UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

Beyond Reflection: A Study of Contemporary Nursing Practice

Susan Schutz

Thesis for the degree of Doctor of Philosophy

May 2015

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ABSTRACT

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Using Casebook Ethnography, nine registered Adult Nurses were observed and interviewed to explore the ways in which they undertook their daily work and the place of reflection in that. The participants were employed in one of two units; a surgical breast care and an acute palliative care unit, both of which were in a large National Health Service trust hospital in central England.

Data collection was illuminated by the researcher's reflective journal. The data collected, rather than simply describing reflective practice, led to wider and more broadly focussed findings which, when analysed, generated one central theme - Communication, Interaction and Discourse and three linked associate themes - Being and Caring, Practical Action, and Knowing. These themes were considered in the light of the key literature around nursing practice and reflection. The findings point to a new understanding of contemporary nursing practice, which illustrates 'what our kind does', amongst the groups of participants in order to deliver patient-focussed care. This practice was directed towards working with colleagues who shared the same values and understandings, and who used these shared beliefs to adapt their practice to achieve individualised and exquisite care.

As they communicated and interacted with one another, the participants went about their work with attention to empathy and caring, articulated as a common humanity with their patients. They prioritised action where patient need was clear, and used a form of knowledge that was negotiated and validated within a community of practice. As they maintained a dialogue in their teams, the participants developed a sense of their professional identity and of who qualified as 'our kind'. The implications of this study are that a fuller understanding of how nurses work in contemporary practice will inform

the preparation and continuing professional development of nurses and the ways in which effective clinical leadership may be implemented.

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DECLARATION OF AUTHORSHIP

I, SUSAN ELIZABETH SCHUTZ

Declare that this thesis entitled

Beyond Reflection: A Study of Contemporary Nursing Practice

And the work presented in it is my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. 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;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given; With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. 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;
7. None of this work has been published before submission.

Signed:.....

Date:.....

Acknowledgements

I am greatly indebted to many who have supported, guided and challenged me over the years. Firstly my previous supervisors: Dr Mary Gobbi, Dr Lynda Rogers and Dr Debbie Craddock. My current and final supervisors Professors Judith Lathlean and Andree le May are thanked with all my heart for their inspiration, patience and hope; they kept faith with me when my own was waning.

I would also like to thank sincerely my colleagues at Oxford Brookes University Faculty of Health and Life Sciences for their support and for covering up my lapses in concentration, especially during the final phase of this study. In particular Helen Walthall, Sue Atkins and Chris Bulman.

I would like to acknowledge the help given by the nurses who participated in this study, their colleagues and their managers. They gave of their time and wisdom freely to me and patiently answered my questions.

Finally it would be remiss not to acknowledge the love and support of my family, my ever-patient husband John and my beautiful daughter Madeleine for so many years of love and understanding

Chapter 1: Introduction and Background

1.1 Introduction

At the start of this research journey I set out to explore reflective practice, which I believed was a useful approach to the construction and use of professional knowledge in the work context; one that had been influential in teaching, learning and in nursing over many years. The beginning stages of my research were built upon my own initial understanding of reflective practice, based on reading the work of Dewey (1933) and Schön (1983, 1987), together with my experience as a nurse and a lecturer in nursing. The organisation in which I am employed has made reflective practice a central part of how nurses are taught and assessed and undoubtedly this has had an influence on the value that I have placed on it. These understandings led me to believe that reflective practice might not only be discerned in the work of nurses but that it could be a plausible explanation of why and how they act in practice. However, during this research journey I realised my study had exposed something more than reflective practice: this thesis tells the story of this transformation.

1.2 The Study Journey

This study was initially designed to seek out the features of reflective practice in professional nursing. As a prelude to the study, I explored the literature on this topic in both nursing and other professional areas. Through a critique of what is already written about reflective practice, I identified what seemed to constitute the features of reflective practitioners and designed a research study that aimed to seek these out in a sample of professional nurses through the use of participant observation and in-depth face-to-face interviews.

Whilst searching for the skills and features of reflective practice remained an aim of the study during this time, it became clear during the data collection and analysis period that this was an over-simplification and that the data were

showing me a wider and more complex picture of contemporary nursing, about what nurses do and how they go about their work. What I was seeing and hearing could not be directly attributed to, or firmly located within, any current conceptualisations of reflective practice. Rather the findings of this study suggested a broader understanding of contemporary nursing of which reflective practice was but a part.

1.3 Research Question

This study, at its outset, sought to answer the following question: 'How is reflective practice demonstrated in the daily work of nurses in a National Health Service hospital?'

As I collected and analysed the data I began to see that the original research question was too narrow and contained assumptions that may have been unhelpful. The new perspective that became apparent at this time showed me that no one concept, however compelling, could be argued to explain the practice observed and about which the participants talked. The data were in part resonant of some of my previous understandings about reflective practice but they painted a picture that was of a more complex kind of nursing, placed within the context of contemporary health care. This new perspective therefore drove my final analysis of the data. This is reported from chapters 4 onwards.

1.4 Personal Experience

My personal interest in reflective practice stems from my career as a nurse and as a teacher in nursing. The ideas proposed by Schön (1983, 1987), although somewhat problematic in parts, have had an influence on me both as a teacher and as a professional nurse in changing the way I think about nursing practice. I have come to believe that nurses may use rather more informal knowledge or *practical wisdom* than they do formal, propositional knowledge and that in many situations this can lead to successful practice. What seems to be needed in this area is research undertaken in the real world of practice; this might

therefore provide a better understanding of reflective practice and its place alongside other explanations of what nurses do in practice.

1.5 Content of the Thesis

Chapter 2 of this thesis draws on the original literature in the field of reflection. The methodology and research design used to investigate the research question is described and justified in chapter 3 along with a detailed description of the methods of participant observation and in-depth interviewing. Chapter 4 reports the findings that marked the divergence from the original research aims. The discussion in chapter 5 explores these findings contextualising them in relevant literature and explicating the new knowledge derived from this work. Chapter 6 concludes the study by summarising the new insights lent by this study of contemporary nursing practice; in particular what nurses do and how they go about their work, centered around the notion of '*what our kind does'*.

Chapter 2: Literature Review

2.1 Introduction

This chapter identifies what is already known about reflection and reflective practice through both empirical research and discursive literature, in the light of the strengths and credibility of this body of evidence; it describes the process of searching for the relevant literature and the nature and value of what was found. The review of the literature began in 2004 and was continually added to and reviewed throughout the course of the study. Initially, only literature around reflective practice in nursing was explored, but it soon became clear that it would not be possible to understand the evidence in the area without consideration of the research and debate in other disciplines, although a largely United Kingdom (UK) research base was used. Recent evidence has developed reflective practice as a social activity, something that most professionals share (Hargreaves 2010) and so the aims of the literature review therefore were to identify and review primarily UK literature pertaining to reflective practice in nursing, allied professions and education as well as what might be deemed to be seminal texts or evidence outside of these boundaries.

Of the vast amount of literature that has been published about reflective practice in the professions, Sweet (2010) asserted that the majority has been concerned with individual retrospective reflection around events in practice that have caused concern or anxiety to the professional. For this reason, this review refers to literature that relates to reflection as well as that around reflective practice. One of the key problems with the literature reviewed for this study is that a large proportion of the empirical evidence relies on self-report methods and therefore embeds an introspective and subjective flavour to the data reported. Additionally, lecturers and teachers have undertaken much of this research with their own students and the influence of this relationship may be enough to call into question the findings of some of these

studies. This important point has been borne in mind when critiquing the literature cited in this chapter.

2.2 Approach to the Literature Review

The approach taken to the review of the literature was a narrative one (Aveyard 2010). However, a systematic method was used to identify the literature for inclusion in order to establish rigour; this is outlined below. The aim of this review was not, therefore, to construct a systematic or thematic analysis but to tell the story of the background literature that has been influential at all stages of the research process. Care has been taken to present as comprehensive a review as possible of the key sources.

Inclusion and exclusion criteria were used in order to focus the review, to limit the on-going search to a manageable size and to ensure that the key phases of publication were covered. This meant that the search included the wealth of literature published following Schön's seminal texts (1983, 1987) and that regular searching and alerts would provide the most recent literature. Databases periodically searched included: *Ovid*, *British Nursing Index*, *Cumulative Index of Nursing and Allied Health Literature*, *Medline*, *Web of Science*, *Education Research Complete*, *Physiotherapy Evidence Database* and *Social Care Online*. These sources were selected as being the most comprehensive and frequently updated databases containing literature relevant to both nursing and the allied health professions.

It was important to identify search terms that would reveal the pertinent literature and therefore the key words identified were: *reflective practice*, *reflection*, *nursing*, *health*, *teaching* and *professions* to which were applied Boolean operators and truncation in order to ensure that variants of these terms would be included in the results. 'Wild cards' were also applied, as was the facility that allows synonyms to be searched. In order to generate literature that would inform the wider concept of reflective practice, exclusions were

applied. Key terms for exclusion were *account*, *portfolio*, *diary*, *journal*, *model*, *clinical supervision* and *assessment*. The justification for this decision was based on the need to restrict the literature reviewed to a clear focus on nursing practice and to keep to a manageable size. The literature that met the search criteria was exported to the bibliographic management software package EndNote.

The result of the search was extensive; this included qualitative and quantitative research reports, journal editorials, evaluative papers, critical literature reviews and descriptive accounts of the use of reflection and the implementation of reflective practice. From this, secondary citations were sought from reference lists in order to access wider sources and to pursue the publications of experts in the area. A Zetoc Alert was set up in order to receive any new publications on the topic and receive the contents lists of twenty key journals by e-mail. A search of the World Wide Web using the search engine Google and its application Google Scholar produced previously unknown sources of information such as reviews, teaching resources and summaries, which were of background use.

The researcher needs to ensure that literature reviewed is critically appraised for relative value, in particular in terms of the methodological strengths (Aveyard 2010). The primary tool used for the critique of the literature was the Critical Review Form – Qualitative Studies version 2.0, published by McMaster University (Letts *et al* 2007) for qualitative research studies, since this formed the bulk of the empirical work. The small number of quantitative studies and literature reviews were appraised for quality using the relevant version of this tool. To review non-research publications (such as scholarly debate and evaluation), the framework developed by Wallace and Wray (2012) was used. The structure of this chapter is based on the nature and content of the literature retrieved.

2.3 The Nature of Reflective Practice

This section draws on literature to describe the evaluation of reflection and reflective practice in the professions. As Bulman (2013) has pointed out, it is probably unrealistic to expect one universal definition to illuminate such difficult concepts, but it is important in the context of this review to note the close relationship between the use of the terms reflection and reflective practice, which may be argued to have held back development of these concepts in nursing.

Gustafsson *et al's* (2007) meta-study synthesis of qualitative research on reflective practice did not identify problems with a lack of definition of reflective practice, but it did show that assumptions about reflective practice tended to be based on what was known about it from relevant theory rather than from empirical research conducted in a clinical context. Gustafsson *et al's* (2007) study, based on a design that aimed to provide a dynamic method for interpreting existing data, was well constructed and reported. Gustafsson *et al*. (2007:156) concluded by describing reflective practice as:

> *'Pre-, present and retrospective meta-cognition triggered by emotions involved in clinical nursing.'*

This was not offered as a definition, but it does encompass many of the fundamental aspects that have previously marked the evolution of the notion of reflective practice, including the timing of when reflection is done and the presence of an emotional reaction, also noted by Atkins and Murphy (1993). Concepts that were closely related to reflective practice by Gustafsson *et al* (2007) included reflective techniques, reflection-on-action, critical thinking and critical reasoning.

Retrospective reflection on practice can be defined from the literature reviewed as the use of experience along with both formal and informal sources of

understanding, to create a new way of looking at a practice problem after the event. Reflective *practice* is a term that has become somewhat synonymous with retrospective reflection but is more usefully taken to mean the use of reflection in the *immediate context* of daily professional life (Eraut 1995). Using reflection to make sense of and learn from, professional practice has become embedded in many professional fields in the United Kingdom (UK), including in teaching and in health care. In these fields, reflection has been used to help professionals learn from their experiences, and to use this learning to improve practice. Many health professions have taken on the notions of reflection and reflective practice eagerly so that the teaching of the skills for reflection has become embedded in many UK education and training establishments for health and social care professionals. The aim of these initiatives has been to create practitioners who use reflective practice in their work. Additionally, teachers in these organisations have been encouraged to use reflection and reflective practice in their own development. This has engendered an enduring interest in these concepts and how they may be utilised in preparing health and social care professionals.

Atkins and Murphy (1993) defined reflection as a combination of individual cognitive and affective elements, leading to a changed perspective and new action. This was largely congruent with Mesirow (1981) and Boud *et al*. (1985) who had previously cited this affective element. In earlier conceptualisations these emotions were usually identified as a negative experience leading to retrospective reflection. Whilst Atkins and Murphy also cited critical analysis as a skill for reflective practice, James and Clarke (1994), Brookfield (1993), and Johns (1995) defined this as critical *thinking*. This, they argued, is associated with higher-order abilities in individuals and is the source of a form of knowledge that is socially constructed (Barnett 1997). The critical consideration of one's own assumptions and values (and those of others) would therefore be an accepted part of the day-to-day interaction that reflective practitioners have in their practice.

Dewey (1933) was a particular influence on the evolution of reflective practice because he explored the notion of reflective thinking and action. Dewey (1933) wrote for educationalists, and the influence of his work is evident in contemporary understandings of reflective practice. Dewey's ideas drew on the early philosophers such as Plato, referring to the tentative nature of knowledge, in particular knowledge born of belief or opinion. Dewey saw reflective thinking as a habit that led from thought to belief, from belief to reflection and from reflection to action and his original definition still has a strong resonance for these ways in which reflective practice centres on action:

'Active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends' (Dewey 1933:6)

Dewey's ideas foreshadowed those of Schön (1983) perhaps more than the latter acknowledged and he embedded the key feature of critical thinking into reflective practice. Dewey (1933) sought to exclude the assumptions and values that an individual may hold from this activity, and at this stage the literature around reflection and reflective practice has in the past mirrored this traditional stance.

Schön (1983) argued that the professions have struggled with the tension between traditional, tried-and-tested sources of knowledge and understanding that have been in customary use over decades and a more constructivist paradigm of understanding. These ways arose from the emergence of hermeneutic and phenomenological thought in nineteenth century Europe, represented in the work of Husserl, Heidegger and others. The emergence of alternative ways of generating knowledge stimulated Schön, whose PhD thesis was based on Dewey's notions of reflective thinking, to propose a more artistic paradigm of professional practice.

The work of Schön (1983 and 1987) influenced the introduction and development of reflective practice in the health and social care professions and

is, in particular, responsible for the original impetus to introduce reflection into nurse preparation. This early up-take in nursing was due to the fact that Schön (1983) argued that the traditional ways in which professionals create and use knowledge from technical-rational sources are not adequate for the complex problems that professionals face in day-to-day practice. These troublesome areas of practice are familiar to nurses who work in an unpredictable and dynamic context. Schön (1983) proposed a new epistemology of how knowledge for practice is gained from practice, through the use of on the spot reflection. He proposed that professionals largely learn from practice by reflecting in the midst of action:

'In each instance, the practitioner allows himself to experience surprise, puzzlement or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him and on the prior understandings, which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomena and a change in the situation.' (Schön 1983:68)

To Schön (1983), technical rationality as the dominant source of knowledge led to instrumental ways of solving problems in practice using traditional scientific theory to guide action. This, he argued, side-lined the roles of art and intuition in professional practice. Schön's (1983) proposition was that technical rationality was an inheritance of positivism where the art or craft of a profession had little or no value. This, he claimed, created a tension between the *rigour* of understandings gained through technical rationality and their *relevance*; the epistemology of technical rationality being clear and logical but the relevance to uncertainty in practice being poor. Schön (1983) posed two possible means of generating understanding that would help professionals to solve these troublesome practice problems: retrospective *reflection-on-action* and situated *reflection-in-action*.

Schön's (1983) original thesis was very much centred on immediate, on the spot reflective practice rather than simple retrospective reflection. But while

the idea of knowledge generation by reflection-on-action has been generally well accepted in the literature, the notion that a professional practitioner could weigh possible solutions, try them out and adjust actions in the light of their considerations, all within the immediate moment, have been severely criticised (see Clinton 1998). Schön's arguably contradictory thesis has not been helpful in gaining any credibility for reflection-in-action and some authors dismiss it as an implausible theory. Clinton (1998) argued that without any practical reasoning, immediate, on the spot reflection cannot occur and if there is deliberation of this kind taking place then the practitioner is using retrospective reflection. Schön himself was unclear in his publications about the specific nature of reflection-in-action in that he at times talked of it as intuitive and at others as a deliberation. From the earliest published literature on reflective practice in nursing, the tension between these notions has been evident (Atkins and Murphy 1993). The consequence of this is that the operationalisation of the term *reflective practice* has come to be that of post hoc reflection or reflection-on-action and few authors have questioned this.

Atkins and Murphy's (1993) early review of the literature on reflection identified problems with defining and clarifying reflective practice, and indeed debate remains around the language that may be used to discuss this topic. James and Clarke (1994) however, argued *against* rigid common definitions of reflective practice in nursing, due to the influence of the context of practice within which reflection might be used. Despite some commonality, a lack of consequent agreement about the nature of reflective practice was evident in the literature reviewed, as were some possible misconceptualisations including those of Carr (1996) and Burton (2000). Of these, Carr (1996) included a wide range of educational activities in what was meant by reflection, whilst Burton (2000) criticised the move towards reflective practice in education for a lack of testing of the theories involved.

The conceptual blurring between reflection and reflective practice in the literature led me to make a distinction for the purposes of this review between reflection and reflective practice:

> Reflection *is a purposeful activity that is a retrospective process of reviewing practice in order to describe, analyse and evaluate it for the purpose of learning about that practice.*
>
> Reflective practice *is the use of a range of affective and cognitive abilities in the context of immediate professional practice, to address uncertainty and challenges in practice. It is a way of going about practice that is different from that traditionally established by utilising personal knowledge gained from practice as well as technical - rational knowledge whilst going about ones work.*

Conceptualisations of reflection and reflective practice are largely based on a sense that a reflective practice is active and purposeful (Dewey 1933), challenges values and beliefs (Boyd and Fales 1983), embraces emotions (Boud *et al* 1985) and takes a broad view of what knowledge for professional practice consists of (Schön 1987). It is important to note that whilst Schön's thesis was that reflective practice creates a particular type of knowledge from experience, he did not reject the value of traditional natural science understandings. Thus in the professions, any agreed definition of reflective practice would need to include both perspectives.

The major concern with reflective practice in nursing has perhaps been around concerns about professional knowledge. Schön's (1983) key thesis was that there existed a crisis in how professional knowledge is constructed and he formulated his ideas on this basis. This clearly struck a chord of familiarity with certain professions that took this up with great energy. In nursing, this engendered a large volume of publications debating how and why reflective practice might help to solve some of the perceived problems of the time. Jarvis (1992) published an early debate about these issues where he differentiated

between *thoughtful practice* and *reflective practice*. Jarvis suggested that one of the key problems in nursing was the tendency of the nurse to take practice for granted. According to Jarvis (1992), the best way to avoid this is for practitioners to see patients and clients as individuals. Whilst this was not by any means a new idea, the failure of initiatives such as the nursing process and nursing models to have the influence in the UK that they had engendered in North America had left a void that needed filling (Heath 1998a).

Heath (1998a), taking a pragmatic stance, warned that reflective practice could become as much an historical artefact as nursing models and the nursing process if a clearer explication of the shared understandings of it could not be established. Heath (1998a) saw reflective practice as being about two basic issues: the uncovering of experience and the development of expertise. In the light of other later literature (for example, Kinsella, 2009) this argument appears to be rather simplistic, but it does address some of the more negative polemic that was published at around the same time by authors including Darbyshire (1993), Hulatt (1995) and Burton (2000). Each of these authors raised serious concerns that were widespread during the 1990s and early 2000s, although particular interests sometimes influenced the debate on both sides of the argument. This debate around the nature of reflective practice makes for confusing reading and it is hardly surprising that the notion remains a contested one. What can be concluded at this stage is that there are polarised views about this topic but that the origins of reflective thinking lie with educational and philosophical thought.

2.4 Research and Enquiry in Reflection and Reflective Practice

The nursing profession has eagerly taken up the notions of reflection and reflective practice, and authors such as Johns (2007, 2008, 2011), Driscoll (2007), Jasper (2003), Rolfe (2002) and Freshwater (2002) have written extensively on the potential for reflective practice to enhance nursing, although differences in understandings about reflective practice have been

prevalent from the outset (as Atkins and Murphy's (1993) literature review showed). The use of various reflective techniques to encourage students and qualified nurses to explore their practice, values and beliefs have been widespread and has been assumed to embed reflective *practice* in an undefined way. In the health and social care professions, the preponderance of the research literature largely relates to retrospective reflection on practice in nursing, medicine (Mann *et al* 2007), Gordon and MacLeod 2009) and social work (Ruch 2007), although there is also evidence of an interest in allied professions such as physiotherapy (Clouder 2000 a and b). In medicine, there has been an increasing belief that reflection and reflective practice are useful tools by which to explore complex clinical problems (Mamede *et al* 2007).

The need to find an explanation for how professional knowledge is generated in nursing has inspired a great deal of the literature around reflective practice. The notion that reflective practitioners use *personal* sources of knowledge is embedded in the work of Schön (1983), who asserted that professionals have a *knowing-in-action* that is transformed into *knowledge-in-action* through the process of reflection. The idea that an individual may have a personal way of understanding or knowing is not new; it was a feature of the work of Polanyi (1958), a significant influence on Schön (1983). This *tacit* knowledge, as Polanyi described it, is characterised by an intuitive and unconscious understanding that *'exceeds the powers of articulation'* (Polanyi 1958:92), thus making it difficult to uncover. This would seem to pose a challenge for researching reflective practice in professionals, but Clouder (2000a) suggested that the fact that this kind of knowledge is based in and arises from practice, may aid the researcher in uncovering it because practice provides a strong starting point.

Whilst tacit knowledge seems to play a part in reflective practice, Gobbi (2005) explored how nurses use intuition through a powerful small-scale study using participant observation and discourse. Following her interaction with four nurses, Gobbi argued that the *bricoleur* tries to use whatever is at hand to

solve a particular problem and that this sometimes involves *'a skilled utilisation of a variety of compatible knowledge sources, tools and evidence'* (Gobbi 2005:123) and that may embrace tacit or intuitive sources of understanding. Similarly, Heath (1998b) viewed reflective practice as being predicated on various ways of knowing, including those derived from experience and from empirical knowledge. However, Gobbi (2005) showed credibly through her in-depth work with nurses that they use not only a wide variety of sources, but more specifically they also use *'shards and fragments of the situation at hand'* (Gobbi 2005:117), and that these produce *'cobbled together action'* (Gobbi 2005:123). Thus, not only might a reflective practitioner be using knowledge from a variety of disciplines, but also in certain situations she/he may be using understanding gained from grey, intuitive and perhaps even questionable sources.

According to Kinsella (2009) the essence of reflective practice is as a constructivist concept and she argued that this philosophy is crucial in order to understand professional knowledge and practice. Using the work of four key philosophers, Dewey (1933), Polanyi (1958), Goodman (1984) and Ryle (1945), Kinsella (2009) asserted that Schön's key argument was about the problems that arise from a technical-rational approach to practice rather than promoting his notion of reflective practice:

> *'Reflective practice posits attention to an epistemology of practice that attends to the knowledge professionals generate through reflection-in and reflection-on professional practice.' (Kinsella 2009:6)*

Kinsella's (2009) argument in this paper was that the very nature of reflective practice means that it cannot sit comfortably within any other paradigm or world-view than that of constructivism. Kinsella suggested that professionals in nursing have been in a state similar to that of denial, whereby they have been more concerned with the 'how' than the 'what' and have therefore not addressed what reflective practice is before trying to use it. Describing reflective practice as dialectic, Kinsella emphasised the importance of the

epistemology of reflective practice, that is, how it may be useful to generate new knowledge for practice.

Silva *et al*. (1995) however, had previously argued that nursing had moved from epistemological concerns to those of the ontology of nursing knowledge and practice. These authors argued that the philosophical basis of nursing knowledge has not been explored in terms of a *'science-art view'* of nursing (Silva *et al*. 1995:1). The notion that nursing is both a science and an art is congruent with the idea of reflective practice in that Schön (1983) argued for more prominence to be given to the artistic nature of professional practice. Silva *et al*. (1985) proposed a view of nursing knowledge that embraced lateral thinking; this they described as the '*in between'* and the *'beyond'.* This paper was found to one of a number that began at this stage to consider reflective practice from an ontological as well as an epistemological perspective.

Whilst this philosophical argument went on, research on reflective practice in nursing education concentrated on the *how* of reflective practice rather than the *why*. Although Atkins and Murphy's (1993) review of the literature around reflection could not be claimed to be systematic in contemporary terms, it has become seminal in teaching nurses about the skills for reflection and is embedded in definitions of reflection (Reid 1993). Atkins and Murphy (1993) reviewed the literature that was available at the time, focussing on the implications of reflection for nursing education. Placed in the early days of what Greenwood (1998) went on to call *reflective madness*, this review began by defining reflection and provided a critical consideration of the key publications proposing a framework of skills for reflection. Atkins and Murphy concluded that reflection consisted of three stages: *awareness of uncomfortable thoughts*, *critical analysis of a situation*, and a consequent *new understanding*. They also identified what they claimed to be the key skills for reflection: *self-awareness*, *description*, *analysis, synthesis* and *evaluation*.

There have been some further attempts to construct reviews of literature on reflective practice. Ruth-Sahd's (2003) review of research evidence in reflective practice showed that little more could be considered to have added to the evidence base. Ruth-Sahd aimed to maintain a focus on empirical literature whilst giving a few new insights into reflective practice but she did identify some common themes and their implications for nursing education. Ruth-Sahd was able to base her review on a wider range of background literature and later publications than Atkins and Murphy had access to but Ruth-Sahd's 2003 review has not had a similar impact. This may be due to the slower rate of publication that marked the early 2000s and the preponderance of research that was both qualitative and of a self-report nature, from which it is difficult to generalise. Similarly, Duffy's (2007) review, designed as a concept analysis, failed to clarify reflective practice because the model case presented was of retrospective reflection-on-action only and it lacked further consideration of the more qualitative elements of reflective practice. However, a useful set of critical attributes of reflective practice were asserted by Duffy, including reflexivity and what she termed an *'active and deliberate constructive process'* (p.1402), although it is not clear how this was linked to the study findings.

Educationalists and philosophers took up the notions of reflection and reflective practice that Dewey had posited. Boyd and Fales (1983), Boud *et al* (1985), Eraut (1995) and others developed the idea of learning through experience using reflection, building on the work of Mesirow (1981), Goodman (1984), Kolb (1984), Habermas (1987), van Manen (1995) and others. In the ways in which reflection has been argued to aid learning, the Experiential Learning Cycle (Kolb 1984) has been central. Kolb's description of the way adults learn has influenced the development of frameworks and models for reflection and reflective practice developed by Gibbs and Britain (1988) and later Driscoll (1994) and Johns (1995).

Authors in teacher education have also had a great interest in enquiry around reflection (Newman 1999), and consider reflective practice to be a

distinguishing feature of their profession (Gilroy 1993). The great interest of the teaching profession in reflective practice is understandable because the essence of Schön's theories about reflection-in-action and reflection-on-action were based on his assertion that this was a new epistemology of practice (Gilroy 1993). Much of the debate has centred on reflection-in-action, which was the most difficult and controversial of Schön's ideas (Eraut 1995) yet was perhaps the most relevant to discussions about reflective *practice*.

The overriding concern in the educational literature reviewed was the claim by Schön (1983) that he had proposed a new epistemology. This epistemology was, Schön suggested, able to answer the *learning paradox* first posed by Plato of how professionals come to know explicitly what they know implicitly and, in particular, how the tacit elements of professional practice constitute a form of knowing in their own right. As Gilroy (1993) emphasised, there are many ways to answer this paradox, but few have been asserted as alternatives to Schön's thesis because authors have been more concerned with understanding his ideas than their critique. Schön (1983) gave exemplars of his theories; vignettes of professional practice and professional education that he asserted demonstrated the veracity of his ideas. However, Schön (1983) did not explicitly justify his thesis because he argued that the exemplars he gave spoke for themselves.

For Gilroy (1993) and Eraut (1995) this lack of justification was a fatal flaw, and both proposed alternative epistemological solutions to the learning paradox orientated around the context of practice. Schön (1987) proposed an explanation of how new professionals learn from experts through reflection-in-action, but failed to make explicit how it is that knowledge is transferred from the expert to the novice. Challenging this, Gilroy (1993) asserted that Schön's (1983) epistemology was not new at all and that the learning paradox could be solved by the application of Wittgenstein's theory of *Language Games*. Gilroy (1993) argued that Wittgenstein's ideas enabled the structuring of knowledge so that a novice, who had some familiarity with a profession (in this case,

teaching) before entry, simply needed to be socialised into practice. Thus the novice was not considered to need knowledge as such, but they did need to know 'how to play the game'. Although Gilroy acknowledged the need for a novice to 'learn how to learn', the main message of this critique conveyed a danger that such socialisation may result in the acquisition of habituated and uncritical practice.

Newman's (1999) discussion paper followed up Gilroy's (1993) critique, emphasising that it was not the *following* of the rule that accounted for how novices learn, but the *action* of following and the *attitude towards* this action. Newman (1999) asserted that people in a profession tend to understand one another, but that this was not reflective practice as Schön (1987) suggested through his case examples; rather, it was an everyday fact of life. Newman (1999) then went on to suggest alternative terms for reflection-in-action, such as 'critical practice' and 'practical philosophy', which he asserted might be more acceptable in practice. Newman reframed Gilroy's (1993) ideas, but the argument remained unsuitable for the purposes of a practice such as nursing where the practice is dynamic and involves patient safety.

