

**School of Nursing**

**A Grounded Theory Study of the Clinical Use of the Nursing  
Process within Selected Hospital Settings**

**Beverly Olivia O'Connell**

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## **Abstract**

The nursing process is the espoused problem solving framework that forms the basis of the way in which patient care is determined, delivered, and communicated in a multiplicity of health care settings. Although its use is widespread in educational and clinical settings, some nurse clinicians display negative attitudes towards the use of the nursing process. They claim that both the structure and language that underpins this process is cumbersome and unreflective of the way in which nursing care is planned and delivered. To date, there has been no study cited that has examined its use within a clinical setting and determined if and how the nursing process is being used and whether there is substance in the clinicians' claims. Additionally, some of the research on problem solving has used laboratory based designs that are limited as they are not sensitive to contextual factors that affect the use of a problem solving process, nor are they sensitive to the efficacy of the communication process. As patient care involves many nurses working under diverse contextual conditions, these factors need to be taken into consideration when studying this phenomenon.

Using grounded theory methodology, this study examined the clinical application of the nursing process in acute care hospital settings. Specifically, it sought to answer the following two questions: (1) How is the nursing process used by nurse clinicians in acute care hospital settings? and in the absence of its use, (2) How is nursing care determined, delivered, and communicated in acute care hospital settings in Western Australia?

Data were obtained from semi-structured interviews with predominantly nurse clinicians, patients, and patients' relatives, as well as participant field observations of nurse clinicians, and in-depth audits of patient records. Textual data were managed using NUD•IST and analysed using constant comparative method. Data generation and analysis proceeded simultaneously using open coding, theoretical coding, and selective coding techniques until saturation was achieved. This resulted in the generation of a substantive theory explaining clinical nursing in acute care hospital settings.

The findings of this study revealed several problems with the clinical application of the nursing process. It also revealed a process used by nurses to overcome many

difficulties they experienced as they tried to determine, deliver, and communicate patient care. Specifically, nurses in this study experienced the basic social problem of being in a state of “*Unknowing*”. Properties and dimensions of unknowing were found consistently in the data and this problem was labelled as the core category. This state of “*unknowing*” was linked to a number of factors, such as, the existence of a fragmented and inconsistent method of determining and communicating patient care and work conditions of immense change and uncertainty. In order to deal with this problem, the nurses in this study used a basic social process termed: “*Enabling Care: Working through obscurity and uncertainty*”. The first phase of the core process, termed: Putting the pieces together: making sense, involved four subprocesses. These subprocesses were labelled: drawing on the known, collecting and combining information, checking and integrating information, and sustaining communication. The second phase of the core process was termed Minimising uncertainty. It involved three subprocesses which were named: adapting work practices, taking control, and backing-up.

The findings of this study have implications for nursing practice, research, theory, and education, as it exposes problems with the clinical application of the nursing process in acute care settings. In addition, it further explicates a substantive theory that describes a process of nursing used by nurses in these settings. As the articulated process was supported by a number of studies and opinions of nurse scholars it is worthy of being considered as being foundational to an understanding of a process of nursing used in acute care hospital settings in Western Australia.

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# Chapter One

## Introduction and Statement of the Problem

Traditionally, nursing care was primarily based on the patient's medical condition and prescriptive medical orders (Johnson & Hales, 1989; Meyers, 1978). In the 1960's, the combined effect of a rapidly changing health care system and increasing demands on health care services led to the introduction of defined roles for health care professionals (Yura & Walsh, 1988). To establish the professional role of the nurse and to develop nursing as a separate discipline within the health care system, there was a deliberate move to scientise nursing (Donnolly, 1987). As part of this process, in 1967, a group of academics at Catholic University in Washington, explicated an organisational framework called the nursing process that defined deliberate, systematic stages of nursing practice (Henderson, 1987; Yura & Walsh, 1988). Advocates who were involved in the development and ongoing refinement of the nursing process argued that the implementation of a structured framework that underpinned nursing practice and the use of standard labels would result in improved communication among nurses, the provision of quality care, and a system for evaluating this care (Gebbie & Lavin, 1974; Gordon, 1987a; Yura & Walsh 1988).

Although these theoretical ideals have *a priori* support, some nurse clinicians continue to display negative attitudes towards the use of the nursing process in practice. These clinicians claim that, due to work-based issues and the complex nature of nursing, it is an inappropriate framework for clinical use (Higginbotham, 1991; Masso, 1990; Prideaux, 1991). In support, a number of nurse scholars question the appropriateness of using this reductionistic approach to care and caution its use in nursing practice (Barnum, 1987; Cooney & Watts, 1992; Hagey & McDonough, 1984; Henderson, 1987; Lawler, 1991a; Masso, 1990; Mitchell, 1991; Owen & Kelly, 1991; Pearson, 1988). Specifically, nurse academics and theorists have been critical about the process due to mainly philosophical anomalies between the nursing process structure and nursing's theoretical base.

According to O'Connell (1996a), the nursing process and, in particular, the diagnosis stage, has been widely debated in the nursing literature. Nurse scholars have argued from a philosophical stance whether articulating nursing care within a mechanistic framework using discretely defined labels to detail patient problems can adequately capture the complexities of patient problems, and whether it can therefore act to facilitate the determination, delivery, and communication of nursing care. This philosophical discourse raises several issues. Barnum (1987) questions the congruency between the reductionistic approach used in the nursing process and the assumptions of nursing's holistic philosophy. Several authors allude to the similarities between the nursing process, in particular the diagnosis stage, and the biomedical model stating that the latter is reductionist and has a narrower focus than that espoused by nursing (Cooney & Watts, 1992; Lawler, 1991a; Pearson, 1988). In addition, questions have been raised regarding whether this approach to patient care fully encompasses the nature of nursing or takes account of the unique characteristics of individuals and their responses to health problems.

Henderson (1982) states that the nursing process confines nursing practice to a narrowly focused regime, ignoring the intuitive approach to care. Masso (1990) adds that, as other members within the health care team do not understand the nursing process, it acts as a barrier, limiting communication among health care team members. Furthermore, from an ethical perspective, Mitchell (1991) emphasises that the lived experience of illness is multi-dimensional and unique to the person experiencing it. The issue of the nurse diagnosing and labelling the responses of another human being also raises certain ethical questions. Mitchell emphatically argues that nursing breaches the ethical principle of "to do no harm" when nurses judge and label their patients using certain diagnostic categories. For example, diagnosing and labelling a patient as being "Non compliant" may cause the patients to feel "misunderstood and disconnected" from the care (Mitchell, 1991, p. 99). Additionally, the labels used in some of the diagnostic categories, within the context of what they purport to label (human responses to their state of health), challenges nursing's commitment to delivering care within the frameworks of advocacy, reciprocity, and collaboration (O'Connell, 1996a). While this scholarly discussion is necessary it should not overshadow the views of clinicians who also voice concerns



(Elliot, 1994; Prideaux, 1991). Although the literature has raised germane questions about the nursing process, the substance of these claims has never been investigated within an acute care clinical setting.

In Australia, the nursing process underpins professional nursing standards, competencies, nursing practice, and documentation of nursing care in a multiplicity of settings. However, there is no substantive empirical study cited in the literature that has examined the use of the nursing process within clinical settings. In support, Openshaw (1984) argues that it remains unknown as to whether the nursing process results in improved care as this process has theoretical assumptions that have not been clinically proven. Given that this process is purported to be widely used, it is important to critically examine and describe its use within selected hospital settings in order to determine whether and how it is being used. In addition, as the literature has argued that some nurse clinicians display negative attitudes towards the nursing process (Henderson, 1987; Higginbotham, 1991; Masso, 1990; Prideaux, 1991), it is important to review nurse clinicians' interpretations of the usefulness of the nursing process in terms of guiding the determination, delivery, and communication of patient care. An exploration of nurses' understanding, experiences, and interpretations of its use in clinical practice may shed light on practice-based issues that need to be addressed. This is especially important and timely as there is a worldwide move to further refine and standardise the nursing process and develop standard nomenclature in the form of a diagnostic, interventions, and outcomes taxonomy (Fitzpatrick et al., 1989; McCloskey & Bulechek, 1994).

## **Brief Literature Review and Rationale for the Study**

The nursing process, as it was originally developed, comprised of four stages. These stages were: assessment, planning, implementation, and evaluation of care. During the first decade of its use, several nurse scholars claimed that there was a missing link in this four stage nursing process (Aspinall, 1976; Gebbie & Lavin, 1974; Mundinger & Jauron, 1975). They argued that, although nurses assessed the patient and then planned care based on this assessment, they did not label the patient's condition/problem that was treated. To address this deficiency and to identify and

label common problems that nurses managed, several nurse scholars introduced an additional stage, termed *Diagnosis* (Aspinall, 1976; Gebbie & Lavin, 1974; Gordon, 1976; Mundinger & Jauron, 1975). This stage follows the assessment stage and involves the nurse diagnosing the patient's problems and stating these problems using standard labels known as nursing diagnoses. It was postulated that the use of standard labels, as part of this process, would assist the nursing profession in the identification of nursing phenomena that would enhance nursing discourse and research. More specifically, it was argued that it would assist in naming, communicating, teaching, and researching health problems that were the focus of nursing care (Gordon, 1976; Woolley, 1990). Given that nurses work within a multidisciplinary team, where nursing care was traditionally seen as being synonymous with medical care, this explication of nursing's unique contribution to health care was said to be professionally important as it helped delineate the nursing domain.

According to Carnevali (1983), identifying the nursing domain was crucial for nursing's professional recognition. The two main reasons given were (1) it would assist nurses to explicitly understand the parameters of their practice, and (2) it would assist in establishing nursing as a specific discipline within the health care system and not solely as a supportive adjunct of other disciplines. Furthermore, it was said to assist in making explicit and communicating nursing's contribution to patient care (Crosby & Dunn, 1988) which could ultimately lead to the reimbursement of nursing care (Gordon, 1987b; Hovenga, 1991; Yura & Walsh, 1988).

Since its inception, the nursing process has been used increasingly by nurse academics, managers, clinicians, and staff development nurses. In 1980, the American Nurses Association endorsed the diagnosis stage of the nursing process by defining nursing as "the diagnosis and treatment of human responses to actual or potential health problems" (Carlson, Craft, McGuire, & Popkess-Vawter, 1991, p. 4). The nursing process is used in a multiplicity of clinical settings for the determination, delivery, and documentation of patient care. It also underpins the framework of nursing curricula both in the United States of America (USA) and Australia. More recently, the Australian Nursing Council Incorporated (ANCI) has listed nursing competencies for national registration which are classified under domains of practice.

One domain, Problem Framing and Solving, has been developed based on the nursing process (Thompson, 1991; ANCI, 1994).

Although the nursing process is used widely in clinical settings, some clinicians resist its use and question its utility. More specifically, surveys have shown that clinicians acknowledge the usefulness of the problem solving approach to patient care; however, they emphatically argue that the prescribed documentation within the nursing process framework is time-consuming and unreflective of actual nursing care (Masso, 1990; Prideaux, 1991). The clinicians' arguments have been and still are contested by some nurse academics, managers, and staff development nurses. Nurse academics involved in developing the North American Nursing Diagnosis Association's taxonomy argue that it enhances communication among nurses. Nurse managers argue from a legal and audit standpoint that the documentation is necessary as it provides the basis for evaluating patient care through quality assurance programs (McCourt, 1986; Warren, 1983). Also, it is suggested that it provides the framework to increase the quality of nursing care by providing patient care that is based on assessment and diagnosis and thereby specifically and scientifically addressing the unique needs of each patient (Mallick, 1981). From an educator's perspective, it provides a structured framework to teach nursing.

It may be that these differences in opinions between nurse academics, managers, staff development nurses, and clinicians are due to the different objectives and roles of these groups. Specifically, clinicians are involved in the direct delivery of patient care rather than focusing on management and theoretical aspects which, though acknowledged, may seem removed from actual care and, therefore, unimportant. In support, Latimer (1995) adds that the so called "professionalisation" of nursing has been brought about to serve management purposes that have restricted nursing practice. On the other hand, the clinicians' resistance to the use of nursing process has been explained by some academics and staff development nurses in terms of a lack of knowledge about the nursing process and a need for further in-service education (Cunning & Pflederer, 1986; Nolan, 1987).

In support of the latter view, a study conducted by Bowman, Thompson, and Sutton (1983) indicated that the use of a structured educational program conducted on the

nursing process created positive attitudes towards its use among nursing staff. By contrast, other studies produced results that conflict with this finding. A study conducted by Meade and Kim (1984) demonstrated that an education program on the documentation of nursing diagnoses (an integral part of the nursing process) had no effect on overall standards of documentation of nursing diagnoses in clinical practice. These findings are supported by Carstens (1984) who found that an in-service program on the nursing process had no effect on registered nurses' ability to identify and label valid nursing diagnoses. Furthermore, Fredette and O'Neil (1987) and Myers et al. (1986) examined the relationship between increased didactic theory on nursing diagnosis and the efficacy of diagnosing in clinical practice. The findings revealed no significant differences between the two groups. In addition, Smeltzer and McCreary-Juhasz (1990) found no significant relationship between nurses' educational preparation and planning patient care. The results of these studies raise the question as to whether the argument of a lack of knowledge about the nursing process is valid or whether there are other reasons that are rooted within the structure, framework, and diagnostic nomenclature of the nursing process, or other factors, that explain this occurrence. For example, Bleich (1990) argues that experienced nurses are unable to think in a linear way as articulated by the nursing process and, therefore, voice difficulties with its use.

The nursing process, and in particular the diagnosis stage, has been widely debated in the nursing literature. Nurse academics have argued from a philosophical stance whether articulating nursing care within a mechanistic framework, which uses discretely defined labels to detail patient problems, adequately captures the complexities of patient problems and can, therefore, facilitate the delivery of nursing care (Barnum, 1987; Cooney & Watts, 1992; Henderson, 1982; Lawler, 1991a; Masso, 1990; Mitchell, 1991; Pearson, 1988). This philosophical discourse supports the clinicians' claims that the structure and language of the nursing process is limiting and unreflective of actual nursing care. It is, therefore, important to review these claims and examine the clinical use of the nursing process in order to determine how it is being used and whether its use supports and reflects the care that is given and documented within a clinical setting.

The literature does not provide sufficient information on the clinical use of the nursing process. Studies have tended to focus on more peripheral issues, such as, reviewing nurses' attitudes to the nursing process rather than examining the clinical use of the nursing process (Bowman et al., 1983; Prideaux, 1991). Furthermore, studies conducted in this area have used study designs that have not adequately addressed this topic, focusing on stages of the nursing process rather than reviewing the process as a whole (Aspinall, 1976; Castles, 1984; O'Connell, 1992; Serrell, 1990; Ziegler, 1984). Thus, although much is known about particular stages of the nursing process, not much is understood about the clinical use of the process as a whole. By reviewing only stages of the nursing process rather than focussing on the process as a whole these studies have tended to raise more questions than were answered (Castles, 1984; O'Connell, 1995a; Prideaux, 1991; Serrell, 1990; Ziegler, 1984). Furthermore, the use of controlled study designs conducted in laboratory settings using case studies, vignettes, and multimedia platforms raises questions about the external validity of the findings as they have presented a contextually disassociated view of the whole picture, and the findings may not apply within the context of a clinical setting.

In addition, these studies (Castles, 1984; O'Connell, 1992) are also limited in that they examined individual nurses' responses, which give an incomplete view of what is clinically practised. Within a clinical setting, patient care is continuous over several work shifts; care is assessed, diagnosed, planned, implemented, and evaluated, therefore, by more than one nurse either concurrently or sequentially. In keeping with this, it is important to examine the clinical use of the nursing process, taking account of not only the individual nurse's perceived use and actual use but also the use of the nursing process as it occurs within the context of patient care and the handover of this care to other nurses over the total patient stay. MacLeod (1994) stated that the complexity and context-related nature of nursing work is frequently overlooked. Referring to the work of Benner (1984) and Brykczynski (1989), the author argued a need to explore the process, the content, and the context of nursing practice as these studies have revealed fruitful insights. According to White (1995), understanding the context of nursing practice is fundamental to the future of nursing and the relevancy of nursing's knowledge development. Furthermore, Walker and

Avant (1995) argue that “nursing knowledge for knowledge sake is useful, but knowledge for practice is paramount” (p. 207). Hence, research that evaluates the clinical application of the nursing process must use a study design that adequately represents a clinical situation and enhances understanding of issues within the context of clinical practice.

This argument of inadequate study designs is further illustrated in the following studies. Ehnfors and Smedby (1993) reviewed 106 nursing records for adherence to nursing process standards. The record audit revealed that the admission assessment was completed in 50 % of records, 66 % had no care plan, and 90 % had no nursing diagnosis. This retrospective study design had a few limitations. Specifically, although this information provided a good account of the level of documentation, it did not give an account of the level of care on these wards or whether the documentation was a true account of this care.

It seems that acontextual study designs present findings that are often unexplainable. For example, O'Connell (1992) conducted a controlled laboratory study to determine whether nurses who assess the same patient state the same nursing diagnoses and whether the type of assessment form used had an effect on the efficacy of diagnosis. The results revealed that the type of assessment form used significantly influenced the type of diagnoses that were identified. More importantly, it identified conceptual problems with the use of nursing diagnosis as both student and registered nurses labelled the same patient problems using different diagnoses. Furthermore, the diagnoses listed sometimes conflicted with the conceptual definition of nursing diagnosis. However, the researcher could not determine whether the nursing care (within the context of a clinical environment) was the same, regardless of the way in which nurses stated the problem. Moreover, when nurses did state the same nursing diagnosis it was not clear whether this diagnosis would result in the same nursing actions being planned and implemented within the context of a clinical reality. It would seem that this is a fundamental and important question that needs to be examined in the clinical setting. While laboratory based studies have some merit their limitations must be acknowledged. Furthermore, Rapley, O'Connell, & Tibbett (1995) reported no significant findings from a study conducted in a clinical setting,

that evaluated whether the assessment form used significantly influenced the type and number of diagnoses that were identified. Unable to offer a substantive explanation for these findings, the researchers recommended a need to develop a research design that involved field observations as the study raised many unanswered questions.

By contrast, another study conducted in a ward setting also raised concerns about the diagnostic stage of the nursing process. Castles (1984) found that nurses who assessed the same patient during a period when the patient's condition was stable stated different diagnoses and reported different signs and symptoms as bases for their conclusions. These findings were inconsistent with what may have been expected, as the unit where this study was conducted had a high reputation for care. Therefore, one could argue that regardless of the way in which nurses stated diagnoses they apparently delivered appropriate care. This raises the question of how nurses relate their assessments to nursing diagnoses and whether they actually use nursing diagnoses to determine patient care or, indeed, whether they use another strategy altogether to plan patient care.

Furthermore, Ziegler (1984) evaluated 168 nursing diagnoses, derived by 90 master's level graduate nurses, for adherence to the structural and conceptual definition of a nursing diagnosis. The results revealed that only 10 diagnostic statements complied with these definitions. These studies suggest there is a lack of conceptual clarity and some confusion regarding the assessment and diagnosis stages of the nursing process. If the conceptual confusion identified in the literature mirrors what is clinically practised then there is need for concern. However, it is not known whether nurses actually use the nursing process, as it was developed theoretically, in clinical practice or whether there is another underlying approach to patient care. One must question whether the *espoused theories* of the nursing process, are consistent with the *theories-in-use* in clinical practice (Argyris & Schon, 1974, 1978). Additionally and more importantly, many of the studies used positivistic study designs that were conducted in laboratory controlled settings and hence the external validity of the findings are questionable. It is argued that nursing practice is influenced by many contextual factors which need to be taken into consideration when designing studies that focus on nursing practice.

There is a strong textbook assumption that patient care is based on nursing assessment and diagnosis. This literature supports the notion that the first two stages of the nursing process are vital and pivotal to the rest of nursing care (Aspinall, 1976; Alfaro-LeFevre, 1994; Carpenito, 1995; Iyer, Taptich, & Bernocchi-Losey, 1995; Kim, Suhayda, Waters & Yocum, 1984; Ziegler, Vaughan-Wrobel, & Erlen, 1986). It is claimed that if potential and actual problems are not identified and made explicit through assessment and diagnosis then nursing interventions that prevent, minimise or alleviate the problem will not be implemented (Gordon, 1987a), thus compromising the quality of total patient care. Similarly, Baker (in press) argues that patient problem identification and nursing care that is locked in the nurse's mind, rather than being communicated to the team via the nursing process, will perpetuate a model of care that is haphazard and lacking in continuity. Although this argument seems logical, there has been no cited study that has examined within a clinical setting whether the use of nursing diagnosis has facilitated the planning, implementation, and evaluation stages of the nursing process. Furthermore, the above studies raise questions as to whether the diagnostic stage is really used in clinical practice. Another issue that is of professional concern, is that, most of this literature and publications on the nursing process stem from the USA. It is, therefore, important to determine whether a theoretical ideal developed in North America has clinical utility in Australia.

Nursing standards dictate the use of the nursing process. However, there is not much known about the clinical use of the nursing process and the congruency between the theoretical ideal and what is practised. A study that examines this process in a substantive way from a clinical perspective is indicated. In support, Varcoe (1996) states that there has been a lack of research conducted on the clinical application of the nursing process and, therefore, any argument for and against the use of this process remains unsubstantiated. Hence, research on this phenomenon is necessary. It is also important that the research design takes cognisance of contextual factors as these factors have a profound influence on nursing practice (Pratt, 1996).

Lawler (1991a) further adds that Australia has been "intellectually colonised" by imported ideas from the USA and she questions the need for the use of the nursing



process in Australia. Additionally, she argues that nurse clinicians have rejected the nursing process and their rejection should be appraised as being a sign of its inappropriateness for use in practice. Furthermore, Street (1992) states that within clinical nursing there exists an oral culture which is effective, though disconnected from the highly organised written culture. This oral culture is inherent in the type of interactions in which nurses engage, their day-to-day dealings with their patients, relatives, and the interdisciplinary team. She states that the organised written culture has been driven by the need to mirror the more recognised medical culture. As the nursing process is an example of this written culture, then the question of whether it is appropriate for nurse clinicians whose professional culture is purported to be different needs to be explored. This argument raises the question of whether the oral or tape-recorded nurse handovers, currently used, are the actual mechanism used to communicate and plan patient care rather than the formal documentation system. Research is indicated to further explore this aspect of the nursing process within clinical settings. In support, Chenitz and Swanson (1986) state that the nursing process used by nurses in daily practice needs to be identified and described in order to enhance our understanding of nursing.

## **Purpose**

The nursing process underpins professional nursing standards, competencies, and the practice of nursing in a multiplicity of settings. Although widely accepted by certain groups of the nursing profession, some nurse clinicians display negative attitudes towards its use in clinical practice. Whereas much has been written about the nursing process, there is a paucity of cited empirical literature. Furthermore, studies conducted in this area have focussed on particular stages of the nursing process and were conducted in contextually different environments, rather than reviewing the process as a whole within a clinical setting. There has been no study in the literature that has critically examined the substance of the clinicians' claims and studied the use of the nursing process as a whole, using multiple sources of data generated in different contexts. Such a study design is indicated, as there remain many unanswered questions and conflicting research findings about the clinical application of the nursing process (Castles, 1984; Smeltzer & McCreary-Juhasz, 1990;

O'Connell, 1995a; Serrell, 1990; Prideaux, 1991). More importantly, no cited study was found that has examined whether the nursing process is actually being used to deliver nursing care or remains an imposed structure that is only claimed to be used. Davis, Billings, and Ryland (1994) argue a need for the use of a study design that incorporates a period of field observation, as surveys and review of patient documentation provided limited information when reviewing the nursing process.

The purpose of this study was to explore, describe, and analyse nurse clinicians' use of the nursing process within a clinical setting. Using grounded theory methodology, it systematically examined and described the use of nursing process as documented in patient records, as stated by nurses, and as observed in clinical practice within selected Western Australian acute care settings. This study also examined how the nursing process was being used and the extent to which its use complied with the theoretical standards and definitions on which it was developed. It sought to uncover information from nurse clinicians and described their understanding, experiences, and interpretations of factors that enhanced and impeded the use of the nursing process. It also sought to discover not only ways in which nurses used the nursing process but also the ways in which they accommodated this framework within clinical practice. In addition, it described within a clinical setting where the nursing process was purported to be used and not used, how nurses actually determine, deliver, and communicate patient care.

## **Research Questions**

This study was guided by the following questions:

1. How is the nursing process used by nurse clinicians in acute care hospital settings in Western Australia? (and in the absence of its use);
2. How is nursing care determined, delivered, and communicated in acute care hospital settings in Western Australia?

## **Study Objectives**

1. To explore and describe nurse clinicians' perceptions of how they use the nursing process in acute care hospital settings.
2. To explore and describe nurse clinicians' perceptions of how the nursing process assists or hinders the determination, delivery, and communication of nursing care in acute care hospital settings.
3. To identify factors perceived by nurse clinicians that assist or hinder the use of the nursing process in acute care hospital settings.
4. To examine and describe, from the patient's record, how the nursing process is documented in selected acute care hospital settings.
5. To describe, through observations, how nurse clinicians use the nursing process in selected acute care hospital settings.
6. To develop a substantive theory which explains how nurses determine, deliver, and communicate patient care in selected acute care hospital settings in Western Australia.

## **Significance of the Study**

This study is of significance for nursing practice, theory, research, and education as it developed a theory that conceptualised the clinical application of the nursing process within Western Australian acute care hospital settings. Specifically, it described the way in which nurses determined, delivered, and communicated patient care in these settings. It outlined practice-based issues and factors that influenced the use of the nursing process within clinical settings. It made recommendations based on information that emanated from the experiences of nurse clinicians within the context of clinical practice, about the clinical use and utility of the nursing process. This information provides a sound basis for further research conducted in this area.

## Definition of Terms

The following definitions were used in this study:

**Level Two Nurse:** The Western Australian nursing career structure was developed in 1988. It contained four specialist streams. These streams were: clinical, staff development, management and research. Each stream comprised levels one to four. All positions from Level 2 and above are promotional positions. Nurses appointed to these positions are deemed to be advanced clinicians (McCarthy, 1987).

**Shift coordinator:** A senior nurse who was responsible for coordinating the shift. This nurse was usually a Level Two nurse. As there were usually four Level Two nurses who worked permanently on a ward, this position was rotated.

**Agency Nurse:** A nurse who was employed by a Nursing Agency and had work assigned to them via the Nursing Agency.

**Casual Nurse:** A nurse who was employed by the hospital and worked for the hospital on a casual basis as required by the hospital.

**Acute Care Hospital Settings:** Any ward in a public hospital that admits acute care patients who are not day cases.

## Overview of the Thesis

This thesis is presented in six chapters. Chapter One has provided a brief literature review, the rationale for the study, and the study objectives. Chapter Two will outline the methodology used to address the study objectives. Chapter Three will describe the basic social problem experienced by the nurses who participated in the study. Chapter Four will describe the basic social process used by nurses who participated in the current study to deal with the core problem. Chapter Five will explain and illustrate the overall grounded theory of the way in which nurses determined, delivered, and communicated patient care. Chapter Six will discuss the findings in the context of the extant literature. Additionally, it will discuss the implications of

the findings and make recommendations for nursing practice, theory, research, and education. The limitations of the study are also discussed in the final chapter.

## **Chapter Two**

### **Methodology**

#### **Overview of the Chapter**

This study was designed to discover the process nurses used to determine, deliver, and communicate patient care over the total patient stay. Specifically, it sought to describe the clinical application of the nursing process and to develop a theory that explained its use in acute hospital settings. This chapter will discuss the methodology used to address the study objectives. Additionally, it will outline the research trail in order to enable readers to determine how the theory was developed and to facilitate a similar study to be conducted.

#### **Research Design**

Grounded theory method as described by Glaser and Strauss (1967) and Glaser (1992) and to a lesser extent Strauss and Corbin (1990) was used to address the study objectives. The aim of this method of inquiry is to develop a theoretical framework and a substantive theory that proposes hypotheses from the information within the data. It does not seek to test existing hypotheses within a setting (Glaser, 1992; Streubert & Carpenter, 1995). Furthermore, it is designed to provide information that is grounded in nursing practice rather than information that is framed within the researcher's conception of the major issues (Abbott & Sapsford, 1992). The main reason for using this method was that the existing studies on this topic had been developed using reductionistic research designs, such as laboratory based case studies or vignettes (Cianfrani, 1984; Henning, 1991; Kerr, 1987; O'Connell, 1992). It is argued that these types of study designs have not fully explored the problem solving process used in nursing and have limited the understanding of this topic. Specifically, these approaches were not sensitive to contextual factors that affect the use of a problem solving process, nor were they sensitive to the efficacy of the communication process. As patient care involves many nurses working under diverse contextual conditions, these factors needed to be taken into consideration when studying this phenomenon. Additionally, the cited literature revealed that the

reductionistic research methods had raised more questions that remain unexplained and, therefore, required further investigation (Serrell, 1990; O'Connell, 1995a; O'Connell, Rapley, & Tibbett, in press). A more comprehensive and exploratory approach that takes account of all these factors was necessary. According to Hughes (1990) "positivist methods not only give a partial account of social life they distort its nature in profound ways" (p. 94). Given these circumstances, grounded theory methodology was deemed to be an appropriate method for the study of the clinical application of the nursing process in acute ward settings.

## **Grounded Theory Method**

### **Background**

In 1967, grounded theory as a research method was explicated by two sociologists Barney Glaser and Anslem Strauss (Glaser & Strauss, 1967). As part of a sociological field investigation on the awareness of dying as a social problem, Glaser and Strauss as co-investigators formalised the grounded theory method. As a result of this endeavour, they proposed an alternative research method using a more interpretive approach to knowledge construction, rather than using the then traditional quantitative empiricist approach (Benoliel, 1996; Glaser, 1992). The extrapolation of this approach into nursing gained momentum in the 1970's and 1980's in the University of California at San Francisco. During this period Strauss and Glaser conducted grounded theory classes for both sociologists and nurse scholars enrolled in the doctoral program. Grounded Theory as a method, therefore, gained recognition and acceptance by this group of nurses as it seemed to take account of the social context, hence, suited the study of phenomena that were of nursing concern (Lowenberg, 1993). Chenitz and Swanson (1982) so aptly argue that, as nursing shares knowledge with many disciplines and its domain spans a spectrum from the neonate to the aged, the reduction of phenomena into variables that are controlled limits generalisability of the findings. The momentum of using this approach was sustained by a number of publications in the nursing literature that raised interest, namely, those by Stern (1980), Chenitz and Swanson (1986), Strauss and Corbin (1990), Hutchinson (1993), and Wilson, Hutchinson, and Holezmer (1997). In Western Australia, Vera Irurita pioneered this methodology in her doctoral

study entitled “Optimising as a leadership process: A grounded theory study of nurse leaders in Western Australia” (Irurita, 1990). Since that time, Vera Irurita has continued to use this method in other studies (Irurita, 1992, 1993, 1996a, 1996b, 1996c). Additionally, she has been conducting grounded theory classes and weekly seminars for postgraduate students both studying and using the method. These classes have provided the avenue for further support, debate, clarification, and understanding of this method. Glaser (1978) stated that this type of support and training in the method was a necessary and important part of the research process. More recently, Stern (1994) adds that there are elusive stages in the method that have not been described and hence emphasises the importance of mentoring researchers using this method for the first time. In addition, these seminars were used to assist researchers using this methodology to further verify the emerging codes and in the analysis of the data, thus assisting with the reliability and validity of the data analysis.

### **Epistemology of Grounded Theory**

The epistemological assumption that underpins the grounded theory method is symbolic interactionism which arises from social psychological theory. According to Denzin and Lincoln (1994), symbolic interactionism is difficult to summarise as it is informed by varying theoretical positions. One of these positions, however, that influenced grounded theory and is of concern in this thesis is that of Blumer (1969). Herbert Blumer drew on the work of Mead an American social interactionist theorist to develop a theory of symbolic interactionism. He claimed that symbolic interactionism rests on three premises: Firstly, human beings act toward the physical objects and other beings in the environment on the basis of the meanings these things have for them. Secondly, these meanings derive from the social interaction (communication, broadly understood) between and among individuals. Communication is symbolic as we communicate via languages and other symbols; further, in communicating we create or produce significant symbols. Thirdly, these meanings are established and modified through an interpretive process (Cited in Denzin & Lincoln, 1994, p. 124). In grounded theory, the researcher needs to understand behaviour as the participants understand it, learn about their world, learn their interpretation of self in the interaction, and share their definitions. Behaviour



then is studied from both the symbolic and interactional levels and it must be observed in context because meanings are derived from social interaction (Baker, Wuest, & Stern, 1992, p. 1357; Wilson & Hutchinson, 1991). Specifically, “the research interest is in understanding how individuals take and make meaning in interaction with others. The emphasis is on the pressures of meaning-making in social organisation” (Marshall & Rossman, 1995, p. 2).

The development of the Grounded Theory Method was also linked to the tradition in Sociology at the University of Chicago. Specifically, from the 1920’s to the 1950’s researchers at the University of Chicago used field observation and intensive interviews as sources of data for research on the sociology of work (Strauss, 1987). Additionally, Chicago Sociology subscribed heavily to the view of grasping the participant’s view on interaction, process, and social change (Strauss, 1987). In summary, grounded theory has at its base the social philosophy of symbolic interactionism (Denzin & Lincoln, 1994). It seeks to study social phenomena in their natural settings through the data collection processes of field observation, in-depth interviews, and document analysis (Glaser & Strauss, 1967). Stern (1994) argues a controversial point that this method is linked to the philosophy of phenomenology “... that is, methods that are used to describe the world of the person or persons under study” (p. 213). As the purpose of this study was to describe and theorise about the way in which nursing care was determined, delivered, and communicated within the context of acute care settings, this methodology was deemed to be suitable for the study of this phenomenon.

### **The Grounded Theory Debate**

Grounded theory method was explicated by Glaser and Strauss who co-authored texts describing the methodology and co-researched phenomena using the method. According to Stern (1994), although Glaser and Strauss thought they were using the same method, they had different *modus operandi* that were apparent to their doctoral students. This difference came to light in 1990 when Strauss co-authored a textbook on grounded theory with Juliet Corbin who was one of Strauss’s doctoral students (Strauss & Corbin, 1990). This textbook entitled “Basics of Qualitative Research: Grounded Theory Procedures and Techniques” was designed to assist beginning

grounded theory researchers by detailing a step by step guide on how to use the method. This publication and its further explication of the grounded theory method was appraised by Barney Glaser as being in breach of the tenets of grounded theory. Specifically, he stated that the proposed guide was too prescriptive and imposed a framework on the data analysis that promoted the forcing rather than the emerging of the theory. Glaser unsuccessfully tried to get the book withdrawn from publication (Glaser, 1992). In an effort to point out discrepancies in that text, Glaser published his own text entitled *Basics of Grounded Theory Analysis* where he outlined his concerns (Glaser, 1992). Glaser is critical of the Stauss and Corbin text for the following two main reasons:

1. The text encourages researchers to ask questions of the data that depart from the central underlying question of -what is the chief concern or problem of the people in the substantive area and what accounts for most of the variation in processing the problem; and
2. The use of a preconceived framework (paradigm) for asking questions of the data and hence subsequent data analysis forces data into the framework rather than allowing the categories to emerge from the data itself.

Acknowledging this difference between the two researchers who were the founders of the method, the literature alludes to the Glaserian and the Straussian grounded theory approaches. Although this difference needs to be acknowledged, it must be recognised that there is overlap in the use of some terms in both approaches. For example, terms like axial and theoretical coding, are used in both schools; however, they may vary marginally in their definition. While the method used in this study is informed by recent publications on grounded theory methodology, it follows as closely as possible the descriptions of the method in the original textbook *Discovery of Grounded Theory* Glaser and Strauss (1967), and those by Glaser (1978, 1992), and Irurita (personal communication, 1994-1997; 1996c).

## **Design**

The purpose of this study was to describe and theorise about the way in which nurses determined, delivered, and communicated patient care in acute care settings. It also sought to identify the contextual factors that influenced this process. Grounded theory method was deemed to be suitable and was therefore used to address the study objectives. The goal of grounded theory method is to develop a substantive theory from data that is collected in natural settings. Grounded theorists support the view that each group experiences a basic social psychological problem that is not usually known or articulated by the group (Wilson & Hutchinson, 1991). By developing theory, the research seeks to explain the basic social problem experienced by a group of participants and the basic social process used to deal with this problem (Glaser & Strauss, 1967). Additionally, a core category emerges that explains and accounts for the greatest variation in the data. This core category may be the basic social process or to lesser an extent the basic social problem. Furthermore, grounded theory method generates theory through the process of induction and deduction, providing explanations (hypothesising) about social and psychological processes (Glaser & Strauss, 1967; Baker et al., 1992). In order to achieve this outcome, the grounded theory method has several stages that were used in this study and therefore will be defined and discussed.

### **Stages of the Grounded Theory Method**

Figure 2:1 on page twenty-two provides a schematic representation of the overall study design. Each stage will be discussed in greater depth further on in this chapter. Although data collection and analysis occurred concurrently these activities are reported separately to assist in the clarity of the discussion.

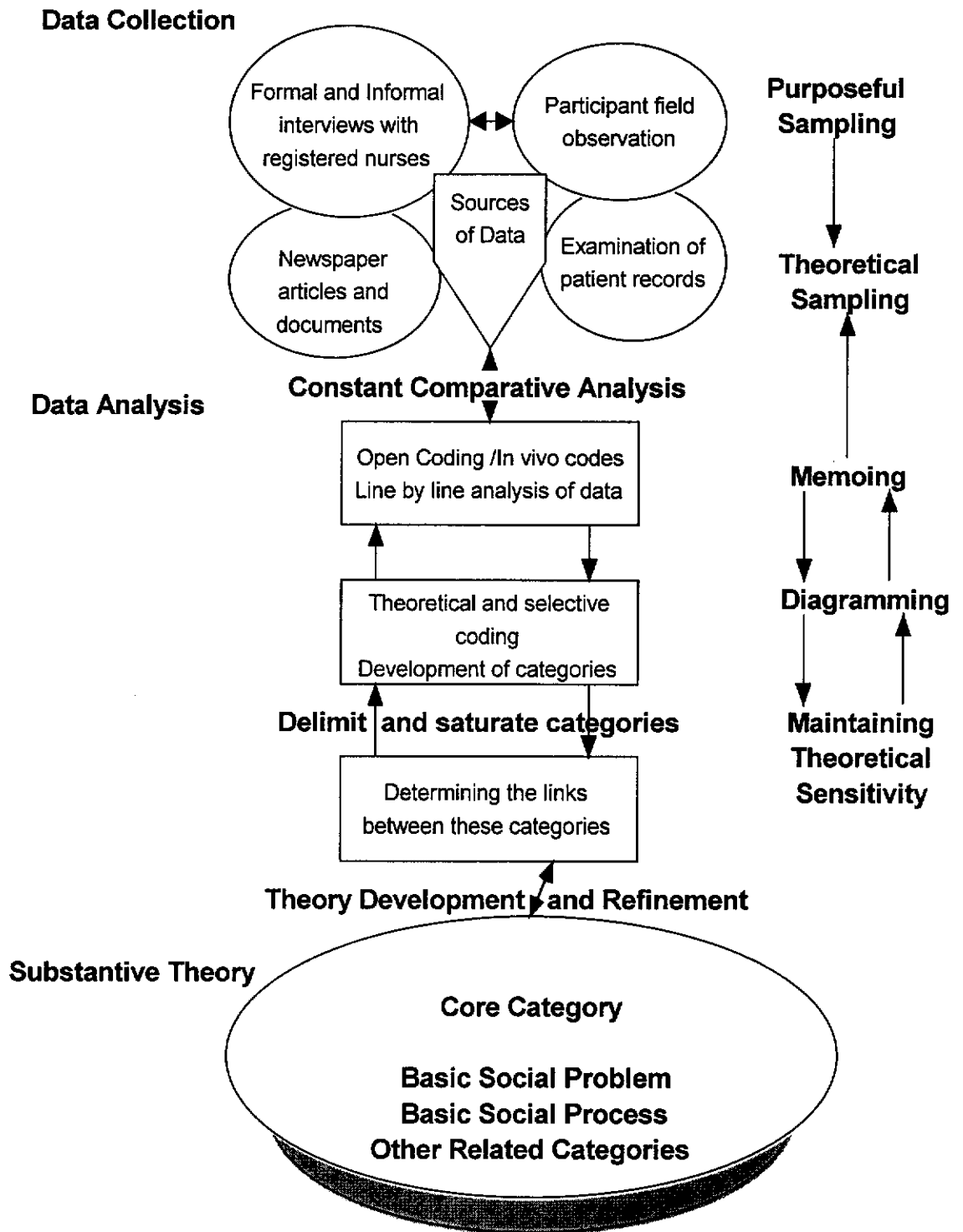


Figure 2:1 Schematic Representation of the Grounded Theory Method

## **Setting**

This study was conducted in the state of Western Australia. The findings reflect the views and social processes experienced by nurse clinicians, the majority of whom had worked in a number of wards and acute care hospital settings. Registered nurses who worked in public hospitals that used the nursing process were invited to participate in this study. Participants were initially accessed through a large University where they were undertaking post registration studies. They were approached in groups at the end of a lecture and invited to be interviewed. Interviews were conducted at a mutually agreed venue and time. In addition, subsequent field observations and informal interviews were conducted at a total of five acute medical and surgical wards in a major teaching hospital that used the nursing process. Alongside this, in-depth analysis of patient's case notes were also conducted at the same major teaching hospital. Field observations were commenced only after the hospital's Nursing Research and Ethics Committee had given permission to conduct the study.

## **Sample**

Purposeful sampling was used during the first part of the study. Specifically, registered nurses who worked in acute care hospital settings that used the nursing process were invited to participate. After the analysis of the first five interviews, theoretical sampling procedure was used to access informants (Strauss & Corbin, 1990). According to Field and Morse (1992), this sampling procedure is designed to maximise accessing key informants who provide information that addresses the study objectives. At the start of the study, it is difficult to predict the type of information, themes, and concepts that will emanate from the data, Strauss and Corbin (1990), therefore, argue the need for the use of a flexible approach to the sampling procedure. This flexibility is necessary in order to obtain relevant data that will shed light on, confirm or deny the emerging hypotheses. Additionally, this process is necessary as it supports the concept of "constant comparative analysis" where sections of data are constantly compared with one another in order to derive the theory that is informed by many sources of information.

Initially, as part of the purposeful sampling procedure, participants who worked in acute care settings that used the nursing process were invited to participate in the study. To elicit a broad-based understanding of the phenomenon, participants were selected from both medical and surgical wards. Early analysis revealed several perspectives on the clinical application of the nursing process. This information formed the basis of the theoretical sampling procedure. As the data revealed an increasing use of agency and casual staff, whose work practices influenced the study phenomenon, agency and/or casual nurses were also asked to participate in the study. Their perspectives on how they determined, delivered, and communicated patient care informed the study. Early data analysis indicated that experienced nurses determined and communicated care differently to more junior nurses. In order to explore these differences, junior and experienced nurses were sought and asked to participate in the study.

Participants were invited on the basis of how their information added to the understanding of the study phenomenon, the development and refinement of the emerging categories, and the overall formulation of the grounded theory. Other issues, such as participants being professionally disillusioned and patient care being compromised, emerged coincidentally from the interviews and field observations. These issues were explored in subsequent interviews with the participants and with new participants entering the study. As data analysis continued, it seemed necessary to interview patients, patients' relatives, and doctors to determine their perspectives on the overall communication process in acute care ward settings. It was also necessary to determine whether their views were different or similar to the nurses participating in the study. All this information obtained from theoretical sampling assisted with the further refinement of the emerging categories and with the development of the overall theory. In summary, as the data analysis revealed gaps in information or alluded to a clue that should be further investigated the most appropriate person who could shed light on the developing grounded theory was invited to participate in the study.

A total of 27 semi-structured interviews were conducted, each lasting approximately 40 to 60 minutes. This sample of participants comprised a total of 20 registered

nurses, three patients, two relatives of patients and two participants who were recently hospitalised registered nurses. Additionally, there were eight follow-up interviews conducted, either face-to-face or via the telephone. These interviews lasted approximately 15 to 20 minutes. Furthermore, during the field observation period more than 50 nurses with diverse levels of experience and backgrounds were also informally interviewed and, therefore, form part of the sample. As the nursing process was purported to be used widely, it was important to involve all levels of nurse clinicians in order to accurately address the study objectives. Enrolled nurses were excluded from the study as this group of nurses were not permitted to diagnose nursing problems or take full responsibility and accountability for nursing care.

In addition, as part of the theoretical sampling procedure patients and patients' relatives were interviewed in order to confirm or deny some emerging categories. Convenient sampling procedure was used for this group of participants. Patients and patients' relatives were accessed through informal channels and invited to participate. Both patients and relatives of patients were invited on the basis that they had recently been an in-patient, or a relative of an in-patient, in an acute setting that used the nursing process.

### ***Sample Description***

A total number of 20 registered nurses were formally interviewed. Demographic data obtained from the registered nurses indicated that the majority (n=19) were female and one was male. Their ages ranged from 22 to 49 years with a mean of 34.95 years (SD = 7.58). They had been nursing a mean of 12.75 years with a range of one to 28 years. All staff interviewed had used the nursing process. Eleven of the nurses had a Bachelors degree in nursing. Five nurse participants had a Hospital Based Diploma and three participants from this group of five were in the process of completing their nursing Bachelors degree. Four of the participants had postgraduate qualifications one of which was at the Master's level. Seventeen of the participants worked in diverse medical and surgical settings, two worked in coronary care area and one in a geriatric setting. The majority of nurses (12) worked in teaching hospitals and four nurses worked in non teaching hospitals. Three nurses who worked as agency nurses,

and one nurse who was a lecturer, had work experience in a number of teaching and non teaching hospitals.

The Western Australian nursing career structure contained four specialist streams. Although these positions have altered from their original construction, generally, they comprise the following streams: clinical, staff development, management, and research. Each stream comprises levels one to five. Nurses working in all health department hospitals and some private hospitals are employed to work within a stream at a designated level (McCarthy, 1987).

Data revealed that 17 participants worked in the clinical stream, one in the management stream, and one participant's job spanned the streams of clinical, management, and education. One participant was employed as a lecturer at a University where she had experience working in multiple surgical wards in different hospital settings supervising students on their clinical practicum.

Eleven nurses were employed at level one in the career structure, four were level two nurses, three were level three nurses and one participant from level four. One participant who was employed at a University School of Nursing was excluded from this description. The demographic data revealed that there were no level five nurses or nurses from research streams who participated in the study. It is important to note that the majority of participants interviewed had worked in multiple acute care settings and, therefore, their accounts of the phenomenon under study were broader than that inferred by their demographic description. Additionally, most of the nurse participants had worked as agency nurses in this State.

Demographic variables of patients, nurse-patients, and patients' relatives who participated in the study were not taken. These participants were invited to participate in the study as they had recent experience of being patients or relatives of patients that were recently hospitalised in acute ward settings and were able to provide information that further clarified emerging categories.

### **Data Collection**

Data were collected from four main sources as described in the following paragraphs.



***Source 1      Formal Semi-Structured, Open-Ended Interviews.***

This study commenced after approval had been granted from the University's Human Research Ethics Committee. Initially, registered nurses who worked in a range of acute care hospital settings that were using the nursing process were approached in groups, at the end of a lecture, and invited to participate in the study. All participants were provided with information about the purpose of the study and the potential benefits to nursing (see Appendix A). They were all given an opportunity to ask any questions in relation to the study. This cohort of nurses (n=7) from diverse backgrounds was initially accessed in order to yield a broad spectrum of data that sensitised and informed the researcher of a wide range of initial codes and categories.

After obtaining formal consent, semi-structured, open-ended interviews were conducted at a mutually agreed time and location. The majority of the interviews were conducted in a meeting room at the School of Nursing. Two interviews were conducted at the participants' homes and three interviews were conducted in a meeting room at a hospital. According to French (1993), semi-structured interviews are necessary when the researcher requires specific information which is guided by the use of broad questioning. However, the interviewer also asks participants to expand on their answers and further explore other issues as they arise and as appropriate addressing the phenomenon of inquiry. An interview guide was developed and used as a general checklist of items to address during the interviews. This guide was developed based on the study objectives (see Appendix B). The interviews were approximately 40 - 60 minute duration and were tape recorded. The tape recorded interviews were transcribed verbatim in preparation for analysis. Informants were advised that follow up interviews conducted either face to face or via the telephone may be performed at a later stage and permission to do this was sought on completion of the first interview. The informants were required to complete a questionnaire providing demographic information (see Appendix C). Memos were recorded on the completion of each interview and throughout the analysis stage (Strauss & Corbin, 1990). These memos contained information about any visual cues, body gestures of the participant, or any aspect of the interview process that would assist with the analysis of the interview transcripts. This procedure, combined with writing theoretical memos and diagrams pertaining to data

analysis, continued throughout data collection and analysis stages. Based on the emerging categories and theoretical sampling procedures, subsequent interviews (n=13) were conducted as necessary. All the formal semi-structured, open-ended interviews (N=20) were conducted from October 1994 through to November 1996.

Additionally, during the participant field observation period further informal interviews were conducted to clarify observations and developing categories. Specifically, informal interviews were conducted with registered nurses, casual, agency, and permanent nurses working on the wards at the time of the observation period. Two medical doctors were informally interviewed during this period. Other informal interviews were conducted during meal breaks and included other Clinical Nurse Specialists who serviced all ward areas.

### ***Source 2      Participant Field Observations***

After approval had been granted from the University's Human Research Ethics Committee, and the Hospital's Research and Ethics committee, and registered nurses in the wards had consented to participate in the study, participant field observations within the selected wards were conducted. Although the researcher was not permitted to deliver patient care, the term participant field observations was used based on the position held by Atkinson and Hammersley (1994) who espoused that all social research is a form of participant observation as the researcher remains part of the social context. In this study, it involved interactions with the nurses, those being observed, in the form of informal interviews. These participant observations occurred at randomly selected periods (spot observation techniques) unknown to the nurse clinicians (Field & Morse, 1992). The length of each field observation period varied from one and a half hours per day to six and a half hours per day. Field notes and memos were recorded during and on the completion of each observational period. Ashworth (1995) in his discussion on the phenomenology of participant observation states that "where members share in a stock of knowledge, communication is easy and participation can occur. Where they do not, communication and participation are flawed" (p. 374). As the researcher was a registered nurse, field notes conducted during this period were particularly enriching as they shed light on the phenomenon and added meaning to the spoken words of the nurses who were formally and

informally interviewed. In order to validate observed information, informal interviews with nurse clinicians involved in the observation were conducted periodically throughout the field observation period.

Participant field observations were conducted in five ward areas, three medical and two surgical wards. A total of sixty three hours were spent in acute ward settings, observing patient handovers, reviewing patient's nursing and medical notes, and generally observing nurses going about their daily work. Field observations were conducted over a four month period, from June, 1995 to November, 1995. These observations were conducted over two distinct periods. According to Germain (1986), data analysis from initial observations informs the researcher to be more focussed and selective in subsequent observational periods. During the first observational period, participant field observations were conducted over nine days. The researcher attended the ward at select times to enable the collection of information that addressed the study objectives.

Field notes were thoroughly reviewed each night and a list of unanswered questions was constructed to sensitise the researcher to particular aspects that required attention in the next observation period. This procedure prompted the researcher to be more focused in the data collection period and to seek information on the properties of the categories and to confirm or refute emerging categories and the theory. All data obtained from the first observational period were analysed and thoroughly coded prior to the commencement of the second period. In the second period, the observations were conducted over 11 days. During both periods approximately 50 nurses were informally interviewed in ward areas. These interviews were conducted with agency, casual, part time, and permanent registered nurses who worked on the wards at the time. Two medical doctors were also informally interviewed during this period. All interviews lasted approximately five to fifteen minutes and were documented as field observation interviews. In addition, informal interviews were conducted with consenting participants well after the observational period. This was performed in order to verify emerging propositional statements with the participants. Nurses from levels one through to four within the streams of clinical, staff development, and management were informally interviewed.

## Reflecting on entering the field

According to Field and Morse (1992), negotiating entry that enables acceptance and cooperation in the setting are a necessary and important aspect of field research. In order to minimise any Hawthorne effect, caused by participants' awareness of the research process, and to enable the accurate observation of behaviour, purposeful strategies were used by the researcher. These strategies are reflected upon in the following paragraphs taken from the researcher's diary (O'Connell, 1995b).

*During the field observation period, negotiating entry occurred at many points and each point of entry required specific attention. Initial entry into the hospital was negotiated through the Nursing Research and Ethics committees. Before commencing field observations, I liaised with several people within the hospital's hierarchy. Firstly, I had to make an appointment to meet the Nurse Clinical Coordinator of the particular directorate in which the ward was located and discuss my study with her. She in turn introduced me to the ward Clinical Nurse Specialist who introduced me to the nurses on the ward, a three-tier introduction process. Meeting all these people from the top down was very helpful as it gave my study some endorsement. This procedure was repeated before entering each ward.*

*Although I negotiated entry into the ward via the formal channels, I felt that I negotiated entry every day, as the wards not only had their routine staff, there were many agency and casual nurses. In addition to this, the new graduate nurses periodically rotated wards as part of their graduate program and did so during the field observation period. As I saw new faces every day, I had to continually seek nurses' consent and approval and more importantly gain their trust. Gaining entry was not only about gaining physical entry but also about gaining entry into participants' "mental space" in order to determine not only how they enacted care but their thoughts that underpinned their actions. To achieve this, I had to remain sensitive, friendly, and unobtrusive which was physically and emotionally demanding. At all times, I was conscious of being in someone else's space. However, I did not feel any resistance from the nurses. I also felt that with the demanding pressure of working through a busy shift, nurses*

*had to get on and complete their work, my presence did not impact on their work routines.*

#### **Acceptance and cooperation in the setting**

*From the outset of my study I was quite grateful that I was a modest 5 feet 4 inches and that I could easily blend in within the hustle and bustle of a busy shift. In order to assist "blending in" I did think carefully about what to wear whilst doing field observation. It was the hospital's requirement that I did not formally work as a nurse during these periods, so wearing a nurse's uniform would have been unsuitable. The nurses in this hospital usually wore grey cardigans (fictitious colour) on the top of their white uniforms. Grey and white, therefore, was a very common colour seen around the hospital in winter and spring. In keeping with this, I wore a white blouse, a grey cardigan, and black trousers. I wore these same colours every day so it seemed like a uniform. In addition to being accepted by the nurses, I also had to be accepted by patients and relatives on the wards as I moved around reviewing patients' documentation. As there were many different types of uniforms used in this hospital, I felt that any person wearing a uniform was tacitly accepted as belonging to the hospital.*

*Additionally, I also thought about the name badge I used. I remember Street's (1992) account of the problems she had encountered using a particular badge. Annette Street, a sociologist who conducted field research in a Melbourne hospital, used the badge "researcher" and everyone in the ward spoke to her except the nurses, whom she was most interested in, so she decided to change her name badge to "nurse researcher". This new title received better results as the nurses then started to talk to her. I rang Annette Street prior to commencing the field observation period in order to seek her views and any handy hints that would assist the process.*

*The hospital provided field researchers with visitors' badges which had the hospital crest with no name on the actual badge. The University provided students with badges titled "postgraduate student". Alternatively, I could use Annette's idea and use a badge with "nurse researcher" written on it. I thought*

*that both labels "postgraduate student" or "nurse researcher" may affect the way in which different participants interacted with me. The reason why these name badges seemed unsuitable was that they could bias participants' feelings towards me, which could affect their level of acceptance of me and their subsequent responses. Not all nurses working in the hospital were university graduates, and there existed, though not overtly, some under-current or an "us and them" syndrome between hospital educated and university educated nurses. Hence, I did not want to be overtly associated as being a University student. I eventually decided to use the hospital's visitors badge and my name written on a very neutral and friendly badge, which did not align me as being any type of person or belonging to any particular institute other than the hospital. Quite often, participants asked me where I worked, I told them that I was a nurse who worked out at a University teaching students rather than saying I was a Lecturer. I tried as much as possible to play down my position and lecturer role.*

*Another hurdle I had to overcome was trying to minimise the effect of writing field notes in front of staff. I know the literature stated that it is ideal to write field notes away from the setting, but I found it quite difficult to remember specifics and detail of what was being said and being able to capture the essence verbatim. I thought it was important to write field notes while I was listening to handovers, reviewing patient's notes, and at other times. The one thing in my favour was that every nurse took notes during handover so it wasn't uncommon to be writing notes. This set the pattern for my behaviour. I did, however, have to pay particular attention and constantly tell staff that I did not write anyone's name down and that I used a code when referring to patients or nurses. For example, the nurse coordinator spoke to patient X about her wound care. To put staff at ease, I periodically showed them my field notes, pointing out the codes. I found they soon got used to me writing. At all times, it was very important to behave as they did and to blend in, laugh or smile when they laughed even if I didn't think it was funny. I also had to make sure that I did not respond in an alarming way to situations where I was hearing something that was routine on that ward though sounded strange to me. I also tried to use their terms, and put aside the theoretical terms. For example, just simple words like medications and*

*observations and use the abbreviations “meds” and “obs” or the “2 O’ clocks” referring to the medications due at that time.*

*Another difficult situation I had to overcome was determining who I sat with in the dining room and who I was seen with. As I knew some of the more senior staff members in the hospital and occasionally passed them in the corridors, they often asked me to have lunch with them. I did not, however, want to be seen mixing or aligning myself with this group of senior nurses. This was very difficult and I found no solutions. I often tried to meet these senior nurses in their office for a cup of tea rather than be seen having lunch with them in the cafeteria. I made it a point to lunch with the nurses on the ward.*

### **Source 3      Examination of Patient Records**

After consent had been obtained from the Hospital’s Ethics and Research committees within the selected hospital, patient records were randomly selected and examined for evidence of the use of the nursing process and the coherence of the trail of care.

Records were accessed through the Medical Records Department. Seventeen in-depth analysis of patient records were conducted in order to determine the continuity and trail of care. Each document was reviewed to determine whether it was coherent and assisted in the understanding of how patient care progressed. Additionally, admission assessment forms, the master problem lists, and the nursing care plans were reviewed to determine in a qualitative sense whether they were completed and as to whether each document provided informative information that could direct patient care. A total of twenty-four hours were spent in medical records reviewing these documents. As this review was performed after the observational period, questions arising from the previous data analysis was followed through and given specific attention. For example, the number of different signatures on the nursing care plan was one area of inquiry.

### **Source 4      Documents and Newspaper Articles**

Relevant documents obtained from newspaper articles, and professional newsletters published during the study period, were also used as data in this study. Additionally, letters were sent to the four largest nursing agencies asking questions relating to the

usage of agency nurses across hospitals. Only two agencies replied to the letters. One stated that they had no specific information or report that they could give me other than anecdotal evidence that there was an increasing demand for agency nurses. The other Nursing Agency that replied declined to comment on usage stating that it was not in the best interest of their business to reveal this information.

### **Data Analysis**

Data analysis was undertaken, using the process of open coding, theoretical coding, and selective coding techniques. Once several categories (codes) emerged through the process of open coding, constant comparative analysis of data, combined with theoretical and selective coding, was used to define and to refine the development of categories and the propositional statements. Alongside this process, it was necessary for the researcher to remain theoretically sensitive to the data and data analysis.

Theoretical sensitivity, as defined by Strauss and Corbin (1990), refers to the researcher being aware of subtleties of meaning in the data and being analytically creative. This process is informed by the researcher's past, professional, and personal experiences, being sceptical about the data, as well as constantly checking one's own biases to see that they are not being imposed on data analysis. In addition, methodological and theoretical memos were written concurrently, in order to assist the researcher maintain a dialogue between data, data analysis, and the emerging theory. All of the above processes were used to analyse the data and develop the theory. Although these processes occurred simultaneously, each will be described individually to assist with the clarity of the discussion.

### ***Constant Comparative Analysis***

Following the tenets of grounded theory, data were analysed using constant comparative analysis as described by Glaser and Strauss (1967) and Strauss and Corbin (1990). This method which is informed by observed reality (Portney & Watkins, 1993) resulted in the development of common categories and concepts that led to the generation of hypotheses, a theoretical framework, and a substantive theory (Field & Morse, 1992). Constant comparative analysis used in this study observed Glaser and Strauss's (1967) definition of the term and their definition of the stages.



According to Glaser and Strauss (1967), constant comparative method has four stages. Stage One involved comparing incidents applicable to each category. Specifically, it involved analysing each incident into as many categories that emerged. Writing theoretical memos was a necessary activity that assisted the process. Stage Two involved integrating categories and their properties and further clarifying incidents in order to determine similarities and differences and to establish boundaries between categories and their relationships. In Stage Three, the theory was delimited by integrating similar categories under the one name, thus reducing the total number of categories and theoretically saturating the emergent categories. Stage Four involved writing the theory through the process of integrating the categories cognisant of the theoretical memos written on each category.

### ***Coding Techniques***

In grounded theory, data generation and analysis proceed simultaneously using open coding, theoretical coding, and selective coding techniques. According to Iurita (1996c), the coding techniques are described in a chronological order; however, they tend to be used simultaneously. This statement is reflective of the analysis procedure used in this study. Using the open coding technique, data were initially reviewed line by line to enable close examination, interpretation, and categorisation of information (Glaser, 1978). This type of coding is sometimes referred to as Level I codes, called *in vivo* or substantive codes where specific words from the data are selected as they reflect what is happening and the substance of what is emerging (Hutchinson, 1984). This initial analysis of the data revealed a total of 221 labels. In the first instance, as many labels that emerged were used so as not to limit or frame the emergent theory (French, 1993). Further analysis involved identifying common categories in terms of their properties and dimensions. According to Glaser (1978), several questions need to be asked of the data in order to determine emerging categories, their properties, and their linkages. Some examples of these questions are: To what category does this incident relate? What is actually happening in the data? (p. 57). During this process memos were written about what appeared to be happening. An example of a memo written during this process is as follows:

*A group of codes have something to do with working conditions. They should be umbrellared under the category working conditions and sub categories within that.*

These emerging and unrefined categories are then coded theoretically. In theoretical coding, the data are brought back together, determining and labelling the emerging substantive codes and hypothesising about their relationships. This process uses aspects of *axial coding techniques*, that involved comparing contexts, antecedent events, and outcomes of these events (Glaser, 1978; Strauss & Corbin, 1990). This resulted in the generation of categories and subcategories within each category. Theoretical coding also involved using a coding family that assisted the researcher to ask further questions of the data (Hutchinson, 1986). This moved the analysis from a descriptive level to a theoretical level (Streubert & Carpenter, 1995). The coding family used in this study was the Six Cs, which were causes, contexts, contingencies, consequences, covariance, and conditions (Glaser, 1978). Not all of the six Cs were used in this study as covariance was not evident in the data. Two other questions that were asked of the data were (1) What is the basic social problem with which these people must deal? (2) What is the basic social process used to cope with the problem? (Hutchinson, 1986). An example of a memo written during this process is as follows:

26/08/95

*The general emerging category seems to be SURVIVAL, nurses are just trying to survive doing their work, with the conditions within which they work. Because the environment is so uncertain, nurses had to do something to combat this uncertainty.*

This category was further developed and emerged as the basic social process entitled: *Enabling care: working through obscurity and uncertainty*. During the *selective coding* process, the core category, which was central to the theory, was identified and the relationships between major categories were determined. It also involved further refinement and development of categories (Strauss & Corbin, 1990). Specifically, condensing categories into higher levels of abstraction that have broader explanatory power and determining the linkages between the categories. Theoretical sampling (described in the sampling section p. 24) and data analysis continued until saturation of categories was attained, no new categories emerged and a sense of closure was

achieved (Glaser & Strauss 1967; Hutchinson, 1986; Strauss & Corbin, 1990). Saturation refers to the completeness of the categories (Hutchinson, 1986). Strauss and Corbin (1990) label this concept as theoretical saturation where (1) no new relevant data emerge about a category, (2) each category is conceptually dense, and (3) the relationships between the categories are established and validated. Morse (1995) further adds that goal of saturation is to obtain diverse data, “valuing variation over quantity” (p. 147) and emphasising “knowing it all” rather than hearing the same thing repeatedly, which runs the risk of giving a false sense of saturation. The process of saturation was enhanced when categories were amalgamated and subsumed thus reducing the total number of categories. As the newly developed category generally took relevant properties from the subsumed categories this assisted the saturation process. Where gaps occurred in the analysis, some gaps were filled by further reviewing existing available data. However, in some instances, further information from informants was sought to fill information gaps. This process was in-keeping with the theoretical sampling procedure and assisted with further development and refinement of each category. Constant comparative analysis and refinement of categories and their relationships continued until the substantive theory was developed (Field & Morse, 1992; Strauss & Corbin, 1990). As part of the grounded theory methodology, it was necessary to discover the core category, the basic social problem, and the basic social process used to deal with the problem.

