colleague Dialogues

Those nurses who I have identified as self-aware on the whole appear to be team players, concerned about the well being of the team whilst those nurses who lack self-awareness are less concerned about their team and tend to focus more on communication with the medical staff. Status within the nursing team was also important to these nurses.

Learning Dialogues

From examination of dialogues there is also a correlation between being self-aware and being able to identify learning needs. Nurses who lack an awareness of self did not discuss their competence or learning needs/future development.

From examining these various dialogues found in the reflective tapes and the follow-up interviews I have identified that there are some differences amongst nurses. These differences are to do with self-awareness, how nursing is practiced, and relationships with colleagues and about how learning is structured.

By examining the dialogues I began to wonder if there were two different types of nurses. Nurses who tended to lack an appreciation of self, who were preoccupied with getting the work done and focussing on technical care. And those nurses who were predominantly patient focussed and caring, who tended to have an appreciation of self, consciously spent time thinking about what they were doing and how they were communicating with patients in a thoughtful manner. These nurses were concerned about their own professional development and learning and their relationships with colleagues.

Conversely, those nurses who were more concerned with technical care, completing tasks and getting the work done, tended to spend little or no time reviewing actions or events. I found that these nurses appeared less concerned about other team members tending to focus more on communication with doctors. Status within the team also tended to be important to these nurses.

CHAPTER FIVE

ANALYSIS: DIFFERENCES ACROSS CASES

In the previous chapter by analysing dialogues using the conceptual areas of self, role, colleagues and learning I was able to identify some differences amongst nurses. These differences were to do with self- awareness, role, and relationships with colleagues and how learning is structured. Having established there are some differences amongst nurses I will now need to consider what effect this has on how the nurse performs her role. I.e. does the self -aware nurse make a better nurse? If so, what differences are demonstrated in everyday practice? Using the conceptual headings previously devised, I will now consider each nurse in turn to establish what are the effects on practice and the nurse's role. The data is drawn from reflective diaries, semi-structured interviews and non- participant observation.

[I have highlighted aspects of the quote/s that I particularly want to emphasise]

Staff nurse A

What struck me about this particular nurse when examining her reflective diary was that the account of her practice was largely, descriptive. I.e. the number of staff on, the type of patients to be cared for, their medical conditions. When reading her account I rarely got the impression that she appeared to be a caring nurse. Her comments were all so matter of fact, clinical and lacked any real concern for her patients or colleagues. She mostly talked about the workload or circumstances that gave her or the team less to do. Comments that to me demonstrated her preoccupation with getting the work done were:

Role

"The clinical practice **wasn't particularly stressful,** we **didn't have a lot of complications or post surgical patients, and they were more or less self caring."** Similarly on another occasion she commented,

"They have transferred this gentleman to ward… as he has been taken over by the medics, he's been transferred there. **So that takes quite a lot off our hands because we were quite busy with him and his trachy and doing his peg feed."**

Other examples showing that this nurse's practice has become routine and repetitive were:

> **"Didn't have any admissions, didn't have any empty beds**. It's Tuesday so, **had a number of post op patients.** Lady with an epidural started to have pain, had a bolus injection. Major post op surgery patients – **lots of I.V. antibiotics, I.V. fluids, maintaining fluid balance charts, pain management, managing patients' nausea and vomiting.** That's it really."

Any descriptions of her practice lacked depth and appeared to be discussed in a very matter of fact fashion. Some examples to illustrate this were:

> "It's the second night shift of four. Still had my lady with the epidural in. **Still doing hourly obs and hourly urine with her. Level of block really not working that much. Quite a lot of discomfort, quite a lot of pain, got the anaesthetists up - quite reluctant to take it out.** I did suggest a PCA (Patient controlled analgesia) but, he didn't want to put it up at that time of day. I don't know, I suppose it wasn't convenient for him. **So made the lady comfortable with an antispasmodic for the kind of pain she was feeling and she kind of settled for the night. I kept an eye on her. She really didn't have a level of block."**

This description of a patient in pain suggests to me that this nurse could have done more to relieve the patient's discomfort. When the patient continued to experience pain she could have insisted that the doctor return to see the patient and resolve the problem. Failing this, or if the doctor had refused her request she could have bleeped the duty manager to deal with the problem. Although, she did suggest to the doctor an alternative when he first visited the patient, she failed to follow this through to a satisfactory conclusion. There were other courses of action she could have pursued. She failed to advocate for this patient. This highlights to me that this nurse has become stuck in an unchanging form of practice, whose practice has become routine and repetitive, missing important opportunities to think about the situation creatively and act appropriately.

> **"My post op's are third day post op's so I don't need to keep an eye on them as much as I was. They're on regular obs, I.V. fluids, I.V. antibiotics, fluid charts (still doing them at midnight)."**

Even when this particular nurse described a problem with an aggressive patient on the ward she stated,

> **"Quite a hectic day, quite a stressful day particularly, with staff nurses crying and having to go home early and what not"**

This last comment is interesting because to me it seems to demonstrate that the nurse is rather less concerned about the fact that colleagues were upset by out bursts from an abusive patient than the inconvenience of staff having to go home early.

She also, appeared to be quite conscious about her rank in the team and being in charge. The following comments highlight this point:

Colleagues

> "I was in charge as I was an E Grade." On another occasion, she commented, "I've got quite a lot of good staff on today, quite a lot of support, everybody knows their job, **and didn't have to pull rank at all,** which you don't really need to do anyway. Everybody worked well."

On another occasion she commented,

> **"Not really clinical more a need for team support."** "We had support for the juniors of the team."

When examining her reflective diary for evidence of how she felt about particular experiences it was difficult to determine what she felt about her practice or whether in fact she consciously thought very much at all about what she was doing or was going on around her. This suggests that this is a nurse who spends much of her time reacting to various demands in a superficial, erratic and non-reflective manner. Her diary lacked detail.

Regarding her own professional competence she made reference to this twice thus:

Learning

> **"I'm not qualified to put up TPN's** (Total parental nutrition) so, an E Grade on nights has to come and put up my TPN's for me. **I feel a bit silly** because I should be able to do this by now." And another comment, **"Nothing that I didn't know or was unable to get help with such as prescription drugs or antibiotics."**

It is difficult to draw any conclusions from these comments apart from to suggest that this nurse isn't very bothered about her own professional development and has reached a stage in her career where she doesn't really expect to need much help and if, she does this is likely to be related to technical aspects of care such as drug therapy. The fact that she was not trained to administer TPN's suggests

that rather than taking responsibility for this aspect of her own professional development she sees it as a failure of management or someone else's fault perhaps. The latter statement is a vague attempt at self assessment but, lacked any depth or appreciation that her own self assessment needs might be broader than just related to technical skills.

Staff nurse B

When I began studying this respondent my overall impression was that she was a caring nurse who enjoyed nursing yet, felt frustrated at times, when it wasn't possible to meet her own personal high standards of care, due to shortage of staff or workload pressures. When asked, what do you think about nursing? Her response confirmed this:

Self

> "At the moment it is very **stressful with the short staffing problems continuing** but, on the whole I think it is a very enjoyable profession, **very misunderstood**.
>
> Q. What do you mean by misunderstood?
>
> A. "I don't think, especially from the doctors that they fully understand how difficult it is on the ward, managing the patients. **When they come back from theatre you're very busy trying to recover them, making sure everything is all right and they seem to think it's a very easy job from what I can gather. It's very, very busy, stressful and you don't always have the staff to support you".**

The following quote highlights how working conditions can contribute to the nurse feeling stressed,

> "Today's shift was particularly horrible. **Somebody phoned in sick in the early hours of the morning and we couldn't fill the shift with an agency. We had one of the senior nurses counted in the numbers (co-ordinating the shift) and we were therefore, a qualified member of staff down to look after the patients.** So, I was busy in the high dependency unit on my own with a student. It was extremely stressful. I felt very alone, although there were people to ask they weren't always immediately available. So I had to find the time to look for them. **The patients were all very poorly** and when the shift finished I must say I was extremely relieved to get home. I just feel that **when days like this happen it's unsafe** and I shouldn't need to put up with that. When patients are coming back from theatre they shouldn't be coming back to such an unsafe ward. I feel demoralised and extremely fed up. I'm getting use to the fact that people phone in sick and we cannot always cover the shift. Nothing else springs to mind about the shift, **it's just been over shadowed by lack of staff."**

The following statement taken from a diary entry further confirmed the fact that this nurse sometimes felt frustrated about not being able to do things to her standards.

Role

> **"I felt I hadn't done things properly because I didn't have enough time to spend on individual things.** There were care plans to update and new ones that I wanted to write. I had to hand that over to the night staff as I just didn't get the chance to do it."

When examining Staff nurse B diary it was interesting to note that the descriptions of her day to day nursing activities was always discussed with an emphasis on patient care rather than a description of work to be done and tasks to be completed. When technical care was discussed this was done in relation to patient safety, physical and psychological comfort of the patients. She talked about "patient/s" when discussing nursing care rather than talking about conditions, IVI's and post op's – such as,

> "**One of our patients** was acutely ill, came in overnight and subsequently died. This caused a bit of an upset amongst the staff on the ward. **The patients** as far as I was aware did not know what was going on until the time came for the body to be taken away and we had to draw the curtains and they were all curious to know what was going on. So, I explained that **one of the patients** had passed away and that seemed to satisfy their curiosity. On the whole it was just like any other day, busy, stressful at times but, enjoyable."

She often talked about how she and other staff within the nursing team were feeling and I was given the impression that this nurse was bothered about her colleagues and valued working in a team. This can be illustrated by the following comment, from a diary entry:

Colleagues

> "Our ward manager was on holiday so we had someone else managing our ward that doesn't usually do it. This created a bit of confusion amongst the staff as to what she **wanted us to do. It was felt amongst us that she was asking us to do** things un-necessarily and at times when we were particularly busy. So it was difficult to focus on what she wanted us to do when it was just bed moving and it would have been much simpler to move people around as we had suggested to her but, she wasn't having any of it. So, that was a little bit difficult **and quite a few of the staff** were angry with her but, that seemed to subside when she saw **our point of view.**"

When discussing experiences she used the term "we" rather than "I" which seemed to suggest that is nurse was a team player.

When being interviewed and asked what she thought about nursing she talked about the importance of teamwork thus:

> "Now that I've left and I'm doing the Midwifery Course **I feel that I miss certain aspects of it, especially the team work that you get with nursing.** I miss that because in Midwifery you are very much on your own."

She tended to talk about the nursing team and communications with medical staff as well as discussion about individual patients relatives. She referred quite often to the degree of senior staff support thus,

> **"Support was very good on the ward today.** I felt I had people I could ask if I wasn't sure what was going on."

Another example of her sense of team working can be demonstrated by the following comment,

> "Today's shift was a Sunday which generally tends to be a lot quieter because there is nobody being rushed off to surgery first thing in the morning. You have time **to have a chat with the rest of the nurses** in the morning. One of our health care assistants, who is very good, does tea and toast to start off the weekend. On Saturday and Sunday she will do that first before we start the washes. **We had a good chat for 15 minutes** before we started to wash the patients."

The nurse when discussing staff morale and the role of debriefing meetings as a means of coping with difficult cases on the ward described this extract concerning the care of a young patient:

> "The arrests that I've seen and been involved with, we didn't have any debriefing. We had one incident – a young chap, he was only 18, I was a student nurse before I qualified and I was with him. I always seemed to be put the end where he was and I guess I was with him for the 6 months of qualifying. He died a horrible death, it was really very sad. A very sad family background as well and because we had all been so heavily involved in his care for that length of time and knew him so well. And I knew him pre-op when he was just a normal, 'jack the lad' 18 year old. I came back from holiday after I qualified to find that he had bleed in ITU and never regained consciousness. He died and all the staff felt we needed a debriefing. **Everybody was really upset** and things had happened that other staff didn't agree with and the sister was very uncaring at that point in time. Maybe that was her way of dealing with it. One particular thing was he was on a monitor and it was nearing the end and the family became fixated by this monitor. We said we think we should turn off the monitor and then they can focus on him. We were on nights, me and a girl I trained with. Sister came on in the morning and turned the monitor straight on. And three hours later he did die. **I think it was just so awful**, the last three hours of the poor boys life, the mother was staring at the monitor. It was unnecessary. Well she didn't see our point of view and **our ward manager said I think we need a debriefing and a critical incident analysis. Everybody was very angry, very upset."**

Q. "And did that help?"

A **"It helped because we could say we didn't feel it was done right.** She didn't like it at all. She was that sort of person who is always right. But, even the ward manager supported us and said look I'm not saying who was right or wrong but, if this happens again and someone is nearing the end I don't think it's right to have monitors on. She is O.K. now, the point accepted. **From our point of view it was good to get it out in the open because it would have simmered for a long time and we would probably have felt bitter towards her forever. But, no after we got it all out, the working relationship was fine from then on, which is important.** You don't want to bear grudges on the ward do you? Yes, that was helpful"

The following example demonstrates that this nurse is patient centred and demonstrates I believe a caring attitude. It was in response to the question, "Can you describe a memorable event, recently or in the past where you felt you learnt something or made a difference to an aspect of care?"

A "Yes, as I said to you I do a shift on Sundays on the ward. The last couple of weeks there have been a very sick man with a very aggressive brain tumour and I don't know **some patients you get more attached to than others.** This particular man has a lovely family, with lots of small grandchildren. **I went home that night and felt very upset that this man up to about six months ago was very active with a small business of his own.** Now he can't stand up, can't see and because he is on very high doses of steroids his blood sugar levels are very erratic, and the doctor's didn't want him to go home for the weekend. It was the bank holiday weekend and it was his birthday on the Monday. He wanted to go home on the Saturday but the doctors said that his blood sugar was too erratic. **So, I said, this is palliative care we are doing for this patient, he doesn't need to be in hospital. He has been diabetic for 25 years and he and his wife are probably much better able to deal with it than we are. And I said to the doctors I think he should go home. He is miserable, and he doesn't want to get out of bed. So, he said O.K he can go home. I said to his wife when she came in, if there is any problems give us a ring and we will see what it is.** And initially they wanted him back in the evening. He was able to stay home all weekend and for his birthday on the Monday. I just thought if I hadn't said anything they would probably have kept him in hospital all weekend and is all he wanted to do was sit in his garden. **I felt really pleased with myself.** I was so desperate that this man should get out of hospital. I saw him last week, he has detoriated and probably has only a couple of weeks left and yet we wanted to keep him in for his last few days. He was so grateful and so were his family. **I went home that evening and thought nursing is really good. I had a good day and felt very positive about it."**

This is a good example of a nurse who is able to function autonomously, who is confident enough to challenge a doctor's decision, and can advocate for the patient and his family with a positive outcome.

The following quote, an extract from the interview again, highlights how this nurse is able to assert herself, is proactive and able to judge the worth of her action (taking a break.)

"How would you define a bad day?"

A. "A bad day would be when you don't have any support, not just support from senior staff but, no support in the team. You haven't got anybody there to say, 'Can you just help me with this?' Simple things like people needing turning. Sometimes you have to wait an hour for someone to come and help you turn a patient. And some days you are so busy wanting to get your work done that you don't even have a break. So, you've worked 12 and a half hours with very little time off the ward and it just gets a bit much I think. You just need a break to get away from the stress, even if it's just a few minutes. To say to someone can you take over for a few minutes because I've just had enough? I think initially, it's very difficult to do when you are newly qualified. You just take it all because you are afraid people will say you are not coping and that you are a really bad nurse. But, when you've been on the ward a while you say, look **this isn't life threatening and I'm going for 10 minutes. Get yourself a cup of tea and you feel better when you come back."**

Staff Nurse C

When reading Staff nurse C's diary my overall impression was that this nurse was thoughtful, cared about her patients and was concerned about whether or not she was doing a good job or not. She also was conscious about her professional development and gave examples of experiences on the ward that were learning experiences, thus,

"I learnt so much from being on duty last night watching another nurse perform all those tasks."

The other thing that I particularly noticed about this nurse's diary entry was that she often commented about feeling stressed or annoyed by circumstances, which appeared to be beyond her control. She mentioned feeling stressed on five different occasions and feeling annoyed four times. Typical stress related comments, which highlighted this point to me, were,

Self

"Difficult to cope with"

"Irritated me so much"

"Made me feel terrible"

"I'll never be able to cope"

From reading the diary entries I was also struck by her lack of self-confidence at times and it appeared to me that she was still coming to terms with the role of the qualified nurse. This was highlighted when being interviewed and asked what she thought about nursing.

"Generally, for me lately I've been thinking, why am I doing this job?' That's when you like having bad days. When you have good days and you enjoy your work, working with patients, it's quite rewarding and you get time to do things and you can relax. But, the last few months on the ward it's been a bit of a nightmare."

Q. "Because it's been busy?"

A. "Yes, were down three E Grades and all the senior E Grades have left, there's four E grades at the moment and one is on annual leave. We are just new E Grades since last October. You are left in charge all the time when you are on and it just gets very stressful. I've found going from D Grade to E Grade much harder than going from a student to a qualified nurse."

Learning

The following example I think shows how conscious Staff Nurse C was of her own learning needs and how she appeared to be taking every opportunity to improve herself, demonstrating how seriously she viewed her own professional development. I think one can draw the conclusion from this example that she is clearly thinking and practicing in a critical way:

"About 2 O'clock, on my way back from my break the health care assistant told me that one of the ladies had been taken ill. When I went into the bay one of the E Grade nurses was with her. This patient had suddenly developed chest pain, breathlessness, tachycardia, sats [oxygen saturation levels] had dropped to 60% on air and when I got there they were putting up oxygen and hooking up a monitor to take an ECG reading and trying to record her blood pressure. BP was 80/40 and then went so low there was no recording. The doctor was on the ward when I came back and he was assessing the patient and looking at her ECG [electrocardiogram] recording. **I stood there thinking, oh, my God, what would I do if this was one of my patient's and this happened to me.** I really don't know what I would have done. Sarah asked me to get a few things for her, which I did. The resus [resuscitation] trolley, 100% air breathing bag, things like that. Have the defribrilator standing by.

The lady was now in fast AF (atrial fibrillation). **Then I turned to Sarah and said my God I just would not know what to do! She said, yes you would and she explained the logical steps to take and I thought yes, that's right I probably would have done this in this situation.** The doctors took bloods, gave her morphine and then the Registrar was called. Abdominal X rays were taken and she was diagnosed with a pulmonary embolism and pneumonia.

This lady was quite unwell, two lots of jellifusion were put up, and her BP came up to 88/40 something. Put up a bag of normal saline, catherised the patient as she had wet the bed. Just getting a lot of things ready for the doctor to give her; saturations had now come up to 88% with 100% oxygen bag. But, she was still really poorly. She was now out of it with her eyes in the back of her head, still in fast AF so, the doctors had to call her relatives and advice those to come in to see her as soon as possible as things did not

look very good. Fortunately for us she did not go into cardiac arrest while I was on shift but it just got so busy from 5 to 8 O'clock in the morning.

I had to help the other nurse with her drugs. I was really lucky that none of my men were really ill because I don't know what I would have done. **But, I learnt so much being on duty last night watching another staff nurse perform all these tasks.** It just made me realise if it happens to me I need to think logically, I need to be calm and hopefully and now after seeing that I could manage to do it myself if it ever happens to me on duty. **I feel more confident in anticipating something like this happening and knowing what I'm going to do now. I'll know what first steps to take before the doctor arrives."**

The following is another example (drawn from the interview data), when discussing a memorable event that made a difference to an aspect of care, which demonstrates self-awareness.

> **"My biggest thing was the first night on duty as an E Grade; I had my first cardiac arrest. It was the first one I had seen and I was in charge basically. I did get the woman back so, I felt pretty good about that. I was quite pleased with the outcome.** She had to be shocked twice but we did get her back. **When I look back on it, some things you could have done better, you know. Could have got her down the bed quicker and got oxygen on**. But, when it happens it's such a panic. You can't remember anything; you just deal with the situation. **I feel more confident if one was to happen again. I know what I can do.** Afterwards the duty manager ran through things with me, so things are much clearer. Anyway I can kind of see what I should be doing. **I feel I would be more confident in asking people to run and get things for me.** But, in myself I would feel more confident in getting oxygen on the patient and the steps that I've got to go through."

Staff Nurse D

When examining the data it was interesting to note that this nurse clearly found nursing enjoyable and challenging yet, at the same time often frustrating and difficult.

When examining data from the diary, it was clear that the experience of dealing with an abusive patient overshadowed the entire diary of her practice. This clearly had a profound effect on her thoughts and actions. She constantly referred to this patient throughout.