Both Eraut (1995) and Gilroy (1993) saw reflective practice as operating on a continuum of speeds, with Schön's two components, reflection-in-action and reflection-on-action occurring at intervals during a sequence of events. Eraut (1995) suggested using the prepositions of Schön's (1983) two types of reflection as: in the term *reflection-on-action*, '*on*' would be taken to mean the *focus* of reflection and within the term *reflection-in-action*, '*in*' would be taken to mean the *context* of reflection. Eraut questioned why it was that Schön focussed on unique and puzzling practical problems rather than the everyday issues in professional practice. It is true that Schön gave primacy to this aspect of practice, but this may be because these were the best examples of where reflective practice could be demonstrated, thereby enhancing his propositions. Whereas Gilroy (1993) saw the problems with these theories as solvable by a logical approach, Eraut's (1995) scholarly argument was more cognisant of the

messy contextual problems that are the distinguishing features of professional practice, in particular the pressures of time and resources.

The reframing of reflective practice proposed by Eraut (1995) would then remove the differentiation between the proposed chronology of Schön's retrospective reflection-on-action and in the moment reflection-in-action. If reflection-in-action is viewed in the way that Eraut (1995) proposed, then it may be a more accessible way of describing what professionals do in real-life practice situations and how they learn from their actions. Reflection-in-action can then occur in the situation at hand, with reflection-on-action occurring immediately afterwards, feeding into timely further action. Eraut (1995) was able to show how reflection-in-action, as a component of the wider concept of reflective practice, may be a realistic way of understanding Schön's ideas about how knowing-in-action may become knowledge-in-action in daily nursing practice by proposing a more realistic explanation.

A key aspect of the development of ideas about reflective practice has come from the work of Brookfield (1995) and also of Barnett (1997) who developed the notion of *critical reflection*. Barnett's notion of *critical being* is much more about the day-to-day professional practice context than it is about retrospective critical reflection. Critical reflection was defined by Brookfield (1995) as a process of identifying, scrutinising and transforming one's assumptions that is best achieved through sharing experiences (Mesirow 1981). Hargreaves (2010) and Boud (2010) have discussed how the general notion of reflection has come to be 'stuck' in a definition that is both individual and largely personal. Both argue that this has meant that some re-thinking about the notion in terms of work and social groups has had to occur. This is not entirely new (see Platzer *et al*. 2000b) and this focus on the power of group reflective practices to facilitate change has taken progressively greater hold in both educational and work environments (Hargreaves 2010).

While this debate was on going, researchers in nursing were attempting to build an empirical base for reflective practice. Largely, this was not successful due to the lack of clarification of the concept and confusion between retrospective and immediate or on the spot reflection. As an example, there were several problems with an otherwise promising and early research study reported by Powell (1989). The small number of participants (n = 8), their diversity in work settings, the fact that their practice was observed for very short periods (two hours) and of Powell's acknowledgement of a prior educational relationship with the participants, all affected the methodological strength of this study. The dependability of Powell's findings was also limited by claims that do not appear to relate directly to the reported data. However, the findings did suggest that reflective practice might have the potential to influence nursing practice as well as professional development and formal nursing education

One of the most prolific writers about reflection and reflective practice in nursing at this time and over later years was Christopher Johns. Johns wrote in his early publications about the benefits that he saw from the use of reflection and focussed very much on retrospective reflection through the use of guided reflection and clinical supervision with individual nurses over lengthy periods of time. A review of John's early work (1995, 1996) reveals that one of the major problems with his conceptualisation of reflective practice at that time was a *pervasive positivism* that caused him to see reflective practice as an abstract activity that occurs separated from the actual context of practice. This was demonstrated by an embedded reliance on realism and objectivism in Johns' early work that may have been due to the era in which he was originally writing, that is when the basis of nursing knowledge remained predicated on what might be termed the 'scientific' approach. Johns included a large number of related ideas in his early writing (see Johns 1995, 1996) and often resorted to polemic but he was not alone in this and his work has perhaps inspired a generation of nurses who would call themselves reflective practitioners. Additionally, the influence of his ability to relate reflective practice to a wide variety of well-respected theories in nursing helped to give a clearer view of

what reflective practice might promise. John's original *Model of Guided Reflection* (2011) has undergone several revisions and remains a popular tool for teaching and doing reflection, claiming an emancipatory role for reflective nursing practice.

Such emancipatory claims for reflective practice can be traced back through time as Taylor (2004)'s debate paper showed, using the work of Habermas (1987) to construct three critical dimensions for reflective practice: *technical, practical* and *emancipatory* reflection. Whilst Taylor used the term *reflection*, indicating retrospective reflection, her arguments were related very closely to daily nursing practice and were argued contextually. Technical reflection included using technical and empirical rules or knowledge for nursing work; practical reflection was posited as reflective interaction and communication and emancipatory reflection as the reflective use of power to transform practice. Congruence with Taylor's (2004) domains was also found in Heath (1998a), Platzer *et al*. (2000b) and Gustafsson and Fagerberg (2004), this higher level of reflective practice is reminiscent of the work of many others including Mesirow (1981) and Goodman (1984). This resonance perhaps sums up the history of research and enquiry around reflective practice in that the areas of conflict arise again and again and that concern has been very much with the how, that is the implementation and use of reflection, rather than what it is and what use it might be.

2.5 How Reflective Practice Has Been Utilised

Reflection, as a structured, retrospective process or a cycle of description and analysis leading to the generation of new perspectives, has become a widely espoused approach to education, professional development and practice development in nursing (Ruth-Sahd 2003). UK and North American research in this area includes educational initiatives by McCaugherty (1991), Astor *et al* (1998), Fonteyn and Cahill (1998), Jasper (1999) and Duke and Appleton (2000). These initiatives were designed as educational research and with the exception of Duke and Appleton (2000), explored the self-reported effects of

using reflection in educational courses. Duke and Appleton's (2000) study took a quantitative approach to the analysis of students' written reflection on a postgraduate palliative care course and showed how reflective skills may be developed over time. The influence of reflective practice has thus been greatest in education and this is reflected in nursing education where it may have been a response to the move of nurse preparation into Higher Education.

Following this move, nurse training and the preparation of nurse teachers has taken place in universities with nursing students being absorbed into the university student body and nurse teachers becoming university lecturers. Academic university teachers have been expected to establish a research and scholarly role and this transition has posed challenges (Higher Education Academy 2009). However, this may have provided an opportunity for new nurse lecturers to explore the role and use of reflection and reflective practice, thereby expanding the literature base and clarifying the concepts involved (Nelson 2012).

Some authors have criticised the use of reflection in nurse education (see Hulatt 1995; Greenwood 1998), mostly on the grounds of the lack of an empirical basis and a somewhat rushed introduction into teaching programmes. Other writers have warned that reflective practice may just be the latest 'fad' (Heath 1998a), or that it may be based on unsound educational theories (Gilroy 1993). This broader critical debate about reflective practice has not been significantly reflected in the nursing literature, and discussions about reflective practice in this field often concentrate on reporting small-scale studies of reflection-on-action. As Nelson (2012:203) noted, the concentration has been on *'talking the talk, not walking the walk'.*

The inclusion of reflective practice in UK statutory nursing regulations has been slow, demonstrating the low value that has been placed on reflective practice in a formal sense – perhaps due to some of the unsubstantiated

claims made on its behalf. The Nursing and Midwifery Council (NMC), the statutory body for nursing in the United Kingdom, included a generic clause in the competencies required for entry to the Nursing Register for adult, children's, learning disability and mental health nursing that requires nurses to *reflect on their limitations* (Nursing and Midwifery Order 2001). However, in a broader interpretation Goldsmith (2011) wrote as NMC Assistant Director for Standards (Nursing):

'Reflection as a tool to help maintain and improve practice should be at the heart of continuing professional development'

This interpretation of reflection as a tool for professional development is also evident in the Standards for Pre-Registration Education of Nurses, which states within the Essential Skills Clusters that reflection should be used to progress continuing professional development (NMC 2010). The second progression point in skill 14 is for students to *reflect on their own practice.* The desirability of reflection is not included in the Code of Conduct (NMC 2008); the one point at which statutory regulation requires reflection in a broader sense is in the NMC Standards to Support Learning and Teaching in Practice (NMC 2008), according to which mentors should support students in critical reflection. Other health professions have given reflective practice a formal role, including the Chartered Society of Physiotherapy and the College of Occupational Therapy. These references to reflection and reflective practice vary, but each focuses on reflection as a part of continuing professional development, indicating that it has a valid place in the ethos of many health professions. The incorporation of reflective practice into statutory periodic registration, as is the case in Canada (Nelson 2012), is now reflected in the NMC Revalidation process (NMC 2015).

Driscoll (1994) recognised the inadequacies of nursing education in preparing nurses to critically evaluate their own practice, and proposed that some of the

problems with reflective practice have been caused by too great an emphasis on pre-registration nursing students and too little developmental work with qualified nurses. Driscoll's 'What? So what? Now what?' framework (based on original work by Borton in 1970) was devised to overcome some of the problems that qualified nurses have with transferring a theoretical position to a change in practice, providing a tool that enables analysis of a problem, evaluates its significance and makes suggestions for how it might be overcome. Driscoll's (1994) intention was to start with practice, not theory, and not to separate the two, so that what is valued is what is put into practice. This has formed a credible way of maximising the use of beliefs to inform action as part of reflective practice.

Tate and Sills (2004) reviewed the use of critical reflection in the healthcare professions, covering its use in podiatry, physiotherapy, paramedic practice, nursing, midwifery and complementary therapies amongst others. This extensive and scholarly review, although focussed on the educational uses of reflective techniques in these professions, did serve to demonstrate how broad the belief in reflective practice has been. Mann *et al*. (2007), working with similar aims, concentrated on the empirical research evidence at the time and therefore had less evidence to build on. They clearly synthesised the findings of twenty-nine studies, but they were unable to use their analysis to come to any new conclusions about the value of what they termed *critical reflective practice*. This may be due to the fact that some key research was not included in their sample, which was found to be a problem pervading this and other reviews of the literature.

Platzer *et al*. (2000a and b) in a study working with qualified nurses reflecting on their practice, found that group reflection could be very powerful and identified many barriers to, and facilitators of, reflection in practice. This study illuminated the value nurses may place on such activities. Platzer *et al*.'s work, detailing findings of research conducted on reflective group processes and the perceived benefits of this experience to the nurses involved, Platzer *et al*

(2000a and b) thereby provided evidence for increased open-mindedness, assertiveness and critique of practice through the support and challenge of reflective discussion about practice with peers. This was found to be possible only if barriers to engagement with reflective practice could be overcome. These barriers included those that were internal to the individual (from previous educational experience, for example) and others that were external to the individual (such as the culture of the work place) or inherent in the group processes themselves (such as fear of the judgement of peers)

In their second paper, Platzer *et al*. (2000b) extended and developed their previous findings showing that participants felt they had made significant changes in their ability to think critically about their own practice and their own attitudes. They felt that they acted more professionally and were more confident in making decisions. These claims are credibly demonstrated in the data presented in these papers by using the participants' own words, and they serve to indicate *a potential for reflection to become reflective practice*, where learning is shared and reflected upon with others and used to develop alternative ways of doing things in practice. Despite these findings, the nature of this study is self-report design and validation of the claims made by more objective means is lacking.

This idea, that reflective practice is best shared, was developed by Clouder (2000 a and b) who based the design and aims of her study with physiotherapists on the work of educationalists such as Kolb (1984). Clouder aimed to explore the realities of reflective practice in daily work and was able to report findings that not only had a sound basis but also illustrated the real-life challenges concerning the time and effort that reflective practice demands. She identified the importance of dialogue and the critical nature of both context and experience as key aspects of any conceptualisation of reflective practice. Clouder's (2000a) research highlighted two issues: first, how reflective practice is contextualised and second, the differences in practitioners' modes of reflection. Clouder's (2000a) study was a small-scale

qualitative investigation of physiotherapists using workshops and interviews. Clouder acknowledged the influence of Eraut (1995) whose pragmatic approach, gave primacy to the context of professional practice, the real life situations in which professionals find themselves.

Clouder's research has implications for the understanding of reflective practice in nursing, and would seem to confirm the notion that exploration can be most usefully conducted from a practice perspective. Clouder (2000a) argued for reflective practice to be used as a team endeavour within contexts with practitioners forming *communities of practice*. This notion was defined by Clouder (2000a) as a team of professionals who share goals and values, working to derive new understandings for practice from a shared dialogue. This tension between reflective practice as an individual or internal cognitive process and as a shared and dialogic one was recognised by Gustafsson *et al*. (2007).

Graham (2000) explored reflection with groups of nurses engaged in structured reflection within a mental health nursing development unit. Although no research question was stated and little detail was given about the design of the study, Graham did show that the participants, just like Clouder's physiotherapists, claimed to use the reflective groups to share their understandings of patient care through reflection. This study is one of few that worked with qualified nurses; most research exploring the use of reflective practice has tended to evaluate the use of a particular reflective tool with student nurses. The lack of information about the influence of Graham's own relationship with the participants affects this study's credibility, but there were some interesting findings. Graham concluded that this sharing of understanding increased the nurses' perceptions of reflective knowledge as a valid means of understanding, demonstrating that it was possible to research this openly without disguising the focus of inquiry as did Powell (1989).

Further self-reports of learning from reflection, resulting in effective and informed action and practice change were seen in the mixed methods research conducted by Paget (2001). This study explored the perceptions of qualified nurses regarding specific changes in their practice following a period of reflection during a postgraduate course. It concluded that effective facilitation of reflection on practice led participants to report changes in their practice, but that these were generalised and there was no evidence that this was sustained in the face of pressure from the organisation or from teams in practice. The tension that seems to exist between reflective practice as a personal and individual endeavour and one that may be shared in professional groups is represented in the literature (see Sweet 2010). This literature has suggested that nurses need to work in professional groups in order to engage in critical reflective practice, because the burden of reflective practice is impossible to sustain alone. The experience of alienation outlined by Brookfield (1993) that may result from lone reflective practice indicates that the support of a like-minded group may facilitate reflective practice better than a lone reflective practitioner working in isolation. Platzer *et al*.'s (2000a and b) study shows that the perceived power of a group can be substantial.

Mantzoukas and Jasper (2004) explored through qualitative research the outcomes of reflective practice in a health service where reflective knowledge is considered to be invalid evidence for practice. Through eliciting the views of registered nurses working in a practice setting, Mantzoukas and Jasper (2004) explored how the understandings that they gained from reflective practice were perceived by the organisation. This study was conducted in the 'real world' of practice, and was a credible account of the influence of situational factors in using reflective knowledge. Using both observational and self-report approaches, the authors reported that the participants found problems where there was no language for tacit knowing, where the daily routine was dominant and where professional apathy was ingrained.

This apparent apathy in response to new reflective understandings was also found in the research undertaken by Page and Meerabeau (2000) and much earlier by Reid (1993). These were small-scale practice-based qualitative studies that took an action-based approach and they showed that the nurses studied may have espoused reflective practice *in theory*, but when change was needed they were unable to use their reflective knowledge for informed action. Page and Meerabeau's (2000) study was action-based, aiming to encourage a group of nurses to act on reflective understandings generated in a group setting. What they found was that the values espoused by the participants were not reflected in what they did. This study, although simple, was a stark and credible demonstration that little had changed since Reid's study in 1993,which found that her group of participants saw reflective practice to be something they were already engaged in (erroneously, according to the author). Both studies worked with small groups of participants in discreet settings, but both showed how facilitating reflective practice requires more than discussion, and that there may not be congruence between what nurses say that they *believe* and what they actually *do*.

This dissonance seems, from reviewing this body of evidence, to be a problematic element in research and inquiry in this area. Wackerhausen (2009) argued that a higher level of reflection is needed in order to challenge routine practice. Wackerhausen (2009) explored the importance of professional identity to reflective practice by arguing that nurses tend to engage in '*trail following practice*', utilising reflection for daily challenges without a resulting sustained practice change. He argued that nurses need to have a professional identity that is embodied in common practices and ways of talking which give them a feeling of group inclusion, but that this does not embed inter-professional working or enable critical reflective practice to occur. This may be attributable to the novice-expert theory that pervades health care practice, suggesting that only the beginner needs to reflect, whilst the expert acts on intuition (Sweet 2010).

The problems that this review has highlighted with the current evidence base are several and complicated. Most of the literature that informs the concept of reflective practice is small scale, qualitative and prone to criticisms of its credibility. The preponderance of self-report research, carried out outside of the practice setting or by researchers who have a prior relationship with participants, has not served to aid the profession in understanding what reflective practice is or how it might be useful. There appears to be a need for further empirical study that is based in the real life context of nursing. There is also a need for research that includes talking to nurses but does not rely on self-report data alone. Pursuit of agreed definitions and understandings of reflective practice appear futile but investigation of how it might play a part in nursing practice seems realistic. In particular, gaps in understanding exist around how reflective practice may play a part in nurses' behaviour, decision-making, relationships and shared learning. At this stage of the study I was particularly concerned with what the literature was indicating about the skills needed for reflective practice and the original study was devised therefore to talk to and observe nurses as they go about their daily work in an attempt to discern the nature of reflective practice.

2.6 Contemporary Nursing Practice

The literature around the state of contemporary practice in nursing is challenging to identify. The empirical knowledge base and the issues of concern that arise in the public media and in nursing publications are of a somewhat different nature. Empirical research that refers to 'contemporary nursing' must be date limited in order to avoid the plethora of publications of the 1980s and 1990s and media reports and opinion cannot be taken at face value. What is of concern to the public, to the profession and to statutory bodies and the current government takes rather different pathways. In order to attempt to make sense of this, I scanned the content of key nursing journals for emerging areas of interest and searched nursing databases for empirical, evaluative and review literature that included the key terms: contemporary AND nursing/nurses AND practice. I applied date limitations of 2000 until the

present time, September 2015. The results produced 17 scholarly papers and two textbooks. Whilst this cannot be argued to be exhaustive, the two approaches converged with several key areas including the nature/role of caring and compassion; the impact of cultural diversity; skills, advanced and specialist practice and the impact of technology on nursing. Contemporary working concerns of nurses include the ways in which care is organised and by whom it is delivered; leadership; skill mix; workload and the role of health care assistants/casual staff. There is also literature concerning the impact of contemporary health policy including the need for collaboration; resources; targets; working boundaries and contemporary professional identity. In terms of context, nurses have been subject to intense media scrutiny surrounding poor care and to the pressures of resource reductions and public censorship. This context is important in order to understand some of the current literature.

Colouring the current debates in contemporary nursing are persistent discussions around professional identity and collaborative working which are areas of practice that are often criticised. The relationship between public image, self concept and professional identity was explored by ten Hoeve *et al* (2013) who found that the literature shows nurses to contribute to their 'incongruous' (ten Hoeve 2013:303) public image by failing to engage in public discourse but also because their work is largely invisible. This invisibility has been explored over time relating to women's work and the so-called dirty nature of nursing work. The implementation of technology into nursing (Tjora 2000) and increasing use of casual staff due to staff shortages, (Batch and Windsor 2014) have posed huge challenges to the image of nursing and to nurses' self-concept. Wackerhausen (2009) addressed collaborative practice in relation to nursing and argued that nurses need to engage more in true collaboration and can achieve this by working at opening up to high order reflection.

The impact of the introduction of health care assistants and the reaction (or lack of) from nurses regarding this major change has had a huge effect on

nurses. The professions reactions to this fundamental alteration in their daily work was shown by Daykin and Clarke (2000:358) to lead to 'inherent paradoxes' in nurses' claims to professionalism and an 'exclusionary strategy' to deal with the intrusion of lesser skilled assistants into the nursing world.Rhéaume *et al* (2015) have presented a much more recent image of how this situation is shaping up and show that the ownership of nursing tasks has altered with qualified nurses finding a new way of understanding their patients that does not come from direct intimate care. Importantly, Rhéaume *et al* (2015) noted that there was flexibility in terms of who delivered certain care and that this changed during the day dependent upon patient need. This flexibility was part of a struggle in which the nurses were engaged in order to make the changes in their working lives that resulted from a new care delivery system

A prevailing and long-lived concern in nursing has been that of clinical leadership. Despite the plethora of textbooks of the 'how to' variety, it seems that this remains a concern and influences contemporary nursing practice through consistent debate. Endacott *et al* (2008) explored the nature of leadership in current critical care practice noting how new specialist and advanced nursing role have influenced the detection of deteriorating patients in ward level care. The debate outlined by Endacott *et al* (2008) highlighted the dependent nature in contemporary nursing of health care policy and practice, arguing that changes in policy such as the European Working Time Directive of 1993 have a *'ripple effect'* (p843) on how nursing develops. Roles such as the Consultant Nurse are argued in this paper to be the direct result of such changes.

Nested within these argued effects are contemporary debates around caring and compassion with public and professional media. Crawford *et al* (2014) used a narrative literature review design to argue for a new approach to engaging in compassionate care in nursing within contemporary boundaries. Such boundaries are posited by Crawford *et al* (2014) to include challenging care contexts, time pressures and targets and the resulting reduced nurse-patient contact time. Whilst slightly polemic in nature, this paper argues

effectively for compassion as an increasingly desirable component of nursing as a historical and contemporary concept. Findings from this review suggest that the challenge faced by nurses when attempting to be compassionate in their work result in nurses suffering stress, fatigue, and loss of motivation and feelings of threat. Yet Allan (2001) has proposed that a nurse may be *'good enough'* (p55) without putting patients' experience of care at risk. Allan's context for her research being a fertility clinic may make this evidence difficult to contrast with Crawford *et al's* but it would seem that there may be a potential place for more emotionally distant care as described by Allan (2001) in certain contexts where a more practical approach is needed.

Whilst each of these publications made sound arguments for ways of working in contemporary contexts whilst retaining a realistic role for nursing, few authors consider the changing nature of the recipients of care. Literature exploring the challenges of nursing an increasingly aging and diverse group of people dates back to the 1990s but more recent publications such as the work of Szczepura *et al* (2005) have taken a broader look at the health service in the UK and focussed on particular key areas such as communication. This is key for nursing but takes some translation into the implications for contemporary nursing practice. Searching for empirical research reports in this area leads to North America where gerontology and racial diversity have a high profile. In the UK it is the challenge of dementia that concerns researchers and authors and in particular of what is demanded of nurses as Traynor *et al* (2011) demonstrate. Traynor *et al* (2011) concluded that there is a need for the health service to create dementia competent organisations but the focus on nursing practice here although acknowledging the challenges, concentrates on the development of competencies. In contrast, Gerrish (2000) reported on the findings of one arm of a wider exploration of individualised care in ethnically diverse settings. Gerrish found that nurses, although engaging in a discourse about respecting individuality had to modify this in the light of health care policy and other influences outside of their control.

The advent of advanced and specialist practice roles have perhaps of all the changes in the past 10-15 years, altered the nature and scope of nursing practice. Textbooks such as that edited by Cody (2013), although taking a North American theoretical approach, demonstrate how extensive are the effects of implementation of such roles and how the scope of practice evinced by specialist and advanced nurses (including consultant nurses) has changed the nature of the nursing mandate irrevocably. This has been seen to be a positive influence on nursing (Doherty (2009), having produced these extended roles. This is not a new debate in nursing nor has it produced any more clarity within the profession regarding the extent of the scope of nursing and who should do what (Eagar *et al* 2010).

Allen (2004) prolific in this area, asserts in a publication exploring the nursing mandate through empirical sources that nurses all play a common core role as health care mediator and that this is a legitimate path for contemporary nurses to pursue in place of holistic and emotion based care. Compassionate care in nursing has received some considerable attention following the Mid Staffordshire NHS Foundation Trust Public Enquiry resulting in the Francis Report (2013). The image of nursing has been debated in many contexts since these events and some empirical enquiry undertaken. A narrative review undertaken by Crawford *et al* (2014) shows the polemic that surrounds this issue but importantly argues that the contemporary policy and organisational focus on quantity of care rather than quality may be causative of a lack of compassion in nursing by causing stress, time pressures and an increase in bureaucracy. This argument is not novel but the literature reviewed by Crawford *et al* (2014) supports their conclusions.

The work of Allan (2001) who argued the notion of the 'good enough' nurse may have presented a possible route through this dilemma. Allan (2001) explored the emotional awareness of clinic nurses in the eyes of the nurses themselves and of the patients attending the clinic concluding:

'(the) fantasy nurse seemed to coexist with the real nurse who was 'good enough' in patients' accounts, able to 'be there' in the background and convey an emotional awareness while, at the same time, able to focus on the practicalities…' (Allan 2001:55)

Whilst the findings of this study need to be transferred from the fertility clinic to other very different areas, this approach may have more value than it seems to have yet been given. Dingwall and Allen (2001) argued that it is this very dilemma (between what nurses consider to be their emotional work and how this is curtailed by health service reforms) that brings the question of what the nursing mandate is to the table. Dingwall and Allen (2001) argued that the notion of an age of caring is a fantasy or at least an over estimation of the time spent in such emotional work with patients. They conclude that many nursing tasks do not require a high level of emotional engagement.

2.7 Summary

This chapter has reviewed both the background to the concept of reflective practice and the literature that comprises the body of understanding in this area. Additionally I have explored the major areas that are currently being debated in relation to contemporary nursing practice. The body of evidence in this particular area is commonly focussed on challenges to nursing in the light of changes to health policy and the context of care. This has been shown to impact on the profession and on the perceived role of the nurse.

The published body of evidence regarding reflective practice in nursing to date has been shown to consist of a considerable amount of research but this empirical literature often fails to address reflective practice clearly. Research has largely aimed to explore how reflective practice might be utilised in nursing, rather than what it is, and how it might be useful. *Reflection* is a well-researched and dominant strategy (Nelson 2012), whereas the discreet concept of *reflective practice* remains under-investigated and ill understood. In recent

years, literature that pertains to situated reflective practice has begun to become available but, in terms of nursing practice, there remain some outstanding questions concerning the knowledge that nurses use to guide their actions; how these understandings are generated and valued may be related to reflective practice.

There is a clear gap in understanding about the practice of reflection in the contemporary daily work of nurses and this stimulated the original research aim to explore how reflective practice might be seen. Although the study in eventuality generated data that were more about contemporary nursing in a wider sense, this chapter has given a narrative critical exploration of what is currently known and serves to provide the basis for the original study. Whilst the next chapter outlines the design of the study, the discussion of the findings in Chapters Four and Five will show how a broader base of literature was required and that this was reviewed and incorporated into the Discussion Chapter.

Chapter 3: Study Design and Methods

3.1 Introduction

This chapter presents the aim of the study and the research question posed. The approach adopted to address these, that of ethnography, is detailed and justified and the data collection and analysis processes outlined. A particular form of ethnography, known as *Combinative* or *Casebook Ethnography* (Baszanger and Dodier 2004) influenced the research design in setting the focus on contextuality and the applicability of the findings for the practice of other nurses. The challenges of this type of research and how these were addressed are identified, including the adoption of a reflexive stance. The measures taken to ensure rigour are considered. As a nurse and an educator, I had experience of the specialties of cancer and palliative care but had no previous knowledge of the particular clinical settings where the research was undertaken. The possible impact that this may have had is acknowledged, in line with the recommendations made by Agar (1996) in order to attempt to counteract these challenges to the rigour of the study.

3.2 Aim and research question

The study initially aimed to search for the skills and features of reflective practice in adult nursing and the research question was 'How is reflective practice demonstrated in the daily work of nurses in a National Health Service hospital?' As has been noted in the introductory chapter, the findings from the ethnography revealed the complex nature of everyday contemporary nursing in adult health care in this particular setting. This focus, wider than originally intended, is evident in the presentation and discussion of the findings in Chapters 4 and 5.

3.3 Ethnography

According to Hammersley and Atkinson (2007) the design of choice for any primary study is driven by the nature of the research and the question posed.

The original aim, to uncover what might be seen of reflective practice in the everyday life of nurses working in an adult nursing setting, lent itself to an ethnographic approach. Hammersley and Atkinson (2007:1) defined this type of research as:

> *'An integration of both first-hand empirical investigation and the theoretical and comparative interpretation of social organisation and culture.'*

Ethnography is a research approach that is usually associated with the philosophical foundations of interpretivism (Hammersley 2013). Indeed, ethnographic research has traditionally been associated with the observation and documentation of cultural or group practices by an objective researcher (Agar 1996) and when anthropological research was developing, interpretivism was the theoretical foundation that guided understanding.
Contemporaneously, Hammersley and Atkinson (2007) have noted that ethnography is a social research design that is often conflated with other designs or approaches, but that has been essentially a term used to describe the extended and detailed written account that accompanies an in-depth qualitative study. Modern ethnographic research usually comprises several features including the undertaking of a period of fieldwork over an extended period of time, a focus on the daily life in a group or culture and the use of a variety of data collection methods. Observation, in depth interview and small groups of participants are features of this type of research as is an explicit documentation of the presence of the researcher (Manias and Street 2001).

Silverman (2011) has argued that ethnographic research should have a theoretical frame, and that taken in this study is that the context of nursing practice is central to the understanding of what nurses do and why. His assertion, that no study is free of theory, was based on a belief that this frame or orientation is what enables the ethnographer to see the data in certain ways

and to understand the more tacit aspects of these data. On this basis, Silverman rejected naturalism as a theoretical basis for modern ethnographical inquiry because the latter aims to *understand* rather than just describe and document. Agar (1996:3) argued that this is *'an improvement of the old tradition'* in that the role and assumptions of the researcher and in particular the part these may play in influencing the data, are made clear.

Embedded within a more contemporary understanding of ethnography is the use of reflexivity. Hammersley and Atkinson (2007) pointed out that it is difficult to argue that researchers have no effect on the group studied in such close quarters. Geertz (2003:143) explicated this challenge to the ethnographic researcher in terms of what such enquiry should focus on. He cited Kluckhohn's definition of the concept of culture, including that a culture may be seen as *'a way of thinking, feeling and believing….a store-house of pooled learning…..orientations to standard problems'.* Ultimately, the researcher using an ethnographic design must therefore observe *what the people within the culture do* (Geertz 2003). Geertz's cultural frame was that all meanings are part of a wider significance (Agar 1996, Silverman 2011) and this study would therefore need to explore the group in question in a setting that gave primacy to everyday work practices.