### *The Core Category*

In grounded theory method, the generation of the substantive theory usually occurs around a core category. A category is selected as being the core category when it accounts for most of the variation in the data (Glaser, 1978). Specifically, it is the central phenomenon around which all the other categories are integrated (Strauss & Corbin, 1990, p. 116). According to Glaser (1978), the core category has to observe the following criteria:

- it must be central and account for variation in a pattern of behaviour,
- it must occur frequently in the data,
- it takes a longer period of time to saturate,

- it has clear and meaningful implications for formal theory,
- its relationship with other categories makes it highly variable.

The core category can also be a dimension of the problem or the basic social process. In the present study, the basic social problem “being in a state of *unknowing*” was classified as being the core category as it accounted for the greatest variation in the data and observed all the above criteria.

### ***The Basic Social Problem***

As the aim of grounded theory is to discover social process, the major problem experienced by the group in the setting is of concern and is termed the basic social problem. The basic social problem is the over-riding problem or issue that the group being studied has to deal with and which may not be known to them (Glaser, 1992). Specifically, groups experience a basic social psychological problem that is not usually known or articulated by the group (Wilson & Hutchinson, 1991). The basic social problem identified in this study, that nurses grappled with as they tried to determine, deliver, and communicate patient care, was being in a state of “*Unknowing*”. There were many conditions found in acute hospital settings that were thought to hinder nurses from knowing what to expect within the context of a daily shift and knowing the specific patient’s nursing care needs. Additionally, it appeared from the data that some contextual factors had caused nurses to be uncertain about their domain of practice. Collectively, these conditions contributed to participants being in a state of “*unknowing*”. Properties and dimensions of “*unknowing*” were found consistently in the data. This problem is defined in detail in Chapter Three.

### ***The Basic Social Process***

In addition to discovering the basic social problem, it was also necessary to determine the basic social process (BSPs) used by participants to deal with this problem. The basic social process, as defined by Glaser (1978, 1992), has two or more stages or phases that accounts for the variation in the data. BSPs are durable, stable over time, and account for change over time. Additionally, the BSP is usually found to be the core category. In this study, however, the core category was found to

be the basic social problem. The basic social process used by participants in this study to overcome the basic social problem was: "*Enabling Care: Working through obscurity and uncertainty*". This process involved two interconnected phases that tended to occur simultaneously. These two phases of the core process were: *Putting the pieces together: making sense*, which involved four subprocesses. These subprocesses were: drawing on the known, collecting and combining information, checking and integrating information, and sustaining communication. The second phase of the BSP was labelled *Minimising Uncertainty*. It involved three subprocesses which were labelled: adapting work practices, taking control, and backing-up. The BSP will be discussed in detail in Chapter Four.

### ***Data Management***

Huberman and Miles (1994) argue that it is imperative that qualitative researchers use a systematic process of data management to collect, store, and retrieve data. They further state that an inability to achieve this has the potential to result in data being miscoded, mislabeled, mislinked, and mislaid. In this study, textual data derived from the transcripts of interviews and field observations were managed using Non-numerical Unstructured Data Indexing Searching and Theorising (Nud•ist) software program (Richards & Richards, 1994). According to the developers, this system is based on a code and retrieve facility that goes beyond retrieving text according to how it was coded. Specifically, this computer package assists researchers to analyse the data by providing a number of functions. It allows the researcher to store textual data in a form that can be coded line by line, with the flexibility to change and recode data at any phase throughout the analysis stage. Furthermore, it facilitates the amalgamation of data coded within the emergent categories as analysis proceeds. Search functions are able to illustrate areas of data (categories or codes) that overlap. It also has a search and find function where words or phrases can be identified in all documents that are linked to the project. Additionally, this program enables the researcher to explore ideas about the data, link ideas, and construct theories about the data. This program is also able to generate reports on emerging codes, categories, and written memos on any code, category, or interview document (Qualitative Solutions and Research, 1994). The producers of the program state that the program is designed to be used in qualitative studies as it is able to assist with the managing, exploring,

and coding of complex unstructured data in order to create new ideas and theoretical frameworks (Richards & Richards, 1994).

After interview transcripts were entered into the program, a line by line analysis was conducted using the principles of open coding. Print outs were made of all categories to enable the researcher to review each category in order to determine areas of overlap, identify properties of each category, and to review the data more analytically. After this initial analysis, diagrams were drawn in order to visualise categories and hypothesise about relationships. Theoretical memos that informed the developing theory were documented and attached to the appropriate categories.

Example of a memo:

*3/01/96*

*There is a connection between nurses being task orientated and conforming to hospital policy, ie: meeting the basic requirements and not really being professional (see interview 018, lines 940 - 950 and fobs 5). The CNS's concerns about the way in which nurses practice. This is also connected to interview 04, line 530 -540 being limited, restricted trying to work professionally when time does not allow, the documentation is containing, restrictive, not broader based and encompassing of the care. Link this to interview 6, line 643 all on node 6 1 2. Once again it talks about being restricted.*

This memo led to the development of the category "Nurses lack of control over their professional practice". Based on the emerging hypothesis, excerpts of transcripts were further coded and re coded. All data were constantly reviewed in order to find examples that supported or refuted the emerging theory. Data analysis proceeded as previously discussed. This cyclical process of data analysis, data management and theory development continued throughout the study. An example of the NUDIST print out of an interview analysis is illustrated below.

### **Documentation Identification**

Q.S.R. NUD.IST Power version, revision 3.0.4 GUI.

PROJECT: PHDWORK, User Bev O'Connell, 4:35 pm, Mar 21, 1997.

+++ ON-LINE DOCUMENT: Interview 1

+++ Retrieval for this document: 101 units out of 1141, = 8.9%

++ Text units 200-300

## **Line Numbers and Interview Text**

200 *{Right} .. That poses problems in the*  
201 *mornings sometimes because at 6.00 am. it is*  
202 *the busiest time and with only two staff on*  
203 *we don't have time to sit down and do a*  
204 *nursing assessment. So, it tends to carry on*  
205 *so at handover what information we've*  
206 *accrued, then it's the day staff.. their*  
207 *role to follow through. It's not ideal, but*  
208 *it's the way it seems to work .. um .. for*  
209 *most of the part.*

## **Code numbers      Code names**

(2 3 1)            /Uncertainty/Variations in practice/Rationalising  
(4 9)             /Working conditions/Level of Activity  
(6 3)             /Communicating/Admission Assessment  
(7)                /Theory-Practice gap  
(10)              /Providing minimum requirements

Demographic data were analysed descriptively, using the Statistical Package for Social Sciences for Windows.

## **Validity and Reliability Issues**

Qualitative research has often been critiqued based on criteria that are used to judge positivistic quantitative research (Sandelowski, 1994); yet the two methods emerge from different paradigms that are informed by different epistemological positions. Denzin and Lincoln (1994) state that terms such as validity and reliability should be replaced by words such as credibility and trustworthiness which are more reflective of the goals of this research. Furthermore, external validity which refers to the generalisability of the findings is not usually the aim of qualitative research; hence, this criteria should not be used to judge this type of research. In order to ensure rigour and address credibility and trustworthiness issues, several measures were purposefully employed in this study. Additionally, it is argued that the grounded

theory method of research uses methodological techniques that promote rigour. For example, using the constant comparative method, data were continually validated by triangulating the information that was obtained from the interviews, field observations, examination of patient records, and published documents. Furthermore, inherent in theoretical sampling is the flexibility to verify information from multiple sources and informants. This method also included finding negative cases that added different dimensions of knowledge that informed the emergent theory (Lincoln & Guba, 1985). In support of this claim, Strauss and Corbin (1994) stated that the mandate of grounded theory is to strive for the verification of its resulting hypothesis which is attained as part of the research method itself.

Researcher objectivity is another issue of concern in this study. To ensure objectivity, the researcher documented personal values and beliefs about the research phenomenon. This was done to increase awareness of these underlying biases so as not to impose them on the data collection and data analysis. Interview transcripts, field notes, and analysed data were checked for any evidence of researcher bias. Within the context of using the grounded theory method, it is argued that it is difficult to impose one's beliefs on the data analysis, as the categories that emerge must be substantiated from the study transcripts or data. In many cases throughout the study period the researcher's beliefs and hypotheses about what was occurring were altered and dropped as they were unable to be supported by the research data.

Furthermore, Poland (1995) stated that establishing the trustworthiness of the transcripts is a fundamental component of rigour in qualitative research. In particular, this author emphasised the need for the researcher to spend time listening to the recorded interviews and accurately interpreting variances in voice tones of the participants. To achieve this, all interview transcripts were read concurrent to listening to the tape recorded version. This enabled verification of the typed transcripts and an opportunity to note any apparent covert messages. Additionally, memos recorded on the completion of each interview were also referred to at this time.

According to Sandelowski (1986), in qualitative research, credibility is established through verifying the data. This verification can occur by seeking participants' views



on the researcher's interpretation of the data analysis (Sandelowski, 1993). This process was performed throughout the data collection and analysis stages and the final theory was presented to nurse clinicians for verification. Specifically, data obtained from the interviews were related back to the informants in order to confirm or deny the interpretation of this information. Additionally, during the field observation period, confirmation of information occurred frequently by informally discussing and clarifying issues with nurse participants. Furthermore, some sections of textual data and coding were examined by other researchers (doctoral students) in order to establish credibility of the emergent categories. Initially, the grounded theory seminar groups assisted with verifying the coding of the categories. Subsequent to that, the researcher presented on-going analysis of the findings to this group. In these sessions, members often questioned issues that seemed unclear and prompted the researcher to seek further data using theoretical sampling procedure.

Some findings of this study were presented at conferences in North America and Australia and were received by conference attendants as being reflective of clinical nursing practice in acute care settings in their countries (O'Connell, 1996c, 1996d, 1997). Although generalisability of the findings is not being claimed, this acceptance suggests that there may be some commonalities across countries. In addition, the final substantive theory was presented to nurse clinicians for credibility testing. The theory was presented to a small group of Clinical Nurse Specialist in a major teaching hospital who recognised the process. In addition, many stated that they were glad to see that what they had known for a while had been revealed through the research process.

In addition, in order to achieve rigour a clear description of the study setting (context), choice of participants, and methods of data collection and analyses have been given to enable other researchers to conduct a similar study (LeCompte & Goetz, 1982). Sandelowski (1986) emphasised a need for a clear description of the study, an audit trail, in order to allow another researcher to follow the method. All these methods were employed to ensure credibility and trustworthiness of the findings.

## **Human Subject Protection.**

Permission was sought from both the University's Human Research Ethics Committee and the Nursing Research and Ethical Review Committees of the selected hospital prior to commencement of the study. Potential informants (registered nurses) were approached in groups by the researcher at the end of a lecture at a large University and invited to participate. A consent form and a letter (see Appendix A), were distributed, explaining the purpose of the study and measures taken to observe confidentiality and anonymity. Assurance also was given to informants who were students that their participation in the study would in no way influence their results within their course of study or their student status. The researcher who was a lecturer at the same University was not associated with this group of nurses. Informants were advised of the voluntary nature of the study and given the option to withdraw from the study at any stage without being subjected to any penalty. Initially, nurses who volunteered to participate in the study gave the researcher their phone number in order to make contact and to set up an appointment at a later date.

Prior to the commencement of the formal, semi-structured interviews, written informed consent to participate was obtained; permission to tape record the conducted interviews was also established and a copy given to each person. Confidentiality was maintained using a numerical coding system. The code book was used to keep account of both informants who participated in the study and patient records (patient's medical record number) used in the study. This was kept by the researcher until the data were satisfactorily entered into the computer and analysis completed. This code book will be kept in a secure place and will be shredded five years after the completion of the study. Tapes of the interviews were transcribed verbatim and, on completion of the study, the tapes were erased. In keeping with University regulations, all transcriptions will be stored for a period of five years.

Nurses working on the wards where field observations were conducted were approached at a ward meeting within the hospital setting and advised of the general nature of the study and invited to participate. The method of field observations was determined after discussions with the Hospital's Ethics Committee and senior nursing personnel. As the study was conducted over a few years, at each stage of the study,

consent from the selected wards and informants was sought and renegotiated.

Although the researcher was a registered nurse, the hospital requested that there be no involvement in care during the study period. This request was observed at all times. Additionally, in keeping with nursing professional practice principles, the researcher had the necessary skills to manage and respond to difficult and critical situations and not to collect data during situations that were appraised as being sensitive.

All informants who agreed to participate in the study were asked to give the researcher permission to publish the findings of the study withholding names. Care was taken to ensure anonymity when citing extracts from interviews in all publications and presentations.

## **Chapter Three**

### **Basic Social Problem**

#### **Overview of the Chapter**

The overall aim of this study was to explore the process of how nurses determined, delivered, and communicated patient care. Using grounded theory method, data analysis revealed that nurses experienced a basic social problem within the context of their day to day work. This problem, which emerged as the core category, was labelled being in a state of “*unknowing*” and will be described in detail in this chapter. The basic social process used by nurses to overcome the basic social problem is described in Chapter Four. Data and description of the overall grounded theory is contained in Chapters Three and Four.

#### **State of “*Unknowing*”**

The basic social problem that nurses grappled with as they tried to determine, deliver, and communicate patient care was being in a state of “*unknowing*”. There were two major domains of “*unknowing*” (1) as applied to providing patient care, and (2) as applied to nurses’ job status and state of the nursing profession. There were many conditions found in acute care hospital settings that were thought to hinder nurses from knowing what to expect within the context of a daily shift and knowing the specific patient’s nursing care needs. Additionally, the data revealed some contextual factors that had caused nurses to be uncertain about their domain of practice. Collectively, these conditions contributed to a state of “*unknowing*”. Properties and dimensions of “*unknowing*” were found consistently in the data. The concept of “*unknowing*” is defined, in this study, in the following way.

#### **Definition**

Unknowing was a state of uncertainty and doubt where nurses found themselves in an obscure situation. It was a moving point between total ignorance and total knowledge. Nurses were unable to determine with any certainty what would happen within the context of a daily shift. Additionally, they were uncertain about specific

patient nursing care needs. The system in which they worked hindered and constrained them from knowing the patient and their specific nursing care needs and being able to deliver care in the way in which they had been professionally educated. In summary, the overall situation could be compared to the metaphors: “trying to work blind folded” or “trying to work in the dark”.

Being in a state of “*unknowing*”, as experienced by nurses in this study, was a complex and fluctuating phenomenon that varied in dimensions. It existed as moving point between total ignorance and total knowledge. Specifically, it was a state of uncertainty and doubt that occurred as a consequence of many interwoven conditions that collectively hindered nurses from knowing what to expect within the context of a daily shift, their role as nurses, and their patients’ specific nursing care needs. There were two main conditions that were revealed in the data that contributed to the state of “*unknowing*”. These were the existence of a fragmented and inconsistent process of determining and communicating patient care, and working within a fluctuating and uncertain setting. There were many properties of “*unknowing*” that emerged from the data. The main property of “*unknowing*” was the experience of not knowing, with any certainty, the patients or their specific nursing care needs. This aspect of “*unknowing*” was a consequence of many factors that stemmed from an inability to perform adequate nursing assessments and to identify specific patient problems. This was further exacerbated by the use of a fragmented and inconsistent communication system within the practice setting. Specifically, it was common for nurses not to know whether the patient’s assessment information, listed problems, and on-going progress reports were a true reflection of the patient’s condition and care at any given time.

Furthermore, as the information given during handover varied from nurse to nurse, it was difficult for nurses commencing duty to determine with any certainty whether the information given was an accurate account of specific patients’ nursing care needs. Moreover, as nurses used to store particular patient information in their minds and transferred this information verbally, some information was not communicated and tended to be more easily lost. This was exacerbated by the numbers of nurses involved in delivering patient care to any one patient. Due to rostering constraints and management practices, it appeared that nurses were assigned different patients on

different shifts and their acquired understanding of patients' nursing needs held in the nurses' minds may not have been used to direct care. All these factors, revealed in the data, contributed to and sustained the state of "*unknowing*".

Additionally, these large numbers of nurses involved in delivering patient care further added to the uncertainty. Specifically, they varied in their levels of educational preparation, knowledge, skills, experience, and professional commitment. To add to this uncertainty, there were many occasions when nurses would not know the capabilities of the other nurses with whom they worked. This was a consequence of the increasing use of agency and casual nurses in ward settings. Due to all these differences among nurses there was sometimes very little shared understanding of the patient's condition. Furthermore, as the experience level and knowledge base of nurses rostered on duty tended to vary each shift, depending on the levels of experience of other nurses rostered on the same shift, nurses would be assigned different levels of responsibility and hence different patients. In some instances, it would be difficult for nurses to know the exact level of responsibility they would be assigned each shift. Specifically, this tended to vary according to the experience levels of staff rostered on duty for a particular shift and rostering changes that occurred to accommodate staff shortages in other ward areas.

There were other contextual conditions that were thought to vary the levels of the state of "*unknowing*". Nurses tended to work under conditions of immense uncertainty perceived to be caused by budget cuts and changes that were introduced by management. Other specific issues, such as, patients being admitted or transferred across wards, meant that nurses would not know whether they would nurse the same patients over the entire shift or whether they would be required to nurse new patients. In addition, due to a shortage of beds in some ward areas, it was common for patients to be admitted to a ward area where nurses had little understanding of the patient's specific medical condition and nursing care needs. For example, urology patients admitted to a plastics ward prior to their surgery. Moreover, as the work environment was constantly changing, nurses were unsure of how a work shift would proceed and whether they would have time to deliver all the patient care. Within this context, nurses

lacked control over their professional practice. These factors were thought to exacerbate the problem of being in a state of “*unknowing*”.

Alongside these conditions, prescriptive hospital policies and management practices that controlled the delivery of nursing care appeared to inflame the situation, as they provided other contextual conditions that contributed to the state of “*unknowing*”. More specifically, some newly implemented practices tended to serve management needs, rather than nursing professional needs or patient needs. An example of this was the introduction of short shifts that reduced the overlap time and hence saved money. However, this had a detrimental effect on the handover of patient information, as it fragmented communication, and affected the continuity of patient care. More specifically, it prevented the opportunity for nurses to verbally hand over patient care at the end of a shift. Data revealed that staffing levels were kept to a minimum and there was a growing trend of employing large numbers of agency and casual nurses to fill staffing gaps. Within this context of uncertainty and change, the nurse’s role altered frequently thus adding to the condition of uncertainty.

A combination of all these factors had adversely affected the communication process, exacerbated the levels of uncertainty and change in the work place, and further sustained the problem of being in a state of “*unknowing*”. Given these ever-changing conditions, revealed in the data, trying to determine the real picture and to know the patients and their specific nursing care needs was a difficult task for nurses to achieve. Being in a state of “*Unknowing*” was a consequence of all these conditions. The following discussion and information from interviews and the field notes seek to portray the overall meaning of this problem.

## **Fragmented and Inconsistent Process of Determining and Communicating Patient Care**

The day-to-day conditions of uncertainty under which nurses functioned tended to impede care by providing contextual conditions that hindered nurses from performing adequate patient admission assessments and thus identifying specific patient problems. Specifically, the overall process of successfully determining and communicating patient information within and across shifts for the total patient stay was problematic and

difficult to achieve. There were many conditions, revealed in the data, that fragmented the process of determining and communicating patients' conditions and their specific nursing care needs. These conditions were inadequate patient admission assessments, inconsistent use of nursing diagnosis, inconsistent use of nursing care plans, inconsistent use of progress notes, large numbers of charts and forms, uninformative handovers, information held in the oral culture, breakdown in communication among doctors and nurses and, finally, large numbers of different nurses involved in the delivery of patient care to any one patient, coupled with a lack of a central person consistently coordinating the care. Each of these factors, with the accompanying transcripts that provide supporting evidence of the problem, will be discussed in this chapter.

### **Inadequate Patient Admission Assessments**

It is well documented in the literature that accurate patient assessment is necessary to determine individual patient care needs and forms the basis of patient care planning (Alfaro-Lefevre, 1995; Carpenito, 1995; Gordon, 1987b). Although performing an assessment is fundamental to patient care, findings of this study have revealed that, in general, this assessment stage was poorly completed due to a number of impeding factors. Primarily, the state of "*unknowing*" occurred as nurses were unable to perform complete admission assessments on their patients. There was evidence to suggest that this foundational stage of patient care was performed in an ad hoc manner. While a lack of time was given as the main reason for this, other factors were identified. These related to the time of day the patients presented, and their overall physical and mental health status, as well as how busy the nurse was at the time the patient was admitted. Other factors, such as individual nurses' own frames of reference were found to influence the type of information they collected and documented. In addition, there were many organisational and contextual constraints thought to impede the assessment process. As a result of all these factors, the quality and completeness of nursing assessments were compromised.



### *Time of Day*

The time of day the patient was admitted and the level of activity on the ward at that time either facilitated or hindered nurses from conducting admission assessments.

*Well, it depends, first of all what time it is in the day, it depends if you actually have the time in the day [Fobs Int, 8].*

When patients were admitted during the night, nurses were unable to perform thorough assessments, as having the lights on and making a noise was thought to disturb other patients.

*It does disturb other patients; lights on and asking questions [Int, 01].*

In particular, shift changeover times was thought to be more problematic.

*I hate getting admissions at the last minute - at 9 o'clock [the shift ends at 9:30 p.m.] or something and going off the ward thinking, no I didn't have time to plan all the care and give everything [Int, 08].*

Additionally, data revealed an unwritten code of practice where the nurse who started the assessment was obliged to complete the main page of the assessment form and commence writing the nursing care plan. This unwritten code of practice exerted more pressure on nurses to complete the assessment and the documentation in a short period of time, rather than handing this task over to the nurse on the next shift who may have had more time to complete a thorough assessment.

*Well, one reason is that if you're on an evening shift, so often the patient has come up from casualty, even though you've been notified of them maybe at 5.00 o'clock, they'll come in at 9.00 o'clock . . . again and again and again! That gives you only enough time to get the basics done . . . but our code [referring to an unwritten code of practice] that the person who starts the admission, that you must do the back page, you must get the essentials done, if you've got time [Int, 18].*

Regardless of the specific time of day, if the nurse was busy with other patients when the patient was admitted she/he was unable to perform an adequate admission assessment on the new patient.

*Really, it just depends on how many patients you have and how sick they are. If you're very busy you just put a very brief sketch and then you have up to 24 hours to redo it, so you might redo the status the next day [Fobs Int, 08].*

Another informant's explanation provides additional information that further illuminates the problem nurses experienced trying to conduct these patient admission assessments. It provides evidence to suggest that nurses were unable to take control of the situation. Although they recognised that the prevailing level of practice was far from ideal, due to a lack of time, they were unable to change the situation.

*Sometimes I don't like going off duty until I've completed any assessment [referring to the admission assessment] because often day staff are really stressed and they're not going to get to it. It could be that evening, or never sometimes, that's happened. . . but I know ideally that's not good but the situation is getting worse. Our ratio has been cut, the nurse/patient ratio and there just isn't the time [Int, 01].*

### ***The Patient's Overall Condition.***

The patient's mental and physical status also affected the type of assessment that was able to be conducted. Specifically, it was difficult to conduct assessments on confused or uncooperative patients. Additionally, if patients were in pain or were drowsy, conducting an assessment was not thought to be a priority.

*They've often had narcotics and, therefore, they are really quite drowsy and hopefully usually pain free when they come, [referring to when the patient is admitted] so I usually get basic things which we need overnight, such as, make sure you've got the relatives there [implying that these points should be clearly written in the assessment form] and their allergies and medication . . . that type of thing. If they have had narcotics then I continue observations as ordered, but allow them to sleep [Int, 01].*

It appeared that the intention of these actions was to delay conducting the patient assessment, until the patient's condition had stabilised.

### ***Hospitals' Documentation Policies.***

In some hospitals, nursing management had recognised the problems that nurses experienced trying to complete the assessment forms at the time that patients were admitted and had made allowances for this situation. To address this problem, they had implemented a policy requiring that only the main page had to be completed within the first four hours of admission and the rest of the form could be completed within forty-eight hours of the patient's admission. While this gave the nurses time to catch up on the patient's admission details, it was in conflict with the theoretical ideal of delivering

care that was based on patient assessment. In addition, as there was a number of nurses who were involved in completing the patient's documentation, the process of assessing patients and planning care became fragmented. This was one example of how nursing practice was being regulated and controlled by hospital policy. Some nurses voiced concern as they found this assessment policy confusing.

*Also, what is confusing is that you do not have to complete the assessment form immediately, so if you are busy and/or if the patient is admitted late in the evening or late at night then you only write the nursing care on the care plan [Fobs Int, 01].*

Specifically, the type of information written on what was considered to be the main page of the assessment form referred to more medical and demographic details, such as past medical history, allergies, and names and addresses of family members. While this information was deemed to be necessary, it did not specifically address information that would assist in determining patients' nursing needs. The substantive information that provided cues to the patient's functional status, and was more relevant for nursing care, was contained on another section of the assessment form. These other sections of the forms had to be completed by the following forty-eight hours post admission. This policy on nursing assessment added to and sustained the state of "*unknowing*" as, within this context, patient care was not based on individual patient assessment information.

In order to streamline the process of assessment, some hospitals had developed a short stay admission assessment form for patients who were admitted for less than five days. This form had no section for assessing the patient's functional status, that is, their ability to meet their activities of daily living. In such cases, nursing care was based on medically prescribed interventions and an understanding of the standard care required for the patient's medical condition and not individual patient needs. This reduced nursing to a series of tasks and legitimised and reinforced what is generally considered to be an unprofessional standard of nursing practice. Additionally, while these short stay forms streamlined the assessment procedure, some specialty wards found the assessment information inadequate for patients admitted to their wards. A nurse from the gerontology area voiced concerns about the short stay assessment forms. It appeared that when patients were admitted under the gerontology team from another ward, they

had to insert another form and further reassess this patient before prescribing meaningful care [Fobs Int, 08].

When patients stayed longer than five days, some hospitals' policies stated that the more comprehensive assessment form should be completed. This further assessment of patients who stayed longer than five days, however, was rarely performed.

*You're supposed to update them [referring to the assessment form] . . . complete a long stay assessment form, but it's rarely done [Int, 06].*

As nursing management allowed admission assessments to be conducted over a 48 hour period, these admission assessments tended to be conducted by a number of nurses who would focus on different aspects. This tended to further fragment the process of assessment and patient problem identification. In support of this statement, a secondary analysis of the data that reviewed 155 patient assessments, conducted in four ward areas, revealed that 37 % of assessments forms were completed by more than one nurse (Rapley et al., 1995). This condition further added to the problem of being in a state of “*unknowing*”.

The recognised time allowed to conduct and write up the assessment was thought to be too short and some nurses voiced concerns about this expectation. Specifically, assessment forms usually comprised two major assessment sections. The first section generally contained patient demographic details, medical diagnosis, past medical history, names of the next of kin, and information related to patient valuables. The second section of the forms contained assessment details in relation to the patient's ability to perform activities of daily living. According to a staff development nurse, who represented hospital management views, this procedure should only take about 10 - 15 minutes.

*Weight and all, it should only take about 10 to 15 minutes [Fobs Int, 07].*

However, within real ward contexts, conducting a patient assessment took more than 15 minutes. One Clinical Nurse Specialist's view reinforces this.

*If they had to admit the patient properly it would take one hour. If they had to admit two patients properly it would take two hours and admitting means completing all the documentation, including the nursing care plan and the admission assessment [Fobs Int, 07].*

Another nurse voiced further concerns about the lack of time and the unrealistic expectation of completing the task within the prescribed time-frame.

*[The first section] of the assessment form has to be completed within half an hour of the patient arriving. So when a new admission arrives then you fill out this page, write the care on the nursing care plan, you get most of it from the medical notes, then you set up the medications, all that takes me a good hour, it's unrealistic to think you can do it in less of a time [Fobs Int, 02].*

While hospital policy listed set time-frames by which each page had to be completed, some nurses were unsure and stated different times that varied from the listed policy. It was a requirement that the main page had to be completed four hours after the patient had been admitted. However, when asked about the policy, nurses were unclear and stated different times as quoted above.

As a consequence of not being able to complete the assessment form in the prescribed time frame, nurses tried to comply with hospital policy by conducting a brief visual assessment and transcribing information from the patient's medical notes and medical orders. From a professional stance, nurses also voiced concern about the hospital's assessment policy of not completing the entire assessment. However, they did not seem to contest its use as they understood its pragmatic value.

*Well you get it off the doctor's notes and put in what is routine. Then the next nurse who does the assessment completes it. Yes, the rule is crazy, you should do **the whole assessment** when the patient is admitted [Fobs Int, 02].*

Some physical assessment information on the patient was also transcribed directly from the doctor's notes.

*But our assessment forms, our physical assessment forms, they usually like the nurses say "don't bother too much about them, take it from the doctor's notes". So we've got abdomen--soft non tender straight from the doctors notes, yeah. Oh well, I usually do rush through that, honestly, . . . a time factor and a bit of confidence [Int, 08].*

### ***Individual Nurse Differences***

Due to a number of reasons, which will be discussed, individual nurses completed the assessment forms differently. In particular, it was often stated that nurses who were

relieving in ward areas other than their own specialty area conducted poor assessments due to a lack of specialised knowledge.

*Sure, there's the usual excuse of a lack of time, staff shortages, high turn-over, new staff, agency staff . . . and all these staff turn-over, if they're not our permanent staff then they don't complete the assessment form the way in which we need them to complete it [Fobs Int, 08].*

Furthermore, nurses differed in their opinions as to what constituted relevant data. As a result of this difference, one nurse may have completed an assessment focusing on information that was judged by another to be "lacking".

*What happens is nurses don't put enough emphasis on the patient's pre-admission status and clearly that's extremely important in my area [gerontology] because the whole aim of care is to work the patient towards achieving their pre-illness level of independence [Fobs Int, 08].*

Additionally, different nurses prioritised the tasks that needed to be accomplished when the patient was admitted and, in some instances, completing the initial assessment form may not have been seen to be a priority at the time of admission.

*I think because other things . . . people are busy, it's sort of one of these things that a lot of people, I guess people don't see it as an important thing, in the sense that they see it's more important to actually get the patient sorted out, perhaps they've other pressures of other patients [Int, 24].*

In situations where nurses were able to perform an assessment, there were other intrinsic factors that were said to influence and hinder, or vary, this assessment process. These factors included nurses' negative beliefs about the relevance of the assessment information collected, which was predominantly controlled by and limited to the cues on the assessment form. In particular, the sections which assessed the patient's functional status were inadequately completed. Moreover, nurses perceived that the assessment forms were poorly utilised by their peers and that the information written was sometimes irrelevant. This reason accounted for this poor completion rate of the assessment forms.

*The other thing is that because it's [the assessment form] poorly utilised they don't see the use of it and for a lot of patients it's inappropriate. So it's appropriate for geriatric patients for example, but there's many many other patients it's inappropriate for [Int, 23].*

Nurses also questioned the applicability of collecting standard information for all patients who presented with a variety of patient medical conditions.

*Yes, if a person comes in for a Cholecystectomy and you have to ask them all these questions about their social requirements, and you know they've made arrangements to come into hospital. You have to ask them questions about their diet, their toileting, those sorts of things and people [nurses and patients] don't perceive that as necessary [Int, 23].*

Specifically, some nurses perceived that some assessment information that they were required to elicit was irrelevant.

*And a lot was deemed unnecessary for a lot of patients and even some patients resented being asked some of these questions [Int, 01].*

They further voiced concerns about the invasiveness of this assessment in terms of asking the patient to reveal private details, such as, their usual bowel habits which were seen to be unnecessary and not essential for enhancing patient care. Nurses stated that patients also questioned the relevance of being asked certain types of questions, which in some instances were seen to be invasive. This had some effect on nurses' commitment to ask patients these questions while conducting an admission assessment.

*A lot of the patients seem to be really bothered by you asking these questions. I've had someone ask me "why do you need to know all this stuff?" But I don't know it could just be because they're anxious and they've just been admitted by the doctor or whatever and now answering the same questions [Int, 06].*

As suggested in the previous transcript, some nurses thought that the patients' concerns about the types of questions being asked could be due to the number of times they were asked the same question by nurses and doctors. To resolve this problem and not aggravate the patient, some nurses tended to ask patients only basic general questions.

*Yes, so you just want to ask just basic things, so you only write the little things down, so you're not aggravating them too much. So you just get the basic details a lot of the time. You hardly ever, never ask them about their sexuality like we used to at Uni[versity]. Maybe if it was a different ward it might be more relevant [Int, 06].*

Giving personal details relating to very personal matters was also seen to be problematic from the patient's perspective and nurses empathised with their view. It seemed that the overlapping roles of the health care team were not fully realised and, therefore, patients were subjected to answering similar questions several times. An

interview conducted with a Continence Nurse highlights problems regarding this aspect of assessments and emphasised the situation of patients being required to give the same information to many health care workers.

*I think sometimes in relation to incontinence, patients are reluctant to give this information to nurses on their initial assessment. If you were to think about it, if you had some problems with incontinence. One, you [referring to the patient] need to discern whether it is a problem that other people don't have and that's what elderly people think, because they are old and they have this problem that is a normal problem and it isn't really a problem of incontinence and quite often you need to get to know them over a period of time before they reveal this information, so some of the time - I find that the assessment form doesn't contain the appropriate information in relation to elimination. . . . Just remember, if a patient comes through the Emergency Department, then firstly the patient may have spoken to a Triage nurse, then spoken to the emergency nurse, then to the emergency resident, then to the emergency registrar. Then they come onto the ward and they speak to the nurse on the ward and then after that they speak to the admitting doctor, so they've spoken to around seven people and those sort of things that they tend to not want to repeat [Fobs Int, 08].*

Additionally, as nurses conducted assessments under difficult conditions, there was very little emphasis on collecting psychosocial information as this type of questioning was also viewed by nurses as being inappropriate at the time of admission.

*The admission assessment would be unable to pick the emotional problem, as patients may be reluctant to give all this information to a stranger who is perhaps at the time quite busy [Int, 04].*

Additionally, in instances when nurses did collect psychosocial information and identified the problems, due to time constraints, they were unable to deal with these problems. This was thought to inhibit their commitment to assessing this aspect.

*Even if you have a nurse who can do this issue, [meaning does the psycho-social assessment], identifies a psycho-social problem, she may not have the time to actually deal with it [Fobs Int, 05].*

Nurses tended to voice concerns about the complexity of the patient problems and an inability to resolve some of these psychosocial problems within the time constraints.

*Usually on the longer stay patients we would address their psycho-social problems, but the usual types of problems, that it's difficult for us to care for in a short stay because we have patients who come in, a lot of indigenous patients and their problems are not related, their psycho-social problems are related to financial problems, unemployment problems, alcohol abuse problems and these problems, we really can't solve in a 24 hour shift [Fobs Int, 07].*



In summary, patient assessments were poorly conducted and the process of forming a clinical picture of a patient's health status was fragmented. Specifically, the information written on the assessment forms was sometimes incomplete and considered to be uninformative, and, therefore, not commonly referred to or used. One informant's response to a question about how informative the assessment forms were, provided evidence of the uninformative nature of the assessment forms.

*No, that's what I'm trying to say, they're not. . . . I appreciate how it is to be done and it's [the assessment form] probably not something I would really flick back to, to look. I mean if a question came up, I mean I'd ask the patient before I went and looked at the assessment data on them [Int, 04].*

Secondary analysis of data of a study conducted by Rapley et al., in 1995, supported this statement. A review of 155 patient assessment forms randomly selected from four medical wards revealed that 80 % of the assessment forms were incomplete. Specifically, there was no entry made in each section of the assessment form as required by hospital policy. This incomplete patient assessment information was thought to contribute to the state of "*unknowing*".

After completing a patient assessment, nurses were required to list identified patient problems; in some hospitals these were termed nursing diagnoses. According to the literature, nursing diagnosis is the second stage of patient care planning. The data from this study alluded to several inconsistencies in the use of nursing diagnoses in hospital ward settings.

### **Inconsistent Use of Nursing Diagnosis**

There were many problems identified with the clinical application of nursing diagnosis and some nurses voiced concerns about the diagnostic language. Specifically, they had problems understanding them and questioned the utility of using lengthy diagnostic statements which seemed to offer little direction for patient care. There was considerable evidence to suggest that nursing diagnosis was used inconsistently and the way in which the concept was operationalised was incongruent with the theory. This tended to aggravate and increase the state of "*unknowing*".

In addition, “knowing the patient” in order to identify problems appeared to be a complex phenomenon and difficult to achieve in acute medical and surgical wards with early discharge, fast patient turnover, and time constraints. This was further aggravated by the large numbers of nurses involved in the delivery of care over the total patient stay. Within this context of nurses and patients changing, it was difficult for nurses to get to know patients in any meaningful way. As a result of all these factors, patient problems were identified in an ad hoc manner and there was little evidence to suggest that the patient’s nursing diagnoses directed or formed the basis for patient care. Moreover, in cases where the patient presented with complex problems and a constantly changing health status, the diagnostic language was unable to succinctly represent these problems in an encapsulating and transient way. Thus, the quandary of uncertainty and unknowing was increased and further sustained.

Inconsistent use of nursing diagnosis stemmed from a lack of an adequate patient admission assessment. Specifically, as nursing assessments were not performed consistently, this anomaly hindered the stage of nursing diagnosis. This further contributed to the problem of inconsistent and fragmented communication which led to being in a state of “*unknowing*”.

### ***Inadequate Patient Assessments.***

There were many problems identified within practice settings that adversely affected the use of nursing diagnoses. As previously stated, admission assessments were inadequately conducted and in some instances each patient admission assessment was performed by more than one nurse. This resulted in inadequate and fragmented patient assessment details written on the assessment forms and poor identification of patient problems.

When asked the question -do nurses really think about how they determined and documented the patient’s nursing diagnosis, one informant replied:

*No!! and we’re probably all guilty of that at some stage, because often you’re pushed for time and you scribble these problems down because you’ve done a hasty cursory assessment and you have to start the documentation, but often . . . sometimes . . . they don’t get revised or re-written at a later date, more appropriately [Int, 07].*

### ***Nursing Diagnosis Based on the Patient's Medical Condition***

As patients were not adequately assessed on admission, the nursing diagnoses were said to be derived directly from the patient's medical diagnosis. When asked how nursing diagnoses were determined, in situations where nursing staff were unable to conduct appropriate assessments, one informant's reply supports this statement:

*From the medical diagnosis . . . Mmmm [When further asked whether there was a direct link between the nursing diagnosis and the medical diagnosis the informant replied] . . . Yep [Int, 18].*

In support of this claim, secondary data analysis from a study conducted by Rapley et al. (1995) revealed that the patient's medical diagnosis occurred frequently in the second part of the nursing diagnostic statement. Specifically, a review of 155 nursing diagnoses listed on 155 different patients who were admitted to four different medical wards in a major Perth teaching hospital revealed that 40 % of the listed nursing diagnoses had the patient's medical diagnosis written in the second part of the nursing diagnostic statement.

As a result of this specific link to the patient's medical diagnosis, other patient problems that required nursing care may not have been listed. Nurses often voiced concerns about this issue. One informant's account of this problem supports this stance.

*From my experience is what appears to be occurring and re-occurring on those problem lists is problems like pain. Then you'll see the patient and they might have a PCA as in patient controlled analgesia set up and that indicates to me, oh yeah, that's why pain is on this as a problem. Like pain appears often on the problem list, but you won't see things that are specific to that patient's whole reason for being there [Int, 22].*

Also, in surgical wards there was a greater emphasis on the patient's admission medical diagnosis. Within this context, nurses stated that they were aware of the patient's other problems. However, they tended not to document these in the master problem list.

*Yes we tend to, but usually if it is a long standing collaborative problem, that's managed by medical staff and you don't become very active in the treatment, such as a patient comes in here for some type of surgery and has some schizophrenia and even though the schizophrenia manifests itself in some type of behaviour, you don't tend to want to write that down or have anything to do with it [Fobs Int, 07].*

Within the context of a busy ward, there appeared to be a greater emphasis placed on patient's physical problems with little emphasis on their psychosocial problems.

*And sometimes you'll have a look and it will just be pain written down there anyway. Other little thing, what are other little things? like social problems and other problems with their family or whatever, are not usually written down anywhere [Int, 06].*

The way in which nursing diagnoses were determined also was inconsistent. In some instances, the nurse who conducted the assessment did not necessarily list the nursing diagnoses or complete the nursing care plan. This fragmented the process of nursing assessment and diagnosis and contributed to the state of “*unknowing*”.

*This patient had a short stay admission form and had a total of 15 interventions. Some were communication type instructions, such as, “patient likes milo”. The patient also had four nursing diagnoses, none had expected outcomes and these diagnoses had not been signed by the registered nurse which was a hospital requirement. The handwriting on the master problem list and the nursing care plan was the same. However, the assessment form had different handwriting [Fobs, 02].*

In the above field notes, it could be deduced that, as the handwriting on the assessment form was different to the one on the master problem list, the forms were completed by different nurses. That is, the patient’s nursing diagnosis was made by someone other than the nurse who performed the assessment.

### ***Problems with the Diagnostic Language***

Furthermore, nursing diagnoses were written using terminology that was thought to be inexplicit, difficult to use, and unreflective of the patient’s actual problem.

*Well the nurse who does the assessment, . . . and you write the problems [referring to nursing diagnoses], what you think are the problems, but sometimes I think you're looking for problems, just to have something written down and other times I feel you're forcing the words instead of just saying it. It like takes away your own professional judgement [Fobs Int, 05].*

The majority of nurses thought that the nursing diagnostic language was confusing, lacked meaning, and seemed unrelated to patient care.

*I actually think there seems to be a mental block put off by using things like NANDA [North American Nursing Diagnosis Association] Nursing Diagnosis, they write things up and I feel very strongly against writing things up making it sound, you know, it actually sounds flowery, but it doesn't really relate to the patient [Int, 12].*

Many nurses voiced concern about the use of nursing diagnoses as they believed that they did not express clearly the patient's condition.

*Don't really find it very relevant. I know nurses do need their own way of expressing things, but I find some of the nursing diagnoses just very confusing and they don't really say what you're wanting to say [Int, 01].*

Due to this issue, in cases where nursing diagnoses were identified, it was difficult for other nurses to understand with certainty the exact nature of the patient's real problem. Collectively, these factors contributed to the state of "unknowing".

*I think, alteration in breathing, alteration in comfort, that's OK. There are some cognitive ones [types of diagnoses]. I can't remember them, but there are some sort of multi-section, section after section, and they go on forever and you really wonder what you're talking about at the end of it. I want to know the real story [Int, 01].*

Some nurses voiced concerns about the diagnostic language which they had problems understanding and they questioned the utility of using lengthy diagnostic statements which appeared to offer little direction for individual patient care. Furthermore, in cases where the patient presented with complex problems and a constantly changing health status, the diagnostic language was unable to represent succinctly these problems, in an encapsulating and transient way. It was believed that, in instances where the nursing diagnoses tended to overlap, only the major problems were found to be listed on the master problem list. When asked to comment on the utility of nursing diagnosis, one nurse informant pointed out the difficulties associated with the use of nursing diagnosis.

*You write it down only if it is a major problem. But if you write down the problem, Impaired mobility related to, what ever, due to his immobility this patient inevitably has other problems such as: self-care deficit or an incontinence problem as they cannot get to the toilet on time. Also, you must look at their skin integrity if there are any pressure areas. But you don't tend to write all these down, you just seem to focus on the problem that is the worst [Fobs Int, 01].*

A case study from the field illustrated the problem of the patient's nursing diagnoses being unable to capture the complexity of the patient's condition and further evidences this claim. Additionally, it illustrated an incorrect operationalisation of the concept of nursing diagnoses.

*This patient is totally dependent on nursing staff, he is confused, incontinent, aggressive, he spends most of the day wearing a nappy and sitting on a T chair. This*

*chair has a locked bar across the top of the arm of the chair so that the patient is unable to get out of the chair. The physiotherapist cannot get this patient to walk and it takes two nurses to do anything for this patient. He has a very excoriated groin region, his ankles are swollen and he is unable to feed himself or shower himself. He had three nursing diagnoses written on the master problem list, these were:*

- 1. Alteration in mental status related to medical condition. Expected Outcome: Patient will be orientated to time and place and person in 72 hours.*
- 2. Alteration in Elimination (incontinence) related to medical diagnosis. Expected Outcome: Patient will be continent of urine and faeces in five days.*
- 3. Alteration in skin integrity related to excoriation. Expected Outcome: Excoriation will be healed in 10 days using the Wound Management Plan [Fobs, 02].*

The patient mentioned above was totally dependent on nursing care. Clearly, the nursing diagnoses listed did not adequately capture the extent of the patient's problems. In addition, the expected outcomes were found to be unrealistic as it relied on the notion that the patient was able to be rehabilitated. However, this was not the case as a few days later this patient was classified as being "Not for Resuscitation".

### ***Difficulties Experienced Writing Realistic Expected Outcomes***

As identified in the previous example, there were problems associated with the use of nursing diagnosis, other than the diagnostic language itself. Specifically, some nurses voiced concerns about writing expected outcomes as they claimed a difficulty predicting reasonable time frames within which the problems could be resolved. This was further exacerbated by inadequate admission assessments.

*And they [referring to other nurses] also have a bit of difficulty in [writing] expected outcomes. Predicting when would be a reasonable time for this to be resolved [Int, 02].*

Other nurses voiced grave concerns about the unrealistic expected outcomes that were written on the master problem list. When asked a question as to whether the expected outcomes were realistic, one nurse looked reluctantly at me and replied:

*I don't really like these problem statements at all, truly, people play God and nurses make a commitment on the expected outcome, what doctors cannot even commit to [Fobs Int, 08].*

The example of the patient's nursing diagnosis and expected outcomes previously listed provides an illustration of the unrealistic expected outcome statements. Within the context of an acute illness, writing an expected outcome statement on admission was often an unreasonable task as it was very difficult to predict the outcomes of care, especially as they relied heavily on the patient's response to medical treatment. Given the different recovery rates among patients, outcomes of care were sometimes uncertain and unknown and in many cases what was written was unachievable.

As a result of these unrealistic goals being written on the master problem list, nurses questioned the value of writing expected outcomes and tended not to refer to them when giving patient care. When asked how much attention was given to the expected outcomes in general, one informant replied:

*Never, never . . . never, . . . it's written down it's not implemented [Int, 12].*

It was thought that the reasons why nurses wrote expected outcomes when they never referred to them, was supposedly "to follow hospital policy". This provided some evidence to suggest that the espoused theory of what was thought to occur, that is, working towards achieving the expected outcome, did not actually happen in practice. This contributed to the theory-practice gap and to the problem of being in a state of "unknowing".

*But it is hospital policy that says that the nurse has to write an expected outcome, so basically she just does what she's being told to do [Fobs Int, 08].*

Given the number of anomalies associated with the clinical application of nursing diagnosis, the master problem list was not a true indication of the patient's problems. When asked whether the master problem list alluded to and reflected the patient's major problems, one informant who was an experienced nurse replied:

*No, not at all. [Emphatically] I mean why I say no, not at all, because like I said it was an orthopaedic ward for example and most of my experiences are within orthopaedic [wards] [Int, 22].*

As a result of this lack of clarity surrounding the nursing diagnosis nomenclature and difficulties associated with its clinical application, the nursing diagnoses themselves were interpreted differently by different nurses. This inconsistency in the clinical application of nursing diagnosis further contributed to the state "unknowing". One

informant's comment on the utility of nursing diagnosis provides a good summary of the ambiguity associated with its use.

*Some of it's very ambiguous . . . and can be construed by ten different people in ten different ways, which doesn't help your continuity of care, I don't believe. I mean an alteration in . . . we often used to use an alteration in mobility related to, but I didn't find it specific enough unless people . . . really, really thought about how they came to that diagnosis and documented it [Int, 07].*

In summary, there were many problems associated with the clinical use of nursing diagnosis. These problems stemmed from a lack of an adequate admission assessment and inconsistent problem identification using a diagnostic language that was appraised as being awkward and lacking. These factors further contributed to the state of “*unknowing*”.

All hospitals used some type of care plan to record specific patient care which some nurses termed a flow chart. These care plans usually had several sections under which to list the patient's specific care. According to the literature, the plan of care is established through the patient's nursing assessment and also includes the written medical orders. Data from the ward settings revealed that the nursing care plan was used inconsistently and the information written was sometimes not up to date or representative of the patient's actual care. This anomaly further contributed to the inconsistent and fragmented communication process which caused the state of “*unknowing*”.

### **Inconsistent Use of Nursing Care Plans**

As the process of patient assessment and diagnosis was poorly performed, nursing care tended to be based directly on routine standard care related to the patient's medical diagnosis and prescribed medical orders. In some cases, specific patient problems were not known and hence not addressed.

*Well what happens is . . . people just tend to write in on that section . . . I guess without ever doing an assessment if someone comes in say with abdominal pain, they know things like give them analgesia, they'll have had orders like “nil by mouth”, “IV therapy”, anyway, those things have been written anyway but I guess yes, if there's some deeper problem that hasn't been unearthed, well then it won't actually end up on the care plan [Int, 24].*



In cases where admission assessments were not performed adequately, patient care was determined directly from medical orders. Specifically, data revealed that the care plan was completed by transcribing medical orders on to the nursing care plan and by adding other “routine” interventions.

*Well you get it off the doctor's notes and put in what is routine. Then the next nurse who does the assessment completes it [Fobs Int, 02].*

As care was based on medically prescribed actions and routine interventions, some nursing care plans were incomplete and in some instances the nursing care was not explicit or individualised. This further exacerbated the problem of being in a state of “*unknowing*”.

*It's not explicit, that is never never [strong emphasis] explicit in the notes [referring to the nursing care plan] [Int, 12].*

Additionally, patients' conditions were constantly changing and these changes were not always reflected in either the oral or written communication system. When asked a question about the helpfulness of the nursing care plan in providing patient information, one informant's reply illustrated the nature of the problem:

*Yes, to a certain extent, it gives you a general overview, because patients' conditions change so much [Fobs Int, 04].*

The different levels of nurses' knowledge and experience also caused variations in the documentation. The data revealed that the quality and accuracy of information documented varied from nurse to nurse. The information written on the care plans also varied. One Clinical Nurse's response to the value of the nursing care plans is as follows:

*Only as good as the person using them. It's a good tool, but like any tool it's only as good as the person using them. Sometimes they are too verbose, they need to be succinct, to the point, telling you exactly what you need to know [Fobs Int, 05].*

In addition, it was found that some information that was considered to be minor was not usually updated on the care plan. Therefore, the actual patient care would be difficult to determine with any certainty. When asked a question as to whether the nursing intervention “shower with assistance” ever got upgraded when the patient

showered independently, the nurse replied negatively, thus providing evidence of a failure to update the care plans.

*It will usually stay as shower with assistance for the whole time . . . Yeah, a lot of the time it will have shower with assistance and if they can do it themselves then I won't cross it out or I'll just sign it anyway . . . that's what most people would do. Because it's just a little minor thing, I think, if it's a major thing, like if they get changed from clear fluids onto nourishing fluids then that would get changed then. I think you just evaluate it, you look at the patient and see if they do need the help and if they don't need the help. Because of like your time constraints, then if they need help you give it to them, if they don't then you don't usually write it down. And maybe it might not get changed on the care plan [Int, 06].*

In these instances, it appeared that the actual care delivered was different to what was written on the care plan. This provides another example of the inaccuracy of the documentation which further contributed to the problem of “*unknowing*”.

In some hospitals where the care plans were updated daily, nurses tended to update the care by transcribing the care from the previous day instead of re-assessing the patient and determining the care based on this assessment. As a result of this practice, the interventions written on the care plans may not have been accurate. When asked the question as to whether the care plans were kept up to date, one informant's reply alludes to this issue.

*Yes and no. There are a lot of times, like for three or four days you'll just see the same information being transcribed for the next day, so again, you wonder whether a lot of thought has gone into it. . . . A lot of times people put, as people progress in the hospital and gradually get better, sometimes it just says “shower assistance” and that doesn't change and you'll ask that person, “how much help do you need?” and they say “Oh, I'm right” or “I've already showered” or something [Int, 04].*

Another factor that further fragmented the continuity of the care was a lack of a particular person being responsible for updating the care plan. It was stated that all registered nurses were responsible for updating the care plan of the patients assigned to them each shift.

*No, it isn't anyone's job really I think. Sometimes doctors' orders, but for the most part the registered nurses caring for the patient. It is really up to them. . . . It's common sense and experience I suppose [Int, 01].*

Data revealed that junior nurses found it very difficult to determine when to change the care as they did not know when and how to alter the care. A conversation with a group

of newly graduated registered nurses alluded to this problem. These nurses stated that they often experienced situations where patients, who were on four hourly full neurological observations, were discharged as no-one had altered the frequency of the observations to twice daily or daily as they did not know if this was appropriate. In instances where these graduates did not know the care, they transcribed the care from the previous day and did not alter it [Informal Discussions, 02]. This further contributed to incorrect information being written on the nursing care plans and aggravated the problem of being in a state of “*unknowing*”.

On occasions, nurses stated that the interventions listed on the nursing care plan were difficult to understand. Specifically, some intervention statements were ambiguous and, therefore, had no shared meaning among nurses. This added to the problem of “*unknowing*”. When asked how helpful the nursing care plan was for communicating the care, one informant responded:

*Yes I find it's helpful if it's filled in properly, for example, [and she points to the nursing care plan] I don't know what “comfort assist” means and “voids spontaneously”, why not say goes to the toilet by themselves or if it says “shower assist” well how much, one nurse or two nurses? [Fobs Int, 03].*

There was evidence in the data illustrating that the language used on the nursing care plans was difficult to understand and could be described as being cryptic.

### ***Use of Cryptic Words***

The problem of not knowing was further exacerbated as nurses used their own words, jargon, and cryptic phrases, to document care. Other nurses found this documentation difficult to understand. These factors, combined with the complexity of working with a number of nurses from different backgrounds and levels of experience, tended to add to the problem of being in a state of “*unknowing*”. Nurses complained about the abbreviations used which sometimes were indecipherable:

*But then they use this mind boggling vocabulary of abbreviations that if you didn't write it, you're lucky to know, you're lucky if you can figure out what it means and then you're taking a risk because your interpretation of their abbreviations may in fact not be correct. I can tell you now, that they're not hospital standardised abbreviations [Int, 22].*

These complaints were confirmed by data obtained through in-depth review of patient records conducted as part of this study. Additionally, it was supported by findings of another study that reviewed patient records to determine whether the nursing diagnosis formed the basis of patient care (O'Connell, Rapley, & Tibbett, in press). Secondary data analysis from that study revealed that nurses documented patient care on the nursing care plan using phrases and abbreviations that were difficult to interpret. For example, under the section relating to comfort there was an entry made: "w/c as able"; under the section relating to nutrition there was an entry made: "1000 ml FR", "NBU O/A"; under the section on elimination there was an entry made: "spont void"; under the section on mobility there was an entry made: "transfer x 1", "independent with direction". There were many other examples illustrating that the phrases used to direct nursing care were unclear and difficult to understand. The meaning of these terms appeared unspecific and offered little in terms of directing specific patient care. Hence, this contributed to fragmenting the communication process and the problem of "unknowing".

There were other anomalies found to be associated with the use of care plans. It was a requirement in most hospitals that the nursing care plan had to be ticked or signed by the nurses each shift to illustrate that the care had been given. This served as a permanent record of care and was used to communicate this delivery of care across shifts. Although this was a requirement, in some instances the care plans were not ticked and it was difficult for other staff members to determine whether the care had actually been given or not. Summative field notes, recorded after conducting a thorough review of nursing documentation of seventeen patient records, highlighted several inconsistencies in the documentation of the nursing care plans.

*On reviewing several patients' nursing care plans, it seemed that they were completed inconsistently. Specifically, the tick boxes that were required to be signed each shift indicating that the care had been given, were signed sometimes, not signed sometimes and sometimes there was a slash put through which meant the care had not been given on a particular shift. Additionally, on some shifts there were no ticks and/or no signature on the entire care plan for a particular shift. It was difficult to determine with any confidence whether the care was or was not given. Also, when a patient's status changed and the listed intervention had been changed the old superseded intervention had a line crossed through, thus indicating the change. Anomalies occurred on some occasions, as the superseded intervention did not have a line through and a new intervention was added and in those*

*instances, nurses signed the nursing care plan indicating both interventions had been performed [Memo, Chart Audits].*

Nurses acknowledged that the care plans were completed inconsistently and, therefore, at all times they only served as a guide to care. Some nurses completed the form prior to delivering the care, indicating that the care had been given, when in fact it had not. In addition, there were many other aspects of care that were usually not documented. When asked a question about care plans, one informant's response supports this finding.

*I think they guide the care and a lot of the time some people might just follow that, but then I notice like a lot of people will read it through and then they'll sign it off, like . . . when the shift starts. And so whether they do it or not you don't know. But like I mean, I'll usually do it after, maybe when I'm writing my notes and I'll say, yeah I've done that, I've done that. So I think like, yeah, I've done that care, but then it doesn't mean that I haven't done all the other stuff as well. So like, you're doing stuff that doesn't get written down so I think it acts as a guide and . . . it's just a guide I think more than anything and then people will do stuff or omit stuff [Int, 06].*

It was found that some nurses ticked the boxes in the nursing care plan ritualistically without actually thinking about what they were signing.

*I think probably some people, like for instance you'll find night staff will sign for say showering and you know perfectly well there's no way they've showered a person on night duty. I think people do [sign] and they don't actually [give the care]. I think we do need to probably increase an awareness that what they're actually signing, they're actually signing that they've actually done that . . . therefore, they're liable or whatever, by saying they've done that. . . . So that is a problem [Int, 24].*

As indicated earlier, some nurses ticked the care plans signing that the care had been given at the start of the shift rather than at the end of the shift.

*They just initial off that they've actually done the care, that's how I believe that it's meant to work, but what happens is that, staff come on, most of them come on and stand at the foot of the bed and initial off everything that's to be done for the, like shift, before they've ever done it [Int, 22].*

Data revealed that the information on nursing care plans was completed and updated inconsistently and, therefore, varied in reliability. This was a consequence of the number of nurses involved in giving the care, each with different levels of knowledge, expertise, and commitment to their work, combined with a lack of a central person

taking responsibility for updating the care. This tended to further fragment the communication system and added to the problem of being in a state of “*unknowing*”.

The way in which the patient progressed was usually documented in the patient’s progress notes. Most ward settings had a policy that stated that an entry should be made in the progress notes at least once in a twenty four hour period. Data from the study exposed problems with the progress notes that stemmed from inconsistent documentation patterns used by nurses. In some instances, hospitals’ documentation policies appeared to further exacerbate the problem of being in a state of “*unknowing*”.

### **Inconsistent Use of Progress Notes**

As it was a requirement in all hospitals that on-going patient care was documented in the patient’s progress notes, this requirement was usually observed. Although patient progress was documented, the quality of the information written on these notes varied and in some instances patient progress was not documented. This further added to the state of “*unknowing*”. Data from this study reflected inconsistent use of the progress notes.

*It varies sometimes, you’re rushing to get off, you just write anything [Fobs Int, 07].*

There were other instances where nurses were very busy and consequently forgot to write information in the progress notes prior to the completion of their shift. When asked how she functioned when it was busy, one informant replied:

*Well, I just get the essential things done, for example, graft care is very important and sometimes I just go home and I realise I haven’t written anything up in the notes. I just completely forgot [Fobs Int, 08].*

Another nurse’s response to a general question about the progress notes provided further evidence about the variation in the quality of the progress notes and illustrated how it sometimes lacked detail.

*That varies from nurse to nurse now, for example, Patient Z, she does not use soap and likes you to pat her skin dry and you never know this through the notes [Fobs Int, 03].*

Level of experience and familiarity with specialty knowledge was another factor thought to influence what was written. This condition increased the state of

“unknowing” when nurses were moved into wards or units other than the one in which they usually worked.

*But one of the problems we do find, that if we've got nurses from other areas who don't have the expertise of neurology, their documentation perhaps isn't in the same format that we would like it to be. They don't give as much detail [Int, 02].*

Additionally, it was stated that the progress notes focused on physical details of care and there was very little emphasis placed on the patient's overall psychosocial functional status. Many nurses in this study found the notes to be inadequate. A conversation, about the patient's notes, with a nurse who worked in the oncology area revealed the following description of the inconsistent and fragmented nature of the patient's notes.

*Hopeless, it gives you a bit of previous history, nursing procedures mainly, nursing tasks, no psycho-social or social issues. Sometimes they are and sometimes they're not, up-to-date; it depends on the staff, on the nurse [Fobs Int, 05].*

Data revealed that the documentation policies used in some hospitals may have inadvertently fostered nurses' inconsistent documentation practices. Specifically, in some hospitals nurses were required to document information stating how each nursing diagnosis was progressing. As nursing diagnosis was used inconsistently and the master problem list did not always reflect the patient's real problems or status, the report in some instances concentrated on the nursing diagnosis and did not always reflect other important aspects of patient progress. This inconsistent documentation further added to the problem of being in a state of “unknowing”.

### **The Use of a Number of Different Charts and Forms**

Another emergent issue that further fragmented communication was the number of charts that nurses were required to complete and the spread of the same patient information across these charts. Compared with other allied health professionals, or the doctors, who documented all information in the medical notes which were stored in the ward's office, nursing notes comprised a number of charts which were stored at the bedside and in the ward's office. These charts contained some patient information that could be documented repeatedly in several charts. Hence, in some instances, the trail of patient care was perceived to be fragmented and difficult to follow. Nurses voiced

concerns, as they were sometimes unsure and were unable to determine which was the correct chart to use. In addition, as some documentation was stored at the bedside and some at the office, this further fragmented the trail of care and sustained a state of “*unknowing*”.

*And the other problem is sometimes, you know, if you have something that comes up in that shift, . . . you would tend not to write it down and it maybe something that people should be aware, you would like them to see, because that's usually the first place they look [referring to the nursing care plan]. But it is not appropriate to do that when its just for a limited period of time. In which case, . . . you would have to put it in the progress notes which are kept in the office, so they are separated and again, continuity may not continue because of that [Int, 04].*

Overall, the documentation of patient care was thought to be cumbersome. For example, nurses stated that Health Department hospitals had a total of 30 different patient charts that could be used to document patient care. Field notes written after a discussion with nurses who worked in a country hospital substantiated of this claim.

*The nurses collectively stated that their documentation was of a very poor standard and that they had problems with a number of forms that they were using. This hospital was using forms from the Health Department and the Director of Nursing said that there was a total of 30 forms available for use. While touring the hospital, this nurse showed me the cupboard where all these forms were stored. This abundance of forms that could be used, was perceived to be just one of the problems associated with documentation [Informal Discussions, 01].*

This inconsistency in documentation was exacerbated by the number of charts required by each patient and the practice of documenting similar patient information on a variety of charts. This tended to fragment the flow of the documentation of patient progress and further led to the state of “*unknowing*”. Specifically, it was difficult to determine which chart contained current information.