Self

On the first entry she commented thus,

> **"Had a situation last night that was quite awful. Had a very abusive patient who tried to slap a member of staff and then tried to slap me.** This situation arose due to shortage of staff really. We had a gentleman pass away, we were busy with this gentleman in the side room and this lady wanted some analgesia. Obviously she couldn't find a member of staff to speak to and basically lost her temper when she did find someone. **The whole situation affected me really because, the man who passed away – I like to give a bit of respect and a bit of dignity when I'm dealing with them before and when the family arrive. This was all rushed. I'm quite upset this morning.** I don't know whether it's because I'm tired or not but, I think sometimes we are taught to do these things in College and we've all got the care there, that's why we are nurses but, when you can't fulfil your care it does upset me. Whether it's because there's not enough time or because you are needed elsewhere. I just think their needs to be more staff on at times. Well, when people speak to you like this lady spoke to us it just makes you think really. Anyway, we'll see what happens tomorrow night."

However, what was quite noticeable was that on occasions descriptions of events were brief and lacked detail. This I also noticed when interviewing this nurse - that she required a certain amount of prompting to get her to answer the question properly. I didn't get the impression that it was the way in which I had framed the question because other respondents were able to respond to my questions appropriately and I of course, piloted the semi structured interview schedule prior to collecting the main data. Was I picking up that this nurse is a non-graduate because she is less articulate than some of the other research respondents I have analysed, some of whom would be graduate nurses? I wondered whether graduate nurses were able to make their point more quickly and with greater clarity. Was there I wondered a significant difference between these two groups of nurses, something to bear in mind when examining other diaries and their responses when being interviewed? However, if this research respondent turns out to be a graduate then this would disprove this proposition. I have now looked at the first four cases, A then B then C and now D and I am beginning to notice some differences.

When asked,

> **"What do you think about nursing?"** this nurse responded,

Role

> "Generally I like my job but I don't at the moment because of the way the ward is at the moment
>
> Q. **"What do you mean by that, the way the ward is?"** "It's too busy so I can't really do my job properly, that's how I feel."

Q. "So what keeps you in nursing?" A. "Because I love my job, I wouldn't do anything else. I've already left and come back to nursing."

"I'm down the gentleman's end today which is quite nice, after speaking to the lead nurse and refusing to look after this lady after all the abuse she has given me. It is quite nice to be away from the situation."

This is an example of the nurse being proactive following careful thought and reflection, judging the worth of various options or was it simply the nurse being reactive and responding to a 'gut' feeling. The fact that the patient who had been abusive and rude, had tried her patience to the limit and she had simply refused to care for her because she had, had enough of it. I'm inclined to think (When reading and re-reading the data) that it was the former, that this nurse had carefully considered the options and following careful thought and on reflection had decided that she would adopt a proactive approach to this particular problem. It was clear from this example that support from the managers was not as good as one would hope or expect from the nurses description of events.

"Obviously last night we did actually write a report about what happened with this lady because she made a complaint and we sent this to the Lead Nurse. I haven't heard a reply yet."

A further entry in the diary stated,

"A couple of junior staff was quite upset with the situation again and security has come up. I've got quite strong views on it because **I don't see why we should be put at risk and why we should have to look after these people.** Why they can't be moved to another ward. I just don't feel there is any support for us. The lead nurse and the ward sister know about the situation but, nothing seems to have happened and it is quite scary really. This lady has quite a long history and her boyfriend was banging on the ward door last night at 4 O'clock in the morning. It is quite frightening and you do feel vulnerable as a nurse. Well I do feel quite vulnerable."

In refusing to care for this patient it could be argued that this nurse had considered carefully the options, and having done so, and acting in proactively manner decided to take control of this difficult situation herself. From the description in her diary she felt that that managerial support was somewhat lacking. She also commented on the affect this situation was having on junior staff in the team as well as on other patients on the ward. This experience involved the nurse weighing up the options and making a judgement about what action to take. Clearly from the number of entries in the diary the nurse had given this event a lot of thoughtful consideration.

Staff Nurse E

When reading this nurses diary entries my overall impression was that Staff Nurse E was a caring nurse who felt frustrated because she was not always able to focus enough of her time on the needs of her patients. She talked about having to deal more and more with patients and relatives queries, dealing with cancelled operations and often making excuses for the inadequacies in the service. She described nursing as,

Role

"A very changeable environment".

"Gone are the days when I felt I could spend all of my time at the patient's bedside caring for them in a holistic manner. Now I find myself dealing more and more with patients and their relatives anxieties, dealing with questions about when they're loved ones are going to theatre, why operations have been cancelled. I feel myself making excuses for the constraints of current day environment and the demands are more and more evident as a whole."

The diary described the number and type of patients to be cared for, and some of the critical events encountered in practice.

The only other critical event that she described in any depth, where she attempted to reflect and analyse her input, was a patient that she took to theatre,

"I recently brought a patient to theatre and felt I made a difference to an aspect of his care just by the simple manner of touch. The gentleman was on our ward for some time, he was to and fro to theatre in the six months that he was with us when we were sitting in the anaesthetic room waiting for him to have his operation we just spoke and touched. He was 70 years of age and felt that the end of his life was coming and felt he had no part of play in society. And through the excruciating disease he had, was not able to play his part in society as he had done, prior to his admission. But, I felt just by speaking to him and touching his hand and listening to his fears and anxieties (which maybe I took for granted because he had been with us for so long) **I made a difference to his care.**

Colleagues

The only reference she made to other staff members was that she considered herself as a very valuable link within the multiprofessional team where she was respected and listened to in a very positive manner. No reference was made to any other nursing colleagues apart from when describing an Incident when a psychiatric patient disappeared from the ward even though an RMN [registered mental nurse] was looking after him. She made reference to a lack of communication between herself and the psychiatric nurse and commented,

> "I defused the situation in the end according to Trust policy. I was surprised that I was responsible for this gentleman's disappearance when I was in charge of 38 other patients and he had a psychiatric nurse looking after him."

The diary made no reference at all to professional development or learning. The majority of the diary lacked any detail or depth.

Staff Nurse F

This nurse's reflective diary contained descriptions about her role as a nurse in a changing environment, her relationships with other nurses in the team as well as medical staff, the changing nature of nursing and her relationships with patients.

The reflective diary described the workload, the number of staff on duty and the type of patients to be cared for well as her views of events. Descriptions included triumphs, traumas and trivia as well as aspects that interfered with what she was trying to achieve. On the whole when reading the diary entries I formed the opinion that she was a confident nurse who was experienced enough to manage the demands of a busy medical ward without supervision and appeared clear about her role. She expressed her opinions about events clearly with confidence.

When examining her diary it was clear that she was an assertive nurse who was not afraid to challenge colleagues in the interests of patient safety.

The following extract from her reflective diary highlights how difficult the demands of nursing can be at times,

Self

"Overall, I came away from the shift feeling absolutely drained, physically I was O.K. but my head was pretty spinning by the end of it I didn't have a break at all. I had half a cup of tea. Well it's just not on really, but if you have a break you don't get the work done, and the ward is very heavy at the moment. **Things are getting missed; priorities have to be dealt with first. Didn't really get to speak to a patient on a one to one basis just, zooming around making sure the basics were done.** Task orientated so, it wasn't very good."

Role/Colleagues

When examining her diary it was clear that she was an assertive nurse who was not afraid to challenge colleagues in the interests of patient safety.

This can be highlighted by the following example taken from a diary entry,

> "We were expecting a patient from ITU who was in a diabetic coma, an alcoholic gentleman who was very, very confused and had a history of violence, so we weren't looking forward to accepting him. When he came down to us we did his blood sugar and it was 1.7. So we had to urgently call the doctors to write up 50% glucose to try and get his blood sugar up, but, unfortunately the doctor being a house officer, was quite inexperienced and to be honest just 'faffed about a bit.' **Even though we were telling him that the proven treatment in a diabetic crisis like this is to give 50%/50mls I.V. glucose** quickly. So that held up the patient's care further. Luckily, we got his blood sugar back to normal – 4.1 but it took some efforts on our part. It's quite annoying because we are never believed in that sort of situation. I've seen it time and time again through experience and yet every 6 months we get new house officers who doubt you completely. It's just one of those situations that we have to cope with when we have new doctors.

This nurse acted in an autonomous manner by standing up to the doctor, suggesting what should be done in a critical situation.

There were other examples of this nurse acting proactively, intervening in a clinical situation. A further example of this nurse acting assertively can be highlighted with the following example concerning a patient's resuscitation status:

> "The only surprise we had was a gentleman who was unfortunately very ill and not for resus died on our shift. In our hospital we have clinical E grade nurses who come around to support you and this particular nurse wasn't particularly supportive. I came out of his room and said that the gentleman had passed away. She then said was he not for resus? She then went all through the notes and could not find an entry so, ordered me to put out a resus call. I was extremely distressed at my colleague's actions. I felt really bad, disgusted in fact but unfortunately my hands were tied. So the call was put out. **As soon as the doctors arrived I explained the situation and one of the doctors found in the notes hidden underneath a blood result sheet, orders for 'not for resus'. The resuscitation was stopped immediately.** I just felt awful about the situation. I found her manner very patronising because she didn't take account of the extra stresses and strains I was under running the shift. **The next day I spoke to the nurse about it. She was happy that I pointed it out to her.** She had been like this to other

people and hadn't realised it and was pleased that I had pointed this out to her."

When talking about her role within the multi-professional team she commented,

> **"I see myself as a bit of an underdog really. Often we are not respected as we should be, often we are not invited to multi-professional meetings and we are seen as a bit of a 'dog's body' really, but, then partly that is because we don't participate enough. Not putting us forward enough.** The same old thing we are needed more on the ward than in a meeting with social workers for instance."

Concerning communications with medical staff a number of conclusions can be drawn from the data. That partnership with doctors is sometimes difficult and unequal. The data also seems to suggest that doctors do not always value nurse's opinions. On several occasions she commented on doctors doubting nurse's judgements. This comment was in response to the question seeking views about the nursing team's relationship with medical staff,

> "On the whole it's quite good. You get the odd doctor who comes along; in fact we have got one at the moment who is extremely difficult to get him to do things. It's almost as if he is from the 19 hundreds the way he talks to you…….. I know there are barriers between professions in the NHS, **that's one of the biggest problems and he doesn't listen to our advice.** Consultants are very open to you but you don't see them very often. I would say that 80% of doctors are very open to your ideas and are easy to work with. It's that 20% who for whatever reason or agenda they have will not listen to you."

Role

When analysing the data it was clear that this nurse was committed to nursing and was able to articulate her thoughts about how nursing should be but often felt the demands were excessive.

> **"I think a lot is expected of you.** From talking to people in my family who were nurses, more is expected of you, even compared with 10 years ago. **You are expected to be more technical, to update yourself all the time, research to back up what you are doing in practice.** There's a lot more cases of litigation than there was 10 years ago, you tend to be watching your back all the time, your documentation."

An extract from her reflective diary highlights how difficult the demands of nursing can be at times.

When considering changes in nursing she commented,

"Generally nursing needs to be **more academic** to cope with the change in pace. I think there is such a disparity between nurses. **Some are academic and some are clearly not so and that the problem.** Everyone is expecting us to be at the same level and clearly we are not."

When considering Staff Nurse F's views about how nursing ought to be, the best way is to perhaps examine responses to the question, 'What is a good day?'

A. **"If there is a resolution of a problem or I helped in the resolution of a problem**. It's the only thing that keeps me going if I've done something good for somebody in the day even if it's trivial. If it's a really bad day and I've helped one person with a cup of tea, I feel oh, well it wasn't such a bad day. **Sending someone home that you didn't think was going to make it. Like a terminally ill patient that went home today, to me that's the most brilliant thing you can do."**

The changing relationships with patients was another area that was identified in the data, the following comment was in response to the question,

Q "Has there been any change in the general population's perception of nurses?

A. **"Yes, I would say in the last 5 years there isn't the same respect for nurses**. Just even a thank you card at the end of an admission would be nice. We don't get that as often as I have seen in the past. Just even a simple thank you, we don't get that as often as we would like**. I just think we get more and more abuse. People quite rightly know their rights more. I've certainly been attacked in the past. I've certainly had verbal abuse."**

Dealing with ethical dilemmas in clinical practice is another area that nurses find difficult to cope with from time to time but, perhaps don't spend enough time considering the implications of their actions enough. Reflecting on an event or incident allows this. An example of this taken from a diary entry was

concerning an elderly patient who disappeared from the ward and once found, the actions that were taken to coax him back to the ward.

> "We got him back to the ward and the duty manager said, 'you will need to give him something to calm him down.' So I had to give him some haloprenol in the end. **So I found that I had to pretend that I was taking his blood pressure. So I took his blood pressure and while the cuff was still on gave him an injection, that I know is bad practice and is unethical but sometimes you have to weigh it against patient safety.** He would be in danger of hurting himself and in that situation it's very difficult to watch someone hurt himself or herself because a nurse feels queasy about the ethics of the situation. But, it does make you think controlling and restraining people. I don't know what another nurse would do in these circumstances."

This ethical dilemma highlights that this nurse is reflective about her practice and does consider the implications of her actions.

Learning

There was one example in the data, (taken from the reflective diary) which described an aspect of learning including a change in perception.

> "There have been so many different things that I have learnt as a staff nurse in the last two years but, **one of the worse things that really made me learn.** I learnt the hard way was a blood incident when things were just so busy. I went to get some blood and it happened to be the wrong blood and even though all the protocols for checking were followed it managed to get through to the patient. Luckily it was O positive and the patient was fine but, it was subject to a full investigation. **It just made me realise we need to slow down and even though the ward was 'mental', you just need to be so careful about what you are doing and it doesn't matter whether you are a graduate or an E grade or a sister at the end of the day if you make a mistake it could be someone's life and it really did scare the wits out of me. It made me sit back and think more about what I am doing."**

This example of learning, which includes a change in perception – the change in perception being that the nurse in future resolved to take more time thinking about what she is doing.

Staff Nurse G

This nurse mostly described workload, types of patients to be care for, tasks to be completed and technical care. Interestingly enough, there was very little mention of interactions with patients or colleagues or attempts to analyse care or describe how she felt about her nursing work. Descriptions were brief, lacked detail and appeared to be mostly concerned with getting the work done.

Role

Typical examples to highlight this repetitive and routine practice were,

> "The ward was pretty quiet, had two admissions, two discharges, two admissions – one from A&E, one from the admissions ward. One patient was commenced on I.V. GNTinfusion, which we needed a cardiac monitor for which was difficult to find, as there was none available in the hospital. **The duty manager had to get involved who found one for us. Other than that all was quiet."**

Similarly, on another occasion she commented,

> **"As the ward has been very quiet over the last few days, nothing exciting or challenging has happened.** Had to organise an interesting discharge plan that involved multidisciplinary teams – the disability options team, district nurse, G.P. which all went very well. Other than that nothing else has happened."

The two following examples taken from the diary give some indication of how this nurse felt about her practice and professional development. They were the only examples I found that seemed to suggest analysis of a situation. One concerned a patient who she had cared for the other was to do with her future professional development.

> **"Some nice things about nursing, we discharged home a patient who had been with us for two months. He was at deaths door when he came in. He had pneumonia when he was with us; his prognosis was very, very poor. Very complex discharge, family (son and daughter) remain carers at home, didn't want any social services so everything needed to be perfect before he left. Has a 'peg feed', newly diagnosed diabetic, needed to explain everything. He needed transport. This patient got home fine. No problems reported back from the family.** These are the nice things about nursing, when you see people coming in so sick and see them leave again well; you feel you have done a good job."

This seems to indicate that this nurse doe's care about her patient's and is bothered about providing a good standard of care. It also suggests that she is able to think about her practice in a thoughtful way, breaking the experience down into component parts and exploring how she feels about the experience.

Learning

> "Feel I need to progress and develop my career which needs a lot of thinking about. **At the moment I don't know which way my career is heading, which speciality to go to or whether to stay in nursing. Sometimes I wonder whether I should leave nursing and develop a new career. I see myself as a good nurse, work well within a team, and see myself as caring and considerate. Some patients do tend to annoy you and you do your best not to show this. Emotionally I find nursing very challenging."**

This suggests to me that Staff Nurse F has reached a stage in her development where she is no longer progressing in any meaningful way, and is looking for new challenges.

Staff Nurse H

When examining the data of this respondent it was clear that this nurse is still finding her feet and appears to be lacking in confidence that is typical of a nurse with limited experience. This can be demonstrated by the following comments taken from the reflective diary.

Role

> **"Nursing is a very demanding but, also a very rewarding career.** As a newly qualified nurse I'm still learning and developing my practice on the ward particularly, with time management and also managing other staff and students which are quite overwhelming at times."

> **"I think it's really** because I am new and when you've got students who have just come to the ward and because you have a staff nurses uniform on they think you know everything and it's just a bit daunting at times because you don't know everything. People, relatives all expect so much of you; it's a bit much sometimes."

Staff Nurse H talked about her thoughts about nursing as a career her anxieties and areas of practice that she could have improved upon and her role with students, medical staff and managers. It was interesting to note that the data included very little about technical care, getting the work done or about staff cover but, tended to focus on the holistic care of the patient and the broader issues of her role as a member of a profession.

When discussing Staff Nurse H's views about nursing and as a member of a profession, she made the following comments,

> "I think there are a number of different aspects to nursing but **primarily I think it's to promote the well being of patients.** I definitely think it's a profession in its own right which needs to be autonomous and possess a number of different skills. I mean there are a lot of people who argue whether it is a profession and all the criteria of a profession. I think we get caught up in it sometimes but at the end of the day does it really matter what you are called as long as the job is done?"
>
> When asked what did she like about nursing she responded, **"Patients who get well and go home, even if they are not going to get well you can see they are reasonably happy and comfortable and you know if a patient says thank you. It's only a tiny thing but it's so nice to see that they are doing well."**

She appeared to be conscious of her development needs and the opportunities available to develop her practice. The following highlights her interest in developing her practice,

Learning

> **"Since qualifying my most memorable events have been the first two cardiac arrests I've been involved with.** Obviously, I felt very nervous with the first arrest but it was good to see that I could actually put the skills that I learnt in College and so on into practice on the ward. **After the actual event it was quite good to have time to identify what needs I still had and what areas I needed to develop. I feel I now have a better understanding of what others might need or request, the crash team once they have arrived, what other things I might need to be doing for them. Quite soon after the event I took part in some life support training and I was able to identify how I could possibly have done a few things differently and also how I could have prepared myself a little bit better for the same situation in the future."**

Staff Nurse H has thought about what else could have been done and what she would do differently the next time she was faced with a cardiac arrest. She was able to identify what she learnt from the experience and is better prepared for a similar situation in the future.

Staff Nurse I

When examining the data this nurse like many of the nurses I have studied was concerned about staff cover, senior nurse support, the care environment and staff morale, but, also appeared to view nursing more broadly reflecting on issues such as the nurses' contribution to patient care, the nurses' role as a member of the multidisciplinary health care team and the public perception of nurses. She also talked about her own professional development and learning.

The diary entries included reflections about nursing as a profession, the public perception of nurses, the role of the nurse as a member of the multidisciplinary caring team, the care environment, senior nurse support, her training and professional development and her personal attributes and contribution to nursing.

My overall impression was that Staff Nurse I was a caring and committed nurse but felt frustrated by the quality of the clinical environment, the lack of resources, and poor senior nurse support.

Role

Concerning the care environment she commented,

> **"I do feel that we are under intense pressure to provide a service with minimal resources, high staff vacancies, and high staff sickness** but, it is a challenge, a challenge I am enjoying. To try and develop junior nurses, develop the service in ever decreasing resource constraints is actually a challenge that I am enjoying but difficult at times. However, I do feel for the amount of work that I put in the rewards I receive are minimal. That's my own opinion."

When examining the data it was interesting to note that this nurse looked at nursing quite broadly commenting on the culture of nursing, the contribution nurses make to the caring profession and indeed whether nursing could be considered a profession. This wider perspective can be demonstrated by the following comment made about the nursing profession:

> **"I consider nursing to be a profession in its own right, given that nurses that are trained now and certainly the training that I undertook have a high level of knowledge and expertise and also the respect of other professions.**

This broader view of nursing was emphasised further when she talked about the culture of nursing referring to differences in nursing structure in the current organisation where she is working compared with a previous post:

> "It was **hierarchical** in its nursing structure. There was a designated shift leader that was always known to everybody. They allocated everything. It was **a lot more structured** in the way that nursing care was delivered there. Here there is a much **more relaxed approach** which was quite difficult to get used to I suppose. The fact that the ward is split into two halves with no definite person in charge for each area, although if you are the most senior person you still take responsibility. The **whole attitude** I suppose is quite **laid back**. That's the way we work here."

She appeared concerned about how nursing was viewed by the general public and felt nurses were undervalued. The following quote taken from the diary highlights this,

> **"I do feel that we are undervalued in our contribution both by the public and by some other groups of health workers. I also feel that senior management at times undervalues the nurses who work on the wards given that they do make up the largest proportion of people who are employed in the NHS, but, also some of the most poorly paid.** I think if you were to compare pay and conditions with similar training who work in IT or recruitment the remuneration and respect that they receive would be that bit higher."