3.3.1 Combinative or Casebook Ethnography

One of the key challenges of this study was how to ensure authentic reporting of first-hand experience in the fieldwork (Silverman 2011) and a particular approach to ethnographic research was sought that might enhance the usability, and accessibility, of any conclusions reached. To this end, Baszanger and Dodier (2004:18) described combinative or casebook ethnography whereby the *ethnographic casebook w*as the bringing together of an aggregation of data about the actions of the individual participants that allows the researcher to see how these combine across the participant group. Baszanger and Dodier (2004) saw this as distinct from other forms in that it does not base the interpretation of action solely on participants' membership of a social or professional group. In contrast to traditional ethnography the

design allows the researcher to consider actions as potentially being in the repertoire of others (including the reader), and in doing this the design enhances transferability. It was envisaged that this might enhance the applicability of the findings to other settings by emphasising a potential use in the wider world of practice.

This type of ethnography is not new; rather, it has been implicit since the earliest traditions of naturalistic research. Combinative ethnography does not assume that the actions of members of a group are always indicative of the *whole culture*, but instead suggests that they are attributable more to the *situations in which people find themselves* (Baszanger and Dodier 2004). Thus the *situational* and *contextual* elements of the data are retained so that a reader can see how the findings may or may not be relevant to their own practice setting and in so doing, giving a theoretical framework to the study. This, in contrast to narrative and integrative ethnography, is as Baszanger and Dodier (2004:18) explained:

> *'Unlike the cultural approach, (we) do not presume here that the resources mobilised by people in their behaviour can be linked up to a coherent whole'*

This is further explained as seeking to identify participants as *examples* of the whole, rather than describing the whole culture itself, revealing tensions and combinations that may not automatically be attributed to a culture. In relation to this study, this seemed congruent with the theoretical basis of reflective practice in which the importance of contextual influences on nursing work and the focus on individual participants as well as groups is central to understanding. It also enabled me to see the participants' actions as features of them as individual nurses without assuming these actions to be features of the whole cultural group. The ways in which the observations and dialogue collected are put together in this form of ethnography is known as

aggregation, a technique that is embedded in the data analysis stage of the study in the form of *crystallisation* (Ellingson 2009).

The ethnographic casebook is '*gradually enriched by new examples displaying new forms of activity and patterns of articulation'* (Baszanger and Dodier 2004:19) and, in a distinction from integrative or narrative ethnography, the combinative approach can be used to emphasise what Baszanger and Dodier (2004:20) called *'different modes of otherness'*. This notion emphasises the importance of how the reader of the research might see the participants as the same as, or different to, themselves and reflect on the similarities and differences in terms of how they might apply the outcomes of this study in their own practice.

3.4 Research Design

This research was designed to study participants who were registered as adult general nurses in two different work places, a short stay breast surgery ward and an acute palliative care unit. In keeping with an ethnographic approach, the fieldwork was to be carried out over an extended period of time, envisaged to be approximately one year.

3.4.1 Selection of study sites and participant recruitment

The settings in ethnographic research should be as natural as possible but be selected on the basis of the foreshadowing of the issues that is what might be expected to arise. Hammersley and Atkinson (2007) noted how this might mean that a balance has to be struck between the number of settings included and the depth of data that can be collected in the time available. Ethnographic fieldwork aims to spend extended time *living with and living like* those within a culture (Van Maanen 2011) but, as Silverman (2011) pointed out, pragmatism was a consideration. The sampling strategy for the sites in this study was purposive as this had to be a balance between the requirements for the method and the need to remain open to new data (Baszanger and Dodier 2004). Thus, I sought out two clinical areas within the same National Health

Service (NHS) Trust where I might access a sample of nurses with relative ease, but also where differing types of practice might occur. The desire to explore two differing practice areas was based on the need to enhance applicability.

Access to the sites had to be negotiated via the '*gatekeepers'* (Smith 2001:226). Contacts were sought in a National Health Service (NHS) Trust in order to negotiate contexts where the research could be carried out. The clinical areas approached for participation in the study were previously unknown to me; following initial approaches to several areas, two units agreed to allow me to conduct the study in their area. The initial approaches consisted of telephone contacts with the clinical managers, followed by meetings at which I presented the study and answered any questions the manager had. Each manager then discussed this with their staff and telephoned me to say that the staff would like to participate. This access therefore was of the overt kind (Silverman 2011), whereby the study aims were explicitly stated and potential participants were aware of what I wished to explore.

Unit A was a small five-day breast surgery ward and Unit B was an in-patient acute palliative care unit, both part of a large NHS Trust in England. I selected these areas because they provided access to participants who would meet the study criteria, that is Registered Adult Nurses, working in these clinical areas and therefore would be likely to provide data about the phenomenon under investigation. These nurses are obliged under the then in place Code of Professional Conduct (Nursing and Midwifery Council 2011) to reflect on their practice and when mentoring pre-registration students would be required to engage the student in reflection. The stakeholders in these areas were interested in the study including the Senior Nurses, Ward Managers, and in the case of Unit B, the Education Liaison Doctor. The two units participating each had a philosophy of care that included working reflectively.

The nurses at each site were approached for consent to participate in observation periods and interviews. An initial visit was made in person to the relevant senior nurses and then to a meeting of the wards' teams. Letters of invitation accompanied by information sheets (both following the guidelines then in force of the National Research Ethics Service) were distributed to the nurses at these meetings, and questions were invited following an outline of the study. Potential participants were asked to complete and return a tear-off slip to an envelope marked with my name kept by the receptionist. I intended to locate what Spradley (1979:46) called *'good informants'* within these areas – that is, ones who were currently involved in the situation or phenomena under investigation, familiar with the context and who had the desire and the time to be involved. The potential participants were selected not on the basis of any attempt at representativeness but because they were the nurses with the appropriate qualifications and were in practice in the selected units.

Ethnographic research commonly works with small numbers of participants in order to achieve depth rather than breadth in the data (Silverman 2011), and my review of the current and past research in this area revealed studies that had taken a similar approach to sampling (in particular Clouder 2000a, b; Gobbi 2005). Each unit was therefore approached in an open manner and potential participants were invited to hear about the study with the pragmatic aim of recruiting a sample of a maximum of six nurses in each area, this choice being guided by an estimate of the number that was likely to produce sufficient rich data and the available resources for the study (Silverman 2011).

The study of workplaces can be influenced by politics and access may be skewed by the views of the 'gatekeepers' about the nature of the study (Silverman 2011). Indeed the Nurse Manager in one of the units did attempt to direct me towards certain nurses as participants and I was unsure as to why this was so. In the event, one of these came directly to volunteer and one other enquired but decided not to proceed. Five nurses from unit A and four nurses from unit B responded that they would be interested in hearing more about the

research study. I met with each individual nurse in person and was able to gain written consent. The final sample for the study comprised nine nurses who were registered on sub-part one of the professional register (Adult Nursing) and whose field of practice was adult nursing.

3.4.2 Stages of Data Collection

In the absence of methodological guidance in using Casebook Ethnography, it seemed appropriate to be guided by key texts in ethnographic research. Spradley (1979), a seminal proponent of ethnography, suggested two levels of data collection - the Grand Tour and the Mini Tour. This framework was found to be useful in providing an overview of the context of the participants' practice (the Grand Tour) and then as a means of focussing in on their individual daily working lives (the Mini Tour). As an *'in situ'* study (Baszanger and Dodier 2004: 14) in a real-life context, it was important to frame the specific phenomenon studied in connection with the *backdrop* against which it was happening. This backdrop included the physical characteristics of the study sites and the persons involved in the activities and events that occurred there. These two stages of data collection were therefore designed to complement and illuminate each other.

Many authors, for example Pope and Mays (2006), have suggested that in order to conduct ethnographic work, the researcher must have face-to-face contact with informants over an extended period of time. In keeping with this, up to a year was allocated in this study to collect the data. The rationale for this period was based on the possible seasonal fluctuations of the working year, the need to spend time documenting and reflecting on the data. Figure 1.0 shows process of the study.

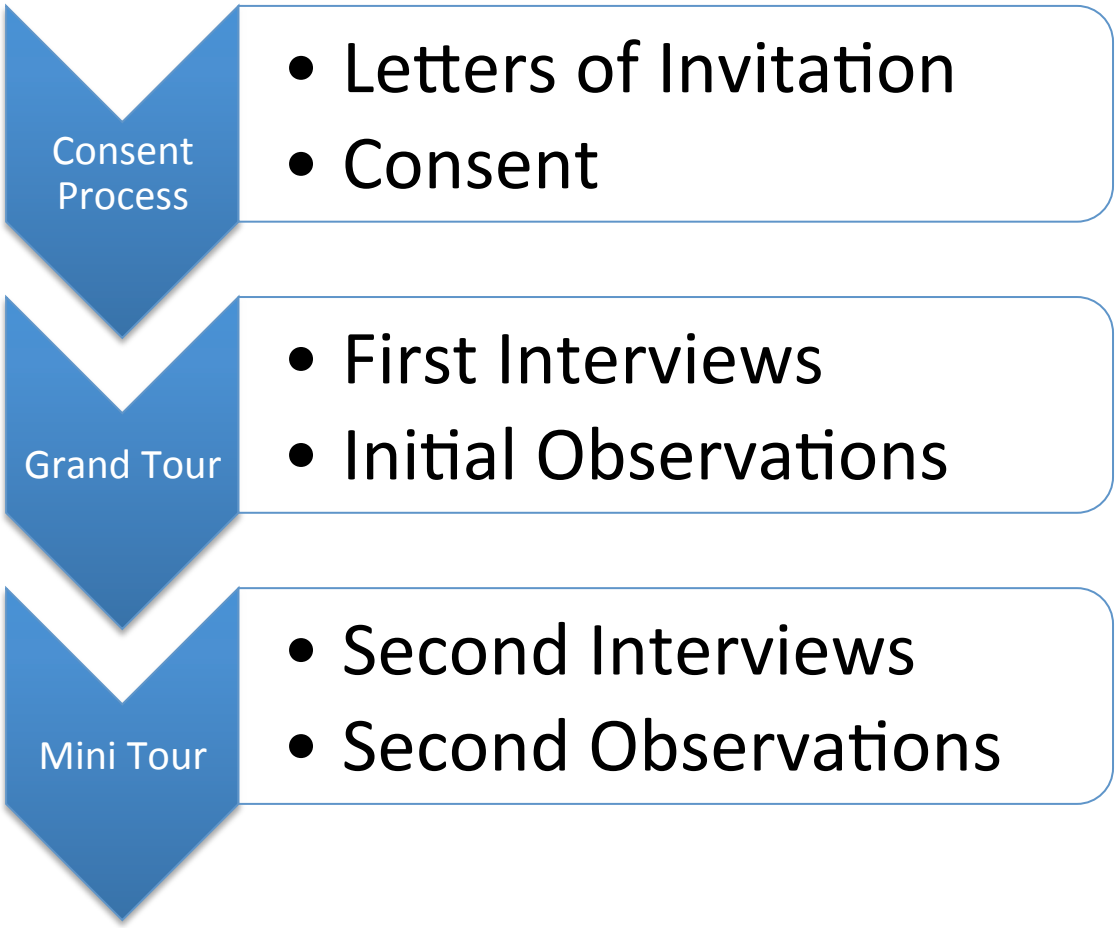

Figure 1.0 Stages of the Research Process

3.4.3 The Grand Tour

The first stage of the study focused on the Grand Tour (Spradley, 1979). This was guided by the findings of the literature review and the iterative and the nature of this phase resulted in the refocusing of the study as outlined in Chapter One. The Grand Tour lasted for three months and comprised a period of one observation day each week in each unit and specific observation days and semi-structured interviews with the nurse participants (see detail below). The purpose was to gain an orientation to, and an understanding of, the ways in which care was delivered in each site (Baszanger and Dodier 2004). I was also interested in the professional relationships that were initiated and maintained within the teams, the demands of the patient groups in each site, as well as the values and beliefs that appeared to influence nursing practice in respect of the individual participants. This helped me to gain an overview of the two units and the work undertaken in line with the Casebook approach outlined by Baszanger and Dodier (2004).

The observation and interview data collected in this Grand Tour stage were recorded in three ways. First, the overview of each unit was tabulated using Spradley's (1980) Grand Tour Descriptive Question Matrix (appendix G). The matrices contained detailed analyses of the attributes of each clinical area, including the physical space, the events that occurred there and the individual actors in the areas. The Descriptive Question Matrix requires the researcher not only to explore how these aspects are seen and sensed in each area, but also how they interact with one another. Spradley's (1980) matrix was used as a guide for my initial observations so that I attended to as many aspects of each unit as possible. Secondly, data from participant observations with participants were recorded using notes taken by myself at the time and later written up into expanded accounts. Finally, recorded interviews were undertaken using an interview guide that was consistent across all

participants. The data collected during the Grand Tour served to help me to plan the Mini Tour.

3.4.4 The Mini Tour

Whereas the Grand Tour stage of data collection provided a backdrop for the study (Baszanger and Dodier 2004), the Mini Tour focused on the detail. This stage aimed to clarify and explore in depth the behaviour seen in the participant observation. Since the original aim of the study was specifically to look for evidence of reflective practice, a particular desire was to see if there were links between what I observed and heard participants talking about, and notions about reflective practice as presented in the literature. In reality, this led me to consider anew the focus of the study and to begin to direct data collection towards a broader understanding of what contemporary nursing was like. I also at this stage returned to some of the issues that had been raised during the first interviews and observations for greater exploration. An example of this would be where the interviews included discussion of the role of experience in informing participants' decisions, and how they ordered their priorities of care.

Baszanger and Dodier (2004) suggested that this link between the Grand Tour backdrop and the Mini Tour observations made in fieldwork is a marker of Combinative or Casebook Ethnography. This part of the study comprised further periods of participant observation followed by semi-structured interviews. The data included interview recordings (see section 3.6.2 below) and field notes taken during observation. I also used a reflective diary in order to record my thoughts and reactions after each period of observation and each interview. The reflective diary acted as a link between the observational and interview data and also as a vehicle to develop my emerging ideas.

3.5 Methods of Data Collection

The main methods of data collection were observation and interview with an integration of data between these, as is typical with ethnographic studies. Each

participant was interviewed twice and I engaged in at least two participant observation periods with each nurse. Interviews were semi-structured as is usual in ethnographic research (Hammersley and Atkinson 2007), and the data collected took the form of expanded accounts taken from field observations, audiotaped interviews and reflective journal entries. The data relating to each participant were retained separately so that interpretations could be made regarding the individual practitioner as well as the whole group of participants (Baszanger and Dodier 2004).

3.5.1 Participant Observation

The term 'participant observation' is characteristically used in ethnography to signify that there is some degree of engagement of the ethnographer within the setting. Gold (1958), outlined four potential roles for the observer: *complete observer, observer as participant, participant as observer and complete participant.* In a similar vein, Spradley (1980) described participation as ranging from low to high involvement, and from passive to complete. In order to retain a degree of neutrality and avoid over-identification with participants, whilst maximising the opportunity to gain the most insightful data; I selected my role as that of the *participant as observer*. I was aware of the danger in ethnography of *'going native'*, to use Agar's term (1996), which can occur with complete participation. Conversely, it was neither possible nor desirable to attempt to be a complete observer, which could have made understanding difficult.

I selected the second level of Spradley's (1980) types of participation that he referred to as *active* or as Gold's (1958) *observer as participant.* This meant that I had to tread what could be a fine line between my role as 'dispassionate' researcher but at the same time considering how my own professional biases as indicated in Chapter One might lead me to draw certain conclusions about what to observe and how to interpret my observations. Active participant observation was adopted to maximise the data collection potential by allowing

me to involve myself in the nursing work and thereby gain entry into all possible areas of the nurses' practice while maintaining a detached position (Agar 1996).

Ethical approval for this study required consent from the participant nurses and the patients in the participants' care each day. Gaining the written consent of patients for me to participate in their care involved outlining to them the study aims. This meant that I had to explain the study to patients and to answer their questions both before and during the observations. Patients in both units had different levels of interest in the study and in my presence. For example, patients in Unit B were often more unwell and therefore showed less interest in my presence. Whilst such patients would have met me at the consent meeting, as they became increasingly ill they did not always remember clearly having given permission for the observation and I sometimes had to gently check that they were happy for me to be there. In relation to the patients, I was keen that having me assisting in their care and/or observing would not adversely affect their experiences. I also did not want my presence to have an impact on the care given by the participant nurses. Thus I avoided asking questions in the presence of patients, but conversations usually included me and this may have altered the dynamic of the nurse/patient relationship, although I was clear at all times that the nurses were the study participants, not the patients.

It was important that the patients in the participants' care would feel able to ask me to leave if they wished for privacy, but despite telling each participant and patient that they were welcome to exclude me at any time if privacy was required, I was welcomed into all situations and was never asked to leave. Thus I participated in all aspects of care giving, including washing, bed making, drug administration, wound care, handover, preparation for surgery, escort from recovery and intimate procedures such as urinary catheterisation. At times I purposely made myself useful, but I attempted to allow the research participants to direct care and to initiate any activity. This was important in

order to retain my primary presence as a researcher and I purposefully played a peripheral part in activities in order to retain this role.

In this way the use of participant observation allowed me to develop relationships in the field of study while maintaining a 'marginal' role (Spradley, 1980). This meant that I was neither a complete insider nor a member of the team, but I developed relationships that allowed me to ask potentially difficult questions and to observe practice in as natural a manner as possible. The advantage of this approach was that I could gain access to perspectives across individuals and groups but I was careful not over-identify with any sub-group, thereby possibly alienating another. Thus, I was a partial insider, aided by the fact that as a nurse this may have enhanced my rapport with the group. The documentation of this was important in order to retain the in-situ context of Combinative Ethnography (Baszanger and Dodier 2004) and this association began to reveal to me that what I was hearing and observing was overwhelmingly influenced by the local and wider settings in which the participants practised.

I entered the field as a qualified nurse but one unfamiliar with the two research areas and unknown by the nurses there. The observational periods were negotiated with the participants to suit their working patterns and the needs of patients in their care. Most of the participants worked regular daily shift patterns and periods of observation took place within these, either for full shifts or for periods of time within a shift. Time spent with participants varied therefore from five to seven hours for each period of observation. The data collection took place in the context of the participants' work and was conducted *in situ*, enabling each participant to behave in an '*endogenous manner'* (Baszanger and Dodier 2004:11). The challenge in attempting this was to maintain a role whereby the participants could see me as honest and unthreatening but also as a marginal member of the team (Agar 1996, Spradley 1980). Thus, as an observer I assisted the nurses in their work in

caring for a group of patients, attempting to take a secondary role in following the lead that the nurse took.

The aim of conducting participant observation was to capture the data by whatever means seemed most appropriate while allowing participants to carry out their work as usual. This meant that stopping to take notes or asking for clarification was not often possible whilst observing; instead I had to store up observations or questions in my head until a moment came when I could record them or ask a question. In order to attempt to construct what Spradley (1980:64) termed an *'ethnographic record'*, I wrote a condensed version of my observations in the field, highlighting significant words, phrases and sentences. Expanded accounts were then written up immediately after observation periods. The detailed nature of these notes was directed by whether the observations were part of the Grand Tour or the Mini Tour (Spradley 1980). The focus of the nurses' practice was identified by the activities in which they engaged, how they ordered their priorities and what they spoke about. This is congruent with the emphasis on the actions of individuals and the context of the study as should be the case in Combinative Ethnography (Baszanger and Dodier 2004). In this way, I retained my particular interests but I remained open to what the participants directed me towards. Trustworthiness is acknowledged as a challenge in participant observation, especially whilst observing in one's own professional field and with members of one's own profession (Silverman 2011). This required me to reflect after each observational period on the part that my presence might have played in influencing what occurred and document it daily (see section 3.7 for a discussion of this).

3.5.2 Interviews

Baszanger and Dodier (2004) acknowledged tensions as inherent in action whereby individuals may be able to overcome situational constraints by redefining the situation and access to this was not likely to be found through

observation alone, but might be available by combining interview with observation and reflection. Each of the nine participants was interviewed twice, once following each of the two observation periods, making a total of seventeen interviews with one interview cancelled due to sickness of the participant. In the Grand Tour, a common interview guide was used in order to provide prompts and the interviews were closely related to the Grand Tour observations as well as being informed by the literature (appendix H). Each first interview took place following the first observation period and was used to establish rapport with participants, to explore their perceptions of their work and to begin to probe the knowledge and motivation behind the observed behaviours. Developing a personal relationship with the participants was a means to enhance the knowledge that I obtained from talking with them (Kvale 1996) but the locus of control was balanced at this stage between attempting to cover the questions planned and allowing participants to raise any issues that they wished to discuss.

At the Mini Tour stage the interviews took place after the second participant observation period and were based on the practice observed in the Mini Tour observations. The questions asked at this stage were geared specifically towards each individual and sought explanation of what had been observed in practice, such as asking questions about why participants organised their daily work according to certain priorities. At this point each interview built upon the others and thus by listening to previous interviews and reading observational field notes it was possible to plan ahead for possible questions and topics of discussion (appendix I). There was a marked difference between the Grand Tour and the Mini Tour interviews as described by Spradley (1979), whereby the former encourages the participant to answer at length, describing the aspects of their daily working lives. In contrast, the Mini Tour interview focuses on specific interests.

The initial and common thread that ran through all the interviews in both stages was the aim of exploring and illuminating observed practice in the light

of understandings about reflective practice. This was in line with the original study aim. However, over time discussion centered around the ways in which the nurses went about their work in their practice communities and how contemporary issues impacted on this. Thus I explored these areas in some greater depth than had been envisaged at the outset of the study. Importantly, it became evident at the second stage that the original research question was an over-simplification; reflective practice was only a part of how experienced nurses in these settings went about caring for patients, and this realisation allowed broader issues to be explored regarding what constituted contemporary nursing albeit with the role of reflective practice implicit.

Each interview lasted between thirty and ninety minutes and was held near the place of work for each participant because they were often still on duty. I attempted to ensure that the room identified for the interview was slightly apart from the clinical area and was as private as possible, in order to attempt to achieve separation from what was going on in the clinical area at the time, and to gain privacy for the discussion. Whilst every attempt was made to ensure that the participants could talk freely, occasionally other nurses requiring information interrupted the interviews.

3.5.3 Relationships between Observational and Interview Data

As previously described there was a close relationship between the observations and the interviews. During the writing up of field notes, the intention was to form a link between observational and interview data by reflecting on both for each participant. Baszanger and Dodier (2004) acknowledged inherent contextual tensions where the individuals involved may be able to overcome particular situational constraints such as resource limitations or organisational policy by redefining the situation as one in which they may achieve at least a partial goal. Access to an understanding of such realities of participants' lives was not likely to be gained solely through observation or interview, but by combining the two methods and by checking out emerging explanations of the behaviour through subsequent observation and interview. The trustworthiness of any resultant account is a challenge

particularly in one's own professional field and with members of one's own profession (Silverman 2011). This required me to reflectively consider after each observational period the part that my presence might have played in influencing what occurred, before analysing the data. In addition my interpretations were shared in detail with my supervisors as a way of testing their 'credibility', (See section 3.7 for a further discussion about rigour and trustworthiness).

3.6 Profile of Participants and Settings

The context of Combinative or Casebook Ethnography is crucial in order for readers to understand how the findings of a study might relate to their own practice (Baszanger and Dodier 2004). Thus this section outlines in detail the two groups of participants and the settings in which they worked. The participants, each of whom has been given a fictional name, worked in one of two units, called here Unit A and Unit B.

Unit A was a twenty-six-bed, five-day breast surgery ward, laid out in what is traditionally called the 'Nightingale style' with four additional single rooms. Unit B was a thirty-bed acute in-patient palliative care unit laid out in single rooms and four bed bays around a central garden area. Both were located at a medium-sized hospital, which is part of a large NHS Trust in central England and included within their unit philosophy a commitment to reflect on practice. A total of nine participants took part in the study. All were female, aged between twenty and fifty-five years. Across both data collection sites, the level of seniority in the speciality was not always commensurate with age. The least experienced participants were two years post qualification, and the most experienced had more than fifteen years in nursing. It is important to point out that some of the participants were more forthcoming than others during observation and interview. For this reason there is a clear imbalance between the amount of data reported for example between Helen and Karen as Helen was very reserved and did not elaborate on points or answers to questions. Karen was a very rich source and the interviews recorded with her were

extensive; Kirsty as acting ward manager had less available time to spend with me and Sally is under-represented due to ill health. I have attempted to balance out the data presented in the light of this.

3.6.1 Unit A

Unit A was a traditional-style in-patient ward that admitted patients for minor breast surgery on a Monday-to-Friday basis. Patients were admitted on Mondays for surgery on Tuesday, or on Tuesday for surgery on Wednesday. In the later part of the week, patients were anticipated to be ready for discharge home; any patients not ready to go home were transferred to another ward for the weekend. Thus the participants all worked from Monday to Friday. The ward was constantly busy with patients going to and from theatre and X-ray, breast nurses' clinics and other departments of the hospital. The four single rooms were used for patients with infections or who were undergoing radioactive implant therapy. All ambulant patients ate their meals in the day room at one end of the ward, where there was a table and chairs, sofas and a television. Unit A was largely nurse-led with no junior doctors in the team. The surgeons who performed the breast surgery and their specialist registrars led the medical care. This meant that the nursing team were expected to have specialist knowledge of the care that the patients required, and to liaise with senior doctors when necessary. It was not customary for junior doctors on call in the hospital to be seen on the ward.

The situation in Unit A in the period during which the data for this study were collected, was a time of change. The unit was due to close and merge with a gynaecological cancer ward in the new Cancer Centre. A new recruit replaced the acting ward manager and tensions among the nursing staff were high as the move to a new building under new management loomed. The nurses faced a challenge in maintaining their shared values and understandings within a larger unit.

3.6.2 Unit B

Unit B was a well-established and purpose-built in-patient wing of a large palliative care centre that holds an international reputation for care, innovation and research. The centre had a thriving research and practice development service with extensive opportunities for education and development. The in-patient area consisted largely of single rooms, laid out in two semi-circles around a central garden area. Each room or bay was designed to be as comfortable as possible with bright fabrics and light furnishings. Some rooms had sitting rooms and sleeping areas for relatives.

The nurses did not wear uniform and largely preferred comfortable and practical clothing, many carrying a small bag slung across the body to carry notes, pens and other necessities. This meant that the various groups of staff were sometimes difficult to distinguish from visitors, although they all ensured that they wore their NHS Trust identity card. The nurses were the major group of workers but unlike Unit A, there were many other types of professionals in the unit at any one time. Healthcare assistants, medical staff, physiotherapists, nutritionists, complementary therapists, MacMillan nurses, volunteers, fundraisers, chaplains and administrators, amongst others, were often present.

The work going on in the associated community team and the charity offices sometimes spilled over into the in-patient unit, making it a busy place in the communal areas. Unlike Unit A, this was largely invisible to the patients whose rooms were set aside and had solid, heavy doors. A vast amount of equipment seemed to be needed on Unit B and storage was a problem; a whole room was given over to the storage and the preparation of medicines because pharmacological interventions were very common.

3.7 Specific Steps in Data Collection

The design of combinative or casebook ethnography espoused for this study was of little assistance in planning and carrying out the data collection. The design did specify certain principles and these were used to guide my data collection. In an earlier section I outlined the essence of this design as '*bringing together or an aggregation of data about the actions of the individual participants that allows the researcher to see how these combine across the participant group'.* This required some translation into actions and required me to approach the collection of data by treating each participant as an individual and recording data accordingly before looking at this across the whole group. Assumptions could not be made that a common theme would apply to all. Whilst the design allows the researcher to consider actions as *potentially* being in the repertoire of others (including the reader), this could not be assumed.

The general approach taken was therefore one of an ethnographic researcher (Spradley 1979, 1980) but with the proviso that I was to view all data in context. I therefore ensured that the data I collected bore evidence of what was happening at the time and any particular events that might have influenced the action. Field notes were written up immediately after each observation so that I could note any such material. In terms of the interviews, transcripts were not used and listening to original recordings enabled me to retain the contextual elements of the event.

Carrying out participant observation is challenging and in order to achieve the aims of this arm of data collection, I had to plan carefully and maintain an awareness of the effects of my actions on those with whom I came into contact. Each participant observation period was individually negotiated and the time of my arrival and departure made clear. Some of the participants did not work full shifts due to their contractual arrangements and started work at 9 or 9.30am. If this was the case I began work with the participant at their start time.

Having acquired a uniform, this was worn for unit A and for unit B I wore my own practical clothing. Arriving in each unit, I presented myself to the nurse in charge and explained what I was doing. All staff were familiar with the project and as time progressed, they came to know me. Before finding the participant I acquired a copy of the handover sheet, giving basic details about each patient, read it and checked that the participant was caring for the patients whom I had consented a day or two previously. This being done, I searched out the participant who would invariably be engaged in an aspect of care and either waited until she had finished with a patient or quietly introduced myself into the situation if appropriate. On unit A the place of the nurse at certain times of the day was more predictable than in unit B and on occasion I had to wait until there was a convenient moment to join the participant.

Even active participant observation means letting the participant take the lead to an extent (Spradley 1980). This challenged me to keep a low profile and to step back to enable the nurse to act as normally as possible. Physically I tended to stay behind or beside the nurse and to take a lead from what she initiated. I took the role of assistant, sometimes replacing another member of the ward team but more often being an extra pair of hands. I was obliged to contain my usual effusiveness and keep quiet whilst often also being asked about the study by staff and patients; the tact required in behaving appropriately was challenging at times. I followed the participant and attended to minor aspects of what she was doing such as tidying away equipment, carrying items, running for forgotten resources and all the time observing.

