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What Influences the Practice of Registered Nurses in the Perioperative Environment?

by

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ABSTRACT

FACULTY OF HEALTH SCIENCES
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EXPLORING WHAT INFLUENCES THE PRACTICE OF REGISTERED NURSES IN THE PERIOPERATIVE ENVIRONMENT

By Dorothy Lorraine Chadwick

This study seeks to explore what influences the practice of Registered Nurses in the perioperative environment. The term perioperative care denotes care given to patients in anaesthetics, during the surgical procedure, and immediate recovery following surgery and is generally referred to as pre-, intra-, and post-operative care

The research design was a qualitative case study involving 10 registered practitioners in the specialty of perioperative care. Case study design was chosen because of its appropriateness for exploratory study.

This research took place in a teaching hospital and the area of study consisted of six operating theatres. Data were collected over one calendar year. The study focused on Registered Nurses. In order to understand more completely factors that influenced these nurses senior medical staff, senior operating department practitioners and the educational coordinator were also included. Information was obtained through individual in-depth interviews with this sample, focus group discussion with the nurses, and the analysis of departmental documentation. Analysis of the data was undertaken by thematic framework analysis and the review of departmental documentation. Study participation was voluntary, with recruitment by self-selection.

Findings highlighted a variety of influences guiding the practice of participants, showing both the similarities and differences in their choice of what was important to them. Discussions of the Focus Group were able to verify information gleaned from the in-depth interviews and the review of departmental documentation.

Responses in relation to the understanding of the concept of evidence identified a knowledge gap within the specialty. In spite of exhortation of professional bodies and Government Directives regarding the use of evidence to support practice, it was not found to be greatly influential. Instead leadership, teamwork, culture, and communication were the most influential perspectives for the participants of the study.

The results will be circulated widely to the practice and academic communities through publication in relevant journals. They will also be disseminated to the participants and related stakeholders, such as professional bodies of perioperative practice, in the form of an executive summary.

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Declaration of Authorship

I, Dorothy Lorraine Chadwick, declare that the thesis entitled *What Influences the Practice of Registered Nurses in the Perioperative Environment?* and the work presented in the thesis are both my own, and have been generated by me as a result of my own original research.

I confirm that:

- This work was done wholly or mainly while in candidature for a research degree at this University;
- Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- Where I have consulted the published work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- None of this work has been published before submission.

Signed: …….

Date: …….

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My Supervisors: Professor Andrée le May, the late Dr Janice Brown, and Professor Judith Lathlean for their advice, challenges, continual support and reassurance.

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Finally, to Tobias, my beautiful ginger cat (recently deceased), who was my constant and uncritical companion during the long hours of study.

Dot Chadwick

Definitions and Abbreviations

AfPP	Association for Perioperative Practice
CINAHL	Cummulative Index to Nursing and Allied Health Literature
CNO	Chief Nursing Officer
NATN	National Association of Theatre Nurses
NHS	National Health Service
NMC	Nursing & Midwifery Council
PCC	Perioperative Care Collaborative

Operating Department Practitioner	Non-nurses, having undertaken the same training as nurses in the three domains of perioperative care

1. Introduction

1.1 Background

In light of changes within the health care arena in relation to improvement of care and its effectiveness, professional development, and on-going knowledge, practitioners must be prepared to support and defend their actions in relation to how they deliver care. It is through reflection on the past, consideration of the present, and cultivating intentions for the future that our practice can grow and develop to address effectively the needs of those in our care. Ciliska and DiCenso (1999) stated that changes in health care, combined with an emphasis on quality care and cost containment, have led to the need for reliable and up-to-date evidence about effective health care interventions by clinicians, policy makers and researchers. The emphasis on quality care improvements should be, as Professor Lord Darzi says in his National Health Service Review (2008), at the heart of everything we do. However, in order to understand better what is at the heart of everything that we do we need to know more about what influences practice.

Developing this study has been influenced by personal observation of some inconsistencies of practice combined with an apparent reticence to challenge them. This is probably due to non-awareness, and/or lack of evidence to support appropriate arguments or in the knowledge base of the specialty itself. Not only did departmental practice influence the study, but also a heightened awareness of some aspects of personal practice through reflection played its part. This is supported by Griffiths (2006), who suggests starting with a question about practice. It is not about questioning everything; it is about focusing on what information is needed to make the decision about patient care, and one could say the very essence of critical appraisal. It is the questioning of actual practice, which will, in turn, affect decisions pertaining to patient care. With this in mind, it was decided to explore what were the influences guiding the practice of registered nurses within the perioperative environment.

The perioperative environment encompasses three domains of care, pre-, intra- and post-operative care. Pre-operative care relates to the care delivered before and

during anaesthesia. Intra-operative care pertains to care during the surgical procedure, and post-operative care denotes the care immediately following surgery.

The expectations of the public through the influences of the media, developing technology, pharmacology and the Internet in respect of health care delivery and treatments have also influenced the study. As a result of these developments and expectations, the health care professions need to be able to defend and support their actions and decisions taken in relation to care. The rationale for undertaking the study therefore formulated the research question:

> *What influences the Practice of Registered Nurses in the Perioperative Environment?*

The location of the study was an Operating Department of a two-star National Health Service (NHS) Trust Hospital of 530 beds. Surgery undertaken there covers a wide range of specialties. Participants included Registered Nurses, both Sisters/Charge Nurses and Staff Nurses, Medical Staff, a Senior Operating Department Practitioner and an Education Coordinator.

Having read various texts regarding the writing of a Literature Review for qualitative study; Cormack (2002) Maltby et al (2010), Parahoo (2006) and Silverman (2006), the latter's explanation of Wolcott's (1990) approach was adopted. The rationale here was Wolcott's overarching thought that a chapter dedicated to the literature review revealed its "unconnectedness" to the rest of the study. Silverman (2006) continued by stating that Wolcott expected his students to know the relevant literature. However, he did not expect them to put it all together as a separate entity, showing no links to the rest of the study. He also expected them to use the information gleaned selectively and appropriately in order to support their findings. Silverman (2006) further explained that Wolcott expected information on key point of the literature review as an introduction. For this study, supportive statements have been used throughout the text as deemed relevant and appropriate. A search strategy has been formulated; Appendix 1.

A preliminary review of the literature failed to find any studies that questioned registered nurses as to what influences their practice in the perioperative environment. Interestingly, some considerable time after deciding on the topic of study and formulation of the research question, a statement by Roxburgh and Gall

(2006), lecturers in Perioperative Practice, was found which said that nurses need to be certain of what guides, informs and supports decisions that they make in relation to patient care. In light of this, it was not felt that the 'wheel was being re-invented' and there was justification in undertaking the study. The study could be seen as one heeding such advice.

The research design used in this study was that of a qualitative case study. Data were collected over the calendar year of 2008-2009 and were obtained from:

- Biographical data sheet completion;
- Individual in-depth interviews;
- A Focus group;
- Review of departmental documents.

The analysis of the data was approached using Thematic Framework Analysis, Ritchie and Lewis (2006), for the individual in-depth interviews and focus group discussion. Departmental documents were reviewed to confirm (or not) the information obtained from the interviews and the focus group respectively.

1.2 Structure

The Thesis is structured around five chapters.

This Chapter introduced the subject of the study and it looked at the reasons why the study has been undertaken. It identified the location and participants of the study. It also states the research design and methods for data collection and analysis and now introduces how the thesis is structured through the remaining chapters.

Chapter Two focuses on an analysis of the concept of influence in order to gain a better understanding of the aim of the study. Influences on practice have been reviewed from both a general and a specific perspective. The analytical steps for the concept analysis were based on a framework proposed by Walker and Avant (1995), which has been applied to nursing and therefore has been chosen as being most appropriate.

Explanations have been given about the analytical steps and how they have provided the clarity sought in understanding the concept. It assisted in guiding discussion, formulating opinion and supporting argument throughout the study.

The methodology of the study is described in Chapter Three. This addresses the research design and the rationale for its choice, the method of data collection, from whom it was collected and how it was managed, and the analytic processes. Ethical considerations are discussed along with the trustworthiness of the study and the role of the researcher in the context of being a practitioner within the specialty of perioperative area. The findings of the study are reported and discussed in Chapter Four. Chapter Five presents the conclusion drawn from the study. This chapter includes a discussion of the achievement of the intention of the study and potential influences on practice are highlighted; identification of new knowledge gained from the study is made; recommendations are suggested as are areas for further research and an overall reflection of the study is provided. Dissemination of the study findings is also addressed.

Chapter contents are supported by relevant appendices.

The following chapter addresses the conceptual analysis of influence.

2. Influences on the Practice of Registered Nurses from a General and Specific Perspective: A Concept Analysis

2.1 Introduction

At the outset of the study information in respect of the influences on nursing practice from both general (the nursing profession as a whole) and specific (the practice within the perioperative environment) perspectives was sought from various sources. These sources were journal articles, texts, and electronic resources such as the Cochrane Library, Medline, CINAHL and the Internet. Other sources of information included professional bodies, such as the Association for Perioperative Practice, and the Nursing and Midwifery Council. Information was also obtained from the Centre of Evidence-Based Practice, University of York and from the Department of Health, England.

An initial search, using the word influence, generated minimal information. The articles and texts reviewed appeared to be written in an advisory capacity. Brown and Gobbi (2007) looked at the influencing factors in relation to professionalism. Wilkinson and McDowall (2003) explored factors influential on the scope of nursing practice; while Barthow et al, in 2008, discussed factors of influence on patient empowerment. No research studies, focusing on influence, were found. The paucity of information generated by focusing on the simple word “influence” led me to re-structure the initial approach taken to searching for literature. This resulted in the literature review being structured around the principles of concept analysis which firstly entailed breaking down the concept of influence into its component parts and then using these to guide the search for literature. A generic list of factors was formulated, based on personal experience, knowledge, education and training in nursing practice. This list (see Appendix 1) was then used to explore the concept of influence more widely in the literature using the search strategy outlined in Appendix 1 and the principles of concept analysis described in 2.2 of this chapter. Information gleaned from this exploration was used in the design of the interviews and the discussion of the findings.

Before moving on to present the concept analysis of influence it is important to highlight readily available definitions of two terms – concept and influence. The Concise Oxford Dictionary defines concept as a general notion, an abstract idea. Lloyd et al (2007) highlights the explanations of Chinn and Jacobs (1983) who state that concepts are complex mental forms of an object, property or event which has been derived from an individual's perception and experience; Meleis (1991) as cited by Xyrichis and Ream (2007) sees concepts as labels which are able to describe a phenomenon or a group of phenomena. McKenna (1997) develops Meleis' (1991) explanation further, in stating that these labels are able to give meaning which enables us to categorise, interpret and structure a phenomenon, but are not the actual phenomenon.

Further explanation by Cronin and Rawlings-Anderson (2004) suggest that all concepts are located on a continuum, namely, concrete through to abstract. Influence would 'sit on' the abstract end of the continuum in light of its link to people's perceptions, feelings, beliefs, experiences and values. Cronin and Rawlings-Anderson (2004) have suggested that the interpretation by individual nurses of such concepts can lead to the inconsistency in the quality and standard of care being given. To reduce inconsistency they highlight the importance of being clear about what the concept under discussion is. In their explanation, they see the first step in achieving this as agreeing the meaning of the concept in the context in which it is being used: this chapter seeks to do this.

The Cambridge Dictionary of Sociology (2006) defines influence as a form of power arising in the context of relationships between individuals, within an individual and in the wider world of nature. It states that given the fact that we live in a society, it is impossible for an individual to undertake any action that does not involve influencing another. We are both influenced and influencing all the time. The question that arises is whether those influences help or hinder us in governing our own lives. What is of interest to the present study is what influences the practice of perioperative nurses.

The Free On-Line Dictionary (http;//thefreedictionary.com/influence) has defined influence as:

- A power to affect persons or events, especially power based on prestige, wealth, ability or position;
- Causing something to happen without any direct or apparent effort;
- A cognitive factor that tends to have an effect on what you do.

Chambers 21st Century Dictionary states:

- To have an effect especially an indirect or unnoticed one on a person or their work;
- To exert influence on someone or something.

The Oxford Dictionary of English defines it as:

- The capacity to have an effect on the character development or behaviour of someone or something;
- The power to shape policy or ensure favourable treatment from someone.

The salient features of these definitions include exerting influence, consistency of influence and being influenced. These definitions assisted the process used in the concept analysis and gave a better understanding of all the uses of the word 'influence'.

Wade and Travis (1998) have discussed the concept of influence in the context of human experience, identifying the experience as biological, cognitive, learning, psychodynamic, social and cultural. From the biological stance they see us as being influenced by our bodies and minds. This in turn affects such aspects as the rhythms of our lives, our perceptions of reality, our ability to learn and our emotions and temperaments. They suggest that our cognitive influences are those that explain things, cognition continually influences our actions and choices and may not always be realistic or even sensible. They see these cognitive influences as enabling response to other people's expectations. Our learning influences are initiated at birth and are affected by our respective environments. The social influences are those that see us conforming to the expectations, pressures and demands of others. We need what they refer to as 'contact comfort' whether through literal touch, shared experience or conversation. Culture dictates norms and roles of how we are supposed to act. It is important to remember that nurses, as people rather than practitioners, will be influenced by all of these things.

In his very complex paper of 1963 on the concept of influence, Talcott Parsons saw influence as a concept of wide applicability across for example, the effects of communications, persuasion, the shaping of attitudes and the formation of voting intentions. In this research study influence is applied to nursing practice and this has focussed the concept analysis undertaken.

2.2 Process Used in the Concept Analysis

Cahill (1996) sees concept analysis as a highly creative, rigorous and intuitive process that can generate and clarify the meaning of a single concept. It is a process which Cronin and Rawlings-Anderson (2004) feel strongly should not be undertaken lightly; indeed they see it as time-consuming and, at times, frustrating. Person and Finch (2009) affirm that through the process of analysis, ideas are broken down and analysed through key features of the concept.

The uses of concept analysis have been highlighted through the opinions of Cahill (1996), Burrows (1996), Cronin and Rawlings-Anderson (2004). They see the value of concept analysis as being central to advancing the knowledge base of nursing. It also enhances critical thinking, improves communication, assists in making clinical decisions and facilitates clinical research. Cronin and Rawlings-Anderson (2004) also feel that it assists in the ability of nurses to appraise evidence, analyse data and as a result synthesise the results into a meaningful whole. It is for these reasons, together with the paucity of evidence gained from the initial search that a concept analysis was undertaken.

The analytical steps used for this concept analysis have been based on a framework proposed by Walker and Avant (1995), as cited by Cronin and Rawlings-Anderson (2004) as they have explained clearly how such an analysis can be undertaken. The rationale for using this framework was its relative ease of comprehension, flexibility and its frequency of use within the context of nursing, (Cahill 1996, Henneman et al 1995, Burrows 1996, Person and Finch 2009, Xyrichis and Ream 2007).

The steps used involved the following, and a brief explanation about each step has been given:

- Select a concept of interest;
- Determine the aim(s);
- Identify all the uses of the concept;
- Determine the defining critical attributes;
- Define empirical indicators.

Selection of the concept has been identified in Chapter One as the reason for undertaking the study. The **aim** of the analysis was to identify factors of influence that are consistent within the practice of registered nurses in the perioperative environment. This consistency is expected to prevail in spite of individuality, personal experience, and perceptions. Having a better understanding of the concept of influence assisted in the design of the data collection tools, and enabled a more meaningful analysis and subsequent interpretation of the data collected, as to what has influenced the practices of registered perioperative nurses.

Ways in which the practices of nurses are influenced are subjective and multi-factorial; this is highlighted in the **ways the concept is used**. As explained earlier influences are rooted in one's upbringing and nurture and should be seen as being part of an on-going process of development. How these particular factors affect practice will vary from individual to individual and be dependent on the context in which these influences interplay. Where nursing practice is concerned, these influences will affect one's delivery of care in whatever speciality a nurse finds her or himself. There will be, however, other influencing factors that affect practice and it is these that the concept analysis focussed on.

As nurses we are influenced by legislation, regulation, subject knowledge, education and employers; by the expectations of our professional body, the public in general and ourselves; by persuasion, an example being that of role models; by culture within the working environment. Needless to say, these aspects of influence have a two-way effect, in that we too are influencers within the health care arena. To reiterate the Cambridge Dictionary of Sociology (2006), we live in a society where we are influenced and influence one another through our actions.

McKenna (1997) explained that the **attributes** of a concept are the characteristics that distinguish it from similar or related ones and that concepts may have several

attributes. These attributes will be discussed in detail later in the chapter and helped to form the key words used to search databases (see Appendix 1).

Defining the empirical indicators is the final stage of the analytical process. In this situation these will be the responses of the participants to the research question and how these responses reflect the factors of the concept. Where clinical practice is concerned, Walker and Avant (1995) stated that indicators are useful in providing clarity of observable phenomena. This in turn determines the existence of the concept. The data collected will provide details of the concept and its component parts/ factors.

In order to identify key factors I turned to The Nursing and Midwifery Council in its role as regulator, educator, protector and standard setter. The key interrelated factors in the Nursing and Midwifery Order, Statutory Instrument (2001) formed a structure for the concept analysis related to the general influences on nursing practice:

- Professionalism;
- Philosophy and Knowledge;
- Legislation and Regulation;
- Scope of Practice;
- Evidence in support of Practice;
- Politics and Policy.

The following factors, drawn from my own practice and education, are those influential to practice in the perioperative environment and form the specific perspective. These factors are:

- Specific Knowledge Base and Skills Required;
- Patient Safety;
- The Productive Operating Theatre;
- New Roles;
- Association for Perioperative Practice;
- Multi-disciplinary Teamwork;
- Research Studies in Perioperative Care.

Another aspect for consideration in respect of the influential factors of nursing practice was the interrelationship between both the general and specific perspective and how aspects of one perspective reflected in the other. The following table shows these relationships; the only differences between the factors affecting both perspectives were the knowledge base, skills and role development within the speciality of perioperative practice.

General Perspectives	Specific Perspectives
Professionalism	Influence of the Association for Perioperative Practice Multi-disciplinary Teamwork Patient Safety
Philosophy and Knowledge	Specific Knowledge Base Skills for Practice, Publications Research Studies in Perioperative Care Patient Safety
Legislation and Registration	Patient Safety New Roles Knowledge
Scope of Practice	New Roles Knowledge, Skills Patient Safety
Evidence in Support of Practice	Research studies in Perioperative Care Publications
Policy and Politics	New Roles Productive Operating Theatre Patient Safety

Table 2-1: The Interrelationships of the factors that comprise the General and Specific Perspectives

Once isolated these factors were explored in the literature to delineate the concept of influence and so to guide the development of this study. A variety of types of evidence was found in the literature in relation to each of the factors. Appendix 2 provides a detailed breakdown of the types of evidence used in this concept analysis. These tables and accompanying critique were used as the background to the following sections which are presented as a narrative review of the factors.

2.2.1 Influential Factors – A General Perspective

2.2.1.1 Professionalism

Basford and Selvin (2003) stated that the professional influence is perhaps the most influential, because it arises within nursing itself, with an aspiration towards excellence and a desire to ensure that practice is safe and effective. As Davies

(1995) cited by Lloyd et al (2007) stated nursing has a long established tradition of caring, compassion, intuition and empathy. This is evident in the legacy of the early influential ladies of the profession, Miss Nightingale, Mrs Seacole and Mrs Bedford Fenwick, whose contributions will be referred to as the analysis develops.

In their statement on the term ‘professionalism’, Brown and Gobbi (2007) have encapsulated a variety of factors that can be seen as influencing the practice of nurses in general. They stated that in order to achieve excellence in patient-centred nursing, nurses should practice with awareness, compassion and competence to high ethical and clinical standards. They continued in stating that these standards should be based on up-to-date knowledge that is cognisant, proactive and responsive to policy, research and knowledge generation. This in turn will gain the respect, confidence and what one feels is vital to care delivery, the trust of the people served. Brown and Gobbi (2007) raised another important point in that these factors can be applied to other health care disciplines. These factors of influence cannot stand alone; they are inter-dependent. This is supported by Brown and Gobbi (2007) who used, as an example, the interdependence of beliefs, attitudes and values. However, they pointed out that these issues are also distinctive in their own right. Mrs Seacole and Miss Nightingale would certainly have exhibited awareness, empathy and compassion as they cared for the British soldiers on the Crimean front.

Professionalism is influenced and enhanced by high ethical standards. Ethics provides us with the moral frameworks and according to Lloyd et al (2007) focuses on issues of duty and responsibility. They further explain that it extends beyond knowledge of ethical codes and conduct; it enables us to discriminate and make moral judgements in complex situations. Selvin (2003) commented that as nurses, we often put ourselves in the position of our patients when we make decisions for their care and, on occasions, moral dilemmas can and will occur. In such situations Lloyd et al (2007) highlight the fact that we are acting as the patients’ advocate, which enables us to understand our patients’ values, priorities and expectations. We are encouraged to challenge if all interventions are necessary and indeed question whether they are in the best interest of the patients or could they be in the interests of medical science, sometimes referred to as a ‘surgical exercise’. Seedhouse

(2002) supports this in that he feels as health care team members we have no option but to participate in moral choices.

The profession is guided by the Code of Professional Conduct – Nursing and Midwifery Council (2008), which provides the main source of professional accountability. Nursing has been guided by such codes for many years and their importance remains, as Holden (1991) stated in their ability to represent the whole process of decision-making entailing both personal and professional responsibility.

The statement of Bergman over thirty years ago and cited by Jolley and Brykczynska (1992) '*It is the totally accountable nurse exercising professional accountability for informed practice who promotes confidence in herself, her profession and the health care system*' (pp 20-21) remains one of relevance for the profession today in the rapid changes and challenges of health care delivery. Nurses are not only accountable to the Council but to their employers, their patients, and the public as a whole. It should also be added that nurses are also accountable to themselves. Cronin and Rawlings-Anderson (2004) in further discussion on accountability referred to Bergman's (1981) model on the preconditions leading to accountability, a model that will always hold relevance for nursing practice. It has been described in a hierarchical format and is shown below.

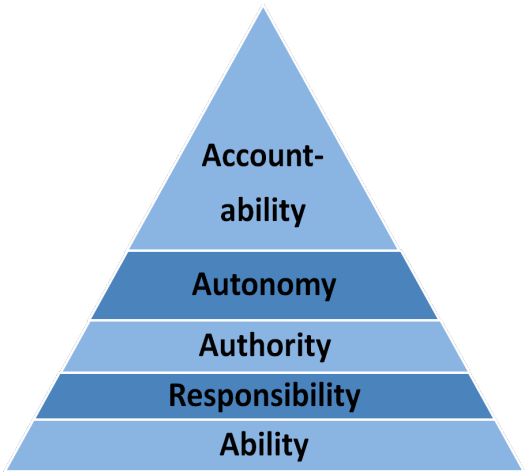

Figure 2-1: Bergman's Model of Preconditions Leading to Accountability.

Professionalism also involves understanding the principles of collaborative working, which is underpinned by the importance of valuing and respecting the contribution of each discipline to health care delivery. As North (1996) emphasised it is through a solid understanding of the ideological, social and political issues involved, that health care professionals adequately fulfil their role as both providers of services and patient advocates in an increasingly challenging arena.

2.2.1.2 Philosophy and Knowledge

The purpose of a philosophy for nursing practice, according to Burns and Groves (1997), is to guide nursing by providing a perspective for practice, in that it identifies the focus and goals of practice and delineates values that guide both practice and practitioner. It provides a perspective for research by identifying phenomena central to nursing.

Burns and Groves, in 1997, described philosophy as the most abstract, but all-encompassing, concept. They saw philosophy as giving unity and meaning to nursing by giving a structure in which thinking, knowing, and doing occurs. They highlighted various philosophical positions of the discipline such as the holistic perspective, the importance of quality of life, and how it influences knowledge. They also pointed out how perception is firstly influenced by philosophy and then by knowledge. Burns and Groves (1997) suggested that this philosophical stance, in general, directs how to view and interact with others in the world. Through their discourse one can appreciate the philosophical influence on research and its subsequent knowledge development in all aspects of nursing.

Johns (2005), writing about nursing and constructing a nursing philosophy, changed the word *philosophy* to *vision* to make it more comprehensible. His vision was formulated around four cornerstones:

- The nature of caring – practitioners give care in terms of therapeutic work processes and outcomes;
- The significance of the practice context – relates to the health-care context/culture of the unit, and the needs of the patients;
- The internal environment of practice – refers to the organisation of nursing and health care, the relationships that exist influence the practitioner to act according to his/her caring beliefs;

- Social viability – this relates to wider societal and professional issues which practitioners need to develop around the importance of nursing and heath care within society.

He feels that a vision for practice gives practitioners the opportunity to begin a process of understanding their practice environment and what is required to ensure that the vision becomes a lived reality.

It is of interest that Johns (2005) has changed philosophy to vision. It may be that he felt the word “vision” was more acceptable and meaningful to nurses than “philosophy” at that time, since the word “vision” was becoming commonly used in policy, for instance, the Department of Health’s Vision for Nursing in the 21st Century (2000,2006). Vision is also used widely in industrial circles in the context of promoting the aims and objectives of the organization. Philosophy, on the other hand, may be viewed by some nurses as a complex and abstract concept associated with higher academia.

The ontological aspect of metaphysics is also pertinent to nursing when we consider our involvement in empathic relationships with our patients since we not only care for them, but also care about them. This more aesthetic domain, according to Selvin (2003), provides insight into clinical wisdom and mastery essential to practice.

Seedhouse (2002) feels nursing has nurtured values of profound moral significance, he states that we are the only health care professionals who have the moral insight and practical wisdom to bring about moral progress. This is probably due to the fact that of all health professionals, nurses spend more time with the patients and therefore have a better knowledge of them as individuals. Nevertheless we, as nurses, should accept that we do not have a monopoly, even though nurses are the largest group of the health care workforce, on moral insight. Other health care professionals also have such insight into the individual needs of patients enabling care to be delivered, even though the amount of time spent with them does not equate to that of the nurse.

Rodgers (2005) gave an intriguing explanation of the influence of Aristotle’s philosophy on nursing today. She highlighted that he and his contemporaries confronted some of the same questions that currently perplex modern nurses. This

is in relation to the problem of unity in diversity – she feels it is not far removed from nurses' values and beliefs in a dynamic and changing nature of the world and indeed of people. Nurses, in Rodgers' (2005) opinion, have struggled with ways to gain knowledge of things not amenable to traditional empirical study, but hold important places in the intellectual history of the profession. She gives a few examples of entities, such as spirituality, energy, reliance, hardiness, 'becoming' and 'presence'. She concludes that Aristotle provided considerable incentive for considering that the combination of perception and logical reasoning can contribute to the growth of knowledge.

As a profession we must acknowledge and value the pursuit of knowledge and in so doing uphold our Code of Conduct. Burns and Groves (1997) looked at how nursing has acquired its body of knowledge over the years. They suggest acquisition through traditions, authority, borrowing, trial and error, personal experience, role modelling and mentorship, intuition, reasoning and research.

Knowledge from various dimensions, according to Jones and Higgs (2002), is needed to understand clinical problems and in turn formulate sound decisions for quality practice. Mulhall (1998) agrees with this and like Le May (1999), reiterates that knowledge for practice comes to us from a variety of disciplines. Mulhall (1998) further explains that it also comes from particular paradigms, and from our own professional and non-professional life experiences. As a result she urges that we acknowledge the real value of knowledge in practice. Mulhall (1998) also feels that because of the dimensions of knowledge acquisition, to access and respond to people's emotions, feelings and/or anxieties requires more than scales and questionnaires.

Parahoo (2006), exploring the nature of nursing knowledge, proposes that much of what we as nurses do with patients is all about the effects our presence, personality and selves have on our patients. He explains that patients wish to be treated with respect and dignity, privacy and confidentiality. To this one can add that these wishes of our patients are also of vital importance to them as individuals. Parahoo (2006) concludes by suggesting that such patients' outcomes are difficult to assess and are rarely used as measures of care. I disagree with this statement, because patient surveys utilising these very issues could be used as a measure of care received.

In undertaking care, Selvin (2003) feels that nurses utilise all the ways of knowing as identified by Carper (1978) - Empirical Knowing, Personal Knowing, Ethical Knowing, and Aesthetic Knowing. Selvin (2003) proposes that we should not relinquish or devalue our tacit intuitive knowledge just because it cannot be explained and justified on a scientific basis. In understanding the nature and credibility of knowledge and evidence Jones and Higgs (2002) see this as the first part of applying evidence to practice. They propose that practice improvement not only requires access to new knowledge, but skills in reasoning to enable the integration of that knowledge into existing knowledge. This also requires knowing when and how to use that knowledge.

Nursing practice has also been influenced by research in several ways – firstly, through nurses developing awareness of research, secondly, by their utilization of research and thirdly, by being involved in the activity of doing research themselves (Gerrish and Lacey 2010). The impetus for nurses to use and be involved in undertaking research started to gain prominence over three decades ago when the Committee on Nursing in 1972 stressed the need for the profession to become research-based. Gerrish and Lacey (2010) stressed that to enhance quality of nursing care it is important that care is clinically effective to achieve the best outcomes for our patients. For this to take place, nurses need to draw on knowledge generated through research to decide which intervention is appropriate and how and where to deliver it. This is supported by Parahoo (2006) who sees this as the goal of nursing research, but stresses that this goal is shared with all health care professions.

Thompson et al (2008) highlighted the studies of Estabrooks et al (2005), which explored the sources of knowledge that nurses rely on most in their practice. The nurses identified the following sources in order:

- Individual patient information and personal experience (these two sources tied for first place);
- Information from in-services – this refers to interactive small group meetings and educational outreach visits;
- Informal from nursing schools;
- Discussions with physicians and information from peers (these also tied);

- Intuition.

Of interest are the knowledge sources the nurses acknowledged as the least relied on. They included:

- Nursing Journals;
- Ways nurses have always done it;
- Nursing research journals;
- Medical Journals;
- The media.