Regarding patients' perception of nurses she commented,

> **"I do feel that nurses are respected by the patients for the role that we have in their care provision and as a relatively senior staff nurse, I feel that I am well respected and also listened to by say for example the medical staff and that my opinions are taken on board and may influence care delivery."**

Regarding patient care it was clear from the data that Staff Nurse H considered that her central or core role was to ensure that the patient was cared for appropriately, to act as the patient's advocate and challenge clinical decisions if they were detrimental to the patient's welfare. Comments like,

> **"I'm quite challenging so, I'm not afraid to question.** Certainly if I feel something is in the best interests of the patient I consider that it is part of my role to actually challenge decisions that are made that I think may be detrimental to the patient. I did feel however, that the respect I have and **the influence has increased as my seniority has increased."**

The following example further confirmed to me that this particular nurse sees the patient as her main focus,

> "I was looking after a patient on the acute admissions ward who had been brought in with essentially a terminal condition. Quite a close family who

were concerned that their relative may die alone and felt they couldn't stay. They were exhausted as a family and I stayed and sat with the patient for several hours until the patient slipped away and died. I also remember the peace of the patient knowing that I was there and also the gratitude of the family knowing that their relative had not died alone. I think fine, there was the argument that well they died but they died with dignity and at peace with themselves. **I had not done a great deal. I was just there and held their hand and talked to them and so I made a difference in somebody's final moment. In fact the last opportunity we ever get to care for somebody. That was very memorable."**

Many nurses I have studied have identified poor working environments, low morale and staff shortages. I was interested to find out given the poor environment what were the positive reasons for Staff Nurse H's career choice. The following was the response to the question,

Q. "Given the pressures and demands of nursing currently, can you sum up in a sentence or two what keeps you in nursing?

A "I'm trying not to sound too text book or corny. **I suppose it's the commitment that I've made, going through training and my professional development to care for a group of people at a time when they are in need of care and support and also the sharing of what I have learnt and the experience I've had with my colleagues in their own development as well.** So, that's the sort of thing that keeps me in nursing. Because I wasn't naive to think that I would be paid millions of pounds to be a nurse. **So, it's the satisfaction that I know when I go home from a shift that the best that I can do for those 27 patients with what we've got available.** That's what makes me stay and **I know that I've helped with somebody else's professional development and learnt from them as well. That's what keeps me in nursing."**

Colleagues

Clearly, Staff Nurse I was concerned about the lack of senior support for nurses because this was referred to on several occasions in the data. In the diary she commented about senior nurses undervaluing the ward nurses role. Highlighted by the following comment,

"I also feel that the nurses who work on the wards are at times **undervalued by senior** management given that they make up the largest proportion of people employed in the NHS."

On another occasion in the diary she commented,

"I feel at the moment I am responsible for a lot of junior members of staff without a great deal of senior support. I think that this is something that is reflected in junior members of staff. They feel **senior members of staff are that bit removed from them and that their decisions and thoughts about nursing are undervalued.** Certainly, from my own experience I have never met the Chief Nurse in any hospital I have worked in, which is an

> unfortunate situation in that junior staff will see these people as some, 'pillars on high', who have very little input on a day to day clinical basis, very little awareness of the modern day to day pressures of health care."

When I questioned this nurse further in the follow up interview about senior nurse support her response to the following question appeared to highlight a general feeling that senior nurse support was often inadequate.

> **Q. In your tape you mentioned that senior nurse support was poor. What sort of support would you find adequate or appropriate?**
>
> A. I think really the issue with that is the **visibility of senior staff.** They are quite difficult to get hold of. In the directorate where I worked before the senior nurse was ward based and very visible. I found that hard when I came here and the F grades that were in post had problems with their own relationships with each other that made it difficult to offer support. Because they were having internal wrangling of their own and issues between each other that they obviously needed to deal with."

When I probed further to find out what level of senior support was available to Staff Nurse I she responded thus,

> "Yes, **there are people at the end of the telephone** however, I do have to say that our senior nurse if you ring him up with a problem **half the time he will leave you to find the solution yourself** which I think if you are referring a problem on to somebody more senior than you, I certainly feel, I need the support of them or sometimes the decision to be made for me and there are certain situations where the answers haven't been forthcoming and I am required to work through the solutions on my own which I suppose is a development exercise for me. But, there have been times when we have been very busy. The management decision is what we will do so that we can get on with something clinical."

From the data Staff Nurse I appeared to understand her role and was clear what her responsibilities were within the multi - professional team.

> "As part of the multi-professional team I suppose I see myself as the nurse in a sort **of co-ordination role linking medicine, nursing and those professions allied to medicine.** Regarding the nurses' role I feel to focus the centre of that sort of group it has to be the patient and I feel at times as a nurse, we have the ability to act as the patients' advocate. In that we know how the healthcare system works and certainly, I'm quite **challenging** so, **I'm not afraid to question. Certainly if I feel that something is not in the best interests of the patient I consider that to be part of my role – to actually challenge decisions that are made that I think are detrimental to the patient."**

Regarding her contribution to patient care, Staff Nurse I described herself as a clinical leader responsible for a lot of junior members of staff. This also included responsibility for students.

> "Because the students are all at different levels, **my own area of responsibility is staff and professional development,** so I take a keen interest in organising the students' teaching programmes. Every Tuesday they have a **teaching session.** It means that they make more of an impact on my time but, **I am the final link for any problems or issues** so, it all comes back to me. It is an area that I have responsibility for. They are a valuable resource and when we have a lot of students they do **make us question what we are doing** because they are fresh and question what we do. The first warders always question what we do which is good for our own development."

The following example further confirmed to me that this particular nurse sees the patient as her main focus,

> "I was looking after a patient on the acute admissions ward who had been brought in with **essentially a terminal condition.** Quite a close family who were concerned that their relative may die alone and felt they couldn't stay. They were exhausted as a family **and I stayed and sat with the patient for several hours until the patient slipped away and died. I also remember the peace of the patient knowing that I was there and also the gratitude of the family knowing that their relative had not died alone.** I think fine, there was the argument that well they died but they died with dignity and at peace with themselves. I had not done a great deal. I was just there and held their hand and talked to them and so **I made a difference in somebody's final moment.** In fact the last opportunity we ever get to care for somebody. That was very memorable."

Learning

There were a number of examples in the data where Staff Nurse I mentions her professional development and examples of learning. Comments such as,

> **"They always question what we do which is good for our own development",** when referring to students on the ward. Another example when talking about senior nurse support and having to work out an issue or problem for one's self thus, **"I'm required to work through the solution myself which I suppose is a development exercise for me."**

Staff Nurse I referred in the diary to her Pre Registration training thus,

> "I feel that the graduate training that I undertook prepared me with an extremely **sound knowledge base for practice and also fostered a questioning attitude** towards my work which means at times I will question individuals or decisions that are made in a sensible non judgemental and constructive manner. And this attitude and ability also, allows me to take **constructive criticism** and also **seek advice** when I am unsure of anything in my career. I feel that the first two years of my grounding sort of course, were very scientific and very structured in nature but, have given me an excellent **basis for which to develop my knowledge** and also to **develop my professional standing within the multidisciplinary team."**

Staff Nurse I has assessed the reasons for her career choice, judged the worth and identified aspects of learning.

Staff Nurse J

This nurse's reflective diary included an interesting combination of contrasts. At times she appeared to struggle with the many demands that she faced on the ward and at other times described circumstances where she appeared to cope well, was confident and appeared to be enjoying the various challenges. The diary described in some depth clinical events, circumstances where she was able to challenge clinical decisions, the interactions with medical and nursing colleagues. She also commented on the nursing culture and the working environment.

When reading the diary entries I formed the opinion that this nurse was at times still coming to terms with the staff nurses role and I was struck by her lack of confidence. She appeared to be concerned about always getting things right, being organised and not relying on colleagues to 'bale me out', as she described it. However, there were as I have indicated previously, occasions when clearly things were going well and she felt confident and in control of her work.

Self

The following description (taken from a diary entry) highlights examples when things appeared to be going well.

> **"I've noticed about myself I'm much happier since I became an E Grade. I think it's something to do with my personality type. If I'm in charge, the decision maker, I will be quick and decisive whereas if I'm not in charge I tend to fanny about a lot.** Having my ability recognised in that I was given my E Grade did a lot for my confidence and motivation."

And on another occasion,

> "Last night was really good. I knew what I was going on. **I was much more in control of things.** We had a much sicker patient who was going into multi organ failure and there was a bit of debate about whether we were treating him a little too aggressively. He wasn't for resus. **But, I felt we shouldn't withdraw treatment because he was elderly and not for resus. I felt happy with that decision and stand by it. I felt we did everything we could for him.** It was nice as well, the doctor who was on was really good, very nice, thoughtful and very good. I totally agreed with everything she decided. I was happy with the decisions she made anyway. **Yes, it was a nice night I think what was nice about it was that I was feeling confident and knew how to handle it. I knew what I was doing.** And I could just get on with it without too many annoying interruptions. **I felt a connection with my patients and the family in this gentleman's case.** And generally everything ran smoothly."

In contrast, when things appeared not to be going so well:

> "I'm not even on the end of my third shift and on my lunch break, its 1 O'clock and I got sent off by my colleagues. Three of us on with 28 patients. (Tearful) A trachy patient that was being specialed in the side room had to be moved down to my bay because we hadn't got a nurse to special him. So I'm on my own in the middle of the bay with two monitors and a trachy patient. We have just had an arrest on me and we got him back. He's got CA so isn't having any more treatment. **I'm really having a problem today. I just feel incompetent. I just didn't have a clue what to do and I feel I should have picked it up before. I didn't think to do any sats on him or anything. I just hate everybody having to bale me out.** The trachy patient kept going on and on about this stupid television he wanted to get. I kept trying to explain to him that I had 10 patients to look after, drugs and everything. **I just feel I can't cope with it. I'm so frustrated by my own limitations, my own abilities. I try so hard to get everything right.** I'll always check a drug if I don't know the name. Other people are all so much more organised. They always have to come and help me out. Do my obs or whatever."

The event is described, broken down into component parts, a judgement is made about the event i.e. what needs to be done differently, for example being more organised, checking the observations of a patient whose condition has changed.

In the data there were many statements that seemed to indicate that this nurse thought about her practice and assessed her input.

Many of the nurses that I have studied have identified that an important role of the nurse is of advocate for the patient. This on occasions involves being critical and proactive and at times challenging doctors' decision making for the benefit of patients.

Staff Nurse J described in detail such a situation in the diary thus:

> "There was an interesting case last night. In January this year I had an elderly gentleman admitted with a G.I. bleed and basically he was one of the sickest patient's that I have ever looked after. He needed to be in high dependency but there isn't a medical high dependency in the hospital. Anyway I ended up specialing him for four nights. **I kind of felt I had saved his life.** His demands were so great. He was made not for resus. **I pushed and pushed to have that decision reversed because I felt it was inappropriate given his history and I didn't feel we had ruled out every possibility with him. It was reversed the next day. I felt it was a point of pride. One of my proudest moments since I qualified.**
> Anyway when I went for my E Grade interview he was on the ward and he was looking really well and I just remembered myself basically keeping him alive by shouting at him and not letting him die.
>
> Anyway I felt very pleased to see him looking so much better.
>
> And last night he was readmitted, not long after he was discharged. I was admitting him and he basically almost word for word said to me, 'what was the point of saving my life because my life is rubbish.' He had come back in with congestive cardiac failure and he had a string of problems since admission. **I felt what was it all for? Why did I bother spending those four days and nights even trying to save his life? Not for his sake. I** didn't know how his life was going to be afterwards. **Maybe I should have questioned having pushed to have his resus reversed. I thought it was right at the time but, it took 'the wind out of my sails' a bit."**

She has described articulately a clinical dilemma, has judged the worth of the situation. It demonstrates the nurse challenging the decision making process and finally includes a change of perception. I.e. should she have questioned the resuscitation being reversed?

Staff Nurse K

In the data this nurse described her role, the type of patients being cared for. The diary entries included details about particular patients she was caring for as well as details about how clinical work was allocated. Like many of the nurses I have studied she commented on staff shortages, stressful situations and heavy workloads. She described her particular responsibilities in the team, her learning and professional development and also included a detailed description of an 'away day' she was involved with that had been organised for the nursing team to address low morale, high staff turnover and lack of teamwork.

When reading over the data I formed the opinion from her descriptions of her work that she was a competent nurse who was clear about her role. She appeared to be a confident nurse who was not afraid to challenge her colleagues and their clinical decision-making. Throughout the data she talked about her learning and clearly was conscious of her career development.

Role/Colleagues

This nurse like many others that I have studied described situations where she appeared proactive and functioned as an autonomous practitioner. The following is a typical example (an extract from the diary) where she challenged a member of the medical team. In her description of events she also advised the doctor what he should do.

> "The nights were quite busy. We had one lady who was seriously ill; she had an emergency laparotomy because she went into sub-acute bowel obstruction. She went to ITU post surgery and came back to us on Friday afternoon. When I came on Friday night she looked very poorly, I couldn't manage to get a blood pressure reading on her with the manual or the dynomat. She had a faint pulse, her resps were only10 per minute, she was on a PCA [patient controlled analgesia] for pain, she had pitting oedema in her hands and legs and her urine output had been 30 mls since 2pm that afternoon. **I immediately called the registrar on call and asked him to come up and review this lady.** He came and reviewed her and advised me to speed up her IV fluids. **I wasn't happy to do this; she appeared to be very overloaded to me. As he didn't know the patient I advised him to discuss her condition with the ITU registrar who had been looking after her post op. I also noted that her albumin was only 8. I asked him to mention this to the ITU registrar- whether she needed an albumin transfusion or not."**

The nurse has challenged the doctor's advice and has instructed him what further action he should take.

Learning

This nurse appeared quite conscious of her own learning and competence highlighted by the following: -

> "Overall, I very much enjoy my job on the ward. I love the speciality of gynae/oncology. I have recently completed the gynae-oncology course that **taught me a lot** about the speciality and has given me **a lot more knowledge.** It has enabled me to **link theory to clinical practice,** hopefully improving patient care. The area that I like best about my job is sharing my **knowledge with other members of staff.** I'm trying to organise for regular teaching to take place on the ward and I've asked each member of staff to become a link nurse and then they can do some teaching on their link subject.
>
> I think during the times of recent change on the ward I've tried to **maintain a stable team by supporting preceptor programmes and becoming a preceptor** for new members. In order to facilitate my preceptorship I aim to commence a **preparation to mentorship course** in October, hoping it will provide me with a broader understanding of effective assessment and teaching strategies, improving my role of preceptor for other members of staff.
>
> I also feel that the staff nurses' meetings that I have been holding have been beneficial even if many do not attend them because through the minutes the nursing team are **informed and actively involved about decisions made about the ward.** I sometimes feel that some of the new members aren't included in decisions about the ward and it makes them feel a bit left out and by holding these informal staff nurse meetings everybody has their say."

From these extracts it can be concluded that she is reflective about her practice and has demonstrated that she practices proactively. Whilst she describes the importance of her own professional development by undertaking various courses to enhance her knowledge she fails to link her learning to clinical experience i.e. identifying from a particular experience what she has learned or how reflecting on this experience has changed her perception.

Staff Nurse L

In the data this nurse described the patients she was looking after, their conditions and their caring needs. She also talked about some of the inadequacies of care environment and the importance of ensuring that patients' psychological needs are met. She demonstrated a patient focused approach to care, clearly demonstrating empathy for the people in her care. She was concerned about her patients as people and particularly emphasised the importance of effective communication as can be demonstrated by the following quote taken from her reflective diary:

Role/Colleagues

> "Tonight I have spoken to a patient who is not even on my ward but, is on the ward opposite and she's an elderly lady, she is terminally ill and has been in for about three months. And one night several weeks ago she was having a lot of pain in the night and I had just gone over to help out a bit, and she really was in a lot of pain and we had to get her written up for some more analgesia even though she was having opiates on a regular basis. After I had given her all the medication I said to her, **'would it help a bit if I stayed and held your hand.'** She said yes, I think it would help. And I stayed with her for about **20 minutes until the intensity of the pain** had eased and she seemed more comfortable and was able to rest a bit. And tonight I've gone over to the same ward to see if I can help out a bit because they have got 2 D Grade nurses on tonight, neither of which have IV qualifications. And the same lady is still on the ward and she is going to a hospice very, very soon and when I went up to her to say hello, she said **you're the nurse that helped me when I had that very bad night a few weeks ago.** And I said yes, I am. And that just shows you because you are ill it doesn't mean your mind has gone. And she said to me tonight, "there are some nurses that do their job but, there are others that have got that little bit extra, do that little bit more.' She said,' that night you really helped me so much just having someone'. Although I couldn't give her anymore analgesia than she had been prescribed but, to do something to make her more comfortable and to stay with her and talk to her and hold her hand. And tonight I thought yes, it's been a good night. A comment like that makes the job worthwhile."

In another example she described the importance of good communication with patients particularly those who are distressed or in need of support and from reading the data the impression is given that she is a caring nurse who values time spent with patients. This can demonstrate by the following comment:

> "I often think when I do a shift that it's not necessarily all the medical procedures that I've carried out or the IV's that I put up or the stitches or drains that I've taken out, sometimes it can **just be sitting with someone and just talking to them. Or if someone is in tears sort of not just leaving them on their own, going and finding out what's happening."**

She was critical of some of the ward facilities thus:

> **"Our ward is doing bench marking on privacy and dignity and I'm afraid some of that is sadly lacking due to just the facilities that we have here.** There is no privacy, the curtains are pulled round but obviously everyone can hear everything. I think sometimes this can be quite difficult. **Difficult for nurses as well as patients."**

Self

Clearly this nurse did spend time thinking about the quality of the care she was providing and was able to articulate clearly, the affects that an inadequate environment had on patients and caregivers alike.

She was able to analyse priorities and judge the worth of a particular event or circumstances.

Differences

From the analysis thus far it has been possible to identify some differences between nurses, the way they practice, think and feel about nursing. The key to these differences, identified when examining dialogues in Chapter five, was that there were two different types of nurses. Nurses who tended to lack an appreciation of self, who were preoccupied with getting the work done and focussing on technical care. And those nurses who were predominantly patient focussed and caring, which tended to have an appreciation of self, consciously spent time thinking about what they were doing and communicating with patients in a thoughtful manner. These nurses were concerned about their own professional development and learning and their relationships with colleagues.

Conversely, those nurses who were more concerned with technical care, completing tasks and getting the work done, tended to spend little or no time reviewing actions or events. I found that these nurses appeared less concerned about other team members tending to focus more on communication with doctors. Status within the team also tended to be important to these nurses.

In this chapter using the conceptual heading of self, role, colleagues and learning previously devised, I examined each nurse and considered differences in the way each nurse performed their role and what differences were demonstrated in everyday practice. I was interested to discover whether a self- aware nurse makes a better nurse and if so, how is this demonstrated in the way she undertakes her role and relates to others.

When examining the data, case-by-case the fundamental difference appeared to be that the **self-aware** nurse tended to be **reflective** whereas the nurse who lacked an appreciation of self tended to be **non-reflective.** Nurses I identified as reflective were patient focused, self-aware, were team players and had an appreciation of their own professional development and learning needs. The non-reflective nurses were more concerned with technical care, completing tasks and getting the work done spending little or

no time reviewing actions or events. The non-reflective nurses appeared to be less concerned about team members and didn't appear to value team working. From the analysis so far it is also clear that whilst there are two main types of nurse, the reflective and non-reflective nurse, it is also clear that there are differences within these two main types. E.g. not all nurses that I have identified as reflective had an appreciation of their own learning but, never-the-less could be considered reflective because they demonstrated an ability to consciously spend time thinking about what they were doing and expressed how they felt about an event. This perhaps suggests that there are different stages or levels within reflection. Clearly, this is a very interesting aspect of the analysis so far and it will be necessary to explore this aspect of the research in more depth. Having identified which nurses are reflective I will now need to examine whether there is any evidence to suggest that graduate nurses are more reflective than non-graduate nurses or have reached a higher level of reflection. In the next chapter I will examine the different stages or levels within reflection.

Chapter SIX

THE REFLECTIVE SCALE

Stages of Reflection and the Reflective Scale

What is reflection

The next step is to define reflection and determine what behaviour is reflective and what behaviour is non-reflective. The definition that follows is my own definition constructed from analysis of the research data so far.

"A nurse who is reflective is self aware, consciously spends time thinking about their actions and feelings about an event and has an appreciation of their own professional development and learning needs."