I found that participant observation required active attention to ensure that I did not miss key moments whilst attending to these minor tasks. Participants talked to me without prompting about what they were doing and I had to attend carefully. This meant a great deal of multi-tasking and was exhausting. During a shift, in unit A the care varied from theatre visits to collect or deliver patients, preparing for theatre, making theatre beds, giving a variety of drugs and admission and discharge. The pace was fast and I often lost my participant and had to search them out. Being in a nurse's uniform meant that I was drawn into situations outside of my remit but participation in which sometimes meant better relationships and so time was spent on this. As a result, there was no

doubt that some time on each shift was spent engaging in activity possibly not relevant to the study. Yet at this stage I tried to keep my attention on everything that could possibly be relevant and balanced this with keeping physically close to the participant. As I became more adept at this, I could make a speedy and informed decision about what to get involved in and what to avoid. This discretion came slowly but once data analysis began, I was able to 'see' more clearly what observations might be useful and what might not.

Face to face interviews were conducted following each participant observation period and the participant largely dictated the place and time because the practicalities were at time difficult. Whilst most participants were happy to stay after a shift or arrive early, invariably the times were fluid as they had other commitments. I sought out so-called quiet areas to hold the interviews and arranged to use these in advance if possible but again, on most occasions the final venue was found at the last minute to suit the participant. The use of a digital recording device was necessary but all participants agreed to this readily. The presence of this device appeared to cause no concern. No participants asked to hear their interview or see the transcript.

The first interviews, following an interview guide, were of a consistent nature but the second interviews varied. Being focussed on the participant observation, the second interviews were often longer, more in depth and more personal. I found in these interviews that the assertions of Kvale (1996) were most pertinent as the participants often engaged me in conversation about practice issues.

3.7.1 Summary of Data Collected

The data reported were collected through two interviews and two participant observation periods with each participant. One participant in Unit A was able to give only one interview due to ill health. This gave a total of sixteen participant observation periods lasting from five to eight hours each and seventeen interviews lasting from forty-five to ninety minutes each. The interviews were carried out after each observation period, i.e. the sequence was Grand Tour

Observation -> Grand Tour Interview -> Mini Tour Observation -> Mini Tour Interview. This took place with participants largely consecutively, over a period of one year. In addition, a reflective research diary was kept during the study and reflection on the data collected and my own perspectives on this process are included in the data presented and analysed.

3.8 Data Processing and Analysis

The principal aim in Combinative or Casebook ethnography is that the ethnographic casebook brings together an aggregation of data about the actions of the individual participants that allows the researcher to see how these combine across the participant group. In order to achieve this, in the absence of clear guidance from Baszanger and Dodier (2004) the process of *crystallisation* (Ellingson 2009*)* was used to guide the integration of the various forms of data collected. The research resulted in different kinds of data, with that gained during the interviews referred to as 'interview data' whereas data collected during other periods such as participant observation, handovers or meetings were categorised as 'observational data'. In addition there was my reflective journal. The following section describes the process of analysing, focusing and handling and coding the data. It will also explain how the initial research question and focus of the study was challenged and reframed.

3.8.1 Early Analysis and Progressive Focusing

Data analysis began as soon as data collection commenced and listening to the interview recordings and reading expanded observational accounts allowed for progressive focusing on emerging issues subsequently. This is in keeping with the recommendations of Hammersley and Atkinson (2007:205) who saw this as an *'iterative process'* whereby initial data collected are analysed informally and influence further data collection. This leads to more analysis, with constant 'feedback' from one stage to another (Spradley 1979). It was this process of progressive focusing that reinforced the altered focus of the study as my original idea that this study was primarily about reflective practice was

challenged by the data that arose. It became clear early on in the data analysis that the research study was not simply about reflective practice and therefore the original research question was inappropriate to pursue. The iterative process of collecting and analysing data showed that it was not possible to explain what I saw and heard just in terms of examples of reflective practice. The early data analysis indicated an emerging picture of a wider notion of contemporary nursing, in which reflective practice seemed to play a part.

3.8.2 Handling Interview Data

In line with argument made by Kvale (1996), who described an approach to interview analysis characterised by the metaphor of *Inter-views,* the interview data were not transcribed verbatim. In this approach the researcher and the participant exchange views and perspectives on a topic rather than the researcher asking questions and the participant answering. Kvale (1996) maintained that the use of original oral recordings is more likely to stay 'true' to the participant's original intentions because they are not transformed by transcription. As a nurse studying nurses, this approach seemed appropriate, and was congruent with the nature of the fieldwork that was an integration of observation and an exploration of what I had observed.

At the first stage, notes were taken from the recordings of interviews as records of what I deemed to be important phrases or passages. These passages would be used later to provide verbatim quotations from participants to illustrate the analysis. The data gleaned from each participant therefore consisted of audio files stored on a personal computer, and written notes taken from each audio file as records of the key passages. The technology now available in the form of digital recording and downloading onto a personal computer enabled me to listen and re-listen several times to recordings during the analysis process. I indexed important points in the conversation, and ensured that the inflections of voice, tone and choice of language were noted. Listening to interviews rather than simply reading transcripts also enabled me to note emotions and cues, and reminded me of the interview itself, including

a reflexive analysis of the influence of my own input on what was said (Kvale's 1996). In tandem with the interview recordings I read and re-read the expanded accounts of participant observation periods, and reflected upon the data as a whole as well as in relation to each participant.

3.8.3 Handling Observational Data

The Grand Tour observational data were recorded using the Descriptive Question Matrix (Spradley 1980). From this, the backdrop to the contexts studied was formed in order to more fully understand the focussed observations (Baszanger and Dodier 2004). The Mini Tour observational data were analysed from expanded accounts of field notes recorded during observational periods. The analytical process followed that suggested by Spradley (1980) based on the progressive focusing of observational data. This meant that, as observation progressed, the focus on what was seen became more selective. Reviewing and reflecting upon the observational notes involved asking the question 'what is going on here?' (Spradley 1980) and this was used as a guide to simple coding of the expanded accounts. These codes were subsequently used to illuminate those gleaned from the interviews.

3.8.4 Coding of Data

The coding process began with coding the data into the margins of interview notes and expanded accounts (appendices J and K). Mind mapping of the codes for each participant was undertaken, at which point I deleted repetitive codes and combined those that were similar. Throughout this process I reflected on the mind maps to translate clusters of codes into themes, naming and developing the themes and finally considering each theme and relating the codes across the participants, a process of looking constantly across the participants as a group and then coming back to them as individuals. This strategy intended to remain true to the essence of Combinative or Casebook ethnography in moving between the individual participants and the possible

generalisations within the context of data collection (Baszanger and Dodier 2004).

Codes at this stage consisted of simple words or phrases such as: '*picks up cues', 'doing things in the right order', 'think and listen', 'trying things out'* and *'gleaning the essence'.* As far as possible, codes were noted using the exact terms included in the accounts or in the participant's own words. Reflection on the coding process allowed me to include synonyms or alternative words or phrases where this made the meaning clearer; for example, one participant talked about '*being smiley*' which I changed to '*being expressive*' to include the varied facial expressions observed. Once all of the data had been coded, a reflection on each individual was written to sum up the observational and coded data.

Coding produced lists of words and phrases organisation if sense was to be made of them. I used Google Documents to create mind maps which could hold and organise the codes, and began to draw similarities within each individual participant's data and then across the participants in each of the two areas and finally across the whole participant group. I used mind maps to group together similar codes into broader categories and to combine the categories across the participants into more abstract themes. I then used the process described by Ellingson (2009) giving credence to the three types of data: observational, interview and reflection. This enabled me to give attention to both the individual participant, the two data collection sites and the group of participants as a whole as is cognisant with the aims of Combinative or Casebook ethnography (Baszanger and Dodier 2004). The resulting themes were discussed at length with a supervisor and feedback gained in order to make any alterations to enhance the credibility of the process. Reflection on the whole process was undertaken regularly in order to ensure that all possible interpretations were considered.

3.9 Reflection and Reflexivity

During the writing up of my field notes, I tried to form a link between observational and interview data through reflecting on both for each participant. Many authors recommend the use of reflection and reflexivity in qualitative research (for example, Finlay and Gough 2003, Jasper 2005, Koch *et al* 2005, Mantzoukas 2005), emphasising their benefits to the research study and to the researcher personally. The social researcher uses reflexivity to expose and acknowledge his/her own role in the research process (Finlay and Gough 2003). In ethnographic research, reflection and reflexivity are crucial in order to engage in the social world in which the study is sited as well as to make interpretations just as one would in everyday life (Hammersley and Atkinson 2007).

The aim of using an ethnographic approach in this study was to produce *thick description*, which aids a researcher in understanding a social group from the inside (Geertz 1973). This is congruent with combinative ethnography insofar as the social group and context form the backdrop for the study of individuals within this group. The role required of the researcher in the field in order to achieve this can cause concerns. In this study, I used two means to enhance my reflexivity: the use of a reflective research journal, and the academic supervision process, the latter of which also challenged my interpretations and thus enhanced the rigour of my findings.

Silverman (2011) raised the related issue of identity in qualitative research, and how the need to make decisions about one's research identity can be problematic. In the interview context I was open about my own nursing perspective, but I attempted not to voice opinions that might influence the participant to be less honest or open about their own. As Silverman (2011) and Agar (1996) have noted, the researcher's behaviour will affect how the participants see them. The awareness of self that comes with using a reflexive approach to research indicated to me that taking anything other than an open

approach was unlikely to be successful. As Baszanger and Dodier (2004) asserted, openness is key to fieldwork research, but there is also a need to maintain rigour. This '*tension'* (Baszanger and Dodier 2004:11) between the openness necessary in order to collect data as close as possible to what might be 'normal' for the participant and the need to maintain rigorous research methods was acknowledged as an inevitable challenge of this type of research.

As a nurse researching nurses and nursing, there was an imperative for me to seek to acknowledge and make use of my own personal, social and cultural understandings through reflexivity as defined by Finlay and Gough (2003). Reflective and reflexive research can facilitate creative and critical thinking, aid active engagement of the researcher with the data, and, by documenting reflection, provide primary data in its own right (Koch *et al* 2005). My own background as outlined in Chapter One would inevitably shape the data collected and the interpretations made (Hammersley and Atkinson 2007) and thus would be a significant factor in the study.

3.10 Ensuring Study Rigour

A key feature of the twin activities of reflection and reflexivity in research is essentially about the process of establishing the credibility of the research findings in the ways propounded by Lincoln and Guba (1985). The criteria by which ethnographic research may be evaluated for rigour are often referred to in terms of reflexivity (see Hammersley and Atkinson 2007). Gerrish (2003) considered the rigour of her own ethnographic research and concentrated on research relationships and reflexivity, particularly with regard to nurses engaging in participant observation in their own field.

Any criteria that may be applied to ethnographic research in order to assess value should take into account Hammersley's (1992) assertion that there is not a single interpretation or representation of events in a social group that might be called valid. Hammersley argued that it is the wider benefit or effect of

ethnographic research that should be the criteria for assigning value, and this is congruent with the aims of combinative ethnography in engaging the reader in consideration of how the findings might apply to themselves. Other concepts are commonly used to evaluate the overall value of qualitative research including *transferability*, *dependability* and *confirmability*. The key to achieving this is in the deliberate laying of a decision trail throughout the work, in the planning, implementation and writing up of the study and in the documentation of decisions made at all stages. This was a central means of achieving rigour.

Hammersley (1992) identified *relevance* as being one of the criteria upon which ethnographic research could be judged. In order to ensure that the findings of the study would have relevance for practice in other areas, a degree of transferability was desirable and is congruent with the aims of combinative ethnography, which attempts to engage the reader in consideration of the relevance of findings to their own field. This posed the challenge of how the study's findings might be useful in other settings than the one in which the data were collected. In order to achieve this, readers need to know details of the context and of the participants in order to consider how the results may be relevant to their own practice (Appleton and King 1997). This was achieved by clear contextual description of the study sites, the nature of the care given in these sites and the people involved, and use of the descriptive question matrices completed for each unit.

The concept of credibility is a judgement about the sense or face value of the research (Lincoln and Guba 1985). In this study, constant reflection and reflective questioning took place through the use of a reflective diary and regular return to the original data, using the actual words of participants to illustrate the interpretations made. The practice of crystallisation (Ellingson 2009) required the integration of all the possible sources of understanding in order to come to the interpretations that best represented the words and actions of the participants. The practice of respondent validation was not used

because the observation and interview data were taken to be a product of the context (the time and place) of the data collected, and there was a possibility that the participants may have changed their views over time (Appleton and King 1997).

Confirmability as defined by Lincoln and Guba (1985) is to do with the effect of the researcher on the data collected, and this challenge was acknowledged by constant reflection on the data and the interpretations made. I attempted to achieve confirmability by being explicit about my own perspectives and by ensuring that there was transparency in my decision-making. The use of reflexivity, reflection and documentation of a clear audit trail (Appleton 1995) were all acknowledged in enhancing rigour in this respect. Although Lincoln (2002) has since developed these criteria, they remain an accepted framework for judging the quality of qualitative research. The use of extensive documentation, both descriptive and (later) analytical, was important because I was using verbal data direct from interview recordings and observational notes, rather than full transcripts. I was aware that there may be some risk to the rigour of the study in taking this decision, but I felt that meticulous attention to documentation during both the descriptive and analytical stages of the study would satisfy the criteria that were required whilst retaining greater contextuality in line with the design selected. Included in this documentation was on-going reflection on the process of the research.

3.11 Ethical Considerations

The National Research Ethics Service (NRES) granted ethical approval for the study after site-specific approval was gained from the NHS trust in which data collection took place (Study REC No: 07/Q1603/8). The study was sponsored jointly between the NHS Trust and the University of Southampton. The major ethical issue raised by the study was identified to be a concern for the protection of the interests and wellbeing of the patients, their families and the staff in the data collection areas. Identification of possible ethical implications of the study was undertaken at an early stage and strategies were put into

place in order to guard against contravention of good research practice by adherence to relevant legislation in force at the time including the Data Protection Act (1998), Caldicott Guardianship (Department of Health 2010) and the Human Rights Act (1998). Additionally there was compliance with guidelines for good practice including Research Governance and the University of Southampton and Local NHS Trust Research and Development protocols. Potential support for participants who may suffer distress caused during data collection was put in place with the assistance of a workplace counsellor. The possible observation of poor practice was discussed with each nurse at the time of written consent and I informed each participant that my own professional code of conduct would oblige me to report this. All participants agreed to this proviso.

I ensured that there was a clear and comprehensive informed consent process as recommended by NRES. This was put in place for both nurses and the patients in their care during observation periods. Each potential participant received a letter of invitation (appendix A) to take part in the study and an extensive information sheet (appendix B). Those who returned the slip expressing interest were contacted by email or telephone and asked to meet for a discussion about the study. If, following this, the nurse wished to participate, they were then asked to sign a consent form (appendix E).

Patients under the care of the participants during observation periods were given invitation letters and information sheets about the study at least twenty-four hours before the observation (appendices C and D), provided by the nurse caring for them at that time. The day prior to the observation, I visited the patients who would be in the care of the participant the next day and talked with the patient and their family, if present, about the study. At this stage, patients were asked to give their written consent to my participation in their care (appendix F). No personal, medical or biographical data were collected or recorded about the patients involved.

Data were stored on a personal computer in password-protected files and in a locked filing cabinet at my home. Although I could not assure participants of complete anonymity due to the nature of the data collected, I did assure them of confidentiality during the presentation and dissemination of the findings. A clause was included in the consent form to request the use of anonymised quotations. All processes followed the requirements of the Data Protection Act (1998) and pseudonyms were used to identify the participants. Original data is required by the sponsoring university to be kept for 10 years in secure storage; in this study this includes the original recordings of the interviews in addition to field notes and my reflective diary.

3.12 Summary

This chapter has outlined the design of the study and methods of data collection. The use of an ethnographic approach is justified in this chapter in terms of the research question and aim of the study. The influence of combinative or casebook ethnography as detailed by Baszanger and Dodier (2004), has been presented with the aim of enhancing the usability of the research findings. This was important because the focus was on the collection of data in the real life context of the participants' daily work. The data for this study were collected using participant observation and interviewing supported by the use of the researcher's reflective diary. These methods have been explored so that the challenges inherent within them are highlighted and solutions posed. The data analysis process has been described with reference to the use of crystallisation of the various forms of data collected during the study. The following chapter describes in detail the findings from the ethnography.

Chapter 4: Findings

4.1 Introduction

The original aim of this study was to explore how registered nurses in adult nursing demonstrate the features of reflective practice in their daily work in a National Health Service (NHS) hospital. The specific objectives were to observe and explore the practice of adult nurses in the light of the features of reflective practice as described in the literature, and to consider how reflective practice may be discernable in the work of these nurses. To this end, data were collected through interviews and participant observation from a group of participant volunteers who worked as nurses in one of two adult in-patient units in an NHS trust. The two contexts studied were an in-patient breast surgery ward and the in-patient ward of an acute palliative care unit. In both settings, care was nurse-led with senior medical staff working as part of a wider team. The context in which data were collected has been emphasised in line with the design features of Combinative or Casebook Ethnography (Baszanger and Dodier 2004) and a thickly described account is contained in this chapter organised into one overarching theme and three associate themes.

4.2 Initial Insights Regarding Reflective Practice

As has been noted earlier, questions that were asked at interview about reflection and reflective practice were kept general and exploratory. This was to avoid the danger of self-report data, found in some of the studies reviewed in Chapter two, where researchers had relied on nurses claiming to use reflection and to benefit from it. Whilst the integrity of these studies is not in question, this formed the motivation for including observation in the study methods and for the intention to explore reflective practice implicitly rather than simply asking direct questions and making assertions based on the answers.

When asked, participants were to a large extent reticent about reflection and tended to generalise about how they talked of their work to colleagues and friends and of formal exploration in the team of problems in practice. This view was supported by the observations made in the Grand Tour. Despite the expectation that mentors and registered nurses reflect on their practice, there were few indications that reflection was embedded in practice. Those who had completed nurse training relatively recently were more familiar with the idea and spoke of assignments and exercises set during their training where reflection was required. The more experienced participants took the term reflective practice to mean thinking about what they had done in practice and considering the outcomes in the light of future situations. Examples of responses to this question included:

'Well, I often think back, you know on the way home' (India, Unit B: First Interview)

'I have to think about where I went wrong and try not to do that again' (Helen, Unit A: First Interview)

Whilst these comments are somewhat resonant of the definitions of reflective practice posed in Chapter two, these responses served to indicate to me that asking nurses directly about reflective practice was not entirely useful. It seemed more helpful to take the lead from them in understanding what they did and why in their own language. Thus indicators of reflective practice such as experimenting in practice (Schön 1983) and creativity (Jarvis 1992), informed action (Johns and Freshwater 2005) and working in a community (Clouder 2000a and b) were explored if indicated in the second interviews and in conversation during observations, but not expressed as reflective practice which would be likely to be seen as a desirable trait and result in biased data. At no time did the participants talk about reflection as something they did formally or even informally, but they spoke extensively about 'checking things out' and 'talking things through' such that it was clear to me that some level of reflection was going on but that this could not be argued to be reflective practice. I had to ask myself at this stage whether

this was the correct decision and the issue was discussed at length with my academic supervisors.

As the data took the study beyond its original aim of identifying features of reflective practice in how the nurses in these settings went about their work, the picture that emerged at this stage was of a wider-ranging nature. Although cognisant in some ways with the notion of reflective practice, it seemed to illuminate the nature of modern nursing. Thus the themes outlined below are argued to provide an understanding of what constitutes contemporary nursing in the chosen settings through analysis of what the participants did and said.

4.3 Study Themes

Analysis of the study data revealed a central theme that ran through the whole data set. This theme, given the label '*Communication, Interaction and Discourse',* centred on the ways in which the nurses communicated with each other, interacted with their patients and the families and maintained a discourse both internally and within the nursing teams to monitor and evaluate their practice. This central theme was linked to three associate themes through the ways in which the participants shared understandings about practice that is the activities in which they were engaged and the ways in which they related to their patients. The associate themes were named *Being and Caring, Practical Action,* and *Knowing.* These associate themes were derived from discrete aspects of what the participants did and said, and were tethered to *Communication, Interaction and Discourse* through both the formal and informal discourse of the nurses (see Figure 2.0).

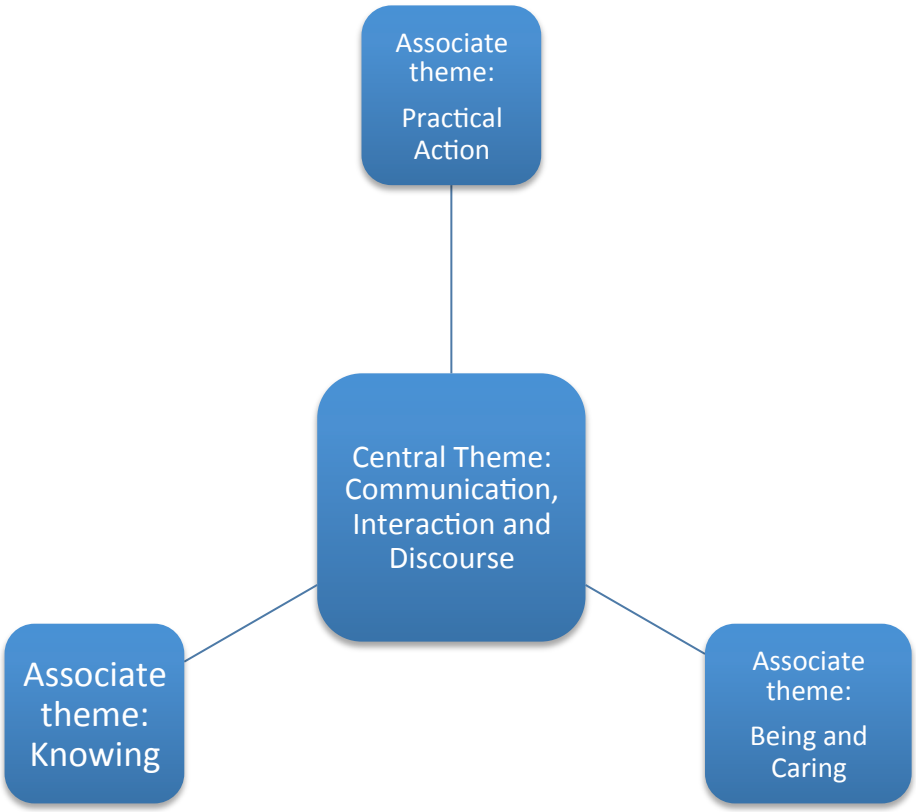

Figure 2.0 Relationship of Study Themes

4.4 Central Theme: Communication, Interaction and Discourse

Communicating with colleagues and with patients and their families was the conduit through which the associate themes, *being and caring, practical action* and *knowing,* were operationalised. Thus, the codes that make up this theme are closely inter-related with the codes within the associate themes. This central theme was abstracted from codes in the data that indicated the many ways in which the participants communicated and interacted with their colleagues and patients. The participants were observed communicating both verbally and non-verbally in handovers, engaging in discussions with colleagues and members of the wider team, with patients and their families, and in giving and receiving information; the labelling of the codes reflects the participants' own terms. The codes in this theme included *talking things through, sounding out, paying attention, picking up cues, building relationships, using the senses, listening and observing* and *using non-verbal means to communicate.*

The codes were clustered into two broader categories*: communicating and interacting with patients and families* and *communicating and interacting with colleagues.* These two categories will structure the presentation of this theme. Figure 3.0 shows how in this theme, the categories and the codes related to each other:

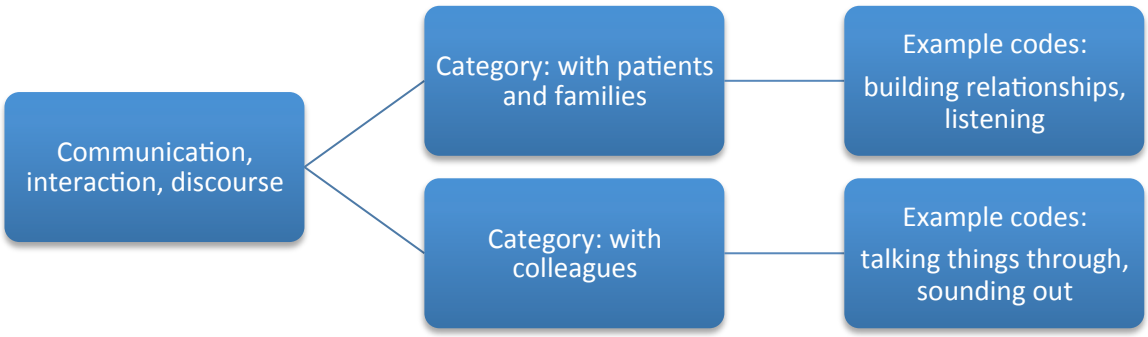

Figure 3.0 Central Study Theme with Categories and Example Codes

4.4.1 Communicating and Interacting with Patients and Families

Talking and interacting with patients and their families in context was a large part of the participants' practice. Giving and receiving information, making verbal and non-verbal assessments and relationship building were the basis on which the planning, delivery and evaluation of care interventions were built. Participants practised within a complex web of communication that both enabled and developed their practice. Both formal and informal modes of communication were used, and these supported the participants' actions, knowledge and ways of being with patients. Communication was therefore viewed as central to good practice, a vehicle for practice development and the means by which patients were kept at the centre of all activity. It was also the vehicle for the development of relationships:

'In order to keep the patient at the centre of the picture you've got to communicate with them.' (Kay, Unit B: second interview)

'With the families and the patients it's about the rapport that you've developed, then there's the multidisciplinary team who will plan where we're going and how we are going to get there.' (Katryn, Unit B: first interview)

'It's communication, it's easy to forget the patient's perspective' (Marie, Unit A: first interview)

The participants as a whole placed great value on effective communication with patients and families. This was perceived to be central to their ability to assess patients' needs and make appropriate responses in their actions. In both units, participants recognised the need to communicate and interact with patients and their families. This was highly valued and seen as the key means by which patients' needs and wishes could be known. The interaction observed ranged from information giving to assessment and the use of body language. This was influenced by the nature and the context of the care given. The outward characters of the participants and the nature of the care given in each unit had an impact on the time and opportunity for relationships to be built up, and thus on the varieties of communication modes used.