*I actually find the notes are a mess, I find the duplicating, you know we duplicate even observation charts, if they're on a big observation chart, you're writing the notes from the big observation chart on the daily observation chart and sometimes you **actually forget to do that**, so if you want to record important details like if they've had a bowel motion, you might put it in [write it on] the one at the bedside, which is the big chart and then at the end of the shift, you're actually **supposed to go** and chart it in the daily charts, so there's an awful lot of messy duplication [Int, 12].*



One informant stated that nurses did not refer to the nursing notes due to this fragmentation of information and difficulties associated with knowing where to access pertinent and informative information.

*Nursing notes as such tend to be sort of something that's fairly low down the priority for most nurses to read. . . . Probably partly because a lot of the time the information you need is not there, they're convoluted to read through, the way that they're set out makes it difficult to find the information sometimes [Int, 29].*

In other instances, due to the large number of charts, some charts were misplaced.

*I think the present system is cumbersome. You end up with so many pieces of paper, that it's very easy to misplace. I don't know how many times we've had to go looking for a particular part of somebody's nursing documentation [Int, 07].*

Due to all these inconsistencies in documentation, it was difficult to determine with any confidence, through reviewing the patients' notes, how the care had progressed. A memo written after conducting a thorough review of a patient's case notes provides evidence of this issue.

*It took me around three hours to audit this patient's notes and it was not clear how she had progressed. She was in hospital for a total of 14 days. There was no functional status assessment recorded by the nursing staff. The patient had a total of three care plans which were completed inconsistently. The progress notes were discontinuous; it seemed that different nurses (a total of 18) documented different information. The trail of care was very disjointed and it was very difficult to know how the patient and the care had progressed [Memo, Chart Audit].*

In summary, the way in which patients were assessed, problems were diagnosed, interventions were written, and the record of patients' progress appeared to be inconsistent, uninformative, and collectively they formed the basis of the state of "unknowing". It was difficult for anyone to determine with any surety what was happening in regard to patient care and patient progress. However, there were other methods used to communicate patient information, such as, the verbal or tape-recorded handover. While this supplemented the written communication system, it too posed other problems that further exacerbated the problem of being in a state of "unknowing".

### **Inconsistent Handover of Information**

Given the inconsistencies within the documentation system, "knowing" exactly what was happening in regard to patient care was a difficult task to achieve. There were other

methods, however, that were used to communicate patient care, such as, the “nursing handover”, which usually occurred at shift changeover times. This type of communication between nurses across shifts was also thought to be problematic. Specifically, some handovers were seen as being dysfunctional. This retarded further the communication process and led to a state of “*unknowing*”. Handovers tended to be conducted in several ways. For example, some were face-to-face verbal handovers and others were tape recorded. Additionally, the number of patients that were “handed over” varied according to the level of activity on the ward and the routines observed on each ward.

*If we come on at two o'clock start, we usually join the handover group which is at two o'clock. If I come on at three o'clock start, I get an individual handover. Depending on how busy they are, I may just get a handover of my rooms, if they're very busy, but if they aren't too busy we get a total handover of the ward [Int, 12].*

There were many other factors that were thought to affect the handover process, such as time and the individual nurse's knowledge base of patients. All of these factors will be discussed as they impacted on the efficacy of the handover process and led to the state of “*unknowing*”.

### ***Factors that Hindered Handovers***

The information that was usually handed over varied from nurse to nurse and was influenced by many factors. Some of the main factors were the time allowed to conduct handover, and the pace of the ward at the handover time.

*Handovers depend on how busy the ward is, and you've got to get out there. Also if you have a meeting to go to and you have to be there by a certain time [Fobs Int, 06].*

The time the handover was conducted also appeared to impact on the comprehensiveness of the handover. The experience level of the nurse was also thought to affect the quality of the handover.

*I don't find the morning handovers particularly useful, because it just usually relates to what's happened overnight. But the afternoon handovers, you find you'll get a lot more information coming from, usually a more experienced nurse anyway, and the sort of information that I'm looking for, particularly, say if it's a new patient [Int, 02].*

Data revealed that patient information that was handed over from nurse to nurse varied due the individual nurse's knowledge of the individual patient's condition and the patient as a person. This knowledge base differed and depended on the nurse's familiarity with the patient. Nurses who had returned from days off, and agency or other casual nurses who had only worked with the patients for a short period, had limited information about the patients and were unlikely to know the patients in any substantial way. Due to these reasons, information given via handovers tended to vary considerably.

*Oh, that varies tremendously. I work three nights per week and most of our staff here work three or two nights so you can be a week off the ward and the ward changes a great deal in that time. And also depending on who's doing handover, often . . . the day staff may not be too familiar with their patients. We do use quite a few agency staff who really don't have the ongoing knowledge of people so you're never really sure [Int, 01].*

Nurses also recognised that on returning from their days off duty they had limited knowledge about the patients and were in a "state of unknowing".

*Another afternoon shift nurse comes on at 1400 hours and is sitting in the office. An orderly walked into the office and asks her a question while she is filling out her handover sheet with the patients' names. She answered the orderly "I don't know". She looked at me and said "I hate it, you just come on from days off and people ask you questions and you don't know anything" [Fobs, 01].*

As a result of this, on many occasions when nurses were handing over, there were gaps in the information that was handed over. These gaps occurred as a consequence of the nurses' own lack of knowledge about the individual patient. This factor was further exacerbated by the number of health care professionals involved in the delivery of care and difficulties experienced communicating information across the health care team. The following excerpts from field observations of handovers further illustrated this point and how it contributed to the fragmented communication process and the problem of being in a state of "unknowing".

*New admission, don't know much about him, he's just come up from casualty. I've not done the obs [Fobs, 02].*

*Patient 11: [States his age and medical diagnosis]. . . he has alcohol problems, needs a sputum. We don't know where he is going to, but the social worker is involved [Fobs, 01].*

*Patient 15: [States his age and medical diagnosis]. . . . sorry I don't know, he's come from another ward and the person who booked him in did not know what operation he was coming in for [Fobs, 07].*

There were many reasons that were thought to affect the quality of the handover. Overall, the working environment of change and uncertainty, and the fragmented communication process used within work settings, exacerbated the problem. Within this context, nurses had various levels of understanding of the patients and their specific care. The quality of the handovers, therefore, were contingent upon this basic understanding that varied from nurse to nurse. The following extracts from the field observations provides evidence of this.

*Nurse's handover of a patient in room G14: The coordinator states the patient's medical diagnosis, high blood sugar level, oral hyperglycaemics, blood sugar level was twenty seven, paged the second on [referring to the medical officer on call], told him of this, ambulating by self, needs supervision, scan should be completed today. The afternoon shift co-ordinator asks, has he had some sort of problem? The morning shift. co-ordinator replied, I'm not sure what's going on anyway, she continued with handover, put cream on his body [Fobs, 01].*

*This patient is a new admission, I've not had time to read the medical notes. States the patient's medical diagnosis and age, IV, had digoxin and theophylline levels. The nurse coming on duty asks a question "Does she need oxygen?" The coordinator replies it does not say that in the notes, really her main problem is that she is quite nauseous [Fobs, 02].*

Furthermore, during the field observation period, nurses who handed over patients were sometimes unsure of the exact nature of the patient's existing medical order. This particular example illustrated, in part, nurses' acceptance of uncertainty and "not knowing" which had the potential to lead to undesirable outcomes.

*Patient 4: He came in last evening. [States the patient's age and medical diagnosis] NIDDM [Non Insulin Dependant Diabetes Mellitus], fell and fractured his ribs, [gives the medical treatment he had on the previous ward], . . . no diet he cannot swallow, naso-gastric tube re-inserted, feeds will be coming up, dopamine infusion 20 ml per hour, also IV fluids, he's dehydrated once feeds start IV can stop, his urine output is very poor, two hourly measurement, suctioning PRN [as required], he needs heaps and heaps of mouth care his mouth looks very bad. He got very agitated when I passed the naso-gastric tube, I don't know he seems confused, Oxygen sats [Saturation] are fine, oxygen continuous with the Hudson mask, CVP [Central Venous Pressure] readings are ceased, He's not for intubation if he arrests.*

Another nurse asks a question: *What, do we just give him cardiac massage?*

The shift coordinator answers: *I expect so.* The handover continued [Fobs, 02].

Individual nurses also had different approaches to handing over patient information. Some methods were thought to be less helpful and retarded the communication process.

*And if they use a sheet of paper they usually read down and follow a format and it has some structure. If they don't use a sheet of paper and they're handing over off the top of their head, then it seems to wander here, there and everywhere. Quite frankly, . . . when it tends to wander here, there and everywhere I don't seem to be able to remember it [patient details] at all [Fobs Int, 08].*

Field notes commenting on the method of handover provides further evidence of this problem.

*Where there is no handover card used by the nurse, the handover tends to be less structured and more story-like [Fobs, 07].*

Additionally, it was found that when some nurses handed over patient information they used many abbreviations that other nurses could not understand.

*From my experience, very limited things, things like I've actually said [to the nurse handing over] could you please define what this definition is. Like they'll have like a name like PCA [patient controlled analgesia] or things like this and I say could you please give me a lengthened version of what your definition is of this, so that I am aware. Many times I have been told, "Oh, I don't know, you'll have to look at the notes" [Int, 05].*

This lack of knowing the patients and their specific care was further exacerbated by organisational constraints. In some wards, nurses did not receive a handover due to the flexible rostering system and lack of overlap time. In these instances, nurses had to rely on the care plan in order to determine patient care. However, in cases where the care plan was not explicit or up-to-date the patient's status was unknown to the nurse.

*I find it's [referring to the nursing care plan] helpful to me . . . because I don't know these patients often. . . . So, I depend on them, so they have to be up-to-date. Because I don't get any handover, so I don't know if someone has ticked that their emotional state is good the night before and I come in and they've had a lousy night, I have no idea. Until they discuss it at morning tea or something [Int, 03].*

The ways in which handovers were given and the content that was handed over also varied according to each nurse's own preference. The following comment from a nurse about handover supports this finding:

*It depends on what their [the nurse's] focus is. I find that some people hand over details that you don't need in a verbal handover which you can get from the notes*

*and aren't vital to your taking over at that particular moment. People probably complain that my handovers don't contain enough information [Int, 07].*

Moreover, the experience level of the nurse was thought to affect the quality and appropriateness of the information that was handed over.

*I mean some of the people [nurses] I work with are starting off and some inexperienced, . . . like starting off at coordinating and they will either hand over too much information or else sometimes they don't hand over enough. And then you have some people, I know there's one lady [referring to a colleague], she was a lovely lady, but she really, you came out [of the handover room] and you really had still no idea of what had happened, because you almost got the feeling she didn't really know what was going on [Int, 24].*

It was thought that senior nurses handed over more pertinent information.

*I think it depends on experience, for example I can think of very senior registered nurses and senior CNs [Clinical Nurses], I believe give a much better hand over on tape, than say a junior registered nurse [Int, 23].*

These uninformative handovers caused problems for other nurses as they did not provide enough information about the patients. One informant's account of the problem is as follows:

*For example, on one of my wards, each individual hands over their own patient onto the tape. Now that can be very variable, I can assure you, sometimes that's very skimpy [emphatically], a bit too skimpy, so that can be a bit of a problem [Int, 23].*

This informant gave an example of how information about the patient was inadvertently omitted as nurses focussed on what had happened on the shift rather than on handing over information about the progress of care.

*They don't look at the patient on a continuum, you know, they don't sort of look at what happened maybe yesterday. So they don't give you any of the history of what's happened, or what's going to happen. They tend to focus on the fact that of all the things that they did that day . . . so this has been a major event of the day, like melaena, then that's what they'll focus on. Yeah, and they'll forget to tell you the endoscopy happened yesterday [Int, 23].*

This lack of continuity was evident in the care and patients' relatives also voiced concerns about a lack continuity of care. They perceived that this problem was due to a lack of a central person responsible for the overall coordination of patient care.

*My feeling is because there wasn't someone who day after day has that responsibility of pulling things together and keeping things moving on. I mean they were looking after Mum quite adequately, but at the end of the shift--so what! . . . she's comfortable, she's had her medication, etc etc, but there's no continuing responsibility [Int, 28].*

Data from this study revealed several problems with handovers in general and other particular problems associated with tape-recorded handovers.

### ***Problems with Tape-recorded Handovers***

Due to the rostering system and lack of staff overlap time, tape-recorded handovers were used to communicate information. While this type of handover had practical benefits, that is, it saved time, it also hindered communication as its use tended to modify and alter the efficacy of the handover process. More specifically, nurses found that they tended to handover information in a more impersonal way, focussing on tasks. Moreover, this type of handover tended to be more brief and did not reveal, fully, the patient's overall condition. A nurse's account of the effectiveness of handover provides an example of the problem.

*Depending on what shift you're coming in on, you miss a lot of the details that's really going on, so until you actually get to the bedside you really don't see what's happening to them. I suppose the pressure area care, like that's really neglected, like they have to be turned two hourly, well that's never really mentioned, I mean that takes a lot of time and that to me means it's a heavy person or heavy patient. I just suppose handover just doesn't fill in the whole day, does it? It doesn't give you the nitty gritty that you need to know, it gives you the basics and then you have to build from that when you see the person [Int, 25].*

In other instances, the handover did not reflect a true picture of the patient's current condition and lacked detail. The data revealed that, in some instances, nurses performed these handovers in a hurried manner.

*They do it on tape [referring to the handover] and the limitation I suppose, especially if you are coming on an afternoon shift, that's taped at 11.30 - 12.00 o'clock and I find the main things are really happening around 1.00 o'clock, after lunch, so that doesn't get handed over on the tape and if they don't see you,-- verbally you don't get it at all, and it's usually by trial and error that you find it out. I know myself, it's such a rush "Oh, I've got to handover on the tape", whereas it would be better to do it verbally, I think you remember more when you're not so rushed [Int, 25].*

This lapse in time from when the handovers were tape recorded and when they were used also caused some nurses concern. It was stated that the information was not up-to-date and this further led to the nurse not knowing the patients' specific nursing care needs and contributed to the problem of "unknowing". Due to this fragmented communication process, some information was lost.

*The other frustrating thing linked to that [the tape-recorded handover] is sometimes the handover might have been taped at 12.30 or 1.00 o'clock in the afternoon and you're here at 3.00 o'clock in the afternoon and a lot of things have happened since then. The staff member often isn't there any more to find out what's gone on, so you're sometimes lost and have to spend a lot of time finding out that information that's lost that wasn't on the tape . . . but often information is just lost [Int, 29].*

Specifically, some nurses complained about the tape-recorded handovers as they sometimes lacked information. These handovers were recorded early for pragmatic reasons and, therefore, did not contain current information about the patient. There appeared to be large gaps in the information that was tape recorded.

*Because you need to use the tape in advance of the time when you would otherwise be handing over. You've got to allow a gap, a time gap, otherwise you're going to get off late every time. Therefore, in between the recording the tape and the time that new staff come on, things could have changed and you can't be running backwards and forwards to the tape all the time. So, yeah, it's not necessarily as accurate as it would be if you handover at ten to nine, . . . much closer to the time [Int, 18].*

Additionally, during tape-recorded handovers, there were discussions about patients that clarified issues for all nurses. During these discussions, the tape recorder was turned off. In these instances, nurses who listened to the tape-recorded handover at a later time did not get this information which would have clarified certain issues in regard to patient care.

*The CN [Clinical Nurse] will tape it as she's giving it, but then some of the other nurses might be asking questions, so they'll switch it [the tape recorder] off and then allow a bit of a chat. . . . Then they'll get back to what they were talking about and then they switch the tape recorder back on, so the little stuff, the discussions that maybe the two CNs, [Clinical Nurses] the morning one and the afternoon one, have, whoever is listening to the taped version, will not get [Int, 06].*

When further asked to clarify the nature of these discussions the same informant replied:



*It's usually good to see, though they might be discussing the type of care they're getting, that they're going to have to get in touch with the doctor, say that this needs to be done, or it's irrelevant . . . which you would miss out on if you were just listening to it [referring to the tape-recorded handover]. You wouldn't hear them discussing this particular care. Or sometimes they might be talking about some other personal thing about that patient. Say like if you've got a drug addict, so they might be telling a little story of what this person has got up to . . . maybe they've been in the storeroom and taken needles and syringes [Int, 06].*

As these handovers were constrained by the length of tape and were brief, nurses handed over information using several abbreviations that other nurses (particularly agency and relieving nurses) did not understand.

*When I relieved on another ward I could not understand all the abbreviations, and I thought "how can I be in nursing so long and know so little" [Int, 32].*

Some nurses complained about tape-recorded handovers and said that it lacked interaction. When I asked a nurse a question about how she found tape-recorded handovers she replied:

*Depends how clearly the person speaks. Often because you're talking to a tape recorder you tended to ramble. To a point, it cuts out all the little exchanges that go on in a handover that has the morning Coordinator and all the afternoon staff' . . . because you're not actually interacting with that person [Int, 07].*

Data revealed that nurses felt more comfortable handing over some information verbally and, in the absence of shift overlap and a verbal face-to-face handover, this information was not handed over.

*So if I'm still on when the next registered nurse comes on, then I'll say this is the updated version [meaning a current handover] and this is what they [the patients] might need. Because if you don't get to do that, if you don't get to see the next RN [registered nurse], then you don't get to hand on that information [Int, 06].*

Furthermore, when tape-recorded handovers were used, nurses had to supplement the information given with another verbal handover. In conditions when the handover could not be supplemented verbally, as when the nurse had gone off duty, some information may not have been handed over. In these instances, some nurses voiced concerns as they were unable to determine priorities at the start of their shift.

*Yeah, if you're not going to see them, [the nurses coming on the next shift] then you won't get to handover to them. . . . If I'm taking over, because sometimes you don't know where to start, which thing is like a priority, whereas if you have the*

*handover--the personal handover--they can say that this is the most important thing that needs to be done and these need to be done later on [Int, 06].*

On some occasions, nurses would have to replay the tape in order to determine what was said. However, if the message was not clear it was said to be difficult to confirm or deny information as the person handing over may not be accessible to clarify any information. The following taped handover is an example of an unclear message.

*PATIENT C3 [states the patients name, age, medical diagnosis] borderline sleep apnoea, ambulant, self-care, IV bunged, if he is **unwell** fast him from 12.00 midnight and call the team [Fobs, 05].*

This information was unclear and it was difficult to determine with certainty what “unwell” meant, and the nursing response that was expected if the patient was unwell after 12.00 midnight.

While there were many problems associated with patient documentation and the handover process that formed the basis of an inconsistent and fragmented communication process that led to a state of “*unknowing*”, there were other conditions found in work settings that further fragmented the communication process. These conditions stemmed from the way in which nurses and doctors communicated patient information.

### ***Fragmented Communication between Nurses and Doctors***

The communication process between nurses and doctors was also fragmented and problematic. This added to the problem of “*unknowing*”. Excerpts from the field notes illustrated the problem.

*At the end of the handover I saw the shift coordinator attend to a patient bell. A doctor approached her and said something and they spoke for a while. I could not hear the conversation but the nurse seemed frustrated. At the end I asked her what was happening, she said “you know these doctors they do a ward round, decide something and never tell you, you have to find out other ways. And then they say, oh the patient should not have gone home, but it’s too late the patient has gone home.” Another nurse who was with her at the time, looked at me, nodded and said “Yes it happens all the time” [Fobs, 02].*

On some occasions, when the doctors commenced their ward round to review patient care, they did not always ensure that a nurse accompanied them. The data revealed that

nurses had to keep an eye out for the doctor and then follow them on the round. However, in some instances when the nurse was occupied elsewhere, they would miss going on the ward round and knowing the changes that are made to patient care.

*I mean if you were there, if you see them, it's great, you go along, but often you're in another room and you don't actually see them. So you may miss out [Int, 24].*

Another nurse's account provided further evidence of the problem of this fragmented communication between nurses and doctors.

*No, you've got to chase them, [referring to the doctors] sometimes you find out from the patient, they say "Oh, I'm going home in the morning" and that's the first time you've actually been told [Fobs Int, 05].*

On some occasions, nurses found out about patient care from the patients. One informant's account of the problem is as follows:

*They may come in and say to a patient, "look, I'm sending you for an angiogram" and sometimes it's even happened that they've said "Oh look, you're going for an angiogram the following morning". And then it might be that afternoon that the nurses might find out as the patient says I'm going for my procedure tomorrow, and you usually say "what procedure I haven't been told?" [Int, 12].*

There were many reasons, revealed in the data, that explained why the communication process was impaired. Some conditions were purely circumstantial and others were given as being due to human error.

*OK, a typical scenario is the doctors do their rounds. I try and be there during the rounds to know what the changes are, but I might be at morning tea. And you come back, now there should have been the shift coordinator doing the round or at least someone doing the round with them, but, yeah, just sometimes they get caught up [referring to the shift coordinator or the registered nurse who went on the rounds], they don't hand over to you, and it's just frustrating. You can spend a lot of time drawing up the IV [Intravenous] antibiotics only to be told that: "no, no, that's all been ceased". Many, many examples of that. Sometimes it's because the coordinator or the person who at the time has direct access to the doctors, hasn't got to you, either because they've forgotten or they've been otherwise engaged. . . . That can be very frustrating, that's one of the big frustration that you're not told [about the changes in care] [Int, 18].*

Field notes written also provided an example of how nurses had to chase information and constantly check the medical notes in order to determine ongoing patient care.

*Quite often the doctor visits the patient, at any time, and writes the medical orders in the medical notes. The doctor tells the coordinator in passing, while she is doing*

*something else, what the orders are for a particular patient. Or, alternatively, he just writes the changes in the medical notes without telling anybody. If the coordinator did not have a chance to review the medical notes before she handed over she would not be able to hand over these changes [Fobs, 01].*

Consequently, it was not uncommon for information to be omitted from handover.

*I haven't had a chance to look at the medical notes so I can't tell you what is happening [Fobs, 01].*

On some occasions, patients also perceived a communication breakdown among staff members. An account from one patient supports this claim.

*Well the nurse would do something and then get called away and a doctor would come up and ask the same question, the same thing, so . . . although they were busy, right, I understood that. There was just--mind you, messages do get waylaid through communication sometimes [Int, 09].*

As there was a breakdown in communication between doctors and nurses, patients were used sometimes as a source of information. Although this was helpful on some occasions, at other times the information given was thought to be incorrect.

### ***Problems Associated with Asking the Patient***

As a result of this inconsistent written and verbal communication process, "knowing the patients" and their specific nursing care needs was a difficult task to achieve. Some nurses overcame this problem by asking the patient. This strategy, however, frequently tended to be unreliable and added to the problem of being in a state of "unknowing".

*Well you ask the other nurse or the patients if they are "with it". Just say "how did you go to the shower yesterday?" and they will say "two nurses helped me"--then you know [Fobs Int, 03].*

Although patients were able to provide the nurse with some direction as to their care, not all patients actually knew the care and, therefore, the information obtained may not have been reliable. When asked whether she questioned the patients in order to determine their care, one informant's reply alluded to this problem.

*Yes you do. I did, like last night I actually . . . a man had abdominal surgery and I wasn't quite sure. I said "Oh have you been moving today?" and he said "No" and I said "Oh, can you shower?" and he said "No, no I can't get out of bed". And I actually had thought, well, . . . he's day one, he should be out of bed, so I actually*

*had to go and ask another nurse, so you don't always get the right information from them, but usually they know [Int, 25].*

Another nurse provided a good example, which was easily recognised by other nurses, about instances where patients tended not to give nurses correct information.

*I find that most patients don't really know what's going on around them, and therefore, don't know to tell you that. They certainly don't tell you, "Oh, I'm supposed to be fasting", if you offer them a cup of water [Int, 18].*

The issue of nurses not knowing when the information given to them by patients was or was not reliable further added to the problem “*unknowing*”.

There were other factors revealed in the data that added to the problem of being in a state of “*unknowing*”. It is well documented in the literature that nurses operate within an oral culture, that is, information held in nurses’ minds and transferred verbally (O’Brien & Pearson, 1993; Street, 1992). This finding was also evident in this study. While this oral culture has many advantages related to being able to communicate personally it was also problematic and contributed to the state of “*unknowing*”.

### ***Oral Culture***

The use of the oral mode of transferring information was thought to aggravate the problem of “*unknowing*”. Specifically, this communication mode was commonly used to communicate sensitive patient information and, without the backing of a written record of care on these issues, this information was more easily lost or misinterpreted. One informant’s account of this situation emphasises the issue of information held in the oral culture being more prone to being lost.

*What you were talking about, not writing things down sometimes, often critical care nurses are I guess notorious for verbal handovers, for retaining a lot in their head, but particularly if you've had a patient who at 1.00 o'clock has handed over to relieving staff who then looked after that patient for a one hour period, they've got all the information in their head, they don't write a lot of it down, all the little things that happened to the patient in the morning that are important, then they will often, because it's not written down, will forget things that are important for me when I come on later to know about. It's partly that. It's partly lack of time, I guess you lose communication as well . . . Tiredness . . . Business [Int, 29].*

There were many examples found in this study of nurses operating and communicating in an “oral mode”. For example, data from this study revealed that nurses conducted on-going assessments; however, they tended not to document this information in the patient’s notes.

*You read the previous day’s notes and you sort of I suppose try to make an assessment in your mind whether or not the patient has sort of come to a halt in their progress or whether they’re going backwards or forwards. But then you don’t actually document that I suppose as having “made” that assessment, but you sort of think about it in your mind and often you’ll mention it to someone else who is involved in their care [Int, 07].*

It was found that the reason nurses tended to operate in this oral mode was linked to its use being seen as less risk-taking. Data revealed that nurses were uncomfortable writing some psychosocial nursing diagnoses on the master problem list. However, they tended to discuss these problems verbally. Some nurses were uncomfortable writing these problems down as they were concerned about patient confidentiality. One nurse’s account of why she did not write psychosocial problems provides evidence of this.

*Rarely, . . . I don’t feel comfortable writing them down [referring to psychosocial related nursing diagnoses]. Sometimes they don’t identify them, sometimes it’s an issue of confidentiality because this information is stored at the foot of the bed and if the patient reads this information, it might not seem very good [Fobs Int, 05].*

Nurses gave other reasons as to why they did not document these types of problems in the master problem list. They stated that it was less important and was not perceived to be the focus of care, especially in the context of a busy surgical ward.

*A lot of the time it would be alteration in comfort: pain . . . it might have, . . . self-care deficit, or nausea. . . . Maybe if they’ve got other problems that aren’t specific to . . . like because it’s a surgical ward, you’re meant to concentrate on that. If they’ve got other problems, you might refer them on to the social worker, whatever, we don’t write it down as a nursing diagnosis [Int, 06].*

Some nurses felt uncomfortable writing problems which were more emotionally oriented.

*Perhaps a part of it may be, since although we know the person’s anxious and everything, we may deal with that from talking to the patient, but perhaps it’s sort of, sometimes I think people might see that as a bit confidential. . . . and they may not want to actually write that in [the notes] maybe they don’t actually. I mean it’s either the problem, but it’s not really a physical problem so they don’t sort of write it in [Int, 24].*

The data illustrated that problems specific to the patients' medical conditions were given priority and seen to be the focus of care. Additionally, what tended to exacerbate the problem of "unknowing" was that some nurses used the verbal handover to communicate sensitive, personal patient information as they felt more comfortable communicating this information verbally rather than writing it down.

*I think verbal handover, if you do it properly it's more efficient in a way [of communication]. There are some things you won't write down in nursing notes because the patient has got access to them and they might be a bit personal or they might not be a problem as such in the problem list, so you might not have documented it, but you might think that it's important to handover [Int, 08].*

Furthermore, in instances when nurses handed over to their colleagues and simultaneously tape recorded the handover, they tended to switch the tape recorder off while they handed over information thought to be of a sensitive and confidential nature. It was found that, within this context, the information held in the oral mode was sometimes not handed over and was lost, thus adding to the problem of being in a state of "unknowing". When asked the question whether the tape recorder was ever turned off during the handover, one nurse informant replied:

*Yes, we stop [the tape recorder] if someone wants to ask a question, if someone wants to add more information to what the nurse has actually given the nurse who is handing over, and if information is being discussed and is confidential or considered to be more subjective [Fobs Int, 06].*

When asked to give an example of this situation, the same informant replied:

*The patient in Room F has chronic pancreatitis, chronic hepatitis and alcoholism, and his pain is fluctuating with very high pain scores and we're trying to determine if he is in pain or [whether he] wants the analgesia because he was withdrawing from his alcohol. So in that instance we would turn off the tape [Fobs Int, 06].*

It appeared that the information that was handed over verbally was more comprehensive than what was actually written in the notes. When asked to compare the value of the content of verbal handover versus the patient's notes, one informant replied:

*I often find [that the verbal] handover is more comprehensive than what is actually recorded in the notes [Int, 04].*

Clearly, as current patient information was usually conveyed verbally, nurses appreciated being able to have the tape-recorded handover supplemented by a verbal face-to-face handover so that any uncertain issues could be clarified. However, this did not happen very often and further contributed to the problem of being in a state of “*unknowing*”. A nurse’s account of what she found assisted her to “know” the care provides evidence to support this statement.

*It’s probably a combination, it’s a combination of the taped handover and then the verbal bit that you do with the person who’s just going off, . . . the previous shift. I usually say to them, what’s going on, if the handovers not been all that good, I might get them to just go through the things that I want to know about [Int, 23].*

In some instances, nurses simply forgot to hand over information before they left the ward. When asked the question “do you ever go off duty and remember something that you haven’t done”? One nurse informant replied:

*Yes, that does happen to me, I remember something I forgot to do or something I forgot to tell somebody. Yes, that does happen to me [Fobs Int, 07].*

Information held in the oral culture appeared to be lost once the nurses went off duty. An account by a patient’s relative, of a communication mix-up provides further evidence of this communication problem. This particular relative told me that the nurses, in the ward where his mother was a patient, had rung his brother at about 1 p.m. and asked him to pick up his mother from hospital as she was being discharged. However, at 2:30 p.m., as his brother was having problems starting his car and it was getting late he phoned the hospital and asked for his mother to stay overnight. This was agreed to by the nursing staff. Much to the family’s surprise they received a phone call to say that their mother had arrived home with a friend at 7 p.m. The mother lived in a big house alone, as her husband was in hospital and she had difficulty walking due to a hair-line fracture of her pelvis. She was using a zimmer frame to walk and was unable to walk unassisted.

I asked the relative whether the nursing staff had told the mother that she should stay overnight. This was his response which provides evidence of this communication mix-up.

*Well, no, no, because what Mum had said was that the nurses had told her that she could come home, so she got everything to leave and she packed her bags and*



*everything and by about 3 o'clock in the afternoon she was sitting on the edge of the bed waiting for someone to pick her up. So, even though Ross [the relative's brother] had rung the hospital back, no-one had told Mum that we weren't able to pick her up, so she was still sitting, waiting to be taken home [Int, 27].*

Although it was difficult to establish the reason for this particular break down in communication, the shift change over time, or the nurse not verbally handing over the change in plans nor writing them in the notes, could be explanations for this occurrence.

Another feature of how nurses used the oral culture was to refer patients to other health care professionals. Data revealed that when nurses referred patients to social workers they did not tend to write this down in the notes. This oral referral provides another example of how nurses tended to communicate information verbally.

*We don't write it down, yeah. So if they need Silver Chain at home or whatever, it gets organised and they get it, but you just don't write it down. You might write it down in your little discharge plan or whether that gets done properly by everyone I don't know [Int, 06].*

Some patient incidents and errors also were handed over verbally and in some cases the incident or error may not have been documented. The following extract from the field notes provides evidence of this situation.

*On this day, one aboriginal patient had visited another patient, his friend, on another ward. This patient's friend was barrier nursed as he had MRSA [Methicillin Resistant Staphylococcus Aureus]. When the patient returned to the ward the nursing staff were confused as to what to do about this situation of this patient being exposed to MRSA. They contacted the doctor and he asked them to swab the patient for MRSA. However, none of this was actually documented in the nursing notes. In another instance, a patient was being monitored for alcohol withdrawal symptoms and if withdrawal symptoms were detected, he was prescribed Valium. During a handover, the nurse handing over to another nurse commencing duty, stated that this patient called a first year RN that evening and said that there had been an explosion. The first year RN instantly gave him 5 mgs of Valium as she thought that he was hallucinating. Apparently, there was an explosion at a nearby power station and the patient was not hallucinating. Several days later the nurses continued to hand this over and have a little chuckle at the same time. However, the actual story was not documented. What was written in the patient's record was that the medication had been given and that the patient was assessed as hallucinating [Fobs, 01].*

Some informants spoke of an unwritten code of practice. When asked to explain this issue further, this informant's reply highlighted the issue of staff covering up for each

other's errors. This is another example of how the oral culture was used. I asked this informant a question to explain the types of unwritten rules that exist in practice. This was the informant's reply:

*Oh lots, [Pause] Stick together, unless it's got grievous consequences, cover up errors, what else [Int, 18].*

Nurses also varied in their confidence levels and this factor appeared to affect the type of information they documented. When asked a question as to whether certain untoward incidents got documented, one informant stated that the strength of what was written was contingent upon the nurse's level of confidence.

*Yes I do now [document untoward incidents] but you need to build your confidence up before you write it all down. The younger nurses just seem to skim over things [Memo: this nurse is a Clinical Nurse and has a Degree in Nursing] [Fobs Int, 03].*

It was found that nurses only documented information about which they felt confident and comfortable. This was further influenced by their levels of experience. As nurses varied in their levels of experience, the oral mode was used more frequently to communicate patient information and patient progress was often documented inconsistently. Given these conditions, where information was held in nurses' minds and transferred orally, this information lacked permanency and was more prone to being lost. This factor coupled with the number and different types of nurses involved in giving care over the total patient admission, and a lack of a central person consistently coordinating the care, tended to add to the problem of being in a state of "unknowing".

### **Different Nurses Involved in the Delivery of Patient Care and the Lack of Continuity**

The number of nurses involved in delivering patient care over the total patient stay was also found to contribute to the state of "unknowing". Specifically, nurses tended to vary in levels of educational preparation, knowledge, skills, and confidence. This in turn affected the way in which they handed over information or documented patient care. Moreover, it appeared that nurse's individual frames of reference influenced what they deemed to be relevant and important for patient care. As there were a number of different nurses who looked after the same patient, each with different perspectives, this

added to the uncertainty and contributed to the state of “*unknowing*”. A review of a patient’s case notes revealed that a patient had been nursed by fifteen different nurses while he was in hospital for a total of seven and a half days. This finding of patients being nursed by many different nurses was very common [Chart Audit, 03].

Patients also voiced concerns about the numbers of nurses involved in giving patient care. In an article published by the Health Consumers Council in Western Australia, in the section Hospital Care: A Consumer’s Perspective, the author who had been a patient remarked about the number of nurses involved in the delivery of care within the total patient stay. Specifically, she voiced concerns about the confusion that resulted as a consequence of the number of nurses involved in delivering patient care coupled with the use of an inadequate communication system (Coghlan, 1996). This patient further stated that a friend of hers who was hospitalised in an orthopaedic ward, voiced concerns about her stay as she rarely saw the same staff member twice.

It was found that on some wards agency nurses were used permanently to fill the gaps in staffing caused by staff shortages. In these instances, if another permanent staff member was off sick and replaced by another agency nurse, 50 % of the staff rostered on duty would be agency nurses. Nursing staff voiced concerns about this issue.

*During a field observation period, a review of the staff allocation book revealed that on a day duty shift there was three permanent nurses and one agency nurse rostered on duty. However, one of the permanent nurses was off sick. Hence, it left only two permanent nurses on duty for that shift. This ward had a total of twenty one patients. As some wards were permanently staffed by agency nurses, when permanent staff were off sick, it often meant that the sick nurse would be replaced by another agency nurse. Nursing staff often complained about this issue of a lack of permanent staff and the high usage of agency staff [Fobs, 04].*

The large number of nurses involved in delivering the care for each patient appeared to confuse some patients. Specifically, some patients were unable to determine which nurse was responsible for their care. The following comment by a patient alludes to the problem of patients “not knowing” who was caring for them.

*The nurse came in and introduced herself and promptly vanished, [then] another nurse came in because this other one was busy, so what you had, you didn’t have the nurse who was actually handed over to you, you had another nurse because the other one was busy. It was sort of confusing to know who the hell was your nurse [Int, 09].*

The number of nurses involved in any one patient's care further exacerbated the problem of "*unknowing*". Specifically, in some instances it was difficult for the nurse to determine how the patient was progressing as she/he was not familiar with the patient's previous status. Nurses agreed that on some occasions they were unable to determine a patient's progress as they may not have been previously involved in their care. This was said to affect the continuity of care.

*Maybe their dressing is giving problems. You write down what you did for that [shift]. You'd write down say skin integrity, if the wound management plan has changed or whatever. Whether the wound's looking better or not, . . . if you know if it's looking better, if you've haven't seen it before then you don't know [Int, 06].*

Some nurses voiced concerns about the numbers of nurses involved in the care of individual patients. This large number of nurses, coupled with the use of an inadequate documentation and communication system, caused certain patient conditions to be missed.

*The patient is incontinent and one nurse thinks it's only a once off incontinence and doesn't document it anywhere and then she goes off and the new nurses come on and they think it's a once off only and they don't document it anywhere. . . . I go onto a ward and I say "Is the patient incontinent?" and the nurse says "Oh yeah, yeah, she was incontinent on one shift, but it was only a once off" and then what I do I put this patient on an incontinence chart, then I see actually that they're incontinent on a regular basis, but none of this has been documented. Each nurse has thought it was a once off and not documented this [Fobs Int, 08].*

Relatives of patients also commented on the lack of continuity of care and the number of nurses looking after the same patient.

*The nurses always seemed very caring, but as to a continuity of care, well there was no-one ever really looking after him, you didn't see the same face very often anyway, let's put it that way, so you were a little bit unsure all the time [Int, 27].*

Furthermore, a lack of a central person such as the "charge nurse" was thought to exacerbate the problem of being in a state of "*unknowing*" and resulted in a lack of continuity of care. When asked a question about how nurses communicate within the present system, one informant replied:

*Poorly. . . especially because . . . there was no, like . . . charge sister, so there was no continuity and a lot was being missed [Int, 03].*

In summary, the major condition of the use of an inconsistent and fragmented communication process was caused by inconsistent use of nursing assessment, diagnoses, patient care planning, and the overall documentation process. Other factors were associated with inconsistent handovers and the use of the oral mode of communication. In addition, the large number of nurses, many of whom were agency nurses, were involved in the delivery of each patient's care. This factor, combined with a lack of a central person consistently coordinating this care, was found to lead to the problem of being in a state of "*unknowing*". Another major condition, found in the data, that caused nurses immense concern and led to "*unknowing*" was the issue of working within fluctuating and uncertain contextual conditions. These conditions led to the second domain of "*unknowing*" that related to nurses' job status and the state of the nursing profession. Specifically, there were many conditions of change that were said to impact directly on the delivery of patient care and caused nurses to be uncertain about their "*domain of practice*".

## **Fluctuating and Uncertain Working Conditions**

Data from this study revealed that nurses worked under several conditions of change and uncertainty that were said to be brought about by budget cuts and changes in the broader health care system. Over the last decade, the overall health care system had been subjected to many changes. According to one hospital's Chief Executive Officer, the Western Australian public health care system had suffered an extraordinary degree of uncertainty in the 20 years he had worked in that major teaching hospital. He claimed to have served under 10 Health Ministers and 10 Health Commissioners and had endured 11 reorganisations (McKimmie, 1996). The fluctuating conditions within the work context caused uncertainty and contributed to the problem of being in a state of "*unknowing*".

These conditions of uncertainty occurred at all levels within the wider health care system, as well as within the hospital and ward areas. The major teaching hospitals in Western Australia seemed to be constantly restructuring and reorganising the case mix of patients, not only within the hospitals but also within each ward area. One

informant's account of this problem is a good summary of the perceived effect this uncertainty had on patient care.

*Once again the public health system is in disarray. Budgets are getting tighter, whilst the services provided are becoming broader and more expensive. . . . We are told that the hospital's restructuring is aimed at increasing efficiencies. . . . We tell Mr Smith that we are sorry he has waited 30 minutes for pain relief but due to [so called] "management efficiencies" his duty nurse, who called in sick was not replaced. We are embarrassed when we explain to Mrs Jones that although she has been coming to our unit for a few years, and she knows all the staff, and feels comfortable with our care, due to hospital restructuring, her next admission could be in one of four different wards, and no, we are sorry we do not know which nurses will be looking after her [Int, 30].*

While this informant presented the effect the changes had on patients, many nurses voiced concerns and feelings of insecurity associated with the number of alterations made to their working conditions. The many changes occurring at hospital and ward levels appeared to be related to budget cuts. Specifically, hospital budgets had been cut and there were threats of further cuts. These cuts tended to fuel a state of uncertainty and force a change in the way in which patient care was delivered. A conversation with a newly appointed nurse manager provided evidence of this occurrence.

*The hospital is only being paid 93 % of an ANDRG [Australian National Diagnosis Related Groups] rate and this rate was going to be cut another two percent in the following year. I am keen to implement critical pathways so that patient costs can be controlled. The Government's attitude is that if you cannot bring it in on budget then someone else will [Fobs Int, 02].*

### **Changing Award and Erosion of Working Conditions**

To add to the prevailing contextual problems of uncertainty, the Nurse's Award, as well as the conditions under which nurses worked, was found to be constantly changing. In addition, there were many other changes that had affected nurses' working conditions some of which have been previously discussed, for example, the introduction of short shifts that reduced staff overlap time or a lack of a permanent core of nurses working consistently in the one ward. While these changes affected the efficacy of the handover process, they also impacted and changed the way in which the nurse enacted her/his role and further added to the problem of uncertainty and being in a state of "unknowing".

*Of course there are changes in holidays, rostering and new pay and things, all sort of simmering [Int, 12].*

More specifically, there was evidence to suggest that the introduction of the six-hour, short shift had caused uncertainty which included nurses not knowing whether they would have the time in the day to complete their work.

*Six hour shifts, I had to stay back every time to complete [my work], . . . it's not nice to leave the work behind. Essentially, you do in six hours what you are supposed to do in eight hours [Fobs Int, 06].*

Nurses constantly complained that their conditions of work were very hard.

*Conditions are very hard, I am owed 21 weeks of annual leave, but they cannot relieve me until April, 1996 [This was in five months time]. Every two weeks I go into the computer, asking for annual leave and I get refused [Fobs Int, 06].*

This issue of the erosion of nurses' working conditions was further supported by an article in the Australian Nurses Federation's (ANF) newsletter. The ANF claimed that there was a growing number of nurses voicing their anger and disappointment with private and public sector employment practices (1997, p. 3). They claimed that recent graduates who have completed a three and half year bachelor's degree and one year in a graduate nurses program, are being offered short term three month contracts for only 70 hours a fortnight worked over 10 days. Additionally, the employers require them to work any shift to suit work needs. These conditions were typical of how professional nurses were being treated by employers.

There was also a variation in the type of specific contract each nurse worked under. Field notes of observations conducted in a teaching hospital revealed that there was a total of 16 nurses assigned to work in a particular ward; some were permanent and some were temporary. The nurses who were temporary had work contracts ranging from three months to one year. Some had different numbers of working hours ranging from 70 to 80 hours per fortnight. The numbers of nurses on each shift also varied. For example, in one ward setting, there were five nurses rostered on the morning shift and four nurses rostered on the afternoon shift and two nurses rostered on the night shift. One of the positions rostered on the morning shift from 7 -12:30 p.m., was permanently filled by an agency nurse as the position could not be filled within the existing

establishment (number of full time equivalents on the ward). This position was called "help" on the roster and had been in place for six months [Fobs, 01].

Later on during the field observation period this position was withdrawn. The nurses complained bitterly about this situation as it meant that the nurse who coordinated the morning shift was required to take a case load.

*When I arrived the morning shift coordinator was filling in her handover sheet in the nurses office, the staff development nurse was telling her how "they" [nursing management] were not going to send the help nurse "agency nurse" any more. They both said how hard it is to coordinate and take a case load on a morning shift [Fobs, 04].*

Some nurses were unhappy about having to work 70 hours per fortnight, especially as it was spread over 10 days. Many stated that they had to supplement their income by working a few shifts, on their days off, through a nursing agency. This practice made them very tired.

In addition to the ever changing working conditions, there appeared to be a general move to multiskill nurses as it was seen to be an efficient and cost effective way of managing staff shortages. A discussion with a nurse illustrated this point.

*They [Directors of Nursing] don't see themselves as nurses and they are controlled by budgets. [This informant has just had his contract reviewed for another three months, but the hours had been reduced to 70 hours per fortnight]. . . . They employ me for less hours and expect me to do the same work. I now can work in any surgical ward, that is, ENT [Ears Nose and Throat], plastics, urology. The urology ward has become a five day ward Tuesday to Saturday. They figured that if they closed them down on Sunday and Monday they don't have to pay double wages on the Sunday and Saturday night. The patients get shunted off to any available bed in the surgical directorate [Fobs Int, 06].*

Nurses also voiced concerns about an inability to conduct on-going staff development activities due to a reduction in shift overlap time. It had been traditional practice for nurses to participate in in-service educational sessions during the shift overlap time which usually occurred from 2 p.m. to 3:30 p.m. This had been possible as there were usually double the number of nurses rostered on duty at this time. Due to the short shifts and a reduction in overlap time, these sessions were no longer possible. Nurses had perceived this lack of staff development as being an erosion of working conditions.



Field notes taken after a discussion with a group of nurses during a lunch break alludes to these changes in their working conditions.

*It seemed that nurses were feeling that their conditions had been eroded because previously a lot of staff development was actually done during the overlap time and nurses considered this to be a working condition. . . . Now due to a lack of overlap time, nurses were unable to attend staff development activities [Fobs, 11].*

Nurses repeatedly commented on their work conditions which they felt were regressing. This extract provides a good summary of their concerns and the high level of uncertainty associated with their fluctuating work conditions.

*In some ways I almost think that we're seeing some regression as far as clinical conditions go, staffing, the hours that are available, sometimes even the equipment that nurses have to work with and things like that, I think there is a regression in work conditions. [When asked to explain further what she meant by regression, this informant replied] I think there's more of a staffing shortage, you are I guess expected to cover areas with less staff for longer periods much more than you were a few years ago. Certainly a lot less time for sitting down and teaching or learning. I think there's often a lot less time to sit down and talk to your patient. I think equipment wise, we're less ready to replace equipment that's malfunctioning and things like that, so you're working in very time consuming circumstances because often you haven't got really well functioning equipment that you're working with [Int, 29].*

In some ward areas, nurses were required to organise cake stalls in order to buy essential equipment such as oximeters.

*Very recently we had a cake stall to raise money to buy essential equipment like oximeters [Int, 07].*

There were other examples of management altering working conditions to address their own requirements. The data revealed that management also experienced uncertainty in relation to the day-to-day running of the ward. In particular, there was an increasing number of "sick days" taken by nursing staff. In an effort to control the situation, management staff introduced a policy requiring nurses to ring the ward directly, instead of ringing nursing management, in order to report their absenteeism. This policy was thought to add to the changing conditions under which nurses worked.

*Recently, management had implemented a new strategy to stop nurses taking sickies. They have introduced a system where the nurse actually has to ring the ward, so she feels guilty, especially if the ward is busy and she comes to work sick and if the ward is busy she feels guilty taking her sickie, so she comes to work sick*

*and then on her days off she does nothing, but tries to recover. The management think it has been successful, as it has reduced sickies [sick days] by 10 % [Fobs Int, 07].*

### **General Changes**

In addition to all this uncertainty, there were general changes that were constantly being made within hospital settings. Some changes occurred as a result of increasing technology and were therefore unavoidable. However, other changes were thought to be disruptive and contributed to the state of “*unknowing*”. Staff often voiced concerns about the number of changes and the issue of not knowing what to expect. In addition, they voiced frustration as they were usually not consulted or involved in discussions prior to the changes being made. A discussion with a Clinical Nurse Specialist illustrated the nature of the problem and the environment of flux.

*It's so totally unfair some of the things, they [nursing management] just bring in things and take things out. The card system's coming in, the documentation's changing . . . really, you don't know where you're at [Fobs Int, 05].*

Nurses constantly voiced concerns about the number of changes.

*Truly, we have changes all the time, the new DON [Director of Nursing] is coming in now and the Chief Executive officer is new. Then they make changes, I get an order and I have to negotiate with staff, they don't like the changes, it's nothing to do with patient care, it's all to do with money cutting and the patient suffers in the end [Fobs Int, 07].*

There were many changes in the types of charts and care plans that were used as well as the type of information that was required to be documented.

*We've had about three care plans in the last six to 12 months. It's an ongoing process. We initially started out with care plans, very very involved, and they've been fine tuned and now it's separated into mobility, observations, and self-care hygiene, that type of thing [Int, 01].*

Additionally, as a result of all the changes at both hospital and ward level, some nurses were required to work in situations where they did not know what to expect. This factor was thought to exacerbate the state of “*unknowing*”.

### **Not Knowing What to Expect**

It was common for nurses to be assigned different levels of responsibility and a fluctuating workload. In addition, nurses were moved from setting to setting to

accommodate gaps in staffing. Patients were also moved from setting to setting due to bed closures and bed shortages. It was difficult for nurses to know with any certainty whether or not they would nurse the patients with whom they were familiar or had the technical specialist skills to deliver competent care. Moreover, it was common for them to be constantly interrupted as they proceeded with their daily work routines. Given all these uncertainties, nurses did not know what to expect within the context of a daily shift.

### ***Assigned Fluctuating Levels of Responsibility and Workloads***

Each nurse's assigned case load varied across shifts and across days of the week. The data revealed that the assigned case load depended on the shift the nurse worked and the experience levels of the other nurses rostered on duty. Furthermore, it was common for the nurse who was coordinating the shift not to take a case load on a morning shift. However, on evening shifts and weekends they would be required to take a patient load, albeit a lighter one.

*Usually we all have about four to six patients, so usually she'd [referring to the shift coordinator] have about four, she'd take the lighter load [Int, 12].*

The shift coordinators were required to take a case load on afternoon shifts and on weekends as there was a reduction in the numbers of nurses on duty during those times.

*It was a weekday on a morning shift I wouldn't actually have a case load as such, if it was a weekend, I'd probably maybe have four or five patients and on evening shift it would probably be about the same [Int, 02].*

In a general sense, the required workload of the shift coordinator varied across hospitals and wards. Staff who worked night duty also had different staff-patient ratios. When asked a question about how many patients were usually assigned to night duty staff, one informant replied:

*In actual fact I work night duty, so I have a ward of 20 beds, there are normally two staff, two nursing staff, one RN [registered nurse] usually, one enrolled nurse so there are 10 patients. But really, the clinical nurse is responsible for 20 patients with some help [Int, 01].*

The responsibility of each nurse varied and was contingent upon the number and seniority of the other nurses working on a particular shift. For example, when there

were enrolled nurses rostered on duty, the shift coordinator would have to take responsibility for doing that nurse's medication round or any other task the enrolled nurse was not licensed to do.

*First thing I do is go out to my patients, if I'm coordinating, I would have to do the enrolled nurse's medications. We've got in-drawer medications but I would have to do the enrolled nurses and my own medications [Int, 02].*

In other instances, due to the short shifts, there was a two hour gap in time from when the nurse on the morning duty went off duty and the nurse on the afternoon duty came on duty. On these shifts, the shift coordinator was responsible for looking after the patients from one o'clock to three o'clock till the next nurse came on duty. Under these conditions, the coordinator would be the person responsible for looking after her own patients as well as doing the essential tasks for the patients who were assigned to the nurse commencing work at 3 p.m..

*See we have short shifts, you have to do their [referring to the nurses who were starting duty at 3 o'clock] 2.00 o'clock meds and obs and you have to do theirs as well as yours [Fobs Int, 05].*

This situation of the nurse looking after her assigned patients as well as patients in another section was thought to be problematic and further fragmented the care and the communication process. In certain circumstances, nurses were put in situations and given responsibilities which exceeded their levels of knowledge.

*I remember last year I was new on this ward working night duty with a senior nurse and this nurse went off sick and I was in charge with two different agency nurses and none of us knew what to do. [I asked her what happened in those instances, the informant replied:] Well, you miss things, things get missed, with the drugs you may make an error. Well, you just **don't know** [Fobs Int, 05].*

While nurses were unsure about the level of responsibility and/or the workloads that they would be assigned, due to a number of reasons related to the reduction in hospitals' budgets, and restructuring of the hospital's work force, it was very common to find nurses in "acting positions". Of the five wards observed in the field observation periods, three wards had acting Clinical Nurse Specialists and three wards had acting Staff Development nurses. This finding was very common across many metropolitan teaching and non teaching hospitals. This lack of appointed permanent staff was thought to increase the condition of uncertainty. Moreover, staffing positions appeared

to change and some nursing positions were disbanded. For example, in some ward areas the Clinical Nurse Specialist was responsible for patient care as well as for staff development needs.

*We have ten new staff recruited from August, [over a two month period] seven first year graduates, three new nurses from overseas on two wards and I'm doing both jobs [referring to the Clinical Nurse Specialist's job and the Staff Development job] [Fobs Int, 05].*

In addition to this uncertainty, nurses varied in their levels of knowledge, skills, and professional abilities which may not have been evident to other nurses with whom they worked. This issue of working with unfamiliar nurses further exacerbated the problem of being in a state of “*unknowing*”.

### ***Working with Nurses who have Different Levels of Knowledge and Experience***

In a more general sense, nurses varied in their levels of knowledge and experience. The following conversation with an informant emphasised how the different levels of educational preparation of nurses working in the same ward caused variation in what was documented.

*We do have a problem statement and we do use NANDA. I suppose when I say we, some do and some don't. It's a bit difficult, we have the new qualified nurses coming out from Curtin and Edith Cowan, we also have many who have never heard of the nursing process [Int, 01].*

As a result of this difference in professional education, there was found to be variation in how the different nurses enacted their role. Data revealed that there were variations in the way each nurse practised. These variations affected the overall process of care as each nurse performed similar tasks differently. As this occurred, any nursing practice delivery mode or procedure varied from nurse to nurse and was not performed consistently. When asked a question about the usefulness of nursing diagnoses, one informant's reply alluded to this inconsistency in work practices.

*I've worked with things like that. It's always been sort of half used, I've never worked anywhere where it's really been done well . . . people only half--how can I put it, when I say half doing it, it appears to me in places I've worked that not all the staff are committed to this, so therefore you find some people do it, some don't [Int, 24].*

Additionally, data revealed a growing trend of using large numbers of agency nurses. These nurses varied in their levels of knowledge, skills, and commitment which were sometimes unknown to the permanent nurses. This factor led to uncertainty as nurses would not know what to expect from other nurses with whom they worked. This added to the state of “*unknowing*”.

### **Agency staff**

It was found that there was an increasing use of agency, casual, and relief nurses. This tended to contribute to the state of “*unknowing*” as these nurses were an unknown entity.

*I think they've [hospitals] had lots of changes in the last while and . . . things like their staffing, it's mainly staffing, they run on a minimum staff and then they call in casual and agency [nurses] [Int, 12].*

According to McKimmie (1995), a major Perth hospital had spent almost \$3 million on agency nurses in the last 15 months and a concentrated amount of \$950,903 in the past three months. This suggested that the use of agency nurses had escalated. In addition, in 1996 a survey of a Nursing agency conducted in Perth, as part of this study, found that in general the demand for agency nurses was increasing. It was found that hospital staffing numbers were kept to a minimum and were constantly being supplemented by agency nurses.

*There aren't enough nurses, permanent staff, and they have to use agency staff . . . very often. Oh, . . . probably twice a day. It's terrible if you are coordinating and you've got your own work load [Fobs Int, 01].*

Agency nurses were viewed by regular staff as an unknown entity, that is, other nurses did not always know them, their level of experience, or their capabilities.

*It's OK if you know the agency nurse and what they are capable of doing, you know some agency staff are back packers, they just work from 3 to 9:30 p.m. for the money, then you have to keep an eye on them and if you are admitting and get five admissions you are really running [Fobs, 02]*

Permanent nursing staff often voiced concerns as they did not know these nurses or their levels of experience and commitment.

*They [referring to agency nurses] are an unknown quantity and incredibly variable in their skills and their knowledge of the hospital . . . and so, that's the biggest worry, and so first of all you have to determine whether they know what they're doing and whether they've been here before. . . . So you might get somebody who has never been here before, in fact it's their first shift in Australia [Int, 23].*

Agency nurses also voiced concerns about working in some ward areas, as they lacked the appropriate experience. Additionally, some also stated that they just worked for the money. It was evident in the data that this group of nurses sometimes lacked commitment to their work. A conversation with an agency nurse supports this claim.

*I finished my Uni [University] degree and came straight over to Western Australia and started working agency. [I further asked him how he found that experience] . . . It was a horrifying experience, but I had to earn some money. . . . Anyway, the staff were pretty good and they looked after me. I only did it for the money and I didn't get too involved in anything, just did my work and went home [Fobs Int, 07].*

Furthermore, agency nurses added to the problem of “*unknowing*” as it was perceived that these agency nurses tended to only write minimum information in the progress notes. So, in instances when the nurse had to rely on the notes for information, the progress notes may not have been very informative.

*Help nurses [referring to agency nurses] only write the basic on the progress [Fobs Int, 01].*

Some agency nurses also voiced concerns about updating or adding problems to the master problem list as they felt uncomfortable documenting a problem that may not be followed through.

*As an agency you are working with the patient for six hours, it is not really my place to go in there and start documenting problems that aren't going to be followed up by regular staff [Int, 04].*

During the field observation period, many nurses voiced concerns about agency nurses, as working with them tended to increase their workloads. While they admitted that some agency nurses were helpful, they claimed that others lacked knowledge and experience

*Sometimes my own patients get neglected as I attend to other agency nurses looking after their queries. We once had an agency nurse who was a midwife who had not worked in general for a while and I had to help her all the time. . . . It's very time consuming and frustrating [Fobs Int, 05].*

Also, in highly specialised areas where specialty skills were required, agency nurses did not know how to perform these specialist skills. More specifically, they were assigned to areas of nursing with which they were unfamiliar and lacked appropriate experience.

*I have to do all the skin grafts for these agency and new nurses until they know what to do . . . plastics is a very specialised area and you need to do about 7, 8, 9, 10 skin grafts or even work on the ward for about 6 weeks before you actually know what you're doing [Fobs Int, 06].*

In these situations, permanent staff stated that agency nurses were unsuitable, as they lacked specific knowledge and skills. When I asked one informant how she appraised agency nurses, she replied:

*No good . . . because it's a highly specialised area and unless they [agency nurses] know what they're doing it's difficult for them to function [Fobs Int, 06].*

Casual and agency nurses recognised their own limitations and lack of knowledge and hence their ability to work in certain specialised areas.

*I mean, when you work casual you do lose skills and when you, especially when you go from area to area, like I've been going from Coronary Care to ICU [Intensive Care Unit]. Now ICU I'm not that familiar with, . . . so it's inexperience, I think it's actually inexperience, when you go from area to area and you're not there constantly, you do make, you do make those sort of mistakes [Int, 12].*

Nurses who were not familiar with or did not know other nurses in terms of their knowledge, skills, and approach to care found this situation difficult. This was seen to fragment and destabilise the team approach to patient care.

*I do think the actual team thing has disintegrated a bit, . . . meaning [you] come on and you know the same staff. Now, because there's so many casual staff and because you know maybe the stability of . . . it's that instability of I guess having other staff [referring to agency and casual nurses] coming to work and you take responsibility for them [Int, 12].*

These large number of agency nurses used in hospitals added to the uncertainty as they were an unknown entity. Nurses who worked with them were never really sure of their level of knowledge, skills, and commitment to their work. This factor of not knowing the clinical expertise of the person with whom one was working or not knowing what to expect, coupled with a lack of a central person consistently coordinating the care, was thought to further exacerbate the problem of “unknowing”.



Another factor that caused uncertainty was the movement of nurses and patients across ward settings. Nurses found themselves in situations where they did not know what to expect and whether they would nurse patients with whom they were familiar or were able to competently deliver nursing care.

### ***Movement of Nurses and Patients Across Ward Settings***

Data from this study illustrated that nurses were required to work and relieve in unfamiliar settings, where they had little or no knowledge about how to nurse the patients or what to expect. There were times when nurses could be moved from section to section in a ward area or from one ward to another in order to assist in a busy area.

*Because nothing is that definite and they could be shifted from section to section and also now from one day to another [Int, 01].*

This movement of nurses across settings tended to contribute to and sustain the problem of being in a state of “*unknowing*”. It appeared that nurses were required to move around and relieve in many ward areas and were required to nurse unfamiliar patients. Furthermore, the types of medical conditions of patients in each ward area varied due to changes in the case mix of the ward or patients from other specialties being cared for in general ward areas. Once again, nurses may not have had the requisite knowledge and skills to adequately nurse these patients.

*We used to work with seven staff on this ward, now we have five, one coordinator and four staff. We usually have about six patients each and it's usually very hard because with the new clinical directorates, we not only have our own patients [referring to plastic surgery patients] we also have ENT [Ears, Nose and Throat], gynae[cology], urology [Fobs Int, 06].*

The data revealed an extraordinary amount of reshuffling of assigned patient beds between wards. Specifically, the types of patient medical conditions assigned to each ward were subject to change. Under these conditions, nurses found themselves looking after patients with medical conditions with which they were unfamiliar and had very little subject knowledge. In these instances, nurses had to learn on the job. When asked a question as to whether the informant was knowledgeable about all patients' medical conditions in the ward, she replied:

*No I'm not, and that is a fact, I mean my background is more general surgery and I've done quite a few plastics as well, but like I've had to sort of pick up on urology*

*and ENT. . . . Well, what happened is it used to be just a surgical speciality ward and then they revamped the hospital, like to make way for this five day ward and they put in this general surgery on this particular ward [Int, 24].*

In some instances, patients were placed in ward areas where nurses did not have the background knowledge to nurse these patients:

*We recently had gynae[cology] patients, I know nothing about gynae[cology] and I have to coordinate and see that the care has been given. The gynae[cology] consultant is rude, and he doesn't talk to you, and that makes life very difficult [Fobs Int, 06].*

The apparent ad hoc nature in which management organised patient care added to the problem of being in a state of “*unknowing*”. Some hospitals closed certain hospital beds or wards for a few weeks in order to save costs. On one occasion, it was planned to open only half the available beds. Hence, the ward was staffed for that number of patients. However, on that occasion, due to a number of emergency admissions, more beds were required to be opened in order to accommodate the patients who were awaiting admission in the emergency department. The extra beds were opened and staff were brought in from other areas or from nursing agencies. This added extra pressure on the regular ward staff as they were required to care for new patient admissions and work with a number of staff members who they did not know. In addition, these relieving staff members may not have been familiar with the patients’ specific conditions and nursing needs.

*Yes, they are closing down beds, they closed down beds in the ward, one of the surgical wards which usually had 21 beds and they decided to open it with only 11 beds because they couldn't staff it. When they opened the 11 beds that morning, they only had staff for 11 patients, but in the Emergency department, there were up to 15 patients lying on trolleys that they couldn't find beds for and these were surgical patients so what they had to do was open another 10 beds instantly to accommodate that backlog of beds. They didn't have enough nurses to staff the extra 10 beds, so what they did was, they pulled in a whole lot of casual and agency nurses from everywhere where they could at that point in time and basically these nurses who came to work in these areas had no knowledge of how to nurse these patients or may I say limited knowledge of how to work with these specialty patients. . . . The nurses who were there, the permanent nurses, had to carry the can for organising the care for all these patients and to be working with people they knew nothing about [Fobs Int, 10].*

This anecdote typifies the uncertain conditions under which nursing staff, in this study, were required to function. Nursing staff often voiced concerns about working in other settings where they did not know staff members or who to ask for direction and help. This was thought to exacerbate the state of “*unknowing*”.