THE REFLECTIVE SCALE

From the data as I have discussed, it was possible to identify whether an event (described by a nurse) was a descriptive or reflective account using the already stated definition. However, the working definition, as an analysis tool is not sophisticated enough to allow me to determine, (if indeed the nurse was exhibiting reflective behaviour), to what extent she is reflective, what level she had reached in the reflective process. I will now develop a scale to determine this. At the lower end, a nurse who is non -reflective who, is reactive to events, focuses on technical care, who switches to 'auto pilot', and is mostly concerned with getting tasks completed and at the upper end, the reflective nurse who considers her practice in a thoughtful, critical way that may or may not include professional self awareness, learning and a changed perception. And a nurse who occupies the middle ground on the scale that is reflective but doesn't exhibit learning or a changed perception.

I therefore have concluded that this is the best way of determining the degree of reflectiveness of my research respondents by developing a reflective scale and plotting each nurse on this scale.

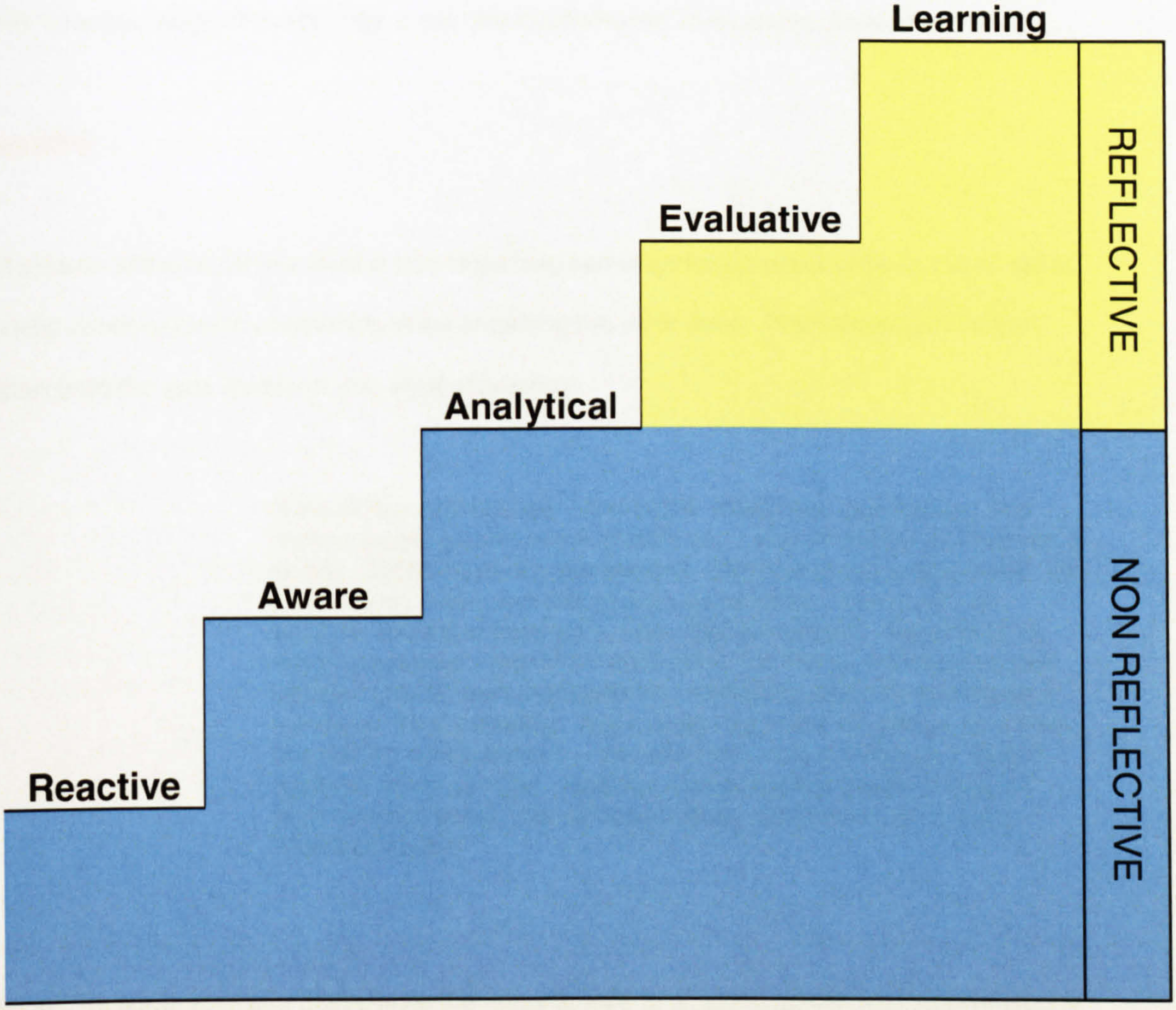
The scale that I have devised consists of five levels of practice with performance characteristics for each level as indicated in the following table:

Level1	Level 2	Level 3	Level 4	Level 5
Reactive	Aware	Analytic	Evaluative	Learning
Non-reactive	Non-reactive	Reflective	Reflective	Reflective
Describes event Spontaneously, reactive response Focuses on completing tasks Focuses on technical Routine skills	Can make sense of event	Assesses event Can articulates how they feel Breaks down experience into component parts Asks why is this happening? What is the reason?	Asks what else can be done? Asks what would be done differently next time Judges worth of Proactive Acts autonomously challenges decision making	Asks self what has been learnt Change of perception

TABLE: 7 LEVELS OF REFLECTIVE PRACTICE

Figure 1

STAGES OF REFLECTIVE PRACTICE (CREBER, 2006)



This scale will allow me to plot where the nurse is in terms of their practice, whether they are reflective or not and if they are reflective, at what stage of the reflective process have they reached. I anticipated that the degree of reflective behaviour exhibited by the nurses would change depending on the circumstances of an individual's practise. This scale I hope would show these variations.

I will now discuss each point in the scale and illustrate with an example taken from the data.

Reactive

The nurse operating at this level is non-reflective, can describe an experience or event, but is mostly concerned with completing tasks or getting the work done. The following example taken from the data illustrates this level of practice:

> "One of four night duties – first night. Had three qualified on, that makes a change and two A grades on. I was in charge as I was an E Grade. Didn't have any admissions, didn't have any empty beds. It's Tuesday so, had a number of post op patients. A lady with an epidural started to have pain, had a bolus injection. Major post op surgery patients – lots of I.V antibiotics, I.V. fluids, maintaining fluid balance charts, pain management, managing patients' nausea and vomiting. That's it really. Not a quiet night kept on going. Had a lot of patients' with pyrexia's – the ward was very hot though? Didn't really sit down all night. Had our normal breaks though – had an hour and half break, not so busy that we didn't have our breaks. That's all really."

It could be suggested that at this level the nurse is able to respond quickly and spontaneously without giving very much thought to the activity. A nurse practising at this level is mostly concerned with technical care. It has been suggested that professionals who practice like this have reached a state of over learning. Schon (1983, p42) describes this situation, in the following way, 'as practice becomes repetitive and routine and as knowing in practice becomes extremely tacit and spontaneous, the practitioner may miss important opportunities to think what he is doing'. Benner (1996) recognises this state amongst some nurses who she says, "seem to get stuck in an unchanging form of practice that severely restricts the

development of their clinical knowledge and their ethical judgement." This mode of practice she describes as, 'impediments to the development of clinical knowledge.' Benner found that nurses who practise in this way have great difficulty remembering details about patients they have nursed even though it may have nursed them very recently. This included lack of detail of a patient's condition or drug therapy.

Aware

At this level the nurse can describe and make sense of an experience or event. But, like the nurse operating at the reactive level, is mostly concerned with technical care, the completion of tasks and is also, non reflective. When examining accounts of their practice, it is possible to see that they are able to make sense of an experience or event and do not simply describe their practice in terms of a series of jobs/ tasks. An example from the data to highlight this level would be:

> "We had one lady who was seriously ill; she had an emergency laparotomy because she went into sub-acute bowel obstruction. She went to ITU post surgery and came back to us on Friday afternoon. When I came on, on Friday afternoon she looked very poorly. I couldn't manage to get a blood pressure reading on her with the manual or dynomat. She had a very faint pulse, her resps were only ten per minute, she was on PCA for pain, she had pitting oedema in her hands and legs and her urine output had been 30 mls per hour since 2p.m that afternoon. I immediately called the registrar on call and asked him to come up and review this lady."

This quote highlights that at this level the nurse can not only describe the experience but, also understands what is happening, i.e (that the patient's condition is deteriorating). Whilst at this level the nurse is still mostly concerned with tasks or jobs to be completed she is also able to think about the reasons why a particular event has occurred.

Analytical

At this level of practice the nurse is able to a assess a situation, breaking the experience/ event down into component parts, is able to explore the reasons why a situation has arisen

and finally be able to describe how they feel about the experience. The nurse practicing at this level is operating reflectively (at the lower end of the scale) but, never- the- less is thinking about her practice in a thoughtful and questioning manner. An example of this level (taken from the data) is:

> "Had a very abusive patient who tried to slap a member of staff and then tried to slap me. This situation arose due to shortage of staff really. We had a gentleman pass away, we were busy with this gentleman in the side room and this lady wanted some analgesia, obviously she couldn't find a member of staff to speak to and basically lost her temper when she did find someone. The whole situation affected me really because, the man who passed away, I felt I couldn't give him enough time and enough care when these events occurred which I found quite upsetting really."

It can be seen with this example that the nurse has described the situation, has made sense of the event but, has also described how she feels about the situation. She has identified that the patient lost her temper because she was unable to find the nurse to give her some analgesia; in addition she has described how she feels about the situation, (quite upsetting).

Evaluative

At this stage the nurse has taken her practice to the next level, and in addition to the analytical level has thought about what else could have been done and what would be done differently next time. The nurse operating at this more sophisticated level of reflection, is able to judge the worth of a particular situation or action, It might include being proactive or acting in an autonomous manner – i.e. advocating on behalf of a patient or challenging a doctor's decision. An example of this level is:

> "I think as well, largely because of staffing problems you make sure people are safe, that the trachy's are not blocked off. Unfortunately the other caring aspects of nursing, for example making sure the tracheostomy is clean, the tube ties are clean...sometimes they have to take a back seat because you are so busy just making sure people are safe at this moment in time. Post Op's – making sure their obs are o.k. Yes, the caring aspects are put back slightly because you don't have the time to do that and I think that's when you come off shift feeling really deflated."

This example taken from the data is evaluative because the nurse is making a judgement of the worth of her actions – the priority being making patients safe when the ward is very busy.

She has recognised that when the ward is busy the caring aspects of nursing have to wait; the priority being to ensure the patient is safe.

Learning

At this level the nurse in addition to judging the worth of a particular situation or action is able to identify what they have learnt from the experience and might also be able to demonstrate a change of perception. An example of this level of reflection would be:

> "But, I learnt so much from being on duty last night watching another staff nurse performing all these tasks. It just made me realise if it happens to me that I need to think logically, I need to be calm and hopefully, now after seeing that I could manage to do it myself if it ever happens to me on duty. I feel more confident in anticipating something like that happening and knowing what to do now."

This quote highlights that the nurse cannot only describe the event, make sense of it, identify what she would do in similar circumstances but, also how she felt about the situation and finally what she has learnt.

CHAPTER SEVEN

DIFFERENCES BETWEEN NURSES

In chapter six I devised a scale that can be used to identify which nurses are reflective and those who are not. Using this scale it is possible to plot the degree of reflectiveness each nurse exhibits. I will now consider each nurse in turn, identifying whether the nurse is reflective and to what degree. A summary is provided at the end.

Staff Nurse A – non graduate

This nurse's account of her practice was routine and repetitive, demonstrating a preoccupation with completion of tasks and getting the work done. The data suggests that she spent most of her time reacting to various demands in a superficial, erratic and non-reflective manner.

Overall the data demonstrates that this nurse is reactive [and non - reflective.]

Staff Nurse B - graduate

This nurse's description of nursing activities was discussed with an emphasis on patient care rather than a description of work to be done and tasks to be completed. She appeared to value working in a team and often commented on how she and other staff were feeling. She is able to function autonomously, challenge a doctor's decision and advocate for a patient.

This nurse has demonstrated that she is a reflective nurse and has met all levels of the scale.

Staff Nurse C – graduate

The data suggests that this nurse was thoughtful, cared about her patients' and was concerned about whether she was doing a good job or not. She was self aware, conscious about her professional

development and identified examples of learning experiences in practice. She often commented about how she felt about events and critically evaluated situations well.

This nurse is reflective and has demonstrated in the data all levels of the reflective process.

Staff Nurse D – non-graduate

In the data there were examples of this nurse acting proactively following careful thought and reflection. She clearly found nursing enjoyable and challenging yet, at the same time often frustrating and difficult. She often commented on the feelings of patients' as well as junior nurses in the team.

This nurse is reflective and has demonstrated in the data that she has reached the level of critical evaluation of practice.

Staff Nurse E –non graduate

The majority of this nurse's diary lacked detail and depth. She made no reference at all to professional development or learning. Her description of practice consisted of a series of tasks to be completed. She appeared to spend little time thinking about what she was doing or communicating her feelings about events.

[Non-Reflective and] reactive

Staff Nurse F – non graduate

From the data it is clear that this nurse is experienced and confident enough to manage the demands of a busy medical ward without supervision and appeared clear about her role. She expressed opinions about events clearly. She is self aware and conscious about her professional development. She is assertive and not afraid to challenge colleagues in the interest of patient safety. There were examples

in the data of the nurse acting proactively, intervening in clinical situations. She has a wider concept of the nursing profession as a whole.

Overall the data demonstrates that this nurse is reflective and has met all levels of the reflective scale.

Staff Nurse G – non graduate

This nurse mostly described workload, types of patients to be cared for, tasks to be completed with an emphasis on technical care. There was little mention of interactions with patients or colleagues or attempts to analyse events or describe how she felt about her nursing work. Descriptions were brief, lacked detail and appeared to be mostly concerned with getting the work done.

[Non-reflective and] reactive

Staff Nurse H – non graduate

This nurse talked about her thoughts about nursing as a career, her anxieties and areas of practice that she could have improved upon and her role with students, medical staff and managers. The data included very little about technical care, getting the work done or about staff cover but, tended to focus on holistic care of the patient and the broader issues of her role as a member of the profession. She was conscious of her development needs and identified opportunities to develop her practice. She often referred to how she felt about events and was able to critically evaluate events well.

Reflective. Has met all levels of the reflective scale.

Staff Nurse I – graduate

This nurse was concerned about staff cover, senior nurse support, the care environment and staff morale but, also appeared to view nursing broadly reflecting on issues such as the nurse's contribution

to patient care, the nurse's role as a member of the multidisciplinary health care team and the public perception of nurses. She also talked about her own professional development and learning, her personal attributes and her individual contribution to nursing. She is self aware, able to critically analyse her practice and challenge doctors' decision-making.

Overall, the data demonstrates that this nurse is reflective and has met all levels of the reflective scale.

Staff Nurse J – graduate

In the data there are a number of statements to indicate that this nurse often reflected about events from practice. She described in detail clinical events, circumstances where she challenged clinical decisions and described interactions with colleagues. There were examples when she acted proactively, challenging doctor's decision-making. The data in her diary entries suggest that she is self aware and conscious of her limitations as well as her strengths. She is aware of her professional development and learning needs.

Overall the data demonstrates that this nurse is reflective and has met all levels of the reflective model.

Staff Nurse K - graduate

From the data it can be concluded that this nurse is reflective about her practice and has demonstrated that she practices proactively and has reached the level of evaluation. She described examples from her practice where she was not afraid to challenge her colleagues and their decision-making. Whilst, she describes the importance of her own professional development by undertaking various courses to enhance her knowledge she fails to link her learning to clinical experience, i.e. identifying from a particular experience what she has learned or how reflecting on this experience has changed her perception.

Overall the data demonstrates that this nurse is reflective and has reached the level of (critical) evaluation of practice.

Staff Nurse L – **graduate**

In the data this nurse mostly described clinical events and was able to critically analyse events and reflect on her contribution to care. No reference was made to professional development or learning needs.

Overall, the data demonstrates that this nurse is reflective and has reached the level of critical analysis of practice.

Having identified which nurses were reflective and which are non reflective, the following table plots each nurse on the reflective scale and summarises the stage of reflectiveness the nurse has reached.

FIGURE 2 **LEVELS OF REFLECTIVE PRACTICE:Summary of research subjects**

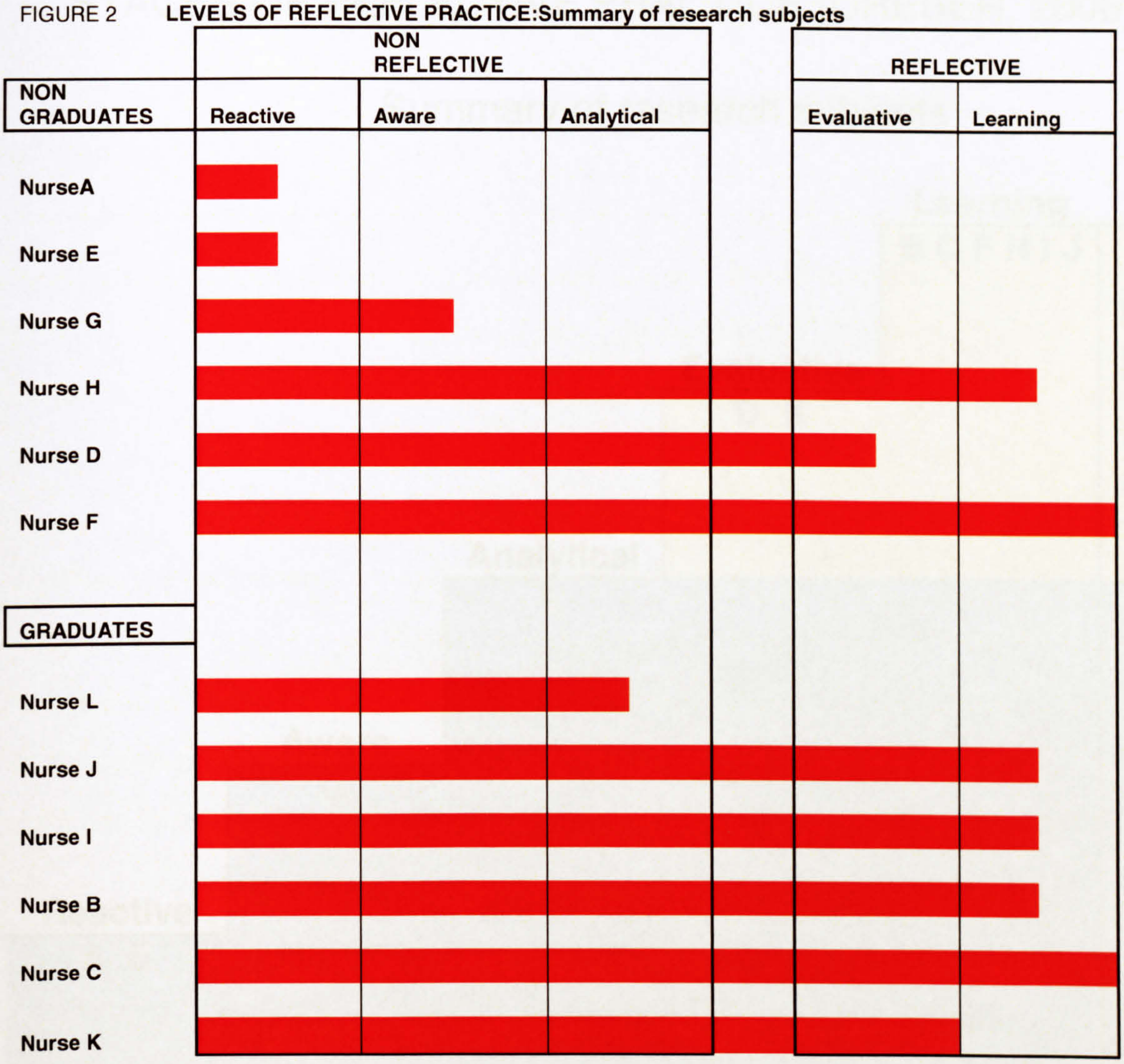
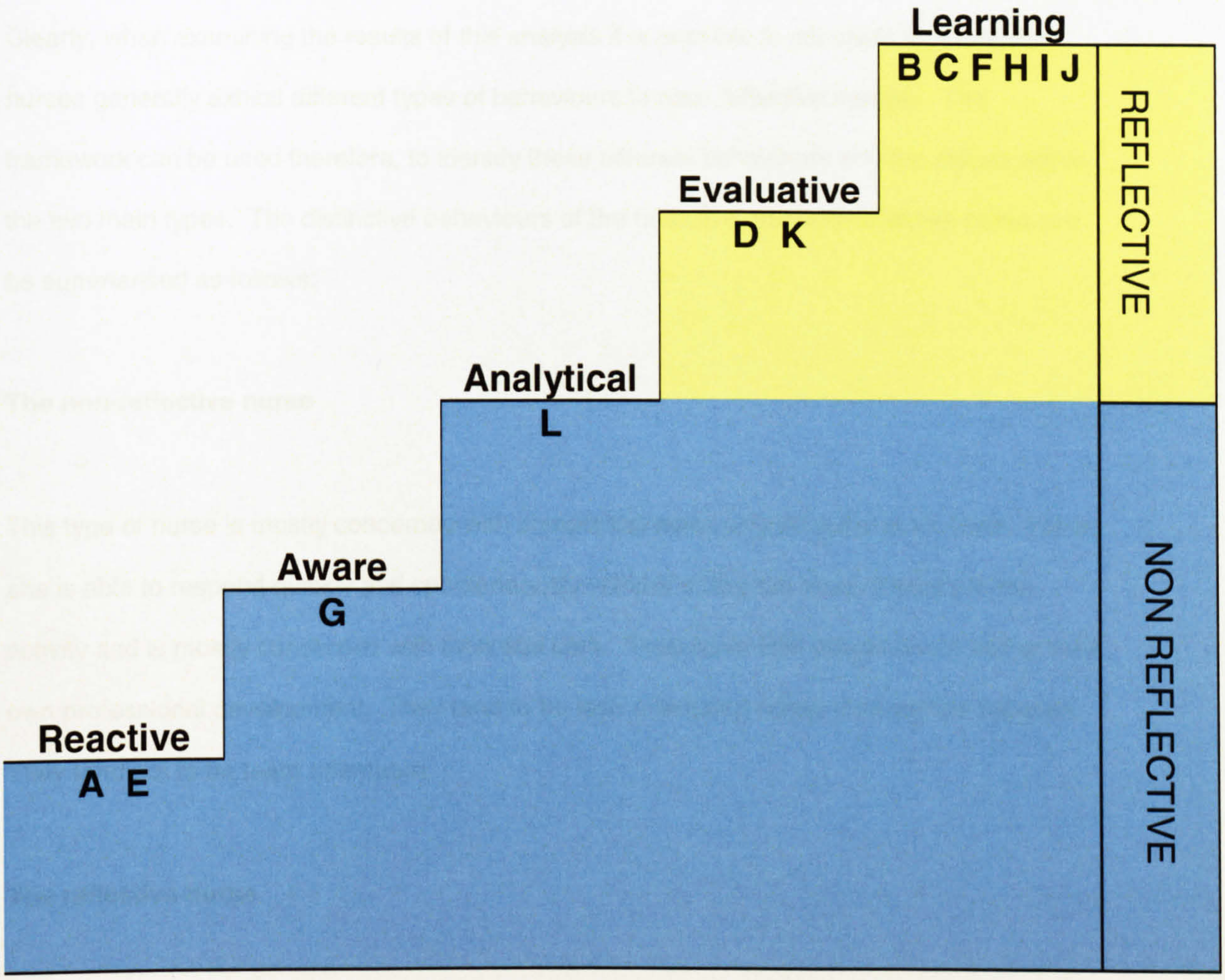