In Unit B in particular, perhaps due to the context and nature of acute palliative care, delivered at the end of life, building up relationships with patients and their families was seen as the key factor on which successful care could be based. This could sometimes be a lengthy process as patients' concerns and problems were gradually revealed, and on other occasions it required the participants to make speedy judgements through the various communication channels open to them:

'In a minute or two you are trying to glean the essence of where they are.' (Kay, Unit B: first interview)

'When you ask 'How are you?' you might use a score, or they might only be able to grunt.' (Ann, Unit B: first interview)

In Unit A the demands of surgical routines and short patient stays made the development of strong and enduring communication channels difficult, although it was still highly valued. Participants in Unit A recognised the importance of communicating effectively with patients and their families, but they also saw how one could not rush this, despite the demands upon them, and that they had to take any opportunities that they might get:

'You need to learn about people but in the right place, don't do a psychological profile when you've only known them one day.' (Sally, Unit A: only interview)

'I do worry about the relatives, (so) even if it's just saying hello.' (Marie, Unit A: first interview)

'I'm not a big talker but I try to give them opportunities' (Helen, Unit A: first interview)

Participants in both units attempted to use every possible opportunity in order to establish communication with patients and families. Often this meant that the participants had to use times when they were engaged in physical activities to make contact. This sometimes took the form of 'small talk' or social conversations. Participants would use an item in the news or the weather conditions to open up a broadly based conversation, or they might notice the

book the patient was reading or the photograph on the bedside table in order to create an opportunity to talk. This sometimes appeared on the surface to be simply social, but the participants saw all communication with patients and families as having a purpose:

'If you invest in your relationship with them they're easier to manage.' (Ann, Unit B: first interview)

'If you pay attention to people, then you learn from that' (Marie, Unit A: first interview)

'Participants in both units communicate constantly. This includes talking with colleagues, families and specialists but most commonly this is with the patients themselves. Little seems to be without a purpose, they find out all kinds of things about patients by just talking with them and they seem to add this to possible sources of understanding of the patient's needs.' (Reflective diary: 11/01/09)

This constant purposeful communication was tempered by a recognition that some forethought had to be given to what to raise and when, In particular in giving patients and families information. The context of care in Unit A did not always allow this, while participants in Unit B tried to use the right time and the best approach:

'You need to share knowledge with the family but you can't always just come out and say it. There's an element of risk but you have to seize the opportunity.' (Katryn, Unit B: second interview)

'Kay was engaged in a conversation with a male couple about the patient going home, and the respect that she accorded them was clear. They were a highly educated and independent couple, so Kay put herself in the position of enabler during the conversation, she asked them how they *felt problems could be overcome.'* (Reflective diary: 13/03/09)

Achieving desirable communication and rapport with patients usually involved finding ways of putting them at the centre of their own care so that they could

guide the interventions undertaken. Sometimes the investment in the relationship involved self-disclosure so that the patient might feel able to reciprocate:

'It's a part of the relationship that you're building up – in order for people to share, you have to give a bit of yourself in return.' (Karen, Unit A: first interview)

'In this job it's easier to be yourself, you have to step into emotional and personal or family territory here, you have to be genuine. Sometimes you're going to get it wrong, it helps them to forgive you if you say the wrong thing. It's you that's talking, not your persona – although that's what got you in the room in the first place.' (Ann, Unit B: first interview)

This kind of interaction was undertaken in order to invest in a relationship with patients and families that might enhance care outcomes. Sometimes this involved persisting in a dialogue to try to get to the heart of a problem that may not have been clear at first. In these situations, participants would gently probe in various ways. I heard the participants' stories about how they had had to be persistent and keep trying in order to engage with a patient and get to the heart of what was troubling them:

'If a patient can talk then I persist and they are glad, even if almost incapable and fatigued.' (India, Unit B: second interview)

'Sometimes Kay's persistence was needed in order to get a patient to admit to what the 'real' problem was. A gentleman with supposed constipation was an example of this. With great respect, Kay persisted in asking him about this problem until she found out what the real issue was.' (Reflective diary: 13/03/09)

This persistence had to be balanced with the patient's wishes; the nurse's desire to open up channels of communication had to be paced at the patient's

speed. Thus the participants were trying to find out as much as they could from the patients without putting pressure on them, while being aware that time might be pressing:

'I don't always ask the patient too much, I wait for them to open up.' (Kirsty: Unit A first interview)

'There's a lot of different speeds going on, the speed at which you get to know the patient; sometimes you get to know the family better than the patient.' (Ann, Unit B: second interview)

The assessment of patients' needs and wishes was a series of encounters that built one upon the other in order to gain a full picture of the patient as an individual. Often this involved using subtle skills in a process of exploration that had to be undertaken over a period of time:

It takes a bit of time" (Helen, Unit A: first interview)

'What I value here is time. You're more aware (that) people are vulnerable; things must be bad to be here. Having time to wash someone, I often think that is a good time to ask questions, just slowly over time, get to know people and say 'how does it feel being here?' Getting under the layers of, people do take a while to open up and some never do until they die.' (Kay, Unit B: first interview)

Directing one's communication skills towards the patient as an individual and at their pace required the participants to develop in-depth knowledge about them. Although this was recognised as a process, the reality was that the nurses needed to get to know the patient in order to plan care. In Unit B patients were often admitted for symptom control, and thus there was an imperative to find out which of their symptoms were distressing them and therefore needed immediate attention. In Unit A patient stays were usually a maximum of five days, so the nurses needed to know quickly what the patients' individual needs were in order to prepare them safely for surgery. This contextual difference is important in the understanding of the nurses' actions and the pressures placed on them by what they saw to be dwindling

resources and staff shortages. The ways in which the participants got to know their patients' needs were largely through rapid assessment:

'We build up an intense relationship as soon as they come in.' (Karen, Unit A: first interview)

'In a minute or two you are trying to find out where they are and I like to just say 'how are you?' It's so basic.' (Kay, Unit B: first interview)

'It's thinking on your feet, forward planning.' (Katryn, Unit B: first interview)

A range of skills was seen during observation periods that were used to communicate effectively with patients. This included verbal and non-verbal channels, written information and discussions with families and patients. The skills needed to effectively communicate with patients could, however, be quite specific. They included listening, sitting quietly, asking direct questions and just being with the patient:

'If you don't listen, you don't hear.' (Marie, Unit A: first interview)

'It's questioning, asking.' (Katryn, Unit B: first interview)

'Sometimes you need to spend time with patients, sit down and talk things through.' (Kirsty, Unit A: second interview)

Much of this interaction was designed to plan ahead or to establish patients' wishes, but it was also often designed to convey a subtler message to patients that the nurses were there to support them. This was a type of 'hidden agenda', operating alongside the usual communication that was observed on a daily basis. Participants talked about this hidden message as being about letting the patient know where you stand:

'He'd lost weight, his skin … checking how short of breath he gets. He's doing almost nothing here but (we need to be) getting him ready for home. There's also an element of making sure he knows we're on his side – maybe there's a barrier there.' (Ann, Unit B: second interview)

'It's about being with them, you need to get on their level so the patient can get the sense that you're there for them.' (Katryn, Unit B: first interview)

'It's having the time to give them that attention, to put everything else out of your mind – I'm going to pay full attention to this person.' (Sally, Unit A: only interview)

Ultimately the communication skills that the participants used were intentionally chosen in the light of their knowledge of that individual, of the time available and of the context of care. This ability to identify which patients had particular communication needs was held in high regard as a means of placing one's energies with those whose needs were the greatest and where it was possible to intervene. Rapid assessment of patients enabled participants to tailor their communication to the individuals for maximum effect:

'You know the ones that are constantly watching you, you know they want to chat with you so you'll spend a bit more time with them. Some don't want it so you know when to be quiet.' (Marie, Unit A: first interview)

*'The ways in which the nurses communicate with the patients is slightly different for each individual. The most unwell patient in Unit B often causes the participants to get down on their level, to speak quietly and gently and to use touch. In Unit A most patients are physically quite well and so humour and light banter are used to assess their reactions.' (*Reflective diary: 09/12/09)

Communication with patients and their families was not restricted to verbal channels. Participants appeared aware of their physical bodies and were seen to use their body language and touch as a means of communication. This may have been related to the participant group being entirely female, but they all used touch to communicate with patients in certain situations. A particular positioning, such as getting down to the patient's physical level, or a touch on the hand while speaking, or simply sitting with someone who was distressed,

were all observed. This physical communication took various forms and differed among the participants; some of them used more than others:

'*After a difficult episode where the patient had remonstrated with Ann that he was well enough to go home and care for his wife, Ann calmly took his pulse, explaining why she needed to do this and nodding her head apparently in time to his pulse rate as if to communicate how strong and regular it was.'* (Ann, Unit B: Mini Tour Observations)

'One thing I have to be careful with – I'm really tactile, you can tell if they don't like that.' (Marie, Unit A: first interview)

'We go to a female patient who is being visited by her sister. Ann relates to her on a very equal level and asks the patient for guidance as if she was the expert in her own care. Ann sits down on the same level with the patient to do this.' (Ann, Unit B: Mini Tour Observation)

This use of the body to communicate attention or empathy was observed in all the participants, although some, such as Marie, considered themselves to use more physical touch than others. The use of non-verbal, physical means to communicate was evident in the facial expressions used, and patients were observed to be trying to read the participants' reactions in their facial expressions. An example of this was in Unit A when surgical drains were being taken out. The participants looked closely at the drain and suture sites to assess healing, and the patients looked at the nurses' faces to try to read their reactions. In turn, the participants would observe the patients' reactions to interventions that might cause discomfort, and try to 'read' their reactions where no verbal response was given. In this way, the limited time available whilst carrying out procedures was used efficiently.

Participants in both units talked at length about the need to communicate with patients and families and sought feedback from their colleagues on the various means that they might use to engage with patients successfully. These forms

of communication could be seen in more formal settings such as discharge planning, but they were more often observed in day-to-day care where they served to help the participants gain access to patients' needs and concerns.

4.4.2 Communicating and Interacting with Colleagues

The participants interacted with their colleagues extensively and were observed in both formal and informal communication with them. These interactions usually concerned patients and participants communicated and interacted with each other to 'sound out' their colleagues about a certain course of action or to ask for advice. The importance of the team was prominent here as the participants used their team colleagues to gain support in what they were doing, to help them find more effective interventions and to talk through challenges:

'Informal discussion with colleagues, that's not only for me to check it out. Every situation is unique so I get someone else's slant.' (Katryn, Unit B: first interview)

The communication observed between the participants and their colleagues were largely of two types – the formal and the informal, both subject to the contextual features of the setting. Informal communication took place at break times and in the mutual meeting places that each nurse used while in practice; the drugs room, the nurses' station, the corridor and the sluice were common areas. Informal communication such as this was seen in both units. It was an enduring feature of the day, and it provided a foundation for more formal communication.

The communication that happened at break time seemed to serve a significant purpose particularly in Unit B, where the nurses brought to the team anything that they needed to pass by the others:

'We re-group at break time, five minutes to stop and take stock. (It's) for reacting and re-prioritising.' (Kay, Unit B: second interview)

'At coffee time in Unit B today the participants and their colleagues discussed a patient that they all found difficult to cope with; one nurse related a story about a small smile seen in a patient who is otherwise unresponsive, and they all discussed how interventions can talk back to them in minute ways.' (Reflective diary: 18/01/08)

In my observational notes I wrote a great deal about the break time discussion in Unit B; it seemed to serve a very particular purpose in that it was the only time at which a number of the nurses met together during a shift and talked about patient care. Often I observed decisions to change the approach with a patient or to try out something new, to alter the patient allocations or to refer a problem to a specialist. There did not seem to be any other period of the day when such intense debate took place. On occasions a member of another discipline was present, such as a doctor or a chaplain, and this gave the nurses the opportunity to raise issues or questions relating to patient care with that person:

'It's drawing on other people's experience. If this works it'll be good, it's a learning opportunity (too). If you share what you can it's ultimately better for the patient and family; certain things you can't, but if everyone has a bit of thought it's easier.' (Katryn, Unit B: second interview)

Katryn's view was particular to the context of Unit B where patient problems were often multi-layered and required creativity to solve. Conversely, the context and pace of care in Unit A meant that break times were 'hit and miss' affairs, and patient care was usually more straightforward and amenable to the usual interventions. Checking things out with the rest of the nursing team was done briefly as participants and their colleagues met at the nurses' station. Once or twice the ward was quiet enough for the nurses to sit down in their break room for a hot drink. At these times patient care was usually the topic of conversation, and ideas were discussed in the same way as in Unit B. These contextual differences influenced how the participants communicated and interacted with each other.

Formal communication between the nurses in Unit A was mediated by the use of a whiteboard that recorded the comings and goings of each patient during theatre lists:

'Every time Karen passes the whiteboard she checks up on the progress of admissions and discharges, theatre lists and returns to the ward. She also takes the opportunity to check in with any other team members that are there.' (Karen, Unit A: Grand Tour Observations)

On one occasion, as Karen checked the status of the patient group on the whiteboard she met a fellow team member and took the opportunity to ask after this nurses' allocated patients. She gave Karen a quick update and asked what she should do about a certain patient's condition. Karen was able to give advice and asked for an update after a period of time. This spontaneous and opportunistic communication and dialogue was dependent for its frequency and depth on the activity going on in Unit A at the time. On busy days or during periods of intense activity it became more of a formal 'catch up', and the participants would purposefully try to stop and 'check in' with their colleagues.

While in both units regular updates occurred as time allowed and need indicated, the shift handover was more of a pragmatic affair where the basic information about each patient was given to the incoming nurses. This event occurred at three specific times during the twenty-four-hour day, and it was a signpost of the changing shift. The group handover was a speedy affair, with a more detailed report being given at the bedside and involving the patient if they were able:

'In both units handover consisted of a rapid commentary on the printed handover sheets that each nurse collected on her way in; the main handover was at the bedside and involved the patient as one nurse handed over to the next coming on duty.' (Reflective diary: 12/11/09)

Thus the vast majority of communication episodes between staff in both the units were not formal but consisted of opportunistic interactions that occurred when passing each other as they went about their work. In both units this method of stopping to catch up was the most frequent way that participants communicated with their team. In Unit A this usually took place at the nurses' station; in unit B it was in the corridor:

'Ann gave a little précis of what she was doing – an update or voicing of concerns she was facing. This was a 'quick and dirty' exchange whilst passing or a few opportunistic words in the drugs room.' (Ann, Unit B: Mini Tour Observations)

'Informal discussion with colleagues, not only for me to check it out – every situation is unique so you get someone else's slant.' (Katryn, Unit B: first interview)

This spontaneous dialogue within the teams in each unit was highly valued as a means of framing and solving practice problems; particularly in Unit B, where patients were nursed in small bays, it was a means for each team member to keep an overview of all the patients' progress. In Unit A, where most patients were nursed in one ward area, it was possible for the nurses as a team to be aware of the conditions of the patients and events were more predictable. In Unit B, some patients' conditions changed rapidly and many presented multiple complex needs; this meant that the participants needed to keep the shift coordinator informed. Ann noted how this reliance on team updating could be lost when they were busy; this was problematic because the contextual and informal interaction was usually the most up-to-date information available:

'Some of it (what we pick up) is from what we call 'huddling', and this is enormously helpful. When we get busy the huddling stops and you (just) get handover and you go to the patient and find something different.' (Ann, Unit B: second interview)

The contextual reliance on the team for gathering the information needed for care and for getting support for one's actions was very high in Unit B. Each participant was observed engaging with team colleagues in this way, and changing their planned actions or receiving validation for what they had done through this means. It was seen as a relief that working in a team meant that there was always someone to ask:

'I don't mind saying that I don't know (what to do), I love working in a team for this reason.' (Marie, Unit A: first interview)

'I really need my team colleagues' (Helen, Unit A: second interview)

Working in a team that communicated constantly with each other was also a way of getting and receiving support. The dialogue that each participant had with their colleagues was viewed as crucial when practice was challenging or when things went wrong:

'I was just thinking that we're probably very good at off-loading on each other.' (Karen, Unit A: first interview)

'If I make a mistake, it's nice to be able to think positively – how could we do that differently?' (Sally, Unit A: only interview)

'We work as a team, we pick it up if anyone needs help.' (India, Unit B: second interview)

In these ways, interacting with each other within teams seemed to be crucial for the participants in order to frame and solve patient problems and to ensure that they were using the broadest possible sources of knowledge and support. Each participant was thereby able to access validation of their actions as well as ideas for alternative avenues. This dialogue was predicated on contextually defined action and desirable practice; its aim was to ensure that the most appropriate action was being taken from moment to moment. The more senior

members of the team provided support and the opportunity to evaluate what action was being taken.

This evaluative dialogue took place on two levels: first, the verbal and team interaction, and second, an internal dialogue with oneself, a constant review of the outcomes of interventions:

'I can identify with that, it's a case of priority and I would hate to forget something so my mind is going through a check list all the time.' (Karen, Unit A: first interview)

'Ann reviewed verbally to herself and tried to come to conclusions about what the problem consisted of.' (Ann, Unit B: Mini Tour observations)

This internal dialogue was not a feature of every participant. Karen in Unit A and Ann in Unit B were the participants that I particularly observed doing this. What every participant did do was to consult their written notes, taken at both formal and informal handovers. The amount of information that each nurse needed to keep at her fingertips could not be stored in the head, and note taking; checklists and jottings were a constant feature and an important aspect of communication.

4.5 Summary of Central Theme

This theme was the one that pulled together each of the associate themes. The participants were communicating and interacting together constantly and this formed a large part of what I observed and mediated the workings of what they did and how they did this. They met together formally and informally and they sought each other out to check out understandings or get validation for certain actions. Much communication was in passing, in the drug room, at the nurses' station but all was purposeful and directed towards a better understanding of the situations at hand.

The communication that was observed between the nurses was a highly valued feature of their practice and was influenced by the context of care. It served to give support to the nurse making difficult decisions, and it helped team members (both senior and junior) to learn new approaches and be creative. Ultimately the changing and dynamic nature of the practice in each unit meant that one formal handover per shift did not serve to keep everyone fully updated. Despite the 'huddles', the break time re-grouping and the whiteboard, constant verbal communication between team members was vital for keeping each other in the picture.

4.6 Associate Theme 1 Being and Caring

The theme *being and caring* was one that was abstracted from the codes that illustrated the ways that participants 'were' when relating to patients – not simply in what they did, but in their emotional reactions, demeanour and their responsiveness in their ways of going about their work. The data clustered into this theme included the following codes: *a common humanity, caring, empathy, using instinct, intuition and emotions.* These codes were aggregated into two categories named: *being human, ordinary and genuine*, *being instinctive, empathetic and caring* and *using emotions.* This associate theme is represented diagrammatically in Figure 4.0:

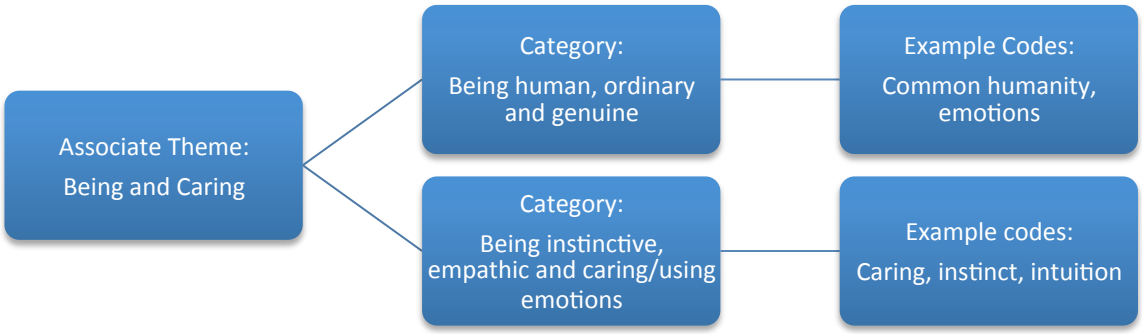

Figure 4.0 Associate Theme: Being and Caring with Categories and Example Codes

4.6.1 Being Human, Ordinary and Genuine

The data collected and coded into this category of the theme *being and caring* included many references to the ways that participants related to their patients and how they recognised, appreciated and used this. During the interviews, each participant talked about being human like the patients in their care. In my reflective journal I wrote about this as appearing to be a common link between the participants, a topic that they all referred to in one sense or another. There were many ways in which this was put across but one of the most prevalent was articulated as a *common humanity with others.* The participants spoke about sharing this with each other and with the people in their care, and how this played a part in nursing practice:

'In this job, it is easier to be yourself. You have to step into emotional, personal and family territory here. You have to be genuine; you're sometimes going to get it wrong. It helps them to forgive you if you say the wrong thing. It's you that's talking, not your persona, although that's what got you in the room in the first place.' (Ann, Unit B: first interview)

'Its easy to forget we're all human too' (Helen, Unit A: second interview)

In Ann's view, a common humanity formed a foundation for her relationships with patients. The nature of nursing and the context in which Ann practised meant that she was open to this commonality with her patients and was able to use it. It also enabled her to achieve something, having this identity with her patients was a route to establishing relationships and maintaining this when things became difficult.

Ann saw her role as a nurse as being the entry point into her patient's intimate lives, but that it was her real self that took the relationship forward. The putting across of this common humanity was a necessary investment for when problems arose, in that it enabled the relationship to survive challenges. This was a particular feature of how relationships with patients

were seen in Unit B, where Kay also recognised that the nature of her work in palliative care could engender this feeling: *'We have such a variety of people here; it's a great leveller'* (Kay, Unit B: first interview). This, as I noted in my reflective diary after the Grand Tour in Unit B was complete, meant that the staff and the patients were not in a power relationship, but were positioned on an equal footing:

'It is so very different in this unit in terms of how the patients and the staff relate. Something about the relationships that I have seen between patients and nurses is rather more intense, more human than professional, although that too of course.' (Reflective diary 10/01/08)

One of the most obvious contextual differences between Units A and B was that the nurses in Unit B did not wear uniform. This apparently minor difference seemed to affect the relationships in the ward; this was recognised by the participants:

'*It's less formal in a way (not wearing uniform) for the patients and the family, it sends a message that we're nothing special.*' (Katryn, Unit B: second interview)

Katryn saw the wearing of ordinary clothing by the staff as a purposeful act. This, as I noted in my reflective diary, made for some confusion at times (certainly for newcomers), but it meant that one's position in the unit was free from some of the more obvious trappings of rank and hierarchy but crucially was determined by what you could do for the patients. At an early stage in data collection on Unit B, I reflected on how this made me feel as a nurse:

'It is odd not wearing uniform; I feel rather exposed. Not sure where to keep pens and notebook, but it made me think hard about what to wear. Something conventional and practical I guess.' (Reflective diary 18/01/08)

The staff in Unit B had therefore made a purposeful choice to appear and act in a certain manner in order to express this common humanity. Although the participants largely liked this, some problems were indicated by India. India was the only participant to talk about the side of common humanity that might result in disliking a patient, just as might happen in non-professional acquaintances. Other participants did not raise this, and I reflected at the time that this might have been due to the seemingly unprofessional nature of a disclosure that one might dislike a patient. With India, the issue arose during a discussion reflecting on involvement with patients:

'I think every now and again you come across a patient who for some reason, well – to put it bluntly, you just don't like; you do everything that you do for the next patient, but for whatever reason … there must be a difference in the … if you could computer-generate the muscles in the face or the eyes, I am sure there would be a difference, if you got down to that level.' (India, Unit B: first interview)

India's honesty here indicated that this humanity was genuine; if one could relate to someone on an ordinary enough level to dislike them, then that relationship would be considered to be deeper than the usual nurse-patient relationship that is predicated on the tradition of professional detachment. India attributed this particular type of relationship to the nature of the nursing in which she was engaged, and offered a practical solution:

'It's because our patients are so very vulnerable; physical, emotional needs, they should be offered someone else.' (India, Unit B: first interview)

In Unit A, although the context and nature of practice was much more structured and subject to external demands, this notion was still recognised and purposefully communicated to patients, as Karen described when talking about how she established relationships with patients: *'(it is) through emotional support, kindness, acts of human kindness'* (Karen, Unit A: first interview). The participants that worked in Unit A wore uniform, but stated that they wished patients to see and relate to them as ordinary human beings.

Marie explained her approach to patients by reflecting on her own experiences as a patient:

'I was a patient once, as a second year student. I had some pretty negative experiences. I felt patronised, but we don't do that.' (Marie, Unit A: first interview)

Marie related to me how keen she was that her own patients did not relate to her in this unequal manner. This desire to put across an ordinary humanity was observed in the participants' behaviour in Unit A. My accounts noted Karen chatting to a patient about her family whilst she waited with her in the anaesthetic room, how Marie flashed a smile at each patient she passed, and Helen was mentioned in my reflective diary as coming across as *quiet and calm*. These ways of being were discussed in the interviews and were attributed to:

'Being hospitable, going the extra mile' (Karen, Unit A: first interview)

'Coming across the right way' (Marie, Unit A: first interview)

Also in Unit A, Sally saw her humanity as being purposeful, but by the same token it was an aspect of her as a professional that allowed her to 'not know' something or to make mistakes: *'I think that's being human, no-one can know all the time'* (Sally, Unit A: only interview). Sally said that over time she expected to develop confidence in her ability to show herself to her patients as an ordinary human being who had limitations:

'It is experience, isn't it? The next time, I thought ... I'm more able now, I don't feel I have to know (everything)' (Sally, Unit A: only interview)

Seeing this as a positive aspect of the nurse-patient relationship was prevalent across both data collection sites, but was more marked in Unit B. The context and nature of the patient care in Unit B and the intensity of the relationships required to help patients and their families at the end of life, was seen by some participants in that unit as being the cause of this.

Being aware of a common humanity was not commensurate with age or experience in nursing, although the more experienced practitioners appeared more likely to be comfortable with talking about it. My reflective notes at the time suggest that this was how I was beginning to see this issue:

'Acknowledging one's common humanity with the patients and feeling comfortable about it are two different things, which may be what differentiates the expert practitioner' (Reflective diary 22/09/09)

For some participants, an appreciation of this was articulated but it seemed to raise contradictions when it was seen in context. India, an experienced cancer and palliative care nurse, seemed to me to be *acting out* her human responses:

'India saw her responses to patients as being unconscious; there was however in my observations of her an element of putting on a persona, of 'being' a certain way with her patients. This she attributed to common humanity.' (Reflective diary: 1/02/09)

Ann voiced a similar belief that she recognised not only a *purposeful* way of being with patients but also one that was an investment; this was described as an investment in the future:

'*If you invest in your relationship with them, they're easier to manage. You can do more for them – it's working in a clever way – put more time in at the beginning. It's not wholly altruistic as you've got to manage your workload'* (Ann, Unit B: second interview)

Thus, there seemed to be a purposeful and therapeutic side to this recognition of identity with patients, in that it had an intention and it was used to establish relationships that would make nursing more effective. This had, however, to be balanced against the resources available at the time. Participants talked about communicating their humanity to their patients; they described putting across

a purposeful message to patients that they were human too, and that this could be achieved by putting across a certain way of being with patients: '*that is a deliberate persona that you put on'* (Ann, Unit B: second interview). This ability, to use one's humanity as a resource and to apply it purposefully, was seen in my reflective notes as developing over time and as context-dependent:

'*Kay talked about thinking on your feet, being able to change direction and re-set boundaries. This had limits, though, because of her awareness of her own humanity, but she saw this very humanity as contributing to her ability to do things better – growing as a person due to working there and this then helping her to do it better.*' (Reflective diary: 13/03/09)

This came across to me at the time as being potentially quite demanding on the nurse, and as involving considerable effort and resilience: *'this must be such hard work'* (Reflective diary, 13/03/09). The need for some feedback or indication of success in the investment of this common humanity would seem to be needed. Patients' situations took their toll on the participants' emotions but they seemed to be able to draw on reserves of strength:

'Ann seemed to possess large amounts of both physical and emotional energy which enabled her to address each problem with vigour. She was never 'put off' or defeated, she just re-thought, re-grouped and tried again.' (Reflective diary: 19/11/08)

This emotional strength seemed to me to enable the participants to cope with the demands of patient care and the limitations of the context. Their colleagues were identified as the support and resource in order to maintain this level of strength, but this did not seem to be sustainable:

'I have no idea how these nurses (particularly in Unit B but in A too) cope with the demands of what they do, they must get so disheartened at times' (Reflective diary 13/05/08)

Kay articulated in a long discussion at interview that this drain on her humanity was not without cost in causing her to doubt herself, but that there was a standard way of being that was expected of her:

'I can't help having some anxiety about my own performance; I need to get it right, do it the right way and be up to the mark.' (Kay, Unit B: second interview)

The context of care in both units meant that the participants were caring for people at a time of great crisis in their lives. This resulted in heightened emotions and a desire to consistently produce the best care at all times. All of the participants seemed to have the resources and strengths that enabled them to be genuinely open to change and to a critique of their practice. They were not afraid to relate to me everyday stories of how they had made mistakes or acted wrongly and learned from this:

'I knew when I came out of the room it was not comfortable, before it had been fine … I had to go away and learn from it, reflect on it and do it differently next time. I did some research, some reading but I felt it was important for me to do that … sometimes we get it right, sometimes we don't. We can learn and grow from each experience.' (Katryn, Unit B: first interview)

Across the range of ages and experience in the participant group, there was an acceptance that mistakes would be made and redress sometimes had to take place. Ann noted how inadequate they all sometimes felt in the face of the human crises unfolding before them:

'What's the appropriate decision? Who can make an appropriate decision? The small decision – you're always getting it slightly wrong.' (Ann, Unit B: second interview)

In Unit A, where the context meant that the pace of care and turnover of patients was so much higher, Kirsty took a pragmatic approach whilst accepting that as a human being, negative events were just as likely to happen to the more experienced as they were to the least, and that this did not put her off from trying to do the best job that she could:

'I use bad experiences to learn rather than avoiding taking that extra step; it's best to admit what you don't know and remedy this.' (Kirsty, Unit B: second interview)

This resilience was a topic in my reflective diary that I attributed to being perhaps '*a feature of reflexivity'* (Reflective diary, 19/12/08) in these nurses, in that they acknowledge that both patient and nurse may be vulnerable and yet still evaluates honestly the effect of their own actions on others. Some participants were more pragmatic than others about the human aspects of their work:

'I think you do the best you can, while you're here. Then home is home, and it's rarely that I get so upset that it impinges on things at home.' (India, Unit B: first interview)

'I have to remember, I am not the patient' (Helen, Unit A: second interview)

India was able to keep separate the human demands of patient care from those of being a wife and mother. Others, such as Helen, did not show or speak of their human side so visibly:

'Helen is not one for small talk. She takes everything very seriously and does not really open up to me. She does everything 'by the book' and concentrates on the job in hand.' (Helen, Unit A: Mini Tour Observation 18/12/08)

Throughout the observation periods, participants could be found in intimate and challenging situations. This often meant that there was a need for them to be as genuine and honest as possible, perhaps more than professional

relationships might usually demand. Commonly, these situations were related to caring for very sick people in very specific contexts:

'All our patients are dying, but you don't need to be wrapping them in cotton wool; you give them time and sit with them but you don't have to give the softy, sugary. They're still the same person, it's a natural life progression, and you don't need to be too precious.' (India, Unit B: second interview)

This approach embodied a reflective recognition of the common humanity that led participants to form ordinary, genuine and authentic relationships with their patients. Although Marie in Unit A saw her patients as vulnerable and in need of protection, ultimately the participants' approach meant that any tendency to paternalism or maternalistic attitudes was rejected in favour of an honest and ordinary relationship in what were perhaps extraordinary contexts.

4.6.2 Being Instinctive, Empathetic and Caring

During interviews, all participants talked about using their *instincts, gut feelings* or *intuition* to guide them in making decisions such as how to handle a patient or when to withdraw from a situation. Participants also spoke about their practice in terms of how they attempted to show empathy to patients; this was often in terms of trying to think about a situation from the patient's perspective, or about what they themselves would wish for in the same situation. This empathy was often a guide as to what to do in a certain situation. Finally in this section, they also talked at length about caring; suggesting that caring for others was a virtue of the 'good nurse'.

Instinctive, intuitive or *'gut' feelings* were often used to express an inner way of knowing how to react in a particular situation. The ability to perceive and use one's instinct was discussed in terms of whether this is naturally present or something that one learns:

'Some of that (decision-making) is intuitive rather than learnt; I'm not sure that I would say that it is something I've developed or came to the job with but you do get better at it' (Kay, Unit B: first interview)

Karen related instinctiveness to experience, in particular to the experience gained at a certain age:

'Whether that is just life or because I went into nursing at eighteen, I've had plenty of time – or one develops that at a formative age.' (Karen, Unit A: first interview)

As experienced nurses, both Kay and Karen felt that their instincts or intuition about practice came to them naturally, but that they had improved with experience. Participants saw instinctiveness as being a virtue that can be learned. Katryn put this succinctly:

'Sometimes I just have this feeling … you can have a feel for where they are going … it comes over time as your confidence grows' (Katryn, Unit B: first interview)

This perception of instinct as a key source of understanding about situations, in particular how to respond in certain contexts was not universal. Sally and Helen, among the least experienced of the participants were unable to see themselves as using an intuitive sense in practice. They looked for more concrete cues as to what to do in a certain situation:

'I sometimes … I feel I have a gut feeling about something, but I don't think it is really. There are all sorts of cues really, the cues are there – it's attention again.' (Sally, Unit A: only interview)

'I'm not sure I am using intuition, I either know or I don't' (Helen, Unit A: second interview)

Sally's need to search for cues that were of a more concrete type marked her out as rather different to the rest of the participants, although the fact

that she was the most recently qualified nurse may have meant that she did not possess the confidence essential for instinct or intuition to be relied upon.