Information gleaned from Estabrooks et al's (2005) study, as cited by Thompson et al (2008), confirmed other related studies such as Baester et al (1994). From these findings Estabrooks et al (2005) deduced that nurses favoured interactive, experiential and relational sources for knowledge acquisition.

The acknowledgement of nursing research journals amongst the least sources relied on is of particular interest as to some extent this goes against the exhortation of nursing's professional body and also opinion leaders, such as Tanner (2007), of the Association for Perioperative Practice in the use of research to support practice.

In general we are influenced by and do place great value on the acquisition of knowledge, this is evident by the on-going development of post registration courses across the disciplines of nursing and the positive attitudes of nurses to on-going education in their quest for the enhancement of patient care and self development.

As a profession, McKenna (2005) stated that our continued existence is based entirely on how we can improve the well-being of our patients, their families and our communities in general. He sees the link between our knowledge base and our practice as the core of our survival as a discipline.

2.2.1.3 Legislation and Regulation

Registered nurses practice by law. It is through the influence and tenacity of Mrs Bedford Fenwick over many years that nurse registration became reality. It took thirty years for the Nurse's Act to be passed and Royal Assent to be granted in 1919. With legislation comes regulation; Wilkinson and McDowall (2003) explain that the primary function of our regulatory body in the UK, the Nursing and Midwifery

Council, is twofold; firstly, to protect the public through maintenance of a Register of qualified nurses, accessible to the public and secondly, to set standards and guidelines to regulate and guide practice. In setting standards and guidelines, the Council has to ensure that educational programmes provide support, knowledge and skill to fulfil the requirements of the role, as highlighted by Cronin and Rawlings-Anderson (2004). They also allude to the aspect of the code that states the responsibility of Registered Nurses to maintain this professional knowledge and competence (Nursing and Midwifery Council (NMC) 2004). They see both a collective and individual responsibility within the profession as a whole that this is maintained. The Council also has powers to remove nurses from the Register in situations of misconduct, lack of competence and ill health. These principle functions are set out in legislation (Nursing and Midwifery Order, Statutory Instrument 2001).

As registered nurses we have to maintain our on-going professional development to ensure the currency of our practical experience and theoretical knowledge. This is recorded and is confirmed to the Nursing and Midwifery Council every three years.

2.2.1.4 Scope of Practice

Hunt and Wainwright (1994) discussed the expanding role of the nurse in the context of historical issues of professional development, reforms in health care delivery, technological advances, the growth of nursing research and knowledge and cultural, educational and legal changes. They referred to the natural process of growth which nursing has undergone in areas of its responsibilities, medical delegation and advances in nursing techniques. As a result of these developments and the context in which they occurred, the scope of practice has had to enlarge. Although Hunt and Wainwrights' 1994 discussion in the expanding role of the nurse was highlighted some eighteen years ago, the reasons proposed still have relevance today where role development is concerned.

The advancements in health care generally has brought a variety of changes in care delivery which Lloyd et al (2007) explained has created opportunities for development and expansion in the profession. They strongly feel that the profession has risen to the challenges of both Government and expectations of modern day health care. The establishment of The NHS Modernisation Agency in 1997, now the

NHS Institute for Innovation and Improvement, has resulted in the development of new roles, new skills and new ways of working. The rationale here is that the quality of patient treatment and care is improved. Innovation, technology, and improved leadership have allowed nurses to practice with autonomy, which in itself has influenced and increased professional accountability for the decisions being made in practice. Lloyd et al (2003) stated that the advancement of the nursing role in health care and the changes in care delivery have meant that nurse practitioners are practicing inter-dependently, managing patient case loads both in hospitals and in communities. The International Council of Nurses, in 2001, defined the advanced nurse practitioner as "*A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expended practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level*". (www.advancedpractice.scot.nhs.uk/defining-advanced-practice.aspx).

The Nursing and Midwifery Council, in 2005, has similarly defined the advanced nurse practioner as "*.....highly experienced and educated members of the care team who are able to diagnose and treat (your) healthcare needs or refer (you) to an appropriate specialist if needed*". (www.advancedpractice.scot.nhs.uk/defining-advanced-practice.aspx).

In the case of new roles, regulation is heightened, as is access to new knowledge and skills and the training and education required. The Nursing and Midwifery Council must ensure that advanced nurse practitioners are on the Register and that they have the required competences. The Council is currently in the process of establishing a project group to examine the basic competences of the advanced practitioner (Nursing and Midwifery Council 2010).

In undertaking new roles nurses must consider carefully, the Code of Professional Conduct; the evidence available; local policies; the law; and critical reflection in relation to previous experience. Not only must these aspects be considered, Wilkinson and McDowall (2003) also made reference to another vital aspect, that of nurses being fully aware of their professional boundaries and personal limitations. One would add that nurses must work within them and be able to feel confident to exercise their right to decline to undertake duties for which they are not competent.

In addition, the importance of the support of senior staff in such situations is crucial and necessary.

2.2.1.5 Evidence in support of Practice

Rycroft-Malone (2006), in tracing the origins of evidence-based medicine, stated that it was a paradigm shift away from a practice founded on observation and experience to one that focused on a systematic search for rigorous scientific evidence. Cullum et al (2008) had seen evidence-based ways of thinking as evolving from clinical epidemiology, a discipline that focused on the application of epidemiological science, into clinical problems and decisions. This is the result of the work of Archie Cochrane in 1972; Reynolds (2003) discussed his profound influence on the National Health Service through his combination of the psychological and physical well being of his patients with a critical research-orientated search for effective care. They highlighted that he was the first in medicine to utilise randomised controlled trials to evaluate methods of treatment and pioneered the use of systematic reviews and meta-analysis. Loftus-Hills et al (2003) discussed the rapid spread of this movement in the United Kingdom and as a result, the Centre for Evidence-Based Medicine and the UK Cochrane Centre both based in Oxford came into being.

The principles of evidence-based medicine are now being applied to other spheres of professional practice in health and further a field, such as the political arena, as highlighted by Pearson and Craig (2005), Cullum et al (2008). With this in mind a variety of definitions have been formulated, but the one which is pertinent to the study is that applied to nursing by DiCenso et al (1998) as stated by Trinder & Reynolds (2003): *'The process by which nurses make clinical decisions using the best available research evidence, their clinical expertise and patient preferences, in the context of available resources.'* (DiCenso et al 1998 p119). Interestingly, patient preference was highlighted as the top source of knowledge relied on by nurses in a study cited by Thompson et al (2008).

The influence of Florence Nightingale is also reflected in Evidence-Based Nursing. McDonald (2001), in looking at the early origins of evidence-based nursing, saw in Miss Nightingale's Collected Works a proponent of the cause. Although the terminology was not used at that time, the concept underpinned Miss Nightingale's

own theory of nursing and health care. She was a 'passionate statistician' and her work favoured a systematic approach. This approach entailed the best possible research, access to the best available government statistics, and expertise and has overtones of the present day's definition of Evidence-Based Nursing.

Commitment to the use of evidence in support of practice is endorsed from various quarters. The Government is committed to modernise health care delivery and improve quality in services to patients (Department of Health 1997 1998a). This reflects aspects of the political agenda and formulation of policy. Crofts (2002) discussed the NHS Executive 1998 framework for which Clinical Governance is a system through which the National Health Service (NHS) is made accountable for continuously improving the quality of their services and safeguarding high standards of care. McSherry & Haddock (1999) favour the concept of clinical governance, seeing it as a motivating environment in which excellence in clinical care will flourish. Evidence to support practice is a key component of this process.

The Nursing and Midwifery Council (NMC) also champions the cause, in that the nursing profession has a commitment to deliver safe and effective care based on current evidence, best practice and, where applicable, validated research. Cullum et al (2008) highlighted that the NMC standards for the nursing curricula demand that the curriculum should reflect contemporary knowledge and so enable development of Evidence-Based Nursing. The Nursing and Midwifery Council's commitment is in line with the Department of Health's Vision for Nursing in the 21st Century (2000, 2006), where all in the profession will be able to search for evidence and apply it in everyday practice. However, concern has been expressed by some protagonists of the concept, that in spite of nursing striving to base care on evidence, current practice did not always reflect it (Le-May 1999). This is an aspect the study will explore as it seeks to ascertain answers to the research question and the views of the protagonists will either be agreed with or refuted, as influential factors are determined during data collection.

This concern of the protagonists supports the theory-practice gap and in the opinion of Melnyk and Fineout-Overholt (2005), continues to cause concern in healthcare organizations. It is thought that nursing will lose its credibility as a profession without a strong commitment to use evidence to guide its decisions (Beyea 2000). This feeling, in relation to professional credibility, could be as a result of public

expectations and knowledge of current health care due to easy access to information from the Internet. In light of these concerns, this study also wishes to investigate what evidence is used and how practitioners, in their daily routine in the perioperative environment, use it. Responses from participants will ascertain if the use of evidence is a factor in the influencing of practice.

Cullum et al (2008) felt that the emergence of evidential support to practice could not have occurred at a more opportune time for the nursing profession. The challenges and demands of health care now, to which we are witnesses on a daily basis, have brought about new roles and responsibilities, an aspect that has influenced nursing practice from both a general and specific perspective – roles and responsibilities intended to enhance the quality of care afforded our patients. This they feel strongly will necessitate the development of knowledge and decision-making informed by evidence. Cullum et al (2008) expounded that health care delivered in ignorance of available research evidence misses important opportunities to benefit patients. This has direct implications for the profession in relation to our Codes of Conduct where acts of omission are concerned. Cullum et al (2008) also sees the provision of evidential support is a key skill for health workers from divers professions and cultures and the ability to deliver it promotes individualism of care and assures the quality of health care for patients today as well as tomorrow.

Jones and Higgs (2002) emphasised that the importance of evidence in support of practice cannot be overstated. They continued by pointing out that the practitioners must be accountable for their decisions to provide care that is effective, efficient, and affordable. This opinion is reinforced by the feelings of Melnyck and Fineout-Overholt (2005) who gave a caveat urging the use of evidence in decision-making, particularly as evidence is evolving continuously. Le May (1999) championed this by seeing evidential support as '*a dynamic process needing sufficient versatility to reflect the varying demands of practice and the uniqueness of patients'/clients' need*' (Le May 1999 p2).

Practitioners draw on multiple types of evidence; for example research findings, clinician expertise and patient experience. This opinion was supported by Pearson (2003) who felt that the eclectic nature of nursing had facilitated this. Rycroft-Malone (2006) saw challenges with this aspect, her argument questioning how such

evidence was weighted; how did they compliment each other and to what extent was its effectiveness on patient outcomes. Another aspect which Rycroft-Malone (2006) alluded to in determining what constitutes evidence is that of quality, with the supposition that higher-quality evidence should, in turn, lead to higher-quality decisions.

In relation to this study, the Trust in which the study site is located has responded to the Government's directives with regard to the use of evidence in practice. Its Mission Statement states that care will be safe and based on sound evidence with well-trained staff. In spite of such commitments of the support to, and the championing of the cause, one cannot help but feel that in the current health climate other priorities such as target attainment replace or overtake these good intentions. Support for what the Government, the Professional bodies and Trusts deemed important is somewhat diminished as a result.

In his foreword to the text Evidence-Informed Nursing, Long (2002) emphasises that every practitioner has an ethical and professional accountability to ensure that his or her practice is informed by best evidence. A point supported by Jones and Higgs (2002) who state that patients depend on such decisions to provide care that is effective, efficient and affordable.

Not only does Long (2002) see the onus on the individual practitioner, but accountability also rests with respective Trusts to provide supportive and enabling structures that will facilitate evidential support to practice. He continued in saying that there is need for access to information and dedicated or protected time to locate, read and appraise evidence. Long (2002) argued that the most challenging of those needs rests with the empowerment in the workplace to implement (agreed) changes in practice, as a result of evidence. However, some practitioners would argue that of equal challenge is the protection of time to locate, read and appraise the relevant evidence. Of equal importance to this is acquisition of skills and knowledge to undertake this, a situation that requires tangible support of management.

Mulhall (1998) makes a valid point in stating that in maximising the potential of evidence in support of practice, the profession considers that concerns that are easily measured or articulated are not the only ones of importance in health care. In

reflection, we can see that knowledge gained from practice as guiding innovative ways of care delivery.

Reynolds (2003) pointed out that opponents of the movement believe that this is another means of rationing resources; it was overly simplistic and stifled professional autonomy. She stated that some critics felt there was no evidence that such practice works. This could be seen as possibly the strongest criticism leveled at the movement and one which would gladden the hearts of its critics. Crofts (2002) argued that Evidence-Based Practice was a result of simple expediency on the Government's behalf as opposed to their altruism of patients receiving better care.

Questions have been asked of the motive of proponents of evidential support in practice in championing the cause (Mitchell 1997). She wondered whether they were calling for decontextualised menu-driven directives based on diagnoses and generalised situations. This does not appear to be so if we take into account the feelings of White (1997), DiCenso and Cullum (1998) and Cullum (2008). The general consensus of opinion here is that Evidence-Based Practice is multi-faceted; it requires the inter-relationship of clinical expertise, patients' preferences, actions, clinical state and health resources. DiCenso and Cullum (1998) explained that those who judge evidence-based nursing as '*cookbook*' nursing are ignoring this important aspect.

Craig (1996) has criticised it in the context of qualitative research. She saw it as an initiative of the government that exacerbates the lack of understanding of this method of research. Her cynicisms continued as she stated that the ideology and rhetoric was not new, but what is surprising is the way it had been packaged as the latest scientific revolution in medicine. It had its own in-house jargon such as randomised control trials, systematic reviews and meta-analysis, the magic ingredients heralded as a cure-for-all. In light of this statement, such terminology could be off-putting and in some ways frightening to many nurses, therefore contributing to the knowledge deficit where the use of research in general was concerned.

2.2.1.6 Politics and Policy

Muir Gray (2009) explains that it is the Government who takes the decision regarding the level of investment to be made in the country's health services. The

policy-making process makes the decision about how the services will be organised in relation to investment made.

Historically, the profession has not had the same degree of influence in the political system as its medical counterparts. This may have been due firstly to the reticence of the nursing profession to project its contribution in the past, the present and its potential for the future to health care delivery. The second point may be the possible remnants of the accepted ‘norm’ of nurses being ‘handmaidens’ to medical colleagues, playing a subservient role.

Masterton and Cameron (2002) highlighted the importance of nursing involvement in policy making, they say it is crucial that the profession has a cadre of nurses who can competently and effectively analyse and influence the formulation of health policies to support nursing objectives. Fyffe (2009) agrees with this and the impression is given that nurses involved in research, endeavouring to base and support their practice on evidence, should be the visionaries taking an active part in the shaping and development of health and social policy.

She also stated that the nursing profession faces major changes in health care and nurses need to be visible in the public debate about future models of health and health care. A statement one feels is of on-going importance. Fyffe (2009) cites Scott and West (2001) who also shared this opinion and felt that the discipline of nursing should participate more in the policy process and exert greater influence by nurses.

Needless to say, nurses are now actively involved in influencing policy. Recent information from the Nursing and Midwifery Council (2010) highlighted the fact that the Council on behalf of the profession works with politicians and policy makers within each of the four United Kingdom governing administrations. This is to help ensure that political debate and public policy reflects the interests of patient safety and public wellbeing. By so doing, the Council ensures that standards are implemented. The Council also guarantees that it is informed on the development and interpretation of healthcare policy in a rapidly changing healthcare and political environment. This is achieved through giving information about the profession’s activity and position on relevant issues and influencing key opinion formers and policy makers so that the aims of the profession are furthered therefore increasing

the protection of the public. Not only is the profession represented by the Nursing and Midwifery Council, Masterton and Cameron (2002) explained that the Royal College of Nursing plays a major part in initiating policy which is then taken forward by its Council. The Chief Nursing Officer (CNO) has input into every policy generated by the Department of Health and some policy from other departments such as Employment and Education. The Council also makes public its Affairs Calendar and is represented at events, meetings and conferences influential to the profession as a whole.

Not only does support for nursing involvement in policy making come from within the profession itself, the sociological perspective as described by Stacey (1993) sees health policy including care and treatment policies developed by consultant clinicians, nurses, midwives and their respective teams.

The ethical perspective of policy and policy-making has been discussed by Thompson et al (2008). The profession is urged from many quarters, such as Fyffe (2009), Thompson et al (2008), Masterton and Cameron (2002), to be active in contributing to the informed debate where the ethics of health care are concerned. This is viewed from the perspectives of moral duty in relation to the well-being of our patients and in the best interest of the profession. Needless to say, the responsibility for our patients' well-being is not without conflict. The difficulty here, according to Thompson et al (2008), arises from both the ethics of care and that needed for managing a complex modern health delivery system. They advise we adopt a professional and corporate ethic and an ethical policy development approach as opposed to one based on personal views of morality.

2.2.2 Influence Specific to Perioperative Practice

2.2.2.1 Specific Knowledge Base and Skills Required

The following highlights some elements of the specific knowledge base and the skill acquisition required for perioperative care. The formulation of these elements is based on personal experience, knowledge of, and education in perioperative care.

- The vulnerability of patients before, during, and after anaesthesia;
- The roles of the Anaesthetic, Theatre and Recovery practitioners within the perioperative environment;

- Knowledge of the variety of surgical procedures undertaken and the techniques and equipment required for each;
- Knowledge of departmental policy and its relationship to Trust and Government Policies;
- Knowledge of Theatre Etiquette;
- Maintaining knowledge base and acquired skills through on-going education and personal development.

At the core of these elements, are several influencing factors, which are discussed below.

2.2.2.2 Patient Safety

The safety of our patients is paramount and underpins all aspects of health care, this in turn reinforces the strong belief of Miss Nightingale that the hospital should do the patient no harm, as cited by Lewis (2003). The Association for Perioperative Practice (2009), (AfPP), formerly the National Association of Theatre Nurses, (NATN) reinforces this as they stated that patient safety is an essential element of effective quality patient care and crucial to this is effective teamwork and optimum communication. Such practice reflects an essential element of clinical governance frameworks and risk management processes.

Safe practice within the perioperative environment encapsulates many areas of care. The most influential of our publications *'Standards and Recommendations for Safe Perioperative Practice'* (AfPP 2007) has addressed these areas, which cover risk management, management/human resources, education, infection control, decontamination, principles of anaesthetics and clinical effectiveness. This text has guided the formulation of policies, procedures and standards which safe guard practice at all times. The monthly peer-reviewed Journal of the Association is also very influential and indeed respected by perioperative nurses. The variety of information gleaned covers various issues not only pertinent to perioperative care but to the wider health care scene. Information regarding actual clinical practice; education; management of personnel; risk and the department; opinion; medical devices; research and legalities are among the issues reported on a regular basis.

In exploring safe practice within the perioperative environment some influences affecting the practice of nurses have been highlighted. These involve the stringent checks of patients arriving in the department for surgery and adherence to the Standards and Recommendations for Safe Perioperative Practice' (AfPP 2007). These standards focus on movement within the actual theatre and surrounding areas of the department; of personnel and equipment; attire both specific and general; maintenance of sterility; equipment to be used and the principles of decontamination. Other influences involve the theoretical knowledge and practical skills required in the three domains of care, anaesthesia, the surgical procedure and immediate postoperative care. Another important influence is the multidisciplinary team working together at all times, it can be said that this is perhaps the one area of care where different disciplines work together for one patient at the same time. This constitutes the uniqueness of the perioperative environment.

Two recent occurrences are currently influencing the practice of perioperative nurses. The first is the global directive of the World Health Organisation (2008) of the use of the surgical checklist. The rationale here was due to the high incident rate of key safety checks not being followed compounded by the variable quality and safety of surgical care around the world. This checklist comprises of three phases, the Sign In phase – prior to anaesthesia induction; the Time Out phase – prior to skin incision; and the Sign Out – before the patient leaves the operating room. This directive generated an eclectic collection of articles addressing safer surgery and as Reid and Clarke (2009) stated, *builds on a strong evidence base, pulling together existing essential safety checks regarded as best practice* (Reid and Clarke 2009 p 337).

The second is the Productive Operative Theatre. This has been designed by the NHS Institute for Innovation and Improvement (2009) to improve the patient experience and outcomes of care. It helps:

- Theatre teams to work more effectively;
- To improve the quality of the patient experience;
- The safety and outcomes of surgical services;
- The effective use of theatre time and staff experience.

Using the Productive Operating Theatre is likely to increase the reliability and safety of care; team performance and staff wellbeing may improve and there may be

added value and improved efficiency. Currently it is being 'rolled out' to operating departments around the country and to date results from test sites have seen very encouraging improvements such as better session uptake and theatre utilisation, increased staff well being, improved rates of normothermia and pain control in recovery and an improved safety culture with the involvement of the World Health checklist. The Institute advocates that the use of this programme will improve the quality and safety of the surgical services and effective team working. Their aim is for departments to run the perfect operating list. Examples of improvement include the saving of £2 million through the reduction of waiting lists at University Hospitals Bristol NHS Foundation Trust and where the Central Manchester NHS Foundation Trust, through the implementation of briefing and debriefing the Theatre Team before and after surgery, saw significant improvements in staff attitude, team work climate, safety and job satisfaction (NHS Institute for Innovation and Improvement 2009).

2.2.2.3 New Roles

The creation of new roles within the department has also influenced perioperative nursing practice. In 2003 the Perioperative Care Collaborative (PCC), as defined by Al-Hashemi (2007) redefined the role of the First Assistant to that of the Advanced Scrubbed Practitioner; a role *'providing competent and skilled assistance under direct supervision of the operating surgeon while not performing any form of surgical intervention'* (PCC 2003 p2). It also involves preoperative assessment and postoperative evaluation. Specific training is required to do this role along with assessment of competence. When undertaking this role nurses must be aware that they are held by law to standards of care expected from medical staff. From each patient's perspective, Al-Hashemi's (2007) definition translates as an opportunity to provide holistic care.

Another role development influencing the practice of the perioperative nurse is that of the Health Care Assistant or Support worker. These new developments are asking registered nurses to devolve key aspects of patient care (McAleavy 2006) – something that they are not used to in the perioperative environment. One key issue is that of the scrubbed assistant's role. The reasoning behind this new role is that on-going development is available to all non-registered staff members across the specialty. Needless to say, this role is not without concern. McAleavy (2006) cited

Hind (2001), who discussed this well in advance of the role becoming reality. The concern of Hind (2001) in this situation was the possibility of alienation of nurses and operating department practitioners. It may also be felt that the new role is a solution to qualified staff shortages and one that would incur financial savings. However, it has been stated by McAleavy (2006) that not only should perioperative personnel work within the defined parameters of their roles, but the perioperative environment should be one which champions scope for growth and mutual respect.

Positional statements with regard to new roles undertaken in the perioperative environment are issued by the Association and used to guide and support such developments.

2.2.2.4 Association for Perioperative Practice

A specific influence for perioperative nurses is that of our professional association, the Association for Perioperative Practice. Its influence is exerted through its aims, which provide the foundation on which care is based (AfPP 2005). They are:

- Determining standards and promoting best practice;
- Facilitating education and practice development;
- Providing professional support services;
- Providing a forum for partnerships with the medical devices industry;
- Shaping healthcare policy.

The Association, the second largest discipline-specific organisation for perioperative practice in the world has influenced, and continues to influence the practice of perioperative nurses by several means. The Annual Congress, which attracts perioperative practitioners both nationally and internationally, is a target-rich environment for the sharing of both tacit and explicit knowledge of perioperative care, discussing challenges, solving problems and celebrating success. Other influential factors of our professional association have been previously highlighted under Patient Safety.

2.2.2.5 Multi-disciplinary Teamwork

From personal experience of working for many years in the perioperative environment, the nature of perioperative care is dependant on a multidisciplinary

approach to care and lends itself to collaborative working. Partnerships are forged with other disciplines of health care that work with us, an aim of the Association (2005), to provide quality of care which is safe, effective and of a high standard. It is not only the multi-disciplinary team within the perioperative environment itself that influences practice but working partners such as the National Patient Safety Agency, the Healthcare Commission, the Audit Office, the Department of Health and the Medical Devices Industry.

The production of a variety of publications which address care delivery and safe practice from clinical, educational, managerial and environmental aspects play a vital role in influencing perioperative nursing practice, mentioned has already been made regarding our most influential text – Standards and Recommendations for Safe Practice (2011).

The exhortation by opinion leaders, such as Beyea (2000) and Tanner (2006), within the specialty for practice to be evidence-based is influential, albeit on a small scale.

In general, the Association is proactive in encouraging and facilitating the organisation of relevant study days at national and local levels, addressing the full range of and influences on the care delivered within the specialty. Not only does the Association influence the overall practice of perioperative nurses, but also it encourages nurses to be influential themselves, both individually and collectively in the delivery of perioperative care.

2.2.2.6 Research Studies in Perioperative Care

Taking into account directives of Government (Department of Health 1997, 1998a) and exhortations of nursing's professional body (Nursing and Midwifery Council 2000, 2006) and the professional association (Association for Perioperative Practice 2006) that research evidence should be used to support practice, a review of research studies pertaining to actual practice in the perioperative environment was undertaken as part of the concept analysis. The research studies in perioperative care reviewed spanned the five-year period 2004-2009. This time was chosen as it was felt that research activity in perioperative care was gaining momentum and it would be fortuitous to ascertain how such activity influenced the perioperative practice of registered nurses at the site of study.

Information obtained from articles in the Journal of Perioperative Practice between 2004 and 2009 in relation to actual practice in the perioperative environment focused on clinical (n118), managerial (n31), educational (n21), opinion (n28), legal issues (n8), ethical issues (n11) and research (n30). The studies were conducted in the United Kingdom. Both qualitative and quantitative approaches were used and the methods for data collection included audit, cross-sectional and comparative studies, randomised selection process, and surveys. An integrated critique of the most appropriate of these studies, in that they reflected the use of evidence in practice, is at Appendix 2.

Tanner (2006) feels strongly that studies that are grounded in clinical practice will find that their respective findings will be implemented in practice, not only on a local basis, but on a national and international basis also. This statement is supported by the studies of Bothamley and Mardell (2005) who reviewed preoperative fasting, as a result of a patient being fasted for an unacceptable time. It describes the audit undertaken which culminated in the change of practice within a large district general hospital. Keegan-Doody (2005) undertook a study looking at patients being walked to Theatre, to determine the patients' perception regarding the possibility of changing a tradition-based practice to a more patient-empowering service. The study revealed that patients wanted to be included in the decision-making process and actively embraced change. As a result of the study, patients were given the choice whether to walk or be transported on a trolley. Tanner, Blunsden and Fakis (2007), conducted a national survey of hand asepsis. 8000 questionnaires were distributed, with a return of 1,471 replies. The result revealed that the reported current practice of those practitioners who replied was moving away from traditional practice to one supported by evidence. Lewsey's (2008) quantitative research study, examined the level and nature of support given to newly qualified Operating Department Practitioners. The results of the study have provided the initial baseline for the provision of support needed by newly- registered Operating Department Practitioners and one which is transferable to other new recruits. Bhattacharayya and Bradley (2008), who undertook a single-centre comparative study, looked at two types of wound closure following arthroscopic surgery. As a result of the findings, practice has been changed.

The common denominator of these studies has been the use of examples that show a move from a traditional, possibly ritualistic practice, to one supported by evidence. Nevertheless, it was noted that some ritualistic practices still occur, as highlighted by the studies of Weaving, Cox and Milton (2008), who looked at infection control in operating theatres and focused the study on surgical site infections.

The influential factors of knowledge, philosophy, ethics, policy and professionalism highlighted in the conceptual analysis have been demonstrated in the content and context of the research studies reviewed and they reflected the three domains of perioperative care delivered, namely:

- Pre-operative;
- Intra-operative;
- Post-operative.

Any influential factor affecting nursing practice is not a static phenomenon. It is a dynamic process resulting from a variety of interrelated and interdependent factors. The combination of these factors with the expectations of a questioning and demanding public, through ease of access to health information via the Internet, will constantly influence the planning, implementation and evaluation of nursing care.

2.3 Conclusion

Undertaking a concept analysis of influence, which in itself played a key role in this study, has proved an invaluable exercise in that it has provided clarity of the concept. Cronin and Rawlings-Anderson (2004) suggested that abstract concepts could not be measured, only inferred. They further explain that, within the context of nursing, problems arise because of the varying perceptions of the concept by both nurses and their patients. Equally, a variety of perceptions can easily occur as the concept is explored during the progress of this study, which also supports Cronin and Rawlins-Anderson's (2004) argument for conceptual clarity.

The analytical steps based on the framework of Walker and Avant (1995) provided clarity and, in turn, a better understanding of the concept. This was achieved through a logical progression and the ability to link the analytical steps as required.

Defining the factors of the concept has proved to be a vital step of the analytical framework. I felt these factors provided the foundation on which understanding of the concept will develop. I also found that I was able to support McKenna's (1997) suggestion that in some situations the defining factors and the empirical indicators are the same.

In relation to the study, conceptual analysis has assisted in the decision of a qualitative approach as the appropriate research design and the formulation of the interview structures. It will also assist in providing relevant links with the research question and the information obtained throughout the study in general. A better understanding through clarity of the concept will facilitate a meaningful analysis of the data collected.

Irrespective of whatever context nursing practice takes place, the concepts identified in the general perspective will always influence and affect individual and collective practice. Where the specific perspective is concerned, what has been identified as underpinning this perspective are the knowledge base, skills, and the scope of practice requisite for the respective specialty of care.

The following chapter discusses the methodology for study and how the influences highlighted here will be utilised in the data collection.

3. Methodology

3.1 Research Design

The research design was a qualitative intrinsic case study. The study was not seeking statistical representation but looking for registered practitioners with knowledge of, and experience in, the specialty of perioperative care. Information gleaned from these practitioners enabled the research question to be addressed.

3.1.1 The Rationale of the Approach

For this study, Stake's (1995) approach to case study design has been influential. This was due to its suitability for qualitative inquiry, for studying contemporary issues and building an in-depth understanding of a single case. It was also suitable for situations where there was no insistence on theory development and where purposive sampling was required.