*Well, one of the difficulties is if you're walking into a new area that you haven't worked in before, or even an area that you've worked in a few times, but you don't know all the personnel in the area, it's knowing who to ask and who is approachable and who is not. And sometimes you'll hesitate a while before you . . . unless it's something quite urgent, before you approach medical officers, because you're really not sure who's who, who the resident is, who the registrar is, who's caring for your patient, if they've broken the patients up into teams etc, where you will find the medical officer if you need to discuss an issue with them [Int, 29].*

In some instances, as specialty wards were closed for two days a week, patients were admitted to other wards prior to going to theatre and were sent back to their specialty wards post operatively. This type of practice perpetuated the problem of “*unknowing*”. Field notes revealed the following situation:

*On this ward two men who should be on the urology ward, who are urology patients were admitted on Monday for their surgery on Tuesday. However, the urology ward is closed on Monday, so they were admitted to this ward on Monday. They have been prepared for theatre, they will go to theatre and then they go on to the urology ward post-operative and they don't return to this ward [Fobs Int, 07].*

As patients were admitted to non urology wards prior to surgery, it had the potential to result in these patients being admitted by nurses who may not be familiar with nursing urology patients. Moreover, as patients were transferred to the urology ward post surgery, nurses working on the urology ward would see the patients for the first time post operatively when the patients were drowsy and recovering from the affects of their surgery. Hence, they had not had the opportunity to become familiar with the patient's usual idiosyncratic physical and mental status.

Another informant's account of how patients were moved from ward to ward provided information about this problem.

*It's not up to one person, . . . it's the system, it's the system that's really wrong. On weekends we usually have about ten discharges and ten admissions. I was keeping my beds for the plastics admissions coming in, but the person who was on coordinating for the hospital last night panicked, and sent me all these urology admissions because there were no beds. So the plastics all went to [ward X and Y] and I've got the urology patients. Then this morning we had to transfer all the*

*urology patients out and get all these plastics patients back into our ward [Fobs Int, 06].*

Nurses often voiced a sense of frustration, concern, and a lack of control as they were constantly asked to nurse patients about whom they were unsure.

*Sometimes it can be very frustrating, especially I find it especially frustrating when you go on night duty and you--like I remember going to ICU [Intensive Care Unit] one night, I had a patient that was a head injury and he had, I can't even think of the name of the actual splint he had, but he had a cranial type of splint, jaw down. He had a C6 fracture, so he had an amazing halo splint and initially I just thought "Oh God", but they were saying "No, don't worry, don't worry, he's routine care, he's routine care" and I was saying "Are you sure?" [Int, 12].*

This movement of patients and nurses from ward to ward was also found to cause uncertainty and added to the problem of “*unknowing*”. Additionally, nurses often complained about the number of times they were interrupted while going about their daily task.

### ***Being Interrupted***

Another source of uncertainty identified in the data was being interrupted. It appeared that nurses were constantly interrupted as they went about their daily work. At the start of any shift, nurses would be unable to predict the number of times they would be interrupted. This added to their problem of “*unknowing*” as they may not have known what to expect and the number of times they would be interrupted. Admittedly, these conditions occurred as a result of the very nature of hospital work.

*Depends what you mean by interrupt[ions], well, notwithstanding the “pour me a glass of water” type interruptions, you’re admitting someone and someone in the next bed wants a pan, you’re doing anything and another nurse comes in “can you give me a hand with a lift”, an orderly turns up “can you sign this admission form for someone”, the phone, the phone is a constant interruption. Not so much when you’re in the patient’s rooms, but when you’re in the office for some reason and you sort of act and all of a sudden you find yourself acting as a kind of secretary for 20 minutes, checking other people’s drugs, yeah, a multitude [of things] [Int, 18].*

During the field observation period, I observed a nurse being interrupted six times while trying to handover. These interruptions were due to the following reasons.

- Visitors seeking assistance for their relatives

Visitor came down the corridor, “could you please come and help put [patient X], she wants me to put her back to bed”.

*The nurse replies “yes we’ll come and put her back to bed when we finish handover”.*

- A student nurse asking a question about patient care

Student nurse interrupts the handover and asks the shift coordinator a question. The coordinator replies and continues handover.

- A visitor asking a question

Visitor walks up to the nurse who was listening to handover and asks her whether she could see a patient as it was the rest period.

- An agency nurse going off duty and handing over the keys

An Agency nurse comes down the corridor into the room where the nurses were handing over. The shift coordinator says “*What are you doing here? you should be off at 1300?*”. It was 1325; she hands over the keys to the nurse.

- A patient (new admission) who arrived from the Emergency Department

A patient arrives from casualty and goes into room G. One of the nurses listening to handover goes over and helps the patient to settle.

- Patient bells

There are two bells ringing in room D and E [Fobs, 02].

Additionally, nurses often said that they were interrupted during the course of a shift.

*[You put] bed rails up as patients may become confused at night and just generally settle them and . . . that usually does take a couple of hours and there are always interruptions, there are usually, at that time, there has usually been one or two admissions [Int, 01].*

Another nurse’s account further supports this claim.

*You know the other day [Patient X] had spat every where, so I had to clean it up. I try to do everything in block, but you know what nursing is like, you get interrupted all the time [Fobs Int, 03].*

These constant interruptions resulted in unfinished work and the nurse being unable to check what was happening in regard to patient care.

*Well, I go in and I check on things, remember last time you were here, I said I was checking on the charts. Then things started to happen and I never finished it. You know it just depends how busy the ward is and how much you are interrupted [Fobs Int, 05].*

The constant interruptions that nurses experienced fragmented their thought processes. This led to a state of “*unknowing*”. When asked a question about what interrupted their daily routine, one informant’s reply provided an example of the effect of these interruptions.

*Patients interrupt my routine [she laughed] demanding patients, oh telephone calls, things like that. I’ll often walk in somewhere and someone calls and needs a hand or something and then you get out and you think “Oh, where was I going?”, “I know I was going somewhere”, you know, standing in the corridor wondering why you’re walking in that direction in the first place [Int, 08].*

Furthermore, as nurses were constantly interrupted during handover, these interruptions were thought to affect the continuity of communication and resulted in patient problems being missed. When asked whether patient problems were missed, one nurse replied:

*Yes, definitely, I think because of time, there is no handover time now, there is no time when like morning staff go off and afternoon staff come on, there is no overlapping, so there is not that time when people can sit and really spend their time without interruption [Int, 03].*

Nurses’ work routines were also interrupted by other factors, such as non functioning equipment and technology. Other conditions, such as attending to patients’ drains or intravenous lines that stopped working or cleaning patients who were incontinent. These unexpected incidents tended to interrupt them and delay their work routine.

*I observed one nurse ask another “how are you going with your obs”? The other registered nurse replied . . .”yes well I’m usually finished by this time, but I’ve been fiddling with that drip, you cannot give Flagyl and Potassium so I’ve had to get a piggy back [a connector] and it all takes time” [Fobs, 04].*

Searching for equipment or contacting doctors in order to deliver patient care was another factor that interrupted nurses’ work plans.

*I have to chase them [referring to the doctors] and page them all day and that interrupts my whole day [Fobs, 05].*

The combined effects of being constantly interrupted and working under very busy conditions further added to the state of “*unknowing*” and affected the continuity of care. Nurses tended to find themselves in situations where they were unable to control their

work environment. A conversation with a nurse informant revealed an incident that illustrated this point.

*The nurses are so busy, [this informant gave me another example of an incident where communication had broken down. This incident illustrates how easy this breakdown can occur]. There was a nurse looking after a patient who had impaired vision and she was taking him to the shower. In the bathroom, the nurse asked the patient to wait as she had forgotten to bring the towels. On the way to the linen trolley, the nurse was interrupted with something else. [This informant did not specify what prevented the nurse from getting back promptly]. The patient thought he'd be able to shower himself and asked another nurse for the towel. The other nurse did not know about this man's condition and she obligingly got him the towel. The patient proceeded to shower himself and he fell on the floor. Later on that day when he was speaking with his daughter over the phone he told her that he took a tumble in the shower. The daughter was furious and rang the ward directly. Another nurse answered the phone. This nurse had nothing to do with any of these patients as she was working in another section. [This ward had up to four sections; each nurse had five or six patients]. The nurse who answered the phone was looking after six other patients who were very sick and she had a busy day. The patient's daughter shouted at her over the phone. The nurse was unable to make sense of what was happening or what had happened. After the phone call the nurse felt so frustrated and angry she wanted to resign right there and then [Fobs Int, 06].*

Patients were admitted, discharged, and transferred to other wards and hospitals continuously. Additionally, these patient movements changed very often. Excerpts taken from field observations provide an example of the changing conditions.

*"[patient x] is going home but we will need to organise a taxi voucher", she also handed over that two other patients will be transferred to the ward, one from Nursing Specials and one from another area. We went down to tea at 14:55 and returned at 15:15 and it was handed over that the situation had changed and those patients would not be coming to the ward. However, two other patients from other wards will be transferred instead [Fobs, 04].*

There were many other situations within the context of a daily shift that made predicting how a shift would unfold very difficult and added to the condition of uncertainty.

*Lots of admissions and lots of . . . things like for instance emergency department ring up and we're getting an admission--fine--they are for theatre, that's no problem and then they say--We don't know what time they're for theatre--that's fine. The patient arrives up in the trolley and the next thing is the theatre trolley arrives straight after them and you feel like saying they could've gone from emergency, not that that would throw the ward into chaos, but like that and things like say our urology ward, you know, a bladder wash out to block off, well that can take time in their section. So then things can tend to fall behind and really a combination of*

*things can affect it. Or maybe having staff, say junior staff or agency staff on a shift and all those things kind of happen. Yeah, just to get a very sick patient in but you haven't actually, obviously when you were given your staff for the afternoon, you hadn't banked on getting this say sick person in and now taking a lot of time [Int, 24].*

Some other examples of these fluctuating and uncertain work conditions include: having to deal with sudden changes in patients' conditions, or the arrival of emergency admissions that required prompt and focused attention, the transfer of patients in and out of the wards, working with agency nurses who were an unknown entity, and not knowing whether the patient's documentation was accurate. Within this context, it was found that nurses were unable to control their work environment and the type of care that was delivered.

In summary, the fluctuating and uncertain working conditions aggravated by the number of interruptions nurses had to work with, within the context of a daily shift, added to the problem of "*unknowing*". There were, however, other intervening conditions that further provoked this problem. Based on the data in this study, nurses lacked control over the way in which they enacted care and their professional practice.

### **Nurses' Lack of Control Over Their Professional Practice**

Data from this study revealed that nurses, in general, lacked control over their professional practice domain. There were a number of conditions that led to this outcome. Firstly, nurses were highly regulated and controlled by hospitals' policies. They often worked in a context of time constraints and could not practice in the way in which they had been professionally educated. This, combined with being constrained by hospital policies that sometimes appeared to conflict with their theoretical base, tended to widen the theory-practice gap. In addition, they were reliant on other health care professionals to perform their tasks before they could proceed with their own professional work. For example, nurses could not change an intravenous fluid order unless the medical doctor had written the order on the fluid chart. Hence, they further lacked control over their professional practice. Moreover, data revealed that other health care professionals impinged on some of their professional role and they appeared to be unable to control this erosion. Their professional opinions were often devalued and unrecognised in the system. Within this context they often doubted their own



worth, their status as a nurse, and were unsure about their professional domain. All these conditions, described in the following section, were found to exacerbate the state of “*unknowing*”.

*Most hospital philosophies and mission statements espouse to value the individual, to provide excellence in clinical [care] and to value their staff. As the restructuring process bulldozes on, it becomes increasingly difficult to see these values reflected in management practices. Broad sweeping changes are forced upon nurses without either consultation or negotiation. This lack of consultation devalues nurses as individuals and does not allow clinical nurses the opportunity to advocate for the individuals for whom they care [Int, 30].*

### ***System Imposed Constraints***

There were a number of system imposed constraints under which nurses worked. In a general sense these were: (1) regulated by hospitals policies, (2) working under immense time constraints that inadvertently led to nurses focusing on performing tasks, and (3) being reliant on other health care workers to continue completion of their work. All these factors disempowered nurses to an extent that they lacked control over their professional practice.

#### **Regulated by hospitals policies**

It appeared that nursing staff were regulated by protocols, policies, and procedures that controlled their practice and, in some instances, altered professional behaviour. Field observation notes provided a list of the number of policy manuals used in ward areas. The large number of hospital policies further impacted on how the nurse’s role was enacted and in many cases it widened the theory-practice gap. This gap caused professional uncertainty and further exacerbated the problem of being in a state of “*unknowing*”.

*On one of the cupboards in the nurse's office was a folder hanging on a clip board. It was entitled: Standards and Policy changes. Nurses were required to sign the form when they had read the policy changes. Also, on the top of the shelf in the office there are a number of policy-type manuals. They are as follows:*

*Bereavement File  
Pharmacy Fact File  
Nursing Practice Manual  
Transfer Referral Forms  
Departmental Manual*

*Annual Leave Roster*  
*Memo File*  
*Diabetes Nursing Manual*  
*Infection Control Manual*  
*The Empowered Health Professional*  
*Housekeeping, Cleaning Procedures for Isolated Rooms*  
*Occupational, Health & Safety*  
*Policy & Procedures*  
*Emergency Procedure Manual*  
*Nursing Diagnosis [Fobs, 08].*

In particular, it was suggested that on the one hand nursing was gaining professional status while on the other hand it was governed by policies. In some instances, these policies were in conflict with professional practice. For example, the policy of being able to perform and complete admission assessments up to 48 hours post admission resulted in the situation of nurses delivering care without conducting adequate patient assessments. This practice conflicts with the premise of using a problem solving approach to care, caused uncertainty with regard to the nurse's professional roles, and further exacerbated the state of "unknowing".

These large number of policies which nurses had to observe inadvertently changed their professional behaviour as they appeared to focus their behaviour on observing policies rather than practising professionally.

*The majority of patients on this ward are short stay, so therefore, you use the short stay assessment form . . . they [nurses] just tend to fill in the boxes so that they have a word in each box. We're so regulated that we are forced into protocols and regulations to cover our butt [protect ourselves], . . . but they [nurses] don't necessarily recognise the relevance of what they are writing down, or whether it is relevant at all [Fobs Int, 07].*

Although nurses observed these regulations, in some instances they did not know why they were following certain policies. However, they did comply in order to observe regulations. For example, some nurses transcribed information from the medical notes to the nursing notes. When asked why this duplication was necessary, one informant replied:

*Well, I don't know, it's because they [nursing administration] tell you to do it . . . you can have a look at it, you can get from the medical notes, the age, the date of admission, you can get whether they were admitted outside, the patient's medical*

*diagnosis, their allergies, the past medical history, whether they are a smoker or a drinker [Fobs Int, 08].*

On another ward, when I asked a nurse why the patient's observations were done at different times when compared to other ward areas, the nurse did not know the answer. This provides another example of this issue.

*I think, I'm not sure why they did that, it's so called best practice ward where they come and think through everything, I think it's a bit of a joke, but, I'm not sure, I must ask [Int, 18].*

Nurses complained of having to sign their names indicating they had completed what seemed to be trivial tasks that were inherent in professional practice. For example, signing that the bed brakes had been checked each shift.

*I hated the idea of having to sign that you'd actually done something, because to me that was trivialising nursing [Int, 02].*

Another nurse's statement provides evidence that further substantiates the finding that the large number of policies that nurses had to observe may have been responsible for stifling and controlling their professional decision making and sowed seeds of uncertainty surrounding their own professional domain. An example of this was the issue of having to collect standard assessment information for all patients, rather than, by using professional discretion and being able to conduct an assessment using a blank sheet of paper like other health care professionals. One informant's statement alludes to this problem of being over-governed by policies.

*What the nurses tend to do is comply more, comply with regulations plus, plus, plus, instead of feeling professionally accountable to achieve some of the goals of assessment. . . . I think this issue of professionalism and following and being compliant is a deep rooted problem. It's not how you're taught at Uni[versity], the system is such here where they operate to rules, protocols, and regulations . . . that nurses don't think [Fobs Int, 07].*

### **Time constraints**

Time constraints was another condition that hindered nurses from delivering holistic professional care. Nurses constantly complained of not having available time to deliver care.

*I mean time just does not allow for the care that many nurses would like to give [Int, 04].*

Furthermore, nurses did not seem to be able to alter their work situation and control their practice which they often thought to be dangerous. One informant's account highlights this problem of lost patient information and nurses perceptions of their difficult working conditions.

*Because often the handover I'm getting is from not the primary carer, but somebody who's just been minding a patient for a two hour period. They often also have another patient or several other patients that they are trying to care for as well, so they're. . . . Often they've had a brief handover and then only a brief period of time with the person, the patient you're taking over, a lot of the information has been lost because they haven't had time to sit down and reflect and look at the notes and really assess the patient, so they forget a lot of the things that they were told. Just the danger, you know, they'll often comment on the danger, the fact that they've felt they've been in dangerous circumstances because they're caring for too many patients at once [Int, 29].*

Errors occurring from this type of situation were a consequence of being in a state of “unknowing”. This lack of time had other professional ramifications. For example, nurses were unable to dedicate themselves to any one task for a long period of time. This appeared to disadvantage them professionally, as they were unable to do formal assessments on patients and practice in the way they had been professionally educated. A theoretical memo written after a field observation period provided a summary of the situation.

*Nurses often complained that they were the ones who were constantly with the patient and assisted them to shower, and feed themselves. However, the Occupational Therapist was called to do the assessment. What seemed to be the problem is that other groups of health care professionals could afford the time to spend with patients while nurses lacked this privilege. Specifically, Occupational Therapists could afford the time to do a shower assessment on this patient, to determine their functional status even though this assessment takes approximately one hour. If the nurse who had been caring for the patient were to take an hour showering a patient, she would not have the time to adequately look after the other patients she had been assigned. There was a conflict of interests, where nurses' professional voice was compromised as the focus of their care was task-oriented addressing organisational goals which emphasised doctor-prescribed care. Additionally, it appeared that nurses were unable to redress this imbalance of tasks and focus on holistic nursing care [Fobs, Memo].*

One nurse's response to a question on how nursing care could be improved provided evidence of the above finding and a good summary of the situation.

*Nurses are burnt out, they are just doing the tasks, doing it day in and day out, so they just get bored, they have lost their focus of why they are nursing and particularly nurses--they do all the ADLs [Activities of daily living] and the OT's actually do the assessment [referring to the patient's shower assessment]. Why do nurses happily do their task, get back to the model of being a doer, not taking it one step forward, assessing and diagnosing. What is the patient's problem? [Fobs Int, 05].*

Nurses in this study voiced concerns that professionalism had been stifled by the prevailing policies coupled with a lack of time. Additionally, it was revealed in the data that adhering to these policies had inadvertently changed nurses' behaviours as they were found to be operating at a level that was not autonomous and relied on delivering prescriptive rather than individualised care. Some senior and staff development nurses voiced concerns about this issue.

*OK, I think time hinders us immensely [Very determined voice] . . . we have these university educated nurses coming out now and sure they are a bit green when they start. Then they're damn good nurses once they get rolling. I mean they're taught to assess and they can do so much and I really think that they are hindered by a system which reduces them to functioning, I mean, at a task level almost [Int, 07].*

As the health care system forced nurses to work faster at what was said to be a more task-oriented level, this focus undermined their theoretical base and their professional status.

*I believe it was a quote from the health minister who said nurses have to be more efficient. I don't know how more efficient nurses can be and efficiency isn't necessarily the best thing because our time can be utilised you know, doing things that he may not see as efficient from a numbers point of view, but that really does have an impact on care. So time is a big hindrance. Umm . . . the status of nursing probably hinders us somewhat as well [Int, 04].*

### **Reliance on other health care workers**

One other factor thought to cause uncertainty in the work place was nurses' reliance on other health care workers. Clearly, nurses' work relied heavily on other health care members to do their tasks before they could proceed with their own work. In these instances, it was difficult for them to plan, control, or proceed with their work with any

certainty. When asked the question “what do you think hinders you from getting on with the job of giving care?”, one informant alluded to this problem.

*Maybe waiting for the doctors to come around, or you've just done a nice dressing and the doctor pulls it down again. . . . Maybe if you don't know, if someone is going for an ultrasound in the morning and you don't know what time they're going . . . usually waiting for other people, if you didn't have to wait for other people you could plan it out exactly and say I'll do that in half an hour and that in half an hour. But if you have to wait and you don't know what's going on, you don't know if they're going home or whatever, you'd be waiting [Int, 06].*

Nurses found this reliance on other health care workers, and not knowing when they could proceed with giving patient care, to be extremely frustrating.

*When you're waiting hours longer to reposition the patient because you can't get somebody to turn the patient. I know personally it's a great sense of frustration because I'm starting to worry that my patient's going to develop major pressure area problems, for example, if I can't turn them because there is nobody available to assist me, then it makes me feel extremely, I guess, disquieted and frustrated, because I really don't feel that I'm delivering adequate care [Int, 29].*

### ***Lacked Recognition***

There was a strong perception that the status of nurses was not recognised as being equivalent to other members of the multidisciplinary team. When asked the question, Do you feel nurses are afforded equal status in the health care team?, one informant replied:

*No. I mean not, . . . I mean in the sense I think, yes, they'd be lost without us, but it really bugs me that I feel this, but I still sometimes feel, not everybody, you definitely get the feeling that we're just, not quite there. I do still get that feeling from some of the people, yeah, not necessarily medical, . . . sometimes by allied health people too, you sort of get that feeling that we're just not quite as good [Int, 24].*

Other nurses stated that some medical staff undermined the status of nurses.

*We have a consultant, Mr X who thinks nurses are down there and they're up there. We never bother going on the round with him; he's just arrogant. I have to ask the registrar for the changes [Fobs Int, 05].*

Some nurses believed that doctors were deservedly entitled to feel superior and that the focus of nursing was to look after the doctor's patient.

*I think that probably most young doctors coming through respect what we do and probably see us on a par with all those other people. I think that doctors see*

*themselves, and I think they've got good reason to see themselves, as a certain tier and then there's everyone else and all those other people do good work, but ultimately to serve the medical needs of their patients [Int, 18].*

Additionally, other nurses believed that nurse managers were responsible for the situation as they did not encourage nursing and promote professional autonomy.

*I think administration is very caught up in restructuring of positions, . . . they're into best practice, best practice's focus is saving money, it's not let's improve practice so people are happy, or, . . . let's see some of your good ideas, you know? [Int, 12].*

Moreover, although nurses were with patients 24 hours a day, their opinions were not valued in the system and they complained of being unable to influence care. An example of this is as follows:

*Do you know they are going to spend hundreds of dollars transplanting Pt X's liver [Pt X has alcohol liver disease, is jaundiced and confused, doubly incontinent and also lacks motivation]. . . . You know we are with patients all the time, we really get to know them, the doctors just come and go they have no real idea. For example, Mr Y they don't see him confused at night banging the zimmer frame on the windows, incontinent everywhere. And then we drug him up to sedate him, tie him up, and you see these things on a more permanent basis, its not very nice. You know, the doctors talk about sending him home. Its unrealistic, they should be telling the relatives, that this man is going to die, he's not going home. You know they should send him to palliative care. But when they do that then almost like conceding failure and the doctors don't like doing that . . . you see so much, and so much of it is wrong, and you cannot influence what is happening [Fobs Int, 03].*

When asked a question as to whether doctors asked nurses questions on the ward round on informant replied, *Rarely [Int, 23].*

When further asked how doctors found out about patient care, the same informant's reply indicated that doctors rarely referred to the nursing notes and that they changed care based on their own assessments. In addition, it appeared that the nurse had to volunteer the information and draw the doctor's attention to what was happening, as she may not have been asked about the patient and their care.

*He [the medical doctor] probably actually doesn't care too much about the care, as such, as long as the patient is happy. He may look at the temperature chart which is probably the most likely and **only chart** he will look at. He will ask the patient how the patient feels, he may sort of look at his registrar or resident and say, you know-- has the Hb [Haemoglobin] come back? He will probably visualise the wound and he will listen to the patient's chest, maybe look at the odd bit of drainage. . . . Well the*

*nurses with them on the rounds will generally speak and draw his attention to any abnormalities that are not routine [Int, 23].*

This lack of recognition tended to cast doubt in nurses' minds. Some nurses in this study stated that they were uncertain about their own disciplinary knowledge and its importance in the delivery of patient care. A staff development nurse's account provides a rich description of this happening.

*They question themselves because they are unsure and when the doctors question them as well it is my belief that most nurses would actually take the doctor's side. Our own disciplinary knowledge is really complex and difficult to define. A lot of the discussion with the patients, the nurses ask and qualify that "I must ask the doctor", or "oh I will have to ask the doctor", statements like "I haven't read the medical notes so I don't know what is happening" makes me believe that care is two fold, nurse initiated with very little credit, and doctor initiated which the nurse just has to get right [Fobs Int, 11].*

This nurse further discussed the issue of nurses being very unsure of where their roles started and finished and how the system suppressed their professional development and controlled their practice.

*Also, there seems to be, once again, conflict of their roles, where their role starts and finishes and if they get staff development [referring to professional education], they may not be able to use this role and then if they do, once again they'll get into trouble with the other doctors. So basically, it's a wider issue into the ways in which they are treated and that type of thing which seems to be the issue [Fobs Int, 11].*

This doubt undermined nurses' understanding of the parameters of their work. Specifically, although nurses were educated to deal with patient's psychosocial problems they very often referred these problems to other health care professionals as they felt it was not entirely within their domain. Once again, nurses were unclear about where their role started and finished

*Oh I suppose we too quickly say oh get a social worker or we'll just think that it's someone else's problem, someone else's responsibility. Yeah, I don't know, we don't do as much of psycho-social nursing as I thought we would when I was in Uni [versity], because we learned a lot about . . . the psycho-social aspects of care and that kind of thing. [When further asked the question why do you think some of that is lost? the informant replied] "Oh, I think maybe nurses are a bit worried about treading on ground that's not theirs" [Int, 08].*

This uncertainty was increased as other health care professionals eroded the nursing role. This caused some nurses concern.



*I found it disappointing several years ago when the medical ward we had quite a few patients who had strokes and part of what we did was assessing how they could swallow, but we just did it while all of a sudden that was taken over by speech therapists and then they proceeded to document it all, then nursing staff weren't even able to feed someone, unless supervised by a speech therapist. Mind you, that's Monday to Friday, 8 to 5 p.m., the rest of the time who else was there but nursing staff. To a certain degree the same with physiotherapy, when I first started my training a few years ago we did most of the chest physio post-op, etc. That's now taken over by a physiotherapist, but they document all that. . . . These things have been taken out of our role [Int, 01].*

Moreover, being recognised in the setting occurred as a function of being endorsed by doctors rather than on individual performance. During the field observation period it seemed that some Clinical Nurses on wards were more recognised than others. This greater recognition was thought to be a consequence of these nurses being accepted and recognised by the medical staff, and this endorsement resulted in this increased status. One informant's response as to why there was a hierarchy among Clinical Nurses, who were all at the same level, provides insights into this problem.

*It's because, essentially they have worked in the traditional system, they have a lot more experience in nursing, they are usually respected by the medical staff, the medical consultants and it is this respect that gets them inadvertently endorsed [Fobs Int, 05].*

Another factor that appeared to undermine the role of the nurse was the level of blame they were often assigned. Data from this study revealed that when things went wrong due to a number of factors, one of which was working with insufficient staff, or agency and casual nurses, the regular staff were blamed for the errors.

*I've gone to tea with somebody recently and they basically said that they were so browned off with the place because this that and the other wasn't done because you know, they don't have adequate staffing or they have staffing that they are not familiar with, and therefore it's left up to the regular staff to cop things like [that] [Int, 12].*

At all times, nurses did not feel in control and often complained of how difficult it was to make changes in the wards as they had to get these changes endorsed by a number of other health care professionals.

*A lot of it is, people are shy to initiate things, I think and that's mainly because it has to go through so many levels so . . . it's like one of the staff recently, last year, she wanted to make up patient information little leaflets for the patients, and she actually did very well . . . and because she was doing a post-grad course and that*

*was the only time it was actually done, because people had attempted to do it before but it hadn't been done. She had to go through a lot of procedures, like she had to go through pharmacy and get the pharmacy to sanction it, she had to get the RMO [resident medical officer] to review it and make sure that there was nothing too much said . . . all those sort of things, it was mainly that she had to go through different departments to get it done [Int, 12].*

Nurses spoke about their work as being medically driven with little emphasis on their own theoretical base.

*I think that hospitals, acute hospitals, I'm not talking about any other kind of setting, are and need to be medically driven, . . . in so far as if your going to try and do things from some kind of nursing perspective, you're going to have problems once you enter an environment that's not receptive to that attitude [Int, 18].*

Although there were large numbers of nurses working in hospitals who were in attendance 24 hours per day, collectively their efforts were said to be unrecognised within the system. This increased the problem of uncertainty and led to a state of “*unknowing*”. In summary, the data from this study revealed that the conditions under which nurses worked disempowered them as they found themselves in situations where they lacked control over their professional domain. One of the conditions that sustained this problem was the number of policies which they were required to observe that sometimes conflicted with nursing’s theoretical base. This factor, combined with a lack of time, forced them to adopt a task-oriented approach to care. They complained of being professionally unrecognised and not being allowed to practice as they had been educated. Within this context, they were found to be professionally compromised and saw little reward in advancing their careers in nursing. In general, nurses worked under fluctuating and uncertain conditions. This, combined with the use of an inconsistent and fragmented communication process, resulted in a state of “*unknowing*”.

### **Being Compromised: Consequence of Being in a State of “*Unknowing*”**

There were many consequences of being in a state of “*unknowing*”, the worst case scenario being an outcome that was detrimental to patient care. Within this context, both patients and nurses were compromised. Hence, being compromised was the consequence of being in a state of “*unknowing*”. Clearly, nurses voiced concerns about

their work situation where they felt professionally compromised. When asked a question regarding how she felt about not knowing what was going on, one informant, who spent some time thinking about her answer, responded in the following way that highlights this situation that nurses experienced.

*I feel very nervous for both me and my patient, a tight feeling in my stomach . . . a sense of loss of control . . . I feel frustrated and professionally embarrassed, being deficient [Int, 29].*

This same informant at a later date stated that when she worked in unfamiliar places where she did not know the routines, it took her a longer time to do things as she spent a lot of time just finding where the equipment was and this tended to slow her down. Therefore, she spent less time with the patients and giving patient care [Phone Int, 29].

Nurses stated that their state of not knowing impacted on patient care.

*Having to get to know the new doctors, the new drugs, you become extremely cautious. Patients know that the nurse does not know what she is doing [Int, 32].*

This problem of “*unknowing*” made it troublesome to investigate patient complaints as it was difficult to decipher exactly what had occurred in any given situation. A Clinical Nurse Specialist’s account of a situation provides an example of this problem.

*You know I had to investigate a patient complaint and the complaint, it ended up it was caused by an agency nurse. So, I had to locate this agency nurse and get her to make a statement. The agency nurse's statement totally conflicted with what the patient said. So whose side must you take? You must believe that the conditions under which we're working are so difficult that sometimes people misinterpret what is actually happening [Fobs Int, 05].*

There were instances where nurses were unable to determine what had happened in relation to patient care and acted on instinct and what they thought to be the correct approach.

*Well, I listen to handover, then I go and check the charts, all naso gastric tubes etc. My nurse has gone off duty at 1 o'clock, or 2 o'clock, I don't really know when the patient was last turned, so I might turn them [Fobs Int, 05].*

Within this context of uncertainty and change, in some instances relatives were given conflicting information about patients’ conditions and this was confusing. One relative’s account highlighting this aspect is as follows:

*Well, I think the information they gave me was to make me feel, to give me some comfort and that's the impression I got, I mean, I got lots of different varying information. Some information was quite detailed and some of it was really not so detailed, there was a large variation. . . . Depending on the nurse and sometimes the information would be different too. . . . Well in one case, on one day, I was told that there hadn't been any severe spinal injuries and that it wasn't a concern, we shouldn't be concerned about that, and then the next day one of the nurses was unsure whether there had been any spinal injury and said that they were really waiting for more information from the x-rays [Int, 27].*

Given the difficulties nurses experienced trying to determine and communicate patient care and the numbers of nurses involved in giving patient care, this discontinuity also impacted on the medical staff. A conversation with a medical doctor about the situation of having to work with so many nurses revealed that he found it very frustrating and discontinuous, as it was very difficult to determine how patients were progressing and what was happening with their care. When asked a question about how he responded to this situation, he replied:

*Well, you can jump up and down as much as you like, but what you really want you cannot really achieve in practice. They'll tell you that someone's off sick, or someone's resigned and they can't replace them . . . it's very difficult [Fobs Int, 11].*

In some instances, due to the fragmented communication system and the use of agency nurses, some patient care was missed. This account from one informant provided an example of this.

*This morning a Registrar came up and said "Why wasn't this care given?" and the nurse told him that she did not know, as there was an agency nurse looking after this patient and she has now gone off duty three hours ago and she won't be back because she's an agency nurse. The doctor said "Well can you do it immediately!". Now whilst the nurse gave that care immediately, it was five hours past the time when it should have been done. Another issue here was that the doctor was very angry with the permanent nurse for not giving the care and so the permanent staff seemed to suffer at the wrath of the doctor's anger, rather than the individual staff members [Fobs Int, 11].*

Relatives of patients also perceived a lack of continuity, uncertainty, and a state of "unknowing".

*Well, there seemed to be a broad continuity of care really. . . . The nurses always seemed very caring, but as to a continuity of care, well there was no-one ever really looking after him. You didn't see the same face very often anyway, let's put it that way, so you were a little bit unsure all the time [Int, 27].*

## Summary

The basic social problem that nurses grappled with as they tried to determine, deliver, and communicate patient care was being in a state of “*Unknowing*”. Properties and dimensions of “*unknowing*” were found frequently in the data and being in a state of “*unknowing*” was identified as the core category that linked and explained all the other categories. There were two main conditions that led to the core problem of “*unknowing*”. These were a fragmented and inconsistent process of determining and communicating patient care and working under fluctuating and uncertain conditions. Under these conditions nurses experienced a state of “*unknowing*” during the course of a shift. The levels of unknowing that were experienced varied according to how successfully nurses could determine with any certainty what was happening in relation to specific patient care needs.

*If we as clinicians remain silent on these issues, not only will our patients suffer, but we as nurses will not remain true to our philosophy and ethical charter [Int, 30].*

The core process that nurses used to overcome the problem of “*unknowing*” will be discussed in the next chapter. Within the present health care system and, in particular within hospital settings, the data revealed that nurses were unable to control their own work environment and practice in the way they had been professionally educated. Given all these factors that contributed to or maintained the problem of unknowing, “*knowing*” with any surety was an unsustainable and elusive state. Data revealed that as a result of all these working conditions, being in a state of “*unknowing*” was the basic social problem experienced by this group of nurses. Nurses in this study found themselves personally and professionally compromised working under these conditions.

# **Chapter Four**

## **Basic Social Process**

### **Enabling Care: Working Through Obscurity and Uncertainty**

#### **Introduction**

The overall aim of this study was to explore the process that nurses used to determine, deliver, and communicate patient care. Data analysis revealed that nurses were dealing with a basic social problem of being in a state of “*unknowing*”. The nurses who participated in this study used a basic social process to overcome this problem. This basic social process was labelled: “*Enabling Care: Working through obscurity and uncertainty*”. This chapter will give a detailed description of this basic social process and provide excerpts from the data to support the analysis.

The basic social process identified in this study involved two interconnected phases that tended to occur simultaneously. These two phases of the basic social process were: (1) Putting the pieces together: making sense, and (2) Minimising uncertainty. The first phase of the basic social process, which was termed putting the pieces together: making sense, involved four subprocesses. These subprocesses were: drawing on the known, collecting and combining information, checking and integrating information, and sustaining communication. The second phase of the basic social process was termed minimising uncertainty. It involved three subprocesses which were labelled: adapting work practices, taking control, and backing-up.

There were instances when nurses were unable to work through the obscurity and make sense of what was happening, in order to overcome the basic social problem of being in a state of “*unknowing*”. Consequently, decisions were made based on limited or incorrect information. Furthermore, on these occasions nurses either professionally compromised themselves and/or patient care. Nurses voiced grave concerns about the predicament as they were unhappy about the declining standards of care. However,

they were unable to control their work situation, became disenchanted with their work, and withdrew professionally. The phases and subprocesses of the basic social process as well as the propositional statements are discussed in this chapter. Extracts from the transcripts of the interviews, the field notes, and the audits of patients' medical records provide evidence of this basic social process.

## **Putting the Pieces Together: Making Sense.**

Data from this study revealed that nursing care occurred within the work context of change, uncertainty, and the use of a fragmented communication system. Hence, determining patients' specific nursing care needs, within the context of an everyday shift, was a difficult task to achieve. This task was further complicated by the number and different types of nurses involved in the delivery of care and problems that arose from the use of an inconsistent and fragmented communication system. Putting the pieces together: making sense, therefore, was the first phase of the basic social process used to overcome this problem. This first phase involved four subprocesses. These subprocesses were termed: (1) drawing on the known, (2) collecting and combining information, (3) checking and integrating information, and (4) sustaining communication. These four subprocesses occurred cyclically with no predetermined start or finishing points. Additionally, the subprocesses had no set sequential order as nurses found themselves in diverse situations, similar to being in a quandary. Under these conditions, nurses experienced varying levels of being in a state of "unknowing" and hence had to act and respond as best they could, given the prevailing work conditions.

At all times, it was common for nurses to find themselves in situations where their levels of knowing varied from knowing to unknowing. This hindered them from giving appropriate patient care.

*I don't know, maybe it's a lack of planning or a lack of knowledge [that] would hinder me from giving proper care, a lack of knowing about my patient, that's what is so important, you know, to really know about your patient [Int, 08].*

From any point along the continuum of knowing, nurses set about their journey of trying to put the pieces together in order to make sense of what was happening in regard to specific patient nursing care needs.

*Sometimes I've come on to the ward when it's been busy and there's an allocation board. . . . Usually, what I'll do is look at the board and see where I'm allocated and then find that nurse in the area, if she's there. If not, I pop into the rooms and look at the charts, the charts are usually kept at the main desk. I have a look at the charts mainly to check to make sure that the accurate drugs have been given. Or if something is happening, like an angioplasty is coming back, I maybe, then sort those things out and then eventually find somebody if I can, and get a handover [Int, 12].*

In summary, determining specific patients' nursing care needs occurred through the process of drawing on the known, collecting and combining information, and checking and integrating information. It was found that nurses followed these subprocesses in order to try and overcome the problem of being in a state of "unknowing". One informant's account of how she worked through situations where she was unsure provided another example of this first phase of the basic social process. It illustrated the basic social problem of being in a state of "unknowing" and the process used to overcome this problem.

*What I have done in the past with this particular person, I've gone back to them and said now I'm a bit confused as to what you meant about Mr So and So or whatever. But the other thing you do is you actually end up going around, you look in the notes and I actually go to the actual care givers who are looking after those patients. So you go to the patients themselves and just, quite surreptitiously, like you don't want to say well I don't know what's been happening to you this morning [Int, 24].*

It was evident that nurses varied in their levels of knowing and there were many strategies used to facilitate the process of knowing. At the start of any shift, nurses' knowledge acquired from experience or their familiarity with the norms of the work setting assisted them to know what to do. This enabled the process of patient care.

### **Drawing on the Known**

The first stage of the first phase of the basic social process was labelled, "drawing on the known". In this phase, nurses knew what to expect and made sense of what was happening, in regard to patient care, as a result of either their own past experience



and acquired knowledge or by being familiar with the norms of the setting. Each ward area had its own routine that was followed by all nurses who worked on that ward. Hence, knowing the routine was one method of alleviating being in a state of “*unknowing*”.

### ***Knowing the “Routines”***

Each ward area had their own routines in relation to the method used to communicate information, the type of handover process used, the sequencing of tasks, and the way in which patient care was documented. Observing work routines, therefore, was a necessary part of nurses’ work. A shift usually commenced with receiving some type of a routine handover.

*I coordinate quite a bit, so if I’m coordinating I come on and I get the book to see who’s meant to be on etc, . . . then we all just sit in a room and we all have our handover sheet and we write down our information [Int, 24].*

Specifically, nurses who knew the routine were able to overcome their initial state of “*unknowing*” and proceed with their work by observing “the routine”. One nurse’s account of her work on a morning shift provided an example of the routine nature of nurses’ work.

*There’s handover and checking the notes, talking to the patient to establish whether they are comfortable. There is the 8 o’clock meds [medications] So, it’s to the old med charts and when I assess [if] people are comfortable, usually there are a few people I take to the toilet or whatever, so I see that’s taken care of. I may help them to get up for their breakfast and we do that at the same time. Yeah, that’s breakfast and usually by that time it’s time to get people washed and attend to their hygiene [Int, 04].*

As it was usual for nurses to start a shift experiencing some level of “*unknowing*”, there were several routine communication mechanisms used on each ward to inform staff of the patients on the ward and their specific care. There was also a communication mechanism in place to advise nursing staff of their assigned patients.

Most wards had a white board on a wall placed centrally in the office. The information written on the white board varied from ward to ward, as each ward listed information that suited their requirements. However, they generally contained the following information: patient’s names, room number, procedures/theatre date and

time, discharge date, type of diet, and whether they required services from Silver Chain or Allied Health. Also listed was the name and page number of the Clinical Nurse Specialist and a column for the names of nursing staff members who were assigned the care of the patient for that shift (see illustration that follows). Rooms within each ward area were alphabetically or numerically labelled. On some wards, all patients' names were written on the board and on other wards only those patients who had particular treatments were listed. For example, the names of patients who were going to have certain procedures or needed a referral to Silver Chain nursing service would usually be written on this board. It was common for other health care workers to use the white board to communicate care. For example, patients who had specific diets would have this information listed for the dietitian to read [Field Obs, 01]. An example of the whiteboard is illustrated below:

**Nursing Coordinator:** May Brown page 2461

Staff	Room Number	Patient's Name	Procedures Theatre	Date Time	Discharge Date	Silver Chain	Misc Physio Diet Clear fluids
Carol Rm A & G	A	Mr Vox	Colonoscopy	25/07 9am	27/07	To see	

The extent to which nurses used the white board varied across settings. This depended on the type of information that was listed and whether or not it was deemed to be helpful or even accurate. An example of a more comprehensive use of the white board is discussed below.

*The first thing I do when I come on, I'd see which patients I was assigned, but we've got a whiteboard, that also has the information under current mobility status written up there and I would be looking at my lot of patients to see which ones require assistance with transfer. On the whiteboard we have little dots next to the patients name which tells you when the showers are morning, afternoon and if they're independent. We've actually got four dots we use, one's for morning, one's for afternoon, one's for the evening shower and one's for independent showers. So that gives me a quick check of how many patients I've got to shower that evening, and from then, I would then go to the clinical care plan. But that's done in two minutes [Int, 02].*

In addition to having the white board, it was common for each ward to have a patient bed list, written in pencil, so that changes could be made easily as patient's were admitted and discharged. The ward bed list contained patients' names, ages, medical diagnoses and the admission dates. Also, within each ward area there was a procedure used to communicate nursing staff's patient case load for the shift. This was done either by writing the nurse's name on the white board next to the patient's name on the staffing column or by allocating the patients by the room names, for example, "Carol, Rooms A & G". Some areas used a specific staff allocation book.

At the start of any shift, nurses were able to determine their assigned patients, by checking either the white board or the staff allocation book. After this, it was common for them to check either the white board or the bed list in order to determine the names and medical diagnoses of their assigned patients.

*I look up on the whiteboard in the office. That's got the room letters, . . . they are done by letters . . . and I just have a look at their diagnosis. Because we've got a bed list, I have a look at that, their age and also on the whiteboard they have things like whether they're a diabetic and any treatment needed and when they're going to be discharged, so I have a look at that [Int, 08].*

Most wards had a printed handover sheet that nurses used as a template to record patient details (see below). This example is typical of the template used in surgical wards. Medical wards tended to use fewer headings, such as: Room, Patient's name, Diagnosis, and Nursing Care.

Room	Name	Diagnosis	IV	Drains	Nursing Care

On arrival in the ward area it was usual practice for nurses to use a new handover sheet and fill in the patient's name, age, and medical diagnosis in preparation for handover. In some instances, however, nurses would use the handover sheet from a previous shift. As patients and their nursing care constantly changed, nurses would erase the old information and add in the new changes. This was routine practice on most wards. As this routine was commonly observed, new or relieving nurses who knew the routines or the ward norms would know what to do at a start of a shift prior to receiving a handover. Each ward also had a set of routine practices in regard to

where patient information was stored and the type of information that was collected. Nurses who used these routines were able to make sense of what was happening and to continue working. Field notes revealed information that illustrated this aspect.

*A nurse arrived on the ward, she was going to coordinate the afternoon shift. She had a new handover sheet and was writing the patients' names and medical diagnoses. She looked on the board and she noted the patients she had been assigned as this was written down next to her name on the white board. She could not find the morning coordinator and was unable to get a handover, so she went down to the room where her assigned patients were and started to read through her patients' charts [Fobs, 01].*

Nurses working on all shifts including night duty followed some type of routine.

*We aim to have the ward settled by 11 o'clock, that doesn't always happen of course. Then after that it's time to actually read the progress notes and the care plans more thoroughly and special observations, any things wanted for the next day as far as lab results and that type of thing and then after, it's basic patient care as needed. . . . and then at 6 o'clock once again, medications and we have medications during the night, but that's routine [Int, 01].*

Relieving and agency nurses who were familiar with the ward routines knew how to proceed with their daily work. The following data illustrated this issue of how knowing the ward routines assisted the delivery of care.

*Wards are really all the same, I go to the white board in the office and I find out where I've been allocated. I take handover from the shift coordinator and find out about the patients. Then because I've arrived a little bit late, I check to see that the medications are given [Fobs Int, 04].*

Additionally, it appeared that some wards required certain routine-type interventions to be listed for all types of patients. Nurses who knew the routine interventions used on the ward could complete the care plan more easily.

*They always do [include in the nursing care plan] oxygen and suction check daily, and for elimination they usually have check bowels open, potential for injury, they have check bed brakes, change IV, the day it was inserted and if the patient has fits or something they might have a seizure chart [Fobs Int, 06].*

While following usual routines was one strategy used to mitigate the problem of being in a state of “unknowing”, experience and knowing what to expect was another factor that helped overcome the problem of uncertainty.

### ***Knowing what to Expect***

Data revealed that experienced nurses, or nurses who were familiar with specific ward norms, had certain advantages and were more able to overcome the problem of being in a state of “*unknowing*”. Specifically, they knew some of the anomalies in the system and were more capable of working around them. For example, as the patient status changed on the ward, this information was updated inconsistently. On some occasions, the information written on the white board in the office varied from the information written on the bed list. However, nurses who had been on the ward previously knew which source of information was more accurate. At the start of a field observation period a nurse greeted me in the following way that supported this statement of discrepant patient information and the issue of nurses knowing the most reliable source of information:

*Sit down and look at the whiteboard and get the names off there, the bed list may not be accurate, we have lots of patients come and go [Fobs Int, 05].*

Furthermore, information about patients was stored in a number of areas and charts. There were many patient forms with information written about the patient’s status. Through experience or being familiar with ward specific norms, some nurses knew which chart would provide them with the most accurate patient information.

*I find the flow chart [the nursing care plan], yes, gives the best picture because, I think the staff seem to be more willing to update that flow chart, rather than the master problem list, they seem to write specific things in the actual flow chart rather than the master problem list [Int, 12].*

Additionally, at the start of any shift, although nurses did not know the individual patients, their past knowledge of the nursing care required for patients with specific medical conditions helped them to determine the general nursing care of these patients.

*All patients with similar diagnoses, yeah, there’s a tradition, there’s a standard course of events that will flow from standard diagnoses unless something happens to indicate otherwise. . . . I mean, care tends to be standardised, you know someone’s got unstable angina and you know a whole series of things flows from that, you know, all being normal [Int, 18].*

Another informant's view on how nurses' determined how sick a patient really was provided further evidence that supports the view of "knowing what to expect" and knowing how to nurse a patient's medical condition, being a helpful prerequisite to knowing patient care in a general sense.

*You just know from their medical condition, what they're going to be like [Fobs Int, 07].*

Some wards, mainly surgical ones, also used standard care plans. These standard care plans, which were used for the first 48 hours postoperatively, were a form of routine care. They contained information in relation to specific routine postoperative care. For example, all nursing interventions in relation to the patient's management of pain, fluid intake and output, and hygiene needs. Specific interventions to prevent postoperative complications, such as deep vein thrombosis, were also included. While these standard care plans helped establish routine postoperative care, experienced nurses who knew the routine care for these surgical patients did not refer to the care plans.

*Well, I don't look at it, [referring to the standard nursing care plan] you just look at your patient and you know, . . . I know what care to give [Fobs Int, 06].*

Other nurses found that the patients' environment, the technology used to deliver treatments very helpful, as they gave them clues to the patient's condition and care.

*Yeah, but first thing you always look at is the patient because I'm looking at . . . you can just tell, just the colour and the way they're lying in the bed and their expression and all of those sorts of things give you some sort of indication, Yes, and then I'm looking at what's around them, what in the environment are they attached to that's going to be relevant to their care, because that tells me a lot about their complexity as well, have they got a catheter in, have they got, how many pumps are attached, what sort of drugs are running through those pumps and that gives me a very quick indication of just the complexity of care that you're dealing with on that particular shift [Int, 29].*

However, nurses would require prior knowledge and experience dealing with the technology for these visual cues to make sense and to be able to inform them of the patient's general condition.

At the start of a shift, nurses had some information about the patients. However, they were unable to determine with any certainty whether the information written on the

white board or on the bed list was up to date. Additionally, they would not have information on the specific care required by each patient. Due to this factor, collecting and combining information was a necessary process and thus formed the second stage of the first phase of the basic social process.

*Obviously, when I start the shift I come on [I have a] handover, so I rely on that information [Int, 04].*

### **Collecting and Combining Information**

Collecting and combining information was the second phase of the first stage of the basic social process that is, Putting the pieces together: making sense. It involved collecting as much information about the patients in order to know their specific nursing care needs. There were several sources from which to obtain patient information. Nurses stated that a combination of all these sources assisted the process of knowing the patient. The most common sources of information that were used include the shift handover and the patient's case notes. At the commencement of each shift, it was common for most nursing staff members to receive a handover.

*You come on, you have a handover, so you find out what the situation is with everybody. Then we are already allocated [our patients] so we know who we are going to be looking after [Int, 06].*

As the handover routine was an important communication mechanism that was used, this process will be described in greater depth.

### ***The Handover Process***

Handovers were conducted using two types of delivery modes. These were either given verbally within a face-to-face context, or by using a tape recorder and a tape-recorded message stating patient information. The verbal handover occurred either in a room on the ward that was sometimes know as the “*handover room*” or at the patients' bedside. Tape-recorded handovers required a quiet environment and, therefore, always occurred in a quieter area or room. The shift coordinator was usually responsible for handing over all the patients to the nurses who were starting their shift. In some wards, however, the formal handover was given by the nursing staff who looked after the patients and not by the shift coordinator. In these cases, the

handovers were also conducted either verbally or by using a tape recorder. This type of handover, however, was less frequently used as it was perceived that senior staff were more proficient at handing over information.

*We found that having the individual nurse handover her own patients was too long winded, and again because of various levels of expertise . . . you might find the information [they were] trying to give you was perhaps not necessary, because it was very routine, there hadn't been a change and it was just too much information for people to absorb, and they would just go to sleep [Int, 02].*

In addition to this type of group formal handover, and when rostering permitted, brief informal handovers were conducted between nurses who were personally assigned the same patients. Specifically, discussions took place between the nurse who was starting the shift and the nurse who was going of-duty.

*And quite often you'll meet the nurse at the notes [referring to where the charts are stored in the office] and you'll run through the charts and discuss the patient, but very briefly, if you've already had a handover [Int, 12].*

Some nurses, especially junior nurses, said they found the personal-type, informal handover very informative and an important adjunct to the main handover as it included specific personal patient information which assisted them to prioritise patient care.

*I think probably a personal handover with the next nurse coming on is probably the best. Because a lot of the time when you give your handover to the CN [Clinical Nurse] who is going to handover later, she just wants to know the main things, you can't tell her that the [intravenous] bag is going to go through shortly and have a look at that [Int, 06].*

However, this type of handover did not always occur, due to the short shifts where some nurses finished work before the next nurse came on duty. This led to the problem of being in a state of “*unknowing*”.

### **Verbal handovers**

In a general sense, handovers were usually given in a structured way mainly focusing on physical and procedural information. Before the nurse commenced the handover, she/he usually tried to determine other nurses' levels of knowledge about the



patients; this assisted her/him to determine and streamline the information that was given.

*The first question is, usually, Do you know the patients? Were you here last night? Were you here yesterday? So that certainly depends on what you hand over [Int, 01].*

The format of handover varied across ward settings. However, they generally followed a standard format. The nurse would hand over the patient's age, medical diagnosis, and where relevant, some past medical history, any procedures that had been performed on the patients, any specimens that needed to be sent, or any patient preparation necessary for any pending diagnostic or surgical procedures. Overall, handovers tended to be quite cryptic and nurses used many technical abbreviations. Some typical examples of verbal face-to-face handovers were as follows:

Patient 9: [States the patient's medical diagnosis] *IV fluids running, intake not very good, bag due at 6 p.m., if OK orally, cease, if you need there is another bag written up, IV ABs [antibiotics], Maxalon PRN, Temp 39, Blood cultures, oral antibiotics after the IV AB's, home on Monday.*

Patient 17: [States the patient's age and medical diagnosis] *had a biopsy, he's got a band-aid and a dry dressing, bi-weekly weights, malignancy, abdo[minal] mass, he needs nilstat, didn't get his oral hypoglycaemic because he was fasting. BSL [Blood Sugar Level] was 28, gave him [drug x] now it is down to 9 [Fobs, 04].*

On day shifts when most of the staff on the morning shift were similar to the staff who worked on the previous day or the evening shifts, the handovers were more streamlined and in some instances they did not include the patient's age or medical diagnosis. For example:

Patient 1: *remains shackled, [hand cuffed] doubly incontinent, he didn't sleep last night.*

Patient 6: [States the medical diagnosis] *bit confused, BD [drug x], she walks to the toilet, has panadol [Fobs, 03].*

There were other factors found in the data that tended to influence the type of information that was handed over. Some of these factors have been discussed in the previous chapter and include: the busyness of the ward, the time of day the handover is given, the experience level of the nurse, their knowledge of the patient, and what

they deemed to be important information to handover. One other important factor that influenced the way in which handovers were conducted was the patient's length of stay. Instances where all the nurses knew the patient (this was usually because these patients had been in the ward for a while) the handover tended to take a different format that focussed on updating the information, rather than giving any background information.

Patient 11: [States the patient's name, age and medical diagnosis]. The nurse handing over asks the question]. *Does everybody know her?* [they all nod] *on a similar feeding regime, does a one or two nurse transfer, antibiotics for her UTI, [Urinary Track Infection] GTN [Glycerine trinitrate], naso-gastric tube draining [Fobs, 05].*

On occasions when the nurse who was handing over had known the patient for only a short period of time, sensitive information tended to be handed over using a more objective, matter of fact approach.

Patient H19: [stated the patient's age and medical diagnosis] *this patient has impaired cognition in social situation, husband has gone to Italy, she's unable to walk, has a bruised pelvis, I've told the doctor, she's for an X ray, two nurse transfer, soft diet, she's incontinent urine [Fobs, 01].*

By contrast, when the nurse knew the patient as a person, usually because they had been admitted for a longer period of time and nurses had got to know them as individuals, some nurses handed over more personal information using a more informal approach.

Patient 10: [Nurse states the patient's age and medical diagnosis] . . . *probably going home tomorrow, ask the doctors to write the drugs, Silver Chain knows, OT's [Occupational Therapist] will supply a bottle, **had a visitor this morning.** He has not had his bowels open since he's been in, we gave him two suppositories, with a good result, can you give him an aperient tonight?, OT [Occupational Therapist] showered him this morning, Sub Cut[cutaneous] Heparin and antibiotics [Fobs, 02].*

*Both these ladies are the same, I call them the terrible twins! [Patient 18] doing really well, going to participate in doctor X's study, seen by the respiratory team, no problems, doing really well [Fobs, 02].*

In order to try and understand patients' conditions, which were constantly changing, nurses often compared the patient's status to the previous shift.

Patient 10: [States the patient's age and medical diagnosis], *she is for an OT [occupational therapist] shower, Fluids normal, Diet taking really well. At this point, a nurse asks the nurse handing over a question. Is she as good as yesterday? The nurse replies Yes. Continue on BP's [blood pressure], BM's [blood multistix], incontinent pads, family meeting, they are trying to take her home on Tuesday, need to get the family involved in the transfer. They discuss her care more thoroughly. As they discussed her care, some nurses contributed information to the overall clinical picture, saying something about the patient that added to the understanding of the patient's overall condition and how she was progressing [Fobs, 05].*

Some nurses stated that when patients had been hospitalised for a long period of time the information that was handed over moved beyond the patient's medical condition and tended to include information on the patient's psychosocial well being.

*Oh yeah, assuming that you're handing over to regular staff, as distinct from agency staff or pool staff, yeah the handover gets, it either gets briefer or it gets further away from, I guess this contradicts what I'm saying, it gets further away from the medical stuff. . . especially if there are no great changes medically speaking going on. If more or less they're stable, they're not likely to change much, their condition, they're just waiting placement. That's when you start talking about it, you know Jim and he's been a bit depressed today, or it gets quite casual and more intimate and more psychological [Int, 18].*

Handovers that were conducted at the bedside posed specific problems, as it was difficult for nurses to handover personal and private information in front of the patient. Nurses would hand over sensitive information by pointing to her/his written notes on the handover sheet and signalling to the other nurse to read this information. On other occasions, they would whisper this information to each other. For example, one patient was a manic depressive and needed a lot of encouragement and the nurse did not want to say this out loud so she pointed to her notes where she wanted the other nurse to read this information [Fobs, 01].

Being familiar with other nurses working on the ward was an important condition that enhanced knowing. It appeared that when nurses received handovers from nurses who they did not know, they usually asked them many questions in order to check what had been done and to confirm information.

*Whenever she receives a handover from a nurse she doesn't know she tends to ask more questions of them to see what has happened. When she has the handover from someone she knows, she relies that they know what has to be done*

*and that it actually has been done. She spoke of an understanding and a trust that develops among staff who know each other and work together [Fobs, 06].*

Each type of handover mode had its strengths and limitations in terms of the information that was handed over and the language that was used. The type and accuracy of the information handed over also tended to vary according to the level of familiarity the nurses had with the patient. While the verbal face-to-face handover was seen as being the more traditional, established type, the tape-recorded handovers emerged as a result of a change in rostering and a reduction in staff overlap time. The peculiarities associated with tape-recorded handovers will be described in order to detail differences.

### **Tape-recorded handovers**

Tape-recorded handovers were used on many wards. Due to the reduction in shift overlap time and nurses starting their shifts at different times, tape-recorded handovers were introduced as they were said to be a more efficient method of handing over. Its use was said to have saved time and repetition of tasks. When asked a question about the driving factor that led to the implementation of this type of handover, one informant replied:

*The issue was all the different lengths of shifts and as a coordinator I spent my entire afternoon handing over, I'd hand over at 1 o'clock and then I'd hand over at 2 o'clock and 3 o'clock and on and on it would go. I'd spend my whole day handing over, or at least my whole afternoon handing over and that was just crazy. We started with the midday, the 1 o'clock handover, we started with that and then it progressed on to the other two [referring to the morning and night duty handover]. Yes. I hand over at 1 o'clock verbally to whoever is there and tape that, so it's like a dual one and then after that everybody just listens to the tape [Int, 23].*

The times these handovers were taped varied from ward to ward. However, they tended to have some broad uniformity. A conversation with a Clinical Nurse alluded to this trend:

*Night duty staff usually recorded their handover at 5 a.m. At 7 a.m., in the morning all ward staff listened to this handover. At 1 p.m. there was a verbal handover which was taped for the staff starting later on at either 2 p.m., or 3 p.m. From about 8:30 to 9 p.m., afternoon staff taped their handover, half an hour, then night duty staff listened to the taped handover from 9:00 to 9:30 p.m., [Fobs Int, 05].*

Tape-recorded handovers were conducted in the office. All nurses who started their shift at the same time would collectively listen to the tape-recorded handover and write the information down on the handover sheet following the format of the verbal face-to-face handovers. Some nurses regarded this type of handover as being a more objective and efficient method.

*We all just sit in a room and we all have our handover sheet and we write down our information [Int, 24].*

In keeping with the verbal face-to-face type handover, tape-recorded handovers were given by either the nurse who looked after the patient or the shift coordinator. It was usual for the shift coordinator to give the afternoon handover. However, there were no set rules, each ward had their own social norms regarding the way in which handovers were conducted.

*Funnily enough on our ward on night duty each . . . like each person does their own patients, they hand over their own lot on the tape. But during the day, the coordinator gets the handover from everybody and does the one handover [Int, 24].*

Tape-recorded handovers were usually constrained by time and the length of the tape used. These handovers were in some ways similar to the verbal face-to-face handovers and tended to focus on more physical and procedural type information. For example:

PATIENT G14: [States his age, allergies, medical diagnosis]. *This patient has HIV, is for an appendectomy, PCA [Patient Controlled Analgesia], IV cannular, bone marrow biopsy, he's ambulant self-caring [Fobs, 05].*

The handover, which was conducted at 1 p.m., involved giving a verbal face-to-face report to the new shift. This report was tape recorded for staff who started at a later time. Like all verbal face-to-face handovers, it was usual for some staff members to ask the nurse handing over a question. On these occasions, the tape recorder was turned off to enable these discussions. A conversation with a clinical nurse explains the reason why the tape recorder was turned off while listening to the handover.

*Yes, when the coordinator wants to add more information or someone asks another question, but usually you just listen [Fobs Int, 06].*

Some nurses complained about the handovers being non interactive and that they were recorded quite fast. It was, therefore, difficult for them to write all the information down. In those instances the tape had to be replayed.

*No, I prefer talking to someone, you find out more information. Besides, sometimes the tape goes too fast and you cannot get all the information down, then you may rewind the tape, play it back if you missed something or cannot understand something, then you just play it back [Fobs, 07].*

Other nurses found that the tape-recorded handovers were more focussed and to the point. These nurses tended not to complain about the lack of interaction.

*I don't mind them, I think they're good because I think it reduces the [time] . . . if you have a verbal handover there is a lot of time spent interacting. People will question it and clarify it [Int, 04].*

As tape-recorded handovers had a certain time limit, a total of thirty minutes, these handovers were brief, matter of fact, and to the point. A handover of four patients within a section provides one example of this type of handover.

*Good morning, Mary here, with ROOMS X, Y and half of Z. [Patient X1: States the patient's medical diagnosis] fasting, theatre at 13.35, nothing else for her. [Patient X2: states the medical diagnosis, discusses pain care] nourishing fluids, mouth care, IV AB's. [Patient X3: States the patient's age] BCC split skin graft, down, BD BM stix, long medical history, IV antibiotics, rash over her body, but no complaints overnight. [Patient X4] Stress, incontinence, that's all [Fobs, 07].*

Nurses were allowed the flexibility of listening to the whole ward or just listening to handover of their assigned patients.

*I mean it depends how much of a hurry you're in, you might just listen to your people, but you might listen to the whole lot and see what is going on with everybody [Int, 06].*

Although receiving a handover at the commencement of a shift was standard practice, there were many problems with handovers that caused nurses to experience a state of “unknowing”.