India's beliefs about intuition in the context of acute palliative care were that this was *not* learned; she believed that being able to access and use these resources was a personality trait and not an acquired skill. She felt that one either had these skills or one did not:

'Some people just can't bear to get involved like that, I think it's something you've got or you haven't got.' (India, Unit B: first interview)

India's reaction to this topic was perhaps indicative of her seeing the use of intuition as a feature of involvement; this may mean that all nurses have these abilities to some degree, but they may choose not to use them in practice. India went on to say that in fact this was what she herself would want in the patient's situation, and that one had to respect that it was the patient's own life in question, this was what led her to this honest perspective.

For some participants, their instinct or intuition was a influence on their practice. Being instinctive or allowing one's instinct to guide actions was articulated by Kirsty, who related a story of her intuitive judgement about a post-operative patient. She finished by saying:

'Something in my intuition told me there was something seriously wrong; she looked at me with fear in her eyes.' (Kirsty, Unit B: first interview)

Here Kirsty was articulating the use of her intuition, and this particular phrase is also referred to later, but she also notes how she picked up on the kind of concrete cues that Sally referred to. This mix of the use of instinct and intuition with more traditional or concrete cues appeared to be common to all the participants:

'In all of the participants with whom I have worked, I can see them using a variety of skills to guide their actions: instinct, empathy, cues given by

patients verbally and cues picked up from body language and non-verbal signs' (Reflective diary: 11/02/09)

The use of intuition was seen as a necessary but not sufficient, condition in guiding action in these contexts, and it could lead to a positive, if unexpected, outcome. I observed Kay who, having been told at the handover that her patient was feeling nauseated but was refusing symptom management, seemed to use her instinct or intuition to try to get to the heart of what he was feeling. However, she had to persist because the patient was not willing to say what the real problem was:

'Sometimes Kay's persistence was needed in order to get the patient to admit what the real problem was. A gentleman who was reported at handover as feeling sick was a good example of this. We went straight to him and Kay got right down on his physical level so that she could hear his whispered voice. She seemed to think that maybe something else was causing his distress and she persisted until she saw past the apparent problem to what was really troubling him.' (Reflective diary: 13/03/09)

In this observation, Kay demonstrated the influence of her intuition about this patient on how she behaved. She instinctively felt that the problem was different to what had been reported at handover, and she persisted in trying to find the real problem based on this instinct. Kay was able to find out that the patient was in fact constipated and that the nausea was a secondary issue to him.

India was more circumspect about the aspects of her practice that she attributed to intuition; she distinguished between the rational response that comes with experience and the instinctive reaction that comes with being able to recognise someone's feelings:

'The rationale is there ... because I've been doing it for so long, I'm thinking about it without realising I am thinking about it ... if someone is a bit agitated, I think I know what it might be due to, that is learned over the years I think but

the instinct that someone wants you to sit with them or hold them ... that is probably instinctive' (India, Unit B: first interview)

In addition to intuition, all participants showed that they responded based on feelings of empathy. This was raised at interview by most of the participants, either directly or indirectly. I use the term empathy here to include an ability to see situations from the patient's perspective; the participants seemed to work at sharpening their empathetic feelings in order to put the patient's perspective first:

'It's easy to forget the patient's perspective, nursing routine causes us to make assumptions' (Marie, Unit A: first interview)

'We may be able to see what might be best but ultimately it is (the patient's) decision. I have to respect their priorities' (Kay, Unit B: second interview)

However, Sally found it difficult to empathise with patients due to not being able to experience their journey:

'I like to spend time with people, it makes a difference to them, they've been through all that experience which I haven't been through so I can't really appreciate' (Sally, Unit A: only interview)

This slightly different perspective may suggest that Sally did not feel empathy for her patients, but perhaps this was not what she intended. I reflected on Sally, who seemed to be preoccupied with gaining competence and confidence and often saw hurdles ahead. In further discussion Sally went on to clarify this comment by saying that she felt that she did not have enough time to get to know patients well enough; as a relatively inexperienced nurse, this may have been a barrier to feeling empathy. Marie helped to clarify what may have been Sally's meaning by identifying the difference between one's own personal experiences and an understanding of the patient's experience that may amount to empathy:

"I do worry and I do know what it is like (to be a patient) but I would never ever say I know what you're going through' (Marie, Unit A: first interview)

This use of empathy to assess how honest to be with patients was common:

'There's also an element of making sure he knows we're on his side; if you take the trouble and deepen your relationship with him ... allow him to express his feelings' (Ann, Unit B: second interview, talking about a patient we nursed together)

'Fridays are anxious days, I would say anything that's honest to help them get through the weekend until the results on Wednesday' (Marie, Unit A: first interview)

During observations, I was often witness to situations in which the participant's empathy led them to a direct course of action. While observing India dress a fungating wound, I noticed that she did not avoid the topic of the unpleasant smell:

'I thought that India would try to ignore the awful smell coming from the patient's fungating breast. Even though she was trying out a new dressing in order to help with this problem she might have skirted around the real reason, but she didn't. She was not scared to get to the heart of the matter and the patient seemed relieved to be able to talk about it. I didn't really know what to say' (India, Unit B: Mini tour observation)

When asked about her perspective on this incident, India said:

'To us it might not be as bad, if it's under your nose you are more sensitive, I would hate it but I think people want to know, else they are worrying about it' (India, Unit B: second interview)

India expressed very clearly here that she was using her empathy with a patient's situation to guide her actions. She could imagine how the patient may be experiencing the problem, and she used this to direct her actions towards a

practical solution. This may have been influenced by the context of care and empathy was most evident in terms of the messages of caring that the participants were all giving to the people in their care. This often involved acting in a particular way in order to show the patient that they cared:

'(You) try to show you care by listening, you need to focus on a patient, forgetting all else.' (Marie, Unit A: first interview)

'It's having time to give them that attention ... to put everything else out of your mind ... I'm going to pay attention to this person, your full attention.' (Sally, Unit A: only interview)

Both Marie and Sally talked at length about trying to help their patients to see that they cared about them. This was a great motivator in their actions and came across to me as a significant imperative:

'Marie's strong ideas about practice belied her youth. She expressed a passion for nursing where the essence of practice is caring. The point that really struck me about this was that she genuinely did care. Marie cared honestly about the patients and it showed – they felt it and they said so.' (Reflective diary: 09/10/08)

For Sally, this could be hard work:

'Somehow I have to clear my mind, not have other stuff, have the space.' (Sally, Unit A: only interview)

This perception that one had to make time in order to 'be with' patients in an empathetic manner was difficult for others too; in the context of Unit A the nurses often had limited time to put across their empathy to the patients in their care:

'There isn't a second chance, you've got to make the best of what you've got.' (Kirsty, Unit B: second interview)

On Unit B, this often related to the amount of time patients had left at the end of their lives, while on Unit A, stays were short and time was limited by the nature of the interventions needed. With the limited time available in both units, showing patients that you had empathy for their situations and cared enough to do something about it was a priority. Katryn, who was often the shift co-ordinator, articulated the desire to act on her empathetic instincts despite the pressures of practice in general:

'If a patient needs me that's it, (even if) I may have to make a judgement (about) the team' (Katryn, Unit B: second interview)

Showing empathy in these contexts was inextricably related to caring; both *giving care* to patients and ensuring that patients felt *cared about*. Caring seemed to be a key concept in this theme, and in particular how this related to the purposeful use of their emotions in order to express professional caring. Some patients were particularly singled out for this attention:

'Some you have to give a bit more, you know, the ones that are constantly watching you, you know they want to chat … some don't want it, you know when to be quiet.' (Marie, Unit A: second interview)

In this discussion about caring, Marie made a subjective judgement about how much of herself to put into a relationship with a patient. She was picking up any cues that she could from her observations of patients in order to make this judgement. Thus, how she *felt about* and how she *cared for* patients became inextricably related; she cared *about* her patients and therefore cared *for* them.

4.6.3 Using Emotions

The Grand Tour observations undertaken in each unit were documented using Spradley's Descriptive Question Matrix, which includes a description of the feelings related to the categories of (for example) the actors, the

events, the space and the time. In completing these Matrices for Units A and B, I reflected on the feelings and emotions that I sensed:

'Objects with a technical purpose were kept out of sight of the patients so that a more homely space is constructed'

'The nurses pay attention to patients' feelings and enquire about them often during the day; they also talk openly about their own feelings, about patients, about the unit and about their work'

'Feelings seem to affect the nurses' actions when they sense that certain acts are inappropriate or need to be undertaken at different times to the usual.' (Descriptive Question Matrix: Unit A)

Unit A was a surgical ward, and thus the impact of the emotions of staff and patients was sometimes difficult to attend to when other more pressing needs were evident. The latter sometimes included patients' conditions deteriorating or changes to the operating schedule. Despite these constraints, the participants recognised the emotional needs of their patients and acted on these:

'One notices peoples' emotions; you can see by their face and meet those needs.' (Karen, Unit A: first interview)

'It's not just about physical treatment, psychological (support) is needed too, you have to spend time with patients, to sit down and talk it through.' (Kirsty, Unit B: second interview)

Unit A, as a breast surgery ward, admitted female patients who were facing a diagnosis of breast cancer and were undergoing surgery which would both remove the primary tumour but also diagnose the histology and stage of the disease. This was a time of considerable stress and anxiety for the patients and their families, which meant that patients needed emotional support. A few patients had extensive disease and were receiving radioactive implant treatment. The ages and situations of these patients could be distressing.

For these reasons the participants were conscious of the emotional needs that many patients had, and they attempted to give the appropriate support. During discussion, participants admitted that the patients' situations often reminded them of their own fears:

'I have to shake myself sometimes, not everybody has breast cancer' (Karen, Unit A: first interview)

'I don't know what I'd do if it was me' (Helen, Unit A: second interview)

In Unit B as an acute palliative care unit, I noted that emotions and feelings seemed to be openly expressed and attended to:

'Feelings affect activities by triggering action. The nurses see or sense a problem or need and try to find out if the patient is distressed about this. If so, then he or she will attempt to fulfil that need or solve the problem. Action may not be taken if the issue is not now causing distress.'

'Emotions may affect events by eliciting positive or negative feelings. For example a death may be the cause of relief from hard physical and emotional work (as I witnessed)'

'Over time during a patient's stay in the ward, the nurses seem to be exposed to a variety of emotions. This seems to lead to a great interest in physical sustenance ... there is a lot of cake eaten at break time, after which they all say 'that's better'. (Descriptive Question Matrix: Unit B)

Unit B cared for people who were at the end of life, not necessarily immediately likely to die but requiring control of symptoms such as pain, nausea, breathlessness and fatigue. These problems seemed to be a source of emotional distress to patients, families and staff alike. For many patients, death was in the near future and the immediate concern was to alleviate suffering; the participants were engaged in attempting to assist. In some cases the participants were struggling to help or were unable to effect a positive outcome, and this was emotionally challenging. Participants talked

extensively about their emotional reactions to practice, responding to questions about their work in terms of how they or their patients felt.

During observation periods it was seen that the practice in both Unit A and Unit B involved the nurses in coping with the emotional reactions of patients and families; additionally, participants expressed their own emotional responses to the situations of their patients:

'Different patients upset different nurses, depending on your home situation. Dealing with families is harder (because) you can see the loss and grief' (India, Unit B: second interview)

'Occasionally somebody will move you and you'll remember them and they'll go through you – you learn survival techniques, you move on.' (Karen: first interview)

The emotional responses that participants expressed were inextricably related to the context of care and sometimes caused them to act in a certain way. This was seen as part of the 'common humanity' that they shared with each other and with the patients. Participants viewed their feelings as being a valid and direct basis for action:

'It was clear that Karen did not want to have to get the patient re-cannulated; the patient had a dread fear of needles and was very frightened. She decided to try to administer the anti-emetic anyway. When we talked about this at interview, Karen said that she felt the patient's anxiety and decided to take a risk in order to avoid causing further anxiety' (Karen, Unit A: Mini tour 18/07/08)

'I don't think it (traditional knowledge) plays a big part here; it's like the hydration debate. There's lots of research and you can weigh it up, but for me the argument is, if the patient is not expressing a desire for it then what's it there for?' (Katryn, Unit B: first interview)

As an ever-present undercurrent, participants took their emotional responses to patients' situations into account when choosing between certain courses of action. Emotions were therefore seen as a more valid knowledge base for action in certain situations:

'When I'm assessing, I'm concentrating on their emotions' (Marie, Unit A: second interview)

'I'd hate to be in a position (to have to) say 'there's nothing more we can do for you'. Better to say 'we'll try this' – it's much more hopeful.' (Katryn, Unit B: second interview)

'The essence of this job is tender loving care, really' (Kay, Unit B: first interview)

In other situations, the use of emotional reactions to guide practice was not felt to be helpful:

'There has sometimes to be a certain degree of detachment or you wouldn't be any use to anybody' (India, Unit B: second interview)

'Even amongst acts of kindness, you have to appreciate that you are doing it for their own good, you have to do certain things that are unpleasant because that's the only way you will achieve that good' (Karen, Unit A: first interview)

Thus, it seemed that although emotional reactions to patients' situations were accepted as a normal and valid reason to act in a certain way in the two settings, this could not be the best approach in every context. However, India felt that an emotional reaction to patients' situations marked out the 'best' nurses from the rest:

'I think that at some level (the way in which care is delivered) must make a difference. The people who gave them a wash the day before may be more ... compassionate isn't the right word, more comfortable with doing it, a difference in the way you touch' (India, Unit B: first interview)

The way that participants talked about their emotions indicated that emotional work was used at times to achieve certain ends or to engender certain feelings in patients. This involved behaving in a certain way or performing certain acts in order for patients to feel the way that the participants wished them to:

'I try to come across in the right way' (Marie, Unit A: first interview)

'Yes, you have to look at physical needs, treat the symptoms if they are overriding, but it is about being with them, getting on their level so that the patient can get a sense you're there for them' (Katryn, Unit B: first interview)

In particular, the participants often used their emotions in order to build up relationships with patients:

'It's part of the relationship you are building up; in order for people to share you have to give a little bit of yourself too' (Karen, Unit A: first interview)

'I try to help patients to see this ward as a safe haven in the midst of chaos' (Kay, Unit B: second interview)

In these ways, participants attended to how they appeared to patients by manipulating their emotions in order to instigate and develop effective nurse-patient relationships. Manipulation of emotions occurred as a daily routine; I reflected as follows:

'Each of the participants attends to how they come across to their patients. They put on a smile before entering a room or pause to compose themselves. Sometimes, a small hint is given to a patient about how they are coping. Ann asked a patient if he would mind if she had her coffee break before helping him to wash and he responded warmly' (Reflective diary: 15/03/09)

This balancing of their true feelings was pervasive, but some participants did more of it than others. For example, on Unit A, Helen was very unlike Marie. Marie smiled at patients and used touch to communicate her feelings; Helen did not seem to display her feelings and had a consistent demeanour. However, when they were very busy, all of the participants used their emotional repertoire to communicate to patients that they still had time for them in order to ensure that patients did not feel they were a burden. India reflected on this:

'It's not the patient's fault, you have to go in calm and smile.' (India, Unit B: second interview)

4.6.4 Summary of Associate theme 1

Throughout this theme, the participants' use of their emotions and intuitive feelings was a clear influence on their nursing practice. While these notions were not emphasised equally by each of the participants in this study, the belief that they shared a common humanity with their patients meant that they all felt that emotions and intuition or instinct were a valid justification for certain actions. The participants spoke readily of these ideas and the effect on their practice, they talked of the empathy that they felt for their patients and how this helped them to build caring relationships. The observations undertaken showed the participants using a variety of skills to pick up on cues that helped them to establish patients' needs including a particular persistence in pursuing the truth of a situation.

4.7 Associate Theme 2 Practical Action

The codes clustered into this theme were about nursing action in terms of the activities that the participants carried out during their working day in each setting. Participants focussed on what was perceived to be practical in the situation at hand and valued attention to detail, including both the major and the (seemingly) minor aspects of what they did. Often this practice was creative and involved trying out new ways of solving patients' problems. To a greater or lesser degree, the participants all demonstrated an ability to experiment in

practice when the appropriate action was not clear. The codes clustered into this theme included: *prioritising patient's needs*, *giving individualised care*, *experimenting in practice.* This theme is presented structured around two categories: *prioritising patients' needs and individualised care* and *experimenting in practice*. This is illustrated in Figure 5.0:

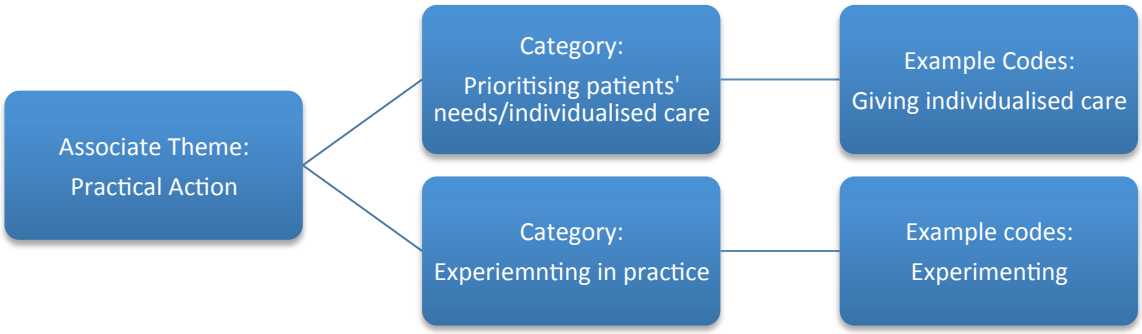

Figure 5.0 Associate Theme: Practical Action with Categories and Example Codes

4.7.1 Prioritising Patients' Needs and Individualised Care

Much of the discussion during the interviews with the participants focussed on the situational and practical aspects of their work and resulted in a reflective discussion about the values and rationale that informed this. Overwhelmingly participants were clear that it was the patients' own wishes and needs that directed the practical action taken:

'It's the patient's wishes, they know best' (Kay, Unit B: second interview)

'It's about assessing how they are feeling and responding in the way they want me to' (Marie, Unit A: first interview)

The participants all talked at length, both in conversation during observation periods and at interview, about the various forms of practical work in which they were engaged and how this was centred on individual patients. Much of this discourse was concerned with the assessment of patients' needs, interventions to fulfil these needs and a desire to constantly work to improve the efficacy of what they did:

'A lot of it is anticipating I think – reading, assessing – all those really back-to-basics nursing skills. Looking at your patient, assessing, reassessing – they're changing so quickly here that each time you go the patient's slightly different and it brings you right back, using your eyes, ears, smell, everything to work out what's going on and how you can improve things, even if it's just moving the pillows' (Kay, Unit B: first interview)

Following completion of the Grand Tour in Unit A the Descriptive Question Matrix was completed and the activities in which the participants engaged were described:

'Activities in which the participants are engaged include very practical functions such as attending to hygiene and comfort, monitoring progress, administering drugs, assessing patients' needs.' (Descriptive Question Matrix: Unit A)

These descriptions embodied participants' tendencies to anticipate and plan care, to have clear goals and also to treat patients as individuals by prioritising their wishes. Unit A, being a surgical ward, required the participants to undertake certain actions at specific times – for example, taking patients to and from theatre and carrying out the activities that ensured the patients' safety and comfort around these events. This resulted in a clear focus on patients' needs for effective preparation and monitoring. The space or opportunity for care to be flexible and orientated around patients' individual wishes was somewhat limited. However, strenuous efforts were taken in order to make care as individualised as possible:

'The nurses in Unit A see their ward as somewhere 'special'; they try to make it a 'home from home' – for example, encouraging patients to get up and dressed, eat at the dining table and make their own hot drinks in the ward kitchen. Patients and staff are known by their first names and treated as individuals.' (Reflective diary: 24/01/08)

In Unit B the delivery of acute palliative care was much more flexible, largely due to the fact that there were few restrictions on what could be done and when. Participants were able to structure their day around the patients' needs and wishes more easily than was possible in Unit A:

'The nurses perform the acts of care when they are needed by the patients and do not force a routine on them. Activities are patient-centred and nurses act by responding to, or prompted by, patient need.' (Descriptive Question Matrix: Unit B)

The opportunity to plan care around patients' needs was appreciated by the participants in Unit B, who all found this aspect of their work to be one of the major attractions of the job:

'I like the hands-on patient contact, you get more out of that ... picking up their cues and responding to their needs as best you can.' (Katryn, Unit B: first interview)

'To anticipate their needs and provide quite basic care ... I love that kind of thing.' (Kay, Unit B: first interview)

In Unit A also:

'Basic nursing, that's the thing' (Helen, Unit A: first interview)

The common central focus on prioritising patient care above all other tasks among the participants was voiced by Karen, who, on a busy observation day, ignored the surgeons who were bemoaning the lack of a ward clerk and got on with her own duties. At interview she explained this:

'My role in the immediate instance is to look after the patients.' (Karen, Unit A: second interview)

Karen was absolutely clear that filling in for the ward clerk was not her role, but that caring for the patients was. Prioritising the patient's needs, however, sometimes meant standing back and allowing them to do things their own way:

'If they want to and can do things for themselves – then please do.' (Ann, Unit B: second interview)

'(It is about) treating people as individuals, allowing them not to conform to the rules, being hospitable.' (Karen, Unit A: first interview)

Ultimately, this was about the fundamental principle of giving patients permission to direct their own care and take responsibility. The context of the data collection sites was important here. In Unit A this may have been easier to achieve in some respects because the patients were largely physically and mentally able to do this. Unit B patients were more often unable to direct their care due to being very unwell or distressed. In both units, however, the

participants tried to access the patients' wishes by various means, and this was achieved largely through watching and listening:

'If you don't listen, you don't hear.' (Marie, Unit A: first interview)

'You're continually assessing, it's automatic to do that. If someone was shadowing me and said 'why did you do that?' I'd say, well, I suppose I looked at them and realised they had slumped down the bed, so it's constantly reassessing, without thinking, you are reassessing ... it's automatically there.' (India, Unit B: first interview)

Although these skills were often referred to as 'basic', they were highly valued, not only as a means of assessing patients' needs but also as a means of establishing relationships. It seemed that far from being of a low order, the 'basic' aspects of care were better described as *fundamental* in that they expressed the foundations of what nursing was about. Through the delivery of these fundamental care activities the nurses were able to personalise care and learn about the patient's needs. Having assisted Ann to wash a patient who was barely conscious and physically fragile, at the end of the shift I observed:

'We washed the lady together. Ann was very calm, patient and sensitive to the patient's responses. These were very minor, but she constantly looked at the patient's face for cues as to how to proceed.' (Ann, Unit B: Grand Tour observation)

This delicate balancing of actions carried out for patients as individuals seemed to be based on the assumption that this fundamental care was of value to the patients as well as to the nurses, because it was possible to achieve a higher purpose by attending to it. This higher purpose centred around getting patients to understand that the nurses were there for them and had time for them:

'Yes, you have to look at physical needs, treat symptoms if they are over-riding, but it is about being with them, getting on their level ' (India, Unit B: first interview)

'It's an act of giving in order to build up a relationship, you give a bit of yourself too.' (Karen, Unit A: first interview)

Karen saw the giving of these fundamental acts of care as her part of a reciprocal relationship. She had to give in order to receive, and fundamental care was the portal through which she could do this. This included washing a patient's feet and helping them to dress and maintain their appearance. The 'prize' for this was the establishment of a therapeutic relationship with the patient. She explained this as being *'part of the relationship that you're building up'* (Karen, Unit A: first interview). In my reflections, I perceived that this orientation toward the basics of care, far from being taken for granted or common to all nurses, was a choice that participants actively made:

'Life for the nurses would be simpler if they just did what they had to, gave the care planned and did not go that extra mile that they mostly seem to in trying to uncover the layers to find out what the patient really wants.' (Reflective diary: 02/04/09)

This desire to try to get to the heart of what patients wanted or needed was an issue that I probed at interview. Marie talked about how she had developed her own priorities by learning from others. The values that she held and which directed how she went about her nursing practice, had been observed in colleagues and absorbed by her. She suggested that each nurse had a choice as to how to use what he or she saw in the actions of others, to emulate or reject the example:

'You have to find which direction you want to go in. I am who I am, but you learn so much from other people, from watching them.' (Marie, Unit A: first interview)

Marie identified herself as a nurse who valued basic aspects of care; she talked about valuing fundamental care as a strong influence on her practice. In this way I began to see practical action as being central to the act of nursing:

'Having time to wash someone, I often think that is a good time to ask questions. Just slowly over time, get to know people and say 'how does it feel today?'' (Kay, Unit B: first interview)

'I like doing my basic care, like washing (someone's) feet, it's an act of giving.' (Karen, Unit A: first interview)

'In both Units, the participants talk about the basic or fundamental aspects of care as being of great value in developing relationships with patients and in assessing their needs.' (Reflective diary: 20/08/08)

The value placed on the giving of fundamental care such as washing and dressing was strong on both units. The nature of the care delivered on each unit meant that this was more obvious on Unit B, where the patients needed more of this type of care. In discussion, all participants placed a value on this being carried out by the nurses themselves in order to gain a better understanding of the patients' needs and to establish and develop nurse-patient relationships.

Treating every patient as an individual might perhaps be considered to be a given in nursing, but the participants talked of this as a value as well as a skill. The value placed on individualised care was common to each of the participants and was exhibited in their actions. Reflecting on my observations of Ann, I wrote:

'Ann's theory of practice is predicated on a belief that all patients are individuals and that most care has to be organised around this.' (Reflective diary: 01/07/09)

In Unit A, where patients were going through similar treatments and procedures, the nurses recognised that this did not mean that they had the

same experiences. Karen, Marie, Helen and Kirsty all talked about how they attempted to get to know patients as individuals and the strategies they used to achieve this:

'People have an impression of how they should be, rather than where they are at. It's making someone a cup of tea, or going and sitting with them.' (Karen, Unit A: first interview)

'If you pay attention to people, you learn from that.' (Marie: first interview)

'It's picking up verbal and non verbal cues and using this to adapt care.' (Kirsty, Unit A: second interview)

'Helen went about care in a quiet and calm manner but tried to treat each patient as an individual in the best ways she could; each was known by name and she talked to them as individual people about what they were planning for Christmas.' (Helen, Unit A: Grand Tour Observation: 18/12/08)

Unit A participants, therefore, made the best of the opportunities that they had to prioritise patients' wishes and to treat them as individuals. This was a challenge given the environment of care, but it was openly acknowledged as a goal:

'I accompanied Helen and a patient to the Breast Care Nurse's room where the patient could look at temporary prostheses; she had said that although she knew that she was not yet needing to use one, she wanted to see and feel some so that she was prepared. Helen took the time to show her a range of breast prostheses so that the patient could understand what she might need to get used to at some stage in the future. Considering that the patient had not yet received a diagnosis, Helen could have told the patient that this was a premature concern; she did not brush her off or minimise her fears, but took practical action to try to alleviate the patient's worries.' (Helen, Unit A: Mini Tour observation)

The nurses' reactions to similar events in individual patient's journeys could differ considerably. I was witness to situations in Unit A, such as the removal of surgical drains, where the manner in which the procedure was carried out varied slightly between participants even though the procedure was the same. This might include more or less conversation or explanation as the nurse went about the activity in the way that she felt was best for that individual patient:

'Marie has to take out a wound drain. She invites the patient to come to the treatment room if this is 'okay', and the patient acquiesces. She has made the room ready and attends to the patient's comfort needs. She does not give complex explanations but gets the patient settled and gets on with it, explaining what she is doing in small steps.' (Marie, Unit A: Mini Tour observation)

Despite this activity being a very routine one on Unit A, Marie (and Helen, whom I also observed carrying out the same procedure) attended to it in a manner that recognised the removal of the drains as a significant step in the patient's journey. During the subsequent interview I asked Marie why she went about this procedure in the way that she did:

'I don't get things ready in front of the patient because (although it's possibly an infection risk to get it ready beforehand) you can see them watching you and thinking 'what else is she going to pull out of there?' and because (then) I can concentrate on my patient.' (Marie, Unit A: second interview)

In Unit B, patients' experiences were seen by all of the participants in that unit as being individually constructed. Each was assessed in great detail over a period of some time, and extensive handovers were given that attended to the most minor of details. This level of understanding of the patients enabled the participants to make informed decisions about the extent to which they could give patients the freedom to make decisions about their own care:

'You have to give the ground-rules back to the patient, try to live by their rules.' (Katryn, Unit B: first interview)

'It's about finding out what is important (at the time when they are dying), what people's wishes are and whether we can think laterally rather than more traditionally.' (Kay, Unit B: first interview)

The creative side of the participants' practical action was tested at times in order to try to find ways to allow patients to act as they wished. One young woman who was dying of breast cancer wished to go out to see her four-year-old daughter being fitted for a bridesmaid dress. Her husband was against the plan and felt that it would be too difficult to achieve. Katryn was pragmatic about the likelihood of success in fulfilling the patient's desire, and saw that the ability to achieve this was about both practical action and a longer-term intention. In this way, practical action had to be considered in a short-term and a longer-term manner:

'It's the closeness with patients and their families, picking up their cues and responding as best we can, to have a vision of the future for them – however long that is – minutes, hours, days, years.' (Katryn, Unit B: first interview)

'Being able to think quickly, hit the ground running – it challenges my brain and my assessment skills. Thinking, what can I realistically achieve, what are the priorities, and what can I leave out?' (Kay, Unit B: first interview)

Getting to know 'your' patient was highly valued and was seen as enabling the participants to achieve both practical and personal goals. The desire to treat patients as individuals and to prioritise their wishes had to be balanced with the needs of other patients and the ward as a whole. The ability to do this was treated as valuable, but it was acknowledged to be a fine balancing act:

'The best palliative care nurses spend a lot of time with their patients. If you invest in your relationship with them they're easier to manage. You can do more for them; it's working in a clever way – put more time in at the

beginning. It's not wholly altruistic as you've got to manage your workload.' (Ann, Unit B: second interview)

As patients were largely treated as individuals, the priorities of care and the values placed on each priority were finely balanced between the patient's wishes and those of the unit as a whole. Sometimes the nurses had their own opinions about what was in a patient's best interests, and this somehow had to be made congruent with what the patient wanted. This created a dynamic and changing set of goals for practice but one that was always congruent with a set of values:

'A lot of it is anticipating, I think, reading, assessing … they're changing so quickly here that every time you go (in) the patient's slightly different and it brings you right back … to work out what's going on.' (Kay, Unit B: first interview)

At all times, therefore, the focus of the participants was to fulfil patients' needs and wishes wherever it was possible to do so. At times this involved a creative use of a variety of practical actions that were centred on the patient as an individual.