Using case study design was also influenced by the points raised by Simons (1988) in that it was located within the practice setting, potential participants share common experiences, and the participants were all qualified practitioners working in the same area of care. Various researchers discussed this design strategy and from their respective discourses the points made by Simons (1988) have been reflected, supported and explained in the following paragraphs. Sandelowski (1999) discussed why she felt there was a renewed interest in case studies, which could be due to the disciplines of social science and practice seeing the value of studying particulars. She saw the epistemological suitability for clinical practice and human experience. She also saw its adequacy for generating knowledge and testing its accuracy, relevance and utility.

Sharp (1998) felt that the potential value of the case study approach to nursing could be seen from various aspects. He suggested that the word *'case'* was affiliated to nursing both from a conventional professional sense of individual patients and from the broader sense that nursing work is situated in particular organizational and social contexts which are said to constitute *'cases'*. He continued that, by definition, case studies take place in the practice setting. It should be noted that the word *'case'* in the perioperative environment refers to a surgical procedure; however, in context

of this study, it referred to the phenomenon being explored, which was what guided and influenced the practice of registered nurses in the perioperative environment.

Holloway and Wheeler (2010), in discussing the features and purpose of case study, stated that researchers using this design were generally familiar with the case and its content prior to research. They continued that it was a way of exploring a phenomenon in its context, using a variety of sources in data collection. This includes observation, interview and examination of documents. This they felt facilitated seeing the case from all sides.

One feature of case study is that of *'a bounded system'* (Stake 1995). In this study the case was the practice of registered nurses in the perioperative environment, in relation to the influences on such practice. The boundaries of the case encompass the working environment of the theatres and the recovery unit, collectively known as the perioperative environment. The area of study consists of six operating theatres and one recovery unit with a complement of 80 whole-time equivalent staff. Surgery undertaken included orthopaedics, trauma, ear nose and throat, urology, facio-maxillary, breast, colorectal, gastro-intestinal and emergencies.

Each theatre team consisted of three staff members; two of whom were qualified, the third being a health care assistant. An Operating Department Practitioner (ODP) works in both the anaesthetic room and the operating theatre. The staff in the recovery unit are a separate team; here each patient is allocated two qualified practitioners. The theatre and anaesthetic staffs are only involved in the pre- and intra-operative care, while the recovery staff are involved in the immediate post-operative care. The research study planned to involve twenty-four registered practitioners.

The location of study was not the workplace of the researcher, therefore the majority of potential participants were not known. Information from participants would not be affected through familiarity of work-colleagues in the same department, which assisted in preventing bias, by both researcher and participants.

3.2 Data Collection

3.2.1 Access, and Sample Recruitment

Access to the study environment had been gained from the Director of Nursing Services, the Theatre Manager and the Medical Director, all subject to National Research Ethics Service approval. The Head of Patient Safety and Healthcare Governance, whose role encompasses Research Governance, had also been informed of the proposed study.

Approval for the study was obtained from both the Ethics Committee responsible for the area in which the study was undertaken and the Healthcare Trust where the study is located. Once approval for the study to be undertaken was obtained, an Honorary Contract was requested and was granted by the Trust.

The study focused on Registered Nurses because of their experience and knowledge of perioperative care. They were the decision-makers, leaders and influencers who planned, implemented and evaluated practice. As Pearson and Craig (2005) suggested, the ones who would assess the impact and outcomes of interventions and interactions for care delivery. This would enable meaningful data to be obtained. There were approximately 50 registered practitioners in the department who would be eligible to join in the study.

The potential participants were:

- Sisters, Charge Nurses and Staff Nurses working in each of the three perioperative domains of practice (Pre-, Intra- and Post-Operative care);
- The Senior Operating Department Practitioner working in the three domains of practice;
- Senior Medical Staff;
- The Education Coordinator, who has responsibility for the training and education of nurses, ODPs and health care assistants.

Senior medical staff, a Senior Operating Department Practitioner and the Education Coordinator were included in order to obtain their views on how they influenced practice within the perioperative environment. Senior ODPs also hold positions of

Team Leaders within the department. Involvement of these staff members was an opportunity to examine influences from a multi-disciplinary perspective.

Participation in the study was on a voluntary basis and potential participants were recruited by self-selection. As there is only one Education Co-ordinator for the department and only one Senior Operating Department Practitioner required for the study, recruitment of those was by invitation from the researcher.

A recruitment letter inviting potential self-selecting participants, the registered nurses and medical staff was displayed by the Theatre Manager in their respective staff coffee rooms. The Theatre Manager was also asked to inform potential participants of the study at Departmental meetings. If a person considered joining the study they were invited by the recruitment letter to take a recruitment pack. The pack contained:

- A pre-paid addressed envelope;
- A letter of recruitment;
- A reply slip; and
- An information sheet for participants.

Recruitment packs were placed in a container marked *'Research Study'* and kept in the staff coffee rooms. The researcher gave recruitment packs to the Education Co-ordinator and the Senior Operating Department Practitioner. All potential participants were asked to send their replies in the pre-paid envelopes addressed to the Head of Research Support, School of Nursing and Midwifery, University of Southampton (now the Faculty of Health Sciences), where they were collected by the researcher. Potential participants were asked to decide if they wish to take part in the study within a week of taking the recruitment pack. Receipt of the reply gave the researcher permission to contact the potential participant and allowed the researcher to respond to any questions they may have had and, where appropriate, arrange the interview. The researcher was responsible for obtaining written consent from the participant at this meeting. The information sheet for study participants is at Appendix 5.

Data was collected over the period 2008-2009 and was obtained from:

- Biographical data sheet completion;

- Individual in-depth interviews;
- Focus group;
- A review of departmental documents, in the context of how they influenced the practice of the registered nurses.

3.2.2 Individual In-depth Interviews

The purpose of the interview was to discover the participants' thoughts, feelings, and perceptions about the subject of study. The rationale for in-depth interviewing, as suggested by Cormack (2002), is that it gave the participants an opportunity to describe their experiences in their own words. He continued that this form of interviewing is the most common qualitative method used in nursing research, a point supported by Holloway and Wheeler (2010) who added that it was particularly used by novice nurse/midwife researchers. They see the reason for this being the researcher's wish to gain the inside view of a phenomenon or problem, both from the patients' and their colleagues' perspectives. This study reflected the latter. On this aspect they cited Silverman (2006), who has criticised interviews for anecdotalism. Their response is that if the researcher applies high standards and rigor, the study goes beyond anecdotes and presents the reality of the participant. The in-depth interviews for this study were based on the semi-structured format.

A Topic Guide was formulated for the individual in-depth interviews. The defining attributes of the concept influence assisted in the design of the Guide. The Guide was based on the following five key sections:

- The biographical perspective;
- Influences on practice;
- Actual practice;
- Specific issues (to the senior operating department practitioner, the Educational Co-ordinator and medical staff);
- Any other issues (points raised by participants).

The Topic Guide was used for all in-depth interviews, but the order of questioning varied depending on the reply given or on information obtained from previous questions. This aspect was a point highlighted by Dearnley (2005) and Holloway &

Wheeler (2010), which stated that the ordering of further questions was determined by the participants' responses.

The Biographical Perspective, Influences on Practice and Actual Practice were the predetermined themes. Aspects generating information of each theme, for example, in relation to Biographical Perspective, 'on-going professional development and education', became the sub-themes.

3.2.2.1 The Biographical Perspective

The Biographical Perspective gave an insight into the participant's individual professional background enabling the researcher to start building the participant's profile and to become familiar with it. This perspective is supported by each participant's biographical data, completed prior to each individual in depth interview. Aspects relevant to the Biographical Perspective form the sub-themes and they include the participants' education and training; this aspect ascertains year of training and whether the curriculum was Hospital or University based; the role in the department; why this chosen area of practice and on-going professional development and education.

3.2.2.2 The Influences on Practice

This second key section looked at the actual influences on practice of each participant. The sub-themes of this theme were values, feelings, beliefs, experience both professionally and non-professionally, internal and external influences and culture and the prioritisation of individual influence.

3.2.2.3 Actual Practice

Actual Practice was explored in relation to the following sub-themes; these are the effects of research, knowledge base of perioperative practice, knowledge update, perception of evidence and sources of evidence, use of evidence in practice, change in practice, strategies for reviewing practice and examples of practice where evidence was used. This enabled the researcher to ascertain the effects of such issues on the individual's and departmental practices respectively.

3.2.2.4 Specific Issues

The specific issues in relation to the medical staff, the education coordinator and the senior operating department practitioner were to establish the influence of other members of the multi-disciplinary body on the Registered Nurses through their respective roles and areas of responsibility within the perioperative environment.

3.2.2.5 Any Other Issues

This aspect of the Topic Guide was to identify any issues that the participants felt were important to them, but not highlighted on the guide or referred to by the researcher.

All in-depth interviews were audio-recorded with the permission of the participants. At the interview meeting, time was given to each participant to ask further questions about the information included in the recruitment pack. Once this was addressed satisfactorily, both the participant and the researcher signed a formal written consent form. The participants were also asked to fill out a biographical data sheet before proceeding with the interview. The interviews lasted approximately 30 to 90 minutes and were held in a private and quiet room away from the Operating Department. Ten participants took part in the study. Prior to undertaking the individual interviews, a Pilot Interview was carried out, shown at Appendix 4.

3.2.3 Focus Groups

The Focus Groups consisted of the registered nurses who had taken part in the study. The aim was to use the information obtained to confirm, reinforce and/or refute that provided in the individual interview findings. It would also be an opportunity to clarify, where necessary, information obtained during in-depth interviews.

The Focus Group discussion was held in the Post-Graduate department of the hospital. The procedure for conducting the focus group was attributed to Grbich's (1999) suggestions. The participants were welcomed to the session and invited to help themselves to refreshments provided. The Observer, who was also the researcher's first Supervisor, was introduced and her presence explained. She took notes (Appendix 10), observed proceedings, identified participants and noted which participant was speaking at any given time. This assisted the researcher to elicit the

similarities and differences between respective participants, compare the information gleaned from the one-to-one interviews with that obtained from the group and from the individual input in the group. No icebreakers were necessary, as all the participants knew each other. The purpose of the session was explained and they were reminded of the research question:

> *What Influences the Practice of Registered Nurses in the Perioperative Environment?*

Ethical principles were reiterated such as confidentiality, anonymity, the right to withdraw at any time during proceedings without question and the right not to respond to any question. The group's permission was ascertained for the session to be audio-taped. Although anonymity was discussed, it must be noted it cannot be upheld among the participants as they now knew who else took part in the study and material will be shared among them. Anonymity was maintained for reporting purposes. The atmosphere was relaxed and friendly which in turn was conducive to effective group discussions. This was substantiated by Gibbs (1997) who, in discussing the role of the facilitator, stated that it is critical in helping group members feel at ease.

Participants were informed that the activity they would be engaged in would form the basis of the group discussion. This information resulted from the analysis of the in-depth individual interviews. This information was written on cards, put into sets that were then given to each participant. They were then asked to put the cards in to order of importance to each individual, and these results were recorded on the flip chart provided marked *'BEFORE DISCUSSION'*. Following the general discussion, the participants were invited to review their respective orders of importance of the influences and change them as required. For ease of collation, participants were also asked to write at the top of each card *'BEFORE'* and *'AFTER'* and to put the number pertaining to that influence accordingly.

The following questions were put to the group at the end of the activity:

- 'What are these changes telling us'?
- 'What is helping the cohesiveness of the Team'?
- 'Is there anything else not already discussed influencing your practice'?

Further discussion ensued, new influences emerged and were discussed, but participants did not alter the order of influence on the flipchart in light of the discussion. These will be reported in the chapter on Findings.

On conclusion of the discussion the participants were thanked for their contributions.

3.2.4 Review of Departmental Documents

Departmental documents analysed consisted of policies and procedures, departmental philosophy statements, on-going education and training programmes for staff members, and journal papers displayed in the department.

These papers/articles were explored to determine if information generated from both the individual depth interviews and the focus groups discussion were reflected in departmental documents. Aspects such as innovation and improvement in practice, research studies, and directives from both government and the professional bodies were included. The review of these documents took place after the in-depth interviews with specific attention being paid to any reference to how practice is influenced. This enabled the document contents to be compared with the information from the in-depth interviews and discussions of the focus group participants. This review will be reported in Chapter 4.

3.3 Data Analysis

Data analysis was undertaken using the Thematic Framework Analysis approach.

3.3.1 Thematic Framework Analysis

This is a method of analysis developed at the National Centre for Social Research in the 1980s and is now widely used by qualitative researchers. The thematic framework is used to classify and organise data according to themes, concepts and emergent themes. The framework analysis as described by Ritchie and Lewis (2006) has been used for this study. The stages of the process were Data Management, Descriptive Analysis, and Explanatory Account.

Thematic Framework Analysis was used for both the individual in-depth interviews and the focus group discussion. The analysis of the departmental documents has already been highlighted in paragraph 3.2.4

The following table represents the steps of the Thematic Framework analysis based on Ritchie and Lewis's (2006) description:

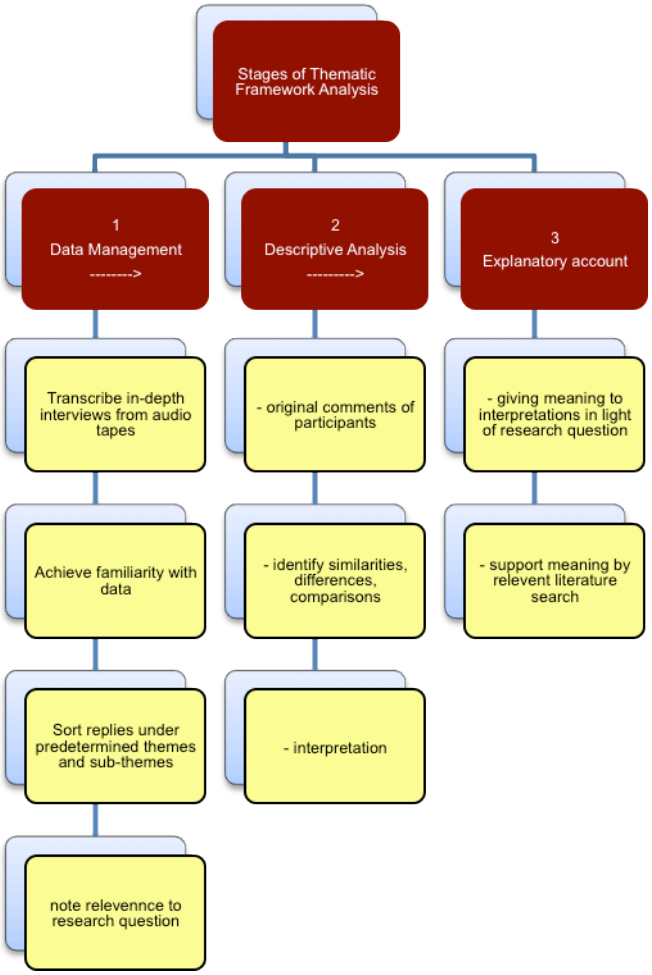

Figure 3-1 Thematic Framework Analysis

3.3.1.1 Data Management

This involves:

- Transcription of in-depth interviews from audiotapes – based on predetermined themes and sub-themes;

Predetermined Theme	Predetermined Sub-Theme
Biographical Perspective	Education and Training Working in Operating Department Why this are of practice On-going professional development and education
Influences on Practice	Values, feelings, beliefs Experience - professional, non-professional Internal and External Influences Culture Priority of Influences
Actual Practice	Effects of Research Knowledge Base of Perioperative Practice Knowledge Update Perception of Evidence Sources of Evidence Use of Evidence Change in Practice Strategies for Reviewing Practice Examples of Evidence Used Priority of Influences

Table 3-1 Predetermined Themes and Sub-Themes

- Transcripts thoroughly read so familiarity with data is achieved;
- Data summarised as to its relevance to the research question.

Tapes of each participant interview were played and replayed as was necessary. During this transcription notes were taken and information obtained was collated under the predetermined themes and sub-themes (Appendix 7). Lists were made of the comments of participants in order to elicit any emergent themes and sub-themes. Frequency of listening to the tapes ensured that notes reflected the original dialogue. Additions to, and amendments of, the information recorded were made. The research question was kept in mind throughout the analytical process.

The predetermined themes and sub-themes were coded in numerical order, (Tables A1 to A3, Appendix 8). The predetermined themes are Biographical Perspective, Influences on Practice, and Actual Practice.

Further coding was undertaken of the responses to the sub themes resulting from the familiarisation of the transcripts of the individual in depth interviews. These have been represented in the Chapter on data findings, Chapter 1:

- Biographical Perspective – Tables 1.1 to 1.4;
- Influences on Practice – Tables 2.1 to 2.4;
- Actual Practice – Tables 3.1 to 3.9.

These can be cross-referenced to the original Tables A1 to A3; the information recorded were comments made by participants on each theme and sub-theme. Comments have also been numerically coded. Appendix 8.

The first two sub themes of the Biographical Perspective; namely, education and training and roles of participants in the department were inappropriate for further thematic analysis. As a result, they have been coded as symbols and letters respectively. The remaining sub-themes of why this area of practice and the on-going professional development were coded numerically.

Because of the nature of this sub theme, it was decided to address it from the perspectives of both experienced staff and those new to the specialty. Comments therefore are those of the researcher and not the participants. Education and training, along with roles in the department and the choice of the speciality, enhanced the biographical details of the participants in order to become familiar with the participants as individuals and health care practitioners respectively.

3.3.1.2 Descriptive Analysis

In this aspect of the analysis, the sub-themes were refined, comparisons made, and similarities and differences identified.

Maltby et al (2010) highlighted that Ritchie and Lewis (2006) described this aspect of their analytic process as 'unpacking' the data and suggested that it may be presented in three columns. The three column format were used to present the findings and has been explained by Maltby et al as such; Column A contains the original statement of the participant, Column B looked at the first stage of abstraction, although its description remains close to the original data. The final column, Column C saw the beginning of the interpretation in a conceptual way (Appendix 9). It should be noted that the original comments represented are just some of those made by the participants for the predetermined themes and sub themes.

Experiences, both professional and non-professional, were amalgamated with internal and external influences. This was undertaken because of the commonalities in the responses of the participants to both sub-themes.

3.3.1.3 Explanatory Account:

This gives an explanation of the meaning of findings in light of the research question and the implication to practice and subsequent care. This aspect, in the opinion of Ritchie and Lewis (2006), goes beyond the raw data collected and forms the substance of Chapters Four.

Both descriptive analysis and explanatory accounts will be discussed in the next chapter.

3.3.2 Review of Departmental Documentation

A review of departmental documents was undertaken in relation to the information generated from both the individual in-depth interviews and the focus group discussion. This enabled the differences and similarities of the documents' content to be ascertained.

3.3.3 Strategies Used

Strategies that have been used for the trustworthiness and authenticity of this study are described in the following paragraphs.

3.3.3.1 Member Checking

Member checking was achieved by the verification of the information gleaned during the individual in-depth interviews with the discussions of the focus group. The focus group was comprised of the registered nurses who took part in the study.

3.3.3.2 Dependability

Aspects of an audit trail as developed by Lincoln and Guba (1985) was used. This trail looked at a record of decisions taken before and during the research and a description of the research process. A diagrammatic representation of the research process and the trail of the study have been devised (Table 3-2).

3.3.3.3 Reflexivity

A process of qualitative research in which the researcher reflects continuously on how their own actions, values and perceptions impact on the research setting, affecting both the data collection and subsequent analysis. A reflective diary was

maintained and its contents were recorded as a part of the overall reflection of the study in the discussion chapter. Porter (2002) highlighted the fact that the involvement of reflexivity at several levels is a hallmark of good research. Lathlean (2007) too saw reflexivity as a very important aspect of the research process. She alluded to its relevance in nursing research because the researchers were usually nurses themselves.

To establish the trustworthiness and authenticity of the study, examples for each strategy have been explained in the following paragraphs.

Holloway and Wheeler (2010) have cited Robson (1993) who stated that a study that establishes credibility would also be dependable. The credibility for this study was ensured through the accurate identification of the roles and description of the participants. This was also ensured through reflection by the researcher of personal experiences as a researcher.

Reflexivity was substantiated through the researcher being a perioperative nurse for many years. Experience in, and knowledge of, the specialty allowed for understanding shared values, feelings, and the beliefs in the subject of the study.

3.3.4 Ethical Considerations

Ethical conduct is an essential feature of rigorous research and includes respect for autonomy, confidentiality and protecting anonymity. Ethical principles and procedures have been based on guidelines from Simons (1988) and the Nursing and Midwifery Council's Code of Conduct (2004). Of particular importance to this study is that all categories of participants will have equal voice enabling fair and respectful treatment. Where participants may be identifiable, they will be made aware of the possibility of their anonymity and confidentiality being compromised and negotiations will take place with them in respect of what information given by them may be reported. Confidentiality and anonymity will be maintained in external reports, publications and presentations.

All information pertaining to the study will be kept in locked filing cupboards in a secured room at the School of Nursing and Midwifery. Once the study id complete, control of data will be passed to the Research Office, School of Nursing and Midwifery, University of Southampton. The data will be stored for 15 years in

accordance with the policy of the School of Nursing and Midwifery, University of Southampton, and then destroyed.

3.4 The Role of Researcher

Rolfe (1998), as cited by Cormack (2002), stated that *'Clinical research to be effective in practice must be practitioner based'*. Holloway and Wheeler (2010) would agree with that statement; they suggested that when interviewing health colleagues, concepts are more easily understood by a researcher who is involved in the culture of the participant. As a result of this, they felt that there may be less room for misinterpretation but misunderstandings can arise due to the assumption of common values and beliefs. They also felt that thoughts uncovered during such interviews might not be questioned. Parahoo (2006) also saw the advantageousness of practitioners undertaking research, stating that the research process starts with practice and advocating that practitioners are best placed to undertake it, a point Tanner (2006) would also agree with. This was substantiated by the researcher, through being an experienced nurse with educational duties within the perioperative environment, being an 'insider'; knowledge insight in Parahoo's opinion and the opportunity to select a subject for study facilitated its relevance to practice. Insider knowledge also facilitated a better understanding of the data and a greater commitment for dissemination of the findings. It was felt that this study has upheld his opinion.

The researcher acted in accordance with, and was guided by, ethical and moral principles of conducting research studies. Commencement of this study did not take place until approval was granted by the Ethics Committee responsible for the geographical area of the study, by the Health Care Trust where the study was sited, and had permission from the relevant gatekeepers and agreement from potential participants who took part in the study. Where the participants were concerned, it was vital that all information in respect of study participation was given and understood.

Another aspect, which needed consideration, was the location of a study in relation to the workplace of the researcher. The location of this study was not the workplace of the researcher, therefore the potential participants were not previously known. Information from participants was not affected through familiarity of work colleagues

in the same department, which assisted in curtailing bias by both researcher and participants. Participants should find giving information of true opinions, feelings, and beliefs less inhibiting which will result in a more meaningful study.

The Practitioner as Researcher appreciated and understood the difficulties in the collection of data. This was most relevant to this study and will be reported in detail in the general discussion. Awareness of constant reminders to participants in the context of taking part in the study was important, particularly when participants had volunteered. The relevance of this to the study was most apparent where the arrangement of the individual interviews was concerned. Avoidance of annoyance with possible withdrawal from the study through constant reminding was of great personal concern and may have contributed to difficulty in the arrangement of some interviews.

The following table is a summary of the combined audit train and methodological process of the study:

	Key Elements of Research		Decisions For Actions Taken
2004-2007	Research Design	Subject Chosen Literature Research Qualitative, Intrinsic Case Study	Practice-initiated Appropriateness for subject to gain information to address research question
	Access	Gatekeepers Director of Nursing Theatre Manager Medical Director Research Governance	Essential Personnel to enable research to be undertaken Face-to-face discussions and written requests
	Sample	Registered Perioperative Nurses Senior Medical Staff Education Co-ordinator Senior Operating Department Practitioner	Key personnel needed to address research question
June 2008	Ethics Committee	Written Proposal submitted	To obtain approval for study to be undertaken
July 2008		Approval Granted	
July 2008	Recruitment	Self-selecting	Registered Nurses
			Senior Medical Staff
		Invitation by Letter	Only 1 Education Co-ordinator in department Only 1 Senior Departmental Practitioner chosen To reflect personal influence on Registered Nurse practice through their roles in the department
July 2008	Data Collection	Individual In-depth Interviews Focus Group discussion of Registered Nurses who had taken part in the study	To obtain information to answer research question
December 2009	Data Analysis	Thematic Framework Analysis	Information Obtained from predetermined themes and sub-themes
Jan 2010 to March 2012	Trustworthiness Authenticity	Member checking Dependability Reflexivity Role of the researcher	Strategies used To prove trustworthiness of the study
Jan 2010 to March 2012	Writing of Thesis	Submission March 2012	

Table 3-2 Combined Audit Trail and Methodological Process

Information obtained from the individual in-depth interviews, the focus group discussion and the review of departmental documents will be analysed as previously stated. The findings, along with relevant discussion, form the substance of the following chapter.

4. Findings and Discussion

This chapter presents and discusses the findings from the data collection. The findings from the individual in-depth interviews with nurses are reported first under the relevant predetermined themes. An account of the focus group and a listing of the main prioritised influences on practice is then presented together with the analysis of the departmental document reviews. Following this, an explanatory account, incorporating relevant literature, of these findings is reported. The chapter concludes by presenting the views of staff seen as influential in forming the nurses' practice in the peri-operative environment. For clarity the key findings of the sub-themes are summarised in tables 4-1 to 4-4 at the start of each relevant subsection.

4.1 Descriptive Analysis Of Individual In-Depth Interviews

4.1.1 Biographical Perspective

The sub-themes of the Biographical Perspective addressed education and training, working in the operating department, why this area of practice and on-going professional development and education.

Sub-Themes	Education and Training	Service-sited nurse training Higher Education sited combined with clinical placements Medical Training National vocation qualifications (non-nursing)
	Working in the Operating Department	Roles of registered nurses – Nurses, Sisters, Charge Nurses Working mainly in the intra-operative domain
	Why this area of practice	Student allocation Service needs Career development Unpredictable development Love of environment
	On-going education and development	Display of relevant journal articles Training programmes Staff presentations Courses Study days

Table 4-1 Sub-Themes and Responses of the Biographical Perspective

The sub-theme of Education and Training identified four examples which were service-sited nurse training; higher education sited training combined with clinical placements; medical training and national vocational qualification (Operating Department Practitioners – Non-nursing). Comparison was made by some

experienced practitioners between the past and present nurse training. In the past, methods for practice were readily accepted. With the current curriculum students are more critical, questioning, and challenging.

The experience within the speciality of the self-selected participants ranged from nine months to over thirty-six years. The roles of the registered nurses were a mixture of staff nurses, sisters and charge nurses. Most participants worked in the intra-operative domains of perioperative care. Further information regarding the Participants is recorded in Appendix 6.

In the following paragraphs, selected responses from the participants are quoted. The full range of responses can be found in Appendix 8. The cross reference in brackets defines the participant, the comment, and which table it is in.

In respect of choosing to work in the perioperative environment, a variety of reasons were given. They included the lasting impression of a student allocation to the specialty and some participant's choices to specialise resulted not from a personal one, but from that of the organisation's situation. This can be supported by the following comments such as: *"came to Theatres by default because of staff shortages" (A1 1.3.1 – Table set 1A).* Other aspects of attraction saw the specialty through its variety of experiences, an avenue for career development – for example role expansion and scope of practice were concerned with a multi-disciplinary environment.

The inability to explain the attraction and love of the specialty was highlighted: *"I just love this area of nursing; can't explain why." (A1 1.3.2 Table set 1A).* This was in contrast to those who saw the nature and unpredictability of the perioperative environment fulfilling their enjoyment of resolving difficulties. *"I enjoy problem-solving in the acute setting, and the Operating Theatres facilitated this" (DA4 1.3.3 Table Set 1A).* It was also felt that this area of practice would facilitate a great experience.

The comment *"impressed by individuals working completely" (E1.3.5 – Table Set 1A)* inferred that care delivered by competent practitioners was enhanced, through effective teamwork.

Where on-going education was concerned, similarities were predominant and it was recognised as being important to personal development. Participants were

ambitious and eager to achieve. Effective utilisation was made of available resources to promote development. As one participant commented: *"learning opportunities were great with the multi-disciplinary team" (B3 1.3.6 – Table Set 1A).*

The importance of on-going education was also supported by observation of relevant articles and training programmes information displayed in the department. The interview with the Educational Co-ordinator also supported these findings. These sub-themes were seen as setting the scene in that a feeling of how participants viewed their work environment began to emerge.

4.1.2 Influences on Practice

The responses of the participants to the predetermined themes and sub-themes on the Influences of Practice were of importance to the study in light of the research question:

> *What influences the Practice of Registered Nurses in the Perioperative Environment?*

Sub-Themes	Values Feelings Beliefs	- Safe Practice - Good Rapport within multidisciplinary team - Reflection - Role Models
	Experience	- Individuals working together competently - Role models (family) - Non-professional dealings with the public - Personal patient experience
	Culture (Departmental)	- Good communication - Team cohesiveness - Roles of mentors and preceptors
	Priorities of Influence	These have been reported for each Participant in Appendix 9 (2.4)

Table 4-2 Sub-Themes and Responses of Influences on Practice

The sub-themes of values, feelings, beliefs, experiences and culture together reflected the conscious experience of everyday life and the responses to them began to provide the evidence required for the study. Collectively, the responses to these sub-themes highlighted commonalities for safe practice by the maintenance of good and safe standards of care at all times. Safe practice was pivotal to care, and the comment *"safety underpins care" (B1 2.1.2 Table Set 2A)* substantiates this. Other influences involved a good rapport with colleagues within a multi-disciplinary team,

the use of reflection in practice, and the importance of a rationale as to why things are done and not a blind acceptance of ritualistic practices.

The influence of role models, both professionally (work colleagues) and non-professionally (familial influences), was highlighted:

> *"looking at how colleagues work, taking what are good aspects of care to improve my own" (A2 2.2.1 Table Set 2A);*
>
> *"I had a brilliant Theatre Superintendent" (A3 non-coded response).*

These were some comments made which showed the value placed on this influence.