### Pooling and combining information

The type and quality of information given within handover tended to vary according to how well the nurse handing over actually knew the patient as an individual person. This depended on many factors, the most important being whether they had previously nursed the patient. Although this was an important factor, there were many instances when this could not be achieved. The findings revealed that on some occasions, nurses were required to coordinate the ward on an early shift having returned from days off or from annual leave. In these circumstances, these nurses experienced being in a state of “*unknowing*”; it was difficult for them to grasp and know what was happening in order to give an accurate and informative handover. On these occasions, other nurses who knew the patients and their care, assisted them with the handover. A memo written during the field observation stage, provides evidence of this occurring:

*The shift coordinator who is handing over has been on annual leave and has commenced duty on an early shift. She really does not know the patients and within this handover she's had information confirmed from other nurses rostered on the afternoon shift. Some of the nurses rostered on the afternoon shift constantly filled the gaps in information that was handed over [Fobs, 04].*

During some face-to-face handovers, when nurses were more familiar with the patient and their care, they were able to add information about the patient and collectively contribute to the handover and the process of knowing the patient.

*A lot of exchange of information goes on at handover and informally. A lot of clarification of what is actually happening. Some nurses know some patients better than others and they tend to fill the gaps [Fobs, 04].*

Within the face-to-face handover context, nurses were able to clarify the information. They also asked questions when they were unsure of the care.

*Patient 8: [States the medical diagnosis and whispers], encourage her to walk and be as independent as possible, need to prompt her. She was continent throughout my shift, I didn't have to put a nappy on her--she will not initiate any care you have to encourage her to eat. [A registered nurse asks a question] do you walk with her ? [Nurse handing over replies] no, just stand by her, recommenced on sorbital, she seems more orientated today she was off the planet two days ago. [the same registered nurse asked] what are her electrolytes ? [Nurse handing over replies] don't know, . . . she had visitors two days ago and*

*they didn't know what she was saying. You really have to encourage her to be normal as possible, as the transplant team is coming in on Monday and if they see her in her present state they will not accept her for transplantation [Fobs, 02].*

Another example of this type of interaction, taken from field notes that described handover, is as follows:

The nurses qualify information with each other, for example, one nurse asks the nurse handing over--*does he call you when he needs a bottle or does he wet himself?* This nurse had been on days off and the patient was quite sick before she went off-duty [Fobs, 01].

During handover, nurses conferred with each other about the care and they also tended to conduct informal, impromptu educational sessions. Field observations conducted revealed the following:

During the handover a junior nurse asked "*why change the insulin?*", the morning coordinator who was handing over replied "*I don't know*", she continued to give a lengthy explanation about the correlation between high blood sugar and stroke. She further explained the specific technique necessary to withdraw insulin from the particular vial. The junior nurse asked another question "*who is going to teach him how to use the pen?*" [referring to the insulin]. The morning coordinator replied "*he will go to the diabetic clinic tomorrow and sister will show him how to use it*". The junior nurse asked another question about on-call pharmacy. The morning coordinator explained how an on-call pharmacist can be obtained [Fobs, 05].

The format of the tape-recorded handovers caused communication problems. Specifically, nurses were unable to confirm or deny information with the previous shift of nurses. Hence, they had to periodically switch-off the tape recorder and where able, clarify information with each other.

*Nurses who listened to the tape-recorded handover, sometimes found that they did not have enough information to direct care, so they would turn the tape recorder off and ask each other questions, clarifying patient information [Fobs, 11].*

Combining information was a process that occurred not only from nurse to nurse but also within the health care team and with patients. During handovers that were conducted at the bedside, nurses tended to confirm or clarify information with the patients.



*As this handover is conducted at the bedside, the patients listen in on the handovers. Quite often the nurse asks the patient what has happened. For example, have you had your X ray today? Has the doctor seen you? What did he say? . . . Once again there is emphasis on the medication chart which is reviewed, and drugs that are not signed off are looked at and the nurse looking after the patient, if she is still on duty, is asked to clarify whether she has given the drug or not [Fobs, 01].*

Although there were several communication mechanisms used in ward settings, and nurses usually received some type of handover, they were never really sure of the accuracy of this information. Data analysis revealed that handovers varied in the quality and type of information that was given. Hence, nurses were never really clear of the patient's actual condition and the information received through handover may not have been adequate to direct care. One example that illustrated this situation was an incongruence between a nurse's mental impression of the patient that was based on the handover information, and the patient's actual status as observed by the same nurse. Due to this factor, nurses sometimes found the actual patient's condition to be different to what they initially expected.

*I've gone down [referring to the bedside] and I've thought, yeah you've handed over so and so, and you think I'll be all right, and then you actually get out and down there you find this person is really quite sick and you know, those sort of things. I mean it's nice to find it the other way round where you think someone's really sick and they're actually not as bad when you see them, but when it's the other way round it can be a bit daunting [Int, 24].*

As nurses were constantly unsure of their understanding of patients' nursing care needs, they had to constantly check and integrate information from other sources of data. After receiving a handover, nurses had to check whether they had enough information to enable them to nurse the patient or whether they had to collect more information in order to determine what was happening with the patients and their specific care. Even on occasions when handovers were thought to be comprehensive, nurses had to seek further information, usually from the patient's notes, in order to check their own levels of knowledge about patient care.

*Then it's really up to you when you've finished handover to go out and get a bed-to-bed handover from the caregiver and to get down to the more nitty gritty. I mean perhaps I look at the care plan and take it from there [Int, 24].*

Due to an uncertainty surrounding the accuracy of information, nurses would have to further clarify their information about patient status. Hence, checking and integrating information was the third phase of the stage “Putting the pieces together: making sense”.

### **Checking and Integrating Information**

Checking and integrating information in order to decide specific patient care was routine practice. It was found that the work context of uncertainty caused nurses to routinely check and recheck in order to determine whether care had been given and to verify their understanding of the care that needed to be given. Nurses tended to use many and varied ways to ascertain what was happening and each nurse also differed in what they believed to be the most effective method.

*It depends on [whether] the staff member is still present, who has cared for the patient in the morning, then I'll speak to that person. If not, it becomes more difficult and very frequently as an agency nurse you'll come on later in the day, the nurse who was the primary carer has gone and so you then need to find somebody who knows the patient. If it's a nursing issue it may be the shift coordinator or one of the other senior staff working nearby may have cared for the patient in the last 24 hours and may be able to fill you in on some information. Obviously the notes and care plan can help as well. Sometimes the patient as well. OK, sometimes if it's an issue, particularly my area of expertise is critical care so the level of expertise are pretty involved. So sometimes they [patients] can help out as far as the information I'm after. And sometimes I just have to make an executive decision about how I'm going to deal with the issue, if there's not the information available or leave messages for the next shift as to a problem that needs following up [Int, 29].*

Additionally, nurses were required to check the patient's charts not only for their own information, but also to see whether the care from the previous shift had been given.

*What happens is that you come on and your nurse has gone [off-duty] and there are those problems when the nurse has gone and you come and check the charts. Now, somebody the coordinator is usually supposed to check those charts before the person leaves, to just identify if they've got any medications missing because quite often if the medication hasn't been signed for, I would have to go and ask the patient, did you remember getting that tablet. And then usually if they don't, try contact the person who was on in the morning [Int, 12].*

Some nurses constantly checked on equipment and patient intravenous lines, not to verify information but to ensure that everything was functioning appropriately.

*In the surgical wing, following handover of say up to twenty patients, I initially go and check all IV's [intravenous lines], to make sure they are not going to run through [Int 01].*

As the whole work environment was said to be in a state of uncertainty, it was difficult, therefore, for nurses to rely on any one source of information.

*I have to go to several sources of information and there are several sources available, there really are multiple information sources and I look at the cards [Referring to the new kardex cards] [Fobs Int, 05].*

As there were several sources of documented information, nurses did not always know the most accurate source. In addition, the information contained within the patient's notes was also lacking, and in some instances it was not specific enough to direct care. This placed nurses in situations where they were constantly trying to make sense of what was happening. Hence, nurses had to check several sources of data and integrate this information in order to determine patients' nursing care needs.

*Experience I suppose, . . . initially, meeting the patient and assessing for myself how they are and what is going on and checking for a few minutes if they are able . . . checking the charts certainly, see the medication that they're on and drips, drains etc, that type of thing. Medical [referring to medical patients] is sometimes a bit more difficult, it is probably more important definitely more important to have a care plan and problem statement [Int, 01].*

Some nurses found the care plan to be most helpful as it gave patient-specific information.

*The first thing I usually look at is the observation chart or the actual flow chart [nursing care plan] is quite useful because that's the one that people tick off each individual thing, so for the observations, you can actually find out from it very accurately what sort of observations they are on, whether they've been on four hourly, two hourly, quarter hourly or if there's any specific observations will be written there. That also tells you the things whether IV [intravenous] fluid line needs changing, the IV cannula needs changing and because each little thing is initialled, that's usually very accurate [Int, 12].*

Other nurses did not find the nursing care plan the most helpful and alluded to other charts that were helpful. In response to a question whether the care plan usually reflected patient care one nurse replied:

*Sometimes it does and sometimes it doesn't, you also have to supplement it with the wound management plan, and other types of obs, like you might have seizure obs and things like that, that tell you the type of care [Fobs Int, 07].*

Nurses tended to vary in their opinions as to what was the most helpful source of information.

*I don't find the care plan very helpful. I find for the most part it is just a tick check list and . . . the verbal handover and also the problem list is very helpful [Int, 01].*

As patients were often transferred across settings the transfer letters were another source of information that was thought to be helpful.

*Getting information from the transfer letters if they've just come in from another hospital, but also ask the patient or their relatives [Int, 02].*

On some occasions, some nurses had to rely on information given to them by patients.

*I do rely on documentation, the information supplied. I also rely on the patient and/or other staff. So you really do have to utilise quite a few resources if you want to [know the care] [Int, 04].*

The information written on the patients' charts varied and in some instances lacked detail. Some nurses, therefore, performed informal personal assessments in order to determine the patient's condition and their care.

*Well [I do a] personal assessment [Fobs Int, 04].*

Looking at the patient was another method used to assess the patient's status and it appeared repeatedly in the data.

*You know the care by just looking at the patient, just seeing them you can see how they are. If they're in pain and things like that [Fobs Int, 07].*

*I like to kind of visualise patients if I haven't seen them before, first I look, a visual scan is often for me the most effective way of determining the patient's status, the patient's condition, but not necessarily so, it's a culmination of a visual approach and vital signs [Int, 18].*

Visualising the patients was found to be beneficial as some nurses stated that just putting a face to a name assisted them to remember the type of care. I asked one informant how often she referred to her handover piece of paper, she replied:

*Well, usually at the start of the shift and then on and off, if I need to clarify information. Once you put a face to the name, you remember things [Fobs Int, 05].*

Additionally, personal assessments provided information about the patient's capabilities, especially in wards where patients' mental status could be impaired. A comment from one informant about how she determined patient care supports this view.

*Asking the patient probably . . . you need to assess whether or not the patient has a mental state that is going to give you an accurate answer. And oh sometimes if you just stand back for 5 minutes and watch the patient at whatever they're up to you will certainly find out whether or not they need just a little bit of TLC [Tender Loving Care] to get them going, or whether they need some serious sort of encouragement, or whether they're doing quite well [Int, 07].*

Although the patient's notes provided some information on the patient's care, nurses found themselves in situations where they did not have the time to read the notes. In these instances, they used other strategies which included asking the patient.

*Well you don't always get a chance to read them, [referring to the patients notes] you usually ask the patients, they know what is going on. [When further asked whether she asked other nurses she replied] all the time [Fobs Int, 05].*

If the patient was lucid, gathering new information and/or verifying information by talking to the patient was said to be the most useful method of determining patient care. The following lines of transcript illustrated how helpful nurses found patients in terms of providing information about their own care. In most instances, however, nurses had to determine whether the information was accurate. Therefore, they had to decipher this information and try to determine what was happening in regard to patient care.

*Talking to the patient gives me the most satisfaction and knowledge . . . appropriate for that patient, . . . I think so, to a large degree if that person is able to [Int, 01].*

The findings revealed that some nurses found having casual conversations with patients and spending time with them to be a very helpful way of knowing their care.

*Going in there and seeing them, asking them, and general stuff from the handover, just the main stuff that you get from the handover, yeah. But, yeah just seeing them, asking them, helping them out, having little chats with them I suppose [Int, 06].*

Additionally, some nurses used a combination of information sources to determine patient care. They stated that the frequency of patient observations was a helpful gauge of a patient's condition.

*I find the care plan very helpful, it tells you everything you want to know. Then I read the progress notes. Also, if the patient is on BD [twice daily] obs then you know that they are quite stable [Fobs Int, 01].*

Within the context of an acute setting, doctors were ultimately responsible for the medical treatment of the patients. Hence, nurses often had to check with the doctors in order to determine what was happening in regard to patient care. Due to this factor, asking the doctors was another useful strategy used to determine specific patient care needs.

*[The patient asked the nurse a question]. I'll just go and talk to your doctor and come back and tell you what is happening [Fobs, 04].*

Determining patient care occurred using a complex and convoluted process whereby the nurses had to use several strategies and then integrate the information in order to determine the overall care. An agency nurse's account of how she determined patient care provided a good example of a summary of the initial strategies nurses used to determine patient care. These subprocesses formed part of the first phase of the basic social process. This excerpt also illustrated how the three subprocesses of this phase occurred concomitantly.

*I usually get a good handover from the night staff, if you're agency staff they give you a longer one. Then I just go and do my medications and look up the nursing care plan, that tells me what I need to do, if the patient is "with it" then I ask them, if not then I just ask another nurse [Fobs Int, 03].*

Additionally, as the state of "unknowing" emerged as a function of the fragmented communication system in place, sustaining communication of information was another strategy used to minimise the basic social problem of being in a state of "unknowing".

### **Sustaining Communication**

Nursing care occurred within the context of many nurses delivering patient care over the total patient stay, coupled with, contextual work conditions that undermined the

effective handover of patient information. It was, therefore, necessary for nurses to use other communication mechanisms to compensate for this discrepancy. These communication mechanisms usually took the form of informal notes.

*I went to the nurse's office and I saw a sheet of paper lying on the top of an X ray folder. It had the shift coordinators name written on it with a few written messages below. The messages read as follows: [Message One] Patient A's daughter rang and they are unhappy to take him home.[Message Two] Tell person X to organise Mr Y to go to Hospital B and two other messages about patient care. This note is not signed. I asked the shift coordinator who had left her the note, she said that it was the previous day's afternoon shift coordinator. This type of handover is usually done verbally through the night duty staff. However, the morning shift coordinator is new at coordinating, as she was acting at clinical nurse level for the first time. Hence, the afternoon shift coordinator was reminding her of these patient care issues. I later checked this patient's notes and there was no record of the daughter ringing and stating that she did not want to take her father home [Fobs Int, 03].*

Data revealed that due to the short shifts and lack of overlap time, nurses were unable to personally hand over patient information. Under these conditions, it appeared that the oral culture had been replaced by an informal written culture. Some nurses also communicated informally with the doctors, leaving notes that reminded them of tasks that needed completion.

*Sometimes I stick notes, actually the most effective thing I find is to actually stick notes on the front of the patient's chart. So if there's something, say, green fluid chart orders hasn't been ordered, or an IV [intravenous] cannula needs to be changed or things that maybe are missed or things that although they may be handed over, they need an extra prompt and usually I stick notes in the front of the chart [Int, 12].*

In addition, where the assessment form had not been completed nurses would leave little notes on the patient's folder written on scrap pieces of paper.

*Oh, they might just leave a little piece of paper on top of the notes, saying that the assessment form hasn't been done or alternatively they will verbally hand this over to each other [Fobs 03]*

As there were many problems associated with handovers (these have been discussed previously), some shift coordinators who were required to handover information to the shift commencing duty found that they were not being given essential

information. In order to address this problem, some nurses had developed a handover guideline sheet that prompted the reporting of specific information.

*Yes, we do have a handover sheet [guide], which is one that I designed. . . . The sort of thing that I actually have guidelines, what I wanted in the handover sheets. The idea was that sometimes as a coordinator I found that I wasn't getting the information that I wanted from the nurses. So I started having a sheet, with guidelines on what information was to be in that, and that covered things like, abnormal blood pressure readings, or alterations of any sort, new patients, with specific information you'd want to have. . . . Yes, it's more that I felt inadequate giving information to people if people hadn't fed it to me. I found that I was so busy I didn't have time to go around and check each patient's chart before one o'clock to get this information, I found it was more effective for them to at least jot down these things next to the patient's name, and I had a sheet there ready to handover on. I leave it on the desk and they fill in the information [Int, 02].*

Other ward areas that used tape-recorded handovers found that the information being handed over was inadequate. These ward areas introduced a card system that had recorded particular physical-type patient information. These cards were stored in a folder and contained information on each patient's name, allergies, past medical history, medical diagnosis, and diagnostic procedures that were performed. These cards were discarded after the patient was discharged. Nurses used these cards to hand over patient information. The cards resembled the old kardex system that was used in wards prior to the implementation of the nursing process and nursing notes. When asked why the cards had been introduced, one informant replied:

*Yes, they've come and they've gone and they've come back. . . . The reason why these cards were reintroduced was because people were having problems giving adequate handovers, so they bought them in, it's a ward-based thing and they haven't been introduced across the hospital [Fobs, 05].*

There were many other mechanisms in place used to communicate patient changes. The number and different types of communication books varied across wards. For example, some wards had what they called a change book that had listed specific patient changes that had occurred from doctors' ward rounds.

*I've always had, what I call the Change Book and that book is actually what goes around with you on the rounds and I write down all the patients' names on the left hand side and then all the changes on the right hand side. Besides the things like ultrasounds, and colonoscopies, endoscopies, and those sorts of things, there's a place for them on the white board [Int, 23].*



Some other wards would also use the change book to communicate information that had been discussed at ward team meetings.

*When they go on this ward round they take a communication book with patient's names and changes for the day. It also communicates any information from ward team meetings [Fobs, 07].*

Each ward also had a folder or a book where they listed information on recent changes in hospital policies and procedures used in the day-to-day running of the ward.

*There was a nurse communication book on the wall where the nurses had handover. It was placed in a plastic container on the wall in the handover room. It also had the general day-to-day changes listed. There was a new assessment form being introduced on a trial basis [Fobs, 07].*

While there were many and varied strategies used to communicate patient information, nurses did not always access or respond to the information. This further led to the state of “*unknowing*”.

In summary, *Putting the pieces together: making sense* was the first phase of the basic social process. It involved the subprocesses of: drawing on the known, collecting and combining information, checking and integrating information and sustaining communication. In addition to this, nurses also tried to stabilise their work environment by trying to minimise uncertainty, this formed the second phase of the basic social process.

## **Minimising Uncertainty**

The second phase of the basic social process used to deal with the basic social problem of being in a state of “*unknowing*” was termed “*minimising uncertainty*”. This phase had three subprocesses that had no predetermined sequential order and could have occurred concomitantly. These subprocesses were termed: Adapting work practices, Taking control, and Backing-Up. As nurses worked under conditions of considerable uncertainty that were combined with the use of a fragmented communication process, some strategies were necessary in order to try and mitigate the effects of these contextual conditions and to enable patient care.

Nurses used many and varied methods to try to minimise uncertainty. Primarily, they appeared to adapt the way in which patient care was delivered and documented. These adapted strategies of care tended to differ from the espoused theories of nursing care. They also tried to actively take control of the situation by trying to minimise uncertainty and sustain communication. In order to achieve this, there were instances when nurses compromised their standards of care and focused on performing tasks. Furthermore, data revealed that some nurses justified these substandard methods of care in terms of trying to do their best whilst working under obscure and uncertain conditions that were compounded by a lack of time. Some strategies used by nurses to take control of the situation and minimise the uncertainty, at times, tended to reduce them to functioning at a prescriptive level, with little to no professional control over their work circumstances. Another strategy that emerged from the data, which was used to minimise the uncertainty, was nurses' resistance to change. It was perceived that this resistance to change was a method, used by nurses, of trying to take control of their work environment. Collectively, these strategies that were used to minimise uncertainty further perpetuated the conditions of uncertainty and led to a state of "*unknowing*".

### **Adapting Work Practices**

It was evident in the data that nurses used many and varied strategies to enable them to work under the prevailing work conditions of uncertainty. As one condition was not knowing whether they would have the time to complete all their tasks, adapting work practices was necessary in order to overcome this uncertainty, and to enable them to try to determine, and deliver care. Some strategies used were: juggling care, taking short-cuts, and trying to avoid interruptions. Nurses often had to adapt the espoused theories of nursing care to accommodate the contextual conditions of obscurity and uncertainty that prevailed within acute care ward settings. For example, the short shifts was one condition under which nurses had to adapt work practices to enable them to finish work on time.

*You're really rushing, you just take short cuts in order to finish on time. If you don't, then you stay back, I used to stay back all the time, but they forced me to go home on time. You know, you hate going off when you haven't completed all the work, it's frustrating, you just have to make do [Fobs Int, 06].*

Nurses who were rostered on the short shifts often had to adapt their practice in order to complete their tasks and finish work on time. They often worked unpaid overtime.

*I have to stay back 30 to 40 minutes to complete my documentation. It can take you about half an hour and by the time you get all the showers done, it's almost 12:45 and I have to get off at 1 o'clock [Fobs Int, 08].*

Other nurses had to take late lunch breaks in order to adequately staff the ward and give an accurate handover to the afternoon staff members. In response to a question as to why she went to lunch at 2 o'clock, this informant replied:

*Yes, it is easier that way, if I go to lunch earlier I miss too much and I'm unable to give an accurate handover [Fobs Int, 05].*

Within the context of short shifts and caretaker nurses looking after patients, nurses had to advise patients that they would have to ring a bell if they required attention.

*The new rostering does hinder patient care because I mean I've felt terrible I have to say to patients, "Look, I'm sorry, I have to go now", or you know "there's no one on for the next hour and a half, but do ring your buzzer" [Int, 12].*

Due to the lack of overlap time, there were instances when the strategies used were directed towards enhancing written communication. This was thought to minimise uncertainty. As the nursing care plan was the most frequently used chart, nurses tended to list patients' functional status assessment information on the nursing care plan instead of using the assessment form. Listing this patient assessment information on the nursing care plan was a very successful strategy that informed other nurses of the patient's status. This adaptation of the use of the nursing care plan was one strategy used to minimise nurses' state of "unknowing". The following excerpt from the field observation period provides evidence of this.

*I spoke to the afternoon shift coordinator and asked her why the nurses wrote so much patient assessment information on the care plan, for example, under the section "comfort" it had listed "turns self" and under the section "elimination" it had listed "voids spontaneously". She said that they wrote this patient information on the nursing care plan as it helped relieving nurses or nurses from another section to know what the patient was capable of doing if they had to attend to the patient at any stage. "If you look after someone else's patient then you know what the patient can do, for example, can they ambulate by themselves, do they use a pan. Sometimes patients are quite confused and they cannot tell you, and if you cannot find the nurse for any reason, then you know what to do by looking at the care plan" [Fobs Int, 01].*

There were many other strategies used to minimise uncertainty. Nurses often voiced concerns about having difficulties completing the documentation within the context of a busy shift. There were many other accounts found in the data, of nurses being unable to complete patient documentation.

*Well, ideally it should be done at the time [referring to documenting patient care], but once again that usually doesn't happen because there isn't the time when something is happening, to sit down and write notes. On night duty usually between 5 to 6 a.m., all being well, is the time for documenting case notes as necessary. I think during the day it's much more difficult because there is so much more going on [Int, 01].*

To overcome this problem of being unsure whether they would have time to complete the documentation at the end of the shift, some nurses completed certain routine documentation tasks early in the shift. Specifically, they signed the nursing care plan indicating that the care had been given prior to completing the care. Nurses justified this practice in terms of being able to complete the documentation while they had the time to do so, thus minimising the problem of uncertainty.

*A new registered nurse who was on an afternoon shift was completing the care plan, ticking that the work had been done. She saw me observing her and said "If I don't tick it [the nursing care plan] now then you never know what will happen. I may never get another chance. But I know I will give the care [Fobs, 01].*

Data revealed that the premature signing of the care plans occurred on all shifts.

*As I was going off the ward, I went to say goodbye to one of the nurses on the afternoon shift. She was ticking and signing the nursing care plan indicating that the care had been given. It was 1600 hours. This nurse was on duty till 2130 hours [Fobs, 02].*

In order to minimise uncertainty and expedite care some nurses bent the rules. On one ward there was a box of discharge drugs used to dispense drugs on the weekend and when there is no pharmacy service available. Nurses are authorised to give these drugs. Some nurses dispensed these drugs at other times.

*I give these drugs all the time because they're routine drugs, because otherwise the patients just waiting around for the doctor, waiting for the pharmacy and the drugs, this usually happens around 4 o'clock . . . around 4 or 5 o'clock if you try to get discharge drugs, it's very difficult . . . you're not supposed to do it, but I do it [Fobs Int, 02]*

Nurses rationalised some modified practice in terms of having no other option given the existing time constraints.

*Well there is so much to do, the drugs, obs, sit them up for breakfast, feed them. The ones who can feed themselves, well then you get their medications ready and leave them to have it. You know, what can you do? [Fobs Int, 03]*

As a result of this practice, it was difficult to determine with any certainty whether care had or had not been given. This was another factor that contributed to the state of “*unknowing*”. There were other instances where nurses tended to compromise professional standards and they justified these actions in terms of doing their best under the prevailing working conditions. Some nurses tried to fill gaps in information which included signing the medication chart indicating that the medication had been given, in cases where they had not administered the drug themselves. This memo written during a field observation period illustrated this point.

*During a bedside handover the nurse on the morning shift picked up the patient's medication chart, she asked the patient “have you had your Nilstat?” The patient said “Yes”, the nurse said “I didn't give it” the patient said “yes, the other nurse gave it”. This nurse signs the chart, indicating that the nilstat has been given. She continued with her handover [Fobs, 02].*

Additionally, nurses constantly improvised on the espoused theory (the technically correct method of delivering care) and tried to adapt it to practice in order to accommodate the condition of uncertainty and the time constraints within the work setting. One respondent's answer to a question on the clinical utility of university education illustrated this issue of nurses improvising on nursing's theoretical base.

*You improvise upon it, you improvise upon that knowledge, in other words, to the extent that time allows . . . you just don't have the time and that's most relevant to the care planning and the problem listing, and the documentation in general [Int, 18].*

Most hospitals had documentation policies that required nurses to document care at set times. It was found that nurses tried to meet these requirements and reduce the uncertainty of breaching hospital policy by writing some type of information in order to observe policy. As a result of this action, the quality of the information documented was substandard. Though these actions minimised uncertainty, they

added to the theory-practice gap. Once again, nurses tended to justify their actions by claiming a lack of time.

*I don't do anything like I do at Uni[versity]. You have about ten minutes to write your notes and you're tired and you want to get off duty, so you just follow what's written before you. The nursing diagnoses are written very simply, not like Uni[versity], but you don't usually get time [Fobs Int, 05].*

Experienced nurses also voiced concerns about the difficulties they encountered trying to implement the espoused theory of the nursing process, within the context of a busy shift. They stated instances when they were able to use the nursing process. However, these types of conditions were not achievable, on most occasions, in all ward settings.

*I think our paperwork reflects the nursing process. I don't believe that the nursing process is used by nurses in the way that "the creators" thought it was going to be used. I just don't think that we've got time. You know what you really ought to do is come on duty, look at the master problem list, look at the nursing care plan, read the previous notes--joke--it just doesn't happen, you haven't got time. If you've got a really ill patient on a one-to-one basis or a one-to-two basis, maybe, but not when you've got six of them, it just doesn't happen [Int, 24].*

Improvising and adapting nursing practice to reduce uncertainty also involved the nurses having to juggle tasks, in order to try and deliver total patient care for all their assigned patients. Under these conditions, certain tasks that were seen to be a priority were performed at a set time, thus reducing the uncertainty of not completing important tasks. Other tasks were performed as and when time permitted.

*You might look at what specific care they need, like what the doctors want you to do, so you might look at if they need a dressing or if they need their drugs or whatever. Usually though that's in the time frame, so they might be due at 8 a.m., so you might stand there and plan, say I'll do that, that and that and then maybe the doctors will come round in the morning, so you might not want them to have a shower or go off for their smoke or whatever they want to do before the doctors come. So you have those, you have your 8 o'clocks and then your 12 o'clocks [referring to medication times] and so in between them you want to fit other things in that you might want to do, so you might want to fit your dressing in between and then you've got to fit it in between their cup of tea and lunches. And then say if I had my four patients, one was going off to theatre, then I'd get them all sorted out first, so they're all ready to go and then for more important things yeah, so that, or maybe like a four hourly dressing I might do, get that over and done with first. I'd get the antibiotics up and done first and then other things like, I mean there's no hurry to have a shower so that can wait [Int, 06].*

Nurses tended to alter their own work time-lines and routines frequently in order to accommodate the changing work situation at the time.

*Well, we usually do the obs [observations] and the meds [medication] and then you actually get the patient out of bed for breakfast. But that might vary because if a patient is sick you might go and attend to them and get held up with the sick patient first off or alternatively if the breakfasts come then you might have to change the order in which you do things [Fobs, 07].*

Within this context, some tasks may not have been completed. The tasks that were usually omitted may have been patient care that was important for the patient's wellbeing.

*Maybe little things like if the patient hasn't been showered and then the patient says "Oh look I didn't have a shower this morning, can I have a shower". . . . Might **not** be little things for the patient, they may not be prioritised [Int, 12].*

As nurses were often interrupted within the course of a daily shift, they often stated that they adapted their work routines to try and minimise the number of interruptions. For example, it was hospital policy that the handover should occur at the patient's bedside. However, handovers were conducted in the corridor outside the patient's rooms. The reason why the handover occurred at the doorway was to avoid being interrupted by patients. One nurse's account of the bedside type handover provides information about this issue.

*Not quite from bed to bed, from door to door of each room. You rarely go into the rooms, because if you do you tend to get caught and nothing gets done . . . you sort of hover round the doorways, have a poke in [Int, 18].*

Another strategy used to avoid being interrupted was not answering patient bells. Very often when patients rang their bells and the nurses were busy delivering care to another patient she/he would complete the task prior to answering the bell. Additionally, during the handover period nurses did not usually answer the bells. Field work observations confirmed this occurrence. It was common to see patient bell lights on for some time before they were answered.

*At this time two nurses are in the rooms looking after the patients. There is a bell on in Room F and bell on in Room A. But there is no one around in the corridors to answer the bells, the coordinator is giving handover and the agency nurse has gone off duty [Fobs, 09].*

Nurses rationalised their decisions of not attending to patients promptly in terms of trying to avoid being interrupted.

*I try to get my work done and I constantly get interrupted. Patients want things now they don't realise that you've got so much to do. You know people spend hours waiting in a queue, yet they come into hospital and they want things now, really to be a nurse you have to be strong--mentally. It's not just looking after patients, they can sometimes be very demanding [Fobs Int, 03].*

Overall, nurses adapted some of their work practices to try and minimise their work uncertainty. Some strategies used were: juggling care, taking short-cuts, trying to avoid interruptions. At times, these adapted practices often breached professional standards and led to a theory-practice gap. Nurses rationalised their actions in terms of a case of having to improvise in order to get the essential tasks (patient care) completed.

### **Taking Control**

In addition to adapting work practices, it was found that nurses tried to minimise uncertainty by actively taking control of their work situation. Some senior nurses would try to minimise the work conditions of uncertainty by prescriptively telling junior and relieving nurses how to perform their work. Additionally, as nurse's work was inextricably linked to doctors' orders, they were constantly required to remind the doctors to perform their tasks. Specifically, nurses organised doctors in order to reduce uncertainty and to proceed with their work of delivering patient care. This role was sustained by nurses' motivation to actively control their uncertain work environment by reminding doctors of their tasks. In other instances, it appeared that some nurses controlled the conditions of uncertainty by resisting change. All these strategies were used to try and overcome the problem of uncertainty and to enable the delivery of patient care.

### **Controlling Care**

Nurses who were coordinating the shift were often called upon to account for situations where patient care had been compromised. Hence, in order to ensure that patient care was not being compromised and that the essential tasks were being



completed, shift coordinators tended to control the situation by checking and re-checking on junior and relieving nurses.

*Now, there's not enough staff, really the tasks are not being done, the beds are not being made, the patients are not having showers, the IV's are not given [referring to intravenous antibiotics], orderlies come to collect patients and they are not prepared for theatre. When you have agency nurses or new graduates they don't know what to do and you get caught. So I have to take measures and check, I have to check on them, so what I do is I check at about 7:45 a.m., I tell them, your patient is going to theatre at 9:00 a.m., have you caught up with your workload so that you will have that patient prepared at 9:00 a.m. [Fobs Int, 06].*

New and agency staff posed greater problems for some shift coordinators.

*If it's their first day and they haven't got a clue, well then you just give up as you know that you'll have to check on them all the time [Fobs Int, 02].*

Junior nurses also stated that the shift coordinators played a major role reminding them of patient care needs.

*I find that the coordinators are always reminding you and handover to you, this patient needs that this afternoon, coordinators are pretty good [Fobs, 01].*

It was found that shift coordinators used many strategies to minimise uncertainty and ensure that the care had been given. It was common for these nurses to give other more junior registered nurses specific instructions (short cuts) on how to work through the shift. This strategy was thought to minimise the level of uncertainty. However, the short cuts used tended to compromise professional standards of care.

*The registered nurse who was receiving handover constantly asked questions and clarified various issues with the shift coordinator. For example, one particular patient had leg ulcers which were soaked in a bowl with Potassium Permanganate. The shift coordinator told her to ensure that all the Potassium Permanganate crystals were totally dissolved as the crystals could burn the patient. The coordinator gave her helpful hints as to how she could streamline her work "I usually do these two dressings together soak Mrs X's while I do Mrs Y's dressing then I come back to Mrs X. Mrs's Y's wound is growing pseudomonas and the tulle gras should not be used on another patient". The shift coordinator discussed the patients' medications and what drugs needed to be given for each patient. She also told the nurse receiving handover what times to give the drugs to enable her to get off duty on time [these times were different to the times listed on the drug chart]. One patient, who was having BD antibiotics, had been given the antibiotics late in the morning, so the shift coordinator told this nurse to give the drug at a later time than it had been prescribed [Fobs, 01].*

Coordinators discussed the role they played trying to keep patient care on track.

*I believe that the coordinator has a great role in assisting that nurse, not necessarily just in a purely physical sense, but by running a smooth operation, that you don't run around ruffling feathers and causing havoc, that you understand exactly what's going on in the ward, so that you can shift work from somebody who's a little bit busy to somebody who's not quite so busy, that you keep things fairly on an even plain and fairly calm and organised. I think that's very very important. People who cause a big fluff, distress nurses and that's no good for good running. The other things is that if a nurse is getting a bit behind, that you can just go in there and do her IV AB's [intravenous antibiotics] for her, or her obs [observations] for her, and that'll just get her back on track before it becomes a real problem [Int, 23].*

On some occasions and where time permitted, some shift coordinators spent time orienting relieving staff and prescriptively telling them what to do.

*You know, you have to go through where the resus[resuscitation] trolley [is] and geographically where everything is on the ward and the fire escapes and then give them handover and then start them off on their routine, go down and show them who their patients are and then say, right I want you to do all the observations and then I want you to do the IV AB's [intravenous antibiotics] next, and then have somebody that they can refer to. . . . Then you've got to check up on them [Int, 23].*

As nurses were required to work with new, relieving, and less experienced nurses, they were also required to juggle their workload, reassigning tasks according to the skill level of the nurses.

*On this occasion, the shift coordinator was assigned two patients. However, she was rostered on duty with two other registered nurses and one agency nurse and one enrolled nurse. The agency nurse had never done graft care before so she had to take the agency nurse's graft care, but she also had to do the enrolled nurse's drugs, so she asked the enrolled nurse to do some of the agency nurse's graft care. . . . She said, "what we do is we re-assign and negotiate the load among each other, according to the level of expertise and experience of each nurse [on duty] [Fobs Int, 08].*

This reallocating of patient care encouraged a very task-oriented approach to nursing practice rather than a holistic approach as espoused by the theory. Specifically, the discipline of nursing upholds the view that nursing practice focuses on the patient as a whole. Driven by a philosophy of "holism", nursing care addresses patients' physical, psychosocial, and spiritual well being (Sarkis & Skoner, 1987). A task

oriented approach to patient care is in breach of this philosophy and it does not promote holistic care.

Overall, although nurses tried to lessen the uncertainty by adapting their practice, this also caused some problems. Specifically, some strategies tended to control nursing actions as they supported the delivery of physical care with little emphasis on the patient's psychosocial well-being. Another strategy used by nurses to take control of the situation and minimise uncertainty was to establish prompting mechanism that reminded them, and other staff members, of tasks that needed attention. This was thought to assist the process of minimising uncertainty.

### ***A Prompting Mechanism***

During the course of a daily shift, nurses were constantly interrupted; this tended to fragment the continuity of their work and their thought processes. Within this context, they often forgot about or missed performing certain tasks. To avoid this happening, some nurses had developed work practices that prompted and reminded them of these particular tasks that had to be completed.

Some nurses listed the particular tasks that needed to be completed on a paper hand towel, kept in the nurse's pocket, which was thrown out at the end of a shift.

*On a paper towel the junior registered nurse wrote the tasks she had to do. She said it reminded her of what she has to do. This nurse had placed the obs chart and the fluid balance chart half out of the main folder, it stuck out of the folder. I asked her why she did that, she said it reminded her that the patient was on a fluid balance chart and needed observation. "I saw night duty staff doing this and I found this helpful" [Fobs, 02].*

On other occasions nurses had developed a coding system in their own personal notes to assist them to promptly decipher the care.

*I have my own private handover book, I cannot remember all the patients' details so I write quite a bit of it down, to help me give handover. I also have a system of codes I use, like circles, stars and asterisks, indicating various things such as IV [intravenous] antibiotics and things like that, so I can look at the whole page and these things just stick out [Fobs Int, 07].*

In some situations, in order to avoid the uncertainty of some tasks being missed, nurses left informal notes in the patients' charts to alert the doctors of their responsibilities. For example, to remind them to write a new medication chart. Nurses were required to leave informal notes as they were unsure as to whether they would see the doctor.

*The patient's medication chart has a sign on it "Doctors please write up a new chart". I asked the nurse who put that sign on, she replied the shift coordinator. This shift coordinator passes the room and said "oh yes I'll grab him now [referring to the doctor] he is sitting right there in the office". She takes the chart for him to complete [Fobs, 03].*

In order to save time and remind themselves of medications that were due, some nurses placed these drug charts in the office.

*When I take handover I grab the medication charts that need doing and I keep the charts in the duty room so I don't have to go and check all the charts again [Fobs Int, 02].*

Data revealed that nurses were often required to check not only on each other but also on doctors and other health care team members. Nurses' work relied heavily on these groups of professionals to complete their tasks before they could proceed with their own tasks. In addition, as nurses were the only health care professional group who oversaw patient care over the 24 hour period, they were required to act as the organisers of patient care. Nurses often voiced frustration at having to continually remind and organise the medical staff.

### ***Organising the Doctors***

As nurses' work relied heavily on doctor-prescribed care, within the context of a day-to-day shift, nurses were required to remind doctors to fulfil a number of tasks to ensure continuous patient care. A conversation with a Clinical Nurses Specialist revealed the following:

*Nurses phone doctors to remind them to order the pre-meds, to remind them that the biochemical results are not what they should be and to order the consequent treatments, to tell them that after a certain procedure they need to order an x-ray, to tell them to order the IV [intravenous] fluid regimes, to tell them to order the discharge drugs, to actually remind them that they need to see a patient [Fobs Int, 05].*

The issue of nurses having to remind doctors to complete their tasks occurred constantly in the data.

*You ring the doctor up usually if you are concerned about a patient to order IV [intravenous] fluids, to order IV [intravenous] antibiotics, order pain killers, a relative would like to speak to the doctor, the consent has not been filled in, the pre-med has not been completed [Fobs Int, 07].*

Another example of nurses having to remind doctors to perform tasks is as follows:

*Besides a patient might need admitting or whatever. If they're planning to discharge a patient you have to remind them to write the discharge drugs, you know, so that you can get them up the day before, instead of hanging around for ages, those sorts of things. But those acute things and then there's heaps and heaps of other things as well [Int, 23].*

When asked a question about why nurses chase the doctors to perform these tasks, one informant's reply supported the claim of trying to minimise delays or interruptions to patient care.

*So it's really the doctor's responsibility to make sure that all x-rays and tests and everything . . . it's really their responsibility to make sure that they're there. It's not your job. So, we were discussing why we thought that was our responsibility. I think really I guess we feel responsible for the patient and we sort of don't want to hold the patient up although we know it's not our job we don't really want to hinder the patient's progress through the system. You know, why should they suffer because of inefficiencies elsewhere in the system. I think we sort of have this maternal protective thing [Int, 24].*

In order to address this problem of having to chase the doctors to complete their tasks, some nurses would write a list of tasks on the white board in the doctor's office and leave the required charts that the doctors needed to complete.

*I write on this white board tasks they have to do in the morning, and I put a whole pile of med [medication] charts, IV's [intravenous charts] that need writing up, in front of them [referring to the doctors] [Fobs Int, 05].*

Nurses voiced concerns that doctors had not communicated the patient care changes to them. To avoid this happening, they used to accompany doctors on the rounds in order to know the changes in patient care.

*There are usually one or two doctors who come in after their surgery hours so you're not bound to accompany them, but if possible it's better because you really*

*know what's going on and they don't come in and shoot through and you don't know what's really going on [Int, 02].*

Furthermore, nurses had to look out constantly for the doctors in order to ensure they attended the ward round and were aware of the changes. One Clinical Nurse's response to a question on how she prioritises her work in the morning alluded to this issue.

*Usually the main thing is to keep tabs on the doctors to see when they come on the rounds, so you can go on the round and get an update of what is happening . . . then you write the changes down in the communication book or you go and find the individual nurse and tell them what is happening, and that way you keep everybody happy [Fobs Int, 07].*

Nurses stated that they had to juggle their work loads in order to accommodate the doctors' rounds and to ensure they were aware of all the changes.

*In the nurse's office, the shift coordinator is getting the ward round book ready, she is writing all the patients' names down. I asked her what she was doing "well I have to get ready, I may have to go from team to team,[referring to the medical consultant, registrar, and resident] sometimes both teams come at the same time, then I have to run from team to team at the same time [Fobs Int, 04].*

Some wards had more than five teams. As these doctors' rounds were unplanned and they arrived at the ward at any time, on some occasions nurses had to accommodate the doctors in order to keep up to date with the changes.

*It is 9:10 a.m., the doctors came on the ward and commenced their ward round. I was speaking to a registered nurse at the time she said "great the ward round without the shift coordinator!" The coordinator had gone to tea. This nurse walks down to the office and gets the ward round book and goes on the round. The second team of doctors arrive and go on their round, the nurse then goes with the second team as they start in room A. The first team continued the round without the nurse [Fobs, 04].*

The role senior nurses played by attending ward rounds was not fully acknowledged. Having senior nurses accompany the doctors on the ward rounds was very beneficial for patient care, as they would draw the doctor's attention to certain patient abnormalities or needs.

*Well the nurses with them on the rounds will generally speaking, draw his [the doctor's] attention to any abnormalities that are not routine, OK, that three litres has come out of the naso-gastric tube, or that the patient's potassium is 3.1 because the resident forgot to look it up this morning, or that the patient's*

*febrile, if he hasn't quite noticed it, or that the negative balance on the fluid balance chart is three litres and we need some more IV [intravenous] fluids because that's why the urine output's down [Int, 23].*

In instances when junior nurses accompanied the doctors and they did not draw their attention to these issues, treatment was delayed. When further asked the question, what happens when a junior nurse goes on the round and she does not ask these questions the respondent replied:

*That does happen [long pause] all of those things get delayed [Int, 23].*

Instances when the nurses were unable to attend the doctors' rounds, they were required to check later with the resident doctor or the patient to determine the changes. Furthermore, on some occasions, nurses would also have to check the patient's medical notes in order to ascertain whether the doctors had recorded their verbal orders in the patient's medical notes. In addition, they had to check the notes to see whether there were any new changes to patient care that had not been communicated to the nurse.

*The shift coordinator goes through all the patients' medical notes at this hour, checking the notes to see that she was aware of the changes that have been made, and that the changes to patient care that have been made verbally, are recorded in the patient's medical notes. Instances where the changes are not documented, the shift coordinator pages the doctor of the particular team and asks him to update the medical notes. The shift coordinator told me that they do this for medico-legal reasons [Fobs, 07].*

Nurses had to check to see that the order had been officially recorded, as they may have delivered patient care that had not been formally prescribed.

*For example, the doctor writes in the handover book, apply skin, [this is a skin graft on a plastics ward] we can apply the skin no problems, but then he has got to come and actually write it in the medical notes [Fobs Int, 08].*

In some private hospitals, nurses recorded all the changes to patient care for the doctors.

*Yeah, actually at the hospital I work at . . . the medical staff don't write medical notes, the nurse who does the round writes the notes up for whatever the doctors do [Int, 25].*

Some nurses resequenced the order in which they performed their tasks to ensure that the patient observation information that was required by the doctors was available prior to the medical ward round. Under these conditions, nurses had to prioritise their work as being less important than the tasks required by the doctors. One nurse's account of how she goes about her work routine illustrates this point.

*Yes I do my meds [medications] and obs [observations]. [I asked her whether she looked at the nursing care plan at this stage she replied] No because the doctors come on their round and they look at the obs chart--so you need to have them done [Fobs Int, 03].*

Data revealed that on some occasions, nurses did not always insist that medical staff follow prescribing protocols. They turned a blind eye to the protocol and administered incorrectly prescribed medications.

*One of the policies when I have been working with students is that if IV [intravenous] antibiotics have been given for 48 hours that they are then to be ceased and represcribed after reviewing. . . . And I know I've gone to draw up IV [intravenous] antibiotics with students and the cease by date hasn't been filled in and it hasn't been filled in as a date to be reviewed either. And there's been IV antibiotics and they've been given for longer than 48 hours and I'll say to the registered nurse who's asked us perhaps to give the antibiotics, I said look I can't give this with a student because it's your hospital's policy, dah, dah dah. And occasionally, they grab the chart off me and sort of walk around until they've found a doctor who will sign it, a review by date and then like they sort of give us back the medication chart and say there you go, you can give it now. I do know that prior to that, . . . it's well and truly past 48 hours, so they're medication errors. But, I mean it's a political thing how you see medication errors and in my personal opinion I don't see that as a nursing medication error, I see that as a medical officer's prescribing error of which the nurse once again takes the flack for [Int, 22].*

Within the context of an acute ward setting, doctor-prescribed physical care appeared to be the major focus of care. As nursing care was doctor driven, nurses were forced into this type of role, organising the doctors, in order to complete their work in a safe and legal manner.

### ***Resisting Change***

Another strategy used by nurses to minimise uncertainty was being resistant to change. As nurses worked under conditions of immense change and uncertainty,



which they were unable to control, resisting change was found to be another strategy used to minimise this uncertainty and stabilise the work environment. Resisting change was a very prevalent factor found continuously in the data. It was suggested in the data that this resistance to change stemmed from a motivation to reduce uncertainty and control their work environment.

*They [nurses] resist change because they like doing what they feel familiar with, what they feel comfortable with [Int, 32].*

Nurses often voiced concerns that making changes in their work environment was a very difficult task to achieve.

*It is very hard to make changes in the area. I have completed my degree and was anxious to make changes, however, my changes were resisted and even blocked. They just don't like what you do. [When further asked the question--How do you know that they don't like what you do? this nurse replied] You just know, they are silent and they just don't talk to you [Fobs Int, 01].*

Some nurses perceived that the nurses who were trained under the hospital, apprenticeship-style scheme were more resistant to change.

*Nurses who have trained in the old system and who aren't accepting of the changes that are going on, I think also hinders nurses, you know, "oh that's stupid why are we doing that?" . . . "that's not the way we did it in the old days", "the old charge sister would never have gone for that". I've heard a bit of that lately [Int, 04].*

Additionally, when nurses had been in ward areas for a long period of time they were said to be more resistant to change. When asked a question on how difficult it was to implement changes, the staff development nurse replied:

*This is very difficult here, it's been very difficult and nurses on this ward, some of the nurses on the ward have been here a very long time and what they say is "I've seen it all before, been there, done that, it's not worth while". Some of the best practice strategies are difficult to implement. One of the Clinical Nurses has been here 17 years and is part of the furniture, they are the gate keepers, . . . so they tend to be very resistant. We can implement some change, but we are not here 24 hours a day so, therefore, the ones who are here 24 hours are more able to influence and have a greater effect on change [Fobs Int, 7].*

Furthermore, other nurses supported this view. However, they felt the resistance to change was more widespread and difficult to explain.

*I still think that nurses do a lot of things just because that's the way they've always been done. Especially in some particular area if you've got staff who have been there for a very long time and they've run the ward their way, it can be very hard to change the system. I worked on a ward that tried a split showering regime, it was a very busy surgical ward with lots of immobile patients because it was orthopaedics. And they trialed a policy of doing 60/40 showers, so you did 60% of your showers in the morning and 40% of them in the afternoon. And it didn't work, because the mentality of the staff was everyone should be showered in the morning. No matter how hard we pushed. I suppose we were all guilty of it to a degree, you came on [in] the afternoon and you thought, I really don't want to do a shower. It was basically a mental block, there was absolutely no reason why the work load in the afternoon prevented you from doing a shower, but it was just a mental thing [Int, 07].*

Other nurses presented views that alluded to the generalisability of this trait and provided evidence to support the claim that it may be linked to the issue of nurses trying to minimise the condition of uncertainty by controlling the number of changes. One informant's response to a question on resisting change highlights this point.

*Sometimes it's the older ones, but sometimes it's equally, you'll find, the young ones. I don't know, it's difficult, I mean to say well I think, to say it's the hospital trained nurses isn't fair because there are a lot of them who have moved with the times or moved forward and are quite happy to. And some of the university ones are equally bad. So you can't say it's any one. Sometimes it's their personality, or it's the fact that the documentation, I mean our documentation, the policies on documentation are changed constantly which could make it very difficult to keep up [Int, 07].*

Under these work condition of immense change, nurses would read the prescribed changes but did not always convert these changes into practice. A conversation with a Clinical Nurse Specialist alluded to this issue.

*Well really the memo went around, but whether or not nurses take in the memo of the changed practice, and actually make the changes in the practice is questionable. [Fobs Int, 05].*

As nurses tended to be very resistant to change, although new policies and procedures were put in place, the level of implementation would vary according to the nurse's level of resisting change.

## Backing-Up

Within acute care settings, there was said to be unwritten rules of practice. One of these unwritten rules of practice was backing-up or alleviating mistakes. It was found that as some work practices were adapted in order to minimise the uncertainty, some professional principles of practice were compromised. As a result of this, some errors tended to occur. Errors that were judged as not having grave ramifications appeared to be smoothed over or covered up. Given the difficult conditions under which nurses worked, no nurse was immune to making errors. Hence, staff were often vigilant of each others work and backed-up each others work thus alleviating or minimising errors. This practice, however, further contributed to and perpetuated the state of “*unknowing*”, as these strategies used to deal with errors were also categories that led to the basic social problem.

A discussion with an informant about this issue revealed that in some instances nurses and doctors backed-up each other when errors occurred.

*Yeah, I haven't found any antagonism and I mean everyone makes mistakes and in my experience so far, doctors have been perfectly tolerant towards our mistakes and visa versa [Int, 18].*

The types of mistakes made that were smoothed over or covered up were said to vary in severity and type. One example of backing-up is as follows:

*The pharmacist walked in with a box of about ten tablet bottles. She said that she found them in Pt x's drug locker. They actually belonged to a patient who was transferred to Hospital B the previous day. The shift coordinator said that an agency nurse had organised her discharge and she should have sent it with the patient. All the nurses look at each other. The shift coordinator rings the registered nurse who liaises with Hospital B asks her to come up and organise for the drugs to be sent to Hospital B [Fobs, 04].*

Further theoretical sampling revealed many anecdotes of this type of cover up or smoothing-over treatment errors.

*We were in handover this morning and someone had put on the wrong dressing and . . . the other registered nurse was told to do the dressing instantly and to scrape all the evidence of the duoderm gel so that no one would know that it was the case. Yes, it was because there was an error when the dressing was made and it wasn't going to be revealed [Fobs Int, 05].*

On some occasions, nurses forgot to give certain medications which did not provoke a response from other nurses. This indicated that some nurses were used to these type of mistakes. The following handover report provides evidence of this.

*[Patient 7] states medical diagnosis, carotid angio [angiography] yesterday, peripheral pulse fine, didn't get the GTN [Glycerin trinitrate] patch last night and didn't realise till the morning. . . . [the registered nurse listening to handover said] oh yes I forgot to put it on [referring to the GTN patch] handover continued [Fobs, 04].*

The data showed that medication errors were the most frequent type of error that was smoothed-over.

*I can remember reading in one of the patient's notes that their drug, I forgot now what drug it was, but their drug that was meant to be withheld for 24 hours in fact wasn't withheld for 24 hours, it was given. And that was written in a very convoluted fashion in the patient's notes. Nothing was handed over to us about it. There was no entry in the doctor's medical record about it. Like it was almost as if it had been entered in the nursing notes and that was the end of it. I don't know if there was an incident report filled out, but I would have assumed if an incident report was filled out that there would also be part of the entry in the medical record nursing notes [Int, 22]*

A conversation with another informant revealed that, when patient's medications were missed, nurses did not always report this issue to anyone else. Nurses appeared to discuss this issue among themselves and decide upon a strategy. The ensuing actions depended on the drug, the time the error was discovered, and the possible ramifications of their actions. The strategies used may not always have been documented. According to this informant, the short shifts where nurses finished duty at 1300 hours or 1330 hours further exacerbated the problem of drug errors. On some occasions, nurses gave the medications which were due at 1400 hours before they went off duty. Other nurses left the drug to be given by the nurse who was taking over from her/him. In some instances, this nurse may arrive on duty at 1500 hours. This variation in practice caused further drug errors.

There were also accounts of nurses backing-up doctors. A good example of this is as follows:

*[As part of theoretical sampling, I asked one informant whether doctors and nurses covered up errors she replied] "Yes". [I further asked her to give me an example of this occurring, she stated the following:] " Very recently there was a*

*trauma case, this patient had surgery and had been in the ward for a number of days. This man had an abdominal drain that had been consistently draining around the drain site, however, the bag on the end of the drain was empty. A few days later one nurse checked the tip of the drain and realised that it had never been cut so the end of the drain was never patent. The senior nursing staff discussed this issue, however, neither the patient or anyone else was told about this matter. This incident was not documented in the notes". [This informant told me that the patient's abdomen was very distended throughout this episode] [Int, 32].*

Additionally, it appeared that in some instances doctors and nurses blamed each other for errors.

*And often there's demarcation disputes over who's responsible. . . . For example, I had a patient for a long time on the surgical ward who had many many problems with . . . [her/his] tracheostomy care over a long period of time and . . . developed a pulmonary embolus, and . . . was on Heparin infusion. . . . [He/she] subsequently some days later went for a routine tracheostomy change and . . . had a serious bleed because . . . [he/she] had been on this heparin and no one had kind of taken this into account, because . . . [he/she] had this difficult trachy change where the nurse had tried to put in one size too large, so that ended up with both sides blaming the other, you know, the nurses were saying you know "Well, you should have known this person was heparinised" and visa versa. But that's unusual in my experience [Int, 18].*

The environment under which nurses worked was extremely uncertain. This resulted in the basic social problem of being in a state of "*unknowing*". Within this context some errors occurred. Nurses were required to back-up each others work and to remedy or minimise errors where possible. Hence, backing-up was one subprocess used to minimise the uncertainty surrounding making an error.

In summary, nurses tried to minimise uncertainty and stabilise the work environment in order to overcome the problem of being in a state of "*unknowing*". They used three main subprocesses. These were: adapting work practices, taking control, and backing-up. Collectively, these strategies were enacted to enable the delivery of patient care. While the prime intention of the process was understandable, it appeared to have inadvertently fostered an environment of professional malaise and an emphasis on getting the tasks done. Some nurses voiced extreme frustration about the situation, while others displayed an attitude of resignation. As nurses were subjected to working under these conditions over a sustained period of time they became professionally disillusioned.

## Professional Disillusionment: Consequence of Working Through Obscurity and Uncertainty

Data from this study revealed that as a consequence of trying to work under difficult conditions of immense uncertainty, coupled with a serious lack of time, some nurses became professionally disillusioned. One informant voiced concerns that, although nurses worked hard, they were unable to deliver appropriate care due to a lack of time. This caused them to feel professionally dissatisfied.

*I think that nurses probably run themselves ragged to give that care, but at the end of the day they are not satisfied because it's been so rushed and the care's been task oriented [Int, 26].*

The lack of time was problematic in multiple settings and nurses were genuinely concerned about the effect this had on patient care and staff morale. Within this context, the prevailing working conditions had limited and controlled nurses' work practices to an extent where they were unable to talk to, and spend time with, patients who needed the care.

*I guess a lot of it is time too, we don't really have the time sometimes to really talk to all our patients. I'm sure a lot of them must be very anxious, but we're sort of so busy. I mean I think we do quite a good job considering. . . . But I actually sometimes think it would be just nice to have that luxury of that extra person, just for the patient and for the staff, I think for staff morale just to sort of help out or yeah, just ease the load a bit. To give people more time with the patients. So that for me is one thing that hinders, you know, you just know you haven't got all the time to spend on someone, that really needs it [Int, 24].*

Other nurses explained this lack of time as being a function of the short shifts which resulted in nurses concentrating on achieving the tasks. Under these conditions nurses had no time to discuss ideas with one another. This was thought to retard nurses' professional development.

*One of the major problems nowadays is the short shift. . . . Because there's less time for handover, nurses have less time to discuss their ideas with each other and less time to reflect on what's happened during the day. . . . I think the tasks are still done, but I think that the nurse can't take back her reflective practice if you like, back to the work setting because she doesn't have time to do it, probably her development is not as advanced so, therefore, I guess in general terms, the patient misses out because the nurse is less developed than she could be [Int, 26].*

It appeared that within this context they were unable to observe professional standards. Some nurses dealt with this disillusionment by reducing the number of hours they worked.

*I used to work permanent full time, but I don't do this any more. I've worked in nursing for 30 years, I used to love my job, but now there's too much stress. I don't need the money, I like the peace of mind and so I reduced my hours to four days a week [Fobs Int, 06].*

Other nurses felt emotionally upset about the situation.

*Well there are periods where it's very busy and just not so long ago, we had a lot of very junior staff to the extent where I could just not get off the ward, that was a problem, I was so stressed, I just went into the loo [toilet] and I sat there and cried [Fobs Int, 07].*

Additionally, it was common for nurses to say that their work environment affected their sleep patterns.

*I think on the afternoon shift people are usually OK because they've had a sleep in or whatever, but come sort of by lunch time the next day, people are starting to get a bit, you can just see they're just a bit tired. A lot of the girls actually have problems sleeping when they go home at night, you hear them saying I didn't fall asleep for ages. Or if it's been a particularly busy shift, the waking up at 3 and 4 a.m., in the morning and particularly if you're coordinating and you're working out what you have to do in the morning and that sort of thing can happen [Int, 24].*

This issue of constantly working under difficult conditions caused some nurses to withdraw professionally. This appeared to manifest itself in a lack of commitment to attend professional further education. When asked a question about the reasons why nurses did not want to participate in professional development, one informant replied:

*I believe that while time is a problem, getting the time to actually go there, it's more than that. What the health cuts have actually done is they've made nurses apathetic to professional issues, because they continually ask the question. "What's the use, even if we get more knowledge then can we use it, and then if by getting more knowledge if we ask critical questions of the doctors then we just get ourselves in hot water". Really all we have to do, is work more and more, with less and less resources. Nurses see no benefit in doing this [Fobs Int, 10].*

This disillusionment and the sustained condition of being unable to deliver professional care resulted in the care being compromised. Some nurses argued that nurses had the necessary knowledge. However, they tended not to use it and

conformed to substandard practices that were used. A conversation with a Clinical Nurse Specialist revealed the following:

*I said to this nurse, "can you please clean up that IV [intravenous] site because it's quite important that we look after it". This nurse then just proceeded to go about pulling the IV [intravenous] site down and she did not use an aseptic technique. This is an example where they have the knowledge, but they don't tend to use it in their day-to-day application, where they become so task oriented. You know, it's just so amazing, we have these nurses coming out of university with all this knowledge now, but they just tend to settle in and do what they are told to do and instantly their theory goes out the window. They don't set an example, they just follow . . . maybe they follow because they want to fit in with the organisation [Fobs Int, 08].*

The previous view was supported by other nurses who voiced concerns that, in general, nurses tended to deliver care to meet the minimum requirements of achieving the basic tasks and not observing professional principles of practice. When asked a question as to whether nurses actually planned patient care through to discharge, this informant's reply illustrated this issue. This informant held a middle management position.

*We do it, but it's all extrinsic for policy, they see the work for the hospital, not for themselves, they will not put in extra time or effort. Everything they do--we have to provide study days for example. Other professions don't do this, they don't get study days, nurses don't attend study days for three to five years sometimes and they have continued to instruct junior nurses to do things that have been outdated [Fobs Int, 05].*

There were many examples that emerged from the data that illustrated behaviours of nurses' withdrawing professionally. One staff development nurse's account of the difficulties she faced trying to get nurses to complete the wound management plan form provides another example of this situation.

*We have huge problems with the wound management plan, it's a real source of annoyance, they don't complete it. When the form was shorter it was better and was completed more thoroughly, but now that they've lengthened the form so that nurses can start to make more judgments about the wound, they tend to be more incomplete [Fobs Int, 07].*

Many nurses complained that their colleagues blindly followed doctors' orders and did not question the appropriateness of their prescribed patient care. Generally, the



data revealed that nurses were delivering prescriptive care without much professional thought.

*I find that nurses don't take an active role in the decision making and are more passive to the process. In that, a nurse came to me and said patient X is going home and I asked her do you think this patient should be able to go home. The nurse said I really don't know, I haven't looked into it, but the doctor said she could go home [Fobs Int, 08].*

Some nurses explained this behaviour in terms of nurses being frightened to make these decisions for legal reasons. Given the levels of uncertainty under which nurse functioned this action could be well justified.

*Sometimes I get a little bit frustrated, that nurses don't use their own initiative. They should use their initiative more, but what nurses tend to do is to wait for doctors to tell them what to do. I'm not sure whether this was an issue related to medico-legal things or whether they were just frightened to make changes [Fobs Int, 08].*

Generally, this disillusionment impacted on some nurses' motivation to stay in nursing. One informant's reply to a question on whether this impacted on care explains this issue.

*I think it does because I mean again staff say things like "Oh, I'm just going to get out" and "I've had enough". "I'm going to move and do something else until things settle down". That sort of thing I think it's more staff morale [Int, 12].*

Some patients also voiced concerns about the care. However, they perceived the problem to be nurse oriented rather than being due to the difficult conditions under which nurses worked. One informant, who was a Director of Nursing, had been recently hospitalised for elective surgery; she had been hospitalised for a total of six days and provided many anecdotes of substandard nursing care which left her feeling very disappointed. This is a collection of some of her comments.

*My impression was anybody could've done this job . . . I had no nursing care plan, no critical pathway. . . . I had no explanation of what to expect post op. . . . No one asked me about my pain, as I was self-medicating, I only saw a nurse when she took my temp. . . . I think it's because the old Charge Sister has gone, the old Charge Sister ensured standards. The whole profession has lost its way from my perspective, as a nurse looking at nursing [Int, 31].*

Another nurse offered other reasons as to why patient care was sometimes compromised.

*It depends on the busyness of the ward, the situation at the time, and it depends on the nursing staff at the time, people come in and bragged about the treatment they got when they were in hospital, yet others have complained that they haven't, it depends on the situation at the time I think. Yes and how much time the nursing staff can delegate to each patient [Int, 01].*

In general, the prevailing work conditions had stifled nurses' ability to deliver holistic care and had caused them to become professionally withdrawn and disenchanted. Nurses in management and staff development positions viewed this issue differently. They stated that their substandard levels of care stemmed from nurses' own lack of professional commitment rather than as a function of their work contextual conditions. In order to minimise the uncertainty of further errors occurring, nursing management introduced more policies or changed documentation practices. These changes tended to further limit nurses' professional autonomy and controlled nursing practice, thus reducing it to a series of prescriptive orders and tasks. This seemed to exacerbate the existing problem and led to nurses becoming more disenchanted with their working conditions and professionally disillusioned.