FIGURE 3

STAGES OF REFLECTIVE PRACTICE (CREBER, 2006)

Summary of research subjects



Summary

The results of this research not only provide new insights into contemporary nursing practice but also, also demonstrate that there are differences in the way nurses tackle the demands and challenges of every day nursing practice and perceive their role and professional development.

Clearly, when examining the results of this analysis it is possible to conclude that reflective nurses generally exhibit different types of behaviours to non- reflective nurses. This framework can be used therefore, to identify these different behaviours and the stages within the two main types. The distinctive behaviours of the reflective and non-reflective nurse can be summarised as follows:

The non-reflective nurse

This type of nurse is mostly concerned with completing tasks or getting the work done. He or she is able to respond quickly and spontaneously without giving too much thought to the activity and is mostly concerned with technical care. They have little insight about self or their own professional development. They tend to be task orientated rather than patient focused. They tend not to be team orientated.

The reflective nurse

A nurse who is predominately patient focussed and is genuinely concerned about the patients they are caring for. They have an insight about self, are concerned about their own professional development and learning. These nurses tend to think about their practice in a thoughtful and questioning manner and regularly review their practice, are able to judge the worth of a particular situation or action, which may include being proactive or acting in an autonomous manner. This process often results in a change in perception or learning. They

tend to articulate how they feel about an event. They are generally team players and value team working.

Reflective	Self	Role	Colleagues	Learning
	Self aware Can identify areas of weakness Can articulate how they feel about events Regularly reviews practice Acts autonomously	Patient focussed Caring Proactive Thoughtful about practice Patient advocate Challenging decision making Has broad concept of profession	Challenges colleagues Is assertive Team player Talks about team rather than self i.e "we" rather than" I"	Identifies learning from experiences Concerned about professional development Reviews events leading to change of perception/learning
NonReflective	No concept as a nurse of self Not articulate Does not review practice Unable to articulate feelings	Concerned with completing tasks Can respond quickly, spontaneously without much thought Task orientated Technically focused Reactive	Not a team player Doctor focused	No concept of learning from experience

TABLE: 7 SUMMARIES OF REFLECTIVE/NON REFLECTIVE BEHAVIOURS

CHAPTER EIGHT

THE THEORETICAL FRAMEWORK

The theoretical framework, that I have developed, has shown that there are different types of nurses characterised by certain behaviours. The research has identified two main types of nurse, reflective and non-reflective and has built up a picture of those behaviours that characterise the reflective nurse and those behaviours that characterise the non- reflective nurse. It also shows that there are different stages or levels within the two main types of nurse. It has attempted to explain the complexities of contemporary nursing practice providing further insights into how nurses perceive their role, communicate with colleagues, and view their professional development and learning. Moreover, the research suggests that nurses approach their work differently as they cope with the various demands and challenges of everyday practice. For example, reflective nurses were predominately patient focussed and caring, tended to have an appreciation of self, consciously spend time thinking about what they were doing and how they were communicating with patients in a thoughtful and reflective manner. These nurses were concerned about their own professional development and learning and their relationships with colleagues. Non-reflective nurses' on the other hand, lacked appreciation of self, tended to be preoccupied with getting the work done and mainly focused on technical care.

Contemporary nursing practice

The research has provided some interesting insights into contemporary nursing practice, highlighting that nurses are bothered about the care they provide for patients/clients and often feel frustrated when the care environment is less than satisfactory or when there is lack of time or staff to do things properly or meet everyone's needs. Effective communication with patients, relatives and staff members is highly valued and considered an essential component of good practice. The research has also, highlighted that nurses value a supportive environment and good senior nurse support appears to affect how a nurse deals with stressful situations such as a cardiac arrest, coping with terminally ill or distressed patients but, also affects how the nurse feels about herself, her role, her competence and

confidence. Interestingly, those nurses who demonstrate an ability to reflect on their practice and their skills seem to be able to articulate what it is that gives them a "buzz" about nursing, when they have had a good day or have felt positive about their input. For example when they have helped a distressed patient or challenged a medical decision resulting in a positive outcome.

Reflective Practice– How may it is defined?

From the research I have offered the following definition of reflective practice thus:

> ***"A nurse who is reflective is self aware, consciously spends time thinking about their actions and feelings about an event and has an appreciation of their own professional development and learning needs."***

How does my definition compare with the literature?

When examining the literature on reflective practice it is clear that there is a plethora of literature on the subject, but many writers appear to be in agreement that it is generally a good thing but, that there is no clear understanding of what constitutes reflective practice. Various definitions are offered.

Some writers believe that reflective practice can be traced back to Dewey who was considered to be one of the first proponents of reflective thinking in the 1890's (Mackintosh 1998) {cited in Cronin & Rawlings-Anderson 2004.} Like my definition, many writers agree that reflection is concerned with critically examining a situation, being able to describe it in detail, exploring how one feels about it, identifying learning and considering future action. It is a process that includes intellectual and affective activities where individuals explore their experiences in order to lead to new understandings and appreciations (Boud el al 1985)

Reflection is firstly, the process by which an experience is brought into consideration, while it is happening or subsequently; and secondly, the creation of meaning and conceptualisation from experience (**Brockbank and McGill**, 1998)

Critical reflection, which occurs as a result of critical debate within oneself and possibly with others, may develop ones potential to look at things other than they are. This type of reflection is important in the development of new ways of being a professional, and in creating transformative learning consistent with the critical paradigm (Mezirow, 1981) as it relates to knowledge generation.

The nursing world is probably most familiar with the work of **Schon** who describes two different types of reflection: reflection in action and reflection on action. The former is concerned with reflecting whilst undertaking an activity and the latter is reflecting by looking back on a situation after it has occurred. Schon is also well known for the way he described professional practice and the problems practitioners face. He referred to the high ground as manageable problems and the swampy low land where messy confusing problems defy technical solution. Problems on the high ground he suggested are relatively un-important to individuals and society but those in the lowlands are problems of greatest human concern. He suggested that practitioners choose whether to remain on the high ground (where problems are solved relatively easily) or to venture into the swampy lowlands where problem solving is more difficult and does not conform according to prevailing standards. Whilst, Schon's work is an important contribution to reflective practice knowledge there are some writers who criticise him for not recognising the importance of reflection before action. (Greenwood 1993, 1998; Burrows 1995).

Schon, also described repetitive and routine practice as a stage of over learning where practitioners respond quickly and spontaneously without giving very much thought to activities. Benner similarly referred to this situation as, being stuck in an unchanging form of practice that severely restricts the development of clinical knowledge and ethical judgement.

Some writers believe that reflection is initiated by exploring a problem or a worry whilst others believe that reflection can be used to explore any aspect of everyday practice, identifying learning and exploring how a nurse might do things differently. As I have identified, most writers agree that reflective practice is a cycle or can be considered to consist of different stages. (Kolb and Fry 1975) outlined three stages of reflection. The first stage involves returning to the experience and describing it in detail, the second stage involves attending to feelings and the third stage is where the experience is

re-evaluated. Boud el al (1985) cited in (Cronin & Rawlings-Anderson 2004) suggest that four aspects should be considered:

- **Association** – the connection of ideas and feelings from experience being fitted with existing knowledge and attitudes.
- **Integration** – the processing of associations. Relationships are observed and conclusions drawn in order that new patterns of ideas and attitudes develop.
- **Validation** – new appreciations are tested for internal consistency.
- **Appropriation**- new knowledge and perceptions are assimilated into the individual's value system.

The outcomes of this model may be new perspectives on an experience and a readiness to apply new insights in the future. However, Boud et al warns that the benefits may be lost if individuals fail to link reflection with action.

The reflective stages that I have identified in my research consist of three levels thus:

- **Analytical** – assessing the situation; identifying how they feel; breaking the event down into component parts; asking self why it is happening? What is the reason?
- **Evaluative** – what else could have been done? What could be done differently next time, judging the worth of the event, challenging a decision or being proactive?
- **Learning** – Asking what has been learnt? Is there a change of perception?

Reflection and Critical Thinking

It is suggested in the literature that **Reflection** is related to **thinking.**

Meleis (1997) suggests that critical thinking is to do with exploring, describing patterns, and discrete facts but is also about engaging in individual ontological dialogues as well as discussion with others.

A theoretical thinker is a reflective thinker who suspends the fragmentedness to allow exploring, explaining and interpreting of wholes. (Meleis, 1997)

Much of the literature written about contemporary nursing seems to suggest that reflective abilities are a necessary requirement/attribute that modern day nurses should possess.

Referring to the modern nurse, (Kuiper 2000:116) suggests that she is, "a self-regulated individual, (who) requires a dependable experiential knowledge base, uses cognitive critical thinking strategies in a reflective manner, and is affected by social and cultural influences." The self-regulation model pivots on: (a) metacognitive self-regulation, which involves critical thinking and information processing (b) behavioural self-regulation based on reflective practice; and (c) environmental self-regulation in terms of nursing social interaction in the clinical context. (Mason & Whitehead 2003, p.111)

This point is further confirmed by the UKCC thus: -

> "The UKCC expects all registered nurses to engage in some form of reflective activity and to keep a personal professional portfolio which includes reflective accounts of practice (UKCC 1990, 1997b)."

UKCC Commission for Nursing and Midwifery Education (**UKCC** 1999, p.38) stated that pre-registration students must be able,

> "To demonstrate critical awareness and reflective practice."

Whilst the Nursing & Midwifery Council (formally the UKCC), advocate that pre-registration students must demonstrate critical awareness and reflection, the reality is that this is not always the case as has shown in my sample. The implication of this for educationalists is that more attention must be given to those nurses who are not reflective. Firstly, these nurses must be identified and secondly, they must be helped to develop and become reflective practitioners.

Other terms discussed in the literature associated with reflection and reflective practice is guided reflection, reflectivity and reflexivity.

Guided reflection is, 'a process of self-inquiry to enable the practitioner to realise desirable and effective practice within a reflective spiral of being and becoming'. (Johns 2001, p. 238)

Reflectivity – the capacity to undertake self-reflection, and to evoke this in others, in order to challenge and overturn traditional ways of thinking (Mason & Whitehead 2003, p40)

Mason & Whitehead describe **reflexivity** as a complicated affair where the human mind bends back on itself or can apprehend it. The mind cannot only think but can hold itself up for thinking about what it is thinking. It can bring into focus its present state as well as relating it to both past experiences and future possibilities. (Mason & Whitehead 2003, p.33)

Recognising particular types of nurses

The research has identified two main types of nurse, reflective and non-reflective and has built up a picture of those behaviours that characterise the reflective nurse and those behaviours that characterise the non- reflective nurse. It also shows that there are different stages or levels within the two main types of nurse. Using this framework it will be possible to not only identify the reflective and the non-reflective nurse but also plot at what stage the nurse has reached on the reflective scale, providing a useful means of assessing a nurse's performance and identifying development needs. It can also indicate when a nurse has regressed or slipped back in terms of their practice and can be useful for individual nurses to use as a self-assessment tool which provides feedback of their practice, their communication with colleagues and their professional development needs. Because it is simple to use and can be shown in a diagrammatic format it is easy to see at a glance the stage that the nurse has reached, by matching the behaviours the nurse exhibits to the framework. The tool will allow educationalists and managers a means by which they can plan and organise mentorship, supervision and teaching.

Explaining reflective practice – Why are some nurses reflective and others are not?

Having identified differences amongst nurses, how can these differences are explained? At first glance it would appear that a reflective nurse might be developed by some of the following:

- Appropriate education input i.e teaching/learning strategies to develop self- awareness, reflective abilities.
- Good mentorship in practice
- Good role models in practice

But, could there be another explanation? Could it for example be argued that reflective abilities develop when there is a need, opportunity or stimulus? This might include one or some of the following:

- To meet personal expectations/high personal standards. The drive to constantly be reviewing personal strengths and improving weaknesses
- To meet the expectations of colleagues, patients and relatives.
- Career enhancement
- Stress/low morale
- Challenging patients and colleagues
- To correct or adjust for a poor working environment
- Personal satisfaction of doing a good job for patients/clients

If one accepts the idea that nurses who are naturally reflective are imaginative, creative with a natural ability to be self-aware, the consequences are that not all nurses have the ability to be reflective.

Although it is possible to improve reflective abilities with education and guidance (guided reflection) it is unlikely that this will be successful if the nurse has non-reflective tendencies. This might at first glance seem a somewhat unlikely hypothesis until one considers why is it that some staff nurses fail to become reflective practitioners even though they may have had substantial input during their Pre-Registration training and following qualification in continuing professional development whilst other nurses who have had very little or no education input, are clearly reflective practitioners.

CHAPTER NINE

DISCUSSION

Whilst, this study has identified differences between nurses this was not determined by whether the nurse was a graduate or a non- graduate. A theoretical framework was developed which identified different types of nurses characterised by different behaviours. The differences were to do with self-awareness, how nursing is practiced, and relationships with colleagues and how learning is structured.

Two main types of nurse, reflective and non- reflective were identified characterised by certain behaviours. It also shows there are different stages within the two main types. The **non- reflective** nurse was mostly concerned with completing tasks or getting the work done. They were able to respond quickly and spontaneously without giving too much thought to the activity and was mostly concerned with technical care. They showed little insight about self or their own professional development. They tended to be task orientated rather than patient focused. They tended not to be team orientated. On the other hand the **reflective nurse** was predominately patient focused and was genuinely concerned about the patients they were caring for. They had an insight about self, were concerned about their own professional development and learning. These nurses tended to think about their practice in a thoughtful and questioning manner and regularly reviewed their practice, were able to judge the worth of a particular situation or action, which might include being proactive or acting in an autonomous manner. This process often resulted in a change in perception or learning. They tended to articulate how they felt about an event. They were generally team players. Whether a nurse is reflective or not was not necessarily related to graduate status. This is an interesting finding because I would have expected that the graduate nurses would be the reflective because their training places greater emphasis on research and deeper study with an enhanced level of analysis, synthesis and decision-making. It could also be argued that because the graduate groups are much smaller than the diploma groups there is more opportunity to meet individual student needs through facilitated group activities. The findings have concluded that **three out of six non- graduates were reflective.** Of the **graduate group one nurse was not reflective and five were reflective.** Of those nurses that could be regarded as reflective, five had reached the level of evaluation, four the level of learning (three non-graduates; five graduates) with two of the graduate nurses reaching the stage of learning, two non-graduates (using my framework of reflective practice).

The results of the research provide new insights into contemporary practice and demonstrate differences in the way nurses tackle the demands and challenges of everyday nursing practice and perceive their role and professional development. Furthermore educating nurses to graduate level did not necessarily produce a reflective practitioner.

Because there is little evidence to suggest that a degree programme leading to registration is better than a diploma programme (Clinton, Murrells 2005), these findings, also, raise the question about whether degree or diploma programmes are better in respect of developing reflective practitioners. Furthermore, if it is unclear what the benefits of educating nurses to degree level are (in terms of competency and patient outcomes), the question to perhaps ask is, will making nursing an all graduate profession produce better nurses?"

Provision of three- year pre-registration nursing degrees in the U.K has increased in recent years and in many Universities degrees are offered alongside the existing three-year diploma courses. Yet, it could be argued that little is known about the relationship between these different educational programmes and the competence of the qualifiers.

Reform of nursing and nursing education

The past decade has witnessed a period of considerable change in the educational preparation of nursing in the UK. Traditionally, the route to registration followed by the majority on nurses prior to incorporation within Higher Education in the 1980's was a hospital-based course leading to a certificate. Nursing degrees (where offered) were four years in duration, were University based and tended to be for a very small minority of students who were more academically able. The Diploma in Higher Education is generally regarded to be the equivalent to the first two years of a standard undergraduate degree, although the length of both diploma and degree courses in nursing is extended to three years in order to provide the opportunity for students to develop clinical practice skills. Many UK Universities offer diploma and degree programmes alongside each other with some shared learning. The assessment of the theoretical component is the distinguishing difference between the degree and the diploma course, differences in outcomes in terms of practical skills is less clear

(Pleasance & Sweeny 1994). Although all pre-registration nursing courses, be they diploma or degree level, are required to fulfil a common set of learning outcomes specified by the Nurses, Midwives and Health Visitors Act (Statutory Instrument 1989), there are no precise indicators of what the difference between a diplomat and a graduate should be. It is therefore left to individual educational institutions to interpret the statutory requirements in the context of a particular programme with which they are offering. Indeed the (UKCC 1999, pp.32-33) have added to the confusion about what distinguishes a diploma course from a degree rather than providing clarity for educationalists by stating that, the graduate may have "an enhanced level of analysis, synthesis and decision making", but, then concludes that the diploma course is a "close approximation to graduate level". Girot (2000a) questions whether the profession is aspiring to one level of competence with two different academic awards or two different levels of competence.

Whilst this study has identified differences between nurses, the findings have not shown that graduate nurses are necessarily better than non-graduate nurses. The findings have revealed that both graduate and non-graduate nurses have similar concerns about how nursing is practiced, the care environment, relationships with colleagues and thoughts about learning and profession development. As the literature suggests it is not obvious in term of practical skills what the differences are between graduates and non-graduates. Certainly, the research has not shown any significant differences between graduate and non-graduate nurses in terms of what they think about or what concerns them.