Responses to professional, non-professional, internal and external influences identified individuals working competently together which enhanced the effectiveness of teamwork as a whole. Other influential experiences included that of dealing with the public prior to nursing training. Of interest was the effect of patient experience through personal illness in relation to care received. The influence of the family, whether by individual members or as a family unit, was important to some participants and this appeared to be an on-going entity. *"My husband's encouragement and the challenge of the family, to do well" (B1 2.2.4 Table Set 2A).*

The culture within the environment also played a significant part in that most participants referred to practice being influenced by good communications: *"the ability to discuss issues at any time" (A1 2.3.2 Table Set 2A)*, and the cohesiveness of the team. They felt supported, encouraged, with an emphasis on development: *"guiding colleagues to fulfil their potential" (A4 2.3.4 Table Set 2A).* Departmental culture also alluded to the valued roles of mentors and preceptors as they provided a great learning environment.

The priority of influence requested of each participant is shown in Appendix 8 (2.4). The order of importance differed; nevertheless there were some similarities, for example Patient Safety recorded by participants 3(A2), 5(A3) and 9(DA5) as their first priority.

4.1.3 Actual Practice

The sub-themes of Actual Practice addressed the effects of research, the knowledge base of perioperative practice; a variety of perspectives in the context of evidence, its perception by participants' sources of evidence, its use, and examples of its effect on practice. The sub-themes also included change in practice and strategies used to review practice.

Sub-Themes	Effects of Research	- Influenced medical staff changing their practice - Researching articles - Tend to research unfamiliar things - Dedicated person to lead research in department - Gradual progression to embrace research - Perioperative practice not quite research-based - Current research support policies and procedures
	Knowledge Base of Perioperative Practice	- Experienced staff with a wealth of knowledge of perioperative care. Some are members of the Professional Organisation of the specialty. - Staff newly qualified and/or new to the specialty
	Knowledge Update	- Sharing of knowledge Internally through Trust/Departmental Audit / Education Days, this involved 'in house' presentations and demonstrations by medical devices representatives, Departmental meetings, Informal discussions (e.g. 1:1 discussions, discussions at coffee time) - Externally through attendance at AfPP annual Congress, study days, relevant courses and visiting other operating departments of other hospitals. - Self direction through reflection, reading relevant articles and texts and the internet - Display of literature relevant to all domains of perioperative practice - Teaching and training of students - Staff encouraged to contribute to learning displays
	Perception of Evidence	- Research to support practice - Searching for the best way to do things - Reviewing a variety of research papers , not just one - Looking around for best practice, systematic reviews, anecdotal evidence, experience - Reviewing research papers. Has to be tried, tested, validated and practiced - Finding the best evidence and putting it into practice, must support practice - Shopping around for best practice, critical appraisal of research - Correct way of doing things, collective research for proof of effectiveness of practice
	Sources of Evidence	- Research, opinion leaders - Experience/experiential learning - Observation - Guidelines, audits, Internet - Scientific trials
	Use of Evidence	- To review policy and procedures - To improve practice
	Change in Practice	- Unable to change due to being a junior Staff Nurse - Communication more effective - Update of practice based on evidence
	Strategies to Review Practice	- Personal reflection - Staff meetings as a forum discussion of practice - Audit - Influence of more experienced staff - Informal discussions with colleagues
	Examples of Evidence Used	- Hand hygiene - Gown and gloving for surgery - Care of patients with latex allergy

Table 4-3 Sub-Themes and Responses of Actual Practice

Responses identified how research affected individual practitioners and the department in general. The comment: *"Medical staff changing their practice has influenced me to research mine" (A3 3.1.1. Table Set 3A)* alluded to the individual as it described reflection on personal practice and development of the existing knowledge base. The effect on the individual continued with the following comment: *"aspects of research have extended some influence; tend to research unfamiliar things" (B1 3.1.3 Table Set 3A)*; *"use research to support argument, drummed into you during training" (B3 3.1.6 Table Set 3A)*.

The effect of research in the department indicated mixed feelings among the participants which was supported by these comments: *"There is a general progression in embracing research" (A3)*; *"Practice is research-based" (B2)*; *"Current Research is used to support policies and procedures" (DA), all at 3.1.5 Table Set 3A*. On the other hand, the comment regarding the environment not being a research-based area of practice was in direct contrast to those already mentioned.

The other effect on the department was a suggestion that the *"department needs a dedicated person to guide research, and needs to be consistent" (A3 3.1.4 Table Set 3A)*.

In respect of the knowledge base of the participants, variation was to be expected in the light of the levels of experience in the specialty of the participants, this varied from nine months to more than twenty years. Listening to the responses of the more junior staff members prompted thought of Benner's *'novice to expert'* analogy.

The influence of senior nurses, particularly where anatomy and physiology and the practical aspects of care were concerned was expressed on varying occasions by the more junior staff members.

> *"I am influenced by the knowledge of older nurses, particularly where practical aspects are concerned" (B1 un-coded response).*

Reflection on practice was also used as a means of building the knowledge base and varied from a daily occurrence, reflection diaries and informal discussions among peers. Knowledge acquisition was also sought through membership of the professional body of the specialty the Association for Perioperative Practice, formerly the National Association of Theatre Nurses; an Association that promotes the use of research findings to support practice.

Of interest was a comment made by a senior staff member who felt that older nurses appeared to take every opportunity both financially and practically of building on existing and updating knowledge, while younger nurses expect this to be provided for them. There may well have been a financial element influencing the behaviour of the younger nurses.

Knowledge update yielded many similarities among the participants. It was achieved through self-motivation and structured programmes within the department, the department's educational day being the most influential.

Participants appeared eager to discuss and share this aspect of actual practice, very little prompting was needed to elicit information and a great variety of means to sustain this knowledge was given.

The following table demonstrates knowledge update from the perspectives of self-motivation and departmental provision.

Self	Department
Teaching students	Education/Audit Day
Reading relevant journals, articles and texts	Courses
Media	Visiting other Operating Departments
Internet	Assessment of staff needs and department needs
Reflection	Liaison with other departments and groups within the Trust
One – One discussions	Educational support from Medical Devices Industry
Questioning issues of practice	Encouragement of ownership/ identifying potential among staff and developing it

Table 4-4: Knowledge Updates

The perceptions of evidence of the participants varied in content. However the common denominator was that of research: "*Research to support practice*"; "*Finding the best evidence and putting it into practice – must support practice*"; "*Shopping around for best practice, critical appraisal of research*".

Because of similarities of responses, a single code was allocated – 3.4.1.Table Set 3A.

Experience as a perception of evidence was also mentioned: "*looking around for best practice, systemic reviews, anecdotal evidence experience*" 3.4.1 Table Set 3A. The source of evidence and its use in practice yielded factual responses. Sources of evidence included research, opinion leaders, observation, scientific trials and experience/experimental learning, while the use of evidence referred to the review of policy and for the improvement of practice.

Comments on respect of change in practice highlighted the roles of the participants with in the department, from newly-qualified to the most experienced: "*unable to effect change due to being a junior Staff Nurse*" 3.7.1 Table Set 3A,

to the experienced staff members who were able to effect change from these perspectives: "*update of practice based on evidence*" 3.7.3 Table Set 3A; "*More effective communication*" 3.7.2 Table Set 3A.

Various methods were used to evaluate the practice. They included staff meetings, audits, self-reflection and the influence of more experienced staff. Staff meetings enable dissemination of information and were a forum for discussion. Self-reflection allowed staff to 'step back' and review personal actions that affected their practice. The comment: "How could I do this better" reflected this. The use of role models was identified as being quite influential by both experienced and inexperienced staff in the specialty.

Participants responded to the sub-theme of Examples of Evidence by identifying the same aspects of practice that had used evidential support. They were:

- Hand Hygiene;
- Gowning and Gloving;
- Care of patients with a Latex Allergy.

In addition to the pre-determined themes five new themes emerged through the interpretation of findings. These were:

- Quality of care
- Communication
- Leadership
- Teamwork

- Ethical Principles

However, Culture, Education, Research, Evidence, Reflection and Experience maintained their influential status. As patient safety is reflected in all the influences on practice, it was not appropriate to allocate it to a particular influence. These now formed the core of discussion by the focus group in relation to priority of influences and are used to list the Influences in tables 4-5 and 4-6 to illustrate the participants' thoughts on the priority of each one.

4.2 Descriptive Analysis of the Focus Group Discussion

Having asked the group to identify the influences in order of priority for each participant, a general discussion took place among the participants as to how they would prioritise the influences. Comments addressed to each other such as:

"Quality of care, goes without saying" (A1),

insinuated that this influence would have been high in the priority of influences

Opinions, questions and comments were voiced aloud; this inferred that group members sought support of each other in seeking answers. The "umms" and "ahs" of other participants to questions, statements and opinions verified this. On the other hand, the audible opinions and suggestions could have been used to gain approval of the others of suggestions expressed.

Individual contributions have been included in the context of the comments made and have been recorded as deemed appropriate.

Table 4-5 illustrates what each participant recorded as his or her priority of influence before the general discussion took place.

	Participants' Choices of Priority Position of Influences Before Discussion										
Influences	1	2	3	4	5	6	7	8	9	10	11
Quality of care	2	1		1					1		
Communications	2	2	1								
Leadership	2		2	1							
Culture	2	1			1			1		1	
Teamwork	1	2	2								
Ethical Principles		2	1					1			1
Education			1		3	1					
Research				1	1	1	2				
Evidence			1	1		1	1	1			
Reflection						1	2		2		
Experience			1	3	1						

Table 4-5: Priorities Before the Discussion

Priorities selected by the participants before the general discussion ensued did not highlight any significant influence. Indeed the diverse results over the limited number of participants after the discussion showed no overall trends.

Similarly, participants were asked to rank their views after the Discussion. Table 4-6 shows the raw results. However, by collating the priorities into groups of most influential and least influential, more meaningful results began to emerge. Quality of Care, Communication, Leadership, Teamwork, Experience, Ethical Principles and Culture of the department were more influential than those of Education, Research, Evidence and Reflection .A split of 4:7 was considered most appropriate to differentiate the priorities into most influential and least influential choices after inspection of both raw data tables.

Following the group discussion, participants had the opportunity to alter, if they so wished, their original priorities.

	Participants' Choices of Priority Position of Influences After Discussion										
Influences	1	2	3	4	5	6	7	8	9	10	11
Quality of care	2			1		1					
Communications	1	3									
Leadership	2		2	1							
Culture	2	1			1						
Teamwork	2	1	1								
Ethical Principles		1	1					2			
Education			1	1	2	1					
Research				1	1	1	1				
Evidence			1	1		1	1	1			
Reflection						1	2		2		
Experience			2	1	1						

Table 4-6: Priorities After the Discussion

Table 4-6 shows the change in to priorities after the group discussion.

Code: 1-11 = Priority Position

Number in the grid = Number of participants who chose that priority.

The next step was to look more closely at the movement of the choices, particular the most influential top choice, after the discussion. The reasoning behind this was to see if a hierarchy of influence on practice could be formulated within the perioperative environment. Table 4-7 shows how the most influential choices generally remained in their respective levels but showed the marked change in choice for some influences.

Order of Influential Choices				
Before Discussion			After Discussion	
Communications	5		Leadership	5
Leadership	5		Communications	4
Teamwork	5		Teamwork	4
Quality of Care	4		Quality of Care	3
Experience	4		Experience	3
Culture	3		Culture	3
Ethical Principles	3		Ethical Principles	2
Evidence	2		Evidence	2
Education	1		Education	2
Research	1		Research	1
Reflection	0		Reflection	0

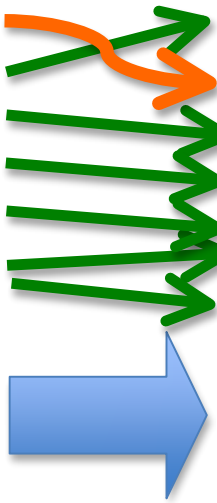

Table 4-7: Changes in Choices after Discussion

Surprisingly Quality of Care, Communications and Experience appeared to be less influential after the discussions in spite of the positive responses of some participants during the individual interviews and the initial sorting of priorities before the discussion ensued. Leadership remained the constant influence with Teamwork following closely behind. Culture also maintained its position, but as the lowest of the most influential, while Evidence, Education and Research remained the least influential.

Reflection did not appear to be of any influence among participants during the deliberations of the Focus Group, even though it was highlighted by some at their individual interviews and at the initial sorting of priority influences of the focus group. However, it was felt that the information gained through both the in-depth individual interviews and the Focus Group discussions were founded on the process of reflection.

Following all deliberations of the group, the priority of influences were:

- Leadership;
- Communication and Teamwork;
- Quality of Care, Culture, and Experience;
- Education, Evidence, and Ethical Principles;

- Research;
- Reflection.

4.3 Review of Departmental Documents

The documents reviewed were:

- Policies and Procedures;
- Departmental Philosophy;
- On-going Education and Training Programme;
- Relevant articles on perioperative care.

Policies and Procedures for standards and recommendations of care were based on those formulated by the professional Association of the specialty and reflected current research. Although written by the Educational Co-ordinator, policies were reviewed by staff members.

The Philosophy statement of the department focused on the quality of care the patients would receive while in the department. Quality of care afforded the patient was highlighted during the individual in-depth interviews and the focus group discussion.

Information regarding Education and Training programmes was obtained during a discussion with the Educational Co-ordinator. The allocation of courses for staff members was based on personal and departmental needs.

Relevant articles displayed consisted mainly of information on clinical procedures and some research studies. Other information displayed referred to training sessions for staff members by medical device representatives.

The influence on practice through information in these documents was substantiated by participants during the individual in-depth interviews. Very little reference was made to departmental documentation during the focus group discussion.

4.4 Explanatory Account and Discussion of the Findings

It was fortuitous that self-selection yielded a wide age range of participants, their respective roles and their knowledge of and experience in the specialty. As a result information gleaned was obtained from newly qualified nurses, nurses with some experience in the specialty and those nurses with a great wealth of experience who held senior and very senior positions. This in itself assisted in a more meaningful collection of data. Interview responses highlighted the similarities and like-minded opinions, as did the differences. These differences resulted from such aspects as educational and training backgrounds and from health care, social and cultural life experience. The similarities were probably due to similar experiences of persons working in the same environment.

Information gained from the participants in relation to the biographical perspective gave some insight into some personal aspects of each individual. The questionnaire completed by each participant prior to the individual interviews provided additional biographical information.

Eagerness to impart information about self varied among the participants. Some information seemed quite sketchy in spite of prompts being given, while other responses were detailed. The assumption that an older and more experienced participant may influence the amount of information given was not proved. It was found that junior nurses spoke freely giving substantial amounts of information.

The on-going professional development and education sub-themes varied in the depths of answers. Some participants only mentioned that it was very important to them while others not only acknowledged the importance but also gave details of how personal development and education had been and is being achieved. These were identified as undertaking courses attending both internal and external study days and conferences relevant to the specialty that, in turn, would facilitate career development, and build on the existing knowledge base and enhance on-going improvement of patient care.

Differences were minimal in respect of on-going professional development and education in light of the research question. There was an eagerness for personal achievement across the participants. Over all this showed the importance placed of

knowledge acquisition and showed adherence to policy and heeding the Codes of Conduct of the Nursing and Midwifery Council where this was concerned.

The perspective of Influences on Practice formed the mainstay of the study. It answered the research question and subsequently provided information required for the study. The sub-themes to this theme were Values, Feelings, Beliefs, Experience (both professionally and non-professionally), Internal and External Influences, and Culture. At the end of each individual in depth interview, participants were asked to put in order of importance what they felt influenced their respective practices.

Responses from the participants in relation to values, feelings, and beliefs in general, along with the formulation of influence priority, showed a mixture of individuality. This was compounded by uniqueness of thought, past experience and education, training and upbringing. Collaborative working within the multidisciplinary team enabled the team to work more effectively, and enabled safe and competent care to be delivered. Not only was this complemented by the maintenance of good, effective standards at all times, but also by the use of reflection to improve practice in general. Together these influences demonstrated aspects of professionalism and the altruistic ethic. This also provides a link with the attributes of the concept as demonstrated in Chapter Two.

The table showing how the participants prioritised their influences has been reported in Table 2.4 of Table Set 2A, Appendix 9. The bold letter in brackets identifies their roles in the department.

In relation to experience, both professionally and non-professionally, the common denominator appeared to be the influence of colleagues from the various disciplines within the environment. This alluded to the importance of mentors/preceptors and facilitators in influencing knowledge and skills acquisition. The influence of role models overall was also instrumental.

Other influences of these sub-themes reflected the use of prior experience and knowledge to effect care, life skills through situations such as non-nursing employment and voluntary service, the influence of the family in encouraging personal achievement (and this was an on-going aspect), and the experience of seniority with an established wealth of knowledge and self-confidence. The effect of

personal illness gave exposure to the patient experience from a personal angle and enriched empathy shown to those in their care.

The prominence of the influence of departmental culture was demonstrated by an effective work ethic in which staff members were able to express their opinion regarding issues of care on both formal and informal bases.

A recently-qualified staff nurse stated that she had to discuss anything she felt strongly about, but felt she needed to have background knowledge of the issue before speaking with senior nurses about it. She also felt that she was able to discuss the issue informally among colleagues and on a more formal basis at the departmental meetings.

Team cohesiveness was apparent through responses that discussed the support to and of each other irrespective of position or role. It also acknowledged the respect for the individual contributions to care. Support to junior staff facilitated them to realise their potential and this was assisted through development, encouragement, and empowerment of self. The culture of the department also provided an effective learning environment, verifying the importance of on-going education.

The perspective of Actual Practice provided information on the current status of practice within the location of the study and involved the effects of research, the knowledge base of the participants in relation to perioperative practice, how this knowledge is updated, perception of evidence, sources of evidence, use of evidence in practice, change in practice, strategies to review practice and examples of evidence in use. Some participants felt that the specialty uses research, though not on a large scale, in support of practice and particularly where policies and procedures are concerned. On the contrary, one participant felt that perioperative practice was not quite researched-based: an interesting comment, which needed to be explored further. The intention was to raise this at the focus group discussions to ascertain if that comment was supported.

The positive comments on the use of research were made by Staff Nurses new to the specialty, one of whom was also newly-qualified. This could be due to the emphasis on research application within the current curricula sited in higher education. The suggestion of a dedicated skilled person to guide research within the

department was a positive thought. This was seen as helping staff to understand the research process, its implementation and sustainability for practice.

Even though the responses to this sub-theme were sketchy, value had been placed on research. Articles pertaining to research studies were visibly displayed and inter-professional influence on the effects of research was highlighted by some participants.

In respect of the knowledge base of perioperative practice, the range of years in the light of experience gained within the specialty demonstrated a mixture of a wealth of knowledge in perioperative care. Attendance at the Congress specific to the specialty, study days, and a vast and varied amount of publications by the professional Association played a vital role in the provision and dissemination of relevant knowledge of the specialty.

The acquisition of knowledge has also been guided by experienced staff members and facilitated through preceptorship. It was seen as an on-going dynamic process in which existing knowledge was built on, developed and disseminated. It is also a process that valued the contributions of all perioperative staff in this important aspect of care. Staff members were encouraged to assist in building on their knowledge base through contributions to learning displays, discussion at departmental meetings and involvement in in-house presentations of relevant topics.

On the subject of evidence, participant's perceptions varied which was to be expected. However, overall information was limited. This implied that this was a weak or limited area of knowledge. These sources gave an insight to the first two aspects of the revised definition of Sacket et al (2000); namely relevant clinical research and the use of clinical skills and past experience to identify the patient's health state, individual risks and the benfit of potential intervention, but no reference was made to the third aspect, the patient's perspective. Not only was the Sacket et al (2000) definition used, but also the statement of the Nursing and Midwifery Council (2000, 2006). This stated that the nursing profession has a commitment to deliver safe and effective care, based on current evidence, best practice and, where applicable, validated research. Although the Council's statement was not stated as written, different participants made mention of one of its components. Interestingly,

this resulted in all areas highlighted by the Nursing and Midwifery Council being mentioned.

Mention was also made, however, of role models and opinion leaders. One participant also mentioned what was felt to be the benefits of the use of evidence in support of practice. Nevertheless, examples referred to in the context of its use in supporting practice revealed a consistency of responses. This was because of the fact that some aspects of practice are research-based and their findings have been implemented. This also verified that policies and procedures of the department reflected evidential support.

Where the type of strategies used to review practice was concerned, there were more similarities among the junior staff than senior members, even though some strategies were shared by both groups. This highlighted the effect of the experience of seniors looking at the wider picture of care improvement and innovation. However, the common denominators for both junior and senior staff, both experienced and inexperienced staff members were peer review, reflection, and discussion with colleagues.

Changes to practice were governed by the participants' role in practice. A feeling among the junior nurses was their inexperience and lack of authority made it difficult to affect change. On the other hand, one of the junior nurses felt that although she could not physically bring about change, she felt able to discuss it and that her contribution would be acknowledged. This emphasised the respect of each other and their contribution among staff members. For the experienced nurses, the expectation of their senior role within the department facilitated the ability to effect change.

A variety of methods were given of effecting change, nevertheless, similarities were also identified. This compromised of identifying an issue of practice, Griffiths (2006) supports this, in his paper on evidence-based practice in which he feels that the most important aspect of such practice is to begin with a question about practice (identifying an issue of practice) and remaining focused on the question that specifies the information required to make a decision about patient care. His argument is that you cannot question everything in practice; one has to be specific. Other similarities were monitoring current practice, discussion among colleagues

and being a role model. Mention was also made of the need of support from all staff to effect successful change, auditing the change, challenging practice and researching the issue in question.

Through interpretation and explanation some response findings of the participants were incorporated into new themes. Examples are highlighted below:

- Doing the best for the patient and on-going development of the knowledge base were incorporated into Quality of Care;
- Good rapport amongst colleagues, team cohesiveness, individuals working together competently reflected Teamwork;
- Leadership incorporated role models;
- Other responses highlighted good communication;
- And ethical principles resulted from such responses as to how patients should be treated.

In relation to the focus group, everyone contributed to all discussions, which created an atmosphere conducive to obtaining the information required to address the research question. General interaction amongst the group members substantiated what Foster-Turner (2009) and Gibbs (1997) said that a defining quality of the focus group was active interaction through dialogue. This statement is supported by Holloway and Wheeler (2010) and Menter et al (2011) and verified by notes made by the Observer during the discussion.

There were no significant differences between senior and junior participants in relation to giving information. Participants with limited experience in the specialty (9 months to 2 years) gave very good accounts of themselves. One could see the influence of the current nurse education curriculum in the manner in which issues were discussed and questions answered.

Without question, the role within the environment supported by years of experience, cognitive processes, social and cultural aspects, feelings and values, was a key factor in the richness of the information. This by no means is a criticism of the information gleaned from the less-experienced participants, as all information obtained was invaluable.

Opinions on the effect of research and evidence in influencing respective practice generated considerable discussion within the group. The responses during the in-depth interviews appeared superficial and some participants were only too happy to move on to the next question. The general discussion on research and evidence by the group may have resulted from the opportunity to share feelings and beliefs and to have them supported, or indeed challenged, by peers. However, in spite of all the discussions, both research and evidence remained in the least influential choices of the participants. This may have resulted from these influences sharing a limited knowledge base among participants. Such a limitation may have been an aspect in le May's (1999) statement that practice does not always reflect research findings.

A thoughtful comment was made by a very experienced participant during this discourse. It was felt that research undertaken by medical colleagues have more kudos in healthcare; the very nature and expectations of their training facilitated this. Obtaining funding for projects is easier for medical colleagues, unlike that for nurses.

The comment made regarding the undertaking of research by medical colleagues owing greater kudos had the support of Parahoo (2006), who stated the significant influence medicine has on the research agenda; quantitative approach to medical research as opposed to the qualitative approach which nursing favours; and that the composition of research panels are predominantly medical were the possible reasons for this.

The choice of education appearing in the least influential was most surprising in light of the comments regarding its importance made during the individual in-depth interviews. Where the most influential of choices were concerned, quality of care did not occupy the highest influential position as was expected.

It could be that Leadership and Teamwork encompassed the perspectives of Quality of Care and Communications to some participants. The comment made in respect of quality of care highlighted this, *"It goes without question",* substantiated Professor Lord Darzi's (2009) statement that quality of care should be a the heart of everything we do. Ethical principles may have also been associated with quality of care.

Minor changes occurred among the influences which participants placed in order of personal importance before and after discussion. The changes that took place involved repositioning in the order of importance of the influences of some participants.

Some of the changes observed with the prioritising of influences could be seen as a result of the group discussion, which enabled each participant to revisit their feelings. On the other hand Asbury (1995) alludes to a situation in which she cites the advice of Carey and Smith (1994) and Morgan (1988). This focused on the group facilitator being aware of the effect of 'group' within focus groups. The 'group' concept relates to whether or not comments made by group participants accurately represented their individual experiences.

In relation to no change in order of priority of influences by senior staff the variety of experience gained over many years working in the specialty had probably fixed their opinions as to what influenced their respective practice. Experiences were not only gained from the work environment, but also from life skills in general. Changes by some junior staff may have been because their exploration of the experiences of practice, opinions and examples of their more experienced colleagues were part of their influences.

From the priorities of influences as a result of the deliberation of the focus group, there was a possibility of the formation of a hierarchy of influence of practice. This was because of the consensus of opinions and was in direct contrast to what was deduced following the in-depth interviews. Needless to say caution must be exhibited as information was obtained from a small sample study involving a single location. Confirmation of a hierarchy of influences on practice of registered nurses within the perioperative environment would most probably require a national survey of these nurses.

In relation to the consensus of opinions, the question arose as to whether or not the psychological phenomenon of "groupthink" influenced the decision of the group in formulating the priorities of influences on practice.

Janus in 1972 described this phenomenon as a mode of thinking that people in a deeply cohesive group engage in. The group exhibited one of the antecedent factors of groupthink which Janus (1972) described; that of cohesiveness. However,

they also demonstrated independent thought, a downside to groupthink. This was seen when following the general discussion; priority choices were altered by some participants, while others maintained their original choice.

One could argue that as the group had only engaged in one focus group discussion, it was difficult to say if this phenomenon was present. Had there been further group discussion a more realistic picture of group dynamics would have been seen and the verification of the phenomenon made.

In the context of the concept analysis of influence, the responses supported the attributes of the concept identified in the conceptual analysis. They reflected both the general and the specific perspectives in the context of the practice of the registered perioperative nurse. Examples were as follows:

- Professionalism promoted safe practice and effective quality of care. However it should be noted that safe practice is reflected across both perspectives;
- New roles and the scope of practice reflected legislation and regulation;
- The acquisition and updating of knowledge and skills was dependant on on-going education;
- Policy was indicative of national directives and recommendations for standards of care.
- Team cohesiveness, peer support and working together demonstrated an effective multi-disciplinary team.

4.5 Other Influences on Practice

Senior medical staff, a senior operating department practitioner and the education coordinator were included in order to obtain their views on how they influenced practice of Registered Nurses within the perioperative environment. Senior Operating Department Practitioners also hold the position of Team Leaders within the department. The Education Co-ordinator was included to establish how the education and training programmes influence such practice. Involving these staff members was also an opportunity to examine their influence from a multi-disciplinary perspective.

4.5.1 Senior Medical Staff Member

The viewpoint described is that of a Consultant Anaesthetist. He felt that he had very little, if any, influence on the practice of Registered Nurses in the domain of intraoperative care. Members of the team who work closely with the anaesthetists are the Operating Department Practitioners, not many registered nurses work in the anaesthetic rooms at the site of the study.

He referred to the intra-operative phase of care, actual surgery, as an obscure area for him, seeing care as very task and protocol orientated, he describes it as such:

> *" ....checking with each other that what is supposed to be happening happens"*

and felt there is very little overlap of care in this phase.

He felt that most of his influence where the registered nurses were concerned was in the immediate recovery aspect of care, where he encouraged nurses to ask about care delivery. Although care in immediate recovery phase has a tendency to be autonomous, he felt that there could be more questioning of practice.

Unfortunately, this could not be challenged or verified as no recovery nurses volunteered to take part in the study, in spite of requests for vounteers being undertaken on several occasions by the Theatre Manager.

The Consultant was very involved in the education of nurses in recovery mainly through invitation of the nursing staff. He stated that nurses were eager to learn, eager to progress care delivery. It was very apparent that he placed much emphasis on education and training and it was not surprising that this was his priority influence on his practice.

When asked how he felt nurses used evidence in their practice to ascertain its influence, his reply surprised me somewhat, in that he did not feel that he was the right person to comment on this aspect of nursing care, he said:

> *"……that would be better coming from nurses, I would not know what evidence nurses used to support their practice."*

On the other hand, he was of the opinion that older nurses relied on their experience, newer nurses appeared keen to learn as they do not have the experience to rely on, both points he felt were very valuable.

4.5.2 Senior Operating Department Practitioner

The Senior Operating Department Practitioner was recently appointed to the Deputy Team Leader post, a role that involves both clinical and managerial duties.

When asked about her influence on the practice of registered nurses, she said that there was no difference in the way she taught nurses and department practitioners. She felt nurses could learn so much from the department practitioners particularly the experienced ones. However, she did view her influence from a general perspective, in that it related to the Department as a whole. She felt it important to promote a happy working atmosphere, she was enthusiastic about good quality care, highlighting aspects we would all refer to as good basic care.

The impression given was that the main stay of her influence was leading by example and being an effective role model, which in turn was supported by her values of and beliefs in good quality care delivery. Some of the examples cited were the importance of maintaining confidentiality at all times, her strong belief in teamwork, the support of each other in their respective roles and treating patients as she would like to be treated.

Good role models were an important influence on her personal practice and she wished to emulate this as her career developed.

Unfortunately this interview had to be terminated before time due to an emergency for which she was required to lead the team.