## Conclusion

Overall, the basic social process used to address the basic social problem of being in a state of "unknowing" was: *Enabling care: working through obscurity and uncertainty*. In order to work through the obscurity caused by the use of a fragmented communication process, nurses had to make sense of what was happening in their work context. This involved drawing on what was previously known, collecting and combining information, checking and integrating information, and sustaining communication. Alongside this, nurses tried to stabilise their work environment by minimising uncertainty. This involved adapting work practices, taking control, and backing-up. Although these strategies assisted this process, it also encourage the practice of taking "short cuts" and promoted a focus on task-oriented care. This encouraged an environment where meeting minimum requirements became the norm. Nurses voiced concerns about this issue. However, they were unable to alter their

work milieux and deliver care in the way in which they had been educated. This resulted in some nurses becoming professionally disillusioned.

## **Chapter Five**

### **A Grounded Theory of the Clinical Application of the Nursing Process**

#### **Introduction**

The purpose of this study was to discover the process that nurses used to determine, deliver, and communicate patient care in acute ward settings and the contextual factors that impacted on the process. More specifically, using grounded theory methodology, it sought to describe and develop a substantive theory that explained the way in which the nursing process was being used in clinical settings. The theory had as its foundation the basic social problem experienced by nurses who espoused to use the nursing process and the basic social process used to deal with this problem. In order to address the study objectives, data were obtained from interviews with nurses who worked in acute hospital settings, participant field observations conducted within ward settings, and in-depth analysis of patients' medical records. Relevant newspaper articles and local documents published during the study period were also used as data. Theoretical sampling procedure led to patients and patients' relatives being interviewed. Data were also obtained from informal interviews conducted with key informants and discussions with postgraduate nursing students. These data were analysed using constant comparative analysis. This was combined with the process of memoing, diagramming, and maintaining theoretical sensitivity. The grounded theory method of open, theoretical, and selective coding was used to develop the theory (Glaser, 1978; Irurita, 1996c).

While the purpose of the study was determined prior to the commencement of the study, early analysis of data revealed findings that required further investigation and exploration. This further data collection and analysis revealed a basic social problem that was also classified as the core category. The basic social process used by nurses to address the core problem was also discovered. Based on the findings of the study a substantive theory on the way in which clinical nurses in acute care settings determined, delivered, and communicated patient care was developed. This grounded theory will be described and illustrated in this chapter.

Analysis of the data revealed that nurses in Western Australian acute care hospital settings experienced a basic social problem of being in a state of “*unknowing*”. There were two major domains of “*unknowing*” (1) as applied to providing patient care, and (2) as applied to nurses’ job status and state of the nursing profession. The state of “*unknowing*” had two main conditions, which were: the existence of a fragmented and inconsistent method of determining and communicating patient care; and working within a fluctuating and uncertain context. As a consequence of working under these conditions, nurses in this study felt personally and professionally compromised. Additionally, these conditions sometimes led to the delivery of substandard care that compromised patients. Being compromised, therefore was the outcome of the core problem. The basic social process used by nurses to overcome this problem was: “*Enabling Care: Working through obscurity and uncertainty*”. The basic social process had two interconnected phases that occurred simultaneously. These two phases of this process were: (1) Putting the pieces together: making sense and (2) Minimising uncertainty. As a consequence of constantly working under these difficult conditions, over a period of time, nurses became professionally disillusioned. This chapter will describe the developed grounded theory and will provide accompanying schematic representation of the discussion to highlight the linkages between the identified categories. For an overview of the theory see figure 5:1 on page 184.

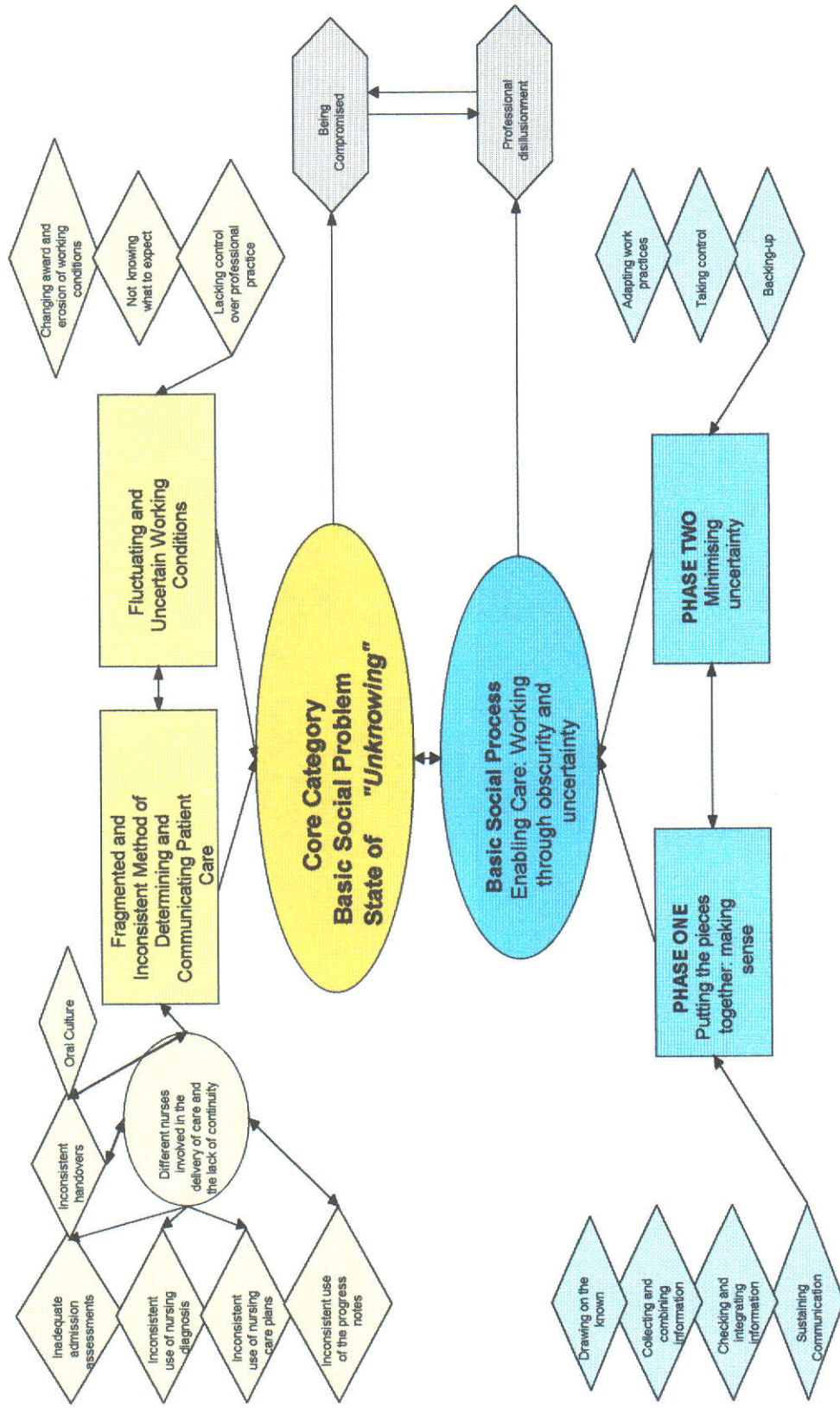


Figure 5:1 Grounded Theory of the Clinical Application of the Nursing Process

## **The Core Problem: Being in a State of “*Unknowing*”**

Nurses in this study had to deal with the basic social problem of being in a state of “*unknowing*”. This problem was defined in the following way in Chapter Three:

Being in a state of “*Unknowing*” as experienced by nurses in this study, was a state of uncertainty and doubt where nurses found themselves in an obscure situation. They were unable to determine with any certainty what would happen within the context of a daily shift. Additionally, they were uncertain about specific patient nursing care needs. It seemed that the system in which they worked hindered and constrained them from knowing the patient and their specific nursing care needs and being able to deliver care in the way in which they had been professionally educated. In summary, the overall situation could be compared to the metaphors: “trying to work blind folded” or “trying to work in the dark”.

There were two main conditions that emerged from the data that led to the state of “*unknowing*”. These conditions were: (1) working in a system that had a fragmented and inconsistent method of determining and communicating patient care, and (2) working under fluctuating and uncertain conditions. These two conditions were prevalent in the work environment and provided the contextual conditions that fostered the basic social problem.

### **Fragmented and Inconsistent Method of Determining and Communicating Patient Care**

The first condition of working in a system that had a *fragmented and inconsistent method of determining and communicating patient care* was characterised by the following properties:

- Inadequate admission assessments
- Inconsistent use of nursing diagnoses
- Inconsistent use of nursing care plans
- Inconsistent use of progress notes
- The use of a number of different charts and forms
- Inconsistent handover of information
- Oral culture
- Different nurses involved in the delivery of patient care and a lack of continuity.

Each of these properties was caused by a number of contextual conditions and intervening variables. Each property and the influencing contextual conditions and

intervening variables, as described in the previous chapters, will be discussed in the following pages.

### ***Inadequate Admission Assessments***

Though patient assessment is espoused as being foundational to patient care, nurses in this study were often unable to conduct thorough admission assessments and hence were unable to determine and know the patients' specific nursing care needs in a meaningful way. There were a number of factors that led to this outcome. These factors can be broadly classified as being contextual conditions, nurse factors, and patient factors. A combination of these three causal factors led to inadequate admission assessments being performed.

#### **Contextual conditions**

There were many contextual conditions that hindered nurses from performing adequate admission assessments, one being the time of day the patients were admitted. Specifically, it was difficult to conduct an admission assessment if the patient arrived on the ward when the nurse was busy and unable to devote time to complete this task. In particular, conducting admission assessments was difficult to perform when patients arrived on the ward at the end of a shift or during shift changeover times. During these times, nurses were usually quite busy completing tasks, documenting care, and handing over to the next shift of nurses. Furthermore, there was an unwritten code of practice that required the nurse who started the admission assessment to complete a set amount of the patient's documentation. When patients presented at the end of a shift, nurses were reluctant to handover the assessment to the nurses commencing duty. As a result of this factor, they conducted hasty, incomplete assessments. Furthermore, conducting an assessment during the night was also found to be difficult as the increased noise and having the lights turned on often disturbed other patients. Due to all these factors, nurses were reluctant to perform assessments at this time. Additionally, allowing the patient to settle into the ward took precedence over completing the admission assessment. In the early hours of the morning, on a night duty shift, nurses were unable to complete these assessments as they were busy doing a number of tasks that were seen to be a



priority at that time. Some of these tasks included doing the medication round, dressing patients' wounds, and completing vital sign observations. Furthermore, there were usually fewer nurses rostered on duty at this time and the focus of care was on getting routine tasks done.

Additionally, hospitals' documentation policies influenced the efficacy of the assessment process as they prescribed the type of information that needed to be collected and the time frame by which this assessment was required to be completed. Some nurses found the assessment form limiting as the information they required to plan care was not listed on the chart. Other nurses found the data collected to be unnecessary for nursing certain types of patients. Another factor said to influence this process was the short time allowed to complete the assessment. Specifically, nursing management had an expectation that assessments should be completed in about ten minutes. However, nurses said that this time frame was too short and in some instances performing an assessment and completing the patient documentation took them up to an hour. Given all these difficulties that nurses encountered trying to complete an admission assessment, hospitals had introduced policies to accommodate this problem. Most hospital policies required that the entire assessment form had to be completed within 24 to 48 hours. This policy allowed nursing care to be developed based on minimal patient information.

### **Patient factors**

In addition to the contextual factors, there were a number of patient factors (intervening variables) that influenced the accuracy and completeness of the admission assessment. Specifically, the patient's overall physical and mental status influenced whether he/she was able to give assessment information. For example, on occasions when patients were in pain or had been given pain killers, nurses only asked minimum information, thus allowing the patient to rest. Patients who presented with family members or significant others assisted the assessment process as the family member could provide relevant information. However, this did not occur in all cases. Additionally, nurses stated that some patients questioned the appropriateness of the assessment details which they were required to provide. This questioning affected some nurses' willingness to ask these type of assessment questions.

Furthermore, some patients were reluctant to give private and personal information to nurses who were seen to be quite busy at the time. An unrelated though interesting finding was that patients also voiced concerns about the number of times they were asked the same information by different personnel.

### **Nurse factors**

In addition to these patient factors, there were many nurse-related factors that also affected the quality of the assessments that were conducted. Specifically, nurses varied in their levels of knowledge and skills on performing assessments. The experience level of the nurse and their familiarity with the patient's medical condition impacted on the quality of the assessment. The movement of patients and nurses across settings meant that, on some occasions, nurses were required to conduct assessments on patients who presented with medical conditions with which they were unfamiliar. Nurses also differed in their opinions as to what constituted relevant information and this influenced the type of information that they collected. One nurse would appraise another nurse's assessment as being uninformative. In particular, agency and casual nurses, who may not have been aware of the hospital's policies or the ward assessment procedures, adversely affected this process as their assessment may not have complied with hospital standards.

Furthermore, some nurses did not prioritise performing a complete assessment as being an important task at the time of admission. There was a greater emphasis placed on completing observations (blood pressure and pulse) and giving medications. Due to all these factors, admission assessments were poorly completed and patients' specific nursing care needs were not always identified or known. Nurses often stated that they did not refer to this assessment document as it was poorly completed and easily out-dated as patients conditions often changed. This further affected nurses' appraisal of the importance of completing admission assessments and their commitment to completing this task. Very often, as nurses did not usually refer to this document, there were occasions when they did not know that the admission assessment had not been completed. Data revealed that there were many patients who had incomplete assessment forms while they were inpatients.

Additionally, due to all the factors that impeded nurses from conducting assessments, some nurses transcribed information from the patient's medical notes without conducting a formal assessment themselves. All these conditions contributed to patient admission assessment being poorly completed and formed the basis of being in a state of “*unknowing*”. For a schematic representation of these factors see figure 5:2.

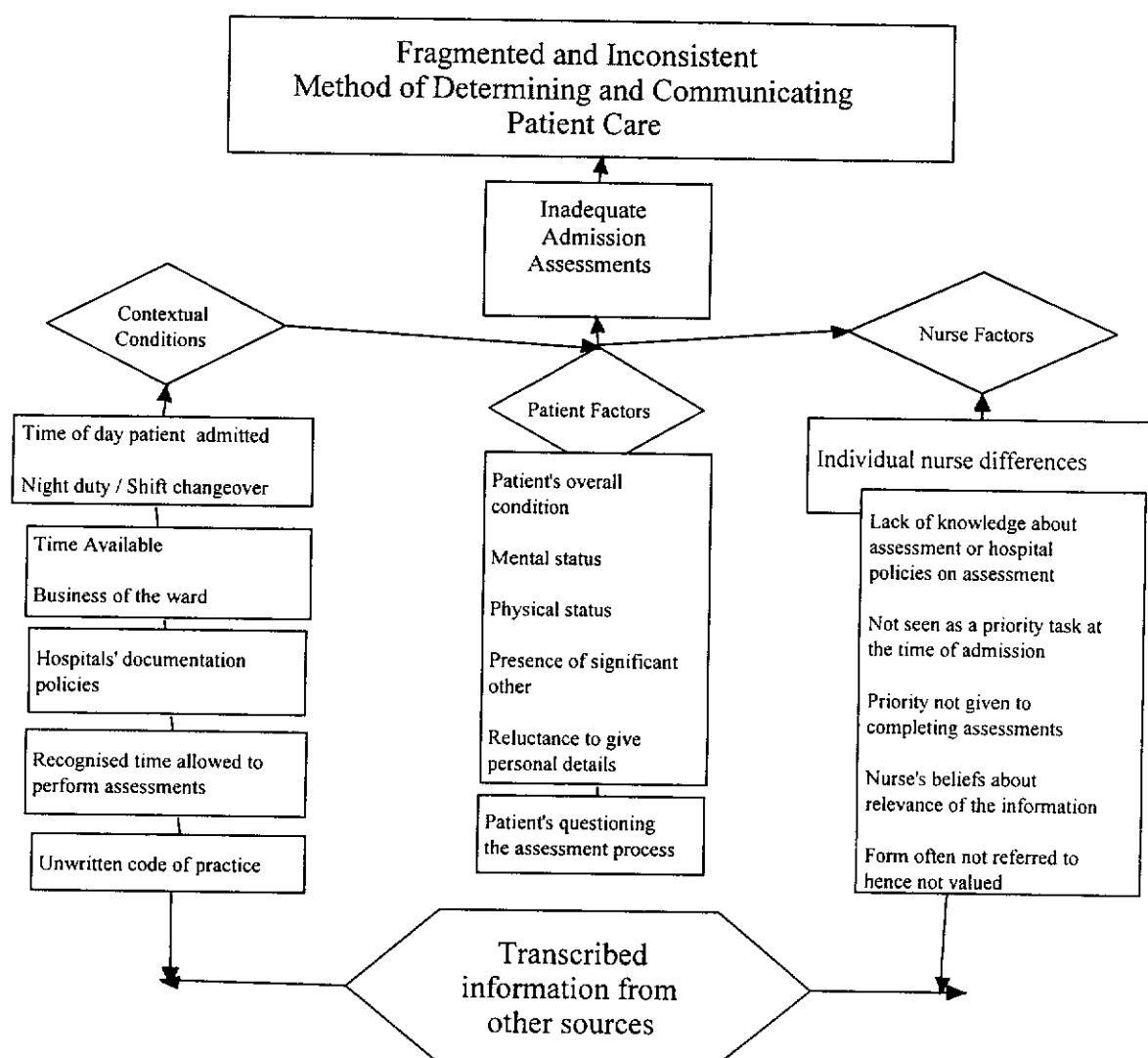


Figure 5:2 Properties of the category: *Inadequate admission assessments*.

### ***Inconsistent use of Nursing Diagnoses***

The second stage of determining patient care was identifying patient problems. This stage was the second stage of the nursing process and is termed nursing diagnosis. There were many intervening variables that effected the use of nursing diagnoses and

resulted in an inconsistent use of this process. In the first instance, patient assessments were poorly conducted and this resulted in poor identification of patient's individual problems and a focus on listing nursing diagnoses that were derived directly from the patient's medical diagnosis.

The use of the NANDA taxonomy was problematic as nurses described this language as being awkward to use, cumbersome, and some complained that the language restricted professional judgements. Specifically, they spoke of trying to apply/fit a NANDA diagnosis to the patient's problem rather than writing the problem as it actually appeared. Additionally, nurses complained that nursing diagnoses were unable to capture the complexity of the patient's problem in an encapsulating way. Often, patient problems overlapped and were not discrete. Furthermore, some nurses voiced a reluctance to write patient problems in the master problem list as they were unsure as to whether the problem was permanent or transient. As they had not been previously involved in caring for the patient, due to a lack of consistency assigning nurses to the same patient, they were unable to make this decision. Furthermore, casual and agency nurses felt uncomfortable adding new problems to the master problem list as they would be unable to follow through and assist in the treatment of these problems. This inconsistency in patient problem identification was further exacerbated by the large number of nurses involved in looking after the same patient, the lack of continuity, and the lack of understanding the patients' problems and the progress of care.

Nurses in this study often voiced a reluctance to document patients' psychosocial problems as they perceived that this would breach confidentiality. They also voiced concerns that these problems were very often too complex to treat and were unable to be resolved within the context of a routine admission. For example, it was difficult to resolve long terms social problems caused by patients' unemployment status and lack of finance. However, nurses tended to discuss this information with other nurses to determine a strategy or they referred the patient to the social worker. It was common for this type of information to be held in the nurses' minds and communicated verbally (use of the oral culture) and not documented in the notes. Due to the number of nurses involved in giving the same patient care, the information that was held in

nurses' minds and transferred verbally was more prone to be lost and hence was not used to direct care.

There were other problems associated with the use of nursing diagnoses and, in particular, writing expected outcomes. In some hospitals, nurses were required to write expected outcomes on the problems that were listed. Very often nurses found it difficult to predict the outcome as the patient's recovery was contingent upon his/her response to medical treatment. Some nurses complained that the expected outcomes that were written were unachievable as some nurses wrote expected outcomes that even doctors would find difficult to predict. As a result of this, the written expected outcomes were largely ignored and not used to evaluate care. In general, the concept of nursing diagnosis was used inconsistently. The Master Problem List may or may not have been reflective of the patient's actual problems. Nurses rarely looked at the master problem list at the commencement of a shift and hence patients' nursing diagnoses were not used to direct care. All these intervening factors led to an inconsistent use of nursing diagnosis which further fragmented the process of determining and communicating patient care and the state of "*unknowing*". See Figure 5:3 on page 192.

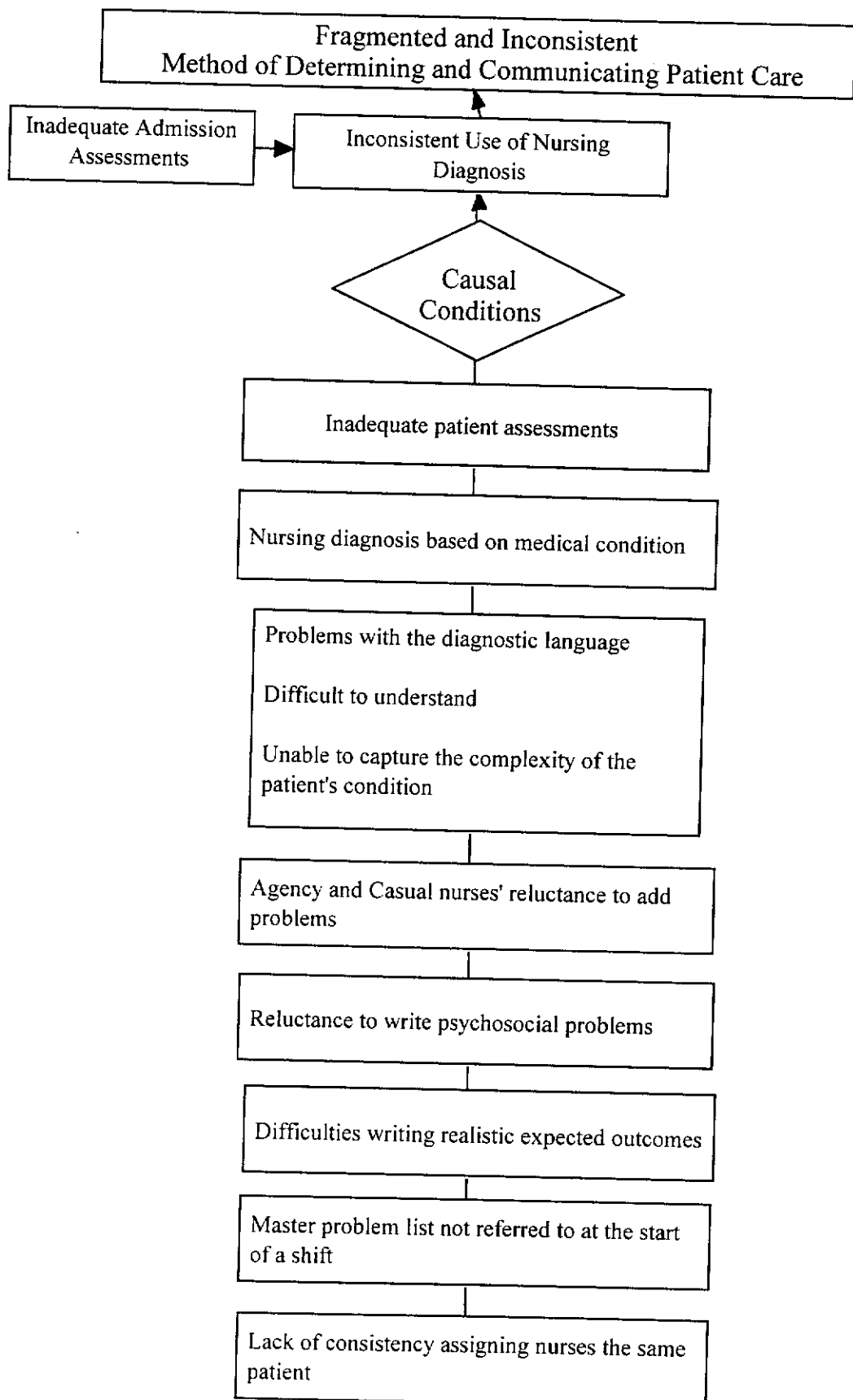


Figure 5:3 Properties of the category *Inconsistent use of nursing diagnosis*.

### ***Inconsistent use of Nursing Care Plans***

There were many problems associated with the care planning stage and the use of nursing care plans. These problems further contributed to the inconsistent and fragmented process used to communicate care. Specifically, as patients were not always adequately assessed nor were their individual problems identified, nursing care plans were developed based on medically prescribed care and routine interventions. The type of information written on these care plans varied as nurses would list information that she/he prioritised as being relevant. This was also influenced by the nurse's level of experience in caring for a patient with a specific medical condition. Additionally, there were many problems associated with trying to keep the nursing care plans up to date. As patients' conditions changed rapidly, these changes were not always documented and updated in the care plans. On other occasions, more junior and inexperienced nurses would not know when to alter patient care. For example, they may not know when the patient would be able to ambulate to the shower. In these instances, they would transcribe the care from the previous day, which may not have been an accurate account of the care given. Under these circumstances, the patient's nursing care plan did not always reflect the care that was given. For example, it was common to see patients discharged on *four hourly observations* written in the care plan, or *shower with assistance* listed for patients who showered independently.

Furthermore, nurses often complained that the information on the care plan was written using a number of abbreviations that were cryptic in nature and difficult to understand. Specialty units used their own abbreviations that had no shared meaning among other nurses. There were other problems identified in regard to the way in which the care was signed for on the care plan. Nurses were required to sign the care plan indicating that the care had been given. The way in which this task was performed was inconsistent and it was difficult to determine with any certainty whether the care had or had not been given. It was common to find the care signed off as given when it had not been completed on that shift. For example, signing that patients had been showered on the night duty shift was a common finding. Other examples include nurses signing superseded intervention indicating that they had

been given along with the recently added intervention. All these factors, coupled with a lack of a central person being assigned the responsibility of updating the care plans, resulted in an inconsistent use of the nursing care plan. This factor added to the inconsistent and fragmented method of determining and communicating care and the state of “*unknowing*”. See figure 5:4.

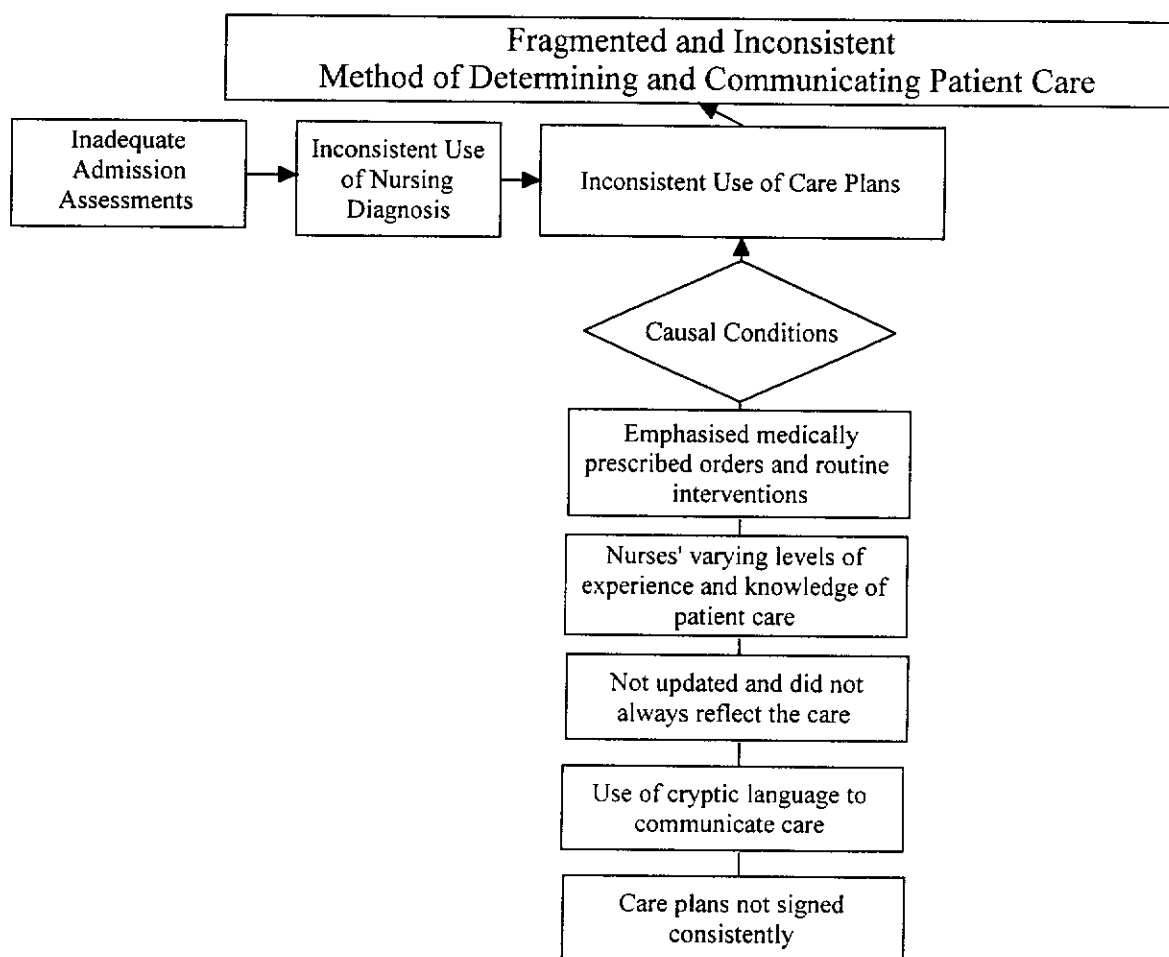


Figure 5:4 Properties of the category *Inconsistent use of nursing care plans*.

### ***Inconsistent use of Progress Notes***

The inconsistent documentation of patient care was found to exist in the progress notes. The quality of what was written in the patients' progress notes varied and further added to the fragmented communication process. Factors that influenced the quality of the progress notes were the experience level of the nurse and her/his ability to focus on documenting appropriate aspects of care. There was an emphasis on



documenting physical aspects of care with little emphasis on noting the patient's psychosocial wellbeing. Documentation of the care usually occurred at the end of a shift and there were many accounts of nurses hurriedly writing anything in the notes in order to comply with hospitals' documentation policies. There were other accounts of nurses forgetting to document care before completing the shift. Hence, under these conditions, the record of care was discontinuous and fragmented. Additionally, hospitals had set policies on documentation that prescribed when and what information should be written in the progress notes. These policies influenced the type of information that was documented. For example, one hospital had a policy that required nurses to document information on how the patients' nursing diagnosis/es listed in the master problem list were progressing. As the list was not always reflective of the patients' problems, the information that was documented was not always informative or reflective of patient progress. This further added to and fragmented the communication process and the continuity of care. See figure 5:5.

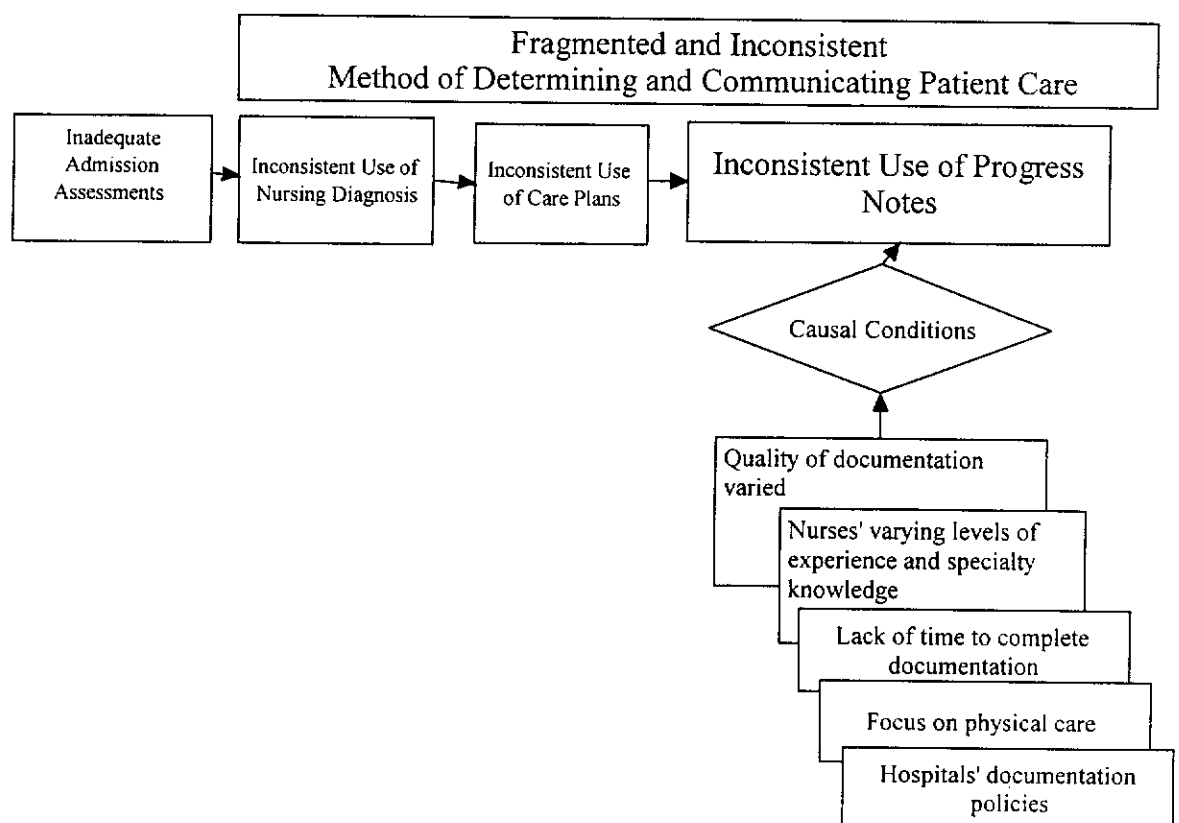


Figure 5: 5 Properties of the category: *Inconsistent use of the progress notes*.

### ***The Use of a Number of Forms***

Overall, the number of charts used to document similar patient information also added to the problem of inconsistent and fragmented documentation of the patient's condition and progress. Nurses complained about having to document the same patient information in a number of different charts. They also admitted that they often updated the information in one chart and consequently forgot to transcribe it onto the other chart. Additionally, as patient notes and charts were stored in two different places, this geographical difference further added to the problem of inconsistent and fragmented records of patient care.

### ***Inconsistent Handover of Information***

Alongside the inconsistencies associated with documentation, there were other problems identified with the verbal handover of patient information across shifts. This inconsistent handover of patient information occurred between nursing staff, and between nursing and medical staff. Specifically, it was common practice for nurses to hand over patient information at shift changeover times. This type of handover was performed verbally or by using a tape recorder. The quality of this type of handover was contingent upon a number of factors. Firstly, the time allowed to complete the handover affected the amount of information that could be handed over. If the ward was busy or nurses had to go to meetings, the handovers were brief and shorter in length. There were other anomalies associated with the numbers of patients that were handed over. For instance, there were occasions when nurses received handovers of their own patients (the section they had been assigned) and would not have information about other patients in the ward. On these occasions, nurses would have minimal information about these patients although they would be expected to answer patient bells in other sections.

The time of day the handover was conducted also affected the handover process. Specifically, night staff handovers to the morning shift would be brief and provide information that focused on what happened overnight. Nurses' own knowledge about the patient varied according to how well they knew the patient as a person and this too impacted on the quality of the handover. Moreover, on occasions when nurses did

not know the patient, there were many gaps in the information and these gaps caused uncertainty. Nurses also complained that some handovers focused on events that occurred within a shift, rather than giving an overview of the progress of care. This type of handover was said to impede the continuity of care and to increase uncertainty; especially as the nurses coming on duty may not have known the patient and their care.

Additionally, the experience level of the nurse conducting the handover also affected the quality of the handover. The more junior nurses often gave rambling and unfocused handovers that were difficult to comprehend by other nurses. Furthermore, nurses had different approaches to handover; some methods were said to be unstructured and unhelpful in directing care. For example, handovers that were given using a story-like narrative approach were appraised as lacking flow and being disjointed. On other occasions, nurses used many abbreviations that were not generally understood and this led to nurses not knowing explicitly what was happening in regard to patient care. Due to all these factors that impacted on the quality and type of information that was handed over, handovers varied and some handovers were not explicit enough to direct patient care.

Furthermore, there were many problems associated with the use of tape-recorded handovers. These handovers were introduced due to the lack of overlap time between shifts and the introduction of staggered shifts. While this type of handover was introduced for practical reasons, its use hindered communication. It was found that nurses handed over information in a more impersonal way with a greater concentration on the tasks. As this type of handover was constrained by the length of audiotape, nurses were required to be more specific about what they handed over. This restriction forced them to focus on physical information which did not always provide an account of the overall care. Furthermore, some nurses felt uncomfortable handing over sensitive information via the tape recorder. In these cases, this type of information would not be handed over.

Moreover, as nurses had to record their handovers a few hours before nurses on the next shift listened to this handover, there were many gaps in the information and some information may not have been up-to-date. Additionally, some handovers were

given verbally and recorded at the same time for staff members who commenced their shift later in the day. On these occasions, important personal discussions between nurses were omitted as the tape recorder was turned off during the discussions. Staff listening to the tape at a later time, would miss these vital discussions that would inform nursing care. Some nurses complained about the number of abbreviations, which they did not understand, that were used during handover. As the nurse who gave the handover was not present, it was difficult for other nurses to clarify the meaning of the terms or any other unclear statements relating to patient care.

While some nurses liked this tape-recorded handover as it was quicker, other nurses found it to be impersonal and lacking in interaction. They often complained about the lack of opportunity to clarify information. Junior nurses felt particularly disadvantaged as they were unable to ask further questions and to seek advice. Collectively, they stated that it was helpful to have this handover supplemented with a short personal handover from the person completing their shift. However, due to the staggered shifts and lack of overlap time this was not always possible. As a result of all these conditions, information about patients was lost and this led to further fragmentation of patient information and the state of "*unknowing*".

Additionally, the communication process between doctors and nurses was also problematic. This process was impaired due to a number of factors. Nurses often complained that doctors would alter patient care without telling them of these changes and there was an expectation that nurses would check up on the changes. Additionally, there were many other problems associated with doctors' ward rounds. On some occasions, as nurses were unable to attend these rounds because they were busy delivering patient care, the changes may not have been communicated to them. It was common for nurses to be told about the changes to patient care by the patient or by looking up the patient's medical notes. On occasions when nurses did not have time to review the patient's notes, newly made changes to patient care may not have been known or handed over to the next shift.

As a result in this breakdown in communication between doctors and nurses, patients were frequently asked about changes to their care. Although they were sometimes

able to clarify the situation, there were other occasions when their accounts would not be accurate. This further added to the problem of fragmented communication and the basic social problem of being in a state of “*unknowing*”.

### ***Oral Culture***

There were many instances found in the data when nurses stated that they felt more comfortable communicating information verbally. This communication mode was often used to convey sensitive patient information and to discuss different strategies of care. Many nurses stated that they felt more comfortable communicating sensitive information in the oral mode as it was seen to be less “risky” and more confidential. Nurses with less experience hesitated to document some patient information as they stated that they “lacked confidence”. Information about the patients’ psychosocial wellbeing was often held in the oral culture as nurses perceived that documenting these problems in the notes was departing from the focus of care. This was especially so within the context of a busy surgical ward where the emphasis was on physical care. Additionally, nurses commonly assessed patients and determined their care on an ongoing basis, without actually documenting this information in the patient’s notes. Data revealed that the verbal handovers were more comprehensive than what was recorded in the patients’ notes. Moreover, “patient errors” that occurred in the ward areas were often not documented and were usually dealt with in the oral culture. While this verbal mode was said to be a more efficient and convenient method of communication, due to the number of nurses involved in the delivery of the same patient’s care, information held in the oral culture was more prone to be lost and hence was not used to direct patient care. Nurses gave many accounts of situations where they had forgotten to handover information that had not been documented anywhere in the notes. The use of the oral culture further added to the fragmentation of information and the delivery and communication of patient care. See figure 5:6 on page 201.

### ***Different Nurses Involved in the Delivery of Care and the Lack of Continuity***

Another factor that fragmented the method of determining and communicating care was the large numbers of nurses involved in the delivery of care and a lack of a

central person coordinating this care. It was common to find patients who had been nursed by approximately 10 to 15 nurses during their hospitalisation. This situation occurred as there were increasing numbers of agency and casual nurses used to deliver care. Furthermore, due to bed and staff shortages, patients were admitted to wards other than their listed specialty area and nurses were moved across wards to relieve staff shortages. As nurses varied in their levels of experience, knowledge, and skills this added to the uncertainty, variations in care and the documentation and communication of information. Some nurses were unable to make clinical decisions about care as they had not been familiar with the patient or their progress. The issue of having a large number of nurses involved in the delivery of the same patient's care also confused patients. They voiced concerns about a lack of continuity. Moreover, as there was no consistent central person involved in coordinating care, information was lost and patient care was compromised. For a schematic representation of the condition "fragmented and inconsistent method of determining patient care" see Figure 5:6 on page 201.

### **Fluctuating and Uncertain Working Conditions**

The second major condition that underpinned the basic social problem was working in *fluctuating and uncertain working conditions*. This condition was characterised by the following properties:

- Changing award and erosion of working conditions
- Not knowing what to expect
- Lacking control over professional practice.

Nurses in this study voiced concerns about the uncertain and fluctuating conditions under which they worked. This uncertainty was fuelled by the many changes that had occurred in the broader Health Care System and the number of changes to the Nurse's award and their general working conditions. Additionally, there were many day-to-day changes that occurred at ward levels, to an extent where nurses found themselves in situations where they did not know what to expect. There were other factors in the work environment that hindered nurses from controlling their professional practice and delivering care in the way in which they had been professionally educated. All these uncertain and fluctuating work conditions added to their state of "*unknowing*".

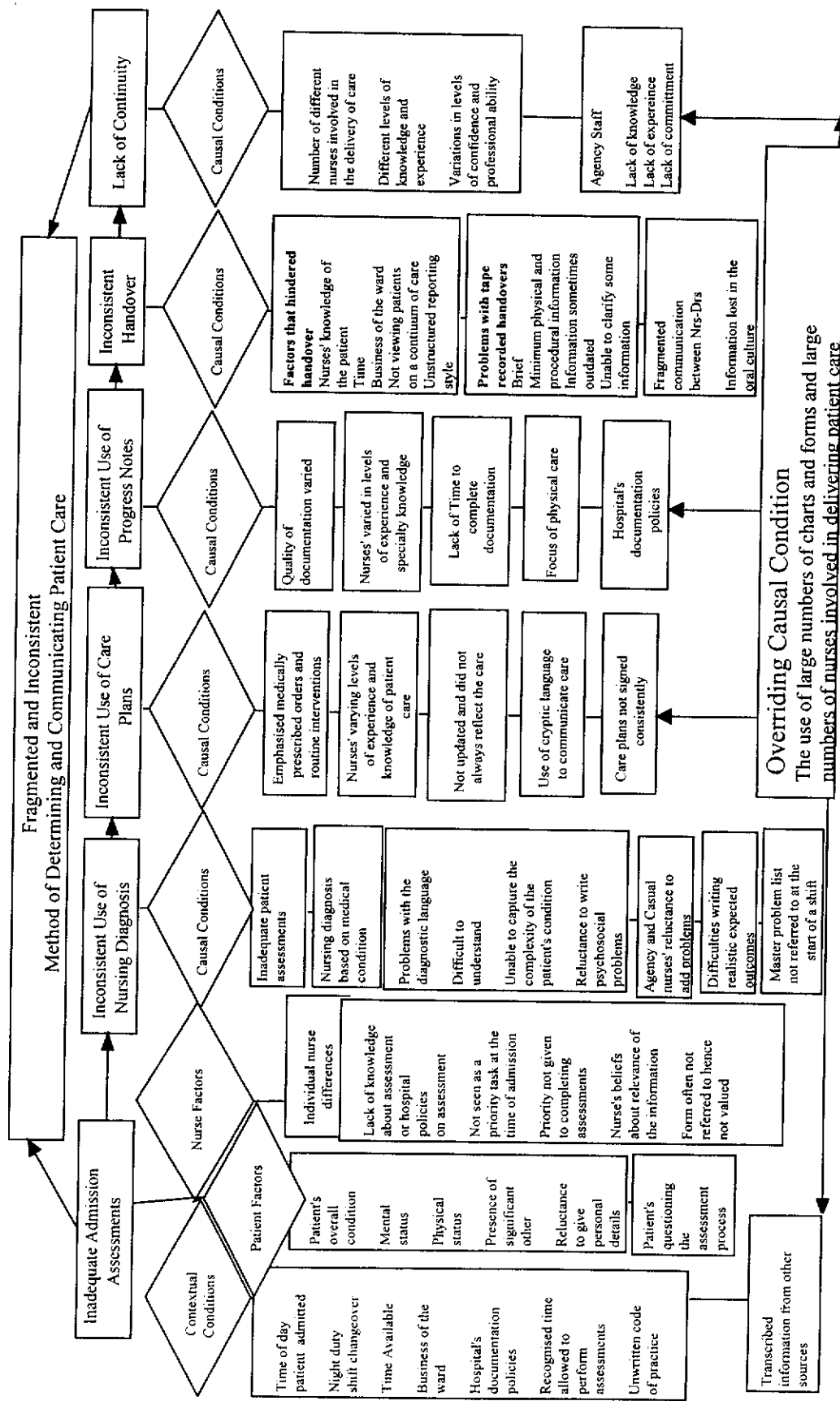


Figure 5:6 Fragmented and Inconsistent Method of Determining and Communicating Patient Care

### ***Changing Award and Erosion of Working Conditions***

There were many changes to the broader Health Care System that were brought about by changes in Government policies, Health Commissioners, and the way in which health care was managed (McKimmie, 1996). There had also been a gradual reduction in hospitals' budgets. This caused a lot of uncertainty and it altered the way in which patient care was delivered. Concomitant with the reduction in hospital budgets, there was an increase in patient turnover and acuity. All these changes were unsettling and caused further uncertainty. In addition to the more state-wide changes, nurses' working conditions were also said to be eroded. There were many changes to the number of annual leave days they were awarded, the number of hours they worked per week, and the lengths of their contracts being awarded were decreasing.

Furthermore, the introduction of the short shifts was one factor that had a major impact on patient care. As some nurses were only rostered on for six hours, very often they were not sure whether they would be able to complete their work on time. Additionally, as they completed their shift before the next nurse commenced duty, nurses who worked these short shifts would be unable to verbally handover information to the nurse who would take over the care of her/his assigned patients. Wards were run on minimum staffing levels and there was an increasing use of agency and casual nurses employed to fill the gaps. There was a general move to try to multiskill nurses and an increasing number of nurses were required to relieve in areas other than their area of expertise. Nurses voiced concerns and felt vulnerable working in unfamiliar wards. Additionally, the introduction of the short shifts had decreased the overlap time that was commonly used for educational sessions. Nurses were unhappy about this issue as they perceived this reduction in overlap time as eroding their working conditions. Many nurses spoke of their conditions as regressing. More specifically, they voiced concerns about the lack of: functioning equipment, adequate staff numbers, and a lack of time to spend with and talk to patients.

In addition to all these changes, there were other changes that occurred within the context of an acute ward setting. For example, the increasing use of technology and



changes to hospital forms and documentation practices. Collectively, all these factors were said to cause uncertainty and had led to being in a state of “*unknowing*”.

### ***Not Knowing What to Expect***

There were other subconditions in the work that were said to cause uncertainty, as nurses did not know what to expect and how a work shift would unfold. Specifically, nurses were assigned fluctuating levels of responsibility and workloads, were required to work with nurses with whom they were unfamiliar, were required to nurse patients with whom they were unfamiliar, and were constantly interrupted during the course of a daily shift.

### **Assigned fluctuating levels of responsibility and workloads**

Nurses, within this study, were assigned different levels of responsibility and their workloads tended to vary from day to day. The assigned level of responsibility was determined by the skill levels of the other nurses rostered on duty. As the skill mix also varied from day to day, nurses found themselves being assigned fluctuating levels of responsibility. For example, on occasions when nurses were coordinating shifts they would be required to take the extra tasks that other nurses rostered on duty were not registered or qualified to perform. Very often, they were also required to assist agency nurses with their work. As staff-patient ratios also varied across shifts and across wards, depending on the shift the nurse worked and the ward’s rostering policy, nurses’ workloads varied accordingly on a day-to-day basis. Additionally, nurses stated that they were often placed in situations and given responsibilities that exceeded their level of competence and, although they were uncomfortable with the situation, they were unable to control what was happening. During the study period, there were a number of Level Two (Clinical and Staff Development nurses) and Level Three nurses (Clinical Nurse Specialists) in temporary acting positions and had been so for lengthy periods of time. This factor added to the levels of uncertainty experienced by nurses in this study.

### **Working with nurses with different levels of knowledge and experience**

Another condition said to cause uncertainty in the work place was the variation in professional characteristics of nurses and the number of different nurses involved in delivering patient care. Nurses varied in their levels of educational preparation, knowledge, skills, and experience. The aspects described in the previous section alluded to the issue of nurses varying in the way in which they determined, delivered, and documented care. As a result of this variation, nurses were unsure what to expect when they worked alongside other nurses with whom they were not familiar. Under these conditions, theoretical ideals of care were only half implemented as all nurses had not been educationally prepared to deal with newly introduced concepts. For example, the concept of the nursing process and nursing diagnosis was said to be only “half used” in any setting. However, although this may have been attributed to an educational deficit, it was found to be influenced by other factors.

Additionally, agency and casual nurses caused further uncertainties in ward settings as they, too, varied considerably in their professional abilities. The findings of the study revealed that there was an increasing number of agency and casual nurses being employed within acute hospital settings. These nurses added to the uncertainty as they were an unknown entity and other nurses working alongside these nurses would not know what to expect. Additionally, they fragmented the team work as many of them were not familiar with the other staff members or the ward routines. Permanent ward staff described the situation as being unsettling and unstable. Specifically, these nurses varied tremendously in their levels of knowledge, skills, and commitment to their work. On many occasions, agency nurses were assigned to work in specialty areas where they did not have the specialist knowledge and skills to function competently. In these instances, permanent staff members were required to fill the gaps and assist agency nurses to deliver safe care. As discussed previously, agency nurses would only document the “basics” and others admitted that they sometimes forgot to document the care. When errors occurred, under these circumstances, permanent staff were blamed for the problems. Permanent staff members complained about constantly having to check on these nurses to avoid adverse situations. The

employment of these large numbers of agency and casual nurses further added to the uncertain working conditions and to the state of “*unknowing*”.

### **Movement of nurses and patients across specialty settings**

There was a lot of movement of nurses and patients across specialty settings. Due to the restructuring of the case mix of wards and the emergence of devolved management structures termed Clinical Directorates or Clinical Specialty Units, nurses were often required to work in wards where they nursed specialty patients with whom they were unfamiliar and lacked experience. They constantly voiced a sense of frustration of having to deal with this situation. Additionally, with the emergence of the five day wards, patients were often admitted to other wards prior to their surgery. In these cases, nurses would be required to admit patients from other specialties. Due to the shortage of beds, patients were sometimes admitted to any ward with an available bed. Under these circumstances, once again, many nurses had not known what to expect in regard to what demands would be made of them within the context of a daily shift.

### **Being interrupted**

Another factor that added to the uncertain conditions under which nurses functioned was the number of times they were interrupted. Within the context of a day-to-day shift there were a number of changes that occurred. Patients were admitted, discharged, and transferred across wards or health care settings. Nurses within this study were constantly interrupted during a course of a shift or even when performing a specific task. These interruptions were caused by requests from patients, doctors, other nurses, relatives, or other health care professionals. Additionally, sudden changes in patient conditions, problems with technology, and a number of other unexpected events were very common. These constant interruptions were said to be difficult to predict, an unknown entity, and distracted nurses from focusing on the tasks that they were performing. As a result of all these interruptions, nurses' thought processes were fragmented. This sometimes resulted in unfinished work where patient care was compromised. Within this context, nurses were unable to control their work environment or how a work shift would unfold. Collectively, this situation

added to the problem of not knowing what to expect and contributed to the basic social problem of being in a state of “*unknowing*”.

### ***Lacked Control Over their Professional Practice***

It was evident in these data that nurses were unable to control their professional practice and this added to the level of uncertainty. There were a number of factors that led to this outcome. In a general sense, nurses comprised the largest number of staff members in the hospital work force. They worked under conditions where they were highly regulated and controlled by hospital policies and procedures and were subjected to many other system-imposed constraints, for example, time constraints. Additionally, many nurses complained of not being professionally recognised. All these factors caused uncertainty and led to a state of “*unknowing*”.

Nurses worked under a number of system-imposed constraints that tended to restrict their professional practice. Some of these constraints were: being regulated by hospital policies, working under conditions of time constraints, and being reliant on other health care professionals. Specifically, one of the main restriction was the number of policies and procedure manuals that regulated their practice. These policies sometimes conflicted with nursing’s theoretical base and increased the theory-practice gap. Having to observe these large numbers of policies had inadvertently distracted nurses from operating from their own professional base; rather, it had caused them to focus on adhering to hospital policies. Under these conditions, some nurses were unable to explain why they performed tasks in certain ways, other than being observant of hospital’s policies. Nurses complained of having to comply more and more with hospital regulations with less room for making their own professional judgements. While on one hand nursing was said to be gaining professional status, on the other hand nursing practice was becoming increasingly regulated.

In addition, nurses worked under immense time constraints. These time constraints caused concern as nurses were unable to fulfil their professional role. They constantly voiced professional dissatisfaction as they did not have adequate time to deliver professional care and felt they were forced to concentrate on completing the tasks.

Nurses were unable to control their work environment and they often stated that they found themselves in compromising situations, which they were unable to change or control. Some described the situation as being dangerous and detrimental to patient care.

Another factor interpreted as contributing to uncertainty was nurses' lack of control over their own professional work. As nurses' work relied on doctors' orders and assistance from other health care workers, they were unable to proceed with their own work until other health care professionals had performed their tasks. This made it difficult for nurses to plan, organise, and control their work routines.

Nurses in this study complained about not being recognised in the system. They felt that some doctors undermined the status of nursing and that nursing administration was more preoccupied with cutting costs rather than encouraging nurses in their daily achievements. Frequently, as nurses were at the bedside for longer periods than other health care professionals, they spoke of being more in touch with the patient's condition. However, they perceived that their opinions in regard to patient care were not asked for or valued. Specifically, they were unable to influence what was going on with patient care as this was largely influenced by doctors. This lack of recognition appeared to cast doubt in some nurses' minds and they became unclear as to where their role started and finished. In many cases, they were reluctant to take further studies as they voiced frustration about being unable to implement their new ideas. It was difficult for nurses to implement any type of change as it had to be endorsed by many other health care professionals. Nurses complained that other health care professionals eroded their role and they voiced an inability to change what was happening. This role erosion occurred during 8 a.m., to 5 p.m., Monday to Friday, as out of these hours nurses would be required to take on these tasks. Within this context, nurses spoke of having little control over their professional practice and described their role as being medically driven and controlled. See figure 5:7 on page 208.

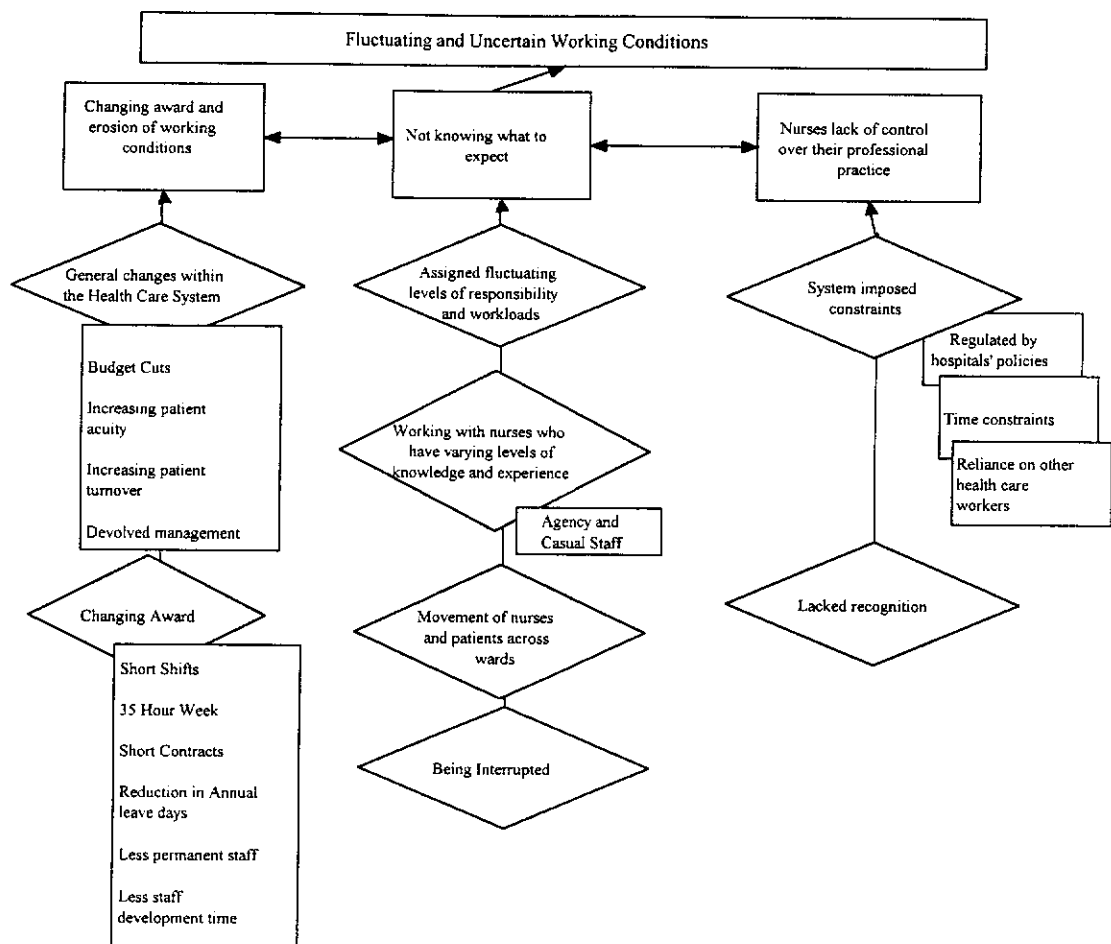


Figure 5:7 Fluctuating and Uncertain Working Conditions

### Being Compromised: Consequence of Being in a State of “*Unknowing*”

As a result of working under a system that used a fragmented and inconsistent method of determining and communicating patient care, combined with working under uncertain and fluctuating conditions, nurses in this study felt personally and professionally compromised. They spoke of feeling unsure, frustrated, and having to proceed with their work very cautiously. Under these conditions of being in a state of “*unknowing*”, patient care also tended to be compromised. Furthermore, these uncertain conditions made it difficult to determine with any certainty what had happened when things went wrong, as there were differing opinions as to what had occurred. Nurses were often blamed for anomalies in patient care that occurred as a function of the anomalies within the overall health care system or the organisation, rather than from the nurse’s own negligence. Patients complained about a lack of continuity which caused them to be unsure about what was happening. Being

compromised, therefore, was the consequence of the basic social problem, being in a state of “*unknowing*”. Further discussion will focus on describing the process used to overcome the problem of being in a state of “*unknowing*”.

### **The Basic Social Process of “*Enabling Care: Working through Obscurity and Uncertainty*”**

The purpose of this study was to discover the process that nurses used to determine, deliver, and communicate patient care in acute ward settings. More specifically, it sought to determine how the nursing process was used in clinical settings. The study data revealed that within the context of day-to-day work nurses were required to deal with a basic social problem of being in a state of “*unknowing*”. In order to deal with this situation, the basic social process used by nurses was: “*Enabling Care: Working through Obscurity and Uncertainty*”. This process involved two interconnected phases that occurred simultaneously. These two phases of the core process were: (1) Putting the pieces together: making sense and (2) Minimising uncertainty. The nurses in this study were constantly required to use this two phase approach to overcome the basic social problem of being in a state of “*unknowing*”.

The first phase of the core process, which was termed *Putting the pieces together: making sense*, involved three subprocesses. In this phase, nurses tried to work through the obscurity (their lack of information about the patient’s specific problems) and their uncertainty surrounding their working conditions through the subprocesses that were termed: (a) drawing on the known, (b) collecting and combining information, (c) checking and integrating information, and (d) sustaining communication. This first phase was combined with the second phase that was termed *Minimising uncertainty*. In this second phase nurses tried to alleviate the uncertainty in their work environment by using three subprocesses that were labelled: (a) adapting work practices, (b) taking control, and (c) backing up. Both these phases occurred in conjunction with one another. The prevailing work conditions required nurses to use a number of subprocesses which often conflicted with theoretical ideals. As a result of working under these compromising conditions, some nurses became professionally disillusioned. Professional disillusionment, therefore, was a

consequence of this basic social process. Each of these phases and subprocesses, along with the consequence of this process, will be discussed in this chapter. For schematic representation of this basic social process see Figure 5:8.

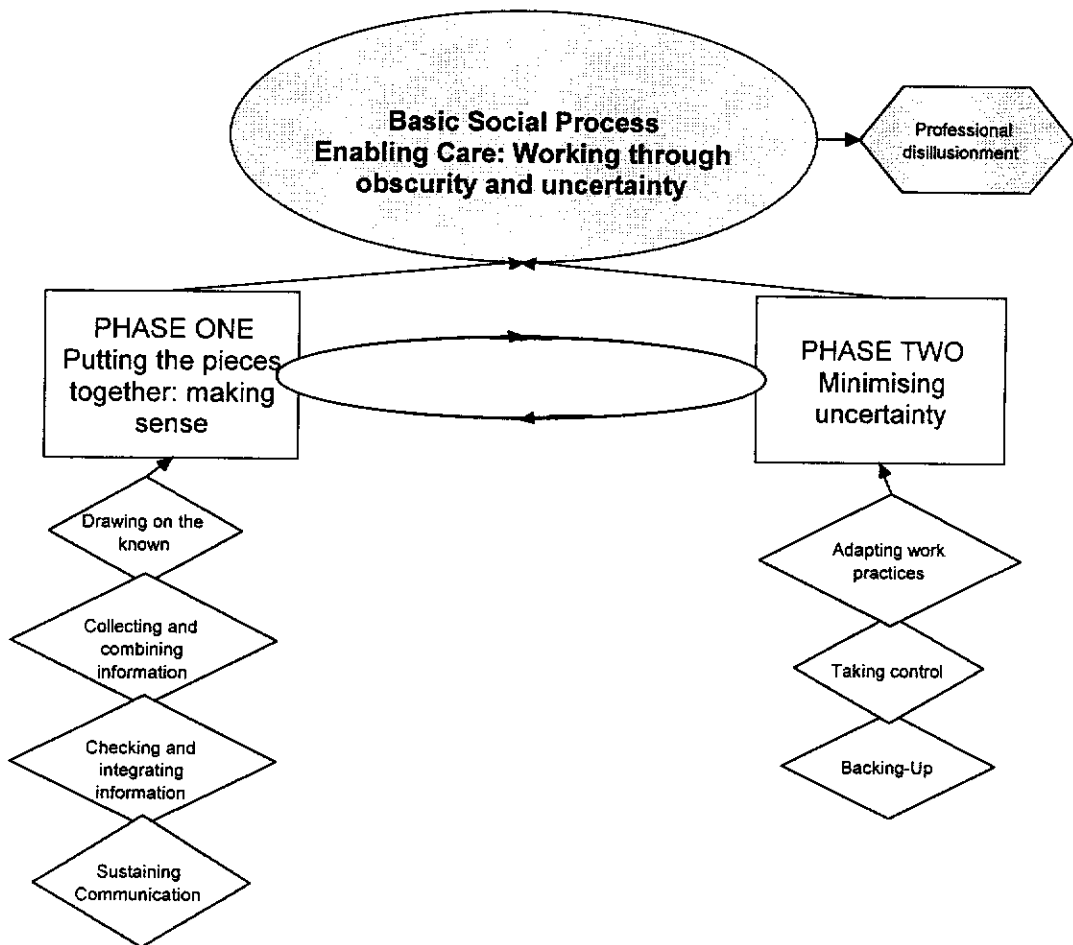


Figure 5:8 Basic Social Process of *Enabling Care: Working through obscurity and uncertainty*

### Putting the Pieces Together: Making Sense

The first phase of the core process was entitled “Putting the pieces together: making sense”. Nurses had to work hard to deal with the core problem of being in a state of “*unknowing*”. In order to make sense of the situation, they used the subprocesses of (a) drawing on the known, (b) collecting and combining information, (c) checking and integrating information, and (d) sustaining communication. A combination of all these subprocesses formed the first phase of the Basic Social Process of “Enabling care: Working through obscurity and uncertainty”.