4.7.2 Experimenting in Practice

A genuine concern about the patients' best interests was the mediating factor in participants' practice, balanced with the nurse's workload and competing demands on her time. These combined influences sometimes led to the participants having to try out a new approach and this feature of the participants' practice I termed 'experimenting'. This included any actions that were creative, unusual or outside of expected practice; where the participants were continuously monitoring a situation and responding to the outcomes of their actions. Some of these activities one might consider as being outside of normal practice; they seemed to be about trying out new ways to achieve a good outcome for a patient in the absence of other more conventional solutions and were dependent on the context and demands of that care.

Having observed such situations, I approached the notion of experimenting in practice by utilising a range of euphemisms in interview or conversation. These included asking about 'unusual challenges' or 'acting outside of usual practice', but I quickly found that the term 'experiment' was more easily understood and did not evoke anxiety:

'Trial and error is probably a better term, (but) there is something true about 'experiment' because you can't always know what is happening. There does come a point when you have to be open with the options. You are trying it out and to that extent it is an experiment. You wouldn't say 'that's the last thing we can try' – not take away hope.' (Ann, Unit B: first interview)

'Yes, it is like the use of cannabis, it's illegal but effective. For the patient I would hate to be in a position to say 'there's nothing more we can do for you'. It's better to say 'we'll try this." (Katryn, Unit B: first interview)

The fundamental valuing of the patient's best interests seemed to override any fear about trying out a new course of action. If the patient could retain hope by being offered some form of help that was outside of the usual range of activities, then this was considered a reasonable course of action.

During a Mini Tour observation in Unit A, Karen needed to administer an anti-emetic to a patient who had a poorly functioning intravenous cannula. The patient was generally anxious while undergoing radiological implant therapy, and also had a fear of needles. Ordinarily, Karen explained, she would tell the patient that the doctor would need to assess whether the cannula needed to be replaced. However, because the patient was so very fearful of this, Karen decided she would try to use the current cannula. Karen explained to me what was going through her mind at the time and why she went ahead with the drug administration:

'I wanted to make her comfortable, that was my over-riding plan of action. I knew she needed the IV (anti-emetic) so I looked and she had pain on the

flush so I was worried that the cannula wasn't patent. I thought I'd just try a little longer because it didn't look red and nothing else seemed to be wrong.' (Karen, Unit A: second interview)

In this situation I observed Karen having to make a decision about how to proceed in the midst of the procedure and in a very particular context. She had the drug in a syringe in her hand and was looking alternately at the IV site and then up at the patient's face as the latter watched with fear in her eyes. In many other similar situations, this might be considered to be unsafe practice, yet in this context it seemed to be carefully considered and ultimately successful. Subsequently I described and reflected on this observation:

'Karen removed the bandage, sitting on the bed and inspecting the cannula site; she asked the patient if she had any pain and having received a negative in answer, proceeded with the 'flush'. She kept looking at the site, asking about pain and checking the patient's face. All the time she seemed to be weighing up the risk of the extravasation of the drug into the patient's skin against the benefits of getting the medicine given and reducing the patient's nausea without having to get the cannula re-sited. It was a difficult call.' (Reflective diary: 09/09/08)

In this situation the usual solution would have been to re-site the cannula, but Karen experimented in order to give the patient the drug she needed without causing extra distress. The risk was that the drug would cause damage to the patient's skin and not be effective, while the benefits were that there would be no need to further increase the patient's anxiety and her nausea would subside. Karen took a clear risk, using her previous experience in order to make a decision. This incident was discussed at length in the second interview with Karen, and when I asked what informed her actions, she related this to her experience:

'It was probably experience, thinking 'that looks alright.' (Karen, Unit A: second interview)

Although many different sources of understanding may have come into play, experience of a similar situation in the past, applied to this context, helped Karen to decide which action to take in the present. Consideration of the options for action therefore often involved reviewing a wide arena of possibilities, many of which held a certain amount of uncertainty and involved a risk of getting it wrong, in relation to the situation at hand.

Observations in Unit B revealed a similar occurrence of experimentation when a dying patient required two drugs to be given by syringe driver. Katryn tried to find out whether it would be safe to administer both in the same syringe to avoid the patient having two separate infusions. Katryn tried every avenue in order to ascertain whether this would be safe to do. I described the incident in my field notes:

'On one occasion, I helped Katryn when we 'bent the rules' by mixing two drugs in a single syringe driver so that the patient could have just one driver instead of one for each drug. We explored the possible sources of knowledge about the compatibility of the drugs and found them wanting; Katryn drew on her own experience (and mine) and could quite reasonably have said that she could not do this, but she took a risk and experimented for the patient's sake.' (Katryn, Unit B: Mini tour observation)

At interview, Katryn explained her reasoning in terms of what was best for the patient:

'I was prepared to give it a go, to make sure the drug was okay and monitoring it when it went up; there was no question in my mind. If it's for the benefit of the patient, but I need to be sure why I'm doing it.' (Katryn, Unit B: second interview)

Katryn's decision was one laden with potential risks; the pharmacist had been unable to recommend mixing the drugs and Katryn would have been on safer ground in giving them separately. However, she was particularly concerned

that the patient should maintain her last vestiges of physical independence if at all possible; this would have been very difficult with two syringe drivers. The context of care in Unit B may have been one that both encouraged and enabled the participants to take these risks. The vulnerability and extremity of the patients' conditions meant that there could be considered that there was little to lose and much to gain.

Both Karen and Katryn took significant risks in these situations, and both were based on achieving optimal benefits for the patient. These particular experiments had successful outcomes and were monitored very closely, but even for the most experienced participants, the chance of failure was seen ultimately as an acceptable and reasonable risk that would add to one's repertoire of experience. This perception of failure as an inevitable part of practice was present in both units:

'It's OK to admit our failures and weaknesses and it's OK to be feeling rubbish. We have a patient who has wanted to kill herself and I feel deeply sad that she is in that position but can understand that it's her way out – she has to think of that as a fall-back and we have to be able to say 'that's all right.' (Kay, Unit B: first interview)

'If something's gone pear-shaped before, you're not going to let it happen again.' (Karen, Unit A: second interview)

'We see people for such a short snippet of their life, you have to be very diplomatic – sometimes we get it right, sometimes we don't. We can grow and learn from each experience.' (Katryn, Unit B: first interview)

There was a danger here that an acceptance of failure on occasion could mean that the participants were engaged in habituated practice. Conversely, the participants saw such experiences as adding positively to their repertoire of

experience for use in the future. The act of taking a risk had the potential to increase their understanding, and the possibility of success was a greater motivator of action:

'Ann tried different approaches to patients – being more assertive, being more supportive, trying to involve families – these she called trial and error, and they seemed to result in new rules for practice and add to her repertoire.' (Reflective diary: 13/04/08)

'I always use my experience, it's innate and gives me confidence and makes me open to different outcomes; I use a bad experience to learn rather than avoiding taking that extra step.' (Kirsty, Unit A: first interview)

Trying out different approaches to care did not always involve such overt experimentation. In both units I observed and heard about aspects of the participants' practice that demonstrated their willingness to risk rebuttal from others in order to achieve a certain aim. In Unit B during a Mini Tour observation with Ann, her willingness to risk an angry reaction from a patient in order to achieve a goal was witnessed:

'After coffee, we go to a patient who needs supervision with a shower. He clearly does not want such attention and says that he can manage alone. The patient is, however, keen to get home to look after his wife and Ann persuades him to have the supervised shower by saying that as soon as she is happy that he can manage alone, he can go home. Twice during the shower he rebuffs Ann's help, saying "No, I can do it". Interestingly, Ann takes this 'on the chin' and does not retire hurt or remonstrate with him. She retreats a little – both figuratively and literally – and waits behind the privacy curtain with me.' (Ann, Unit B: Mini Tour observation)

These processes of trying out different strategies ranged from deciding what was the most important of all of the imperatives – '*the over-riding factor*' (Karen, Unit A: second interview) – or, at the more extreme end, acting in ways

that were 'outside the box'. Ann expressed this as constituting anything from *'work(ing) out what you are focussing on that day'* to *'trial and error'* (Ann, Unit B: second interview). Thus, the range of possible actions could be well within, or outside of, the usual events of a day and seemed to need some boundaries or limitations to enable planning ahead. The boundaries were highly contextual and dynamic thus difficult to identify and seemed in the participants' eyes to require them to be very creative:

'It's about boundaries, setting priorities and changing – it changes every five minutes here so to be a good nurse here you need to be able to change direction. You've prioritised then something else comes up.' (Kay, Unit B: first interview)

'You have to be a bit different to work here anyway – making the best of the worst scenario, thinking outside the box – what is possible?' (Katryn, Unit B: second interview)

The fine line that existed between what was acceptable practice and what was not acceptable action was often encountered and was related to the situation at hand. As Katryn went on to say, sometimes certain courses of action could not be countenanced:

'I was told it was against the regulations … that for me was quite difficult, it was hard to go in and say 'I can't do it' (Katryn, Unit B: first interview)

In Unit A, Karen talked to me about how she was once asked to pray with a patient who was a practising Christian, like herself. The way in which she articulated this seemed to be almost an apology: *'I did pray with a patient once … I was asked'* (Karen, Unit A: second interview). This seemed to suggest that practice outside of the usual was more acceptable in Unit B than in Unit A and should be considered to relate to the context of care.

One Unit B participant was not willing to divulge the nature of these aspects of practice. India was a participant with whom I sometimes found it difficult

to get to the heart of her motivations, and when I asked her to what extent she tried things out in practice she said:

'I think I have, but I can't quite think of something – but I wouldn't admit to it!' (India, Unit B: second interview)

India's apparent reluctant to 'admit' to this kind of practice may be attributed to the questions asked, but when I probed further, India revealed that experimentation *did* take place in practice but that there were certain provisos:

'On an individual patient basis, to get you round a particular problem and if your colleague is willing to give it a go – if you can tell that the patient appears more comfortable or they're happier and there's no traditional solution ... you trust each other.' (India, Unit B: second interview)

Kay in Unit B and Karen in Unit A both echoed this need for the whole team to be in agreement:

'There is a universality here, unspoken teamwork, we know what is going on without having to say, we have a comfortable understanding.' (Kay, Unit B: second interview)

'You have to judge how safe you can be. If that doesn't work then that's the time to withdraw, isn't it? To stand back and ask for help, and that's what makes a safe nurse – you can't stick (your own) neck out too far.' (Karen, Unit A: second interview)

Most of the participants were open about the possibility of experimenting in practice and readily acknowledged the need to try out something that was new, or even risky, at times. This was more often present in the discourse and practice of the more experienced or older nurses such as Katryn, who had a wide repertoire of experience, both professional and personal, on which to draw:

'It's experience, I've lived and worked, it's life and patient care (that you need) to suss people out. You know what you can get away with, what you can say to the family but you just can't (always) come out and say it. There's an element of risk, you have to seize the opportunity.' (Katryn, Unit B: second interview)

'Deviating from the guidelines is the role of expertise and experience. I trust my judgement.' (Kirsty, Unit A: first interview)

These and other more experienced participants, such as Karen in Unit A and Ann and India in Unit B, were more likely to take risks in their practice and were clear that this had to be in the patients' best interests. They tended to explain their rationale as being based on what they had seen previously:

'I always use my experience, it's innate and I thrive on experience, giving me confidence and making me open to different outcomes.' (Kirsty, Unit A: first interview)

'A lot of my tactics is on past experience --if something's gone pear-shaped before you're not going to let it happen again.' (Karen, Unit A: second interview)

This pragmatic approach may not have guided everything that Karen did, but to some extent it sums up the participants' use of past experience and any other understandings that they could gain from internal and external sources in order to make the optimum care decisions.

4.7.3 Summary of Associate theme 2

Associate theme two has indicated the importance placed on practical action by the participants and how they attempted to prioritise patient care for the best outcomes for those in their care. They had to finely balance competing demands on their time and think on their feet. Integral to this was the need

to be open to experimentation, to try out new ways of doing things, sometimes acting on the borders of what might be seen as conventional care. The tendency to do this and the emphasis on timely action was found in both units, but, due to the differing contexts in the two areas, these boundaries and conditions were changeable.

4.8 Associate theme 3: Knowing

This theme embodied the ways in which the participants expressed, analysed and used various forms of knowledge in order to make decisions about patient care. These forms of knowledge were highly contextual and variously expressed as *concrete* (such as research-based or learned in formal education), *informal* (their own experience or that of others and role modelling) or *instinct* or *intuition* (such as a gut feeling or sixth sense). The codes that were identified to be about the participants' ways of knowing included: *using experience; learning from others; anticipating; using one's intuition; thinking outside the box; what has worked before; knowing the boundaries; not knowing; unsaid sources of knowing;* and *using life experiences.*

The codes were clustered into three categories: *using personal experience and intuition for knowledge, drawing on the knowledge and experience of others, using tacit knowledge and working with uncertainty*. This theme is illustrated in Figure 6.0:

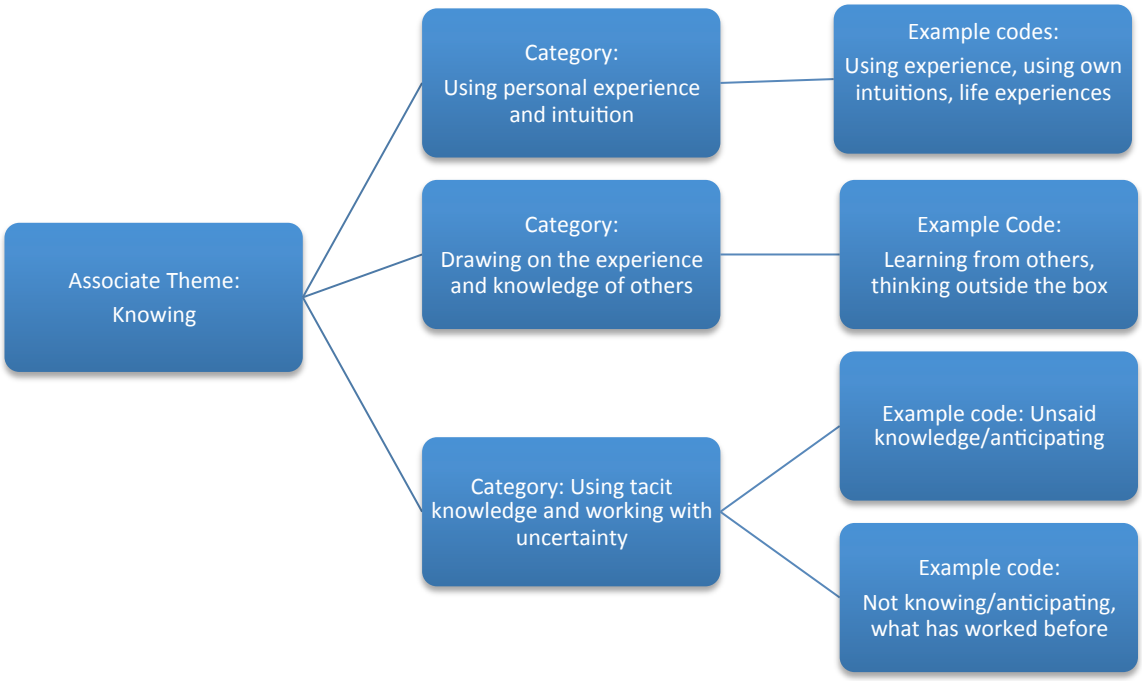

Figure 6.0 Associate Theme: Knowing with Categories and Example Codes

4.8.1 Using Personal Experience and Intuition For Knowledge

Participants indicated that they drew a great deal on both their personal and professional experience for the knowledge that they needed in order to practice nursing. The amount of experience that each nurse possessed, and the context in which that experience was gained, influenced how and when this was used as knowledge to inform action. For some, their own personal and professional experiences directly influenced how they used the knowledge in practice; this included an aversion to paternalism as a reaction to the experience of being a patient oneself (such as Marie in Unit A), or a belief in the value of the patient as expert in their own care:

'I know what made a difference to me' (Marie, Unit A: first interview)

'We go to a female patient who is being visited by her sister; Ann relates to her in a very equal way, asking the patient for guidance as the expert in her own care.' (Ann, Unit B: Mini Tour Observations)

In Units A and B, the participants recognised the influence of their past nursing experience on their actions in the situation at hand. The influence of past experience was referred to as directly affecting the care planned and the interventions made; 'experience' was a common response to questions regarding why the participants chose certain interventions. In both units the participants went about their practice in slightly different ways that were dependent upon their personal knowledge and understanding of what they were engaged in but retained common values at their core. These personal sources of understanding could be concrete or informal:

'It's what has worked previously, whether knowledge, experience or evidence.' (Katryn, Unit B: first interview)

'It's clinical knowledge and experience, sometimes you've come across that situation before and that worked.' (Karen, Unit A: first interview)

For the participants overall, their life and professional nursing experience were referred to as the major source of help when making decisions, particularly decisions about patient care. Kirsty, a senior surgical nurse who was acting up as ward manager in Unit A, not only used her experience but saw it as a reliable source in which she could have confidence in the adaptability that she needed for decision making:

'Adaptability and flexibility result from knowledge that comes from experience ... experience-based judgements tend to be right.' (Kirsty, Unit A: second interview)

Kirsty saw her knowledge as primarily coming from experience but also recognised that her own and others' motivations influenced the ways in which they went about practice. Kirsty advocated *'striking a balance'* (Kirsty, Unit A: first interview) that would enable each of them to find their way through the variety of possible sources of understanding available to them.

While each of the participants talked about their nursing experience as a reliable source of knowledge and understanding, they acknowledged that in some situations their responses were informed partly by their life skills. These life skills might include an individual's other roles in life such as being a wife or mother, their own experience of health care, or of the relationships that they had been through:

'It's difficult to explain why we do things – years of doing it and outside life skills perhaps.' (India, Unit B: second interview)

'I'm learning all the time' (Helen, Unit A: second interview)

*'Experience? I've lived and worked, in life and in patient care, you learn to suss people out.' (*Katryn, Unit B: second interview)

Although each participant in the two units used the experience that they possessed to inform their practice, it was recognised that not every nurse used or valued this resource, even within the same context:

'It's life experience, not just work. Some have none and might handle things differently, you don't just gain experience through your job.' (India, Unit B: second interview)

India appeared to be suggesting here that some nurses find it difficult to use the experience they possess, or else they have not been through some of the life-changing experiences that she had. These life skills were sometimes related to age, and some participants noted that they had acquired them over time and from a young age:

'It would be interesting to examine – is that just life, or because I went into nursing at eighteen? I've had plenty of time and one develops at that formative age.' (Karen, Unit A: first interview)

'I've been doing it for so many years and I've seen a lot of (other) nurses.' (Ann, Unit B: second interview)

The ability to utilise life skills and past experience to inform practice knowledge was not only a feature of the older participants who had more to draw upon. Younger participants appeared to rely on this too, but these nurses tended to feel that they use concrete cues as well as experience:

'You are going through the cues and the experience is there.' (Sally, Unit A: only interview)

'It's what you've been taught, you can tell by just looking at them, watching the way they move, the look on their face.' (Marie, Unit A: first interview)

'Helen is able to verbalise a rationale for her decisions in practice; she knows the patients as individuals but concentrates on the job in hand.' (Helen, Unit A: Mini Tour observation)

Ultimately, the more 'informal' knowledge on which the participants were relying for their actions, was largely a combination of instinctive reaction, their use of past experiences (good and bad), and emotional responses. This was framed by the context of care. Intuition was seen as an outcome of experience in nursing that might form a knowledge base for certain actions.

Kirsty related how instinct was not a valued form of knowing when it was communicated to others outside of the nursing team, such as medical colleagues or outside of the context of care. With those whom she did not consider to be part of her nursing team or community, she did not feel that she had firm grounds on which to relate this kind of understanding. In a multi-disciplinary situation, Kirsty felt that she had to offer something more concrete and formal as evidence of her judgement. In these situations Kirsty looked for more concrete forms of knowledge for back up. Concluding the narrative about an example she gave, Kirsty searched for a more traditional basis on which to argue her point:

'I almost wanted something to be wrong with her observations.' (Kirsty, Unit A: first interview)

There was considerable discussion in the interviews with participants about where their knowledge for practice originated. During these discussions the use of instinct and intuition to guide practice were commonly cited, and were generally thought to be something innate that one either had or did not have:

'It's related to me as a person.' (Karen, Unit A: first interview)

Thus it seemed that understandings gained through intuition or instinct, whilst important to many of the participants, was a source of knowing that was not universal. India explained her interpretation of this instinctive knowing as '*automatic*', as an unconscious or embedded response. Others saw this as integrated with a more concrete process, as a conscious '*knowing*' through experience, from others and from one's own senses:

'I think I concentrate on what I observe and hear, getting evidence from the other nurses as well as the patients.' (Ann, Unit B: first interview)

'It's sixth sense, it's partly experience, and (your) knowledge base coming into play.' (Katryn, Unit B: second interview)

'My adaptability and flexibility result from knowledge – that comes from experience.' (Kirsty, Unit A: second interview)

'It must be possible to be taught (how to prioritise), it must be ... but it does help if you have an intuition for it – you can only learn by picking it up, by absorbing it.' (Kay, Unit B: first interview)

The use of experience, instinct and intuition were largely synonymous in terms of the ways in which participants spoke about them as a knowledge base for practice. Each appeared to have its own specific role and value to a greater or lesser extent, dependent upon the situation and the context. Ann, who suggested that few actions could be identified as being informed by one type of knowledge alone, raised the idea that these various sources might be interdependent upon one another:

'There's a lot of intuitive things right back at the beginning, but you are thinking about your work, perhaps seeing it as concrete, going in a room and picking up a huge number of cues. Maybe there's a bit of a whole view happening.' (Ann, Unit B: first interview)

In this discussion Ann articulated a view that one could not isolate a single source of knowledge and understanding that would inform a certain problem. Whichever source of understanding was being drawn upon, having confidence in one's knowledge base for practice was seen as crucial in order to fully utilise it:

'It's a process, there's a stage of being consciously competent, basically feeling confident enough.' (Sally, Unit A: only interview)

'Your own experience gives you courage.' (Kirsty, Unit A: second interview)

'You can just have a feel for where they are going, it comes over time as your confidence builds.' (Katryn, Unit B: second interview)

The notion that confidence to use any type of knowledge is acquired over time was a common view. None of the participants felt that one came into nursing fully formed; the experiences of being a nurse, adding to one's repertoire and maturing as a person were all recognised as influencing the confidence to use a variety of forms of knowledge in practice. This was no more or less true for concrete sources of knowledge than for more personal sources of knowing.

Using their personal experience and intuition as knowledge seemed to play a large part in the ways that the participants made decisions in practice. While most saw this as being in tandem with more traditional experiential ways of knowing, some felt that they were just not instinctive in that way. These participants looked for more concrete evidence for practice, and they were often the participants whose experience in life and nursing was shorter.

4.8.2 Drawing on the Experience and Knowledge of Others

All of the participants referred in interview or conversation during observation episodes to the key role played by their colleagues in adding to their personal professional knowledge. This took the form of role modelling (both positive and negative), reflective conversations about patients and with patients, handovers, and observations in the world of practice:

'I think I do concentrate on what I observe and hear, based in the nursing part of the team, getting evidence from nurses as well as patients – I'm not standing back a long way.' (Ann, Unit B: first interview)

'It's probably clinical knowledge and experience, but I might have to ask for advice, someone who has come across that before.' (Karen, Unit A: first interview)

The experience of working in a team seemed to be the factor that many participants relied upon for knowledge, especially in situations where the demands on them were very challenging. The fact that they worked in teams seemed to be key in enabling the participants to have the confidence to use a variety of sources of knowledge. The teamwork observed was encapsulated in a common culture, in shared language and meanings and in professional support:

'We work as a team, we pick it up if anyone needs help' (India, Unit B: second interview)

'The team is crucial' (Helen, unit A: first interview)

'It is unspoken teamwork, we know what is going on without having to say, we have a comfortable understanding' (Kay, Unit B: second interview)

The highly contextual practical skills and knowledge used were thought of as a shared resource, and new understandings or ways to achieve certain goals were communicated and shared among the team:

'If you're thinking, I can't get this patient comfortable, you bet another nurse can.' (Ann, Unit B: second interview)

'It's informal discussion with others, to check it out, every situation is unique, you have to get someone else's slant.' (Katryn, Unit B: first interview)

'By getting back to people between every care or at least twice during the morning, you're picking up more stuff.' (Ann, Unit B: second interview)

The sharing of knowledge and skills was not hierarchical, although some more senior members of the team in Unit B did see themselves as an expert resource:

'If I let others in the team sound me out about issues in practice, then that helps them look for the clues and it builds their confidence and knowledge.' (Katryn, Unit B: second interview)

Thus the more experienced participants were commonly those giving advice or helping to solve a problem:

'Katryn participated in the informal dialogue about practice but seemed to be more likely to be giving insights than checking things out (for) *herself.'* (Reflective diary: 09/02/09)

Drawing on the experience of others for knowledge was seen largely as an informal activity. In both units this was seen during observation periods, where participants had short impromptu conversations, sometimes just a few words, specifically focussed around a patient problem. This often took place in the corridor or in passing, in Unit A at the nurses' station and in Unit B in the drugs room. These two locations were not places where more formal handovers or discussions would take place; rather, they were 'staging posts' where there was always a team member to be found if a participant needed someone to pass things by. Thus, the opportunities to gain knowledge, understanding and information from other team members were numerous:

'I was sitting at the nurses' station discussing a patient with Karen and Helen. Marie was walking past and asked Karen about a drain that she was taking out – 'should it come out now because it was still draining fluid?' Karen said 'Yes, it was fine – go ahead,' and Marie went away to do this. As she did, Helen interjected and said that this had happened to her and that the surgeon had said it was best to let him have a look at it first. Karen

said, 'Oh okay, you'd better catch her then!' and off Helen went.' (Helen, Unit A: Mini Tour observation)

Senior nurses coordinating a shift had to keep in regular contact with the team in order to gain an overview of what was happening on the unit. Senior nurses saw part of their role as being to support and develop the knowledge of the more junior members of the team:

'Sounding out the team is important because it highlights points and they can look for the cues, it builds their confidence and knowledge.' (Katryn, Unit B: first interview)

'One of the things I have to do is to look after students and help new members of staff.' (Karen, Unit A: first interview)

'Ann gave a little précis of what she was doing, an update and voicing any problems she was facing to the coordinator. This played a role as a sounding board or for information giving, a request for affirmation or support.' (Ann, Unit B: Mini Tour observations)

'Yes, there isn't a second chance and you need to make the best of what you've got. I can't inflict my feelings on others but I can share my intuitions, whether it's received or not.' (Katryn, Unit B: first interview)

In drawing on the experience of others, the participants were using the widest possible sources of understanding in order to enhance their knowledge in context. This was almost entirely focussed around specific patient problems. Talking with colleagues about their own experiences, either in general or in relation to a specific patient, often solved challenges in patient care. Often, those giving advice were the more senior members of the team, but participants also drew on each other's knowledge and used what they saw in the practice of others to improve their own understanding.

This frequent discourse added to each participant's knowledge base daily, and it was iterative in that the participants would often come back together again to update each other shortly afterwards. This seemed to enable the nurses to give the best possible care in a dynamic and changing context:

'We try to keep each other in the picture.' (Kay, Unit B: second interview)

'You find your colleagues and say 'this is what I've found', and that's when you pick up loads of information – people say 'oh yes I did this and it worked' or 'I did this and it didn't work'. (Ann, Unit B: second interview)

In Unit B the patients' conditions fluctuated throughout the day, whereas in Unit A the level of dependence was more predictable, with the ladies undergoing surgery largely following a common path. In both units break time was a key moment during which the participants 'caught up' with each other and sounded each other out for ideas and understandings, although this was particularly seen in Unit B:

'We re-group at break time, five minutes to stop and take stock.' (Kay, Unit B: second interview)

'When you have your cup of tea, you have a little bit more structure – have you used your time right?' (Ann, Unit B: first interview)

'At coffee time in Unit B today there was a lot of discussion about one patient who is very negative about everything the team does. They find this hard to cope with and they analysed and re-analysed the patient's responses during that morning.' (Reflective diary: 18/01/08)

Use of the experience of others for knowledge was also seen as a kind of informal role modelling:

'You learn so much from other people, from watching people.' (Marie, Unit A: first interview)

'Doing a proper job, it's definitely learnt, I had to be taught and I remember watching nurses who know how to put pillows.' (Ann, Unit B: second interview)

Although there were some participants who needed this support from the experience and expertise of others, the most experienced participants worked with a more internal knowing dialogue. This took various forms and was particularly a feature of the work of the senior participants in Unit A, where the pace of work was fast and sometimes out of the participants' control as patients went in and out of the ward for investigations and surgery. Karen demonstrated this during participant observation:

'Karen continues to go about what is needed, talking to herself and stopping now and again to collect her thoughts. She keeps many threads in her head, remembering both the major and the minor issues. She checks back constantly with colleagues, patients, notes, the whiteboard and other nurses.' (Karen, Unit A: Grand Tour observations)

The creation and sharing of knowledge with others and the iterative discourse that this involved was therefore both a team activity and an internal one. Participants were using each other's' experience and knowledge in order to ensure that the care given was informed by the most recent understanding of the patients' needs, and that recent changes were made known to other members of the team and it was both created and adjusted within and by the community in which they worked.