Graduateness

If there is a clear understanding of what graduateness is, it should be easy to distinguish the differences between a diploma and a degree. Herein lies the difficulty because there appears to be conceptual confusion regarding what exactly graduateness is, what graduateness should be and how graduateness relates to competence. The regulatory body for nursing and midwifery have done little to clarify this confusion by suggesting that the diploma course is a close approximation to graduate level. However, recently the Quality Assurance Agency for Higher Education (QAA 2001) has attempted to clarify the differences between diploma and degree courses by identifying the standards required of nurses qualifying from diploma and degree courses. Although there are similarities the statements for graduates have a greater emphasis on critical evaluation, working strategically, drawing on theory,

challenging practice and working creatively. Similarly, Winson (1993) compared the nursing curriculum of the four-year degree and the diploma courses offered at eight Higher Education Institutions and found that the key differences between the curricula was the emphasis in degree courses on research and its implementation in nursing practice. Robinson and Leamon (1999) found that qualities associated with graduateness were managing change, creativity, innovation and leadership, criticality, research based practice, caring and reflective practice. Burke and Harris (2000) investigated the views on graduate nurses of 34 stakeholders responsible for commissioning and contracting education. Stakeholders identified graduates as processing the ability to be reflective, question practice, and make decisions, transfer knowledge and challenge poor practice. They were also deemed to be more sensitive to the needs of clients and had a broader range of skills including technical, analytical and leadership skills.

Although there does appear in the literature to be some consensus amongst educationalists regarding what graduateness should be, assessment of performance however, has produced inconsistent results. Bartlett et al (1998) compared the self-rated and mentor rated competencies of nurses qualifying from a four-year degree course (n= 52) and a diploma course (n = 28) at qualification and at six months and one year after qualification. Although some differences were found during the first year after qualification no substantial or consistent pattern merged from the data. Similarly, Girot (2000b) found no significant differences between the critical thinking skills of students from a four-year degree course, mature graduate practitioners who had recently completed a part-time degree, mature non-academic practitioners and a control group of first year undergraduate students. This study concluded that only exposure to the academic process was associated with better decision making in practice. A study in America conducted by Professor Aitken concluded that patients are less likely to die if they are cared for by nurses who are educated to degree level. This research which examined the cases of 230,000 patients concluded that in hospitals with a higher proportion of graduates four more lives were saved for every 1000 patients undergoing general surgery, compared with hospitals with fewer graduate nurses. This research, which caused a storm in America when it was published, was unable to offer any reasons why graduate nurses have better patient outcomes. Extrapolating these findings to the U.K should be undertaken with care however, because the educational composition of the workforce is different. Further research is clearly needed before any conclusions can be drawn.

The Demands of Contemporary Nursing Practice

The findings of the research has revealed some interesting insights into nursing as it is practice in 21st Century, the pressures and demands that nurses face on a daily basis but, more particularly about how they perceive themselves as nurses, how they relate to other inter-professional team members and how they view their own professional development.

The findings provide some interesting "snap shots" of the working conditions of today's staff nurse and the challenges they face. The quality of the working environment did seem to be an issue for all nurses which, included concerns about the often poor physical conditions which made it difficult to deliver safe, effective care, lack of resources and poor senior nurse support. Stress and low morale within the nursing team were often commented on and many nurses felt that the fundamental reason for this was lack of staff and workload pressures. Nurses often expressed concerns about not having enough time to spend with individual patients or the frustration of not being able to meet their own personal standards of care. The data also, revealed examples of the dilemmas/ challenges nurses regularly faced which included dealing with demanding, aggressive and sometimes angry patients or relatives, confused and very sick patients, as well as difficult, upsetting situations which had a profound affect on the nursing team. They often talked about how stressful situations affected them, often compounded by lack of senior nurse support or inappropriate actions by the nurse in charge. However, they also quoted examples of supportive situations where the senior staff support was seen to be helpful and as one nurse put it, "everyone seems much more comfortable when Sister is on".

The findings have revealed some interesting insights into staff nurses thoughts about their role, which were both positive and negative. They expressed a range of thoughts about how they felt about their role from being upset, feeling vulnerable to feeling happy and enjoying the nursing role. From the data it can be seen that all nurses have good and bad days and no individuals expressed just negative feelings about their role. They often described situations that made them feel good about the nursing role or where they felt they had had a direct impact on patient outcomes or made a difference to care. Typical descriptions of a good day were when there was enough time to do things properly or when time could be spent talking with patients or spending time with them and their relatives.

However, a number of nurses did say there were also times when they felt disillusioned with nursing and questioned why they had chosen nursing as a career or even considered leaving or pursuing a different career. The biggest frustration for many was that nursing in reality was very different to what they had expected when they began their training and they talked about having idealistic expectations and feeling disillusioned when they realised that a qualified nurse spends much of their time dealing with paperwork and administration of the ward rather than with the patient at the bedside. This was something that many nurses commented on and appeared to be a fundamental frustration to many.

From the data it was clear that nurses approached their role differently, some appeared patient focused whilst others described their role in terms of a condition, type of surgery or a technical procedure or task to be completed and very rarely referred to a particular patient. Some nurses emphasised the importance of sitting and talking to patients, indicating that this was an enjoyable and probably one of the most important aspects of the role.

Regarding, communication with colleagues, the findings have revealed that poor communication, lack of appreciation of roles, poor support and differences of opinions concerning patient care is common.

Many nurses saw themselves as the co-ordinator of care within the inter-professional team, linking various staff together, and saw the nurse as the person who initiates care or treatment even though the doctor may prescribe it. However, many nurses commented upon a lack of understanding of individual roles within the inter-professional team, medical staff in particular, were criticised for not appearing to fully understand the nurses' role and were often reluctant to accept nurses' advice when their knowledge was greater than their own. There were numerous accounts in the data where nurses challenged a doctor's decision, acting as advocate for a patient.

The findings also revealed problems with agency staff and lack of support from senior nurses. Although, there were also positive experiences of working with agency staff and senior nurses.

All the nurses in the study made reference to competence and knowledge, except one, who made no reference at all to her own professional development needs. Discussions about learning and professional development included lack of knowledge and competence and identification of learning

experiences. Some nurses made reference to future career development needs, which included plans for future courses whilst, others tended to focus on learning experiences in the clinical area.

Overall, the data seems to suggest that nurses despite technical advances and improvements in treatment still feel that their fundamental role is to care and support patients and their relatives. As one nurse put it, "to care for a group of people at a time when they are in need of care and support and also the sharing of what I have learnt and the experience I've had with my colleagues in their own development."

Reflective Practice Re-visited

Clearly, reflective practice is an important and significant aspect of nursing education and continuing professional development today and many nurses appear to be in agreement that it is generally a good thing yet; there is no clear understanding of what constitutes reflective practice. The Nursing and Midwifery Council has indicated that it expects all registered nurses to engage in some form of reflective activity and to record accounts of practice within a personal professional portfolio. Similarly, The UKCC Commission for Nursing and Midwifery Education has stated that pre-registration students should be able to demonstrate critical awareness and reflective practice. However, when these terms and phrases are heard, they can bring about a range of responses amongst nurses from excitement and positive enthusiasm to gross ambiguity and bewilderment." (Burton, 2000)

Regarding the question of how reflection maybe defined, Johns and Freshwater (1998) suggest that it is an academic pastime to try to define exactly what reflection is and blame this desire to define things "exactly", on the rational perspective of society, thereby allowing it to be controlled and manipulated toward certain ends. However, Atkins and Murphy (1993) felt that this lack of clarity and common understanding might lead some nurses to believe they are reflecting, when in fact they are not. (Ruth-Sahd, 2003). In the literature most authors agree that reflection begins with an awareness of an uncomfortable feeling, involves synthesis, validation and appropriation of knowledge, (Boud & Walker, 1998) and is not simply thinking about an event in purposeful fashion (Burton, 2000). The

definition of reflection that I have identified through this research similarly identified critical self-awareness, analysis and development as significant thus,

> ***"A nurse who is reflective is self aware, consciously spends time thinking about their actions and feelings about an event and has an appreciation of their own professional development and learning needs."***

How does this research compare with other theorists?

I will focus primarily on Benner's (1984) publication, *From Novice to Expert*, although I will also refer to some of her subsequent publications and compare her work with my own as well as other authors on the subject. Benner, attempted to codify and make sense of nursing in the 1980's. Her approach was developed from Heideggerian phenomenology whereby nurse's experiences were described and analysed by nurses themselves by providing paradigm cases upon which they reflected and used to develop their practice. Benner claimed that the problem solving skills of the novice differ from those of the expert and that this difference can be attributed to experience. She suggested five levels of practice - novice, advanced beginner, competent, proficient and expert. The novice or beginner she claims nurses by the book, following non-contextualised rule governed procedures, whilst the expert who:

> "Has an enormous background of experience, has an intuitive grasp of each situation and zeros in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnosis and solutions." (Benner, 1984, p.32)

The way in which experience is interpreted needs clarification, as it does not refer to the mere passage of time. Benner refers to experience as,

> "The refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of difference to theory." (Benner, 1984, p.36)

Experience therefore needs to be processed if it is turned into personal knowledge, and one way of doing this is by reflecting on it. (Rolfe, 1997). Partly as a result of Benner's work, reflection is now widely accepted as an important part of the nurse's repertoire of skills.

When comparing Benners work with my own it is possible to see that there are some similarities but also some differences. For example like Benner I have identified different levels of practice thus, reactive, aware, analytic, evaluative and learning. When comparing my levels of reflective practice with Benner's performance characteristics it is possible to see some similarities between these frameworks. For example the stage of ***awareness*** equates with ***advanced beginner***; the stage of ***analytic*** equates with ***competent*** and the stage of ***evaluative*** equates with the level of ***proficient.*** I was however, unable to match the level of reactive or with the level of learning to Benner's performance characteristics. Also, I was unable to attribute length of experience as an important factor to explain why nurses operate at a particular level as Benner has done because my research respondents had similar experience, and had been qualified for similar periods of time. For example, staff nurses A and B had been working on their wards for longer than two years and according to Benner's performance characteristics should have been at the stage of at least competent yet, I was unable using my framework to assess them at a level other than reactive. Staff Nurse H had been qualified for only six months yet, I assessed her at the level of evaluation, which would equate with the proficient stage using Benner's performance levels, yet according to Benner taking this nurses experience into account she should have been at the level of novice.

One criticism that has been made about Benner's original work is that it has limited the scope of what nursing could become by suggesting that the level of expert was the pinnacle to which nurse should aspire. (Rolfe, 1997 p.93). As Rolfe, has suggested,

> "In light of more recent writings it has been suggested that there is a sixth level beyond expertise which is characterised by mindful practice and informal theory building. At this level, the practitioner constructs informal theory out of practice, applies that theory back into practice, and reflexively modifies the theory as a result of the changed clinical situation." This probably is more in tune with the view that practioners are lifelong learners and therefore will never achieve perfection but will always seek to improve their practice in light of experience.

When comparing my research with the work of Schon it is possible to see that there were a number of similarities. Schon outlined two types of reflection: reflection-in-action and reflection-on-action. The former is related to thinking actively about what one is doing whilst one is doing it. The practitioner tries to make sense of the experience by questioning their approach and critiquing it while the action is

in progress. In contrast reflection-on –action occurs after the event has taken place whereby the practitioner looks back on the event and analyses the effectiveness of the approach. This process allows new understanding of the situation, which can be used to develop future practice. In the data there are examples of both types of reflection. Schon is well known for the way he described professional practice and the problems practitioners face. He referred to the high ground as manageable problems and the swampy low land where messy confusing problems defy technical solution. Problems on the high ground he suggested are relatively un-important to individuals and society but those in the lowlands are problems of greatest human concern. He suggested that practitioners choose whether to remain on the high ground (where problems are solved relatively easily) or to venture into the swampy lowlands where problem solving is more difficult and does not conform according to prevailing standards. In the data there are examples of both types of problems that nurse's encounter. Generally speaking it is the reflective nurses who tend to venture into the "swampy low lands and the non-reflective nurses who prefer to remain on the high ground where problems are solved relatively easily. For example, nurses who are brave enough to challenge a doctor's decision making, advocate for their patients and challenge the status quo can be considered to have ventured into the, "swampy lowlands".

Schon, also described repetitive and routine practice as a stage of over learning where practitioners respond quickly and spontaneously without giving very much thought to activities. Benner similarly referred to this situation as, "being stuck in an unchanging form of practice that severely restricts the development of clinical knowledge and ethical judgement." In the data I found two nurses who could be considered to have reached this stage. Typical examples to highlight this repetitive and routine practice were, Staff Nurse G who described her situation thus,

> "The ward was pretty quiet, had two admissions, two discharges, two admissions – one from A&E, one from the admissions ward. One patient was commenced on I.V. GTN infusion, which we needed a cardiac monitor for which was difficult to find, as there was none available in the hospital. **The duty manager had to get involved who found one for us. Other than that all was quiet."**

This nurse mostly described workload, types of patients to be care for, tasks to be completed and technical care. Interestingly enough, there was very little mention of interactions with patients or colleagues or attempts to analyse care or describe how she felt about her nursing work. Descriptions were brief, lacked detail and appeared to be mostly concerned with getting the work done.

Similarly, on another occasion she commented,

> **"As the ward has been very quiet over the last few days, nothing exciting or challenging has happened.** Had to organise an interesting discharge plan that involved multidisciplinary teams – the disability options team, district nurse, G.P. which all went very well. Other than that nothing else has happened."

I wondered whether this nurses lack of enthusiasm could be attributed to the ward being quiet and she was bored or was it simply the case that she had reached the stage of over learning where they was nothing further for her to learn.

And Staff Nurse A, whose descriptions of her practice lacked depth and appeared to be discussed in a very matter of fact fashion.

Some examples to illustrate this were:

> "It's the second night shift of four. Still had my lady with the epidural in. **Still doing hourly obs and hourly urine with her. Level of block really not working that much. Quite a lot of discomfort, quite a lot of pain, got the anaesthetists up - quite reluctant to take it out.** I did suggest a PCA (Patient controlled analgesia) but, he didn't want to put it up at that time of day. I don't know, I suppose it wasn't convenient for him. **So made the lady comfortable with an antispasmodic for the kind of pain she was feeling and she kind of settled for the night. I kept an eye on her. She really didn't have a level of block."**

This description of a patient in pain suggests to me that this nurse could have done more to relieve the patient's discomfort. When the patient continued to experience pain she could have insisted that the doctor return to see the patient and resolve the problem. Failing this, or if the doctor had refused her request she could have bleeped the duty manager to deal with the problem. Although, she did suggest to the doctor an alternative when he first visited the patient, she failed to follow this through to a satisfactory conclusion. There were other courses of action she could have pursued. She failed to advocate for this patient. This highlights to me that this nurse has become stuck in an unchanging form of practice, whose practice has become routine and repetitive, missing important opportunities to think about the situation.

Even though reflective practice is supported by a large sector of the profession and is widely included in pre and post-registration nursing education curricula, what it is less clear is why despite all this educational input some qualified nurses fail to use reflection in their everyday work. This research has shown that not all registered nurses can be regarded as reflective practitioners. Clearly, if the

profession regards reflective practice as important it is necessary to ask why nurses do not use reflection more in their everyday work and what more needs to be done to encourage them to be critically aware and reflective. In essence, educational input alone does not at the moment; ensure that nurses practice reflectively in reality.

Firstly, it is necessary to examine why some nurses are not practicing reflectively in the clinical setting and ask the following questions:

- What are the conditions necessary to foster reflection in the clinical setting?
- What are the link teachers' and senior nurses' responsibilities and risks?
- How does reflective practice affect practice

Conditions to foster reflection in practice

I was unable to find any studies in the literature that has specifically investigated reflection in practice however; there are a number of studies that have analysed reflective practice in the classroom setting. Individual characteristics amongst nurses appear to be important in facilitating or impeding the ability to reflect. Coombs (2001) identified flexibility, mindfulness, and creating the mood in oneself (i.e., being introspective and aware of one's thoughts and feelings) as habits of the mind or characteristics that promote reflection. Both Glaze (2001), in a study of advanced nurse practitioners, and Hyrkas et al. (2001), in a qualitative study of 9 teacher candidates in a Masters level education class, found that reflection is not spontaneous but, requires active contribution and motivation. Day (1993) stated that to be reflective one has to be imaginative and dynamic because reflection is not linear and demands creativity. The fact that reflection requires certain personal qualities suggests perhaps, that individuals who are lacking in imagination and creativity do not have the necessary attributes to be reflective.

In the research that I have undertaken this was also found to be significant. Individuals who were reflective tended to be self-aware, thought about their work in a questioning and proactive manner and were able to judge the worth of a particular event.

Davies (1995) in a grounded theory study with 6 first year nursing students found that learning environments that were open, honest and trusting was significant to being reflective. Platzer, Blake,

and Ashford (2000) found that a willingness of students to expose themselves to others judgement and to take responsibility for their own learning was significant. Platzer et al (2000) also, found that reflective learning in a classroom may be unpleasant if other members are not committed to it or are resistant to sharing they're learning and interacting with one another. Reflective practice permits,

> "Private thoughts of nurses to enter the public sphere, where they are subject to surveillance, assessment, classification and control." Cotton (2003, p.512)

Teacher and senior nurse responsibilities/risks

There is an ever growing list of teaching and learning strategies used to promote reflective abilities such as Journal writing (Burrows, 1998; Hiemstra, 2001), reflective teaching portfolios (Huebner, 1997) guided reflection (Johns 1995) and dialogue (i.e.; a form of reflective conversation) (Chandler, 2000). In my research I have suggested that reflective abilities may be fostered by appropriate teaching and learning strategies, but also by good mentorship and role modelling in practice. Clearly, nurse educationalists have many responsibilities in fostering the reflective process. Their role firstly, must be to see the value and relevance in the reflective process. Secondly, to explain the purpose of reflective practice and to create an environment that is safe. Wong et al. (1997) suggested that teachers and students should be partners in the promotion of reflective learning, thereby fostering a collaborative approach, but, also to set aside time for nurses to reflect on practice. Senior nurses too, can have a significant role in promoting reflective practice in clinical area by ensuring that time is made available for reflection and that an open, honest and trusting environment is created. However, facilitating the reflective process can have its risks and it is important that anyone undertaking this role is suitably knowledgeable and able to manage difficult and stressful situations that can result from the reflection process. I.e. an emergency situation such as after a cardiac arrest.

Reflection is an ongoing process often initiated by a significant "trigger, event or a feeling of inner discomfort (Boyd & Fales, 1983). In a qualitative study of 12 practitioners, Mott (1994) found trigger events to be uneasy feelings or intuitive hunches that make one step back and reflect what is happening in the situation. Mott believed intuitive ways of knowing are central to reflective practice. In my

research I have also suggested that reflective abilities develop when there is a need, opportunity or stimulus such as:

- To meet personal expectations/high personal standards. The drive to constantly be reviewing personal strengths and improving weaknesses
- To meet the expectations of colleagues, patients and relatives.
- Career enhancement
- Stress/low morale
- Challenging patients and colleagues
- To correct or adjust for a poor working environment
- Personal satisfaction of doing a good job for patients/clients

The effects on practice

Because reflective practice is under-researched (Wilkinson, 1999) and has mostly been conducted in educational settings it is difficult to say how this has affected practice or whether healthcare has improved. Several studies have however shown that expert practitioner's role modelling of reflective practice was found to significantly affect practice. (Cooms, 2001; Davies, 1995; Doty, 2001; Ferry & Ross-Gordon, 1998; Genor, 2001). Also, that it helps improvements in practice by promoting greater self-awareness in students (Bond, 1998) but, also helps students expand and develop their clinical knowledge and skills (Brown & Gills, 1999; Day, 1993; Glase, 2001; Hyrkas, Tarkka, & paunonen-Ilmonen, 2001; Padget, 2001). Future research must examine reflective practice from holistic, multidisciplinary, multicultural perspectives, but also consider ethical and power issues. More importantly research should be conducted in practice settings to determine whether the outcomes of the reflective process have been met and to what extent healthcare has improved.

Reflection has become a central tenet of both theory and educational development in nursing. The concept of reflection is propounded in the literature as an epistemology for practice that helps practitioners to develop self-awareness and expand clinical knowledge and skills. However, what does appear to have been overlooked is the extent to which nurses use reflection in their everyday practice to

help them solve daily problems and develop their practice. Clearly, this study and others have identified some of the advantages to be gained when nurses are actively encouraged to use reflection but, the challenge currently facing the profession is how time and a suitable environment can be developed to encourage more practitioners to become reflective.