4.5.3 Education Co-ordinator

The Education Co-ordinator was also a senior sister. She described her duties as a 50% split between clinical and educational duties. She felt that influencing starts with appreciating and valuing the team, being approachable, available and accessible to them, the visible presence at the face of care delivery. She described her influence on practice based on the aspects of teaching, support, guidance,

encouragement, facilitation, empowerment and what she felt was very important, being a good role model, leading by example.

She encouraged nurses to take responsibility for their own development within their respective roles and being supportive to enable this to happen. In facilitating their on-going education, she motivated them to present 'in house 'presentations on issues of practice. She felt strongly about empowerment and assisted in building their confidences in questioning and challenging practice as necessary. She stated that there was more awareness of Evidence-Based Practice and she encouraged nurses to look at evidence to support their practice. On questioning the position in the department in relation to its use, she felt practice was moving in the right direction, albeit very slowly as she stated '*we are not there yet'.*

Departmental Policy and Procedures were written by her, based on current research, but reviewed by the staff. This was another area where nurses were encouraged to contribute to practice by joining this important group. Her remit also included looking at what relevant post-registration courses are available and the needs of both staff and Department are assessed in relation to obtaining them.

In accordance with maintaining a trustworthy study, the findings of the in-depth interview with the Education Coordinator was sent for checking of accuracy of information given. No comments were returned, so it was assumed that there were no objections or need for clarification on the Coordinator's behalf of what was reported.

In general, most responses of participants during the individual in-depth interviews supported aspects of the focus group discussion. There was also consistency of the order of priorities of influences between the in-depth individual interviews and the focus group discussion. This played a crucial role where the credibility of the study was concerned. Credibility was also afforded by the verification of the in-depth interview responses, some of the focus group discussion and information gleaned from departmental documentation. The use of predetermined themes and sub-themes in an appropriate balance of wide-ranging choices produced the relevant information as previously stated. Nevertheless, participants were given the opportunity during both the individual in-depth interviews and the focus group discussion to highlight any other influences that they felt would have an effect on

their respective practices. Some additional influences were mentioned, such as media, government targets, and resources; overall the predetermined themes and sub-themes covered the aspects the study intended to capture and addressed the research question of:

> *What influences the Practice of Registered Nurses in the Perioperative Environment?*

5. Reflections, Conclusions, and Recommendations

5.1 Reflections on the Study

Reflections of the study have been focused on conceptual analysis and the methodology used.

5.1.1 Concept Analysis of Influence

This facilitated a better understanding of the concept of influence. The choice of the method to effect this analysis was based on the steps designed by Walker and Avant (1995) for conceptual analysis. The process was clear, concise and logical; the literature selection that highlighted its frequent use within the context of nursing influenced its choice. Cahill (1996) is convinced of the vital role concept analysis plays in nursing practice and advocates and encourages its use amongst nurse practitioners.

Wade and Tavris' (1998) discussion on the concept of influence was certainly exhibited by the responses of the participants particularly as values, beliefs, feelings and experiences were discussed. This supported their reference to the human experience.

The use of concept analysis, in addressing issues of practice requiring clarity or a better understanding for implementation in relation to care delivery, has been highlighted as a recommendation of the study. The discourse on the influences on practice enabled a more meaningful analysis of the overall findings of the data collection. One was able to look beyond the raw data in relation to interpretation of participant responses. It has also facilitated development of the knowledge base, not only of the specialty, but also from a personal perspective.

5.1.2 Methodology

The eclectic nature of nursing facilitates the qualitative approach, and the research question of *"What Influences the Practice of Registered Nurses in the Perioperative Environment"* necessitated its use. The information required to address the question

focused on aspects such as feelings, values, beliefs, experiences and perceptions of the participants.

Identifying and approaching relevant Gatekeepers early on in the study was beneficial, and their approval was readily granted.

Meeting with staff members to inform them of the study was helpful; this allowed me to observe their interest in the study, albeit on a very superficial basis and with no evidence to say they would be willing later to participate.

The research design of Case Study reflected Simon's (1988) opinion of its appropriateness to this study. The study was located in the practice setting, where participants were all qualified practitioners working in the same area of care and sharing similar experiences. Case Study does not appear to enjoy the same kudos as methods such as Grounded Theory, Action Research and Phenomenology. One cannot help but question if it produces the information required to improve the quality of care afforded our patients; should it not be of equal importance as those highlighted? Although a popular choice of research design in nursing studies, case study is not without difficulty. In critiquing approaches to this type of research design Appleton (2002) explored through the work of the two leading exponents, Robert Stake and Robert Yin. One of the difficulties that were alluded to was the decision about which type of case study the study in question pertained to. One can appreciate this, as it was an experience of the researcher.

The choice of nurses is supported by Holloway and Wheeler's (2010) suggestion that as health professionals we have an interest in the views and ideas of our colleagues. Learning from each other is vital to practice and should be seen as an on-going process. Last-minute cancellations of interviews, mainly due to clinical commitments, occurred. However, because of 'insider knowledge' of the speciality, the researcher could emphasise with the situation. Such a situation made the researcher wary of constant reminders to participants, and the fear of contravening ethical principles was realistic. Appearing to be persistent gives rise to the problem of putting people off taking part in the study.

5.1.2.1 In-Depth Individual Interviews

Reflecting on the conduct of the in-depth interviews, aspects of Kvale's (1996) qualification criteria for the interviewer were used as a self-assessing tool. The aspect of interpretation produced most concerns, as it would assist in generation the richness of the information gleaned.

Where participants gave substantial accounts during their individual interviews, every effort was made to guide responses so that they remained pertinent to the respective question. Most participants did not find the interviews distressing and, in general, they went well.

The appropriateness of methodology has been established as findings have addressed the research question, the aim of the study. On further reflection, however, it was felt that instead of self-selection for recruitment of participants inviting colleagues directly face-to-face would be preferable, as people do feel valued when asked personally to do something, particularly when their opinion and/or skills are required.

5.1.2.2 Focus Group Discussion

The focus group comprised of registered nurses only, this decision was taken because the focus of the study was about their practice. Their roles ranged from senior sisters/charge nurses, sisters and staff nurses. The years of experience in the specialty among the participants were between 30 years to 9 months (newly qualified staff nurse). In spite of relative inexperience of the "newest" practitioner in the field of perioperative care, she made a valuable contribution and appeared to show no signs of intimidation in such experienced company. The view of Grbich (1999) regarding juniors versus seniors in relation to the possibility of intimidation was not exhibited. This may have resulted due to her knowledge of colleagues and the cohesiveness of the team within the location of the study.

Discussion was lively throughout with all participants contributing. The group members maintained good interaction throughout, and no 'ice-breakers' were necessary, as participants already knew each other. A relaxed atmosphere helped the effectiveness of the group interaction and the potential for 'social loafing', a

situation in which some group members hardly contribute to the discussion, Carey and Smith (1994) and Morgan (1988) cited by Asbury (1995) did not occur.

On the introduction of my observer, participants were informed that she was also my First Supervisor. Her record of the proceedings was vital in collating information and group interaction. Her extensive knowledge in the field of research raised the question whether her presence would affect the responses of those participants who knew this. In view of the fact that there was no significant movement in the choice of research and evidence in the priorities of influences, it can be assumed that her presence did not affect their response. If it had, I felt the influences of research and evidence would have moved into the higher order of influences. It can therefore be said that participants expressed honest opinions of these two subjects in relation to the research question.

My anxieties about the Focus Group were unfounded; the main concern was whether participants of the group would attend in spite of email reminders. My other concern about the group was my ability to sustain momentum; this too was unfounded as the group maintained this themselves with only the occasional prompt from me.

Information from the reviewed literature was used selectively and appropriately throughout the study. This, in turn, supported findings, opinions and statements.

5.2 Importance to Practice

The study has been of value to the specialty. By focusing solely on the practitioner's perspective, it allowed participants to stand back from the daily pressures of current health care to critically examine what influences their practice.

This is particularly pertinent at a time when the climate of change within healthcare is considerable. Among the influences on practice highlighted from responses of the participants, were quality of care and education. Interestingly, these factors have been identified as significant to face the challenges of rapid changes in healthcare delivery.

The Prime Minister's 2010 commission to the nursing profession and a directive from the Department of Health, also in 2010, have championed the achievements of

high quality care. This was also supported by the quest of the Darzi HNS review of 2008 that quality be at the heart of everything we do.

Achievement and sustainment of such quality care is supported by education. The new pre-registration education curriculum for nurses and the preparation of qualified practitioners to address this must evolve continually. This will allow qualified practitioners to keep abreast of the changes now and in the future.

The study has also explored an aspect affecting care, in light of the literature reviewed, not undertaken in perioperative practice before. The knowledge attained will build on the existing knowledge base of the specialty in providing quality care for patients that is safe, effective, and of a high standard.

This focus on quality care is aimed at the revitalising, as the Department of Health's 2010 directive stated, the universal values of care among nurses and midwives. This is of relevance for the study, in light of the topic guide used for the in-depth individual interviews.

5.3 Limitations

The following points have been identified as the limitations of his study.

Generalisation of findings is difficult in light of the study's research design.

No observations of the participants were undertaken to support further the information gained at the in-depth interviews.

Finally, the mutually inclusive influence of each person with others in the focus group in relation to the concept of "Group Think" may have influenced the outcomes of the focus group.

5.4 Conclusions

The findings of the analysis of the data have shown that the intention of the study has been achieved in that the influences on the practice of registered nurses within the perioperative environment have been identified.

The conclusions of the study are that:

- Leadership, Teamwork, Communications, Quality of Care, Experience and the Culture of the work environment are of the greatest importance in guiding and influencing the practice of the perioperative nurses;
- Education, Evidence, Ethical Principles, Research and Reflection proved to be of lesser influence;
- The previous perception of reticence of nurses to challenge or question practice was not evident;
- The participants' understanding of the breadth of the evidence underpinning practice was narrow.

5.5 Recommendations

As a result of the findings of the data collection, the following recommendations are made.

Perioperative nurses should:

- Seek to improve their understanding of the concept of evidence and to use it more effectively in support of practice;
- Utilise the Concept Analysis approach to achieve a better understanding of issues within practice where necessary;
- Consider forming a Reflective Group to review practice in order to enhance and develop an effective knowledge base for the speciality for on-going quality care, particularly in light of rapid and challenging changes in health care.

A national survey should be considered to capture the opinions of a wider selection of perioperative practitioners to validate the conclusions of this study.

5.6 Dissemination of Information

On completion of the study the results will be disseminated to the participants and related stakeholders, such a professional bodies of perioperative practice, in the form of an executive summary. In addition to this, the results will be circulated more widely to the practice and academic communities through publication in relevant

journals such as The Journal of Perioperative Practice, and by representation at local, national, and international levels.

Appendix 1: Search Strategy

Sources

Information has been obtained from relevant journal articles, texts, and electronic resources such as the Cochrane Library, Medline, CINAHL and the Internet. Other sources of information included professional bodies, such as the Association for Perioperative Practice and the Nursing and Midwifery Council. Information was also obtained from the Centre of Evidence-Based Practice, University of York and the Department of Health, England.

Time Span

Information has been obtained from the 1990's to 2010. However, research papers pertaining to actual perioperative practice have been viewed over a five-year period (2004-2009). This period was chosen as it was felt that research activity in the specialty was gaining momentum and it would be fortuitous to ascertain how research actually influenced practice. Older references were included after careful consideration on whether their contents were still relevant to today's practice.

Key Words

Having decided that the main focus of the research was on:

> *What influences the Practice of Registered Nurses in the Perioperative Environment?*

the key words *Influences, Perioperative Care, Registered Perioperative Nurses* guided the preliminary literature search.

The concept of influence was the primary focus of this search. This was viewed from both general and specific perspectives. The general perspective looked at influences on nursing practice overall, while the specific perspective focused on nursing practice in the perioperative environment. Little information was obtained using this strategy therefore the process of reviewing literature was revised and restructured using the process of concept analysis. Generating a list of the factors

that influenced practice helped to identify more key words used to search the literature.

These key words were then used to search the literature using the data bases detailed above and hand searching in the library. The key words used for the general perspective were:

- Professionalism;
- Philosophy and Knowledge;
- Legislation and Regulation;
- Scope of Practice;
- Evidence;
- Politics, and Policy

And for the specific perspective they were:

- Specific Knowledge Base, and Skills Required;
- Patient safety;
- The Productive Operating Theatre;
- New roles;
- Association for Perioperative Practice;
- Multi-disciplinary Teamwork;
- Research Studies in Perioperative Care.

Types of Evidence

Multiple types of evidence (e.g. opinion, theory, research) were generated from the searches. The tables in Appendix 2 give details of the type of evidence found.

The research studies reviewed in perioperative care were from primary sources. They were both qualitative and quantitative and addressed clinical, educational, managerial, ethical and environmental aspects of care delivery.

Critiquing the Evidence The formats used for critiquing the research evidence are described in Appendix 2.

Appendix 2: Evidence Base of Influential Factors

A General Perspective

General Perspective	Type of Evidence	Source	Comment
Professionalism	Opinion	Basford, L. and Selvin, O. (2003)	Professional influence stems from nursing itself – inspiring excellence and ensuring that practice is safe and effective
	Policy Code of Professional Conduct	Nursing and Midwifery Council (2008)	Provides its main function of protection of the public – through professional standards and regulation
	Opinion	Lloyd et al (2007)	
	Opinion	Brown and Gobbi (2007)	Look at the main factors of nursing
	Opinion	Seedhouse, D. (200)	In conjunction with Nursing Philosophy
	Opinion	Selvin, E. (2003)	In relation to the knowledge base of nursing
	Opinion	Cronin, P. and Rawlings-Anderson (2004)	Its place in Contemporary Nursing Practice focusing on accountability
	Opinion	Holden, R. (1991)	In respect of both personal and professional accountability
Philosophy	Theory (not Research-based)	Johns, C. (2005)	Changed Philosophy for Vision – nurses can more equate with vision
	Opinion	Seedhouse, D. (2002)	The significance of moral values – nurtured general statement that nurses are the only health care professionals with moral insight – point to be challenged
Philosophy	Opinion	Burns, N and Groves, S (1997)	Sees this as providing unity and meaning to nurses through a structure of thinking, knowing and doing.
Knowledge	Theory	Burns, N and Groves, S (1997)	Described Knowledge as a concept and looked at how the profession has acquired its knowledge base from various dimensions
	Opinion	Jones, M., & Higgs, J. (2002) Le May, A. (1999) Mulhall, A. (1998) Parahoo, K. (2006)	

General Perspective	Type of Evidence	Source	Comment
Knowledge	Opinion	Rodgers, B. L. (2005)	Awareness of the difficulty the profession has to find ways of gaining knowledge of things not amenable to empirical study – but which are very important to nursing
	Opinion;	Selvin, E. (2003)	The profession has utilised the many ways of knowledge
	Opinion	McKenna, H. (1997)	Link between knowledge base and practice is pivotal to the profession's survival as a discipline
	Research	Gerrish, K. and Lacey, A. (2010)	Discusses the awareness, utilisation and activity on nursing practice
		Thompson, D.S., Moore, K.A. and Estabrooks, C.A. (2008)	Study explored the sources of knowledge that nurses most relied upon
Legislation and Regulation	Fact – the Law	Nursing and Midwifery Council – Nurses Act 1919	Registered Nurses practice the Law and are regulated by the Nursing and Midwifery Council; the main function being the protection of the public through regulation, standards, and the Code of Professional Conduct
Scope of Practice	Research, Policy, Professional Experience	Hunt, G. and Wainright, P. (1994)	Old reference but still has currency for practice today.
		Wilkinson, J. and MacDowall, J.P. (2003)	Explored and discussed the issues that underpinned the scope of practice – legislation policy and professional regulation
		Lloyd, H. Hancock, H. and Campbell, S. (2007)	Clear explanation of modernisation and subsequent role development – new ways of working – standardisation and professional regulation
Evidence in Support of Practice	Research	Nursing and Midwifery Council (2000, 2006)	Ability of all nurses to search for evidence and apply it to everyday practice
	Policy/Directives	Department of Health; Vision of Nursing – 21st Century (2006)	
	Role Model	McDonald, L. (2001)	Role Model of Florence Nightingale – favouring systematic approaches to care – research, expertise.

General Perspective	Type of Evidence	Source	Comment
Evidence in Support of Practice	Opinions	Rycroft-Malone, J. (2006) Le May, A. (1999) Cullum, N., Ciliska, D., Haynes, R.B. and Marks, S. (2008) Loftus-Hills, A., McInnes, L. and Richens, Y. (2003) Melnyk, B.M., Fineout-Overholt, E. (2005) Jones, M. and Higgs, J. (2002) Long, A.F. (2002) Reynolds, S. (2003) Mitchell, G.J. (1997) Crofts, L. (2002) White, S. (1997) Dicenso, A. and Cullum, N. (1998)	Gives an overview of exhortation of its use, its champions and its critics. Evidence is explored through the definition, its constituents, hierarchy, its importance, how to research it, how to implement it, and how to evaluate it.
Politics and Policy	Policy/Directives	Gray, M. (2009) Nursing and Midwifery Council (2010)	Highlight the responsibility of Government in formulating health policy
	Policy and Research	Masterton, A. and Cameron, A. (2002)	Agreement of opinions – developing care of nurses who are able to competently and effectively analyse and influence the formulation of health policies to support nursing objectives. The importance of nursing being involved in policy – sees nurses in research taking the lead
	Policy and Research	Fyffe, T. (2009)	
	Policy – Ethics	Thompson, I.E., Melia, K.M., Boyd, K.M., and Horburgh, D. (2007)	Discussed policy from an ethical perspective
	Policy	Nursing and Midwifery Council (2010)	Works with politicians and policy-makers within each of the four United Kingdom governing administrations
		The Royal College of Nursing	
		Stacey, M. (1993)	Old reference but has relevance today, looking at health policy from a sociological perspective

A Specific Perspective

Specific Perspective	Type of Evidence	Source	Comment
Specific Knowledge Base and Skills Required	Experience and Knowledge Opinion	Personal	Gained through specialising in Perioperative care for many years
Patient Safety	Policy	Nursing and Midwifery Council (2008)	Code of Professional Conduct
	Policy/Global Directive	Professional Association (AfPP) (2009)	Setting Standards for safe practice in the perioperative environment.
	Policy	World Health Organisation (2008)	Global support for making surgery safer – building on a strong evidence base
	Experience	Personal	35 years of working in the perioperative environment
	Role Model	McDonald, L. (2001)	Explored the influence of Florence Nightingale
The Productive Operating Theatre	Policy	NHS Institute for Innovation and Improvement (2009)	Results from Pilot studies showing improvement for patient care delivery. Exploring new ways of working to enhance quality of care
New Roles	Policy	Perioperative Care Collaboration; Al-Hasheini, J. (2007)	Making an opportunity to provide holistic care for patients
	Research	McAleavy, J. (2006)	Concern regarding alienation of nurses and operating department practitioners' lack of regulation
	Policy	Nursing and Midwifery Council (2010)	Importance of training, education and regulation
Association for Perioperative Practice	Multiple	Association for Perioperative Practice	Its Congress, Study Days, Publications, and Research Articles. Professionalism
Multi-disciplinary Teamwork	Experience	Association for Perioperative Practice	Partnerships with other disciplines of health care are maintained to support quality of care which is safe, effective and of a high standard

Summary of Research Studies Reviewed

Source	Sample	Method	Main Findings	Comments
J Bothamley & A Mardell 2005 Journal of Perioperative Fasting revised	n = 144 orthopaedic patients for both elective and trauma surgery	Audit of the fasting times of food and fluid over a period of two weeks between the times of 08.00 and 16.00 hours. Fasting times for standards to be measured 8 hours – fluid 12 hours – food	94% of patients fasting times remained excessive	Results presented to relevant personnel, surgeons, anaesthetists ward staff New policy formulated. Fasting times reduced with relevant personnel working collaboratively.
M Keegan-Doody 2005 British Journal of Perioperative Practice Study title Walk or be driven? Walking patient to the operating theatre	n = 43 male = 23 female = 20 Age range 20 – 80 years Exclusion Patients requiring Pre-medication Preoperative dilating ophthalmic drops Total hip arthroplasty Total knee arthroplasty Arthroscopy of knee, ankle, foot or leg surgery Discectomy, Laminectomy	Survey, quantitative approach Pilot and Main studies with anonymous patient questionnaires using a randomised selection process	Change in practice well received by all age groups Patients eager and willing to be involved in decisions about their individual care	Rigorous approach to methodology though a small sized study Limitations of study highlighted Change took place on results of evidence-based research
J Tanner, C Blunsden, A Fakis 2007 Journal of Perioperative Practice National survey of hand antisepsis practices	n = 8000 perioperative practitioners	National postal questionnaire Utilising recommended guidelines for maximising response rates Questionnaires were piloted and revised following comments of expert practitioners	Traditional scrub remains the preferred method of antisepsis Compliance with recommended guidelines is patchy Some progress has been made in lessening	Large study, low response rate Rigorous approach to methodology

Source	Sample	Method	Main Findings	Comments
			ritualistic practices in favour of that supported by evidence	
C Lewsey 2008 Journal of Perioperative Practice Newly Registered ODPs: what support do they receive?	n = 22 newly registered Operating Department Practitioners (ODP)	Quantitative methodology Descriptive survey design Structured face-to-face interviews- closed questions Interviews conducted over 17day period	Study identified a mixture of support mechanisms Newly registered ODPs found the support given by peers was the most useful of the types of support mechanisms identified	Rigorous methodology Small study but provided a baseline identifying the needs of newly-registered ODPs. Possible transferability of 'support mechanism' for other newly registered health care professionals.
M Bhattacharyya & H Bradley 2008 Journal of Perioperative Practice Intraoperative handling and wound healing of arthroscopic portal wounds	431 patients 18 -81 years n= 233 Portal wound closed with sutures n= 198 wounds closed with strips inclusion and exclusion criteria in place	Comparative single-centre study researcher - the operating surgeon took initial wound management all patients reviewed by nurse practitioner satisfaction questionnaire completed by patients patients with suture closure asked to report any pain during removal comparison made of wound infection rate and wound healing between both methods of closure	Wound healing characteristics were comparable for both methods Both methods were effective However wound closure strips are safe, cosmetically satisfactory, cost- effective and time sparing. Incidence of needle stick injury reduced with possible reduction in litigation	As a result of findings practice has changed in favour of strip closure for portal wounds in arthroscopic cases. It has facilitated self wound care in carefully selected patients, providing there are no complications Further research by a wider range of hospitals recommended to include an economic analysis

Source	Sample	Method	Main Findings	Comments
E Bigsby K Madhusudana 2009 Journal for Perioperative Practice Study Title To catheterise or not to catheterise A study in Hip and Knee primary Arthroplasty	N = 50 patients Orthopaedic patients	Consecutive patients over a four week period Data collected prospectively Patients' notes checked retrospectively to ensure validity Patients' demographics Type of anaesthetic time of catheterisation cross sectional study computer assisted analysis	High rate of catheterisation following surgery Urinary retention multifactorial Dependant on the anaesthetic given No difference in gender requiring catheter, just old age	Ethical approval required and obtained Study to be developed further using RCT to investigate deep seated infection Possible increase in morbidity Explore the financial situation in financially strapped NHS

Critique of Studies

The above studies have been critiqued using the criteria identified by Cormak (2002) and Parahoo (2006). The studies of both Keegan-Doody (2005) and Lewsey (2008) addressed most of these criteria and thereby greatly enhanced the presentation of their results. The following is an integrated critique of all studies.

Title

All titles reflected the subject of the respective studies.

Researchers

The researchers were a mixture of practising perioperative practitioners and medical staff and were appropriately qualified to undertake the studies, which gives credence because of the currency of their work.

Abstract

All studies had abstracts. However, no study included all the criteria as identified by Cormack (2002) and Parahoo (2006). Therefore the reader did not have a comprehensive overview of the studies before reading each one in depth.

Introduction

All studies had introductions that provided information which enabled the reader to have an insight into the reasoning behind the respective studies.

Literature Search

References used were up-to-date. However, there was a reference in Bigsby and Madhusudana (2009) of more than 20 years old. No explanation was given for the reason why it was used; one can assume that it still has currency for today's practice. Studies, such as those of Keegan-Doody (2005) and Lewsey (2008), recorded quite explicit literature searches and reviews; this hinted at a great deal of systematic reading, relevant to the subject, which was borne out in the quality of their work. Bothamley and Mardell (2005) recorded a review but did not identify their sources so well, and their review did not seem as detailed because of this. The other studies acknowledged them within their texts only.

Methodology

Overall the methodologies used were suitable for the research studies undertaken. Both qualitative and quantitative approaches were used and the methods for data collection included audit, cross-sectional, comparative, randomised control trial, and survey. Descriptions of the data collection by Bothamley and Mardell (2005) would have benefitted from a diagram describing the method of collecting data that was used, as it was difficult to envisage the result from the text.

Findings

In respect of findings, the response rate to the postal survey for the study of Tanner, Blundell and Fakis (2007), was disappointing. Of the 8000 questionnaires sent, only 1471 replies were received. This highlights the limitation of the postal survey method.

Studies of Tanner, Blunsden and Fakis (2007), Bigsby and Madhusudana (2009) and Lewsey (2008) stated their respective methods of analysis of data which, being tried and tested, gave additional credence to their results. In contrast, no reference was made by the studies of Keegan-Doody (2005), Bothamley and Mardell (2005) or Bhattacharyya and Bradley (2008) as to their method of analysis, which required the reader to assume some aspects of the analysis of the study. However, for all the studies the results addressed the title of their research.

Ethical Considerations

Ethical approval was sought by the studies of Lewsey (2008), Tanner, Blunsden and Fakis (2007) and Keegan-Doody (2005). No mention was made of ethical considerations in the studies of Bhattacharyya and Bradely (2008), Bothamley and Mardell (2005) or Bigsby and Madhusudana (2009). This may well have been granted, but the lack of a statement could indicate a lack of rigour in the research.

Credibility and Validity

Credibility of the studies was gained through the experience and knowledge of the researchers. The methods used to collect the data were appropriate to address the studies undertaken and as a result their validity was established.

Conclusions and Recommendations

Conclusions of the studies were supported by findings and implications of the studies were identified. In the Bothamley and Mardell (2005) study regarding pre-operative fasting, a comment was made in the conclusions, which implied that the fasting practices at the site study were no different from most of the rest of the United Kingdom. This appeared to be a generalised comment, but evidence to support this was not highlighted, and so the view lacked sufficient credence.

Bigsby and Madhusudana (2009), Lewsey (2008) Bhattacharyya and Bradley (2008) recommended further research, with Bhattacharyya and Bradley (2008) suggesting a randomised control trial be carried out. The other studies resulted in changes in practice; however, no recommendation was made to audit the changes to note improvement once they were established, thus missing a chance to prove their worth.

All studies, apart from that of Tanner, Blunsden and Fakis (2007), identified the sites of the studies; mention was not made in the introduction that participants had agreed to be identified. This then left the reader wondering if anonymity had been breached in relation to location of the research.

Generally the studies were small with the exception of Tanner, Blunsden and Fakis (2007), whose research surveyed 8000 perioperative practitioners. With small studies, caution must be exercised as to how results are reported. In spite of such a limitation in the data, most researchers were able to explain meaningfully how they arrived at their results from a limited study base

Appendix 3: Topic Guide for Individual In-Depth Interviews

Topic Guide

Research Study: Exploring what influences the practice of registered nurses in the perioperative environment.

Objective

To examine how and what evidence is used in practice

Key Sections

Professional perspective:

- Education and training;
- Working in the operating department;
- Why this area of practice;
- On-going professional development and education.

Influences on practice:

- Values;
- Feelings;
- Beliefs;
- Experience professional – non-professional;
- Internal and external influences;
- Culture;
- Prioritise influences (possible development of a hierarchy of this).

Actual practice - In relation to:

- Effects of research;
- Knowledge base of perioperative practice;
- Knowledge update;
- Perception of evidence and sources of evidence;
- Use of evidence in practice;
- Change in practice ;
- Strategies for reviewing practice;
- Examples of evidence used.

Specific issues

Medical Staff

- Personal influence on departmental practice of registered nurses.

Senior Operating Department Practitioner

- Personal influence on departmental practice of registered nurses.

Educational Coordinator

- Education and training programmes;
- Personal influence on use of evidence.

Appendix 4: Report of Pilot Interview

Analysis of the Interview exploring what influences the practice of qualified practitioners during pre, intra and post operative phases of patient care in the perioperative environment

The interview lasted approximately 30 minutes due to commitments of my volunteer. She is a Practice Coordinator in the operating department and prior to her current role, worked as a Staff Nurse in the Recovery unit of the department. She continues to maintain her clinical skills in this area of care in conjunction with her present duties.

The interview was semi structured and a Topic Guide used to facilitate the questions asked.

A Thematic Framework analysis as described by Ritche et al (2004) is used to analyse the data obtained. The topic guide also facilitated the development of the themes and categories at this time.

The first activity of the analytic process was to transcribe, review, code and sort the information obtained. Both the themes and the categories were coded by numbers. The themes on which the analysis is based are as follows:

- Professional Practice;
- Influences on Practice;
- Actual Practice.

Under each theme various elements have been identified and these form the categories.

Example - Professional Practice:

- Education and training;
- Working in the perioperative environment;
- Reasons for working in specific areas of perioperative;
- Care;
- On going professional development and education.

A thematic chart (Ritchie et al 2004) is used to group points and comments made under the respective themes and categories. (see enclosed)

The next activity of analysis was to ascertain how the information obtained addressed the Research Question and the Objectives of the study.

A5.1 Research Question:

> *What influences the practice of qualified practitioners in the pre-, intra- and post-operative phases of patient care in the perioperative environment?*

The responses to the research question mirrored aspects of the topic guide with little prompting.

Most categories under the theme of Professional Practice were referred to, with education and training and reasons for working in the post operative phase of care yielding most information. Education and training highlighted some differences between her student experiences with those of students in training now example, lectures did not relate to the practical aspect of care about to be undertaken. She feels that this has been addressed and students are now well informed of placements and training programmes are more students friendly. The choice of recovery focused on the reciprocal contact with patients, a situation not afforded during intra operative phase to the extent it is in the post operative one. A good knowledge base of perioperative care is requisite to manage the different areas of the department; this was in relation to duties of co-ordinator, which she undertakes on occasions.