### *Drawing on the Known*

At the start of any shift, nurses found themselves in a state of “*unknowing*”, as they did not always know which patients they had been assigned or the type of care required for each specific patient. Casual, agency, and new nurses commencing on the ward for the first time were further disadvantaged as they did not usually know who they were working with or the ward routines. This state of “*unknowing*” experienced by nurses, therefore, varied according to whether the nurse had any prior knowledge of the types of patients that were admitted on the ward and/or the ward’s usual routines. Nurses in this study were able to, in part, overcome the problem of being in a state of “*unknowing*” by *drawing on the known*. Within this context, nurses who knew the ward routines were able to proceed with aspects of their work as they were able to follow the known routines.

Specifically, hospital environments usually had a number of routines that set in place mechanised work practices. It was also common for hospitals to have several routine mechanisms of communication. An example of this was a white board that communicated patient information and nurses’ caseload assignment. Nurses who were familiar with the routine were able to proceed with their work, as they knew the ward routines and where the information in regard to patient assignment and patient notes would be stored. Furthermore, the way in which nurses proceeded with their work was usually determined by ward routines. All nurses who knew these routines, regardless of whether they were permanent staff or casual staff were able to proceed with some aspects of their work.

Furthermore, nurses who were familiar with ward norms and ward documentation were further able to partially overcome the state of “*unknowing*” by knowing what to expect in regard to which specific document would provide them with the most up-to-date information. Additionally, nurses who were familiar with nursing patients with particular types of medical conditions were able to predict the type of care that would be required by the patient. Experienced nurses who worked permanently in the one ward often stated that they did not refer to the standardised nursing care plan as they knew the patient’s nursing care needs. Another factor that also assisted nurses to determine the patient’s condition and to know the care was the patient’s environment

and the type of technology used in the delivery of nursing care. Specifically, nurses stated that they knew about the patient's condition by observing the type of technology used and the frequency of their observation regime. Additionally, as some wards listed routine-type nursing interventions for all types of patients, being familiar with these intervention statements assisted some nurses to complete the nursing care plan. Hence, knowing the routines, the patient's medical condition, and what to expect formed part of the process of working through obscurity and uncertainty.

### ***Collecting and Combining Information***

At the start of any shift, nurses found themselves experiencing a state of "*unknowing*". Although some nurses were able to partly overcome this state and proceed with their work, they all required further information about patient-specific nursing care needs. Collecting and combining information was the second subprocess used to make sense of what was happening in regard to patient care. There were several ways of obtaining patient information. However, the most commonly used mode was the handover. This handover was conducted either verbally or by using a tape recorder and it usually took place in the nurses' office or near the patient's bedside. Each ward had its own handover routine, which varied across shifts. Generally, it was common practice to have one nurse, who was usually the shift coordinator, handover all patient information to all staff members commencing duty.

Where possible and when rostering permitted, nurses had brief informal handovers with the staff members who were taking over from them. Junior nurses found this type of face-to-face personal handover very useful as it contained specifics about care that were usually missed in the general handover. Most nurses also stated that this type of handover helped them to prioritise their care as they were given specific information that directed care. For example, Patient X's drug being due shortly or information about an intravenous line that needed the bag to be replaced. These types of handovers were not always possible as nurses would complete their shift prior to the next shift commencing duty. This condition was caused by the introduction of the short shifts and a lack of shift overlap time.

## **Handovers**

Verbal handovers focussed on giving physical and procedural information. These handovers generally followed a format where the nurse handing over stated the patient's name, age, medical diagnosis, and current medical treatment. On some occasions, there was mention of the patient's past history and presenting complaint. Being familiar with the patient and the nurse who was handing over was an important factor that enhanced the effectiveness of handovers for those receiving information. Specifically, when nurses received handovers from other nurses who they did not know, they usually asked many questions in order to check what was happening. However, instances where they knew the nurse, there was a shared taken-for-granted trust and less clarification of information was required. Likewise, when nurses were already familiar with the patients they would require less information and asked less questions about care.

Handovers were also given using a tape recorder. Due to the reduction of staff overlap time and the introduction of staggered shifts, tape-recorded handovers were used as they were seen to be more efficient. All nurses starting at a set time would collectively listen to the handover. The information given in these handovers also focused on physical and procedural patient information that was stated in a very cryptic way using many abbreviations. These handovers were conducted in a quiet room and generally occurred using the following two strategies. The verbal handover given by the shift coordinator to staff starting at 1 p.m., was taped for the staff members commencing their shift later on in the afternoon. Alternatively, the whole handover was taped before the shift changeover time. On some occasions, these handovers were given by the shift coordinators, while on other occasions they were conducted by the individual nurses who cared for particular patients.

## **Pooling and combining information**

As nurses who were handing over may have been in a state of "*unknowing*" in regard to the patient's actual care, they were found to overcome this problem by collectively pooling and combining their information in order to determine care and evaluate how

the patient was progressing. Each nurse who had knowledge of a patient or a situation provided their account and collectively nurses would try to build a clinical picture of the patient and determine specific patient care. During verbal face-to-face handovers nurses asked other nurses to clarify and qualify issues in regard to patient care. There was a lot of impromptu teaching that occurred as junior nurses asked more experienced nurses questions. When these verbal handovers were conducted at the bedside, nurses sometimes asked the patient questions in order to clarify what was happening in regard to specific patient care. While listening to tape-recorded handovers, staff members would switch the tape recorder off and discuss unclear information with each other and try to clarify issues where possible. At the commencement of a shift, nurses collected patient information from reading the white board in the office and from receiving a handover.

In addition to qualifying information within the handover context, nurses were often required to check and integrate patient information using other personnel and sources of information. Checking and integrating information was the third subprocess used to make sense of what was happening in regard to patient care.

### ***Checking and Integrating Information***

As nurses worked under conditions of immense uncertainty, checking and integrating information from a variety of sources was a necessary strategy. Nurses in this study constantly checked information in order to determine what was happening with regard to patient care and whether their understanding of patient care was accurate. Additionally, they were required to check that all the care had been given on the previous shift in order to determine the starting point of their shift. At any one point in time, there was a number of sources of patient information, each containing information that would form part of the story that could be used to build on already known patient information. Some sources were out dated and contained inaccurate patient information that would have to be further clarified. Based on past experiences, nurses had preferred sources of information as they found them to be more reliable. For example, some nurses only referred to the nursing care plan as they appraised them as being the most reliable source of information.

Although nurses appraised a particular source of information as being more reliable, they continued to check and verify other listed information. Furthermore, nurses constantly asked patients and other nurses what was happening with regard to patient care. Many nurses stated that just looking at the patient was a helpful way of determining patient status and care, especially when the patients were unable to provide reliable information. Others said they used the patient's latest observations as a indicator of the patient's condition. Additionally, some nurses stated that their casual conversations with patients and spending time with them also assisted in the verification and integration of patient information. Much of the care in acute settings was determined by the doctors, hence, asking the doctors was another strategy used to determine patient care.

### ***Sustaining Communication***

As nursing occurred over a 24 hour period involving a number of nurses, sustaining communication was an important and necessary task. Nurses used a number of strategies to achieve this goal. The introduction of the short shifts and lack of overlap time hindered nurses from communicating verbally with one another. In order to overcome this problem they developed an informal written culture that compensated for an inability to use the oral culture. Specifically, nurses left each other informal notes written on scrap pieces of paper left in the office, on a chart, or stuck to the patient's case notes. These notes reminded other nurses or doctors about patient care or jobs that needed to be completed, for example, ring Patient X's daughter and tell her that her father will be discharged on Tuesday. This informal written communication occurred among nurses and between nurses and doctors.

Additionally, as there were many problems identified with the handover process, some nurses had developed written handover guidelines that prompted nurses to handover specific aspects of patient care. This was thought to optimise the handover process. On wards where tape-recorded handovers were used, nurses had reintroduced a card system that contained specific patient information that was required to be handed over thus encouraging nurses to focus on handing over specific information. The headings used were once again related to the patient's medical condition and procedural information. This card was discarded when the patient was

discharged. This card system resembled the old kardex system that was used prior to the introduction of formal nursing notes which occurred in the late seventies. Individual wards had also introduced the use of various types of communication books that were used to enhance the communication of information from doctors' rounds or changes to hospital policies and procedures. Although this was developed to sustain and enhance communication, it increased the number of places where patient information was documented.

In summary, the first phase of the Basic Social Process termed *Putting the pieces together: making sense* occurred through the use of four subprocess termed (a) drawing on the known, (b) collecting and combining information, (c) checking and integrating information, and (d) sustaining communication. Collectively these subprocesses assisted nurses to try to overcome the core problem of being in a state of "*unknowing*". See figure 5:9 on page 217.

### **Minimising Uncertainty**

The second phase of the Basic Social Process of "Enabling care: working through obscurity and uncertainty", was termed *minimising uncertainty*. This phase consisted of three subprocesses that were termed (a) adapting work practices, (b) taking control, and (c) backing-up. These three subprocesses had no sequential order and occurred concomitant with the four subprocesses used in the first phase. Nurses in this study were often placed in situations where they had to try to unravel what was going on with regard to patient care, as well as trying to minimise further uncertainty. This process of minimising uncertainty occurred not only to protect themselves but also to assist other staff members working in ward areas and to enable patient care.

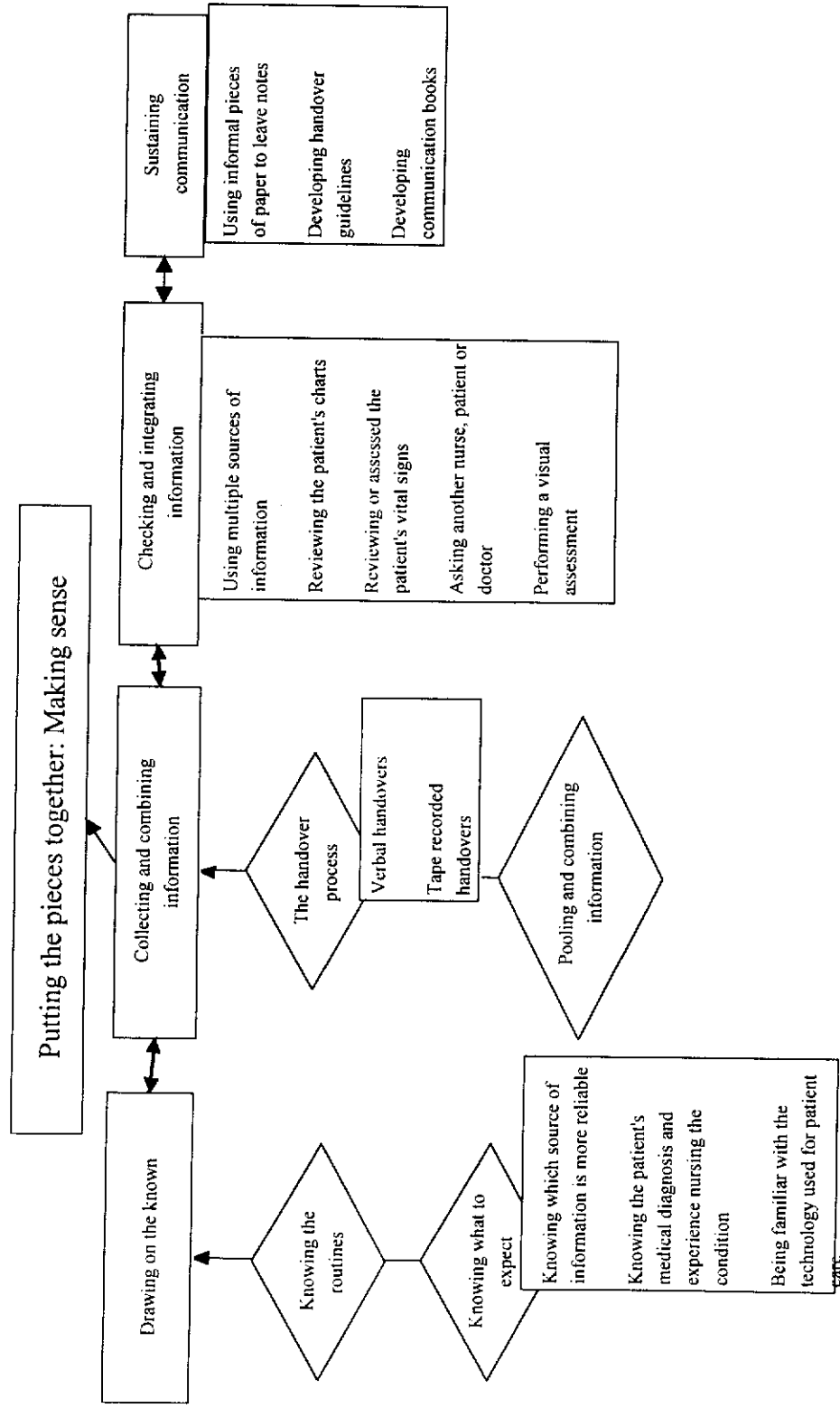


Figure 5:9 First phase of the BSP Putting the pieces together: making sense

### *Adapting Work Practices*

As nurses worked under constantly changing conditions of uncertainty that interrupted them from doing their tasks, they were forced to modify their practices to meet certain deadlines in relation to patient care. These conditions were further exacerbated by time constraints and having to comply with hospital policies that sometimes made unreasonable demands on nurses. Though nurses were unhappy about adapting the way in which they practised, which sometimes breached theoretical ideals of care, many spoke of having no choice, as taking short-cuts was seen as the only available, viable option.

Additionally, to achieve completion of the tasks, nurses compromised themselves by working unpaid overtime or by missing or taking late meal breaks. Nurses who worked the six-hour shift often worked unpaid overtime as they found it difficult to complete what they termed “eight hours work in six hours”. As nurses completed their shifts up to two hours before the replacement nurse commenced duty, they had to ensure that patients were aware of the situation and had been told to ring the bell for assistance.

To minimise uncertainty in relation to “knowing the patient” and to enhance the continuity of care, nurses frequently listed patient assessment data in the nursing care plan. This practice assisted other nurses to easily identify the patient’s functional status if they were required to attend to a patient with whom they were unfamiliar. Additionally, to avoid not signing the care plans at the end of a shift, some nurses signed that the care had been given at the commencement of the shift, that is, before the care was actually given. Additionally, some nurses signed the medication chart for other nurses whom they believed had given the medication though had forgotten to sign the chart. In these circumstances, they had been advised by the patient that medications had been given.

Additionally, time constraints was said to be the most common factor that resulted in nurses having to modify their practice. Nurses stated that nothing seemed to be implemented in its theoretical form; rather, most practices were adapted as time constraints prohibited the implementation of theoretical ideals. Documentation of



patient information consumed a lot of nurses' time. However, this was rarely recognised formally in the system. Nurses were constantly under pressure to complete the documentation at the end of a shift. Additionally, hospital policies required nurses to document patient progress in a particular manner. Some nurses, due to a lack of time, would document information to comply with hospital policies rather than to communicate important information. Within the context of time constraints and trying to comply with hospital policies, nurses spoke of only documenting information that was written on the previous shift, rather than being based on care that was given on the particular shift.

Another strategy used to reduce the uncertainty of not being able to complete essential tasks was juggling the work load. Tasks that were seen as being a priority were performed at a set time and all other patient care was juggled around these tasks. Tasks like showering the patient may not have been prioritised as being essential and may not have been completed. Furthermore, nurses voiced concerns about being constantly interrupted as they went about their daily tasks. To avoid these interruptions, they adopted strategies to minimise this situation. Bed to bed handovers would be conducted outside the patient's rooms so that the nurses would not be interrupted by patient requests. Additionally, some patient bells would not be answered promptly as nurses would try to complete the jobs they had commenced. In summary, nurses had to constantly juggle their work loads, take short cuts, try to minimise uncertainty in order to meet, in some instances, minimum patient needs. Within this context nurses stated that they had to constantly improvise on what they had been taught in theory. All these improvisations led to a theory-practice gap which further caused uncertainty.

### ***Taking Control***

Taking control was another subprocess used to minimise uncertainty. In order to achieve this task and control the level of care, senior nurses would prescriptively tell junior nurses what to do. Some nurses developed and used prompting mechanisms to remind them to complete certain tasks. Furthermore, as nurses' work relied heavily on doctor-prescribed care, they were required to remind and organise the doctors to perform certain tasks. Finally, due to the adverse working conditions some patient

errors occurred. In order to reduce the uncertainty of possible repercussions, some errors were covered up. All these strategies were used to minimise uncertainty and formed the basis of the subprocess *taking control*.

### **Controlling care**

Due to the uncertain working conditions that nurses experienced, junior nurses spoke of difficulties completing their tasks. Shift coordinators were required to constantly check on junior nurse's work in order to see how they were progressing. On some occasions, senior nurses complained that they got "caught" because junior and agency nurses had not completed the required tasks. Under these conditions, patients were not prepared for operating theatre, drugs were not given, and, generally, patient care was compromised. To try to avoid this situation, senior nurses took control and prescriptively told junior nurses how to modify their practice (take short cuts) in order to complete their work. Shift coordinators also reallocated tasks among nursing staff to assist nurses who were falling behind. In these situations, the focus of care changed from being patient centred to being task centred. Although this strategy of minimising uncertainty by controlling the care seemed pragmatic, this action promoted task-oriented care rather than holistic care.

### **A prompting mechanism**

Being interrupted was another problem nurses had to deal with in their day-to-day work. These interruptions often fragmented the nurse's train of thought and distracted them from their work. Nurses often forgot about what they were doing and/or what tasks needed completion. In order to avoid forgetting to complete these jobs, they developed several prompting mechanisms that reminded them of the jobs that needed completion. Specifically, nurses would use a disposable paper towel to write certain tasks that were required to be performed on a particular shift. This paper towel, which was carried in their pockets, would be discarded at the end of a shift. Some nurses used a coding system of circles or stars next to the patient's name to indicate a certain procedure they had to remember or that the patient was on a fluid balance chart. Hence, at a glance, the nurse would be reminded of patient care. Each nurse developed his/her own system of prompts. New graduate nurses would use prompts

commonly used by other nurses. As communicating with doctors was also a difficult task, nurses also left informal notes reminding doctors to complete medication charts or to order intravenous regimes.

### **Organising the doctors**

In acute care settings, another condition that caused uncertainty was the nurse's reliance on medical orders. Much of nurses' work was medically prescribed. Hence, nurses were unable to proceed with their tasks until doctors had written their orders. Doctors were rarely forthright in completing these aspects of their work and nurses often complained that they were not informed of the changes to patient care. These factors caused uncertainty and hindered nurses in their daily work. Nurses in this study stated that they often had to ring doctors to remind them of their work and find out changes to patient care. They were required to organise the doctors in order to minimise the uncertainty surrounding their own work. To assist this process, some nurses had developed a communication mechanism that reminded doctors of their tasks at the start of the day. Additionally, they would purposefully try to be available to attend the doctors rounds in order to keep up with the changes to patient care. Nurses stated that they performed this role so that patients would not suffer undue interruptions to their care. This organiser role was inadvertently sustained as nurses were forced into maintain this role in order to perform their job in a safe and legal way.

### **Resisting change**

Nurses in this study were often described, by other nurses, as being resistant to change. It was suggested in the data that this resistance was brought about by a motivation to reduce the uncertainty in the work place. Making changes to patient care or nursing practice was a difficult task to achieve. Some nurses perceived that the nurses who had been in the wards for a long time or/and trained under the apprenticeship type training were more commonly resistant to change. Other nurses stated that this resistance to change was not confined to these groups of nurses and was more widespread. One explanation given was that nurses were so exposed to change that it may have been difficult to keep up with all the changes. This resistance

to change was said to be one strategy used to minimise uncertainty in the workplace and to try to retain control.

### ***Backing-Up***

As the core problem experienced by nurse in this study was being in a state of “*unknowing*” and some of the subprocesses used to alleviate this problem inadvertently compromised professional nursing practice, some errors occurred. As most nurses were inadvertently prone to making errors at sometime, errors that were judged to be minimal were covered up or minimised by both doctors and nurses. Nurse had to constantly back-up each other work. Backing-up, therefore, was the third subprocess used to minimise uncertainty. Under the conditions described in this study, errors that were judged to be minimal were dealt with in the oral culture and not documented in the patient’s notes. Within this context, there were many accounts of treatment errors being “smoothed over”. Medication errors appeared to be the most frequent type of error that was covered up. When errors occurred, nurses very often discussed the incident among themselves and determined a strategy. What was reported or documented depended on the graveness of the error. The benchmark of the measure of gravity, however, was not clear and varied across settings. As no nurse was immune to making these errors, backing-up each other was a subprocess used to minimise uncertainty. See figure 5:10 on page 223.

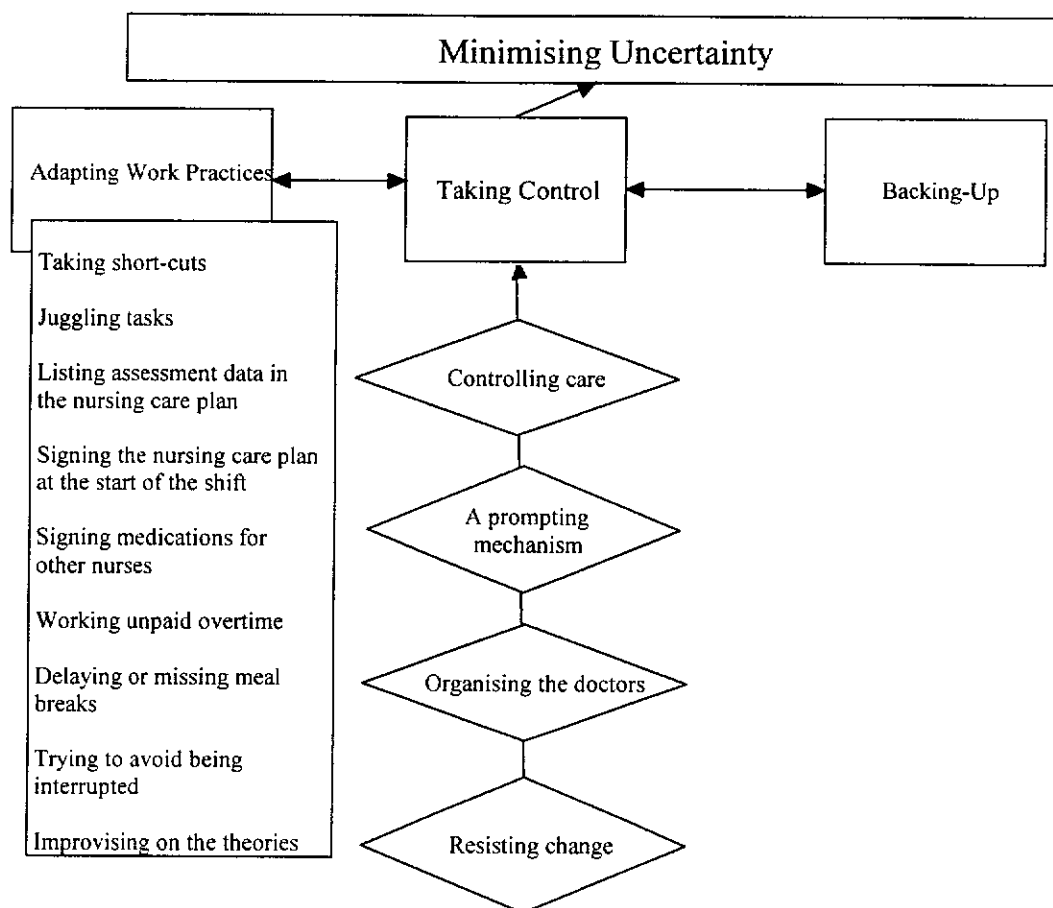


Figure 5:10 Second phase of the Basic Social Process *Minimising uncertainty*

### **Professional Disillusionment: Consequence of Working Through Obscurity and Uncertainty**

As a consequence of working under compromising conditions and constantly trying to make sense of what was happening and to minimise uncertainty, nurses became professionally disillusioned. Nurses voiced a dissatisfaction of having to work hard at delivering task-oriented care. They complained of a lack of time to spend talking to patients. Additionally, they complained of constantly struggling to complete their work. The short shifts were mentioned frequently as being the causal agent and its implementation was said to stifle nurses' professional development. Some nurses responded to this situation by reducing the number of hours that they were contracted to work each week. Other nurses worked unpaid overtime and stated that the situation affected them emotionally and affected their sleep pattern. Within this context, nurses became disillusioned and withdrew professionally. This withdrawal from professional development was thought to be responsible for nurses operating at

a task-oriented level and focussing on observing policies, rather than practising professionally. Some nurses resigned from nursing and spoke of “getting out till things changed”. Patients were also affected by nurses’ professional malaise and spoke of a lack of care. In general, nursing management tried to deal with the substandard levels of nursing practice by introducing more policies. Frequently, this further alienated nurses from being able to practise professionally and resulted in nurses becoming further disillusioned as they were unable to change what was happening, nor able to control their professional destiny.

## **Conclusion**

The contextual conditions under which nurses were required to work were partly responsible for their inability to determine, deliver, and communicate patient care using a problem solving approach, such as the nursing process. The core problem that emerged from the data though was not specifically articulated by nurses, was being in a state of “*unknowing*”. The Basic Social Process used to overcome this problem was *Enabling care: working through obscurity and uncertainty*. This process required nurses to compromise their professional standards in order to reduce workplace uncertainty and to communicate and deliver patient care. An inability to overcome the basic social problem resulted in situations where errors occurred and both patients and nurses were compromised. Ironically, the contextual conditions combined with the basic social process that was used to minimise this problem caused nurses to become professionally disillusioned. In some instances, nurses became professionally withdrawn or resigned from nursing. This put further pressure on a system in crisis and exacerbated the state of “*unknowing*”.

## **Chapter Six**

### **Discussion Within the Context of the Literature**

#### **Introduction and Chapter Overview**

The purpose of this study was to discover the process that nurses used to determine, deliver, and communicate patient care in acute ward settings and to identify the contextual factors that impacted on the process. More specifically, using grounded theory methodology, it sought to describe and develop a substantive theory that explained the clinical application of the nursing process in acute care hospital settings. In addition, it focussed on identifying factors that assisted or hindered the clinical application of the nursing process. This chapter will discuss the findings of this study in the context of the current literature and explicate the implications of the findings for nursing practice, theory, research, and education. Furthermore, based on the findings of the current study and the review of literature, it will make recommendations for nursing practice, theory, research, and education.

#### **Nursing Process**

The nursing process is the recognised problem solving approach to patient care that is used in nursing (Gordon, 1987b; O'Connell, 1996a; Yura & Walsh, 1988).

Developed by a group of nurse academics in 1967, it detailed distinct stages that a nurse should use to determine, deliver, and communicate patient care (Yura & Walsh, 1967). These stages are assessment, diagnosis, patient care planning, implementation of the care, and evaluation of the planned patient care. In recent years, authors on the topic posit that the five systematic stages of the nursing process integrate the mental functions of a problem solving process used in nursing (Alfaro-LeFevre, 1994; Iyer, Taptich, & Bernocchi-Losey, 1995). Others suggest that the stages may not be systematic and that in some circumstances the first two stages overlap. Specifically, although novice nurses use the stages of assessment and diagnosis discretely, more experienced nurses combine these two stages of the nursing process (Carnevali & Thomas, 1993).

Although the nursing process is said to be used widely in clinical areas and the literature abounds with publications on the topic (Aspinall, 1976; Bowman, Thompson, & Sutton, 1983; Carnevali, 1983; Castles, 1984; Cooney & Watts, 1992; Cunning & Pflederer, 1986; Gordon, 1987b; Masso, 1990; McMurray, 1989; McHugh, 1991; Mitchell, 1991; Woolley, 1990; Yura, & Walsh, 1988), some nurse clinicians display negative attitudes towards the use of the nursing process and question its utility in its present form (Henderson, 1987; Higginbotham, 1991; Masso, 1990; Prideaux, 1991). According to Varcoe (1996), to date there has been a lack of research conducted on the clinical application of the nursing process and, therefore, any argument for and against the use of this process remains unsubstantiated due to a lack of clinically established empirical evidence that is able to support any claim. Furthermore, Wurzbach (1991) stated that the current models of clinical decision-making may not always apply in nursing as they do not take into account the changing environment in which nursing is practised. The purpose of this study was to address this gap in knowledge and to discover how the nursing process was used in acute care settings.

The findings of the current study revealed several anomalies associated with the way in which the nursing process was used in clinical settings and exposes weaknesses inherent in the nursing process structure. The current study raises two main concerns in regard to the clinical application of the nursing process in its espoused form. Firstly, the problem solving approach to patient care that is inherent in the nursing process is underpinned by certain assumptions that have not been made apparent and more importantly are not inherent in real world clinical contexts. For example, the problem solving process used in the nursing process does not usually occur on an individual nurse-patient basis; rather, it occurs in the context of many nurses determining, delivering, and communicating care for an individual patient for their total length of stay. Due to this condition, any problem solving approach used in acute care settings, is heavily reliant on the efficacy of the communication process used in these settings and this, therefore, needs to be considered. Secondly, the way in which the nursing process has been explicated in text books was not reflective of the process of nursing used by nurses in acute care settings. Seemingly, the prevailing contextual factors in clinical settings heavily influenced nursing practice and the



communication of patient information. These factors, therefore, need to be taken into account. Specifically, the clinically applied process of nursing was heavily influenced by the basic social problem encountered by this group of nurses. The findings of this study revealed that nurses in acute care settings experienced a basic social problem of being in a state of “*unknowing*”. There were two major domains of “*unknowing*” (1) as applied to providing patient care, and (2) as applied to nurses’ job status and state of the nursing profession. The state of “*unknowing*” was a consequence of two main contextual conditions. These were the existence of a fragmented and inconsistent method of determining and communicating patient care, and working within a fluctuating and uncertain context (see Figure 6:1 page 228). A combination of all these factors offers some explanations of the difficulties experienced by clinical nurses in trying to use the nursing process to determine, deliver, and communicate patient care. In order to deal with this situation of being in a state of “*unknowing*”, nurses employed a basic social process that was termed “*Enabling Care: Working through obscurity and uncertainty*”. This process had two interconnected phases that occurred simultaneously; these were labelled: (1) Putting the pieces together: making sense; and (2) Minimising uncertainty. All these findings will be further discussed within the context of the literature. Some direct quotes have been used in discussing the literature so as to preserve the meaning as stated by the original authors.

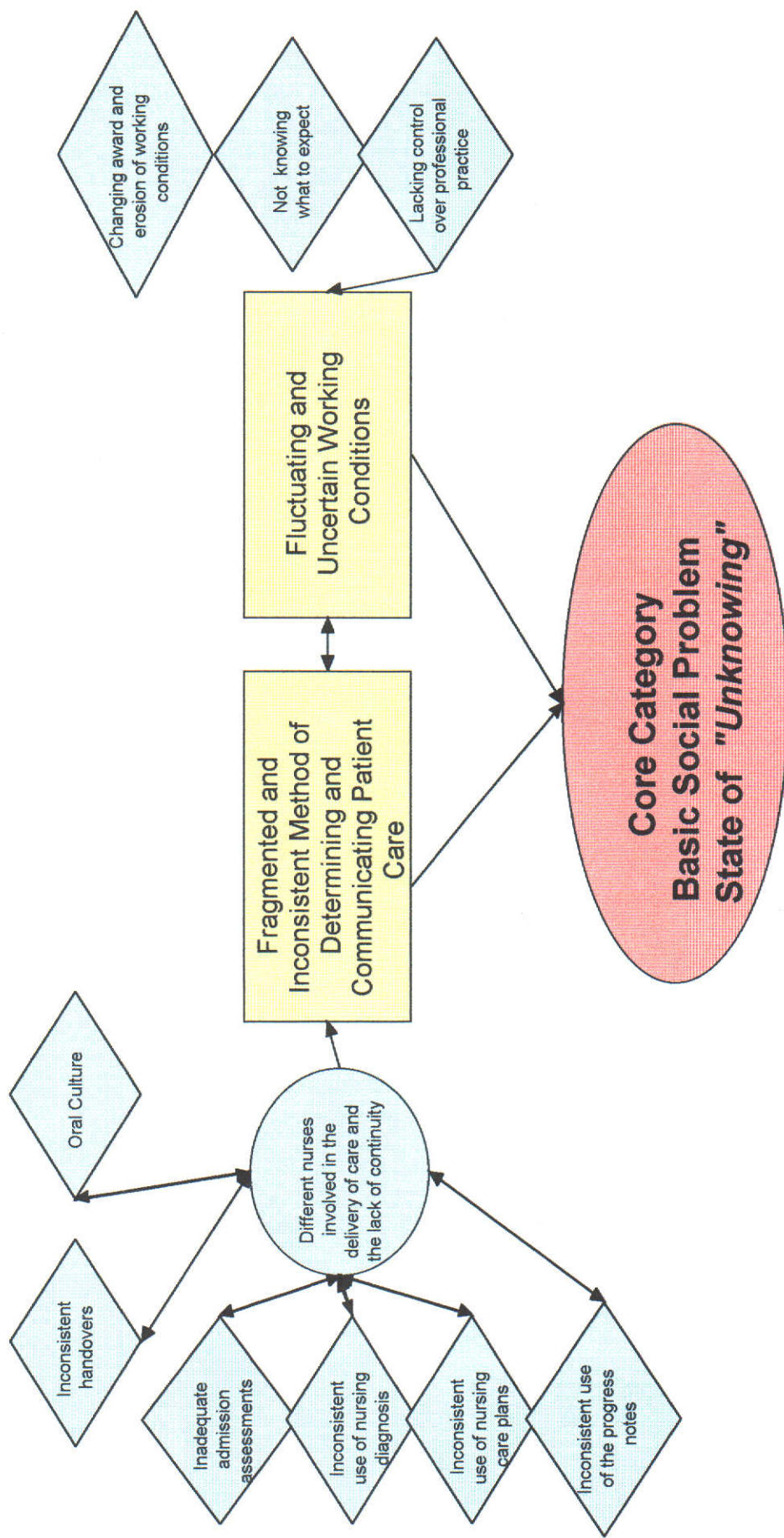


Figure 6:1 Basic Social Problem Being in a State of "Unknown"

## **Admission Assessment**

The literature abounds with information espousing that patient assessment and problem identification are the first two stages of the nursing process (Alfaro-LeFevre, 1994; Gordon, 1987b; O'Connell, 1996a; Yura & Walsh, 1988). In addition, nurse scholars state that these first two stages are vital and pivotal to the rest of nursing care (Alfaro-LeFevre, 1994; Aspinall, 1976; Carpenito, 1995; Iyer, Taptich & Bernocchi-Losey, 1995; Kim, Suhayda, Waters, & Yocum, 1984; Ziegler, Vaughan-Wrobel, & Erlen, 1986). Mallick (1981) further maintained that patient problems should be identified based on assessment data and not on intuition. The findings of the current study revealed that in many instances, due to a number of contextual conditions, nurse factors, and patient factors, nursing admission assessments were unable to be performed. These findings concur with the literature that identified contextual factors known to influence the assessment process. These factors include the settings in which the assessment interview occurs and the time allowed to conduct the interviews (Woolley, 1990), as well as the hospital's documentation policies (Howse & Bailey, 1992).

In addition, the current study revealed other contextual factors such as the time of day the patient is admitted, the busyness of the ward at that time, and consequently the time available for the nurse to conduct admission assessments. Furthermore, the officially recognised time allowed to perform assessments adversely affected this process as it was said to be too short. Moreover, there existed an unwritten code of practice, within clinical settings, which required nurses on one shift to complete a level of admission documentation and not handover this task to the nurse commencing duty. Admittedly, as this replacement nurse may commence duty up to two hours after the nurse had gone off-duty, the unwritten code of practice may have been functionally driven. This code of practice forced some nurses to complete this task in a hurried manner, often transcribing information from the doctors' notes and focusing on meeting minimum physical and safety requirements rather than meeting the goals of patient assessment. This finding of the effects of contextual factors on performing an assessment concurs with Lauri and Salanterä's (1994) findings that the

nursing task and context were the most important factors influencing the decision-making process. Given this factor, one could expect that in acute care settings, where the emphasis is on medical treatment, that nurses would focus on physical aspects of patient care. In support of this argument, Corcoran (1986) concurs that the task itself is a major determinant of decision-making behaviour.

According to Woolley (1990) and Hagey and McDonough (1984), there are a number of patient factors that are thought to impact on this process. These factors include patients' inability to provide a history and to verbalise important issues in a way that is accurately interpreted by the nurse. This finding was supported in the current study, as patients' physical and mental status were found to influence the type of information they were able to give the nurse. This factor, therefore, impacted on the efficacy of the admission assessment. In addition, the patient's condition was also found to affect how the nurse prioritised the task of conducting an admission assessment. Acutely ill patients were often left to rest or the nurse focused on performing other tasks, such as patient observations, which took precedence over conducting an admission assessment. This finding is supported by Wilcox (1994) who stated that "the observation charts have tended to reinforce the narrow conceptualisation of assessment" (p. 41). Nurses stated that some patients were reluctant to give personal details and they questioned the reason behind being asked certain questions. This further influenced nurses as they were reluctant to ask these types of assessment questions. This finding supports Webb's (1981) contention that the patient-centredness of the nursing process threatened patient privacy as they were asked to reveal personal information. Lawler (1991b) further adds that patients may be subjected to unnecessary surveillance under the auspices of "nursing assessment". Furthermore, in the current study, in cases where the patient was unable to provide data, family members or a significant other provided patient information. This was found to assist the assessment process.

The literature also revealed some nurse related factors known to influence the assessment process. These were: attributes of the nurse, such as knowledge base and logical reasoning ability (Benner, 1994; Woolley, 1990), and risk-benefit variables associated with the judgement itself (Tanner, 1986). Specifically, nurses were more

likely to make diagnostic decisions in laboratories than in real world contexts (Rapley et al., 1995). The findings of the current study concur with all the above statements on nurse related factors such as knowledge base, experience, as well as risk-benefit variables that influenced the assessment process in acute care clinical settings. In addition, there were other nurse factors identified, such as nurses' negative beliefs about nursing assessment which were appraised as being an unimportant task to complete when patients were admitted. Moreover, nurses varied in the type of assessment information they considered to be important and tended to focus on different aspects of the patient's condition. Consequently, one nurse would evaluate another nurse's assessment as "lacking" in information. Additionally, nurses did not appraise the information documented on the assessment form as being instrumental in directing patient care as it was usually poorly completed, and was often out of date. As a result of all these factors, nurses did not place great importance on completing admission assessment forms and stated that they rarely referred to this document. Due to all these factors that affected the efficacy of the assessment process, patient admission assessments were poorly completed.

Interestingly, all the above mentioned factors that impeded assessments being performed in clinical settings provided an explanation as to why the findings of a clinical study conflicted with the findings of a laboratory based study conducted by O'Connell (1992). This study indicated that the type of assessment form used to perform an assessment significantly influenced the number and type of patient problems identified by nurses. However, using a controlled study design, this finding could not be replicated in real clinical settings, as the type of form used by nurses, in these settings, did not influence the number and types of patient problems that were identified (Rapley et al., 1995). One explanation for this finding could be that the number of contextual factors that hindered the process of conducting an admission assessment may have diluted any effect that was brought about by using a particular assessment form. If there is substance in this argument, then Guzzetta (1989) and Weber's (1992) position that the assessment format impacts on the efficacy of the diagnostic stage may not always apply in the context of acute care settings.

In summary, a combination of all these factors that hindered the assessment process resulted in not much being known about the individual patient's overall functional status on admission. This lack of "nursing specific" patient information, impacted on the nursing diagnosis stage of the nursing process where patients' individual problems were identified in an ad hoc way.

### **Nursing Diagnosis**

The difficulties experienced by nurses conducting an admission assessment affected the nursing diagnostic stage of the nursing process as not much "nursing specific" information was known about the individual patient. According to the literature on information-processing theory, any problem solving process commences with an assessment and collection of patient data (Gordon, 1980; Radwin, 1995a; Tanner, 1986; Thomas, Wearing, & Bennett, 1991). The absence of an appropriate nursing admission assessment, therefore, impacted on the nursing diagnostic stage of the nursing process.

In the first instance, due to the lack of an adequate nursing admission assessment, what was known about the patient was their provisional medical diagnosis and the doctor's medical assessment. Patients' nursing diagnoses, therefore, were developed based on the patient's medical diagnosis and not from individual nursing admission assessments. Consequently, these diagnoses were predominantly physical in nature. These findings also concur with the findings of other studies, where the majority of diagnoses listed were physical problems (Greenwood & King, 1995; O'Connell, 1992; Rapley et al., 1995). Williams (1996) stated that when nurses worked under time constraints, addressing patient's physical needs was seen to take precedence over the patient's psychosocial needs. The findings of the William's study revealed that nurses were unhappy about delivering patient care that focused primarily on the physical and not the psychosocial aspects of care. However, they found themselves in work situations of time constraints, where they were unable to change what was happening nor the focus of patient care.

Additionally, there were many other problems identified with the nursing diagnostic stage of the nursing process as used in acute care settings. The findings of this study supported other studies revealing an element of confusion and a lack of consensus about the meaning and use of nursing diagnoses (Castles, 1984; Chase & D'Meza Leuner, 1996; George, 1994; Johnson Lutjens, 1993; O'Connell, 1995a; Serrell, 1990; Turkoski, 1988; Zeigler, 1984). Supporting the literature and the findings of the current study, Elliott (1994) reported the results of an Australian survey conducted at 33 health care institutions which sought opinions of the problems that nurses encountered using nursing diagnoses. Some responses to the survey included that the language was too technical, there was a confusion between nursing diagnosis and medical diagnosis, and many felt that NANDA nursing diagnoses and care planning were a waste of time.

Furthermore, the clinical application of the concept of nursing diagnosis was difficult to achieve due to a number of factors. The most prominent factor was that there were large numbers of nurses caring for the same patient over the total patient stay and a lack of continuity of nursing staff to enable patient problems to be diagnosed on an individual nurse-patient basis. In support of this statement, Radwin (1995a) espouses that "knowing the patient" was an important factor in identifying individualised care, and the time spent with the patient was a condition that facilitated the process of "knowing the patient". Nurses in this study stated concerns about writing problems on the master problem list as they were often unsure as to whether the problem was transient or permanent, as they may not have been familiar with the patient's condition. This finding supports Radwin (1993) and Tulloch's (1995) findings that nurses determined patient's problems by evaluating their condition against previously known information about the patient. Furthermore, casual and agency nurses voiced a reluctance to write problems in the notes that they would be unable to follow through with nursing care. Nurses in this study also voiced concerns about listing psychosocial problems in the patient record as they perceived that it breached patient confidentiality and they preferred handing over this information verbally. Additionally, they stated that the nature of some psychosocial problems was complex and unable to be resolved in the context of a routine admission and, hence, they tended not to focus on these issues and usually referred these problems to a social

worker. One could argue that diagnosing problems at cellular level is remarkably different to diagnosing problems at an individual social level where “knowing the patient” is an important factor. These findings support Mitchell’s (1991) claims that nurses faced ethical dilemmas wondering whether they ought to label patients and their problems. Additionally, one could question whether patient problems that are more “social” in their perspective can be labelled with any certainty given that each human being may experience an individual response to their situation (Rapley & O’Connell, 1997). Additionally, Wurzbach (1991) adds that making judgements in conditions of uncertainty are confounded by the nurse’s own biases which can affect the objectivity of the judgement. These findings concur with the findings of other studies illustrating inconsistent use of the nursing diagnostic concept (Johnson & Hales, 1989).

Additionally, the nurses in the current study found the use of the NANDA taxonomy problematic and described the language as being awkward, cumbersome, and also stated that it restricted professional judgements. Specifically, they often tried to match or fit a patient’s problem to a NANDA diagnostic label. These findings concur with the literature that argued that the nursing diagnosis nomenclature was esoteric and posed communication problems across the health care team (Masso, 1990; McHugh, 1991; Prideaux, 1991). While the developers of the nursing diagnosis stage argued a need to use standard labels to describe patient problems that would result in improved communication among nurses (Aspinall 1976; Gebbie & Lavin, 1974; Munding & Jauron, 1975), this *a priori* hypothesis was not evident in this study. Patients’ problems were often very complex and could not be stated using nursing diagnostic labels that succinctly reflected the patient’s condition. Due to this ambiguity, and the practice where nurses tried to label patient problems with supposedly matching nursing diagnoses, each nurse interpreted the listed problems differently. This finding supports Barnum’s (1987) and Henderson’s (1982) concerns as to whether this approach to patient care fully encompassed the nature of nursing or considered the unique characteristics of patients and their individual responses to health problems, which may be difficult to explicate using standard labels. Another explanation for this language problem with the NANDA taxonomy could be that it



has been developed using a language suitable for use in North America and, therefore, Australian nurses find it difficult to use.

The findings of the current study revealed that the master problem list did not always reflect patients' actual or potential problems and that nurses rarely referred to this document at the commencement of a shift. It seemed that the patient's medical diagnosis formed the basis of patient care and it was common for handovers to commence with the nurse stating the patient's medical diagnosis. This statement was supported by Carnivali (1984) who claimed that nurses insist on knowing the client's medical diagnosis before giving care, while at the same time, little attention is given to the client's nursing diagnoses. In light of this evidence, one has to question the relevance of using nursing diagnoses to communicate patient care if they are not referred to in practice settings.

Furthermore, due to all the discrepancies associated with making a nursing diagnosis, the findings in this study resembled other studies that illustrated cases where there was clinical evidence to support the existence of patient problems (nursing diagnoses) that had not been documented on the patient's master problem list (O'Connell, Rapley, & Tibbett, in press; Roberts, Madigan, Anthony, & Pabst, 1996). It may be that nurses in those studies experienced similar difficulties diagnosing patient problems using nursing diagnoses, although they listed possible signs and symptoms in the nursing admission form.

There were other anomalies associated with the use of nursing diagnosis found in this study. Specifically, nurses experienced difficulties writing realistic expected outcomes and they stated that they rarely referred to the ones that were written in the notes. The literature states that each nursing diagnosis should have an accompanying expected outcome statement listing the goal of care and a time frame for achieving this goal (Alfaro-Le Fevre, 1994; Iyer, Taptich, Bernocchi-Losey, 1995). As the nursing diagnoses listed were based on the patient's medical diagnosis and, therefore, contingent upon the patient's responses to medical treatment, predicting an outcome was a difficult task to achieve. This finding supports Masso's (1990) view that determining goals in regard to patient care is a difficult task that requires a lot of

skill. Many nurses voiced concerns that the listed expected outcomes were unrealistic and unachievable. It was stated in the current study that the reason why nurses wrote expected outcomes in the notes when they never referred to them, was supposedly “to follow hospital policy”. This provided some evidence to suggest that the espoused theory of what was thought to occur, that is, diagnosing patient problems and working towards achieving the listed expected outcome, did not actually happen in practice. That is the *espoused theories* of the nursing process were not consistent with the *theories-in-use* in clinical practice (Argyris & Schon, 1974, 1978).

Given this situation, it would seem that some authors and/or theoreticians have created expectations of nursing practice that are difficult to achieve in real world, acute-care contexts where nursing is inextricably linked to medicine and the impact of medical treatment on patient care. Even some nurse authors have been known to experience difficulties articulating the nursing diagnostic concept without using a medical diagnosis as a link to put forth a point and enhance understanding of the concept. In support, Turkoski (1988) stated that in a review of 150 articles written on nursing diagnosis, 87 % used medical language descriptions to discuss nursing diagnoses, thus illustrating the link between the patient’s medical diagnosis and nursing diagnosis. In light of this finding, one could pose the question as to whether the patient’s nursing diagnoses was a sign or symptom of the patient’s medical condition and, hence, question the need for listing a nursing diagnosis that only reinforced information that is already known about the patient. For example, a patient who was admitted with a medical diagnosis of Asthma was found to have a nursing diagnosis of “*Ineffective Breathing Pattern*” listed in the problem list. Patients who are admitted with Asthma usually present with breathing difficulties and one could question the reason behind relabelling a usual sign or symptom.

All these anomalies associated with the clinical use of nursing diagnosis provide some evidence to explain the reasons behind curious and unexplainable research findings. In particular, although the literature alludes to a link between nurses’ years of experience and efficacy in making clinical judgements (Benner, 1984; Thomas et al., 1991), studies that examine the effects of experience on clinical decision making in terms of nursing diagnoses conflict with this finding as they were unable to

demonstrate a positive correlation (Aspinall, 1976; Myers et al., 1986; O'Connell, 1992). Smeltzer and McCreary-Juhasz (1990) found no significant relationship between nurses' experience level and educational preparation with efficacy in planning patient care. Furthermore, studies have found no relationship between the efficacy of diagnosis and nurses' years of experience (Aspinall, 1976; Myers et al., 1986; O'Connell, 1992). Aspinall (1976) explained these findings stating that experienced nurses were still very action orientated in that they identified and treated problems without actually stating them. While this offers some explanation for this discrepancy, the substance of the argument does not seem to address the real problem. Nurses in the current study stated conceptual and implementation problems associated with the use of the NANDA taxonomy. Given this situation, one could argue that the diagnosis stage as enunciated by NANDA, due to its reductionist approach and esoteric language, confused experienced clinical nurses and limited their clinical judgements. Thus, when clinical judgements were measured using nursing diagnosis language they did not actually measure or reflect clinical expertise. Many authors espouse a need for the development of standard labels to be used in nursing (Fitzpatrick et al., 1989; Wake et al., 1993).

According to Carlson-Catalano (1993), "the only way society will understand professional nursing is through the language used by nurses" (p. 24). If the language used by nurses is difficult for other nurses to understand, one could question the likelihood of patients or other health care professionals finding it meaningful. Other reasons given for the development of standard labels (nursing diagnoses) were to detail nursing's unique contribution to client care and to assist the profession in naming and communicating health problems that are within the domain of nursing (Woolley, 1990). Furthermore, it was proposed as a mechanism by which nurses could receive monetary acknowledgment for professional advice and treatment (Gordon, 1987a). The findings of this study challenge this theoretical notion as there was no evidence to suggest that nursing diagnoses were used in any consistent way that assisted nursing practice; rather, they posed many clinical application problems for experienced nurse clinicians. In support, Avant (1990) argues that "Abstractness, ambiguity, and overlap among diagnoses contribute to professional miscommunication and the risk of mis-diagnosis" (p. 52). This being the case, it may

very well be that the diagnostic concept has been introduced into clinical settings prematurely and more concept development and refinement work is further required.

Interestingly, clinicians' resistance to the use of nursing process and, in particular, the diagnostic stage has been explained by some academics and staff development nurses in terms of nurses' lack of knowledge about the nursing process and a need for further in-service education (Cunning & Pflederer, 1986). However, besides Bowman et al's. (1983) study, which indicated that the use of a structured educational program on the nursing process created positive attitudes towards its use, a number of other studies evaluating the effect of an educational program on the use of nursing diagnosis have failed to increase nurses' proficiency with using nursing diagnosis (Carstens, 1984; Fredette & O'Neil, 1987; Meade & Kim, 1984; Myers et al., 1986). One explanation for this outcome could be that the nursing diagnostic concept is incongruent with the way in which nursing is practised and, hence, any educational program would be unable to solve the real problem of a theory-practice schism.

This inconsistent use of nursing diagnosis also has legal ramifications. According to Fortin and Rabinow (1979), the definition of nursing diagnosis contains a clause that suggests: *the nurse being able to intervene independently and is accountable for the care*, therefore, if a nurse should inadvertently diagnose a patient problem and label it as being a nursing diagnosis, though the definitive treatment is with medical treatment, she/he could be deemed to be neglectful. Given that nurses in the current study often developed nursing diagnoses based on patients' medical diagnoses and where the medical treatment was the definitive action, within this context, nurses could easily find themselves in breach of a legal code.

In summary, there were many problems that hindered nurses from conducting admission assessments and thus identifying individual patient problems. Alongside this, there were other problems identified with the use of nursing diagnosis and in particular the use of the NANDA taxonomy. As these two stages are said to be fundamental to developing an individualised patient care plan, the care planning stage of the nursing process also presented certain clinical application problems.

## **Nursing Care Planning**

The literature recommends that the nursing care plan should be developed as a consequence of nursing assessment and diagnosis (Alfaro-LeFevre, 1994; Iyer, Taptich, & Bernocchi-Losey, 1995). The findings of this study, in part, contradict this statement as it was found that patient care was developed primarily on doctor-prescribed orders and hospitals' routine interventions. Nurses in this study listed nursing interventions based on their knowledge of the patient's medical diagnosis and their understanding of the routine care associated with a particular diagnosis. In the current study, care plans often did not reflect actual patient care as patients' needs changed rapidly, and the care plans were not always updated regularly. Consequently, nurses usually used the care plan as a general rather than a specific guide to care. However, they supplemented this information by asking the patient or asking another nurse about specific patient care. Street (1992) reported in her ethnography of clinical nursing practice that the nursing care plans and nursing notes were written in a cryptic form that assumed it would provide meaning to what was known about the patient orally. She further added that "This assumption shapes the written format as a record of memory jogs to support the oral communication rather than as a record of care and projected plan of care" (p. 182). This finding explains why Ferguson, Hildman, and Nichols (1987) report that the use of patient care planning system had no effect on the outcomes of patient care.

Furthermore, Lawler (1991a) adds that the nursing care plan is a cosmetic document that becomes a focus of attention as hospitals work toward achieving accreditation, following which, emphasis on its use usually dies down again. The findings also supported Nichols and Barstow's (1980) claim that only 49 % of nurses reported using the standard care plans while 51 % of nurses stated minimal usage. In the current study, experienced nurses who routinely worked on the same ward said they never referred to the care plan; rather, they knew the care by looking at the patient. It also supports Palmer's opinion as to the relevance of the "inane repetitious writing of care plans that do nothing whatsoever to guide nurses in the planning process" (1988, p. 1357).

The majority of the nursing care plans reviewed in this study were written very cryptically using abbreviations that may not have been known to other nurses. One reason for the continued use of abbreviations could be explained using Lawler's (1991b) concept of minifisms. Lawler stated that nurses minimised the significance or the severity of an event in order to ease its gravity. The abbreviation *SOC* meaning *Sit on Commode* rather than Sit on the Chair when the patient was faecally incontinent is minimised in its abbreviated form and it is likely that any relative would be unable to decipher its true meaning. Additionally, nurses in the current study used multiple terms to describe the same interventions. This finding supports McClosky and Bulechek's (1994) claim for developing a standard nursing intervention taxonomy. These authors state that, as nursing is a large and complex group, a common language is necessary to facilitate communication among nurses. While the need for a standard language has pragmatic outcomes as the interventions can be coded and costed, the large numbers of interventions presented by McClosky and Bulechek (1992, 1994) would make it difficult for any nurse to memorise and use this language consistently and could once again pose clinical application problems. According to McClosky and Bulechek (1992, 1994) and Micek et al. (1996) there are many professional advantages related to the development of an intervention taxonomy. This development would assist with: (1) the development of a nursing information system, (2) the communication of the nature of nursing, and (3) the expansion of nursing knowledge. In Australia, some academics and informatics specialists have emphasised the need for the use of standard nursing labels to assist in delineating nursing care and the development of a computerised data base that could be used for the reimbursement of this care (Conrick & Foster, 1994; Hovenga, 1991).

While all these reasons seem professionally worthwhile, they resemble the reasons given by nurses involved in the development of a diagnostic taxonomy. The findings of the current study supports the literature in demonstrating that the development of a diagnostic taxonomy has not achieved its espoused goals due to clinical application problems. It is important, therefore, to clinically evaluate any intervention taxonomy before it is implemented in Australia as it may pose similar problems in its clinical application as the NANDA nursing diagnostic taxonomy.

In addition, due to a number of factors that impeded the use of care plans, these forms were completed inconsistently and were not always reflective of the actual care that was given. This supports Peterson's (1987) claims that the patient's plan of care is often more a historical document listing care that has been given previously, rather than recording the care that is current. One could argue that the complexity of patient care and patient's changing needs posed documentation problems for nurses. These findings were consistent with those of Ehnfors and Smedby (1993), who reviewed 106 nursing records from 12 wards for the adherence to nursing process standards. The authors reported that the admission assessment was completed in 50 % of records, 90 % had no nursing diagnosis, and 66 % had no care plan. Furthermore, they reported many anomalies with documentation that breached legal and professional standards.

### **Progress Notes**

The inconsistent documentation of patient care was also found to exist in the patients' progress notes. The quality of what was written in the patients' progress notes varied according to the experience level of the nurse and her/his ability to focus on documenting appropriate aspects of care. Once again, there was an emphasis on documenting physical aspects of care with little emphasis on noting the patient's psychosocial wellbeing. This finding is supported by Parker and Gardener's (1992) appraisal of the nursing progress notes where they stated that much of nurses' work, patient care, is taken-for-granted and not documented in the notes. These authors stated that documentation emphasised "body as an object of nursing interventions rather than a more personal, involved, human dimension of caring" (p. 6). Taylor's (1994) account of ordinariness in nursing further supports this statement and offers another explanation for this lack of documentation. She stated that nurses involved in the basics of care hide behind professional facades, whether this is on a personal basis or is manifested more overtly, by nurses not documenting real accounts of care in the progress notes. In support, Heartfield (1994) posits that nursing decisions and their contribution to care are hidden in a "scientific discourse that sanitises their meaning and worth" (p. 40). The above mentioned factors provide one explanation why nurses in the current study found commenting on the patient's nursing diagnosis

a helpful prompt to guide report writing in the progress notes. It may be that it provided them with a “scientific” structure on which to focus the discussion as what occurred during the course of a shift may have been difficult to capture succinctly in a written form.

The findings of the current study support Howse and Bailey’s (1992) claims that hospitals’ documentation policies influenced the type of information that was documented. Time was a factor that affected this process as documenting care usually occurred at the end of a shift. Due to the short shifts and nurses trying to complete their work, they often hurriedly wrote anything in the notes in order to comply with hospitals’ documentation policies, or sometimes forgot to document care before completing the shift. Hence, under these conditions, the record of care was discontinuous and fragmented and patient progress was difficult to assess via the notes.

Overall, there were many anomalies found with the assessment, nursing diagnosis, and patient care planning stages of the nursing process. It would seem that, in regard to these three stages of the nursing process (assessment, diagnosis, and developing a plan of care), there was conflict between the espoused theory and the *theory-in-use* (Argyris & Schon, 1974, 1978). Moreover, the theoretical ideals of the espoused theory, due to contextual factors, were unable to be operationalised. The large numbers of nurses involved in the delivery of care and the number of charts used for one patient further exacerbated the problem of communicating patient information. Many authors have claimed that nurses’ negative attitudes towards the use of the nursing process may be one factor influencing the misuse of this concept. It is argued here that it is the clinical use of a theoretical ideal that is problematic and results in nurses’ negative attitudes, rather than nurses’ preconceived notions about its clinical utility. In support of this statement, a study reported that students’ attitudes to the nursing process and the nursing diagnosis stage became more negative as they progressed through their nursing degree (Kohler, Koss, Burley, & Ogdon, 1995). The study focused on students’ perceptions of the helpfulness of the nursing process to assist with diagnosing patient problems, planning, and implementing patient care. The researchers found it hard to explain these findings and thought it could be related



to their assigned tutors' attitudes which had influenced students' perceptions. Another explanation could be that, after using the concept, students realised that it did not assist with determining and communicating care. In support, Daws (1988) found nurses who worked in a ward where the nursing process had been used for more than twelve months displayed less positive attitudes to its use than nurses who had used the process for less than 12 months.

The findings of the current study challenge the development of a diagnostic and interventions taxonomy for use by nurse clinicians as it is argued that its development is unable to serve conflicting purposes. On the one hand, the development of a language that enhances the focus of nursing care, the development of nursing knowledge, and the costing of nursing services offers worthy professional advantages required for a developing discipline. On the other hand, however, one could question its applicability, as the language itself is problematic for nurse clinicians and in some instances poses translation difficulties when used in non English speaking countries (Coler & Boisvert, 1996). If there is tension between the espoused theory and the theory-in-use, then a return to the drawing board is necessary as nursing is and remains a practice based discipline, hence, the theory should assist practice.

According to Meleis (1991), research is a mechanism by which the theory-practice gap can be minimised. If research findings illustrate a gap in the clinical application of a theoretical ideal, then it is important for nurse theorists to take heed. Furthermore, it may be necessary for the nursing profession to view this taxonomic development differently. Donaldson and Crowley (1978) state that:

*"although the discipline of nursing and the profession are inextricably linked and greatly influence each other's substance they must be distinguished from each other. Failure to recognise the existence of the discipline as a body of knowledge that is separate from the activities of practitioners has contributed to the fact that nursing has been viewed as a vocation rather than as a profession" (p. 115).*

Based on this stance, one could consider this taxonomic development as being disciplinary in nature and hence not impose it on nurse clinicians who have voiced difficulties using the concept. For example, the concept of hope can be theoretically

developed and the understanding of this concept, “nursing knowledge” could be used by nurse clinicians to understand patients’ experiences and assist them to deal with their responses without actually labelling them with the nursing diagnosis of “hopelessness”. This formula could be applied to a number of nursing diagnoses ranging from physical problems through to psychosocial ones. The development of this knowledge using research methods that do justice to the phenomenon being studied, and the further synthesis of this knowledge in practice, will provide nursing with part of its theoretical base. For if the discipline of nursing is to survive, it is reliant on its clinical success and the efficacy of its knowledge base to enhance patient care. It would seem impractical to encumber nurses with ideals of care that are difficult and some cases impossible to implement. On the other hand, it would be naive to “throw the baby out with the bath water” and totally reject the concept of nursing diagnosis. This knowledge development of nursing diagnostic concepts forms an important aspect of nursing’s theoretical base which should inform nursing education and thus nursing practice.

## **Handover of Information**

The findings of the current study revealed factors that influenced the efficacy of the handover process. They also supported the literature and provided evidence to illustrate problems associated with handover that have been previously stated (Reiley & Stengrevics, 1989). The findings concurred with the literature, illustrating that the information handed over varied considerably from nurse to nurse (Mosher & Bontomasi, 1996; Sherlock, 1995) with a greater emphasis on handing over physical, task-oriented information (Liukkonen, 1993; Mosher & Bontomasi, 1996; Strange, 1996). Liukkonen (1993) analysed the content of nurses’ shift reports in homes for elderly people and she stated that the reports were random, situationally dependent, and emphasised medical treatment. Additionally, the reports did not provide a discussion of the overall state of the elderly people and their life in institutions.