CHAPTER TEN

CONCLUSION

When I began this research it was my intention to discover what the benefits of educating nurses to graduate level were and to discover whether indeed graduate nurses make better nurses. The aims of the research were:

To:

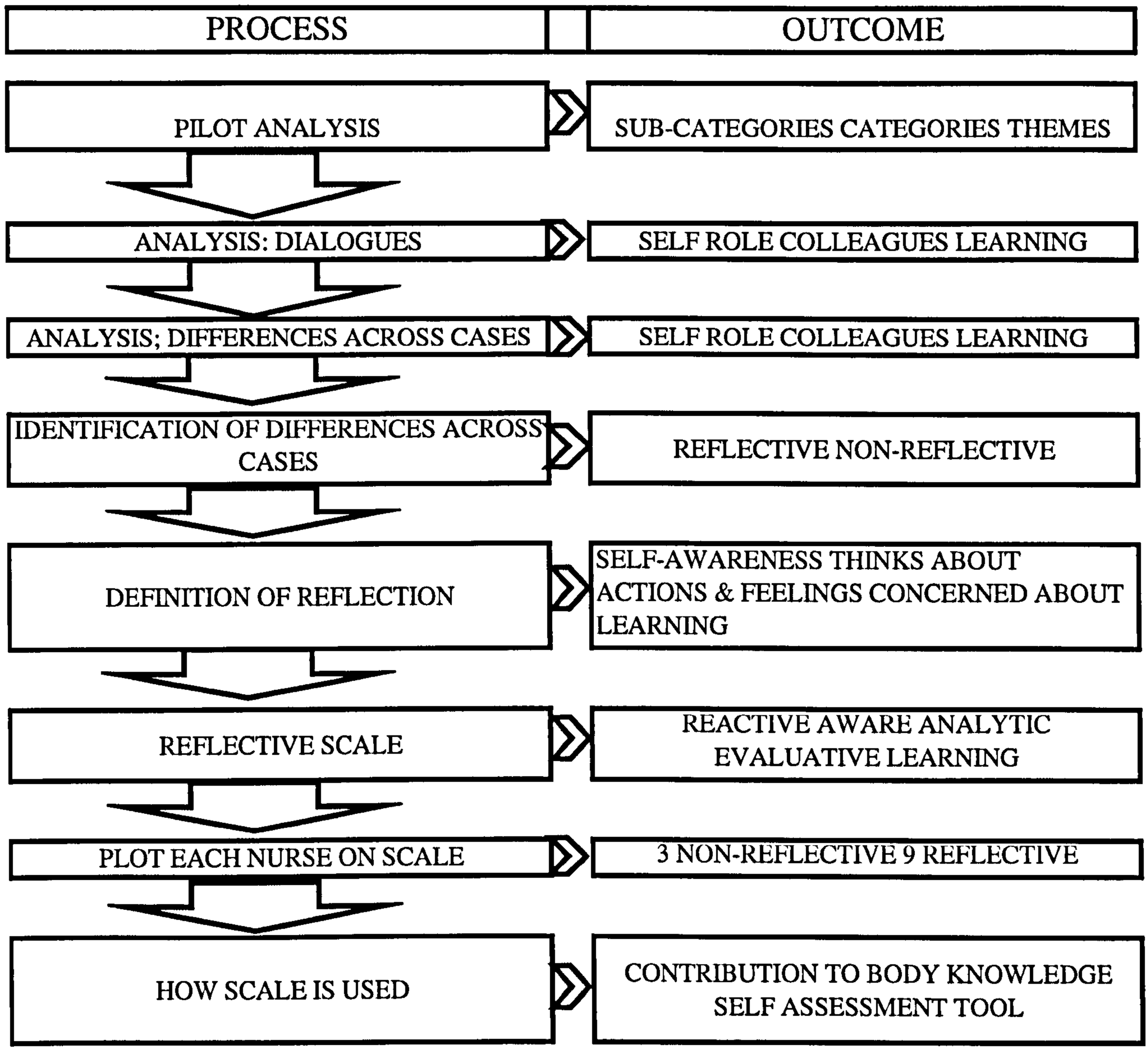
- Explore the process of professionalisation of nursing to evaluate whether graduate nurses make better nurses when compared with non-graduate nurses, in terms of impact on practice, the profession and professional development.
- Identify the benefits of educating nurses to graduate level
- Provide new insights into contemporary nursing practice.
- Understand better the demands nurses face in contemporary practice
- To be able to recommend whether all nurses should be graduates.

The research has revealed some interesting insights about contemporary nursing practice as well as shedding light on the nature of reflective practice and the extent to which nurses use reflection in their everyday practice.

The following table overleaf summarises the stages in the research process and how the theoretical framework was developed.

Figure 4

THEORY BUILDING



The research has also provided further insights into what nurses do, what they think about, how they relate to others and what contribution they make to patient care. Interestingly, I did not imagine that this research would turn out to be a study of reflective practice as it is practiced in the real world of nursing. Whilst clearly the merits of reflection have been well documented in the nursing literature what is less clear is to what extent nurses use reflection in everyday practice. It is also unclear why some nurses fail to use reflection in clinical practice to aid development.

The research has identified two main types of nurse, reflective and non-reflective and has built up a picture of those behaviours that characterise the reflective nurse and those behaviours that characterise the non-reflective nurse. It has attempted to explain the complexities of contemporary nursing practice providing further insights into how nurses perceive their role, communicate with colleagues and view their professional development and learning. Moreover, the research suggests that nurses approach their work differently as they cope with the various demands and challenges of everyday practice. For example, reflective nurses were predominately patient focused and caring, tended to have an appreciation of self, consciously spent time thinking about what they were doing and how they were communicating with patients. These nurses were concerned about their own professional development and learning and their relationships with colleagues. Non-reflective nurses on the other hand, lacked an appreciation of self, tended to be preoccupied with getting the work done and mainly focused on technical care.

In identifying two main types of nurse, reflective and non-reflective the research has built up a picture of those behaviours that characterise the reflective nurse and those behaviours that characterise the non- reflective nurse. It also shows that there are different stages or levels within the two main types of nurse. Using this framework it will be possible to not only identify the reflective and the non-reflective nurse but also plot at what stage the nurse has reached on the reflective scale, providing a useful means of assessing a nurse's performance and identifying development needs. It can also indicate when a nurse has regressed or slipped back in terms of their practice and can be useful for individual nurses to use as a self-assessment tool which provides feedback of their practice, their communication with colleagues and their professional development needs. Because it is simple to use and can be shown in a

diagrammatic format it is easy to see at a glance the stage that the nurse has reached, by matching the behaviours the nurse exhibits to the framework. The tool will allow educationalists and managers a means by which they can plan and organise mentorship, supervision and teaching.

Professionalisation of Nursing

The research questioned whether professionalisation of nursing and the move to Higher Education has benefited nursing and more particularly patient care or whether graduate status was more concerned with improving the standing of nursing as a profession when considered alongside other healthcare professions. Clearly, the issue about whether nursing and patient care has improved since nursing education moved into Higher Education has been constantly debated in the profession. This debate has to be considered alongside the issue of whether education to degree level produces more confident nurses and better patient outcomes. Whilst there were clearly some disadvantages to these changes not least the disruption to staff and students during the process of change, the benefits have been the opportunity to utilize the facilities and expertise available in a University and of becoming part of a wider academic community (Quinn 1995). Other advantages were the management structure within Higher Education, which was flat and much less hierarchical when compared with nursing Colleges. The move to Higher Education also allowed nurses to consolidate their position in academia and research.

Graduates and Non Graduates

Whilst this study has identified differences between nurses, the findings have not shown that graduate nurses are necessarily better than non-graduate nurses. The findings have revealed that both graduate and non-graduate nurses have similar concerns about how nursing is practiced, the care environment, relationships with colleagues and thoughts about learning and profession development.

Contemporary Nursing Practice

The research has provided some interesting insights into contemporary nursing practice, highlighting that nurses are bothered about the care they provide for patients/clients and often feel frustrated when the care environment is less than satisfactory or when there is lack of time or staff to do things properly/meet everyones needs. Effective communication with patients, relatives and staff members is highly valued and considered an essential component of good practice. The research has also, highlighted that nurses value a supportive environment and good senior nurse support appears to affect how a nurse deals with stressful situations such as a cardiac arrest, coping with terminally ill or distressed patients but, also affects how the nurse feels about herself, her role, her competence and confidence. Interestingly, those nurses who demonstrate an ability to reflect on their practice and their skills seem to be able to articulate what it is that gives them a "buzz" about nursing, when they have had a good day or have felt positive about their input. For example when they have helped a distressed patient or challenged a medical decision resulting in a positive outcome.

The research was a qualitative study of nursing practice in acute adult nursing areas. Using a phenomenological approach, two groups of qualified nurses were compared, a graduate and non-graduate group. Nursing practice was analysed at three different levels: -

- Individual – how the nurse perceives herself as a nurse.
- Team – as a team member and how he/she relates to other team members.
- Professional level - perception of the nursing role and professional development.

Data was collected by means of diaries (of their practice) provided by nurses, by observation whilst nurses are engaged in direct nursing care and by semi-structured interviews with these nurses.

Data was analysed using coding procedures based on the work of Strauss and Corbin (1990) whereby data is broken down, analysed, conceptualised and put back together in new ways.

From the data a theoretical framework developed which identified different types of nurses characterised by certain behaviours.

CONTRIBUTION TO BODY OF KNOWLEDGE

The results of the research provide new insights that help understand and explain contemporary nursing practice and the contribution nurses make to patient care. It demonstrates differences in the way nurses tackle the demands and challenges of everyday practice and perceive their role and professional development. A theoretical framework was developed which identified different types of nurses characterised by certain behaviours.

Implications for Nursing Education

Nursing Educationists must first reflect on the past and identify more clearly those practices and strategies that allow reflection to be fostered not just within the classroom setting but also, in practice. In an effort to promote reflective practice nurse educators must value reflection for improving practice and understand, transfer and apply reflection from its theoretical origins to the practice arena. They must refocus their attention in the clinical area to ensure that theoretical concepts are translated into practice.

Strategies for developing future reflective practitioners

There are a number of models and strategies to promote reflective learning, both verbal and written, such as Journal writing, reflective teaching portfolios and dialogues. When strategies are used together they elicit reflection and help students make connections between content and practice. Some theorists however, propose the use of human guides or critical friends to facilitate the process of reflection (Cronin and Rawlings-Anderson, 2004). These can be colleagues or facilitators but the most usual format is clinical supervision. Clinical supervision is also the favoured method by the statutory bodies who also require practitioners to keep a portfolio) UKCC, 1997b). It can be carried out on an individual basis or in groups where supervision can be tailored to suit a particular clinical area. Clinical supervision is a system in which practitioners meet with another more experienced practitioner and discuss issues related to their practice. The particular features of clinical supervision are:

- There is contact that includes confidentiality within professional boundaries.

- Supervisees bring to the session practice encounters or critical incidents that they have begun reflecting on.
- It makes use of reflection, preferably through a model of reflection.
- The supervisee works at being open to challenge and support from the supervisor.
- The supervisor uses a variety of models and methods to challenge supervisees to learn and increase their ways of knowing about specific incidents and also to generate their learning for the future.
- Written notes are kept of each session
- Supervision is formally evaluated by both supervisee and supervisor at specified intervals.

(Higgs and Titchen, 2001).

For Pre-Registration students a popular method for facilitating reflective practice is with the use of reflective assignments or reflective groups. The skills of reflective writing can be enhanced with good facilitation and (Rolfe et al, 2001) suggest that reflective writing is useful because it enables students to order their thoughts, and to develop their critical thinking skills by making connections between ideas, providing a permanent record which can be returned to at a later stage. They also suggest different strategies for reflective writing that will suit a variety of writing approaches such as journal writing, storytelling, critical incident analysis and writing unsent letters.

As with any approach, the learner nurse requires more direction than the experienced practitioner. The skills of reflective practice are not as easy and straight forward as might be imagined and it requires sufficient time, thought and the assistance of another person to help when things become difficult or the practitioner gets "stuck".

Levels of Reflection

Clearly nurses practice at differing levels of competence depending on their experience, attitudes and knowledge base. (Benner et al, 1984). It has also been suggested by a number of authors that there are also different levels of reflection depending on the practitioners experience, critical thinking skills but, also their ability to analyse situations. Goodman (1984) [cited in Burns and Bulman, 2000] outlined three levels of reflection that a practitioner might achieve thus:

- Level 1 – limited to technocratic issues of efficiency, effectiveness and accountability
- Level 2 – implications and consequences of actions
- Level 3 – ethical and political concerns

Kim (1999) similarly, suggests a method of critical enquiry that involves a descriptive, reflective and a critical or emancipatory phase. Kim suggests that these different phases move the practitioner from a superficial phase to a final phase whereby the need for change and how change can be brought about is thought through.

These levels of reflection equate with single and double loop reflection suggested by Argyris and Schon (1974). They differentiated between single loop learning where underlying assumptions are unchanged and double loop learning whereby assumptions are challenged and changed.

Similarly, Wong et al (1995) identified three different levels of reflective abilities amongst student nurses in relation to reflection – non-reflectors, reflectors and critical reflectors. Non-reflectors were very descriptive and their thinking was concrete whereas, reflectors were able to frame problems in context and were able to pursue alternative views and possibilities drawing on prior knowledge and could modify this for future practice. The critical reflectors were able to frame problems in context, and were able to modify future practice in light of prior experience, knowledge and the literature.

> Probably, Wong's research findings on [levels of reflection], is most closely aligned to my own research findings. However his work focused on student's abilities in relation to writing abilities whereas my research was undertaken in the practice setting and focused on how nurses tackle the demands and challenges of everyday nursing practice and perceive their role and professional development. I identified three levels of reflection thus:
>
> - **Analytical -** At this level of practice the nurse is able to a assess a situation, breaking the experience/ event down into component parts, is able to explore the reasons why a situation has arisen and finally be able to describe how they feel about the experience.

- **Evaluative** - At this stage the nurse has taken her practice to the next level, and in addition to the analytical level has thought about what else could have been done and what would be done differently next time. The nurse operating at this more sophisticated level of reflection, is able to judge the worth of a particular situation or action, It might include being proactive or acting in an autonomous manner – i.e. advocating on behalf of a patient or challenging a doctor's decision.
- **Learning**- At this level the nurse in addition to judging the worth of a particular situation or action is able to identify what they have learnt from the experience and might also be able to demonstrate a change of perception.

Recommendations for further research

Future research must examine reflective practice from holistic, multidisciplinary, multicultural perspectives, but also consider ethical and power issues. More importantly research should be conducted in practice settings to determine whether the outcomes of the reflective process have been met and to what extent healthcare has improved. It should examine the nature of reflection and investigate to what extent nurses are reflective and use reflection in everyday practice.

Conclusion

During the past decade, reflective practice has been one of the most promoted subjects at professional conferences, in journals and within the nursing education. Reflection can be an effective teaching method that facilitates self-awareness and expands clinical knowledge and skills, helping teachers and practitioners identify what guides their practice. It can also help narrow the gap between theory and practice, ultimately enhancing practice.

Clearly, this study has identified some of the advantages that can be gained when nurses are actively use reflection but the challenge currently facing the profession is how to develop workable strategies that will encourage more practitioners to embrace this concept and to use reflection in their everyday practice.

REFERENCES

Abel-Smith, B. (1960) A History of the Nursing Profession. London. Heinemann.

Alkins S & Murphy K (1993) Reflection: A review of the Literature. Journal of Advanced Nursing 18(8): 1188-1192.

Argyris C Schon D (1974) Theory in Practice: Increasing Professional Effectiveness. London: Jossey Bass

Ashford D, Blake D, & Platzer H (2003) Barriers to Learning from Reflection: A Study of the Use of Group work with Post-Registration Nurses. Journal of Advanced Nursing, 31(5), 1001-1008

Bartlet H, Westcott L, Hind, P & Taylor H (1998) the Limits of Competence: Knowledge, Higher Education and Society. The Society for Research into Higher Education, Buckingham

Benner, P. & Wrubel, J. (1989). The primacy of Caring: Stress and coping in Health & Illness. Addison-Wesley.

Benner, P. (1984). From Novice to Expert: Excellence and Power in Clinical Nursing Practice. Addison- Wesley Publishing Company.

Benner, P. (1994) (Ed) Interpretive Phenomenology: Embodiment, Caring and Ethics in health & Illness. Sage Publications.

Benner, P., Tanner, C., Chesla, C. (1996) Expertise in Nursing Practice: Caring, Clinical Judgement, and Ethics. Springer Publishing Company.

Boyd E.M & Fales A.W (1983) Reflective Learning: The Key to Learning from Experience. Journal of Humanistic Psychology 23, 99-117

Boud D., Keough R. & Walker D. (1998) Reflection: Turning Experience into Learning, Kogan Page, and London.

Brockbank A. & McGill I. (1998) Facilitating Reflective Learning in Higher Education. The Society for Research into Higher Education & OUP, London

Burke L & Harris D (2000) Education Purchasers Views of Nursing as an all Graduate Profession. Nurse Education Today 20, 620-628

Burton A (2000) Reflection: Nursings Practice & Education Panacea? Journal of Advanced Nursing 31(5): 1009-1017

Burrows D (1995) The Nurse Teachers Role in the Promotion Of reflective Practice. Nurse Education Today 15 (5)): 346-350.

Coombs M (2004) Power and Conflict between Doctors and Nurses: Breaking Through the Inner Circle in Clinical Care. London: Routledge

Cotton a (2001) Private thoughts in Public Spheres: Issues in Reflection and Reflective Practices. Journal of Advanced Nursing, 36(4), 512-519

Carper, B.A. (1978) Fundamental patterns of Knowing in Nursing. Advances in Nursing Science 1, 13-23.

Cerervo R M (1992) Professional Practice, Learning and Continuing Education: An Integrated Perspective. International Journal of Lifelong Education

Chandler, S.M. (2000) Conservation as a way of Knowing (Doctoral dissertation, University of Colorado at Denver, 2000). Dissertation Abstracts International, 61, 1726

Clinton M & Murrells T (2005) Assessing Competency in Nursing: a Comparison of Nurses Prepared through Degree and Diploma Programmes. Journal of Clinical Nursing, 14(1), 82-94

Colley, S (2003) Nursing Theory: its importance to Practice 17 (46) pp33-37

Coombs, C.P. (2001) Reflective Practice: Developing habits of Mind (Doctoral dissertation, University of Toronto, 2001). Dissertation Abstracts International, 62, 1280

Davis, C. (1980) Ed Rewriting Nursing History. Croom Helm Publishing.

Day C. (1993) Reflection: A Necessary but not Significant Condition for Professional Development. British Educational research Journal

DHSS (1938) Report of Committee on Nursing Services (Chairman, Earl of **Athlone**) HSMO, London.

DHSS (1972) Report of Committee on Nursing (Chairman Lord **Briggs**) HMSO, London.

DHSS (1947) Report of the Working Party on Recruitment and Training of Nurses (Chairman, Sir Robert **Wood**) HMSO,London.

Draper, (1990). The Development of Theory in British Nursing: Current Position and Future Prospects. Journal of Advanced Nursing. 15, 1, 12-15.

Dreyfus, H.L. (1979) What Computers Can't Do: the Limits of Artificial Intelligence. Revised Ed. New York: Harper & Row.

Fjelland, R. & Gjendgedal, E (1994) A Theoretical Foundation for Nursing as a Science In P, Benner (Ed), and Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness (pp3-25). Sage Publications.

Neeb, K. (2006) Mental Health Nursing. Philadelphia. F.A.Davis. Company.

Nightingale, F. (1974. first published1859) Notes on Nursing. What it is and what it isn't. Blackie & Son Ltd.

Glaser & Strauss BG, Strauss AL, (1967) and the discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Adline

Glaze J.E (2001) Reflection as a Transforming Process: Student Advanced Nurse Practitioners Experiences of developing reflective Skills as part of an MSc Programme. Journal of Advanced Nursing 34, 639-647

Girot E (2000a) Assessment of Graduates and Diplomats in Practice in the UK – Are We Measuring the Same Level of Competence? Journal of Clinical Nursing, 9, 330-336

Gray, G & Pratt, R (Eds) (1995) Scholarship in the Discipline of Nursing. Churchill Livingstone.

Greenwood J (1993) the role of Reflection in double loop learning. Journal of Advanced Nursing 27(5): 1048-1053

Guidelines on the Practice of Ethics Committees in Medical Research Involving Human Subjects (1996)

Hammersley, M., Atkinson, P. (1995) Ethnography Principles & Practice, Routledge.

Heidegger, M. (1962) Being & Time, New York: Harper & Row.Higgs, J. & Titchen, and A. (2001) Practice Knowledge & Expertise in the Health Professions. Butterworth-Heinemann.

Higgs J & Titchen A (2001) Practice Knowledge & Expertise.Butterworth Heinemann

Huebner, T. A. (1997) Pre-service Teacher Preparation Reflective Practice and Teaching Portfolios (Doctoral dissertation, Stanford University, 1997). Dissertation Abstracts International, 58, 3476

Hyrkas K., Tarkka M T, & Paunonen-Ilmonen M. (2001) Teacher Candidates Reflective Teaching and Learning in a Hospital Setting-Changing the Pattern of Practical Training: A Challenge to growing into Teacherhood. Journal of Advanced Nursing 33, 503 511

Johns C (2002) Guided Reflection: Advancing Practice Blackwell: Oxford

Johns, C (2001) Reflective Practice: Revealing the art of caring, International Journal of Nursing Practice, vol7 (4) p.237-245.