Influences on Practice appeared to focus on her professional experience, and reference was made on varying occasions of the effect students have on her, she is inspired, motivated and enthused by them. Of the external factors family and family pride, particular reference being made to her Nan who believed in her and encouraged her to do the best in whatever she undertakes. Internal factors can be seen as her values, feelings and beliefs. Value was placed on to being the best not in the sense of being number one, but giving the best possible care to her patients.

Information on actual practice highlighted her reflective practice, the appropriateness of care facilitated by research and the involvement with students.

Updating her knowledge base was an on going process, reading widely and undertaking own research. Reflective practice in conjunction with research facilitated questioning the appropriateness of care as required and assisted changes in practice to suit both patient and personal needs.

When asked to prioritise these influences in order of importance, she felt the overriding influence was that of obtaining her professional registration making her what she is today and did not suggest a list as such.

A5.2 Objectives

- To determine how evidence is perceived by qualified practitioners
- To explore the relationship between these perceptions and the influences guiding practice
- To examine how evidence is used in practice

The perception of evidence was viewed as reviewing care given in the context of its appropriateness and best way to deliver. The aspect of exploring sources of evidence was not addressed; overall this area needed much more information to make a meaningful analysis.

This section looks at possible explanations to some responses. The appeal of recovery may be also be due to a greater autonomy in practice than that in the actual operating theatre, a more nurse led environment. Her quest to be the best at what she does may be the influence of her grandmother in encouraging success in whatever she undertakes.

Personal reflection on the interview and analysis

- Time was limited in which to obtain information and some aspects of the topic guide had to be omitted as my volunteer had other commitments at this time
- Look at internal influences from two aspects
    - Internal influences of self and group together values feelings and beliefs as there is some overlapping
    - Internal influences in the actual work environment
- Were my questions too long?

- Background noise, her office is close to some changing rooms and the Theatre reception area!

Theme 1	Professional Practice	
Category 1.1	Education and Training	Project 2000 cohort Changes in nurse education to date Cohort student lead working with Cohort leader to change education training to suit current needs of practice Too much theory not enough emphasis on practice Balance between these needs to be addressed Not student-friendly Lectures did not relate to what practical aspect was about to be undertaken This is being addressed in current education and training Education now more student led Students well informed of placement More support from University Mentors have better idea of students needs now Students using reflective practice
Category 1.2	Working in the Perioperative Practice	Works as a practice co-ordinator Co-ordinates Department on occasions Need the knowledge to manage different areas of the environment
Category 1.3	Reasons for working in specific area of environment (Recovery)	Opportunity to meet people Patient advocate One to one care High and acute care given each day is different reciprocal contact with patients fast turnover not sure what is going to happen until it does no patient is the same needed a course to do anaesthetics did not really like the actual operating theatre smells and masks created a barrier to communication
Category 1.4	On-going professional development and education	Undertaking a degree course in Education Reads relevant journals and articles Undertakes research

Theme 2	Influences on Practice	
Category 2.1	Values	to be the best not in the sense of being
Category 2.2	Feelings	challenges of and questions from students keeps you on the ball and one step ahead helps to identify personal knowledge gaps
Category 2.3	Beliefs	patients deserve the best deal possible
Category 2.4	Professional Experience	looking at daily occurrences to effect change in practice to suit both patient and personal needs working with students motivated and inspired by them their fresh and updated ideas changes within nursing practice and education – a dynamic process use of reflection on a daily basis
Category 2.5	Non-professional Experience	
Category 2.6	Internal Influences	
Category 2.7	External Influences	Grandmother influenced belief in self – to succeed and be the best at what I do family only nurse in the family also friends advice sought from both groups facilitates reflection on practice the media
Category 2.8	Culture	
Category 2.9	Priority of Influences	professional registration seen as the overriding influence –'makes me what I am today' patients students

Theme 3	Actual Practice	
Category 3.1	Effects of research	questions the appropriateness of care reflection on care delivery
Category 3.2	Knowledge base of perioperative practice	
Category 3.3	Knowledge Update	reads widely undertaking own research through project work , personal development influence of students
Category 3.4	Perception of evidence	reviewing care given in the context of the best way to deliver credibility of people producing the evidence are they the best source opinion leaders?
Category 3.5	Sources of evidence	research standards and guidelines
Category 3.6	Use of evidence in practice	project in progress to investigating dyslexia among students nurses with a view to developing a training programme with mentors to address their needs
Category 3.7	Change in practice	changing -+ the theory- practice balance during training and education as a student
Category 3.8	Strategies for reviewing practice	reviewing relevant articles reflection students undertaking research professional development

Appendix 5: Information for Study Participants

All information sheets start with the Study Topic:

What guides and influence the practice of registered nurses in the perioperative environment

Information Sheet for Registered Nurses

1. Invitation to join the study

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the Principal Investigator (PI) (see No 12), if you would like more information.

Thank you for reading this.

2. What is the purpose of the study?

This study seeks to explore what influences the practice of registered nurses in the perioperative environment to determine how and what evidence is used in perioperative care. The term perioperative denotes care given to patients in anaesthetics, during the surgical procedure and immediate recovery following surgery and is generally referred to as pre, intra and post operative care.

The study is over a period of two years 2007 – 2009

3. Why have I been chosen?

You have been chosen because of your work experience and knowledge of perioperative practice.

It is anticipated that there will be a maximum of 24 registered practitioners in the study.

4. *Do I have to take part?*

It is up to you to decide whether or not to take part in the study. This information sheet will give you more details about the study. If you decide to take part or wish to ask any questions please complete and return the reply slip to the University where it will be collected by the PI. This will enable the PI to make contact with you and to answer any questions you may have. If you agree to take part you will need to sign a consent form. You are free to withdraw at any time during the study and without having to give a reason. A decision to withdraw at any time or a decision not to take part, will not affect your employment or position in the Trust.

5. *What will happen to me if I take part?*

On receipt of the reply slip, the PI will contact you to ask if you have any questions about the study. If you have, these will be addressed to assist you in your decision making. If you wish to take part a convenient date will be arranged for the first interview. At this meeting, the Investigator will ask you to sign a consent form agreeing that you are willing to participate in the study, a copy of which will be given to you. You will also be asked to complete a short biographical data sheet which will remain confidential to the study and be anonymous in any reporting of findings used for publication. Participation will involve an individual in-depth interview and a focus group discussion of self selecting nurses already involved in the study. It is anticipated that all interviews will last 60- 90 minutes. With your permission, the individual interview will be recorded to allow my entire attention to be focused on what you have to say. This will also ensure an accurate record of your views allowing me to make a more meaningful analysis later.

Whilst it is not desired that the interview should cause you any distress, it may be helpful to discuss with the PI to identify someone who would be supportive to you in such a situation. You will also be able to contact Occupational Health for advice.

6. *Will my taking part in this study be kept confidential?*

If you consent to take part in the research, your name will not be used and every effort will be made so that you will not be personally identifiable in any study reports. Your confidentiality will always be maintained unless during the course of the study there is any perceived threat to yourself or to others. In this case, the Investigator will inform you before any necessary action is taken**.**

This principle is informed by the Nursing and Midwifery Council professional code of conduct (2004). The PI may wish to use the information you provide for further analysis in the future, but your anonymity and confidentiality will be maintained. In accordance with the Data Protection Act (1998), all information obtained through biographical details, consent forms, reply slips, audiotapes of interviews will be securely stored. All information pertaining to this study will be in locked filing cabinets in a secured room at the School of Nursing and Midwifery, University of Southampton and kept for 15 years. After this time period, they will be destroyed.

7. What will happen to the results of the research study?

It is anticipated that the final report of the study will be completed by March 2009. Summaries of the report will be available to you from the PI. It is also intended that the research findings will be published in academic journals. Your anonymity and confidentiality will be maintained.

8. Where can I seek independent advice about being involved in a research study?

Provision for independent advice about being involved in a study can be gained from:

Consumers for Ethics in Research

PO Box 1365

London N16 OBW

9. What do I do if I need to complain about the conduct of the research.

If you have any cause for complaint about the conduct of the research in this study, you may contact

Professor Judith Lathlean

Research Director

School of Nursing and Midwifery

University of Southampton

SO17 1UA

Tel: 023 8059 7967

10. Who is funding the research?

The research study is being self-funded. The research sponsor is the University of Southampton.

11. Who has reviewed the study?

The NHS Research Ethics Committee is the Main Research Ethics Committee for

LREC Number.....

12. Contact for further information about the study

The P I is based at the University

Her contact details are as follows:

Dot Chadwick

Tel: 023 8069 6591

E-mail dlc2@soton.ac.uk

THANK YOU FOR TAKING TIME TO READ THIS INFORMATION SHEET

If you wish to ask any questions or to take part in the study please complete the reply slip and post it to me in the pre paid addressed envelope provided

Information Sheet For Medical Staff

1. Invitation to join the study

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the Principal Investigator (PI) (see No12) if you would like more information.

Thank you for reading this.

2. What is the purpose of the study?

This study seeks to explore what influences the practice of registered nurses in the perioperative environment to determine how and what evidence is used in perioperative care. The term perioperative denotes care given to patients in anaesthetics, during the surgical procedure and immediate recovery following surgery and is generally referred to as pre, intra and post-operative care.

The Study is over a period of two years from 2007 - 2009

3. Why have I been chosen?

As a Consultant and a member of the perioperative team, I would like to find out how you feel you influence practice in the perioperative environment.

It is anticipated that there will be a maximum of 24 registered practitioners in the study.

4. Do I have to take part?

It is up to you to decide whether or not to take part in the study. This information sheet will give you more details about the study. If you decide to take part or wish to ask some questions, please complete and return the reply slip to the University where they will be collected by the PI. This will enable the PI to make contact with you and to answer any questions you may have. If you agree to take part you will need to sign a consent form. You are free to withdraw from the study at any time

and without having to give a reason. A decision to withdraw at any time or a decision not to take part, will not affect your employment or position in the Trust.

5. *What will happen to me if I take part?*

On receipt of the reply slip, the PI will contact you to check if you have any questions about the study. If you wish to take part a convenient date will be arranged for the interview. At this meeting, the PI will answer any further queries you may have and you will be asked to sign a consent form agreeing that you are willing to participate in the study, a copy of which will be given to you. You will also be asked to complete a short biographical data sheet which will remain confidential to the study and be anonymous in any reporting of findings.

Participation will involve an individual in-depth interview. It is anticipated that the interview will last 60-90 minutes. With your permission, the interview will be recorded to allow my entire attention to be focused on what you have to say. This will also ensure an accurate record of your views, allowing me to make a more meaningful analysis later.

Whilst it is not desired that the interview should cause you any distress, it may be helpful to discuss with the PI, to identify someone who would be supportive to you in such a situation. You will also be able to contact Occupational Health.

6. *Will my taking part in this Study be kept confidential?*

If you consent to take part in the research, your name will not be used and you will not be personally identifiable in any study reports.

Your confidentiality will always be maintained unless during the course of the study there is any perceived threat to yourself or to others. In this case the PI will inform you before any necessary action is taken.

This principle is informed by the Nursing and Midwifery Council professional code of conduct (2004). I may wish to use the information you provide for further analysis in the future, but your anonymity and confidentiality will be maintained.

In accordance with the Data Protection Act (1998), all information obtained through biographical details, consent forms, reply slips and audio tapes of interviews will be securely stored. All information pertaining to this study will be in locked filing

cabinets in a secured room in the School of Nursing and Midwifery, University of Southampton and kept for 15 years. After this time period, they will be destroyed.

7. What will happen to the results of the research study?

It is anticipated that the final report of the study will be completed by March 2009. Summaries of the report will be available to you from the PI. It is intended that the research findings will be disseminated to the practice and academic communities through publication in relevant journals such as the Journal of Perioperative Practice and by presentation at local, national, international levels. Your anonymity and confidentiality will be maintained.

8. Where can I seek independent advice about being involved in a research study?

Provision for independent advice about being involved in a study can be gained from

Consumers for Ethics in Research

PO Box 1365

London N 16 0 BW

9. What do I do if I need to complain about the conduct of the research?

If you have any cause for complaint about the conduct of the research in this study, you may contact

Professor Judith Lathlean

Research Director

School of Nursing and Midwifery

University of Southampton

SO17 1 UA

10. Who is funding the research?

The research study is being self-funded. The research sponsor is the University of Southampton

11. Who has reviewed the study?

The NHS Research Ethics Committee is the Main Research Ethics Committee for

LREC Number.....

12. Contact for further information about the study

The PI is based at the University

Her contact details areas follows:

Dot Chadwick

Tel: 023 8069 6591

E-mail dlc2@soton.ac.uk

THANK YOU FOR TAKING TIME TO READ THIS INFORMATION SHEET

If you wish to ask any questions or to take part in the study please complete the reply slip and post it to me in addressed prepaid envelope provided.

Information Sheet Education Co-Ordinator

1. Invitation to join the study

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the Principal Investigator (PI)

(See No 12), if you would like more information.

Thank you for reading this.

2. What is the purpose of the study?

This study seeks to explore what influences the practice of registered nurses in the perioperative environment to determine how and what evidence is used in perioperative care. The term perioperative denotes care given to patients in anaesthetics, during the surgical procedure and immediate recovery following surgery and is generally referred to as pre, intra and post operative care.

The study is over a period of two years from 2007 - 2009

3. Why have I been chosen?

You have been chosen because of your experience and knowledge of both perioperative practice and the education and training required in this area of care.

It is anticipated that there will be a maximum of 24 registered practitioners in the study.

4. Do I have to take part?

It is up to you to decide whether or not to take part in the study.

This information sheet will give you more details about the study. If you decide to take part or wish to ask some questions, please complete and return the reply slip to the University where they will be collected by the PI. This will enable the PI to make contact with you and to answer any questions you may have. If you agree to take part you will need to sign a consent form. You are free to withdraw at any time

during the study and without having to give a reason. A decision to withdraw at any time or a decision not to take part, will not affect your employment or position in the Trust.

5. *What will happen to me if I take part?*

On receipt of the reply slip, the PI will contact you to check if you have any questions about the study. If you wish to take part, a convenient date will be arranged for the interview. At this meeting, the PI will answer any further queries you may have and you will be asked to sign a consent form agreeing that you will are willing to participate in the study, a copy of which will be given to you. You will also be asked to complete a short biographical data sheet which will remain confidential to the study and be anonymous in any reporting of findings.

Participation will involve an individual in-depth interview. It is anticipated that the interview will last 60-90 minutes.. With your permission, the interviews will be recorded to allow my entire attention to be focused on what you have to say. This will also ensure an accurate record of your views allowing me to make a more meaningful analysis later.

Whilst it is not desired that the interview should cause you any distress, should this occur it may be helpful to discuss with the PI someone who would be supportive to you in such a situation. You will also be able to contact Occupational Health.

6. *Will my taking part in this Study be kept confidential?*

If you consent to take part in the research, your name will not be used, but being the educational coordinator of the department, you could be identified by practitioners at the site of the study. A report of your interview with the PI will be submitted for you to check the accuracy of what was discussed and what information you wish disclosed. The site of the study remains confidential.

Your confidentiality will always be maintained unless during the course of the study there is any perceived threat to yourself or to others. In this case the PI will inform you before any necessary action is taken.

This principle is informed by the Nursing and Midwifery Council professional code of conduct (2004). I may wish to use the information you provide for further analysis in

the future, but you will be contacted to obtain your permission as you could be identifiable within the site of the study.

In accordance with the Data Protection Act 1998, all information obtained through biographical details, consent forms, reply slips and audiotapes of interviews will be securely stored. All information pertaining to this study will be in locked filing cabinets in a secured room at the School of Nursing and Midwifery, University of Southampton and kept for 15 years. After this time period, they will be destroyed.

7. What will happen to the results of the research Study?

It is anticipated that the final report of the study will be completed by March 2009. Summaries of the report will be available to you from the PI. It is also intended that the research findings will be published, your anonymity and confidentiality will be maintained.

8. Where can I seek independent advice about being involved in a research study?

Provision for independent advice about being involved in a study can be gained from

Consumers for Ethics in Research

PO Box 1365

London N16 0BW.

9. What do I do if I need to complain about the conduct of the research?

If you have any cause for complaint about the conduct of the research in this study, you may contact

Professor Judith Lathlean

Research Director

School of Nursing and Midwifery

University of Southampton

SO17 1U

10. Who is funding the research?

The research study is being self-funded. The research sponsor is the University of Southampton.

11 Who has reviewed the Study?

The NHS Research Ethics Committee is the Main Research Ethics Committee for

LREC Number.....

12. Contact for further information about the Study

The PI is based at University

Her contact details areas follows:

Dot Chadwick

Tel: 023 8069 6591

E-mail dlc2@soton.ac.uk

THANK YOU FOR TAKING TIME TO READ THIS INFORMATION SHEET

If you wish to ask any questions or to take part in the study please complete the reply slip and* post it to me *in the addressed prepaid envelope provided.

Information Sheet Senior Operating Department Practitioner

1. Invitation to join the study

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact the Principal Investigator (PI)

(see No 12), if you would like more information

Thank you for reading this

2. What is the purpose of the study?

This study seeks to explore what influences the practice of registered nurses in the perioperative environment to determine how and what evidence is used in perioperative care. The term perioperative denotes care given to patients in anaesthetics, during the surgical procedure and immediate recovery following surgery and is generally referred to as pre, intra and post operative care.

The study is over a period of two years from 2007 - 2

3. Why have I been chosen?

You have been chosen because of your experience and knowledge of perioperative practice and your personal influence as a team leader on such practice.

It is anticipated that there will be a maximum of 24 registered practitioners

in the study.

4. Do I have to take part?

It is up to you to decide whether or not to take part in the study.

This information sheet will give you more details about the study. If you decide to take part or wish to ask some questions, please complete and return the reply slip to the University where they will be collected by the PI. This will enable the PI to make contact with you and to answer any questions you may have. If you agree to take

part you will need to sign a consent form. You are free to withdraw at any time during the study and without having to give a reason. A decision to withdraw at any time or a decision not to take part, will not affect your employment or position in the Trust.

5. *What will happen to me if I take part?*

On receipt of the reply slip, the PI will contact you to check if you have any questions about the study. If you wish to take part, a convenient date will be arranged for the interview. At this meeting, the PI will answer any further queries you may have and you will be asked to sign a consent form agreeing that you will are willing to participate in the study, a copy of which will be given to you. You will also be asked to complete a short biographical data sheet which will remain confidential to the study and be anonymous in any reporting of findings.

Participation will involve an individual in-depth interview. It is anticipated that the interview will last 60-90 minutes. With your permission, the interview will be recorded to allow my entire attention to be focused on what you have to say. This will also ensure an accurate record of your views allowing me to make a more meaningful analysis later.

Whilst it is not desired that the interview should cause you any distress, should this occur it may be helpful to discuss with the PI someone who would be supportive to you in such a situation. You will also be able to contact Occupational Health.

6. *Will my taking part in this Study be kept confidential?*

If you consent to take part in the research, your name will not be used, but as the only senior operating department practitioner taking part, you could be identified by practitioners at the site of the study. A report of your interview with the PI will be submitted for you to check the accuracy of what was discussed and what information you wish disclosed. The site of the study remains confidential.

Your confidentiality will always be maintained unless during the course of the study there is any perceived threat to yourself or to others. In this case the PI will inform you before any necessary action is taken.

This principle is informed by the Nursing and Midwifery Council professional code of conduct (2004). I may wish to use the information you provide for further analysis in

the future, but you will be contacted to obtain your permission, as you could be identifiable within the site of the study.

In accordance with the Data Protection Act 1998, all information obtained through biographical details, consent forms, reply slips and audiotapes of interviews will be securely stored. All information pertaining to this study will be in locked filing cabinets in a secured room at the School of Nursing and Midwifery, University of Southampton and kept for 15 years. After this time period, they will be destroyed.

7. What will happen to the results of the research Study?

It is anticipated that the final report of the study will be completed by March 2009. Summaries of the report will be available to you from the PI. It is also intended that the research findings will be published, your anonymity and confidentiality will be maintained.

8. Where can I seek independent advice about being involved in a research study?

Provision for independent advice about being involved in a study can be gained from:

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PO Box 1365

London N16 0BW.

9. What do I do if I need to complain about the conduct of the research?

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Professor Judith Lathlean

Research Director

School of Nursing and Midwifery

University of Southampton

SO17 1UA

10. Who is funding the research?

The research study is being self-funded. The research sponsor is the University of Southampton

11. Who has reviewed the Study?

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LREC Number.....

12. Contact for further information about the Study

The PI is based at University

Her contact details areas follows:

Dot Chadwick

Tel: 023 8069 6591

E-mail dlc2@soton.ac.uk

THANK YOU FOR TAKING TIME TO READ THIS INFORMATION SHEET

If you wish to ask any questions or to take part in the study please complete the reply slip and* post it to me *in the addressed prepaid envelope provided.

Appendix 6: The Participants

This gives some background information about each participant, which has been derived from the biographical details. The focus of these details are on education and training, experience of the specialty, their roles in the department and their reasons for choosing to work in the perioperative environment.

The participants were registered nurses, at both Sister/Charge Nurse and Staff Nurse levels, Senior Operating Department Practitioner, the Education Coordinator and Senior Medical Staff. The age range of the participants was between 21 and 36+ years.

Participant No 1 (A1)

A Sister whose nurse training was service based. She qualified as a State Enrolled Nurse, later converting to a Registered Nurse. She has a vast experience of the perioperative specialty that covered twenty years, nine of which have been at the location of the study. Her main area of work is in the intra operative domain of care, with responsibility for the day-to-day organisation of the operating theatre.

She stated that she came to perioperative nursing by default, being recruited to the specialty as a result of staff shortages. She was recruited on a temporary basis, but enjoyed this move, liked the precision of theatres, found it a ‘comfortable’ environment in which to work and subsequently stayed. She has undertaken post registration courses and obtained the Diploma in Nursing Studies. She is also a qualified mentor for students to the department.

Participant No 2 (E)

A Senior Consultant Anaesthetist whose education was University based. He qualified in the nineties and has worked in the perioperative field for fourteen years; six of these have been at the location of the study. He has a wide knowledge and experience across the three domains of care in the specialty. He enjoyed the anaesthetic aspect of his training and decided to specialise in this area of care, he was also very impressed by individuals working competently in this environment and wished to emulate his role models. His reason in doing anaesthetics was also influenced by his experience of being a patient himself and the care he received.

Among his medical qualifications is the Fellowship of the Royal College of Anaesthetists. He works mainly with the Operating Department Practitioners and Recovery nursing staff.

Participant No 3 (A2)

A Sister whose nurse training was service based and qualified in the eighties; a qualified midwife who also worked as a school nurse for the Army. She undertook a Return-to-Practice Course following a break to have her family. She has worked in the perioperative specialty for five years and eight months and all this time has been at the location of the study. Her first experience of perioperative care was working in Day Surgery. It was not a conscious decision to work in this area of care but it suited her family and home circumstances. She has thoroughly enjoyed working in Theatres and felt that she has learnt so much in the last three years. Her area of care is in the intra operative phase where her responsibility is in the organisation and running of operating lists. She has undertaken various post registration courses and is a qualified mentor in the department.

Participant No 4 (B1)

A Staff Nurse whose nurse training was University-based. She obtained the Diploma in Nursing, Adult Branch. She is also a qualified dental nurse. Her main area of practice is in the intra operative domain of care, where she favours general surgery. Her clinical placements were at the location site of the study and she has worked in perioperative environment there for one year. Her keen interest in anatomy and physiology *'prefers what is happening inside the body, rather than outside it'* has influenced her choice of area for practice. Her preferred discipline of care within the specialty is general surgery and she has undertaken some post registration courses pertinent to the specialty in general.

Participant No 5 (A3)

A Senior Sister whose nurse training was service based. She is very experienced in, and has a vast knowledge of, perioperative nursing having spent over twenty years in the specialty.

Her post-registration qualifications include a Diploma in Nursing Studies and a BSc (Hons) in Health and Social Policy and an 'in-house' Theatre Course. She is also a qualified mentor for students and a National Vocation Qualification Assessor. She is a member of various groups within the Trust with interdisciplinary links to the specialty; these include Benchmarking, Standards of Professional Practice and Training Programmes. She is also an active member of the Association for Perioperative Practice.

She thoroughly enjoyed her student allocation to the theatres and as a result returned to this area of care following 'a break' to have her family. She was also greatly influenced by her Theatre Superintendent who she acknowledged was an excellent mentor.

Her main area of practice is in the intra-operative phase of care where she holds a very senior position.

Participant No 6 (B2)

A Staff Nurse whose training was University-based, having obtained an Advanced Diploma in Nursing. She has worked in the perioperative environment for 2 years at the location site of the study and is currently studying for her degree.

The difficulty in finding a job after qualification led to a job-sharing post in the Operating Department. This she enjoyed having felt that this area of care would clarify the patient's experience of surgery in the context of the perioperative environment.

Her area of care is in the intra operative domain of the specialty where she is involved with the duties of both scrubbed and circulating team members and works closely with the team leader.

Participant No 7 (C)

Commenced work in the National Health Service as a porter and having been exposed to the perioperative environment through these duties and enjoyed the 'atmosphere ' of the area and she decided to pursue a career in the specialty. She now works as a Senior Operating Department Practitioner having completed her initial training programme and obtaining a National Vocational Qualification at Level

three. Her clinical placement was at the site of the study. She has worked in the specialty for the past five years. She has also obtained a BTEC Diploma in Science. She is a Deputy Team Leader and works across all domains of perioperative care. She is a qualified mentor to all students and newly appointed staff.

Participant No 8 (A4)

His initial training was undertaken abroad. He has worked in perioperative care for the past fourteen years, but at the site of the study for the past nine years. He has a Bachelor of Science degree in Nursing, a Bachelor of Science in Clinical Practice and is currently in undertaking a Leadership and Management Course at Master's Level.

He specialises in the intra operative phase of care and holds a Team Leaders position within the department. He has always wanted to work in the perioperative environment which he felt was a very stable one and one where he gained considerable experience. He has had experience of commissioning a theatre in his own country. He feels very strongly about facilitating junior staff members to fulfil their respective potentials.

A very ambitious person, who is eager to achieve more and has made plans to undertake an Advanced Practitioner role within his current area of care.

Participant No 9 (DA)

She is a graduate nurse, having obtained a Bachelor of Science (Hons) in Clinical Nursing. She has undertaken mentorship and theatre courses and is a qualified Advanced Scrub Practitioner. The Advanced Scrub Practitioner assists the surgeon during the surgical procedure, undertaking such duties as tissue retraction and wound closure.

She decided on a career in perioperative care because of her love of problem solving in an acute setting and she felt the perioperative environment was conducive to this.

She has worked abroad and found practice to be similar, not different as expected so felt 'she had remained within her comfort zone'. She has worked in the

perioperative environment for ten years, two of which have been in the department of the site of the study.

She undertakes a dual role of clinical practice and education. She coordinates the on-going education and training for perioperative practice across the Trust and has responsibility for the development of non-medical staff in this specialty. Her role as the department's education coordinator enables her to meet and liaise with fellow coordinators of other Trusts. Clinically, she specialises in the intraoperative domain of perioperative care.

She is instrumental in the writing and updating of the Policies and Procedures of the department.

Participant No 10 (B3)

She works as a newly qualified Staff Nurse in the department. She obtained an Advanced Diploma in Nursing at a local University. She has worked in the specialty for the past nine months.

She is currently working in the intra-operative domain of perioperative care. She chose the specialty because she felt that learning opportunities were great within a multidisciplinary team, communication was good and an enjoyable environment where she was respected as a student.

Experience in and knowledge of the specialty varied from newly qualified nurses, nurses with some experience to very experienced senior staff.