According to Ekman and Segesten (1995), as information handed over in shift reports emphasised medical orders, it locked nursing into a medical framework and consumed nursing time to an extent that nurses gave little attention to their own work

and patients' nursing needs. These authors further added that this situation was a form of medical control and that the invisibility of nursing care in the handover did not necessarily mean that "good" nursing care had not been given. The findings of the current study support this claim, as the handover changed emphasis as patients progressed. Specifically, on admission the focus of handover was on medical care and gradually as the patient progressed the handovers focused on "patient as a person". It also supported Ekman and Segesten's claims about a lack of time to focus on discussing patients' nursing care during the handover period. Another explanation for this situation could be that due to a lack of nursing assessment that extends beyond the patient's medical condition, what is known about the patient by the nurse is predominantly medical information which is given greater emphasis during handover. Ekman and Segesten's findings concur with findings of the current study where, due to a lack of relevant information being handed over, the nurses got to "know" the patient by seeing them rather than from the handover report. MacLeod (1994), however, offers a counter argument stating that nurses are hindered in their communication efforts due to the complexity and inexpressibility of their work.

Additionally, the findings of the current study support Parker, Gardner, and Wiltshire's (1992) hypothesis that the verbal handover served a useful purpose where nurses sought group support to develop a clinical picture of how the patient was progressing, and to confirm or deny decisions about patient care as well as to discuss and share problems, solutions in relation to other aspects of care. To add to this discussion, O'Brien and Pearson's (1993) study highlighted the aspect of nurses' oral knowledge as an important source of "knowing" and the informal nature of the transfer of this knowledge between nurses at ward level. Hence the value of handovers extends beyond just a transfer of patient information; it also provides an avenue for the development and transfer of nursing knowledge via the oral mode. This exchange of information and informal teaching sessions was found in the current study. In the absence of verbal handovers and with the increasing use of tape recorded handovers, this avenue for knowledge exchange was lost and had fostered the problem of nurses being in a state of "*unknowing*". Furthermore, verbal handovers and handover time also played a social role, where nurses were able to group and discuss issues informally (Strange, 1996). Some authors refer to this as

creating solidarity; handovers provided an arena for debriefing which is sometimes difficult to achieve in patient areas within the ward (Parker, Gardner, & Wiltshire, 1992). Talking to other nurses was an important aspect of nursing practice as it assisted nurses to make what they do manageable for them as nurses (Lawler, 1991b). The use of the oral culture was strongly supported in the current study and concurs with the findings of other studies that reinforce nursing's ease of communicating orally and where a meaningful dialogue about patient care is sustained (O'Brien & Pearson, 1993; Street, 1992). One explanation for the continued use of this mode of transferring information and knowledge could be that as nurses' frequently found themselves in a state of "*unknowing*" they had to check and clarify information before committing words to a written form in the patient's progress notes. Additionally, handovers supported this practice by providing one arena for this to occur.

In support of the findings previously discussed about the social aspects of handover, the current study alluded to a reduction in shift overlap time and hence difficulties associated with being able to hand over patient information and socialise. Though not overtly expressed, the data suggested that staggered shifts and a lack of stable staff impacted on the cohesiveness of the team.

A study conducted by Hawley and Stilwell (1993) that investigated the use of nursing resources in acute hospital settings reported interesting findings. The researchers cautioned a reduction in shift overlap time as they found that the reduction in this time stifled the opportunity for staff to plan and document patient care. Hence, when they reviewed care plans on ward areas that had reduced shift overlap time, they reported that little or nothing had been written in the care plans. Additionally, they reported a reduction in time spent teaching learners and further added that this lack of overlap time has the potential to contribute to staff dissatisfaction. These findings concur with the findings in the current study where the short shifts and the lack of shift overlap was found to limit and hinder communication and to create a sense of uneasiness among nursing staff.

The findings of the current study also revealed that the handover of patient information was problematic due to instances of poor communication between doctors and nurses. While the study objectives did not focus on reviewing this particular situation more intensely, one could assert that as the focus of patient care was heavily based on doctor-prescribed care, this lack of communication affected the currency and continuity of care. These findings concur with other studies that report communication difficulties between doctors and nurses (Coburn, 1988; Irurita, 1990, 1993; MacKay, Matsuno, & Mulligan, 1991; Street, 1992). In wards where doctors and nurses documented patient information in different sections of the patient's notes, this practice further exacerbated the doctor-nurse communication problem.

### **Large Numbers of Nurses Involved in Giving Care**

Another factor that influenced the way in which patient care was determined, delivered, and communicated was the large number of nurses involved in the delivery of care and a lack of a central person coordinating the overall process. Peterson (1987) argued that for the nursing process to work there needed to be more organisational commitment to assigning the same patient to the same nurse over the total patient stay. As this consistency in assigning patient case load is difficult to achieve, due to a number of reasons including the employment of part time staff and rostering constraints, other patient care delivery models need to be considered. For example, a form of team nursing. Jenks (1993) conducted a descriptive field study in a 700 bed university hospital in order to gain a practice-based understanding of clinical decision making. The findings revealed three main themes that assisted the informants' clinical decision making abilities. The themes identified were: knowing the patients, knowing the peer nursing staff, knowing the physicians. The findings of the current study revealed that nurses were often put in situations where they did not know the nurses and doctors with whom they were working. This lack of knowing one's work colleagues contributed to the core problem of being in a state of "*unknowing*". Another factor which further exacerbated this condition was a lack of a central person coordinating the patient's overall care.

According to MacLeod (1994), nursing practice within a ward was led by the “ward sister” who offered leadership, coordinated patient care, and maintained a standard of care. In the current study, the ward was usually coordinated by a Level Two nurse. As each ward had approximately four Level Two nurses, there was no specific central person that was responsible for coordinating overall patient care. In some instances, these nurses were employed part-time and may not have shared the same philosophy of care as other Level Two nurses on the ward. These differences further complicated the issue of continuity of care. At an operational level, this lack of a central person hindered communication and the overall coordination of patient care.

In summary, due to all the above listed problems associated with the use of the nursing process, determining and communicating patient care occurred in a fragmented and inconsistent way. While many of the problems associated with the clinical application of the nursing process were exacerbated by the prevailing contextual conditions, there were other problems that occurred due to a theory-practice dissonance. In support of this argument, Orb (1994) adds that, as the nursing process was developed by a group of nursing education scholars who wanted to consolidate the independent role of the nurse, it was prone to being problematic due to the different objectives of each group of nurses. Furthermore, the findings of the current study revealed that the way in which the nursing process is explicated is different to the way in which the process of nursing occurs. Many authors have stated that the process of nursing is a multidimensional activity that involves more than just problem solving and should be described in a non mechanical, logistical way (Henderson, 1982; McHugh, 1886; McMurray, 1989).

## **Fluctuating and Uncertain Working Conditions**

The findings of this study revealed other anomalies in the work situation. Specifically, that nurses worked under fluctuating and uncertain working conditions where they found themselves in situations where they did not know what to expect. This was due to a number of factors and conditions in the hospitals that appeared to be related to hospital budget cuts. This uncertainty was caused by nurses’ changing award and what appeared to be an erosion of their working conditions. These

findings were supported by Irurita (1990) who conducted a grounded theory study of nursing leadership in the city where the current study was conducted. Irurita reported that the conditions under which nurses functioned were uncertain, turbulent, and constantly changing. In addition, the current study found there were many other uncertainties caused by organisational practices. Specifically, nurses were assigned fluctuating levels of responsibility and workloads, they worked with nurses who had different levels of knowledge and experience which were sometimes unknown to them. Furthermore, as nurses and patients were moved across wards they often nursed patients from specialty areas with which they were unfamiliar. These findings are supported in the literature and one could conclude that the experience of uncertainty in acute care settings is more widespread than just this study setting (Holzemer, 1996; Shindul-Rothschild & Gordon, 1994; Twedt, 1996). A short article published in the Australian Nurses Federation (ANF) newsletter defended nurses' position of being blamed for poor care and provides supporting evidence of the problem of a lack of time and resources.

*How can nurses deliver quality care when the overall number of nurses employed is reducing or conversely their hours are reduced; and while the throughput and acuity of patients is increasing and when the average working day is reducing to as little as six hours, yet the expectation for care delivery are unchanged. . . . Nurses are still committed to caring and our capacity to give quality care is proportional to the time and resources available (ANF, 1997, p. 6).*

In addition to this uncertainty, nurses were constantly interrupted within a course of a shift; this was said to interrupt their work and their thought processes. There was no literature found that discussed this issue and it seemed that "being interrupted" was a taken-for-granted condition of nursing practice.

It was found that nurses, in some situations, lacked control over their professional practice for many reasons. Some of these reasons include being regulated by hospital policies. These findings concur with Latimer (1995) who stated that "nurses are being enrolled by managerialism" (p. 218). Through this process of enrolment, nurses are not constructing their own territory. Rather, they are being drawn into other's grounds, that tends to serve management needs not nursing professional needs. Latimer further stated that nurses experienced difficulties implementing the nursing

process due to inadequate resources, though at the same time they are evaluated, through quality assurance programs, on the efficacy of its use. Casey and Hendricks-Thomas (1994) further support this argument as they posit that the nursing process gathers momentum because it is consistent with health policy based on principles of economic rationalism with little benefits for nurses and patients. Furthermore, Dobos (1994) reported that nurses were often in situations where they felt they were up against a brick wall as they were unable to change aspects of patient care. Orb (1993) further states that as the doctor can often override a nursing decision, the issue of whether nursing is an autonomous profession is unclear. Additionally, nurses in the current study stated that they found it difficult to influence care due to doctors frequently not including them in decision making. These findings are supported by the literature that give accounts of medical dominance and the Doctor-Nurse game (Irurita, 1990; Lupton, 1995; Orb, 1993; Street, 1992; Sweet & Norman, 1995; Warelow, 1996).

As a result of the use of a fragmented system for determining and communicating patient care, coupled with working under conditions of uncertainty, nurses experienced a basic social problem of being in a state of “*unknowing*”. One explanation as to why this problem occurred could be because nurses were locked into using a process that was incongruent with how nursing is practised in acute care settings where contextual factors mitigated against optimising the way in which care was determined, delivered, and communicated. All these factors of uncertainty in the work place sometimes led to nurses and patient care being compromised. This finding was supported by Twedt (1996) who reported many anecdotes of patient care being compromised in the work place.

### **Towards a New Process of Nursing, *Enabling Care: Working Through Obscurity and Uncertainty***

The Basic Social Process used by nurses to overcome this problem of being in a state of “*unknowing*” was termed *Enabling Care: Working through obscurity and uncertainty*. It had two phases. The first phase was entitled: *Putting the pieces together: making sense*, comprised four subprocesses. These subprocesses were



termed: drawing on the known, collecting and combining information, checking and integrating information, and sustaining communication. This phase describes the process nurses used to overcome the problems associated with determining and communicating care. The second phase of the process was labelled *minimising uncertainty*. It involved three subprocesses which were termed: adapting work practices, taking control, and backing-up. This phase describes the process nurses used to overcome the uncertain conditions under which they worked.

Collectively, these subprocesses explained how nursing care was determined, delivered, and communicated in the context of acute care settings. The findings of the current study revealed a process of nursing used by nurses who worked in acute care settings, which was different to the nursing process as developed by Yura and Walsh in 1967 (see Figure 5:9 on page 217).

### ***Drawing on the Known***

Nurses in this study were able to, in part, overcome the problem of being in a state of “*unknowing*” by *drawing on the known*. As patients and nurses in acute care settings constantly changed during any shift, nurses experienced being in a state of “*unknowing*”. Within this context, nurses who knew the ward, ward routines, the patient, the patient’s medical condition, and more broadly knew what to expect were able to proceed with aspects of their work and deliver patient care as they were guided by what was known. Specifically, the findings of the current study revealed that at the commencement of any shift, nurses who were familiar with any of the above-mentioned aspects could proceed more aptly with their work. In support of this finding, a grounded theory study that reviewed clinical decision making in an Intensive Care unit found that the process of forming a patient’s clinical picture commenced at a stage prior to the nurse meeting the patient (Tulloch, 1995). Specifically, the researcher stated that nurses’ informal discussions with staff members about the patient’s condition, the medical diagnosis, demographic information, and observing the patient from a distance provided nurses with information about the patient that assisted their decision making. Additionally, in the

current study, knowing and following ward routines was another factor found to assist the delivery of patient care.

According to Deluca (1995), nursing routines and rituals should be understood in context and while some require questioning others assist by stopping the chaos in any acute hospital. This statement is supported by other studies on this topic that revealed the value of ritual and routines. Strange (1996) conducted an ethnographic analysis of ritual in nursing and concluded that ritual served as a legitimating factor in nursing knowledge and should not be disregarded. Given this situation, making ward routines more explicit would be one strategy that could assist the delivery of care as it provides guidance which minimises the nurses' state of "*unknowing*" in acute care hospital settings.

### **Knowing the patient**

Knowing the patient in order to deliver specific patient care occurred using other processes besides reading through the patient's notes and/or handover. These factors, identified in the literature, need to be considered as they formed the basis of the subprocess of "*drawing on the known*" and one of its properties *knowing what to expect* which was found in the current study. There is an emerging literature on "knowing the patient" as being a foundational stage that assists with the planning of individualised patient care (Evans, 1996; Irurita, 1993; Jenks, 1993; Jenny & Logan, 1992; Radwin, 1996; Williams, 1996). The literature identified properties associated with "*knowing*" the patient which include the nurse's experience with caring for the patient, time, and a sense of closeness between the patient and the nurse (Irurita, 1996a; Jenny & Logan, 1992; Radwin, 1995b).

Other processes that assisted patient care were assessing patient progress in the context of what was known about the patient or drawing on previous experiences and knowledge (O'Brien & Pearson, 1993; Radwin, 1993; Tulloch, 1995). One factor identified in the literature that hindered knowing the patient was stereotyping the patient. Moss (1988) claimed that nurses, over a period of time, stereotyped patients into certain categories and they classified them as having certain attributes based on

these preconceived ideas which may be incorrect. Taylor (1994) supports this notion stating that nurses label patients using words such as “the demanding patient” or “he’s just like Mr Brown” to communicate patient information which may be subjective and detrimental to patient care. Within this context, one could question whether using diagnostic labels is another form of stereotyping. As knowing the patient as a person transcends stereotyping the patient, this process is an important state for the nurse to achieve in order to nurse successfully. Jenny and Logan (1992) assert that failure to know the patient can result in ineffective care and patient outcomes. Irurita (1996a) adds from a patient’s perspective that knowing the nurse and the nurse knowing the patient enhanced the nurse-patient relationship which increases the quality of nursing care. Rowles and High (1996) state another perspective, that is, involving family members in care is a very important factor as they can often reveal concerns about the patient before they became apparent to the nursing staff. The findings of the current study revealed that many factors such as: employing large numbers of agency and casual nurses, the movement of nurses and patient across wards, and increased patient turnover, militated against “knowing the patient” and led to the nurse being in a state of “*unknowing*”. As a result of this, nurses had to draw on previous general knowledge and experience in order to assist with the understanding of the patient and their care. Hence, *drawing on the known* was the first subprocess used to determine and deliver patient care.

There is an abundance of literature on the concept “knowing” that links with the subprocess *Drawing on the known* and further adds to the understanding of how nurses overcome the problem of being in a state of “*unknowing*”. According to the literature, nurses have varied and complex ways of knowing that are influenced by many factors. Some of these factors include experience, intuitiveness, nurses’ use of prime sources of knowledge, oral knowing, somology, knowledge and use of the patterns of knowing, paradigm used to construct knowledge as well as the attributes inherent in the nurse as knower (Benner, 1984; Carper, 1978; Lawler, 1991b; Moccia, 1994; O’Brien & Pearson, 1993; O’Connell, 1996b; Schultz & Meleis, 1988; Vaughan, 1992; Wolfer, 1992). Schultz and Meleis (1988) so aptly stated that there are multiple ways of knowing in nursing and that clinical knowledge is a combination of intuition, subjective knowing, personal knowing, and empirics. A

summary of this literature is explicated as it is proposed that these factors form the basis of what is known and assists with the understanding of the subprocess *drawing on the known*.

Knowing as a concept occurs at various levels of complexity, some of which are more objective and explainable and other forms that remain tacit and less tangible. Vaughan (1992) alluded to three prime sources of knowledge used in nursing. These were given as: tenacity, authority or expert, and *a priori*. While some of these sources have merit they also need to be constantly challenged as they present with inherent weaknesses that can lead to a false understanding of what is known. Specifically, knowledge that stems from experienced nurses is contingent upon the currency of the knowledge and whether that knowledge is informed by contemporary views of nursing practice. Nursing for a number of years does not necessarily equate with being knowledgeable if what is practiced is out of date. Rodgers (1991) stated that very often, in nursing, there is an unquestioning adherence to authority that supports dogmatic thinking and should be viewed questioningly. Meleis (1991) further adds that the transfer of knowledge from generation to generation of nurses should be evaluated periodically as it may be misleading. In order to optimise what is known, these factors need to be taken into consideration and appraised in light of their presenting weaknesses.

The findings of the current study supported the literature in demonstrating that nurses were comfortable using the oral culture as a mode of operating and communicating (O'Brien & Pearson, 1993; Street, 1992). According to O'Brien and Pearson, "how to nurse" is transmitted orally from nurse to nurse and occurs within the context of day-to-day care. The researchers reported that as nurses work together they constantly engage in conversations that confirm or refute information and build on their knowledge through these discussions. What is particular about this knowledge is that it is held in nurses' minds and transferred verbally in clinical settings. This was found to be the case in the current study where nurses often conferred with one another about patient care and senior nurses provided junior nurses with advice about care. Hence learning about patient care, "knowing", occurred at the bedside and was a situationally based process that occurred in the oral mode.

In addition, Lawler (1991b) espoused the concept of somology, “knowledge of body care”. She stated that within the context of everyday work nurses dealt interactively and intimately with other people’s bodies. Through this experience, they had developed an understanding, knowledge of the body, that was dependant on the person (patient) and the context of the interaction. However, nurses did not talk or write about this knowledge as it was thought to be “dirty” and not worthy of further discussion. Lawler added that this knowledge is important as it assists nurses in their practice and, hence, needs to be acknowledged and discussed.

Other factors that influenced what is known by the nurse was their level of experience (Benner, 1984). According to Benner, experience and knowledge base are critical factors that affect clinical decision making. Benner (1984) referred to experience as being “greater than the mere passage of time or longevity, rather it is the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory” (p. 36).

Experienced nurses, therefore, had a richer understanding of situations that they could draw on in order to make decisions. Furthermore, intuition was another aspect identified that assisted knowing. This attribute is said to be linked to nurses’ years of experience (Benner, 1984; Rew, 1988; Young, 1987). Agan (1987) further described this way of knowing as being subconscious and instinctive. According to Moch (1990), intuitive knowing is a form of experiential and personal knowing. Intuition was defined by Benner and Tanner (1987) as “understanding without a rationale”. . . . “intuitive judgements is what distinguishes expert human judgement from the decisions or computations that might be made by a machine” (p. 23). Hampton (1994) claimed that expertise in the form of being intuitive is an artful form of nursing and an untapped source of knowledge.

What is known by the nurse is also believed to be influenced by the patterns of knowing that informs the nurse’s thinking and knowledge base. Carper (1978) explicated four patterns of knowing used to construct nursing knowledge and hence to inform decision making. These patterns were: *empirics* which is associated with the science of nursing; *aesthetics* which is associated with the art of nursing; *ethics*

which is associated with the moral component of nursing and *personal knowledge* which stems from knowledge about oneself and the use of therapeutic self. Some authors state that this pattern is linked to intuitive knowing (Agan, 1987; Moch, 1990). Interestingly, Munhall (1993) espoused that “unknowing” is another pattern of knowing, where the nurse learns to “unknow” in order to become detached from what is known. Munhall’s definition differs from the definition of being in a state of “*unknowing*” espoused in the current study (Refer to Chapter Three). This process, as stated by Munhall, ensures that the nurse does not bias any decisions made about patient care based on prior knowledge. This concept of unknowing is one method that could be used by nurses to avoid stereotyping the patient. According to O’Connell (1996b), Munhall’s explication of the concept of unknowing embraces the concept of advocacy and is subsumed within Carper’s patterns of knowing and, therefore, the need to articulate it separately is questioned. The use of all these patterns assists in the process of nursing, as they are foundational to “knowing how to nurse”. While the literature states that nurses deliver care using these patterns, very often nurses in the current study were controlled by a number of policies that prescribed how care should be given. Additionally, some nurses stated situations where they were unable to influence care as it was medically prescribed and controlled. Furthermore, the issue of medical dominance over nursing impacted on the autonomy of nurses (Irurita, 1990; Lupton, 1995; Street, 1992; Sweet & Norman, 1995; Warelow, 1996). These two factors, therefore, filtered what knowledge was permitted to be used in clinical practice.

According to Carper (1978), one of the influencing factors that affects personal knowing is “knowing oneself”. Based on the work of Belenky et al. (1986), who identified five different types of women knowers, Schultz and Meleis (1988) proposed that these types of knowers can be found in nursing. The five types of knowers are: silent knowers, received knowers, subjective knowers, procedural knowers, and constructed knowers. Each of these types of knowers present with individual ways of interacting that are underpinned by different values and belief systems about what constitutes knowledge and how it is gained. As Carper suggests that part of developing personal knowledge is to understand oneself, therefore, it is important to take cognisance of this literature.

Additionally, in regard to the pattern *empirics*, the type of research method used to construct knowledge and the underlying philosophical assumptions of the method will also determine what is known. Many nurse scholars state that the research question will drive the type of method used for the study. This limited view tends to misrepresent the overall picture, as the underlying assumptions of the study design and the phenomena being studied also need to be considered in the design equation (Moccia, 1994; Wolfer, 1993). Hence, what is known through empirics is influenced by the philosophy and assumptions underlying the research method that is used and this further impacts on what is known.

All of the factors, previously discussed, are said to influence what is known by the nurse and used in practice. As knowing is a fairly elusive state, due to the complex environment of an acute care setting, knowledge about patients varied from nurse to nurse. Hence, confirming what is known was also found to be an important part of the process used by nurses. The findings of the current study identified two subprocesses used to achieve this goal. These were collecting and combining information, and then checking and integrating information.

### ***Collecting, Combining, Checking, and Integrating Information***

Collecting and combining information was the second subprocess used by nurses to assist with knowing the patient and understanding patient nursing care needs. Handovers were usually the first point of contact where nurses collected and combined information about patients. Verbal handovers were said to be more efficacious when compared to the tape-recorded handovers which were less interactive and brief. During handover, nurses pooled information about the patient and their care and clarified decisions about care with other nurses. These findings concur with the other interpretive studies that state that within the handover context nurses collectively constructed a “collaborative narrative about the patient” (Parker, Gardner, & Wiltshire, 1992; Street, 1992). The accuracy of the handover was contingent upon many factors that impinged on what is known about the patient and their specific care. Due to this uncertainty, nurses constantly checked and integrated this information with other available sources. Some of these sources included the

patient, the medical and nursing notes, other nurses, and the doctor. This finding is supported by other studies that looked at clinical decision making. Specifically, they reported that it occurred in a “collective form” where information was gained from several sources, each source adding information or confirming or updating what was known about the patient (O’Brien & Pearson, 1993; Radwin, 1995a; Tulloch, 1995).

In support, Morrison’s (1989) study conducted on nursing rounds found that 40 % of the questions that nurses asked were classified as seeking clarification. Within this context, nurses were constantly building a clinical picture of the patient that was constantly changing and, hence, they often sought clarification. A number of sources were often used to decipher and determine care. These sources included: asking the patient, doctor or another nurse, looking at the patient’s charts and observations, and performing a visual assessment. This finding is important as it explicates the depth and breadth of information necessary to determine patient care and the complex method used by nurses to understand each patient’s care within an uncertain and changing environment.

This finding of constantly checking and integrating information is supported by Crow, Chase, and Lamond (1995) who asserted that nursing assessments were conducted more frequently than medical assessments as they focused on providing a current account of the patient’s condition which often changed. This finding of collective decision making is important as it reinforces the team approach to patient care. It also challenges the findings of studies that examine clinical decision making on an individual nurse-patient basis. del Bueno’s (1990) study on nurses’ levels of experience and education on the efficacy of decision making reported more within group differences than between group differences. This finding was interesting as one would expect that more experienced nurses would display better results. While the researcher offered superficial explanations for this finding, it may be that nursing and nursing decisions are so complex that they are made in the context of pooled knowledge and that each nurse has a different understanding of patient care and collectively they are able to arrive at an accurate judgement. Thus, when the efficacy of decision making is evaluated on an individual nurse-patient basis the findings may not reflect decision making as it occurred in acute care contexts.



In addition, due to the changing nature of the patient's condition, the oral mode was most often used to communicate information as it was more immediate and meaningful. As there were a number of nurses involved in the patient's care which was a function of the continuous nursing coverage required throughout the patient's stay, coupled with a large number of agency and casual nurses used to deliver care, maintaining continuity and consistency in the transfer of patient information was a difficult task to achieve. In addition, the use of the short shifts, lack of handover time, use of tape-recorded handover further impeded the accurate communication of information. These factors, combined with a lack of adequate written documentation about patient care, meant that in these settings nurses had to try and optimise the process of communicating patient information. Within this context, nurses had to use other strategies to sustain the communication. Hence, sustaining communication was the third subprocess used to determine, deliver, and communicate patient care.

### ***Sustaining Communication***

Due to the use of short shifts and tape-recorded handovers, nurses were unable to handover information verbally. To address this problem, nurses in the current study developed an informal written culture that compensated for an inability to use the oral culture. Specifically, nurses left each other informal notes written on pieces of scrap paper left in the office, on a chart, or stuck to the patient's case notes. These notes reminded other nurses or doctors about patient care or jobs that needed to be completed. This informal written communication occurred among nurses and between nurses and doctors.

In order to optimise communication via handover, some nurses had developed written handover guidelines that prompted nurses to hand over specific patient information. The prompts used were once again physical and task-oriented and enforced knowing the patient as a biophysical individual who was a recipient of nursing interventions. Individual wards had also introduced the use of various types of communication books that were used to enhance the communication of information from doctors' rounds, to changes in hospital policies and procedures. Although this seemed to enhance communication, it increased the number of places where patient information was documented and very often nurses would not have

time to read this information. This further added to the problem of being in a state of “*unknowing*”. See figure 6:2 on page 261 for a schematic representation of the discussion.

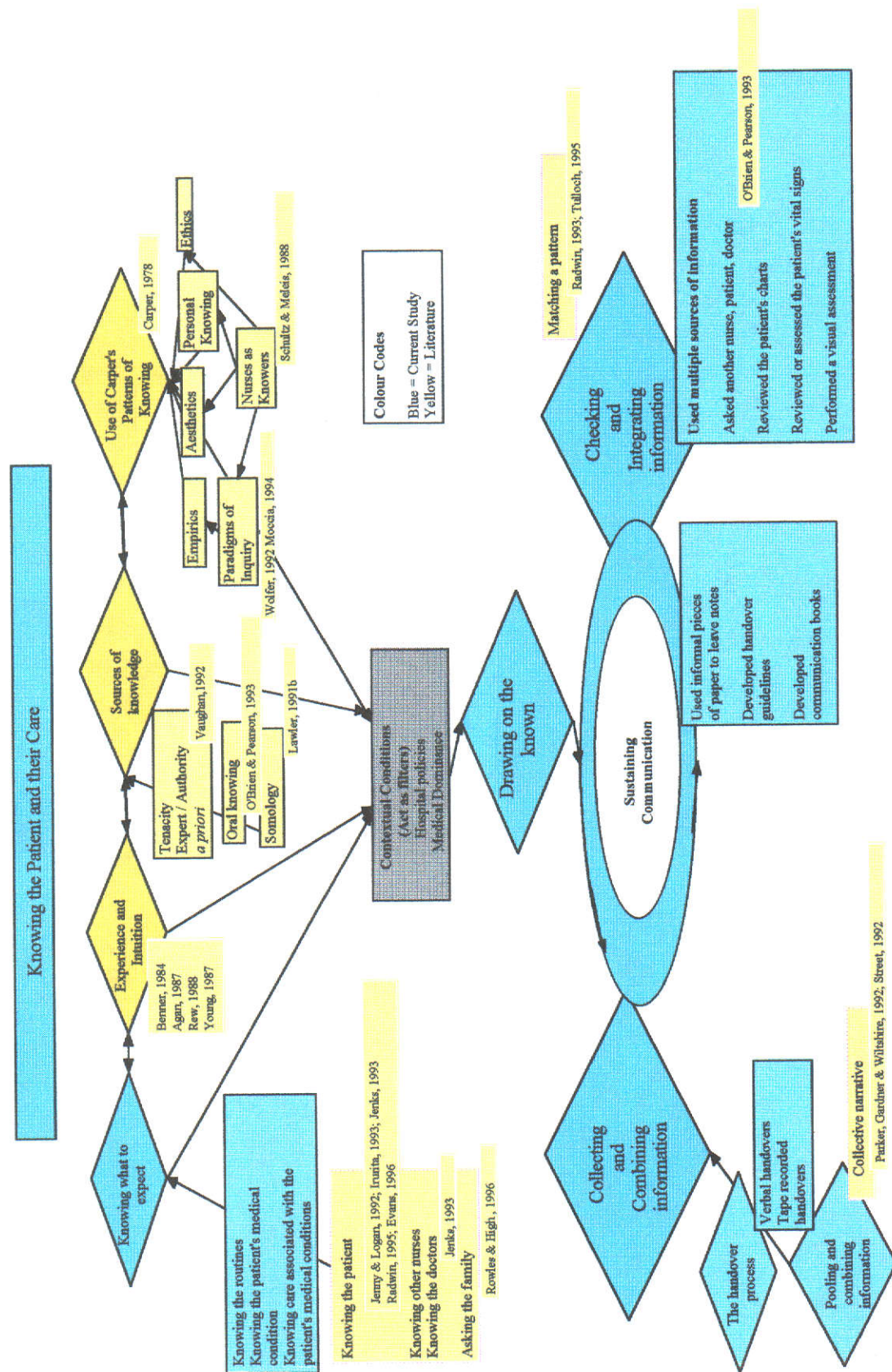


Figure 6.2 A schematic representation of "Towards an understanding of a process of nursing".

The schematic representation of the findings of the current study and other studies listed provides a clear summary of an emerging process of nursing which was different to the nursing process as articulated by Yura and Walsh (1967). The process illustrated (see figure 6:2) lent some support to Paterson and Zderad's (1976) humanistic theory which is proposed as a philosophy and a methodology of nursing. These theorists proposed five phases of phenomenological nursology (Paterson & Zderad, 1976; Meleis, 1991; Raymond, 1995; Stevens Barnum, 1994). These phases are entitled :

- (1)Preparation of the nurse knower for coming to know (the patient). This process is achieved by the nurse reflecting, contemplating, and discussing literary works as they relate to the knowers already known [*Knowing, Drawing on the known*].
- (2)Nurse knowing of other (patient) intuitively. A process where the nurse sees the world through the eyes of the patient [*Drawing on intuitive knowledge*].
- (3)Nurse knowing the other (patient) scientifically. By replaying and reflecting on subjective experiences and further analysing and synthesising information [*Drawing on the known, Collecting, Combining, Checking, and Integrating information*].
- (4)Nurse complementarity synthesising known others. By comparing and contrasting the differences of like nursing situations to arrive at an expanded view [*Drawing on the known, Collecting, Combining, Checking, and Integrating information*].
- (5)Succession within the nurse from the many to the paradoxical. Evolving from multiple realities to an inclusive conception "where the nurse propels knowledge forward. In this phase a nurse struggling with the mutual communion of multiple nursing situations arrives at a conception that is meaningful to the many or to all" (Paterson & Zderad, 1976, p. 81) [*Drawing on the known, Collecting, Combining, Checking, and Integrating information*].

While the findings of the current study in combination with the literature partly supports Paterson and Zderad's humanistic theory, it also differs as it is argued that nursing practice in acute care settings occurs in a "collective milieu" of many nurses and patients and not specifically on an individual nurse-patient basis. Hence, all the identified phases usually occur in a combined way with many nurses, patients, and doctors involved in patient care. The theory espoused in the current study also provides empirical evidence supporting Schultz and Meleis's (1988) statement that "clinical knowledge results from engaging in the gestalt of caring, from bringing to bear multiple ways of knowing in order to solve the problems of patient care" (p. 219).

### **Minimising Uncertainty**

The second phase of the basic social process of "Enabling care: working through obscurity and uncertainty" was termed *Minimising uncertainty*. This phase consisted of three subprocesses that were termed (a) adapting work practices, (b) taking control, and (c) backing-up. These three subprocesses had no sequential order and occurred concomitantly to the four subprocesses used in the first phase. This process of minimising uncertainty occurred not only to protect individual nurses but also to assist other staff members working in ward areas.

As nurses worked under constantly changing conditions of uncertainty and time constraints, they were forced to modify or streamline their practices to meet certain deadlines with regard to patient care. Baker's (1995) findings concur with this, where she reported that nurse clinicians modified practices, not based on theory, to achieve particular goals under certain circumstances. Nurses stated that nothing seemed to be implemented in its theoretical form; rather, most practices were adapted as time constraints prohibited the implementation of theoretical ideals.

In support of this statement a short article published in the *Reader Enquiry* section of the Australian Health and Aged Care Journal states that "they constantly struggle to provide the level of care. That is why you see high levels of burnout. . . . Nurses are

tired, tired of making excuses, tired of not having enough staff to provide the care they want to, and tired of pushing patients through the system” (1995, pp. 42-43).

Some examples of modified practices used by nurses in the current study to minimise uncertainty are listed.

- Worked unpaid overtime or missed meal and tea breaks;
- Listed patient assessment data in the nursing care plan as this document was used more often;
- Signed that the care had been given at the commencement of the shift, so that the record would be complete;
- Signed the medication chart for other nurses whom they believed had given the medication though had forgotten to sign the chart;
- Copied what was documented on the previous shift;
- Juggled the work load to accommodate priorities (tasks);
- Tried to avoid being interrupted, some patient bells would not be answered promptly as nurses would try to complete the jobs they had commenced;
- Constantly improvised on what they had been taught in theory due to time constraints.

Taking control was another subprocess used to minimise uncertainty. Nurses used four main strategies. Firstly, in order to complete their work and control the level of care, senior nurses would prescriptively tell junior nurses what tasks to do and how to take short cuts. This finding supported Williams (1996) study that nurses purposefully altered their care depending on the available time, using what she termed a process of *selective focussing*. Secondly, nurses had developed several prompting mechanisms that reminded them of the jobs that needed completion. Thirdly, as nurses’ work relied heavily on doctor-prescribed care, they had to constantly organise and remind doctors to perform certain tasks. Finally, nurses in this study were often described as being resistant to change. This resistance to change was said to be one strategy used to minimise uncertainty in the workplace and to try and retain control. In support, Street (1992) also found that nurses resisted change. She further stated that this resistance stemmed from nurses’ lack of trust of nursing management as their changes disempowered nurses more than they empowered them.

All these strategies formed the basis of the subprocess *taking control*. Although this strategy of minimising uncertainty by controlling the care seemed pragmatic, this action promoted task-oriented care rather than holistic care.

In addition, the difficult and uncertain working conditions meant that most nurses were inadvertently prone to making errors at some time. Errors that were judged to be minimal were covered up by both doctors and nurses. Backing-up, therefore, was the third subprocess used to minimise uncertainty. Under the conditions described in this study, errors that were judged by nurses to be of minimal consequence were remedied where possible and dealt with in the oral culture and not documented in the patient's notes. In support of this finding, a published article written by the Australian Nursing Federation (ANF) alluded to this issue of how errors were managed. This article in their newsletter entitled: "A tragedy waiting to happen" stated:

*We know that there are incidents and accidents occurring now but they are being "managed" in ways which don't necessarily capture public attention. ANF staff keep confidential the confessions of members who say they don't have time to report incidents, while negotiating with managers who say there can't be a staffing problem because there are no incidents (ANF, 1997, p. 6).*

These findings support Baker's (1995) findings that some medication errors are redefined as not being considered as errors in some situations. She further added that errors were more likely to be reported if they were made by outsiders (casual and agency staff). While data from the current study revealed that errors were usually dealt with in the oral culture, other recent Australian studies report incidences of adverse patient events that were documented in the notes and may not have been openly discussed (Harlow, 1995; McNeil & Leeder, 1995; Wilson et al., 1995).

The findings of this study, in particular the basic social process, should be reviewed in light of the art of nursing. Johnson (1994) examined the nursing literature published between 1860 and 1992 to identify conceptualisations of the art of nursing. The discourse on nursing art revealed five distinct processes. They are as follows: "(1) the nurse's ability to grasp meaning in patient encounters, (2) the nurse's ability to establish a meaningful connection with the patient, (3) the nurse's ability to skilfully perform nursing activities, (4) the nurse's ability to rationally determine an

appropriate course of nursing action, and (5) the nurse's ability to morally conduct his or her practice" (p.3).

The working conditions experienced by nurses in the current study made it difficult, if not impossible, for them to enact this type of care with any consistency. However, there was evidence of nursing art that was consistent with the fourth process *the nurse's ability to rationally determine an appropriate course of nursing action*. For within this study's context, one conceptualisation of the art of nursing could be the process of being able to work through obscurity and, in particular, minimise uncertainty. Some of the processes that were used by nurses to minimise uncertainty included taking control, adapting work practices, and backing-up. It is acknowledged that all these processes, revealed in this study, may not be viewed as being congruent with the literature's view on "nursing art". The nurses in this study, however, purposefully used these processes to deliver patient care to ensure patient safety and that the tasks, relating to patient care, were complete. Nevertheless, they were unable to establish meaningful connections with all patients or skilfully perform nursing activities of an acceptable standard, hence the need for backing-up each others work or minimising errors was essential. Much of the literature on the art of nursing, espouses the view that nursing art is not rational and is more holistic (Benner, 1984; Benner & Wrubel, 1982; Moccia, 1994). Johnson's (1996) argument adds to the debate, as she contends that there is no clear view on nursing art and that there may be a place for the inclusion of rationality. Not denying the merit of associating the art of nursing as being a more subjective experience that results in the delivery of holistic patient care, the issue of the influence of contextual factors needs to be considered. Within the constraints of an acute care ward setting, it may be that nursing art must be rational and purposeful, in order to enable the delivery of patient care. Thus, the process of "taking control" in conditions of uncertainty may be a form of nursing art, a type of art that is context bound and in many instances developed and learnt in the ward setting. For the overall process used by nurses in this study combined with the literature see Figure 6:3 on page 267.



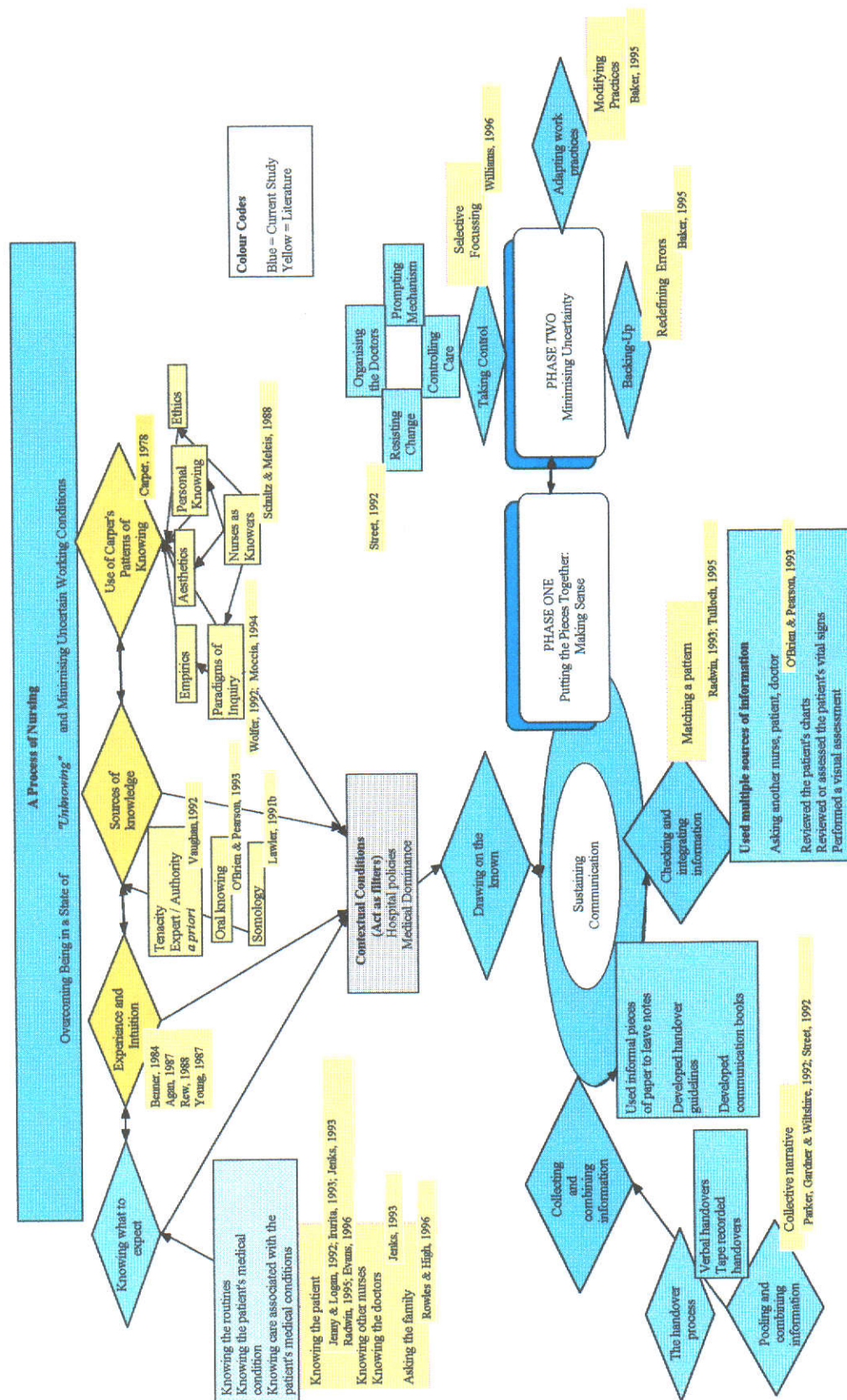


Figure 6.3 A Process of Nursing

## Professional Disillusionment

As a result of working under the conditions described in this study, nurses became professionally disillusioned as they were unable to deliver care in the way in which they had been professionally educated. Additionally, some spoke of leaving nursing. These findings were supported by a number of studies conducted in North America. Boon's (1997) study found that nurses hurried work-pace resulted in less time for, what she termed, "essence of nursing". This resulted in nurses withdrawing support for each other and experiencing a sense of frustration with their work. Additionally, other researchers report that the changing conditions under which nurses were required to function resulted in low morale, high turnover rates, and ultimately burnout (Droppleman & Thomas, 1996; Shindul-Rothschild, 1994; Shindul-Rothschild, Berry, & Long-Middleton, 1996). Furthermore, this finding was also supported by another Western Australian study that reviewed nursing practice (Williams, 1996). Williams stated that the stressful conditions under which nurses functioned had caused them to become disillusioned as they were often unable to deliver patient care at a satisfactory standard and focused on delivering physical care which they found professionally unsatisfying.

The findings were also supported by an article published in the *Reader Enquiry* section of the Australian Health and Aged Care Journal (1995, p. 42).

*Is there time to care? Nurses across Australia have started voicing criticism of the systems in which they work, tired and frustrated at the way constrictive budgets and unreasonable demands on their time have impacted upon their traditional provision of care. . . . What often gets lost in the debate is the enormous responsibility nurses have, without the authority to match it. What doesn't change is that level of responsibility. The more resources are squeezed, the more nurses are expected to do, the greater their responsibility, the more vulnerable they are, and the more vulnerable the people they care for are.*

## Summary and Implications

The findings of the current study revealed that nurses experienced being in a state of "unknowing" as a consequence of two main contextual conditions. These were the existence of a fragmented and inconsistent method of determining and

communicating patient care and working within a fluctuating and uncertain context. Furthermore, the nursing process was not used in the way in which it has been explicated. It is argued that the use of the nursing process has been driven by an impetus to make nursing more visible and scientific. While this visibility may serve the interests of some groups of nurses, namely nurse administrators and academics, using the nursing process as a means to achieve this is problematic for nurse clinicians. In support, Lawler (1991a) highlights the mismatch between nursing process and the way in which experts make decisions. Specifically, the clinical application of the theoretical ideals underpinning the nursing process was unachievable in acute care settings.

Within the Australian context, problem solving is one competency domain necessary for registration (ANCI, 1994). Due to many factors, a problem solving approach as explicated by the nursing process was not evident in this study. While the nursing process is the espoused problem solving process to be used in practice and Schools of Nursing educate nurses to use this process, there were many factors found in work settings that militated against its use. Clearly, due to many contextual factors the nurses in this study were unable to conduct patient admission assessments. Additionally, there were many problems identified with the use of nursing diagnosis and nursing care plans. It is acknowledged that the development of a diagnostic, interventions, and outcomes taxonomy has the potential to make “nursing” and “nurses’ work” more visible and thereby more researchable, teachable, and explicit. However, based on these findings the clinical application of nursing diagnosis should be reviewed. It may be more useful for the profession to consider using these diagnostic labels as a source of disciplinary knowledge (Donaldson & Crowley, 1978), detailing nursing concepts and nursing phenomena, rather than being used as labels in practice. Additionally, the use of an outcomes taxonomy in acute care settings is questioned, as predicting patient outcomes in acute care settings is contingent upon the patient’s responses to medical treatment and may be beyond the realm of nursing responsibility, judgement, and interventions. To continue to impose a structured framework on nurse clinicians framed within an esoteric language may be detrimental to nursing as its use was found to be incongruent with how nursing was practised and promoted a state of “*unknowing*” that did not enhance patient care.

Nurses in this study used a basic social process entitled: *Enabling care: Working through obscurity and uncertainty*, to determine, deliver, and communicate patient care in an acute care hospital setting. This process commenced with “*drawing on the known*” where the nurse drew on a number of factors, such as previous knowledge, experience, and intuition to determine patient care. As patient care was often complex and involved decision making at many levels, information was collected from various sources. Knowing the patient was often a function of pooled knowledge and the integration of this knowledge from a number of sources. Specifically, problem solving occurred in a combined context of collecting, combining, checking, and integrating information from nurses, patients, doctors, and the patient’s notes. There were many nurses, patients, and doctors involved in the care, hence, sustaining communication was another aspect that was used in practice to enable knowing the patient and their care. A combination of all these subprocesses comprised the first phase of the basic social process that was termed “*Putting the pieces together: making sense*”. To overcome the fluctuating and uncertain work context, nurses developed work practices to minimise this uncertainty. Thus *Minimising uncertainty* was the second phase of the basic social process. As this process was supported by a number of studies and opinions of nurse scholars, it is worthy of being considered as being foundational to an understanding of a process of nursing in acute care hospital settings. Given this situation, it is important that the nursing profession continue to discuss and debate the clinical use of the nursing process in its current form and to consider using other approaches that are more compatible with everyday nursing practice in acute care ward settings.

## Limitations

This study was designed to be exploratory, descriptive, and to result in the development of a substantive theory of the clinical application of the nursing process in acute care hospital settings in Western Australia. Measures to ensure rigour have been discussed in Chapter Two. In keeping with grounded theory principles, the proposed theory reflects the experiences of the study population and generalisability is not claimed. In addition, as with all qualitative designs, much of the analysis is a product of the researcher’s own mental output and the naming of categories occurs as

a result of the researcher's use of words and language. While dictionary definitions were used to select words and transcripts have been used to illustrate meaning and the derivation of this meaning, limitations that result from the human element of this process are acknowledged. However, these limitations were minimised as the final substantive theory was presented, for credibility testing, to a number of nurse clinicians and nurse scholars in seminars, informal and conference presentations both locally and internationally. More specifically and importantly, the theory was presented to a small group of Clinical Nurse Specialists in a major teaching hospital who recognised the process. In addition, many stated that they were glad to see that what they had known for a while had been revealed through the research process.

## **Recommendations**

Based on the findings of the current study and the review of the literature, the following recommendations are made for nursing practice, theory, research, and education. Although the recommendations have been presented under four discrete headings, some overlap may occur.

### **Practice**

The findings of the study revealed that nurses did not use the nursing process in the way it is explicated in the literature. Additionally, it found that nurses experienced a basic social problem of being in a state of "*unknowing*". This state was caused by the use of a fragmented and inconsistent method of determining, delivering, and communicating patient care and prevailing uncertain and fluctuating working conditions. Furthermore, due to this uncertainty nurses had to constantly check on information, using a number of data sources to determine patient care. In light of these findings, it is necessary for nurse managers to try to minimise these uncertain working conditions and to enhance the process of determining, delivering, and communicating patient care. Primarily, it is necessary to review the nursing assessment process as it was found to be dysfunctional in its present form. It may be necessary to consider a multidisciplinary approach as the findings revealed that patients were asked the same questions a number of times by different health care

professionals. In addition, in acute care hospital settings, much of initial nursing care was derived from the medical assessment and one could question the utility of nurses recollecting this information. Moreover, the policy of collecting standard information for all types of patients needs to be reviewed, as each patient case should be assessed according to the nurse's professional judgement on what information is deemed necessary for delivering patient care. Additionally, as "drawing on the known" was an important subprocess used to determine patient care, it would be beneficial to have senior nursing staff on wards responsible for checking admission assessments and patients' care plans as these nurses have a greater wealth of knowledge from which to draw upon. As data revealed that nurses experienced clinical application problems using the diagnostic concept, as explicated by NANDA, it is important to review whether it is necessary to use NANDA terminology and/or the diagnostic concept in its current form in these clinical settings. The multidisciplinary nature of the work in acute care settings, requires the use of a language that is simple and understood by all health care professionals. In addition, the use of multidisciplinary patient notes is necessary in order to enhance communication and avoid duplicating patient information.

The study findings also revealed that the communication of patient information was fragmented and this was, in part, caused by the large number of nurses involved in patient care, the use of the oral culture, and the lack of a central person consistently coordinating patient care. In order to enhance continuity of care and communication of patient information that occurred in the oral culture, it is necessary to consider the appointment of a central person who consistently coordinates patient care in a ward or in a team. Assigning the same nurse to the same patients may be another useful strategy to enhance the process of "drawing on the known" and the continuity of patient care. Additionally, agency and casual nurses had variable knowledge, skills, and commitment and were often unsure of specific patient care needs and performing certain technical tasks. Due to these factors, it is necessary to consider buddying these nurses with permanent ward staff and not giving them the responsibility of an individual case load.

Additionally, nurses stated that the use of structured guidelines to hand over patient information enhanced the communication process. It is, therefore, important for hospitals to review their handover procedures and to try to develop the use of a more structured approach to handover containing key domains of patient care that have been developed within each specialty unit. Furthermore, it may be helpful to encourage the use of verbal face-to-face handovers as this type of handover provided an avenue for meaningful discussion of patient information and the exchange of nursing knowledge. The literature adds that it is also used as a forum for staff to feel part of a team and to debrief when necessary. Given the varied and difficult working conditions that prevailed in these study settings, avenues that provide collegial support are indicated. Moreover, as the use of short shifts hindered the handover of patient information and the understanding of patient care that was held in the oral culture, the use of short shifts should be reviewed and where possible kept to a minimum. Furthermore, strategies that enhance communication between doctors and nurses need to be considered, in order to assist with the continuity and completeness of patient care.

The findings of the study also revealed that nurses worked under conditions of immense uncertainty that were detrimental to patient care. In light of this finding, it is recommended that nursing management work towards minimising uncertainty by not moving staff and patients across wards and by using a more stable work force. Additionally, as nurses were constantly interrupted during the course of a shift and these interruptions impacted on the continuous delivery of patient care; it is necessary, therefore, to discuss and develop strategies that minimise nurses being interrupted so frequently.

The study findings also revealed a process used by nurses to overcome this basic social problem of being in a state of "*unknowing*". More specifically, a substantive theory of clinical nursing practice was interpreted and described that was different to the way in which the nursing process is explicated. As a key subprocess used to overcome being in a state of "*unknowing*" was "*drawing on the known*", which was optimised by the nurse "knowing what to expect", factors that enhance this subprocess should be considered. It is suggested that nursing management implement

practices that optimise this factor. Some strategies to consider include: making ward routines explicit for relieving staff, stabilising the movement of patients and nurses across settings, and assigning the same nurses to the same patients where possible. Additionally, the findings indicate the need for medical administration to develop guidelines for doctors to ensure that they follow a routine that is known by nursing staff as this will assist nurses with the planning of patient care. In addition, nurses' understanding of the patient's condition and their care occurred within the context of combined knowledge from nurses, doctors, and patients. Hence the links between these three groups need to be acknowledged and made more explicit. The reintroduction of health care teams may be one approach to strengthen these communication links and enhance this concept of "knowing the patient".

As nurses worked under conditions of immense uncertainty, they often modified their practices to minimise this uncertainty and enable the delivery of patient care at a task-oriented level. Furthermore, time constraints and, in some instances, lack of staff resulted in nurses and patient care being compromised. It is important that managers deal with the contextual factors that militate against the provision of holistic patient care. These findings are of professional concern and need to be acted upon. It is suggested that hospitals develop staffing formulas that enable the delivery of safe patient care. As some hospital policies were said to restrict professional nursing practice it is necessary for these organisations to consider reviewing and streamlining the number of hospital policies that are used to control nursing practice. Finally, from a professional stand-point, it is essential that nursing professional organisations introduce measures to sustain professional commitment in challenging times and to become more vigilant of sub-standard working conditions where professional standards are unable to be sustained.

## **Theory**

The findings of this study identified major problems with the use of NANDA nursing diagnosis; it is, therefore, important for the profession to review that the way in which this concept is operationalised. Some consideration should be given to developing and refining diagnostic labels as the basis for nursing knowledge, rather



than to be used to label patients' problems in acute care settings. Additionally, the findings revealed that in acute care settings nursing practice was linked to the patient's medical condition. Given this situation, nursing's link to the Biomedical model in acute care settings needs to be acknowledged, accepted, and some aspects incorporated into nursing approaches to delivering patient care in these ward settings. Additionally, in regard to understanding how nurses determine patient care, the process "drawing on the known" was identified as being an important process used by nurses working in conditions of uncertainty. This process should be viewed as being a factor worthy of consideration in context-bound, clinical decision-making theory. Moreover, it provides some evidence to support the notion of specialisation in acute care settings rather than multi-skilling nurses.

## **Research**

As the current study explicated a grounded theory of clinical nursing practice that was group and context specific, it is necessary to conduct further research at other sites or with other similar groups in order to test and further develop the proposed theory to a formal middle-range theory. It is also necessary that the oral culture as a way of communicating patient information and nursing knowledge be recognised and further researched as this mode is used continuously in clinical practice to communicate patient information and practice based knowledge. Additionally, it may be useful to explore the subprocess of "backing-up" in greater depth, as it may provide insightful evidence of the quality of patient care and conditions under which quality care is able to be sustained. Furthermore, the nurses in this study talked about being professionally disillusioned with their working conditions. This factor needs to be explored further and strategies implemented to minimise this outcome. This is especially important in light of the shortage of nurses that is being experienced in some acute care ward settings.

## **Education**

The study findings identified some weaknesses in clinical practice. More specifically, the use of the nursing process and the verbal and written handover of patient care.

Some of these weaknesses may be addressed through undergraduate nursing curricula. It is suggested that Schools of nursing consider reviewing how the nursing process is taught, as it is unable to be used in acute care settings in its present form. It may be beneficial to emphasise critical and adaptive thinking skills rather than the linear thinking approach inherent in the nursing process. Additionally, if “knowing what to expect” assists with the process of nursing, then nursing curricula should take cognisance of this factor and try to minimise areas where the theory-practice gap is large. This is especially so as this gap has the potential to cause students to become perplexed as the theory is unable to be applied in practice. For example, conducting comprehensive physical assessments on patients as opposed to teaching students to perform more focused, patient-specific assessments as required in acute care settings. It is also suggested that it is worth considering whether students should be taught nursing diagnostic concepts as being foundational to nursing knowledge development, rather than being used to label patients’ human responses to their state of health in acute care ward settings. Additionally, the written and verbal handover of patient information was found to be unhelpful and sometimes unclear. It may be worthwhile for Schools of Nursing to place more emphasis on teaching students methods of delivering meaningful handovers and documenting patient care so that they do not model their techniques on present practices.

## **Conclusion**

This study explicated a substantive theory of the way in which nursing care is determined, delivered, and communicated in acute ward settings in Western Australia. The processes outlined in this theory of clinical practice differed to the processes and/or stages explicated in the nursing process. This appeared to be related to a number of contextual conditions that hindered knowing the patient and their specific care. These factors were: increased patient turnover, movement of nurses and patients across settings, short shifts, tape-recorded handovers, time constraints, and the use of increasing numbers of agency nurses. In addition, due to reduced patient length of stay, the large numbers of nurses involved in the delivery of each patient’s care, and the complex and ever changing status of patients, determining and communication patient care using the nursing process structure was unable to be

sustained in a meaningful way. Clearly, within this context, the espoused theory was not the theory in use, thus, illustrating a theory-practice schism. As nurses in this study experienced being in a state of “*unknowing*”, they used a process to overcome this situation termed *Enabling Care: Working through Obscurity and Uncertainty*. A combination of both the basic social problem and the basic social process illustrated the difficult conditions under which nurse clinicians were required to work and the complex nature of nursing practice. The findings were also supported by many other studies that used context based designs, thus alluding to the context bound nature of nursing practice.

These findings are of professional concern, as the basic social problem of being in a state of “*unknowing*” has legal ramifications. Specifically, due to contextual factors in acute care settings in Western Australia, nurses were unable to determine and deliver patient care in the way in which they had been professionally educated. The state of “*unknowing*” impacted on patient care as nurses did not always know patients’ specific nursing care needs. Due to the uncertain working conditions nurses were unsure as to whether they would have time to deliver all the patient care. This finding should be of concern to patients whose care was sometimes compromised. Furthermore, the issue of nurses backing-up each others work and covering-up errors is serious, as these errors may not be apparent to management or the patients and have the potential to create a false understanding of the efficacy of the care in acute care settings. Additionally, nurses were displeased about the situation and experienced professional disillusionment which caused them to withdraw or to leave nursing. This factor needs to be addressed and the wellbeing of nurses considered, especially as there is evidence of a shortage of nurses and hospitals are experiencing problems recruiting nurses in some acute care settings.

It is important that management seek ways to stabilise nurses’ working conditions and to try to minimise the uncertainty. Furthermore, it is necessary for them to review working conditions that militate against nurses “*knowing*” the patient. As knowing the patient occurred through the process of collecting, combining, checking, and integrating information it is necessary to optimise the handover procedure and the communication of information between nurses, doctors, and patients.

Furthermore, the findings of the current study and the literature, previously discussed, present a professional challenge. It is necessary for the profession to conduct further context bound studies, evaluating the clinical utility of the nursing process as a problem-solving approach to patient care. Clearly, within this study, its use was found to be unsustainable in acute care contexts. Additionally, it is necessary to determine the balance between developing theories derived from nursing practice and prescriptive theories about nursing practice that in some instances are unable to be clinically applied. This study illustrated the difference between the espoused theory and the theory in use. It also described reasons why this dissonance occurred. There is a need to try to bridge the theory-practice gap. If the discipline is to survive, it is contingent on its clinical success. Hence, it is important to get the balance right and to try to develop practice theories that have clinical relevance. This study revealed a process that was used in clinical settings. It is, therefore, worthy of being considered foundational to the development and understanding of a process of nursing used by nurse clinicians to enable the delivery of patient care in acute care settings in Western Australia.

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## Appendix A

Dear Colleague

My name is Bev O'Connell, I am a registered nurse and enrolled in a PhD program at Curtin University of Technology. As part of my studies I am interested in examining the process of delivering patient care. The knowledge gained will be of major significance to practicing nurses as it will provide us with information which will increase our understanding of current nursing practices.

I invite you to participate in this study which will be conducted using tape recorded interviews. We can organise a mutually agreed time and place. The interviews will be approximately 45 - 60 minute duration. During the interview you can decline to answer any question and request that the tape recorder be turned off. Tapes will be erased following completion of the study. No names will appear on the transcribed interviews. Extracts of interviews may be used in the research report, but you will not be identified in any way. Participation is voluntary and consent can terminate at any time. Also, your participation in the study will in no way effect your course results or your status as a student.

If there are any questions or concerns you have regarding this project, please do not hesitate to contact me.

Bev O'Connell.  
School of Nursing  
Curtin University of Technology  
Phone no: Work 3517993 Home 4548958.

### **PARTICIPANTS CONSENT**

I \_\_\_\_\_ have read the above information on the study. I understand the nature and intent of the study and have the opportunity to ask questions. I understand where to direct any future questions that I may have. I have received a copy of the consent form. I hereby give permission to be interviewed and for these interviews to be tape recorded. I understand that my participation is voluntary and that I may withdraw my consent and terminate my participation at any time without incurring any penalty.

Signed \_\_\_\_\_ Nurse  
Signed \_\_\_\_\_ Researcher  
Date \_\_\_\_\_

## **Appendix B**

### **Nurse Clinicians Interview Guide**

(Interview will be **guided** by the questions only).

- When you get to work, how do you find out about the conditions of the patients you have been assigned?
- How do you find out about the care of the patients you have been assigned?
- What procedure do you use to admit a new patient?
- How do you determine what care needs to be given?
- How do you document this care?
- How do you communicate this care?
- What do you believe to be the most effective way to communicate care?
- How do you assess patients ?
- How do you state the patient problems that you identify?
- How helpful do you find nursing diagnosis?
- Does it help you plan care?--in what way?
- Do you find it hinders care?--in what way?
- Is there anything you would like to change about the way in which you document and communicate patient care?
- Do you know why the nursing process was developed?
- Does the nursing process help you deliver care?
- Which parts do you find helpful?
- Does the nursing process hinder the process of care?
- Which parts do you find a hindrance?

**Questionnaire**  
**OFFICE USE Only**

ID Number

--	--	--

1. What is your age in years?  
(Fill in Boxes)

2 What is your sex?  
(Circle one number)  
Male 1  
Female 2

3 How many years have you been a practising Registered Nurse?  
(State the number of years in boxes)

4. Have you used the nursing process?  
(Circle one number)  
Yes      1  
No        2

(State the number of years in boxes)

5. On graduating from your initial nursing course, what qualification did you receive? (Circle one number)

Hospital Based Diploma	1
Diploma in Nursing	
(Tertiary)	2
Bachelor's degree Nursing	3
Other	4
Specify _____	

6. What tertiary qualifications have you completed since your basic training/education?  
(Circle the appropriate number/s)

None	1
Bachelor	2
Post Graduate Diploma	3
Masters	4
Other	5

13  
14  
15  
16  
17

(Specify) \_\_\_\_\_



**OFFICE USE ONLY**

7. Indicate your place of employment 18  
(Circle one number)
- |                       |   |
|-----------------------|---|
| Teaching Hospital     | 1 |
| Non Teaching Hospital | 2 |
| Nursing Home          | 3 |
| Other                 | 4 |
| Specify _____         |   |
8. What level in the career structure 19  
are you currently employed?  
(Circle one number)
- |                                   |   |
|-----------------------------------|---|
| Level 1                           | 1 |
| Level 2                           | 2 |
| Level 3                           | 3 |
| Level 4                           | 4 |
| Level 5                           | 5 |
| Not Working                       | 6 |
| We do not have a career structure | 7 |
9. What stream does the majority 20  
of your job lie within?  
(Circle one number)
- |                   |   |
|-------------------|---|
| Clinical          | 1 |
| Management        | 2 |
| Staff Development | 3 |
| Research          | 4 |
10. Name the Clinical Speciality you are 21-22  
currently practicing in  
(Circle one number)
- |               |    |
|---------------|----|
| Medical       | 01 |
| Surgical      | 02 |
| Oncology      | 03 |
| Geriatrics    | 04 |
| Other         | 08 |
| Specify _____ |    |