Johns C, & Freshwater D (1998) Transforming Nursing through Reflective Practice. Oxford, Blackwell Science

Johnson, T. (1972) Professions and Power, London, Macmillan.

Kierkegaard, S. (1843/1885) Fear and Trembling. (A. Hanney, Trans.). New York; Harper & Row.

Kim H (1999) Critical Reflective Enquiry for Knowledge Development in Nursing Practice. Journal of Advanced Nursing, 29(5), 222-224

Kolb D and Fry R (1975) towards an applied theory of experiential learning. In Cooper C L. ed. Theories of group processes. London: Wiley: 33-57

Kuiper R A (2004) Nursing Reflections from Journaling during a Perioperative internship. AORD Journal, 79, 195-198

Lawler J (1995) Response: To Be or Not to Be? Nurse? Researcher? Or Both? Nursing Inquiry 2(1), 57

Le Vasseur J (1999) Towards an Understanding of Art in Nursing Advances in Nursing Science. 21, 4, 48-63

Lincoln, M. & Guba, A. (1985) Naturalistic Enquiry. Beverly Hills CA, Sage.

Local Ethics Committees (1991)

Mackintosh C (1998) sited in Cronin & Rawlings-Anderson (2004) reflection; a flawed strategy for the nursing profession. Nurse Education Today 18(7)): 553-557

Malmosten K (1999) Reflective Assent in Basic Care (Uppsala: University Press)

Mason T and Whitehead E (2003) Thinking Nursing. Buckingham: Open University Press

Meleis a I (1997) Theoretical Nursing: Development and Progress. 3rd Edition. Philadelphia: Lippincott

Melesis, A. (1985) Theoretical Nursing, Lippincott, Philadelphia.

Mezirow (1981) A Critical Theory of Adult Learning & Education. Adult Education 32 (1), 52-63.

Mott V W (1994) A phenomenological inquiry into the role of intuition in reflective Adult Education Practice. Unpublished Doctoral Dissertation, University of Georgia

Murdaugh C L (1999) Relationship of Research Perspectives to Methodology: Handbook of Clinical Nursing Research. Sage Publications

Padget T (2001) Reflective Practice and Clinical Outcomes: Practitioners Views on how Reflective Practice has influenced their Practice. Journal of Clinical Nursing, 10(2), 201-214

Peplau H (1988) The Art and Science of Nursing: Similarities, Differences and Relations. Nursing Science Quarterly 1, 1, 8-15

Parse (1995) Building the Realm of Nursing Knowledge. Nursing Science Quarterly, 8: 51. New York: NLN Press.

Report on Reform of Nursing Education: response and discussion. (Platt). General Nursing Council for England and Wales. 1964.

Pleasance P & Sweeny J (1994) Nursing for Change: The Orientation and Values of Project 2000 Diploma and Undergraduate Nursing Students. Journal of Advanced Nursing, 20(6), 1156-1161

Peplau H (1988) The Art and Science of Nursing: Similarities, Differences and Relations. Nursing Science Quarerly 1(1), 8-15

Polit D. &Hungler B. (1999) Nursing Research: Principles & Methods, 6th edn. Lippincott, Philadelphia

Project 2000, UKCC: A New Preparation for Practice: United Kingdom Cetral Council for Nursing, Midwifery and Health Visiting

QAA (2001) Benchmark Statement: Health Care Programmes Stage 1. Quality Assurance Agency for Higher Education, Gloucester

Quinn, F. 3rd Ed (1995). The Principles and Practice of Nurse Education. Stanley Thorns (Publishers) Ltd.

Robinson J & Leamon J (1998) A Documentary Analysis of Nursing Degree Curricula. Research Highlights 38. English National Board, London

Robinson, J. (2004) Mary Seacole: The Charismatic Black Nurse who became a heroine of the Crimea. Constable.

Rolfe, G. (1997) Beyond Expertise Theory, Practice and the Reflective Practitioner. Journal of Clinical Nursing 6(2): 98-97

Rose P and Parker D (1994) Nursing: An Integration of Art and Science within the Experience of the Practitioner. Journal of Advanced Nursing. 20, 6, 1315-1320.

Roy (1980) the Roy Adaptation Model. In Riehl J, Roy C (Eds) Conceptual Models for Nursing Practice. Second edition New York NY, Appleton- Century-Crofts

Rubin, J. (1984). Too much of Nothing; Modern Culture, the Self and Salvation in Kierkegaard's Thought. Unpublished doctoral dissertation, University of California, Berkeley.

Schon, A. (1987) Educating the Reflective Practitioner, Jossey-Bass Inc.

Small, H. (1989) Florence Nightingale, Avenging Angel. Constable.

Strauss, a Corbin, J. (1990). Basics of Qualitative Research. Sage Publications.

Tanner, C. A., et al. The phenomenology of knowing the patient. Image J. Nurs.Sch 26:273-280, winter 1993.

Taylor, C, (1985a). Philosophical Papers (Vols 1 &2). Cambridge, MA: University of Cambridge Press.

Timpson J. (1996) Nursing Theory: Everything the Artist Spits is Art? Journal of Advanced Nursing 23 (5): 1030-1036

United Kingdom Central Council (1990) Commission for Nursing and Midwifery Education: Fitness for Practice. UKCC, London

Wilkinson J (1999) Implementing Reflective Practice. Nursing Standard 13, 36-40

Winson G (1993) Comparing Degree and Diploma Courses. Senior Nurse 13, 37-41

Wong F, Kember D, & Yan L. (1995) Assessing the Levels of Student Reflection from Reflective Journals. Journal of Advanced Nursing 22, 48-57

Wong, S.P. (1997) Honouring a Life. Exemplar presented at University of California School of Nursing, San Francisco

BIBLIOGRAPHY

Andrews M, Gidman J & Humphreys A (1998) Reflection: Does it Enhance Professional Practice? British Jounal of Nursing, 7(7), 413-417

Benner P (2000) The Wisdom of Our Practice. American Journal of Nursing. 100(10), 99-105

Benner P (1984) From Novice to Expert. Addison-Wesley Company

Benner P (1999) Nursing Leadership for the New Millennium: Claiming the Wisdom & Worth of Clinical Practice. National League for Nursing, 20(6), 312-319

Benner P (Ed) (1994) Interpretive Phenomonology: Embodiment, Caring and Ethics in Health and Illness. Sage Publications

Benner P, & Tanner C (1997) Becoming an Expert. American Journal of Nursing, 97(6), 16BBB, 16DDD

Benner P, Chesla C & Tanner A (1997) Expertise in Nursing Practice. Springer Publishing Company

Benner P, Hooper-Kyriakidis P & Stannard D (1999) Clinical Wisdom and Interventions in Critical Care. W.B. Saunders Company

Billings D (2006) Journaling: A Strategy for Developing Reflective Practitioners. The Journal of Continuing Education in Nursing, 37(3), 104-105

Bradshaw A (1995) what are Nurses Doing to Patients? A Review of Theories of Nursing Past and Present. Journal of Clinical Nursing, 4(2), 81-92

Bryman A (2001) Social Research Methods. Oxford University Press

Burnard P & Morrison P (1997) Caring and Communicating. Macmillan

Burton A (2000) Reflection: Nursing's Practice and Education Panacea. Journal of Advanced Nursing, 31(5), 1009-1017

Carr Eloise C J (1996) Reflecting on Clinical Practice: Hectoring Talk or Reality? Journal of Clinical Nursing, 5(5), 289-295

Clouder L & Sellers J (2004) Reflective Practice and Clinical Supervision: An Interprofessional Perspective. Journal of Advanced Nursing, 46(3), 262-269

Cronin P & Rawlings-Anderson K (2004) Knowledge for Contemporary Nursing Practice. Mosby

Edwards S D (2001) Philosophy of Nursing. Palgrave

Eraut M (1994) Developing Professional Knowledge and Competence. The Falmer Press London

George J, B (1980) Nursing Theories: The base for Professional Nursing Practice

Gomm R, Needham G & Bullman A (Eds) (2000) Evaluating Research in Health and Social Care The Open University in association with Sage Publications

Gray G & Pratt R (Eds) (1995) Scholarship in the Discipline of Nursing. Churchill Livingstone

Gustafsson C (2004) Reflection, the way to Professional Development? Journal of Clinical Nursing, 13(3), 271-280

Hannigan B (2001) A Discussion of the Strengths and Weaknesses of Reflection in Nursing Practice and Education. Journal of Clinical Nursing, 10(2), 278-283

Higgs J & Titchen A (2001) Practice Knowledge & Expertise.Butterworth Heinemann

Jenkins A (2005) Mind Mapping. Nursing Standard, 20(7), 85

Johns C (2002) Guided Reflection: advancing practice. Blackwell Science

Johns C (2001) Reflective Practice: Revealing the [he] art of Caring. International Journal of Nursing Practice, 7(4), 237-245

Kenny G (2002) Interprofessional working: Opportunities and Challenges. Nursing Standard, 17(6) 33-35

Lishman J (Ed) (1984) Research Highlights in Social Work 8: Evaluation. Biddles Ltd GB

Maggs C (2000) Reflections on the Role of the Nursing Development Facilitator in Clinical Supervision and Reflective Practice. International Journal of Nursing Practice, 6(4), 192-195

Mantzoukas S, & Jasper M (2004) Reflective Practice and Daily Ward Reality: a Covert Power Game. Journal of Clinical Nursing, 13(8), 925-933

Markham T (2002) Response to: 'Private Thoughts in Public Spheres: Issues in Reflection and Reflective Practices in Nursing. Journal of Advanced Nursing, 38(3), 286-287

McBrien B (2006) Clinical Teaching and Support for Learners in the Practice Environment. British Journal of Nursing, 15(12), 672-676

Minter M (2005) Teaching and Assessing: Reflection Upon Planning, Delivery and Evaluation. British Journal of Midwifery, 13(11), 722-727

Nolan M, Lundh U & Tishelman C (1998) Nursings Knowledge Base: Does it have to be Unique. British Journal of Nursing, 7(5), 270-276

O'Callaghan N (2005) The Use of Expert Practice to Explore Reflection. 19(39), 41-47

Olofsson B (2005) Opening Up: Psychiatric Nurses Experiences of Participating in Reflection Groups Focusing on the Use of Coercion. Journal of Psychiatric and Mental Health Nursing, 12(3), 259-267

Oppenheim A. N (1966) Questionnaire Design and Attitude Measurement. Heinemann London

Padget T (2001) Reflective Practice and Clinical Outcomes: Practitioners views on How Reflective Practice has Influenced Their Clinical Practice. Journal of Clinical Nursing, 10(2), 204-214

Price A (2004) Encouraging Reflection and Critical Thinking in Practice. Nursing Standard, 18(47), 46-54

Price B (2006) Encouraging Reflection in Practice. Nursing Standard, 20(27), 55-56

Rolfe G (1997) Beyond Expertise: Theory, Practice and the Reflective Practitioner. Journal of Clinical Nursing. 6(2), 93-97

Strauss A & Corbin J (1990) Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Sage Publications

Taylor C (2003) Narrating Practice: Reflective Accounts and the Textual Construction of reality. Journal of Advanced

Teekman B (2000) Exploring Reflective Thinking in Nursing Practice. Journal of Advanced Nursing, 31(5), 1125-1135

Timmins F (2006) Critical Practice in Nursing Care: Analysis, Action and Reflexivity. Nursing Standard, 20(39), 49-54

Tomey A M (2003) Learning with Cases. The Journal of Continuing Education in Nursing. 34(1) 34-38

Williams B (2001) Developing Critical Reflection for Professional Practice Through Problem-based Learning. Journal of advanced Nursing, 34(1), 27-34

Yin R (2003) Case Study research: Design and Methods. Sage Publications

Leppa C (2004) Reflective Practice in Nursing Ethics Education: International Collaboration. Journal of Advanced Nursing, 48(2), 195-202

Ruth-Sahd L (2003) Reflective Practice: A Critical Analysis of Data Based Studies and Implications for Nursing Education. Journal of Nursing Education, 42(11), 488-497

REPORTS

DHSS (1938) Report of Committee on Nursing Services (Chairman, Earl of **Athlone**) HSMO, London.

DHSS (1972) Report of Committee on Nursing (Chairman Lord **Briggs**) HMSO, London.

DHSS (1947) Report of the Working Party on Recruitment and Training of Nurses (Chairman, Sir Robert **Wood**) HMSO,London.

United Kingdom Central Council (UKCC, 1990) **Commission for Nursing and Midwifery Education: Fitness for Practice**. UKCC, London

General Nursing Council (UKCC, 1964) Report on Reform of Nursing Education: response and discussion. (Chairman, Lord **Platt**). General Nursing Council for England and Wales.

APPENDICES

Appendix 1

INFORMATION FOR NURSES PARTICIPATING IN THE RESEARCH

Title of study:

Research Methods:

Data will be collected using the following methods:

- Asking nurses participating in the study to complete a verbal reflective diary.
- Participant Observation to be undertaken by the Researcher
- The researcher will interview the nurses participating in the research following the period of observation.

Guidance for nurses participating in the research:

Prior to the period of observation please consider the following questions and record your responses into the tape recorder provided. Your responses can be as long or as short as you feel is necessary to answer the questions.

1. What do you think about nursing?
2. How do you see yourself as a nurse within the multidisciplinary caring team and within the nursing profession as a whole?
3. Describe any memorable event (recent or past) where you learnt something or made a difference about an aspect of care.

Observation period

I, (the nurse researcher) will observe you during part of a shift (between 2-4 hours). **The aim of the observation period is to understand, rather than judge practice against a particular standard.** I am interested to discover what the everyday challenges are that nurses face and how this impacts on patient care and the decisions they make. At the start of the observation period I will require you to brief me on the patients you will be caring for, your work priorities and what you hope to achieve during the shift. Whilst you are being observed I will ask you questions about your work to seek clarification and understanding of the practice being observed.

At the end of the observation period please record into the tape recorder your thoughts about:

- Your shift
- How you felt you did
- Were there any surprises?
- Did anything interfere with what you set out to achieve?

BARBARA CREBER DECEMBER 7, 1999.

APPENDIX 2

QUESTIONS: FOLLOW UP INTERVIEW SCHEDULE

1. What is a good day?
2. What is a bad day?
3. What is it like working with medical staff?
4. What is it like working with agency nurses?
5. How do you see yourself in the wider context of the nursing profession as a whole?
6. Are senior nurses supportive?
7. What do you think about nursing?
8. How do you see yourself as a nurse within the multiprofessional team?
9. Describe any memorable event (recent or in the past) where you learnt something or made a difference to an aspect of care.

APPENDIX 3

A STUDY OF NURSING PRACTICE: TO INFORM LEAD NURSES, CHARGE NURSES AND WARD SISTERS

This leaflet provides information about a research study I will be conducting in acute medical and surgical areas at.....

Title of Research Study

Goals

To explore how nurses use knowledge, work collaboratively with doctors and other healthcare professionals within the ward team and deal with everyday nursing practice problems.

Subjects

Qualified registered nurses (adult) working in medical and surgical areas, who pocess a diploma or degree in nursing and have been qualified for at least 6 months and no longer than 5 years.

What's involved For Those Nurses Who Volunteer To Take Part in the Study?

- I will require each nurse who has volunteered to take part in the study to keep a verbal reflective diary of their perceptions of nursing (I will provide the nurse with a tape recorder for this purpose). I will ask the nurses to describe their thoughts about nursing, to record their thoughts on how they see themselves as a nurse within the multi-professional team and within the nursing profession as a whole. I will also ask them to describe any memorable event (recent or in the past) where they learnt something or made a difference to an aspect of care.

- Observing the nurses for part of a shift whilst they are engaged in nursing care (between 2-4 hours). I will ask them at the start of the observation period to brief me on the patients they will be caring for, their work priorities and what they hope to achieve. Whilst I am observing them I will ask questions about their work to seek clarification and understanding of the nursing practice being observed e.g. "what are you doing with this patient? Why are you doing that?

  At the end of the observation period I will ask the nurses to record into the tape recorder their thoughts about the shift, how they felt they did, any surprises? And if anything interfered with what they set out to achieve.

- Interviewing the nurses following the period of observation. (For approximately 30-40 minutes in a quiet room away from the ward). This will take place as near to the period of observation as possible, once I have listened to the tape recordings. I will seek clarification of the tape recordings and question the nurses in more detail about their perceptions of nursing and their nursing practice.

I will seek the nurse's permission to audiotape record interviews. Tapes will be destroyed following transcription.

Are there any benefits to taking part in the research?

Involvement in the research will allow the nurses the opportunity to reflect on their practice and consider aspects of care where they made a difference or learnt something about an aspect of care.

How will confidentiality be protected?

No one apart from me (the researcher) will have access to the records pertaining to the research. All tape recordings will be erased once the study is completed. My research supervisor will only have access to the anonomised typed transcripts.

The final written thesis will not contain any personal details or any other information, which could be traced to any individual or place where the study was conducted.

Who should be contacted if anyone requires further information?

Barbara Creber

(Address and telephone provided)

APPENDIX 4

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF PROJECT:

NAME OF HOST INSTITUTION

I am writing to invite you to take part in a research study, which I think, may be important and I hope will benefit nurses and nursing. The information, which follows, tells you about it. It is important that you understand what is in the leaflet. It explains what I will be asking you to do during the research. Whilst I do not think the research involves risks, I do explain what you should do if you have any concerns. Whether or not you take part is entirely your choice. Please make sure you fully understand what the research involves. So please ask questions you want to about the research and I will do my best to answer them.

Why have you been identified to take part in the research?

Because you are:

- A qualified Registered General Nurse (adult nursing) working in a medical or surgical ward.
- Possess a Diploma or Degree in Nursing
- Have been qualified as a Registered General Nurse for at least 6 months.

What are the goals of the research?

To explore how nurses use knowledge, work collaboratively with doctors and other healthcare professionals within the ward team and deal with everyday nursing practice problems.

If you participate in the research what will this involve?

- Ask you to keep a verbal reflective diary of your perceptions of nursing (I will provide you with a tape recorder for this purpose). I will ask you to describe your thoughts about nursing, to record your thoughts on how you see yourself as a nurse within the multi-professional team and within the nursing profession as a whole. I will also ask you to describe any memorable event (recent or in the past) where you learnt something or made a difference to an aspect of care.

- Observing you for part of a shift whilst you are engaged in nursing care (between 2-4 hours). I will ask you at the start of the observation period to brief me on the patients you will be caring for, your work priorities and what you hope to achieve. Whilst I am observing you I will ask questions about your work to seek clarification and understanding of the nursing practice being observed e.g. "what are you doing with this patient? Why are you doing that?

At the end of the observation period I will ask you to record into the tape recorder your thoughts about the shift, how you felt they did, any surprises? And if anything interfered with what you set out to achieve.

- Interviewing the nurses following the period of observation. (For approximately 30-40 minutes in a quiet room away from the ward). This will take place as near to the period of observation as possible, once I have listened to the tape recordings. I will seek clarification of the tape recordings and question the nurses in more detail about their perceptions of nursing and their nursing practice.

I will seek your permission to audiotape record interviews. Tapes will be destroyed following transcription.

Are there any benefits to taking part in the research?

Involvement in the research will offer you the opportunity to reflect on your practice and consider aspects of care where you made a difference or learnt something about an aspect of care.

How will confidentiality be protected?

No one apart from me (the researcher) will have access to the records pertaining to the research. All tape recordings will be erased once the study is completed. My research supervisor will only have access to the anonomised typed transcripts.

The final written thesis will not contain any personal details or any other information, which could be traced to any individual or place where the study was conducted.

Who should I contact if I require further information about the study?

Barbara Creber

(Contact address and telephone number supplied)

Glossary

A Grade – Health Care Support Worker

AF- Atrial Fibrillation

BP – Blood Pressure

CA – Cancer

D Grade – Staff Nurse

E Grade – Staff Nurse

ECG – Electrocardiogram

F Grade - Ward Sister

G Grade – Senior Ward Sister

GI Bleed – Gastro- intestinal Bleeding

GP – General Practitioner

GTN – Glycerine tri-nitrate

Gynae – Gynaecology

I.V- Intravenous Infusion

ITU – Intensive Therapy Unit

Neuro – Neurological

Obs – Observations

OT – Occupational Therapist

PCA – Patient controlled Analgesia

Physio – Physiotherapist

Post Ops – Post Operative
Resps – Respirations

Resus – Resuscitation

RMN – Registered Mental Nurse

Sats- saturation

TPN – Total Parentral Nutrition

Tracy – Tracheostomy

NOTES

1. When discussing the research respondents I have referred to them as "she" although some respondents were male.

2. I have highlighted in bold aspects of respondents quote/s that I particularly want to emphasise]