Appendix 7: Transcripts Notes of Individual In-Depth Interviews

Predetermined Theme 1: Biographical Perspective				
Sub-Theme	*Education and Training*	*Role in the Department*	*Why this area of practice*	*Ongoing Professional Development and Education*
Participant 1(A)	Hospital trained Qualified in 1984 State Enrolled Nurse Diploma in Nursing	Sister (A) Working in actual Theatre	Has worked in Operating Department for over 20 years. Came to theatre by default, recruited to theatre because of staff shortages. Volunteered on a temporary basis. Likes the precision of Theatres, a comfortable environment in which to work. *"You are in control of what you do"* Likes the completeness of the job	Mentorship Course
Participant 2(E)	Qualified in 1992 University Degree	Consultant Anaesthetist (C) Works in anaesthetics, theatres and recovery	Has worked in the Operating Department for 14 years Enjoyed anaesthetics during training Impressed by individuals working competently in this environment Wanted to emulate his role models	Feels that ongoing education is very important
Participant 3(A)	Qualified in 1980 Hospital based School Nurse for the Army Return to Practice Course following a break to have her family	Sister (A) Working in the actual Theatres	Has worked in the Operating Department for 4 years 2 months First experience in Theatre was working in Day Surgery, enjoyed this very much. Suited her home circumstances but this was not the conscious decision to work in Theatres (Not really sure what it was). Just loves this area of nursing: Has learnt so much in the last 3 years, "can't explain"	Mentorship Course in Health and Social Care Advances in Perioperative practice, Research practice course
Participant 4(B)	Qualified in 2007 University – Diploma in Nursing Adult Branch Qualified Dental Nurse	Staff Nurse (B) Working in the actual Theatre	Has worked in the Operating Department for 1 year Keen interest in anatomy and physiology.- ''prefers what is happening inside the body rather than outside'' Prefers general to orthopaedics	Laparoscopic Course Extended role , male catheterisation
Participant 5(A)	Qualified in 1972 Hospital-based Diploma in Nursing BSc in Health &	Sister (A) Working in the actual Theatre	Has worked in the Operating Department for 20years + Enjoyed student	'In house' Theatre Course ENB 925 Member of Association for Perioperative

Predetermined Theme 1: Biographical Perspective				
	Social Policy Feels in her day one accepted things more readily; present day students are more critical, questioning and challenging Had time in the past for learning quote "*they hit the ground running these days*		allocation, had great support, encouragement, facilitation praise excellent experience Had a break to have her family went back to Theatre on return, never looked back	Practice (AfPP) Attends AfPP Congress on a regular basis. NVQ Assessor. Mentorship Course. Attends courses relevant to the her speciality. Serves on various committees – Benchmarking Standards & Professional practice. Training
Participant 6(B)	Qualified in 2006 University	Staff Nurse (B) Actual Theatre		Currently studying for top-up degree
Participant 7(C)	Qualified in 2004 NVQ Level 3 Operating Department Practice	Senior Operating Department Practitioner (C) Deputy Team Leader Works in Anaesthetics Theatre and Recovery	Worked as a porter and loved the buzz of the environment Influenced by her mother who is herself an ODP	BTEC Diploma in Science Foundation Management Mentorship Course Basic Life Support Teacher
Participant 8(A)	Qualified in 1993 Trained overseas BSc Nursing BSc Clinical Practice	Charge Nurse (A) Actual Theatre	Felt this area of practice would facilitate a greater experience Always wanted in operating department Felt like a stable environment	Currently studying for an MSc in Leadership & Management Mentorship Course Orthopaedic Course Very ambitious wants to achieve more Plans to do the Advanced Scrub Practitioner Course
Participant 9	Qualified in 1998 University BSc(Hons)Clinical Nursing Mentorship Course Theatre Course Advanced Scrub Practitioner	Sister & Education Coordinator (DA) Actual theatre Responsible for developments in practice and ongoing education for the department	States she is a hands on sort of nurse Enjoys problem solving in the acute setting and the operating department facilitates this	Personal knowledge and development is very important to her
Participant 10	Qualified in 2008 University Advanced Diploma in Adult Nursing	Staff Nurse(B) Actual Theatre	Learning opportunities were great within a multidisciplinary team Communication is good which is vital to safe patient care New experiences Enjoyable environment Felt respected while a student	About to do the Theatre Course Prefers to read about procedures retrospectively feels doing this before the procedure does not relate to anything she has experienced

Predetermined Theme 2: Influences on Practice (1)				
Sub-Theme	*Values*	*Feelings*	*Beliefs*	*Experience Professional – Non-professional*
Participant 1(A)	Honesty Good rapport with colleagues in multidisciplinary environment Old fashioned Not dictatorial Giving the best possible care Each individual's contribution to care Caring Christian upbringing	Enthusiasm Open to new ideas curious Energetic Effective team leader sense of humour efficient Parents influence Only child		Other staff members including Medical colleagues Role models leadership Ability to influence change in practice Safe practice Experience dealing with the public Experience of personal illness
Participant 2(E)	Compassion Empathy through being a patient	Consultant Anaesthetist (C) Works in anaesthetics, theatres and recovery		Individuals working competently Ongoing education Role models emulation of some senior colleagues
Participant 3(A)	Working to the best of my ability for my patient Making the best of What I have	Happy in work environment Does not want to stagnate Feels very strong about learning new things	In doing things to the best of her ability	Looking at how colleagues work taking what she feels are good aspects of care to improve her own. Finding evidence to support practice Role models More experienced colleagues. Learning new things Flexibility Lots of changes in her life makes it easier to fit into a new environment
Participant 4(B)	Care of patients Safety in care delivery	Always wanted to be a nurse although there is a cousin in nursing did not feel that exerted any influence Older nurses tend to be more practical, recently trained more theoretical Team building exercises	Reward of successful surgery Team work essential for best practice	the experience and knowledge of older nurses especially where anatomy is concerned Husband's encouragement and influence
Participant 5(A)	Loyalty to department & hospital. Getting things right has a passion for this Best care for all patients. Respect for junior staff discussing issues with them. Knowledge of specialty. Logical approach to care. Felt valued as a junior Professional approach to duty. Being a role model	Leads through example Instilling in junior staff her passion for perioperative care Ensuring they are happy in their work Hope she maintains what she gained in her training and that her practice reflects it	safe practice – passionate about this changing negatives to positives negativity makes her more aware of personal practice doing to the best of her ability	Medical staff changing their practice influenced her to research practice. Peer groups. What is happening elsewhere Professional body –AfPP – multi-professional discussion on aspects of care Medical imput Expansion of role development Facilitating same Influencing standards of practice Passing on knowledge and skills Her enthusiasm

Predetermined Theme 2: Influences on Practice (1)				
Participant 6(B)	Caring for others Not in it for money Providing the level of care patients deserve Ongoing education Others opinions	Providing care you are happy with is a drive in itself		Perioperative environment good example of the patient's journey Mentors- multidisciplinary team Mother is also a nurse – role model Personal preference /choice
Participant 7(C)	As Participant 02 Need to record Influence on RNs			
Participant 8(A)	Quality patient care Reflection on practice to improve care To do my best for the patient	Personal achievement Interest in what I do fulfilment Need of knowledge and skills to deliver patient care, to undertake his role	What ever you do, do your best	Government directives, targets European working initiatives, Trust strategy Plays his part to achieve this Knowledge and skills required
Participant 9	likes order in both home and work life challenges of the job people who are in control and calm in difficult situations experience of colleagues the team and team work	Likes to know why she does things Theorist Rationale must be present Emulates good practice of peers Asks for guidance as necessary A good role model	Patient safety, safe practice underpins all she does In evidence based practice Giving staff responsibility , ownership and accountability of their practice, Must maintain clinical skills Accepting own limitations	Very experienced in specialty Guided by national developments Keeps abreast with new technology Remains hands on practitioner
Participant 10	Colleagues Multidisciplinary interrelationships	Admiration of colleagues experience Knowledge, skills Authority, Delegating & Organising skills	In discussing things she feels strongly about Having the courage of her convictions	Safety of patients Friends' experience of hospitals- awareness of anxiety Family reassurance Grandmother was a nurse, discusses things with her

Predetermined Theme 2: Influences on Practice (2)				
Sub-Theme	*Internal Influences*	*External Influences*	*Culture*	*Priority of Influences*
Participant 1(A)	Greatly influenced by previous Sisters Emulated them Able to question their practices to inform her own	Childhood experiences influenced choice of profession	Empowering the team Leadership; Policy Theatre etiquette Communication through communication book staff meetings both formal and informal ability to discuss issues at any time encouraging assertiveness among junior staff Support to junior staff	Best service I can give to patients Communication Safety in practice Team work
Participant 2(E)				Education & training
Participant 3(A)			Great learning environment lots of scope feels department uses research to support practice influence on Policies and Procedures good access of information for staff displays of articles discussion groups	Safe practice Patients Staff Environment Working to best of own ability Teamwork Contribution of others to practice Valued opinions Communication could be improved
Participant 4(B)			Access to courses Audit governance Education half days Lectures Demonstrations of practical aspects of care Tries to influence colleagues to undertake relevant courses	Husband's influence Family being proud of her Enjoyment of work Success of surgery for patients Mentor pleased with her progress Colleagues People feeling she is competent at her job Role models Happy in her job
Participant 5(A)	Her 1st Theatre superintendent A great teacher who supported her staff Great influence on her Initial training still influences practice	Caring for a family member	Lack of time for discussion Financial constraints Guiding colleagues Facilitating their learning Support to junior staff	Patient safety Good teamwork Happy environment Happy management To be valued
Participant 6(B)			Supportive staff Encouraging Protective Brilliant mentor Scary area to work in (nature of care) Ritualistic practices	Care of patients- best practice Research Learning from more Experienced colleagues, equally important as research Finance vital to effect practice Working within multidisciplinary team; Opinions Constantly improve care delivery
Participant 7(C)				

Predetermined Theme 2: Influences on Practice (2)				
Participant 8(A)		Family challenges him to do well Role model at home Family support	Role models Guiding junior staff to fulfil their potential. Compare his overseas training care culture Motivation of junior staff Support to each other Helpful team	Quality patient care Personal and professional development High standards Interest in what you do Fulfilled to deliver best care Attitude to duties
Participant 9	Experience of colleagues Contribution of senior medical staff	Ordered individual	Idiosyncrasies of surgeons	Note her influence on the Department due to Role
Participant 10	Emulating colleagues	Family & friends NMC Codes of Conduct Working in a nursing home prior to training Gave an insight into “good and not so good practices”	supportive of each other irrespective of position or role able to rotate around the specialty close environment daunting intense good role models attitudes in theatre	Best quality care for patients –appropriate Fellow colleagues Evidence for practice Family – experiences as patients Friends – views on health care

Predetermined Theme 3: Actual Practice (1)				
Sub-Theme	*Effects of Research*	*Knowledge Base*	*Knowledge Update*	*Perception of Evidence*
Participant 1(A)	Looking at scientific evidence – trials Feels practice is research based	Experienced Theatre Sister with a wealth of perioperative knowledge	Reads nursing journals Media Internet Teaching student nurses Visiting other operating departments to learn from their practices Attendance at relevant courses Display of relevant articles in department	Research to support practice
Participant 2(E)	Separate report for this participant			
Participant 3(A)	Finding information about a subject from reading a variety of articles to what is Best evidence available	Member of AfPP Professional organization uses information from the Association as a resource	Reading relevant journals and text Previous knowledge helps in acquiring new Uses reflection	Searching for the best way to do things
Participant 4(B)	Aspects of research has exerted some influence Tendency to research things she is not familiar with Tries to influence by word of mouth	Qualified 1year.- feels knowledge base is developing well Influenced by older nurses particularly where practical aspects of care are concerned Prior to 'taking a case' will always do background reading	AfPP member Reads relevant journals Internet Department audit & governance Looks at department needs & decides what courses are relevant for her Staff training Researches aspects of care not known Department education day Discussion with development lead regarding needs of self	Reviewing variety of research papers, not just one
Participant 5(A)	Some research used but not on a large scale Feels department needs a dedicated person to undertake the role to guide the department, needs to be consistent Sees the importance of research Research undertaken has influenced her practice Feels there is a gradual progression to embrace research	Very experienced and knowledgeable about perioperative care	AfPP member Regularly attends AfPP Congress Self direction Internet Assoc website Shares information on a wide scale Trust audit Mornings used to discuss local practice Staff members sharing information obtained at Courses attended Study days	Looking around for best practice Systematic reviews Anecdotal evidence Experience
Participant 6(B)	Perioperative practice not quite a research based practice, but better than other areas Use of research in dept could be influenced by new development of Treatment Centre	Developing newly qualified	Knowledge is ongoing in this department not static Staff encouraged to research issues Gains from experienced staff Encouraged to	Reviewing research papers, quality who the authors are! Has to be tried tested validated and practised

Predetermined Theme 3: Actual Practice (1)				
	Research is communicated		question practice Education days Policies are kept up to date	
Participant 7(C)	Use this information when writing influence on RNs practice			
Participant 8(A)		Experienced senior staff member very good knowledge base written a paper on team work	Courses Information through the internet Sharing with others e-journals general 1.1 discussions Education day Attends AfPP Congress Uses communication book Relevant articles displayed on notice board Staff encouraged to contribute to this avenue of learning	Finding the best evidence and putting it into practice Evidence must be robust Must support practice Has included benefits of EBP
Participant 9	Uses current research findings to support policies & procedures Uses Professional Body's guidelines to formulate policy these are based on evidence	Excellent knowledge base of specialty	AfPP member Reads relevant journals Attends AfPP Congress Study days, opportunity to discuss with colleagues current issues on national basis Member of Educational forum of AfPP Shares information Trust wide	'shopping around' for best practice Critical appraisal of research
Participant 10	Feels this is second nature " as drummed into you during training" Practice must be supported by evidence Critical analysis Of research papers Uses research to support argument	Developing newly qualified uses reflection discusses Case taken with experienced staff member developing a structured way to do practice feedback build on understanding attending relevant courses meeting & sharing information with others from other theatres training from Medical Devices Reps aware of AfPP rotation through specialities preceptor guidance experienced staff members	Relevant journals Library Policy & procedures Discussion with colleagues Reflection	Correct way of doing things Collective research for proof of effectiveness of practice

Predetermined Theme 3: Actual Practice (2)					
Sub-Theme	*Sources of Evidence*	*Use of Evidence*	*Change of Practice*	*Strategies for Review of Practice*	*Examples of Evidence used*
Participant 1(A)	Experiential learning feels this is the best as it has more influence with newly qualified nurses Scientific trials (RCT's) Opinions of others	Method of hand washing Swab counts	Has ability to change practice And the confidence to do it Influencing the team Sustaining change through being a role model	Communication with colleagues Staff meetings Informal discussions	See Use of Evidence
Participant 2(E)					
Participant 3(A)	Professional bodies Journal Association guidelines on safe practice	Finding the evidence Evidence supporting the Policies of department	Challenges practice updating policies using current evidence Change by Discussion to identify problem Research Support of manager and team members	Reflection, feels this can be automatic, but doing it on a structured way makes it easier How could I do it better What has influenced me at the time Reflects on a regular basis	Hand washing technique Wearing & non wearing of masks Updating Policy
Participant 4(B)	Research Experience	Patients with latex allergy Feels older nurses embrace evidence based practice well her mentor is a good example	Feels due to her inexperience as a junior S/N difficulty in influencing	Keeps diary of cases done, what was good what was bad, what could I do better Influences other juniors to keep diaries	Care of patients with Latex Allergy
Participant 5(A)		WHO safe site surgery Wound dressings Scrubbing technique			
Participant 6(B)	Multi factorial Research Opinions backed by evidence Feels evidence is not always accessible (not done at all)	To review Policy	Feels she could not affect this , but would take issue to experienced staff Feels her contribution would be acknowledged		
Participant 7(C)					
Participant 8(A)	Anecdotal evidence Observing practice of others Professional bodies Experience Communication	Policy & procedures are based on evidence feels evidence in practice is used by a fair amount of staff	Communication has changed practice	Reflection on a daily basis Past experiences 360* evaluation by/of colleagues Discussion with colleagues To question practices – informal basis	How department communicates with each other on a multidisciplinary approach

Predetermined Theme 3: Actual Practice (2)					
				Audit; Presentations feedback	
Participant 9	Guidelines Audits Opinions internet	To formulate policy and procedures	Monitor current practice Discussion with staff; Change Audit change Assess its benefits Endeavours to inspire confidence Role model Needs support to effect change	Observation Incident reporting Audits Appraisals Shadowing more experienced staff Identify weak areas of practice	Hand washing Aseptic techniques
Participant 10	Research experience	Policy & procedures based on evidence discussion among staff members of information on a variety of subjects using findings to improve practice	Discusses anything she feels strongly about Need background knowledge Speaks with senior staff; Passes information on by informal approach Formal at department meetings	Uses reflection to question practice And change where applicable Reflection diary Personal log /journal of activity Speaking with colleagues in relation to personal progress	Scrubbing Gowning and gloving

Appendix 8: Coding of Predetermined Themes, Sub-Themes and Comments

Data Management

Results Table A1: Biographical Perspective

Theme	Code
Professional Perspective	1
Sub Theme	
Education and Training	1.1
Role in Department	1.2
Why this area of Practice	1.3
On-going Professional Development	1.4

Results Table A2: Influences on Practice

Theme	Code
Influences on Practice	2
Sub Theme	
Values Beliefs Feelings	2.1
Experience Professional Non Professional Internal and External Influences	2.2
Culture	2.3
Priority of Influences	2.4

Results Table A3: Actual Practice

Theme	Code
Actual Practice	3
Sub Theme	
Effects of Research	3.1
Knowledge base of perioperative practice	3.2
Knowledge update	3.3
Perception of Evidence	3.4
Sources of Evidence	3.5
Use of evidence in Practice	3.6
Change in Practice	3.7
Strategies for reviewing Practice	3.8
Examples of evidence used	3.9

Table Sets 1A: Biographical Perspectives

1.1 Education and Training (1A)	Code
Service sited nurse training	♠
Higher education sited training combined	♣
Medical training	♥
National Vocational training (Operating Department Practitioners)	♦

1.2 Role in Department (1A)	Code
Sister	A
Staff Nurse	B
Operating Department Practitioner	C
Education Coordinator	DA
Consultant Anaesthetist	E

1.3 Why this area of Practice (1A)	
Comments	Code
Came to theatre by default due to staff shortages	1.3.1
Just love this area of nursing can't explain why	1.3.2
Enjoys problem solving in the acute setting operating theatres facilitates this	1.3.3
Felt this area of practice would facilitate a greater experience	1.3.4
Impressed by individuals working competently in this environment	1.3.5
Learning opportunities were great within a multidisciplinary team	1.3.6

1.4 On-going Professional Development and Education (1A)	
Comments	Code
On-going education is very important	1.4.1
Personal knowledge and development is very important to me	1.4.2
Variety of Courses available	1.4.3
Would like to achieve more	1.4.4
Attends courses relevant to specialty	1.4.5

2.4 Priority of Influence (2A)			
Participant	Order of Priority	Role in Department	Code
Number 1		A	
Best service I can give to patients	1		2.4.1
Communication	2		2.4.2
Safety in Practice	3		2.4.3
Teamwork	4		2.4.4
Number 2			
Education and Training	1	C	2.4.5
Holistic Care	2		2.4.6
Nature of Care	3		2.4.7
Number 3		A	
Safety in Practice	1		2.4.3
Working to best of ability	2		2.4.8
Teamwork	3		2.4.4
Contribution of others	4		2.4.9
Communication	5		2.4.2
Number 4		B	
Husband's influence	1		2.4.10
Enjoyment at work	2		2.4.11
Success of surgery	3		2.4.12
Acknowledgement of personal competence by peers	4		2.4.13
Role Models	5		2.4.14
Number 5		A	
Patient Safety	1		2.4.3
Teamwork	2		2.4.4
Happy Management	3		2.4.15
Feeling Valued	4		2.4.16
Number 6		B	
Care of patient Best Practice Research	1		2.4.3, 2.4.17,2.4.18
Learning from more-experienced staff	2		2.4.19
Finance	3		2.4.20
Teamwork	4		2.4.4
On-going care improvement	5		2.4.21
Sharing knowledge	6		2.4.5
Number 7		D	
Patient Respect	1		2.4.22
Value Staff	2		2.4.16
Honesty	3		2.4.23
Patient Safety	4		2.4.3
Number 8		A	
Quality patient care/high standards	1		2.4.3
Personal & professional development	2		2.4.24
Interest in what I do	3		2.4.25
Fulfilled in care delivery	4		2.4.26
Number 9		EA	
Patient Safety	1		2.4.3
Evidence to support practice	2		2.4.27
Teamwork	3		2.4.4
Number 10		B	
Best care patient can have	1		2.4.1
Fellow colleagues	2		2.4.19
Evidence to support practice	3		2.4.27
Family as patients	4		2.4.28
Options of non-medical friends of hospital care	5		2.4.29

Table Sets 2A: Influences on Practice

2.1 Values, Beliefs, Feelings (2A)	
Comments	Code
Good rapport with colleagues in a multidisciplinary team	2.1.1
Safety underpins care	2.1.2
Reflection on practice to improve care	2.1.3
Rationale must be present	2.1.4
Best care for all patients	2.1.5

2.2 Experience: Professional, non-Professional, Internal and External Influences (2A)	
Comments	Code
Looking at how colleagues work, taking what are good aspects of care to improve my own	2.2.1
Individuals working competently together	2.2.2
Experience of dealing with the public before nurse training	2.2.3
Husband's encouragement; challenge of the family to do well	2.2.4
Ability to influence change in practice	2.2.5
Personal illness	2.2.6

2.3 Culture (2A)	
Comments	Code
Supportive of each other, irrespective of position or role	2.3.1
Ability to discuss issues at any time	2.3.2
Encouraging assertiveness amongst junior staff	2.3.3
Guiding colleagues to facilitate learning Guiding colleagues to fulfil their potential	2.3.4
Great learning environment	2.3.5

Table Sets 3A – Actual Practice

3.1 Effects of Research (3A)	
Comments	Code
Medical staff changing their practice has influenced me to research mine	3.1.1
Finding information about a subject from reading a variety of articles to find the best available	3.1.2
Aspects of research has exerted some influence, tend to research unfamiliar things	3.1.3
Department needs a dedicated person to guide research, needs to be consistent	3.1.4
There is a gradual progression in embracing research Practice is research based Perioperative practice not quite research-based Current research is used to support policies and procedures	3.1.5
Use research to support argument, 'drummed into you during training'	3.1.6

3.2 Knowledge base of perioperative practice (3A)	
Comments	Code
Experienced staff with a wealth of knowledge of perioperative care. Some are members of the Professional Organisation of the specialty.	3.2.1
Staff newly qualified and/or new to the specialty	3.2.2

3.3 Knowledge Update (3A)	
Comments	Code
Sharing of knowledge Internally through Trust/Departmental Audit / Education Days, this involved 'in house' presentations and demonstrations by medical devices representatives, Departmental meetings, Informal discussions (e.g. 1:1 discussions, discussions at coffee time)	3.3.1
Externally through attendance at AfPP annual Congress, study days, relevant courses and visiting other operating departments of other hospitals.	3.3.2
Self direction through reflection, reading relevant articles and texts and the internet	3.3.3
Display of literature relevant to all domains of perioperative practice	3.3.4
Teaching and training of students	3.3.5
Staff encouraged to contribute to learning displays	3.3.7

3.4 Perception of Evidence (3A)	
Comments	Code
Research to support practice	Due to the similarity of comments, a single code was allocated. 3.4.1
Searching for the best way to do things	
Reviewing a variety of research papers , not just one	
Looking around for best practice, systematic reviews, anecdotal evidence, experience	
Reviewing research papers Has to be tried, tested, validated and practiced	
Finding the best evidence and putting it into practice, must support practice	
Shopping around for best practice, critical appraisal of research	
Correct way of doing things, collective research for proof of effectiveness of practice	

3.5 Sources of Evidence (3A)	
Comments	Code
Research, opinion leaders	3.5.1
Experience/experiential learning	3.5.2
Observation	3.5.3
Guidelines, audits, Internet	3.5.4
Scientific trials	3.5.5

3.6 Use of Evidence (3A)	
Comments	Code
To review policy and procedures	3.6.1
To improve practice	3.6.2

3.7 Change in Practice (3A)	
Comments	Code
Unable to change due to being a junior Staff Nurse	3.7.1
Communication more effective	3.7.2
Update of practice based on evidence	3.7.3

3.8 Strategies to review practice (3A)	
Comments	Code
Personal reflection	3.8.1
Staff meetings as a forum discussion of practice	3.8.2
Audit	3.8.3

3.8 Strategies to review practice (3A)	
Comments	Code
Influence of more experienced staff	3.8.4
Informal discussions with colleagues	3.8.5

3.9 Examples of evidence used (3A)	
Comments	Code
Hand hygiene	3.9.1
Gown and gloving for surgery	3.9.2
Care of patients with latex allergy	3.9.3

Appendix 9: Coding of Participants' Comments

Descriptive Analysis of Participants' Comments – Individual Interviews

Table Set 1B: Professional Perspective

1.3 Why this area of Practice (1B)		
Original Comments	1st Stage Abstraction	Interpretation
Came to theatre by default due to staff shortages	Default not a conscious decision	Not a personal choice, organisational situation resulted in this placement specialty
Just love this area of nursing can't explain why	Enjoyable	Unable to explain the attraction to the specialty
Enjoys problem solving in the acute setting operating theatres facilitates this	Resolving difficulties	The nature and unpredictability of the perioperative environment
Felt this area of practice would facilitate a greater experience	Variety of experience	An avenue for career development eg role expansion /scope of practice within a multidisciplinary environment
Impressed by individuals working competently in this environment	Competent practitioners	Care enhanced through effective teamwork and respect for the contribution of individual team members
Learning opportunities were great within a multidisciplinary team	Development within a multidisciplinary team	Self actualisation/ personal development

1.4 On-going Professional Development and Education (1B)		
Original Comments	1st Stage Abstraction	Interpretation
On-going education is very important	Key role of education	Not only is ongoing education recognised by the participants as very important to respective personal development. They are ambitious and eager to achieve. Utilisation is made of the available resources.
Personal knowledge and development is very important to me	Key role of education	As responses of the participants to this sub theme were similar, it was felt that this interpretation would be appropriate for the comments made
Variety of Courses available	Good access to post registration courses	
Would like to achieve more	Ambitious	
Attends courses relevant to specialty	Attendance at Association Congress and study days	

Table Set 2B: Influences on Practice

2.1 Values, Beliefs, Feelings (2B)		
Comments	1st Stage Abstraction	Interpretation
Good rapport with colleagues in a multidisciplinary team	Good teamwork among the disciplines	The importance of collaborative working
Safety underpins care	Safe practice	Pivotal to care and its importance was highlighted at all times

2.1 Values, Beliefs, Feelings (2B)		
Comments	1st Stage Abstraction	Interpretation
Reflection on practice	Devising personal methods of reflection	How could this be improved to be more effective
Rationale must be present	Likes to know why things are done – theorist	Does not blindly accept ritualistic practices
Best care for all patients	Equality of care altruistic ethic	Maintaining good and safe standards of care at all times

2.2 Experience: Professional and non-professional, Internal and External Influences (2B)		
Comments	1st Stage Abstraction	Interpretation
Looking at how colleagues work, taking what are good aspects of care to improve my own	Influence of Role Models	Reflection on own work and critically analysing the practice of colleagues to enhance own
Individuals working competently together	Knowledge of different roles	The effectiveness of teamwork
Experience of dealing with the public before nurse training	Life skills	Using prior experiences and knowledge to effect care
Husband's encouragement; Challenge of the family to do well	Familial influence on-going	Family's ambition for achievement in career
Ability to influence change in practice	Experience, knowledge, competence	Seniority, established knowledge-base and self-confidence needed for this
Personal illness	Internalisation	Personal experience of illness influencing decision

2.3 Culture (2B)		
Comments	1st Stage Abstraction	Interpretation
Supportive of each other irrespective of position or role	Team cohesiveness	Respect and acknowledgement of individual contribution to care
Ability to discuss issues at any time	Good communication formally and informally	An effective working ethic opportunity given to staff to say what they think
Encouraging assertiveness among junior staff	Empowerment	Facilitating junior staff to see respective potential
Guiding colleagues to facilitate learning Guiding colleagues to fulfil their potential	Support, encouragement and development	Facilitating junior staff to see respective potential
Great learning environment	Importance of ongoing education	Common factor amongst the participants

2.4 Priority of Influence (2B)		
Comments	1st Stage Abstraction	Interpretation
These results been displayed in Table Set 1A . What it has shown is the individuality of the participants on the whole. The order of importance differed, nevertheless, with some similarities identified: e.g. Patient Safety recorded by Participants 3,5, and 9 as No 1.		

Table Set 3B: Actual Practice

3.1 Effects of Research (3B)		
Comments	1st Stage Abstraction	Interpretation
Medical staff changing their practice has influenced me to research mine (A)	Reflection on personal practice	Positive inter-professional influence
Finding information about a subject from reading a variety of articles to find the best available (A)	Appraising supporting evidence	Critically analysis of relevant articles
Aspects of research has exerted some influence, tend to research unfamiliar things (B)	Developing existing knowledge through research	Placing value of research

3.1 Effects of Research (3B)		
Comments	1st Stage Abstraction	Interpretation
Department needs a dedicated person to guide research, needs to be consistent	Skilled researcher for department to guide development of research skills	Ability to sustain and support this i relation to resources
There is a gradual progression in embracing research (A) Practice is research based (A) Perioperative practice not quite research-based (B) Current research is used to support policies and procedures (EA)	Mixed feelings about research use in Department between senior and junior staff	Mixed feelings about research use in Department between senior and junior staff
Use research to support argument, 'drummed into you during training' (B)	Sees research as integral to practice and on-going	Sees research as integral to practice and on-going

3.2 Knowledge Base of perioperative Practice (3B)		
Comments	1st Stage Abstraction	Interpretation
Experienced staff with a wealth of knowledge of perioperative care. Some are members of the Professional Organisation of the specialty	Experience Excellent knowledge base	Utilisation of knowledge for both enhancement and development of junior practice staff members
Staff newly-qualified and/or new to the specialty	Acquisition of knowledge through facilitation and guidance of experienced staff	Facilitation through preceptorship

3.3 Knowledge Update (3B)		
Comments	1st Stage Abstraction	Interpretation
Sharing of knowledge Internally through Trust/Departmental Audit / Education Days, this involved 'in house' presentations and demonstrations by medical devices representatives, Departmental meetings, Informal discussions (e.g. 1:1 discussions, discussions at coffee time)	Knowledge acquisition is on-going, existing knowledge built on and developed	A dynamic process
Externally through attendance at AfPP annual Congress, study days, relevant courses and visiting other operating departments of other hospitals.		
Self direction through reflection, reading relevant articles and texts and the internet	Knowledge built on and developed	Development of specialty knowledge base
Display of literature relevant to all domains of perioperative practice	Knowledge acquisition is on-going, existing knowledge built on and developed	A dynamic process
Teaching and training of students	Imparting existing knowledge gained	A dynamic process
Staff encouraged to contribute to learning displays	Facilitating the importance of ongoing knowledge base development	Valuing the contributions of each staff member to knowledge base

3.4 Perception of Evidence (3B)		
Comments	1st Stage Abstraction	Interpretation
Research to support practice	The common denominator of these	Limited knowledge base on the subject
Searching for the best way to do things		

3.4 Perception of Evidence (3B)		
Reviewing a variety of research papers , not just one	comments was research. Experience was also mentioned	
Looking around for best practice, systematic reviews, anecdotal evidence, experience		
Reviewing research papers Has to be tried, tested, validated and practiced		
Finding the best evidence and putting it into practice, must support practice		
Shopping around for best practice, critical appraisal of research		
Correct way of doing things, collective research for proof of effectiveness of practice		

3.5 Sources of Evidence (3B)		
3.6 Use of Evidence (3B)		
These were not analysed as described by Ritchie and Lewis (2003). The rationale here was that the responses of the participants were factual and no further interpretation was deemed necessary.		

3.7 Change in Practice (3B)		
Comments	1st Stage Abstraction	Interpretation
Unable to effect change due to being a junior Staff Nurse	Inexperience within the specialty	Combination of experience and possible lack of self-confidence
Update of practice based on evidence	Some areas of practice are utilising evidential support	Some areas of practice are utilising evidential support
More effective communication	Improvement in giving information	Information acted on, overall awareness heightened.

3.8 Strategies to Review Practice (3B)		
Comments	1st Stage Abstraction	Interpretation
Staff Meetings	Dissemination of information and a forum for discussion	Staff feel able to express opinions in a comfortable environment and feel empowered. Contributions respected and valued
How could I do this better	Reflections of personal actions	Enhancing and improving practice as necessary
Influence of more experienced staff	Use of role-models	Lasting effect of this influence to affect values, feelings and practice
Audit	Evaluation of practice	Feedback to staff, information given on the effectiveness of care and identify areas for improvement

3.9 Examples of Evidence (3B)		
Comments	1st Stage Abstraction	Interpretation
Hand Hygiene Gowning and Gloving Care of patients with Latex Allergy	Effect of evidence on practice	General compliance with findings of evidential support
How could I do this better	Reflections of personal actions	Enhancing and improving practice as necessary
Influence of more experienced staff	Use of role-models	Lasting effect of this influence to affect values, feelings and practice
Audit	Evaluation of practice	Feedback to staff, information given on the effectiveness of care and identify areas for improvement

Appendix 10: Observer's Notes – Focus Group

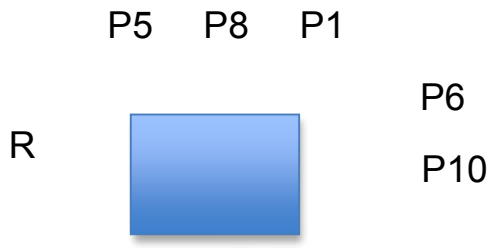
A transcription of the Observer's notes.

Focus Group 24.11.09

Start 6:15 p.m.

Finish 7:10 p.m.

Taped



- R = Researcher
- O = 1st Supervisor
- Observer 1st Supervisor
- Food & Drink @ start
- Grp seated around central low coffee table
- R uses flip charts & cards with themes printed on them
- R explains meeting & my purpose. Ground rules etc., confidentiality etc., permission for tape.
- Goes back to res. Question & reminds grp.
- Focus Group – check analysis – i.e. the categories need confirming, dis….. & challenging
- Asks people to take grps of cards.
- (BEFORE) – order them in hierarchy (before discussion)
    - (AFTER) – do it again after discussion.
- P1 – clarifies instructions
- R – gives out pens & explains no significance to coloured paper
- TAPE ON Everyone concentrating on task 6.25
- P1 – asks what influences getting your job done
- R – explains need to sort them in order
- P8 – what we experience in theatre?
- R – well what is important to you
- P8 – could some get same scores?

- R – yes
- All sorting cards out; R sorts blutac for next task – sticking cards on board
- Hierarchy BEFORE
- Goes without saying. Quality of care = a given; what we're here for.

1 Comm x 2 Culture x 2 Teamwork x 1
Leadership x 2 Q of C x 2

2 Ethical Principles x 2 Q of C x 1 Comm x 2
Teamwork x 2 Culture x 1

3 Evidence x 1 Leadership x 2 Ethical Principles x 1
Experience x 1 Teamwork x 2 Comm x 1
Education x 1

4 Leadership x 1 Research x 1 Experience x 3
Evidence x 1 Q of C x 1

5 Research x 1 Education x 3 Experience x 1
Culture x 1

6 Research x 1 Evidence x 1 Reflection x 1
Education x 1

7 Reflection x 1 Research x 2 Evidence x 1

8 Evidence x 1 Ethical Principles x 1 Nursing Culture x 1

9 Q of C x 1 Reflection x 2

10 Culture x 1

11 Ethical Principles x 1

- P1 – want to put reflection at end because it comes at end but that's not right.
- P6 – And research & evidence
- P1 – also says something – (listen to tape)
- R – explains culture = culture in Department

- R – Reminds everyone to write number on & use blutack to stick it.
    - 6.30 tasks ends and cards stuck up

- The discussion
- P6 – hard to prioritise
- P10 – hard to order
- Ideas
    - Lip service to research
    - Read little unless on course
    - Theatre – not much res. 'non-sexy area'
    - Hard to find good quality, relevant
    - Do with what we've always done
    - How do you find the time to find evidence
    - Usually pushed from on high
    - Top down and then we do it (e.g. WITO)
    - Not enough research-based evidence and is it good enough
    - Has to be in policy no – can't just change

General discussion suggests that leadership & communication are central to everything, & teamwork given that they work in teams. Even in the e-p era its in the low side. But it's a luxury.

Suggest that Drs may have done to research and know what's best – useful to transcribe this.

- P10 – describes nature of Drs training
- P1 – i.e. luxury
- P5 – need to persuade Drs about validity of evidence

- R – How would you define evidence?
- P1 – Benchmark/Guidance of Best Practice

- P6 – Doesn't have to be research

P6 – Balanced

Research & practice base

What prs want What works well research

Experience Qual Quan

- P8 – An analysis of what works & what doesn't
- Analysis = comparison – what works well in particular situations
- R – Weak area
- P6 – practice/research – what do you mean by evidence
- P10 asks questions – but people to back up practice with evidence (but perhaps don't notice this)
- P1 – I do try
- P10 – I think you do but don't notice it
- P8 – knew rational net just because Sister said do it?
- P1 – Culture changed – much more questioning need to provide evidence
- P6 – Need to provided best care so aware tact need evidence
- P1 – I'd crunch it up a bit more, not stretch to 11
- P1 – Says she's not making any changes
- P8 – ditto
- P5 – Ditto
- P10 – Changing
- P6 – Changing

Actually, many did change the position of their cards.

NB 2 of the participants know Supervisor's work has made a difference

AFTER

1 Communication x 1 Teamwork x 2 Q of C x 2
Leadership x 2 Culture x 2

2 Communication x 3 Teamwork x 1 Ethical Principles x 2
Culture x 1

3	Evidence x 1 Ethical Principles x 2	Teamwork x 1 Leadership x 2	Experience x 2 Education x 1
4	Leadership x 1 Research x 1	Experience x 1 Education x 1	Q of C x 1 Evidence x 1
5	Research x 1 Culture x 2	Experience x 1	Education x2
6	Education x 1 Research x 1	Reflection x 1 Evidence x 1	Q of C x 1
7	Reflection x 2	Research x 2	Evidence x q
8	Ethical Principles x 1	Evidence x 1	Ethical Principles x 1
9	Reflection x 2		
10			
11			

Some positions have changed. 10/11 reduced/left out

- R – What us coming out
- P10 – More influences from people in a paper
- P1 – We're all very similar in mind-set: talking to people with same priorities - practices
- P8 + P6 – team with same goal, but not all same – have own priorities, but reaching towards a common goal
- P5 – across wide age range but still a constant theme
- ?
- R – What is helping the cohesiveness of your team?

- P1 – Common good
- P8 – Teamwork
- P1 – People who aren't team players stand out like sore thumbs
- P10 – Also notice deficit if good team players not in

- R – Anything else that influences your practice?
- P8 – POLICY & PROCEDURES
- (xxxs of agreement)
- P5 – POLITICS (18w waits), possibly negative because of stress
- How does negativity influence practice?
- P5 – makes leadership more important
- P6 – if good leader people will follow
- P1 – style of leadership
- R – ROLE MODELS
- P – TARGETS maybe why Q of C is at the top (check on tape)
- P6 – PEOPLE ON OUTSIDE
- P10 – MEDIA
- P10 – RESOURCES

- R – Thanks everyone
- Ends 7.05

List of References

Al-Hashemi. J. (2007) 'The role of the advanced scrub practitioner,' *Journal of Perioperative Practice,* 17 (2) p 77.

Appleton, J.V. (2002) ' Critiquing approaches to case study design for a constructivist inquiry', *Qualitative Research Journal* 2 (2) pp 80 - 97.

Asbury, J. (1995) 'Overview of Focus Group Research,' *Qualitative Health Research, 5 (4) pp 414 - 420.*

Association for Perioperative Practice. *Standards and Recommendations for Safe Practice (2007).* Harrogate: Association for Perioperative Practice.

Association for Perioperative Practice. *Time Out Poster (2009).* Harrogate: Association for Perioperative Practice.

Barnum, B.S. (1996) *Spirituality in Nursing From Traditional to New Age.* New York: Springer Publishing Company Inc.

Barthow, C. Moss, C., McKinlay, E., McCullough, L. and Wise, D. (2008) To be involved or not: Factors that influence nurses' involvement in providing treatment decisional support in advanced cancer. Available at: http://www.ejoncologynursing.com/article/PIIS1462388908001270/fulltext/ (Accessed: 15 July 2010).

Basford, L. and Selvin, O. Editors (2003) Theory and Practice of Nursing An integrated approach to caring practice. 2nd edn. Cheltenham: Nelson Thornes.

Beasley, C. Department of Health (2010) *The Nursing Roadmap for Quality - A signposting map for nursing*. London: Department of Health.

Beyea, S. (2000) Why should perioperative RNs care about evidence-based practice? *American Operating Room Nurses Journal,* Vol 71 No 7 pp1-3.

Bhattacharyya, M. and Bradley, H. (2008) 'Intraoperative handling and wound healing of arthroscopic portal wounds,' *Journal of Perioperative Practice,* 18 (5), pp194 -198.

Bigsby, E. and Madhusudana, K. (2009) 'To catheterise or not to catheterise: A study in hip and knee primary arthroplasty,' *Journal of Perioperative Practice,* 19 (3), pp 114 - 116.

Bothamley, J. and Mardell, A. (2005) 'Preoperative fasting revisited', *The British Journal of Perioperative Nursing,* 15 (9) pp370 – 374.

Brown, J. and Gobbi, M. (2007) *Introduction to Professional Studies in Nursing* in Brown, J and Libberton, P (eds) Principles of Professional Studies in Nursing. Basingstoke: PALGRAVE MACMILLAN pp 3 – 24.

Burns, N. and Grove, S. (1997) The Practice of Nursing Research Conduct, critique and utilization 3rd edn. Pennsylvania: WH Saunders Company.

Burrows, D.E. (1996) 'Facilitation: a concept analysis', *Journal of Advanced Nursing,* 25 pp 396 - 404.

Cahill, J. (1996) 'Patient Participation: a concept analysis,' *Journal of Advanced Nursing* (24) pp 561 - 571.

Carper, B. (1978) 'Fundamental Patterns of Knowing In Nursing,' Advances in Nursing Science 1(1), pp 13-24.

Chambers 21st Century Dictionary (1999) Chambers Harrap Publishers Ltd p695.

Ciliska, D. and DiCenso, A. (1999) Centres of evidenced-based nursing: directions and challenges, *Evidence-Based Nursing,* 2 (4) p 102.

Cormack, D. Editor (2002) *The Research Process in Nursing* 4th edn. Oxford: Blackwell Publishing.

Craig, G. (1996) Qualitative research in an NHS setting: uses and dilemmas, *International Journal of Psychology and Psychotherapy,* 14 (3), pp180 – 186.

Crofts, L. (2002) 'The Context of Research in the NHS', in Tarling, M; Crofts, L Eds (2002) 2nd Edn. *The Essential Researcher's Handbook for Nurses and Health Care Professionals,* London, Harcourt Publishers.

Cronin, P. and Rawlings-Anderson, K. (2004) *Knowledge for Contemporary Nursing Practice,* London: Mosby.

Cullum, N., Ciliska, D., Haynes, R.B. and Marks, S. Editors (2008) *Evidence-Based Nursing – An Introduction.* Oxford: Blackwell Publishing Ltd.

Dearnley, C. (2005) 'A reflection on the use of semi-structured interviews', *Nurse Researcher* 13(1), pp 19-42.

Department of Health (1997) *The new NHS: modern and dependable.* London: Department of Health.

Department of Health (1998a) *A first class service: quality in the new NHS.* London: Department of Health.

Department of Health (2006) *Vision for Nursing 21st Century*. London: Department of Health

Department of Health. (2008b) *High Quality Care for All.* London: The Stationery Office.

Department of Health. (2009) High Quality Care For All – NHS Next Stage Review Final Report. London: Department of Health.

DiCenso, A. and Cullum, N. (1998) Implementing evidenced-based nursing: some misconceptions, *Evidenced-Based Nursing,* 1 (2) pp 38 – 40.

Foster – Turner, J. (2009) 'Focus Groups,' in Neale, J. (ed) *Research Methods for Health and Social Care.* Basingstoke: PALGRAVE MACMILLAN, pp 211 – 216

Free on-line Dictionary. "Influence" (2010). Available at http:/www.definitions.net/definitions/influence. (Accessed 13th September 2010).

Fyffe, T. (2009) ' Nursing shaping and influencing health and social care policy,' *Journal of Nursing Management 17 pp 698 - 706.*

Gerrish, K. and Lacey, A. Editors (2010) *The Research Process in Nursing.* Oxford: Wiley Blackwell.

Gibbs, A. (1997) 'Focus Groups'. *Social Research Update*, 19 p1.

Gray, M. (2009) Evidence-Based Health Care and Public Health, How to make decisions about health services and public health.3rd edn. Oxford: Churchill Livingstone.

Grbich, C. (1999) *Qualitative Research in Health,* London, SAGE Publications.

Griffiths, P. (2006) What does evidence-based practice mean? *Journal of Advanced Perioperative Care*, 2 (4), p 137 – 141.

Henneman, E.A., Lee, J.L. and Cohen, J.I. (1995) ' Collaboration: a concept analysis,' *Journal of Advanced Nursing,* 21 pp 103- 109.

Hodkinson, P. and Hodkinson, H. (2001) 'The Strengths and Limitations of Case Study Research'. In: Learning and Skills Development Agency Conference, *Making an Impact on Policy and Practice*. Cambridge, 5-7 December 2001. University of Leeds.

Holden, R. (1991) ' Responsibility and autonomous nursing practice,' *Journal of Advanced Nursing,* 16 (4) pp 398 - 403.

Holloway, I. and Wheeler, S. (2010) *Qualitative Research in Nursing and Healthcare* 3rd Edn. West Sussex: Wiley- Blackwell.

Hunt, G. and Wainwright, P. Editors (1994) *Expanding the Role of the Nurse.* London: Blackwell Science.

Johns, C. (2005) 'Constructing a Philosophy for Practice' in Johns, C. *Becoming a Reflective Practitioner*. Oxford: Blackwell Publishing pp 1-17.

Jolley, M. and Brykcznyska, G. Editors (1992) *Nursing Care The challenge to change.* Kent: Edward Arnold.

Jones, M. and Higgs, J. (2002) 'Will evidence-based practice take the reasoning out of practice?' in Jones, M. and Higgs, J Editors *Clinical Reasoning in the Health Professions.* 2nd edn. Oxford: Butterworth Heinmann pp 307 – 315.

Keegan-Doody, M. (2005) 'Walk or be driven', *The British Journal of Perioperative Nursing,* 15 (12), pp 529 – 536.

Kvale, S. (1996) Interviews - An introduction to qualitative research interviewing. California: SAGE Publications.

Lathlean, J. (2010) 'Qualitative Analysis', in Gerrish, K. and Lacey, A. (eds) *The Research Process in Nursing.* Oxford: Wiley Blackwell, pp 423 - 436.

Le May, A. (1999) '*Evidence-based practice',* NT monographs 1, London, NT books Emap Healthcare Ltd.

Lewis, J.J. Florence Nightingale Quotes (1820-1910). Available at: http://womenshistory.about.com/cs/quotes/a/qu_nightingale.htm. (Accessed 29 August 2012).

Lewsey, C. (2008) 'Newly-registered ODPs; what support do they receive?', *Journal of Perioperative Practice,* 18 (8) pp 430 – 345.

Lincoln, Y.S. and Guba, E.G. (1985) *Naturalistic Inquiry.* Beverley Hills CA: Sage.

Lloyd, H., Hancock, H. and Campbell, S. (2007) *Vital Notes for Nurses: Principles of Care.* Oxford: Blackwell Publishing Ltd.

Loftus-Hills, A., McInnes, L. and Richens, Y. (2003) 'Evidence-Based Practice' in Hinchcliff, S., Norman, S. and Schober, J. Editors *Nursing Practice and Health Care* 4th Edition. London: Arnold, p151.

Long, A.F. (2002) 'Foreword', in McSherry, R. Simmons, M. and Abbot, P. (eds) *Evidence-informed nursing: a guide for clinical nurses.* London: Routledge.

Maltby, J., Williams, G., McGarry, J. and Day, L. (2010) *Research Methods for Nursing and Health Care.* Essex: Pearson.

Masterson, A. and Cameron, A. (2002) ' The influence of professional and statutory bodies on decision-making,' in Young, P. and Cooke, M. Editors *Managing and Implementing Decisions in Health Care.* London: Harcourt Publishers Limited. pp28 – 29.

McAleavy, J. (2006) 'Operating department support Level 2 NVQ: Some perceptions,' *British Journal of Perioperative Practice,* 16 (9), pp 448 - 455.

McDonald, L. (2001) 'Florence Nightingale and the early origins of evidence-based nursing', *Evidence-Based Nursing,* 4 (3), pp 68-69.

McKenna, H. (1997) *Nursing Theories and Models.* London: Routledge.

McSherry, R. and Haddock, J (1999) '*Evidence-based health care: its place within clinical governance',* British Journal of Nursing, Vol 8 No 2 pp113-117.

Melnyk, B.M. and Fineout-Overholt, E (2005) *Evidence-Based Practice in Nursing & Healthcare, A guide to best practice*, Philadelphia, Lippincott Williams & Wilkins.

Menter, I., Elliot, D., Hulme, M., Lewin, J. and Lowden, K. (2011) *a guide to Practitioner Research in Education.* London: SAGE Publications Ltd.

Mitchell, G.J. (1997) Questioning Evidence-Based Practice for Nursing, *Nursing Science Quarterly,* 10, (4), pp 154 -155.

Mulhall, A. (1998) Nursing, research and the evidence, *Evidence-Based Nursing,* 1 (1).

National Patient Safety Agency. WHO Surgical Safety Checklist (2009). NHS National Patient Safety Agency.

Newell, R. and Burnard, P. (2003, 2006, 2008) *Vital Notes for Nurses Research for Evidenced – Based Practice.* Oxford: Blackwell Publishing.

NHS Institute for Innovation and Improvement. The Productive Operating Theatre (2009). NHS Institute for Innovation and Improvement.

NHS Scotland. (undated) *Advance Nursing Practice Toolkit.* Available at: http://www.advancedpractice.scot.nhs.uk/definitions/defining-advanced-practice.aspx (Accessed: 23 September 2012)

Nilsson, U., Unosson, U. and Kihlgren, M. (2006) 'Patients' experience of post operative recovery', *Journal of Advanced Perioperative Care,* 2 (3) pp 97 – 106.

North, N. (1996) 'Partnerships in care: the health and social care interface' in Moon, G. and Gillespie, R. Editors *Society and Health.* London: Routledge.

Nursing & Midwifery Council (2002, 2004, 2008) *Code of Professional Conduct, London,* Nursing & Midwifery Council.

Nursing & Midwifery Council (2010) *The Nursing and Midwifery Order 2010* (SI 2002/253).

Nursing & Midwifery Council. (2010) *Policy and Public Affairs.* Available at: http://www.nmc-uk.org/About-us/Policy-and-public affairs/Politics-and-parliament/ (Accessed: 13 September 2010).

Nursing & Midwifery Council. (2010) *Politics and Parliament.* Available at: http://www.nmc-uk.org/About-us/Policy-and-public affairs/Politics-and-parliament/ (Accessed: 13 September 2010).

Nursing & Midwifery Council. (2010) *Regulation of Advanced Nursing Practice.* Available at: http://www.nmc-uk.org/About-us/Policy-and-public affairs/Politics-and-parliament/ (Accessed: 14 September 2010).

Nursing and Midwifery Council, (2010) *Pre-registration Nursing Education in the UK,* Available at: http://www.standards.nmc-uk.ofg/PreRegNursing/statutory/Standards.aspx Accessed: (6th September 2010).

Nursing Theory. Patricia Benner. Available at: http://www.nursing-theory.org/nursing-theorists/Patricia-Benner.php (Accessed on 14th February 2012).

Parahoo, K. (2006) *Nursing Research Principles, Process and Issues.* 2nd edn. Basingstoke: PALGRAVE MCMILLAN.

Parsons, T. (1963) 'On the Concept of Influence,' *Public Opinion Quarterly, 27 (1) pp 37 - 62.*

Pearsall, J., Editor (2001) *The Oxford Dictionary of English*. Oxford: Oxford University Press. p936.

Pearson, A. (2003) 'Liberating your conceptualization of 'evidence'', *Journal of Advanced Nursing,* 44 (5) pp 441- 442.

Pearson, M. and Craig, J.V. (2005) 'Evidence-based Practice in Nursing' in Craig, J.V., Smyth, R.L. Editors (2005) *The Evidence-based Practice Manual for Nurses,* London, Churchill Livingston, pp 4- 20

Person, A. and Finch, L. (2009) *' Bedside Manner: Concept Analysis and Impact on Advanced Nursing Practice.* Available at: http://www.ispub.com/journal/the_internet_journal_of_advanced_nursi...anner_concept_analysis_and_impact_on_advanced_nursing_practice.html/ (Accessed: 17 January 2011).

Porter, S. (2002) 'Qualitative Research' in Cormack, D. (ed) *The Research Process in Nursing* 4th edn. Oxford: Blackwell Publishing pp 141- 151.

Prime Minister's Commission, (2010) *Front Line Care The Future of Nursing and Midwifery in England.* London: Prime Minister's Commission.

Reid, J. and Clarke, J. (2009) 'Progressing safer surgery', *Journal of Perioperative Practice,* 19 (10) pp 336 - 341.

Reynolds, S. (2003) 'The Anatomy of Evidence-Based Practice: Principles and Methods', in Trinder, L; Reynolds, S Eds (2003) *Evidence-Based Practice, A Critical Appraisal*, Oxford, Blackwell Publishing, pp 22-23.

Rice, P.L. and Ezzy, D. (2001) *Qualitative Research Methods, A Health Focus*, Singapore: Oxford University Press.

Ritchie, J., Spencer, L. and O'Connor, W. (2006) 'Carrying out Qualitative Analysis', in Ritchie, J. and Lewis, J. Eds (2006) *Qualitative Research Practice, A Guide for Social Science Students and Researchers,* London, SAGE Publications Ltd, pp 219 – 262.

Rodgers, B.L. (2005) Developing Nursing Knowledge Philosophical Traditions and Influences. Philadelphia: Lippincott Williams & Wilkins.

Roxburgh, M. and Gall, P. (2006) '*Fool's gold or real gold'*, Journal of Perioperative Practice, 16 (No 9) p 429.

Royal College of Nursing (2010) *Members Survey.* London: RCN Publishing Company.

Rycroft-Malone, J. (2006), *The Politics of the evidence-based practice movements: Legacies and current challenges,* Available at: (http://jrn.sagepub.com) (Accessed: April 8, 2010).

Sackett, D.L., Richardson, W.S., Rosenberg W. and Haynes, R.B. (2000) *Evidenced-based medicine: how to practice and teach EBM.* London: Churchill Livingstone.

Sandelowski, M. (1999) 'One is the Liveliest Number: The Case Orientation of Qualitative Research', *Research in Nursing* 19 pp 525-529.

Seedhouse, D. (2002) Practical Nursing Philosophy: The Universal Ethical Code. West Sussex: Wiley.

Selvin, E. (2003) 'Empirical Knowing: A Knowledge Base for Nursing Practice', in Basford, L. and Selvin, O. (eds.) Theory and Practice of Nursing An integrated approach to caring practice. 2nd edn. Cheltenham: Nelson Thornes, p182.

Sharp, K. (1998) 'The case for case studies in nursing research: the problem of generalization', *Journal of Advanced Nursing,* 27, pp 785-789.

Silverman, D. (2006) *Doing Qualitative Research.* 2nd edn. London: SAGE Publications Ltd.

Simons, H. (1988) 'The Ethics of Case Study Research', in Burgess, R. Eds (1988) *The Ethics of Social Research,* Lewes, Falmer Press.

Stacey, M. (1993) *The Sociology of Health and Healing.* London: Routledge.

Stake, R.E. (1995) *The Art of Case Study Research.* California: Sage Publications.

Svensson, M., Rosen, S. and Nilsson, U. (2006) 'Local warming to reduce pain on peripheral intravenous cannula insertion', *Journal of Advanced Perioperative Care,* 2 (3) pp 107 – 111.

Tanner, J., Blunsden, C. and Fakis, A. (2007) 'National survey of hand antisepsis practices', *Journal of Perioperative Practice,* 17 (1) 27 – 37.

Tanner, J. (2006) 'The naked researcher', *Journal of Perioperative Practice,*16 (8) pp 394 - 399.

Thompson, D., Editor (1995) *The Concise Oxford Dictionary* Oxford: Oxford University Press. p697.

Thompson, D.S., Moore, K.N. and Estabrooks, C.A. (2008) 'Increasing research use in nursing: implications for clinical educators and managers', *Evidence-Based Nursing,* 11 (2), pp 35 – 39.

Thompson, I.E., Melia, K.M., Boyd, K.M., Hosburgh, D. (2007) 'Corporate Ethics in Healthcare: Strategic Planning and Ethical Policy Development'. *Nursing Ethics* 5th Edn. pp260-291. Edinburgh: Churchill Livingstone.

Trinder, L; Reynolds, S (eds) (2003) *Evidence-Based Practice, A Critical Appraisal,* Oxford: Blackwell Publishing.

Turners, B.S., Editor (2006) *The Cambridge Dictionary of Sociology.* Cambridge: Cambridge University Press.

Wade, C. and Tavris, C. (1998) *Psychology.* United States of America: Addison Wesley Longman Inc.

Walker, L.O. and Avant, K.C. (1995). *Strategies for Theory Construction in Nursing* 3rd edn. Norwalk, Connecticut: Appleton and Large.

Weaving, P., Cox, F. and Milton, S. (2008) 'Infection prevention and control in the operating theatre: reducing the risk of surgical site infections', *Journal of Perioperative Practice,* 18 (5) pp199 – 204.

Wikipedia, the free encyclopaedia. "Groupthink". Available at http:/en.wikipedia.org/wiki/Groupthink. (Accesses 9th February 2012).

Wilkinson, J. and McDowall, J.P. (2003) 'Harm Reduction in Context - The Scope of Nursing Practice' in Milligan, F. and Robinson, K. (eds) *Limiting Harm in Health Care.* Oxford: Blackwell Science Ltd, pp 61 -78.

Xyrichis, A. and Ream, E. (2007) 'Teamwork: a concept analysis,' *Journal of Advanced Nursing,* 61 (2) pp 232 - 241.

Bibliography

Ellis, L.B. and Crookes, P. A.(2004) 'Philosophical and theoretical underpinnings of research' in Crookes, P.A. and Davies, S.(eds) *Research into practice*, *Essential Skills for Reading and Applying Research in Nursing and Healthcare* 2nd edn. London: Bailliere Tindall pp 51-67.

Finch, H; Lewis, J (2006) 'Focus Groups', in Ritchie, J; Lewis, J; Eds (2006) *Qualitative Research Practice, A guide for Social Science Students and Researchers*, London, SAGE Publications, pp 170-198.

Kvale, S. (1996) Interviews - An introduction to qualitative research interviewing. California: SAGE Publications.

Lewis, J. (2006) Design Issues, in Ritchie, J; Lewis, J; Eds (2006) *Qualitative Research Practice, A guide for Social Science Students and Researchers,* London, SAGE Publications Ltd, pp 47- 76.

Lipp, A. (2005) 'An evaluation of preoperative skin antisepsis', *The British Journal of Perioperative Nursing* 15 (1) pp 12 – 19.

Mackey, M.C. (2011) ' Evaluation of Qualitative Research', in Munhall, P.L. *Nursing Research, A Qualitative Perspective.* 5th Edn. Massachusetts: Jones & Bartlett Learning, pp 517 - 529.

Marshall, C. and Rossman, G.B. (2006) *Designing Qualitative Research* 4th Edn. California: Sage.

Meier, P. and Pugh, E.J. (1986) 'The Case Study: A Viable Approach to Clinical Research', *Research in Nursing and Health,* 9, pp 195-202.

Merton, R.K. and King, R. (1990) The Focused Interview: A Manual of Problems and Procedures. New York: NY Free Press.

Pontin, D. (2002) 'Interview', in Cormack, D. (ed) *The Research Process in Nursing* 4th edn. Oxford: Blackwell Publishing pp 290-297.

Pontin, D. (2002) 'Single Case Study', in Cormack, D. (ed) *The Research Process in Nursing* 4th edn. Oxford: Blackwell Publishing pp 238-246.

Porter, S. Carter, D.E. (2002) 'Common terms and concepts in research', in Cormack, D. (ed) *The Research Process in Nursing* 4th edn. Oxford: Blackwell Publishing pp 17 -28.

Punch, K.F. (1999) Introduction to Social Research Quantitative and Qualitative Approaches. London: Sage Publications.

Schwandt, T.A. (2001) *Dictionary of Qualitative Inquiry* 2nd Edn. California: Sage.

Spencer, L., Ritchie, J. and O'Connor, W. (2006) 'Analysis: Practices, Principles and Processes', in Ritchie, J; Lewis, J; Eds (2006) *Qualitative Research Practice, A Guide for Social Science Students and Researchers,* London, SAGE Publications Ltd, pp 199 – 218.

Tod, A. (2010) 'Interviewing' , in Gerrish, K; Lacey, A; (eds) *The Research Process in Nursing.* 6th Edn. Oxford: Wiley - Blackwell, pp 345 - 357.

Topping, A. (2010) ' The Quantitative - Qualitative Continuum', in Gerrish, K; Lacey, A; (eds) *The Research Process in Nursing.* 6th Edn. Oxford: Wiley - Blackwell, pp 129 - 141.

Yin, R.K. (2003) *Case Study Research Design and Methods.* 3rd edn. California: Sage Publications.