4.8.3 Using Tacit Knowledge and Working with Uncertainty

During observation periods and interviews it became clear that although there was a large amount of knowledge and shared understanding in use by the participants, there remained areas of their practice for which there was no apparent evidence to guide them. This gap seemed to be filled by two

phenomena: first, an *unsayable* or abstract way of knowing the best course to take; or second, an acceptance that nursing practice was riddled with uncertainties. These uncertainties were about which course of action to take for certain patients in particular situations, and whether what had worked before would work again. This category of the data had inherent links with other data in that the responses gained from participants and the actions observed seemed to be part of a complex web of knowing and acting, being and communicating in which the participants were working.

Some aspects of the participants' understanding seemed to be difficult for them to put into words. When asked about the basis on which patient care decisions were made, participants either resorted to generalities such as *previous experience* or cited a range of different sources of knowing:

'It's probably clinical knowledge (that guides my decisions) and experience, we sometimes have out-patients and we have to make a decision – that's knowledge, trying to look at recent research, asking for advice, sometimes you've come across that situation before and it worked.' (Karen, Unit A: first interview)

'It's experience ... intuition ... knowledge.' (Katryn, Unit B: first interview)

This web of sources from which participants might glean an answer to a problem rarely seemed to provide clear solutions. Instead the participants were looking at the boundaries or frames of problems, trying to find something similar to another situation they (or someone else) had encountered before, or to something they had been taught:

'Yes, perhaps if you're looking at a paper, you can think about what's happened in the past and think 'that's rubbish' or 'there's a valid argument' or whatever' (Karen, Unit A: first interview)

'It's instinct … but sometimes I go back to Faulkner's book – it reminds and challenges me.' (Kay, Unit B: second interview)

This complex knowledge base was articulated in various ways, but often the participants might offer to try to explain how they knew what to do for the best. On more than one occasion, with Ann and then with Sally, the examples given were contradictory in terms of the point being made. This, I reflected at the time, suggested that the participants themselves were unclear where their understanding came from in challenging situations:

'Some of the challenges in practice, the problems that have to be solved, rely on these nurses to have the powers of telepathy. All they can do in certain situations is to use something that I cannot see and they do not seem to be able to articulate, except as 'experience' or 'knowing'.'
(Reflective diary: 02/02/09)

The discourse around sources of knowing often reverted to anecdotes or exemplars that did not really illuminate the point. The knowing was unseen, unsayable and highly contextual. On many occasions the participants made the best use of the information that they had:

'When you ask 'how are you?' you might use a score, or they might only be able to grunt.' (Ann, Unit B: first interview)

'It is often just a case of asking, seeing how they interact with you, the family, you get a sense from going into the room, you have to test the water with them.' (Katryn, Unit B: first interview)

Ultimately this often involved working with uncertainty, where knowledge was not available and they had to use their 'best guess' as to what to do. The cues available were used to the best effect in order to make the right decision, but the final decision on which action to take sometimes had to be pragmatic:

'I suppose you just do it quickly because there's always the next event coming along.' (India, Unit B: first interview)

'I tend to say 'let's do it so you don't have to worry about it anymore'.' (Kirsty, Unit A: second interview)

'It is a cycle of evaluation – for example with pain, you need to have lots of confidence that you know what you are doing, some patients can only stand it for so long waiting for your experiment to work.' (Ann, Unit B: first interview)

The different conclusions that participants arrived at in certain situations where knowledge was lacking were predicated on the patient as an individual, and on this basis, no two situations were the same. There was also a perception that the action taken would depend to some extent on the participants themselves. Certain nurses might act in certain ways, and this might be due to experience, personality, knowledge and their relationship with the patient:

'I am who I am ... you have to find which direction you want to go in.' (Marie, Unit A: first interview)

'Ann clearly had her own theory of practice – this was more about her way of going about things than in what she did.' (Reflective diary: 18/11/08)

In observing the participants individually and in reflecting on them as a group, it was clear that each participant would use a slightly different set of knowledge sources in order to inform a certain course of action in context. However, the principles were shared: the centrality of patients' wishes, and safety, the maintenance of support in a team of trusted colleagues and other agreed values. Participants also used their own personal repertoire of resources to enable them to try to predict what was going to be the outcome of an intervention or what to expect in the care of a particular patient:

'(I use) my experience, my intuition, sometimes you don't get it right.' (Katryn, Unit B: first interview)

'I think it's interesting, we try to build up an intense relationship as soon as they come in – get to know them, befriend them, know how they normally react – are they the same postoperatively? The facial expressions, are they withdrawn?' (Karen, Unit A: first interview)

In some cases, there was not time to develop a relationship in order to create sufficient knowledge about a patient. In Unit A the turnover of patients was fast, while in Unit B many were admitted in a state where they were already too unwell to communicate. In delivering care to these patients, the participants had to anticipate what might be needed and prepare themselves and their work area for all possible eventualities:

'Somehow we have to try to do things in the right order; it's the patient's wishes – they know best – but we are juggling a whole load of priorities.' (Kay, Unit B: second interview)

'Ann seemed to know what equipment she was going to need for care interventions; for a morning wash we would prepare extensively, taking in a great deal of equipment that we might need. At first I thought that she had some insight that I did not; in fact, she just said that they thought as broadly as they could about what might be needed so that they did not have to keep leaving the patient to get supplies.' (Ann, Unit B: Mini Tour observations)

While the participants used this balance of what they could glean about patients and individuals and what they could predict, there were situations where the knowledge that participants thought they could rely on was not adequate:

'In a minute or so you are trying to glean the essence of where they are at, and I just like to say 'how are you?' It's so basic; 'have you had a good night? Sometimes they'll say one thing and they'll look completely differently, they say 'oh I'm not too bad' and they look absolutely dreadful. Even just watching them talking or sitting in bed or trying to get up, you can gain so much just having quickly seen that patient. Trying to have a handle on things – that's what we are trying to address.' (Kay, Unit B: first interview)

'It is a lot from observation. I don't get it right all the time, there's what you've been taught but you can tell just by looking at them, watching the way they move, the look on their face, as a nurse you are not always aware of how much attention you pay, just going around, you're still assessing; it's easy to read people when they don't know, it's everything you were taught.' (Marie, Unit A: first interview)

The type of knowledge that the participants are describing here is one that comes from a web of experience including life, nursing and a certain way of thinking about what constitutes knowledge. Very often, participants remarked on how the anticipation of a patient's needs or of outcomes helped to strengthen their understanding of practice:

'Predominantly with nursing, you are thinking of physical needs, cleanliness and comfort. But here it's more holistic, looking at the essence of the human being. So, things like that (having pets visit), trying to get that old hospice feel, 'home from home' – thinking outside the box – do they want a priest? Are they open to complementary therapies?' (Katryn, Unit B: second interview)

'If you can meet them at their point of need, we have the time, ability to get to know people before even they express it' (Karen, Unit A: first interview)

'Thinking on your feet – it's about forward planning' (Katryn, Unit B: second interview)

This was often a long process and involved developing relationships in order to get to know the patient well enough to have the knowledge to anticipate their needs:

'For the patient, the first person they meet is crucial; in admission we have to cover all the detail, but by just asking you are challenging (her); the second nurse is following up but not delving, you are developing the relationship. A lot of patients here are too poorly on day one, so it's the second nurse who finds out.' (Ann, Unit B: first interview)

'One notices people's emotions, you can see by their face and meet those little needs, if someone is in pain, feeling sick, scared and they don't want to vocalise it.' (Karen, Unit A: first interview)

In many of the situations observed there was no guarantee of the outcome; the knowledge available could not help the participants to predict what would happen. Working with this uncertainty was largely seen as inevitable, it defined the context of care; it was accepted, although it was sometimes distressing; in asking about the incident, India replied:

'I wouldn't really know what's out of normal, it's all normal for me' (India, Unit B: first interview)

'Working with India today, we cared for a young woman with a brain tumour. She was suffering intense and sudden onset headaches. The team were at a loss as to how to help best. When her bell rang, I stayed with her and India ran for the Oromorph. We both felt pretty helpless.' (Reflective diary: 12/05/08)

An acceptance of the limits of one's knowing was a feature of the more experienced participants; these nurses were cognisant of the notion that they could not always know what to do for the best and the more experienced nurses such as Kirsty and India accepted that they could not always know the best way to act. This was tempered with a desire to change the situation, but ultimately they accepted that it might be something about

which they could do nothing. In this situation, they had to come to terms with not knowing:

'I would have to admit to wanting to have reasons for doing something, but I am happy to wait and see' (Kirsty, Unit A: second interview)

'If I look back, I can't always defend every decision, it's probably a generational thing, we revert to what we've done before.' (India, Unit B: second interview)

The condition of uncertainty meant that participants, particularly in Unit B where outcomes were much less predictable, spent a great deal of time assessing and re-assessing the results of interventions and making minor changes in order to try to solve a problem. Much of this was based on little more than informed guesswork. Ultimately the participants' knowledge came directly from patient care – from being exposed to people in similar situations, from making rapid assessments, and from knowledge of what had worked or not worked in the past. This was the fundamental basis of all that they ascribed to their 'knowledge':

'My adaptability and flexibility, that results from knowledge that comes from experience.' (Kirsty, Unit A: first interview)

'Helen says that she knows that removing drains can often be painful – patients have told her this in the past. So now, she gives them all painkillers before the procedure.' (Helen, Unit A: Mini Tour Observation)

In these ways, the participants appeared to work with any source of understanding that they could grasp; this might be what would in normal parlance be termed valid sources of understanding, or it might be from sources that were highly personal or taken from the experiences of others. Throughout the times when the participants were working in areas of uncertainty, the processing of the problem appeared to be largely subconscious:

'Ann reviewed verbally to herself as she worked, apparently trying to find some sense in what she saw and to come to some conclusions about what the problem consisted of before trying to solve it.' (Reflective diary: 19/11/08)

'The rationale is there but I don't think I'm ... I just ... because I've been doing it for so long, I'm thinking about it without realising I'm thinking about it.' (India, Unit B: second interview)

Thus the sources of understanding used by these nurses was varied but crucially was validated by the team or community in which they worked. Many conventions of care, or traditional interventions were not congruent with the values they shared, thus they created new ways of doing things and drew on internal sources in order to make sense of what was happening around them.

4.8.4 Summary of Associate theme Three

The key element of this theme was that of the nurses' knowledge; this was a common topic of discussion. Each nurse possessed their own store of personal knowledge and a variety of sources were identified including their family life, parenthood, life and professional experience and nursing background. Some referred right back to why they went into nursing in the beginning and how this influenced their valuing of particular forms of knowledge. Crucially perhaps, this knowledge was contextual but not bounded, it was shared; they created opportunities to agree strategies based on common understandings and checked things out with each other. The nurses valued the knowledge that they created between them, and they used their community to develop and test out this knowledge so that they were constantly striving for better understandings and greater opportunities to use what they knew. Each seemed to be saying however that this knowledge was not finite, they were always learning more.

4.9 Summary

This chapter has described the findings of this study structured into one over-arching major theme and three associate themes. The basis for this argument is that *communication, interaction and discourse* brings together the associate themes with each being operationalised by formal and informal means of communication and interaction in the practice context. The practical action that the participants took, the ways in which they established and developed their relationship with colleagues and the nature of their knowledge for practice were each dependent upon their interactions and discourse with others. These were the participants' key activities in their practice context but each depended upon dialogue with trusted others, with sharing ideas and validating concerns and by learning from their own practice and that of others.

At this stage it became clear that whilst what I had seen and heard was associated with what I had read and understood about reflective practice what I was witnessing was a broader picture of what contemporary nursing was like, at least in these two units. The participants seemed to be demonstrating what nurses like them did; they had agreed meanings that were attached to certain aspects of their practice and they had established values that informed what they did and how they did it. This way of practice was operated through a community, membership of which was bounded by these shared values and meanings and through which understandings about practice, upon which their work was predicated, were agreed upon and adjusted in the light of experience.

Chapter 5: Discussion

5.1 Introduction

The themes identified from the findings of this study show that the nurses who participated had common and shared ways of going about their work that were developed and validated by their community of practice. This was predicated on a purposeful rejection of habitual practice and an embracing of each patient as unique. Whilst Wackerhausen (2009) argued that there is a need for professionals to work *across* boundaries in order to act effectively, the two groups of participants worked in close-knit professional groups and saw their values as guiding their actions, with their professional identity embodied in *talking like we do* and in having *our criteria of relevance.* As several participants noted, they had to communicate concerns to other professionals by using a different language, trying to speak in that group's own terms of reference in order to be understood outside of their community.

5.2 What Our Kind Does

Participants in this study had clear ideas about what good nurses did, and in particular what they as *a team of like-minded professionals* did. The main study theme of communication, interaction and discourse is what enabled the participants to identify their communal values and to practice in a like-minded manner. In this way the study has uncovered new understandings about what nurses do and how they do it in contemporary practice. Interactions with patients and their families were influenced by the shared way of being and the desire to demonstrate *care*; the knowledge that they possessed was shared and validated by the community in which they worked and the practical action taken was based on mutual understandings.

Wackerhausen's (2009) notion of 'what our kind does', the following of rules, beliefs, values and understandings that are shared in a profession, was based on his argument that avoidance of 'trail following practice' (p462) is predicated on three conditions: interprofessional collaboration, professional identity and reflection across boundaries. What it is to be a nurse and to act as a nurse is likewise concluded by Fagermoen (1997) to be central to professional identity in nursing, with action being the key to this, giving priority to the exploration of the mandate of contemporary nursing as a research imperative (Allen 2004) alongside a need for investment in clinical leadership in the light of changing policy and practice (Endacott *et al* 2008).

5.2.1 Communities of Practice

Brookfield (1993) posed the notion of community as being the 'safety net' for critically thinking nurses. This community (also described in health care by Clouder 2000a and b) empowers professionals to challenge the status quo and provides a supportive and sustaining force for them. Such groups also share understandings about how knowledge should be created and it has been acknowledged that this can impact on both individual practitioners and groups (Clouder 2000a and b). Clouder debated how an individual's knowledge is made accessible to colleagues, and highlighted the role of interaction in professional teams. The ways in which this operates Clouder argued, are akin to those propounded by Habermas, which is to say by dialogical, interactive and socially constructed means, in this case in a community of practice.

Brookfield (1993) also identified professional identity as a factor in nurses' reluctance to engage in critical thinking in practice because they risk alienating themselves. Brookfield's conclusion was that nurses need a feeling of community, one that enables them to share common experiences and engage in critical thinking together in a trusting team.

In this kind of informal community of practice, where the nurses were trying to apply shared principles and mutual, negotiated understandings to practice (Wesley and Buysse 2001) they were engaged in situational learning (Amin and Roberts 2008). Having explored two different practice areas, it is interesting that Boud and Middleton (2003) emphasise the context in which this occurs and that communities of practice of this type engage particularly when they have to cope with *atypical* challenges. These would be most commonly represented by the complex needs of patients and families and were characterised by Schön (1983) as the *swampy lowlands* where the general rules and principles that guide practice may not be seen to apply. In such situations, the professional brings to bear their repertoire of practice, seeing the new situation in the light of a previous experience. A community of like-minded peers each with their own repertoire may be able to offer solutions, ameliorating feelings of alienation, through a dialogue created and maintained through informal communication.

Gobbi (2009:69) described this repertoire of previous experience as one's Personal Professional Capital, which includes relationships of trust; reciprocity and discourse with trusted others. Gobbi (2009) associated personal professional capital with communities of practice where learning allows members to develop a '*distinctive epistemology – their shared way of knowing about the world'*. This membership allows individuals within to learn together in a community of trusted others, much like that described by Gabbay and le May (2011) in relation to General Practice. In this integrated and constructed type of knowing within a community, the members '*can be themselves'* (Gobbi 2009:150) and can participate in relationships that are authentic. The participants within this study practised and learned in ways that both showed and developed their personal professional capital, and operated within the freedom of a community likened by Gobbi (2009:150) to the Greek concept of *koinonia*, where members act to seek a common goal, based in this case on a set of constructed and common understandings for the good of others.

5.2.2 Interprofessional Collaboration

Interprofessional collaboration was argued by Fagermoen (1997) to be a frame of reference by which nurses see phenomena in similar ways, although Wackerhausen (2009) argued this to be reliant on an understanding that no single group of professionals have a complete understanding of any phenomenon. The participants' understandings were that they had to work with others outside of their team, although their primary responsibility and passion lay within their own field. True collaboration, argued Wackerhausen (2009) is not working side by side with others but in the *genuine sharing of understandings*. Being part of such a community enhanced the participants' professional identity and enabled them to cope with the pressures of contemporary nursing and established those who could be trusted and what was meaningful:

- Having an ability to care;
- Being able to show that you care;
- The use of past experience;
- The ability to prioritise action based on patient need.

Wackerhausen's (2009) major thesis was that professional groups need to open up to inter-professional working through *reflective practice* rather than relying on their professional identity in order to develop and validate their shared meanings. For a profession such as nursing to remain 'agile' a higher level of reflection is required. In this higher order reflection the nurse can achieve better outcomes through genuine collaboration with others (Wackerhausen 2009). Wackerhausen (2009: 460) argued that what identifies 'our kind' is: '*talking like we do*, *asking the type of question we do*, *understanding, explaining things the way we do* and *see*(ing) *and value*(ing) *one's own profession the way we do*'. It is argued here that the participants in the study defined their practice *within contemporary boundaries* as 'what our kind does' and that this operated within a community of practice to which membership was restricted to those who satisfied this criterion.

Participants in this study whilst working in a close knit uni-professional group, valued and attempted to act upon the need to communicate outside of their teams in order to prioritise practical action, generate new knowledge and to be there and care for their patients.

5.3 Communicating and Interacting

The communication by participants in this study was largely of two distinct types, that with patients and families and that with colleagues. The importance of the former is clearly laid out in policy and guidelines but the latter is an area of continuing exploration. The participants described how they worked in teams of trusted others and formulated understandings of what was meaningful in their practice within these teams. These understandings were constantly modified, as patient focused problems were discussed and new approaches explored. Participants spoke explicitly about this informal interaction as a source of learning and of improving their practice, this '*process of constant interaction*' (Tabari-Khomeneiran 2007:212) was the means by which the participants developed their competence and skills by obtaining feedback and validation from trusted others. Much as Gabbay and leMay (2011) found in their ethnographic study of General Practice, the validation of practice was most valued if it came from those whom the professional trusted.

Street's (1992) classic ethnography of clinical nursing classes this as an *oral culture of unspoken values* that, in being unrecorded, is considered to lack legitimacy. Schön's (1983) proposition was that this type of understanding, *knowing* in action, becomes *knowledge* in action through reflection. The nurses in this study relied on informal and reflective communication of their understandings and values; they legitimised these through confiding in trusted others and by creating a community where this was valued as a legitimate basis for practice, translating knowing into knowledge. Szczepura *et al* (2005) argued that communication of this knowledge remains a challenge in contemporary practice, raising the imperative for this often-neglected area.

The challenges of communicating with patients, particularly those with cancer, have been explored extensively (for example McCabe 2004 and Sivesind *et al* 2003) and are enshrined in health policy (NHS Cancer Plan 2000, Improving Outcomes: a Strategy for Cancer 2011). Whilst the patients in the care of the nurses in this study could not be said to be entirely those with malignant disease, the majority were already diagnosed with cancer or were undergoing investigation likely to lead to this conclusion. Research interest in this area has grown due to a concern about how communication may have an impact on patient outcomes (Kruijver *et al* 2000). Effective communication with patient and clients, and between nurses and other health care providers has been taken up by the Royal College of Nursing (RCN) as a professional standard (RCN 2011) and by the Nursing and Midwifery Council (NMC) in the Code of Conduct For Nurses, Midwives and Health Visitors (in effect at the time) (NMC 2008) as a statutory requirement.

5.4 Prioritising Practical Action

The participants in this study cared passionately about their nursing practice and saw this as primarily about actions. In doing this they showed how practitioners bring together a range of influences to ensure their use of knowledge-in-practice-in-context (Gabbay and le May 2011), the shards and fragments (Gobbi 2005) that unite to enable them to create solutions. Getting things done was as important to the participants as it is to most nurses, but prioritisation was not centred around routines and tasks but overwhelmingly on *what the patients needed at that time*. No single influence could override the importance of the actual situation at hand but crucially for these nurses, this had to be set within the wider context of organisational boundaries. These boundaries could be, and were, tested where patient need required and on occasions, blocked the actions that the nurses wished to take. In both units to some extent, consideration of what needed to be completed soon and what could wait were individual and dynamic albeit bounded by certain limitations.

This focus was not only on practical activities but on moral or good action, congruent with the concept of *phronesis* that Flaming (2001:255) argued should guide action in nursing:

'A nurse using phronesis deliberates about the ethically correct nursing actions (praxis) in a particular situation.'

Higgins (2001) noted that it is the moral sensitivity of the nurse that separates the Aristotelian notion of the *phronetic* (or the nurse with practical wisdom) from the nurse who has only the craft knowledge (*techne*). The participants in this study showed both: the art of discerning a patient's needs when communication is problematic and the craft of painless wound drain removal. Ultimately these nurses focussed on action, on acting in some way to relieve suffering and distress through the art and craft of nursing. The literature on action in nursing contains a clear rejection of habitualised practice (Jarvis 1992) while recognising that some aspects of nursing work require adherence to the rules and regulations that dominate health care organisations (Mantzoukas and Jasper 2004). This tension was recognised, sometimes struggled with, by the participants in this study who often had to decide to break these rules or to admit failure. Where these conflicts arose, values came into question and those that were shared were reiterated and strengthened by discourse or change was agreed within the community.

The contemporary pressures of time, resources and context, along with the pace at which practice has to take place, were found by Clouder (2000a and b) to seriously impair professionals' desire to change practice. The two sites in which data were collected for this study might indicate an amelioration of some of these pressures, being generally well staffed and largely nurse-led. The participants attributed their persistent pursuit of good practice to caring, empathy and a desire to *do good* (Fagermoen 1997). The most expert amongst them consistently challenged regular practice and worked at the boundaries of

their own knowledge and skills to provide for patients' needs within the resources they had. If something could possibly be achieved, they would try to do it. Thus the practice observed was at times routine, but was not habitualised because it was monitored constantly for the cues that might indicate success or failure.

Where force of habit provided no answer, they tested out new approaches and experimented with different interventions (Schön (1983). This practice, argued Bleakley (1999) involves risk, passion and improvisation and a kind of reflective practice that looks out into the world and uses intuition and vision. Gobbi (1998) described this in her thesis as 'seeing as' in that the practitioner requires a certain orientation in order to perceive cues in a particular way. As Polanyi (1958), Argyris and Schön (1974) and Bleakley (1999) all argued, the essence of this is about tacit understanding, which makes it difficult for theories of action to be articulated. This was borne out in the discussion that I had with the nurses who did not find it easy to articulate what is was that influenced their clinical decisions in an abstract way, but resorted to generality and anecdote.

In the nursing practice observed, the community and interactive aspects of Argyris and Schön's (1974) notion of 'theory-in-use' were in evidence. This theory describes what people actually do rather than what they say they do. It is argued to be more contextual, flexible and community-dependent than 'espoused theory'. The testing out of new ways to practice are argued by Argyris and Schön to be a key component of ones' personal theory-in-use that must be validated by the community, by interaction with others, responses to clients and by the community as a whole; it is argued that the professional identity of nurses relies on this (Brookfield 1993). Brookfield (1993:198) considered model II behaviour (Argyris and Schön 1974) to be evidence of how nurses develop as critical thinkers and therefore as reflective practitioners. Being open to change in practice is, argued Brookfield, to place oneself at risk

of what he called *cultural suicide*. Brookfield's research led him to the following conclusion:

'Being critically reflective entails asking awkward questions about the nature of power and control, and calling people to account for their ideas and actions.'

The *constant flux* of the world of contemporary practice requires nurses who are critical thinkers to be at risk of what Brookfield (1993) called *impostorship,* the companion to experimentation in practice whereby nurses working in uncritical contexts begin to question their own integrity. In an uncertain world, nurses have to be open to both change and failure and to see the latter as a positive outcome (Argyris and Schön 1974) as many of these participants did. Challenges to 'practice as usual' within this study were framed around prioritising patients' needs and organising care individually within care contexts that were bounded by contemporary limitations.

5.5 Knowing and Nursing Knowledge

The nurses that took part in this study talked at length about what they '*knew'* and what they '*did not know'*; the possession of, or lack of knowledge was spoken of as personal and professional, as knowledge that they shared, and as the product of experience. It was at one and the same time concrete, tentative and intuitive. This apparently contradictory perception of professional knowledge was necessary in order to do the best that they could for the patients in their care. They would use whatever it took, without breaking the law, to help patients in their care. Thus they used textbooks left over from their initial training, they consulted each other, the chaplain and medical colleagues, they acted on instinct; sometimes elements of each of these sources of knowledge played a part in a single intervention.

Nurses need to use a variety of types of knowledge in practice, including those types of understanding that are principle-based and generalisable (Kim 1998). The nurses who participated in this study were all clear that some understandings may be relied upon in many circumstances. However, as Kim (1998) noted, practice also involves the generation of new knowledge, and the value accorded to this has been criticised. Like most nurses, the participants utilised knowledge that came from their education and training, their cultural and historical belief systems, their values and personal experiences, and from role models. This pluralism may be seen as a virtue (Pitre and Myrick 2007) while also being problematic due to the uncertainty created. The ability to work professionally within such shifting parameters and with knowledge from so many sources demanded an ability to discern and attend to what was most pressing at any one time. Organising care around individual patients' needs has been a mainstay of nursing since the 1980s but this cannot guarantee that what is done is correct or effective. A practitioner could take either correct or incorrect action but as Ryle (1945:3) theorised, the difference would be in the action itself, in '*the way the moves are executed'* not in the specific procedural moves themselves. Like Schön later, Ryle argued that *knowing how* to do something and *knowing that* about the action had to be viewed as one and the same, but *knowing how* precedes *knowing that*.

The participants in this study worked towards a vision that was predicated on a love of nursing (Boykin et al 2003) and did not focus on tasks but on each patient as a human whole. Thus the knowledge that they used was of a certain kind. Many of these participants could be described as what Belenky *et al* (1986) termed *constructed knowers* whilst others might be seen as *subjective knowers*. The description and illustrations given by Belenky *et al* (1986) of constructed knowledge are highly resonant of that articulated and demonstrated by most of the participants in this study. This way of knowing is described as:

'Weaving together the strands of rational and emotive thought and of integrating objective and subjective knowing' (Belenky et al 1986: 134)

This definition is relevant because it does not reject or dismiss the role of the technical rational knowledge that nurses are obliged to use in many situations. It is highly resonant of the concept of the bricoleur in nursing postulated by Gobbi (2005), who argued that nurses use a bricolage of knowledge and resources to address problems in practice. Belenky *et al*. (1986) presented this form of knowing as a high level and sophisticated form that arises following a history through a journey of self-discovery and critique. While this might be taken to be commensurate with age, the findings of this study would suggest that it is more about the fundamental values and beliefs of the nurse; these may be acquired over time, but are also related to human nature and individual character.

Bleakley (1999:327) argued that the *'education of attention'*, is an expression of critical reflexivity where the professional practices attention to the world, the context at hand and the consequences of his or her actions. Bleakley's (1999:324) definition of critical reflexivity has some resonance with the findings of this study, and shows why it is difficult for an observer to see or hear this:

'Being grounded in passion and body rather than cognition and mind, with an outside-in, rather than inside-out focus.'

This recalls the content of the interviews with the nurses in this study, and some of the practice observed. Bleakley related this holistic reflexivity to care and caring, to seeing the mind and body as integrated, and to orientation to the (patients') journeys that the participants spoke of. The participants each had their own worldview or theory-in-use that framed their understandings of practice problems. This perspective included emotions, and both caring and empathy are the results of this (Belenky *et al*. 1986).

Although the participating nurses often referred to *knowing* something, they similarly talked of *not* knowing, of being unsure about *giving it a go* or *trying it out*. This paradox seemed odd at the time, but consultation of the wider

literature has shown that these dilemmas and contradictions may be a product of the competing paradigms through which nursing knowledge has been taught and historically understood (Pitre and Myrick 2007). In contemporary health care, the value and nature of professional knowledge has been tested as patients themselves have become more knowledgeable about their care and medical knowledge has come to be seen as less esoteric. Thus the ability to admit to colleagues and patients that one does not possess an unlimited reservoir of professional knowledge is perhaps now a necessity. As the nurses in this study attempted to create a genuine relationship with their patients, it would be counterproductive and foolish for them to pretend that they possessed a mystical understanding.

The conceptualisation of knowledge presented by Ryle is highly relevant for this study; a nurse with expert knowledge may not be able to perform a patient-care action in the 'right' manner, nor could one who can do it in the right manner tell how this differs. Ryle (1945) argued that the 'true' expert nurse would be one who uses knowledge in skilful action, showing a *'knack'* or *'flair'* (Ryle 1945:11) in so doing. Ryle (1945:15) described an expert thus:

'The experts in them cannot tell us what they know, they can only show what they know by operating with cleverness, skill, elegance and taste.'

This was raised in this study by several of the participants, and was described as 'that feeling' or 'a good nurse' to suggest that although two nurses may act in similar ways, the effect on the patient can differ. In Ryle's view, knowing-how cannot be reduced to knowing-that, it is more than the sum of its parts. It is not an accumulation of years of experience, of educational courses and training; it is about being able to act intelligently. Ryle linked this with Aristotle's ideas about acting for the greater good. It suggests that a *good nurse* does *good things* and *a nurse that acts for the good* is a *good nurse*.

5.6 Being and Caring: The Good Nurse

Within the associate theme *being and caring*, participants in this study aspired to be what they called a *good nurse*. The good nurse was described as genuine and open, one who really cares about the patients. This good nurse was highly valued. The importance of practitioners' values and beliefs was discussed by Brookfield (1995), who termed this *epistemic moral thinking*. Brookfield argued that such thinking involves having an understanding of one's own moral certainty. This moral certainty was embodied in a belief that truly understanding a patient as an individual and creating unique practice appropriate to that person, were the constituents of the *good nurse*.

The internal sources of knowledge that mediated the participants' emotional responses were often motivated by empathy. The participants associated feelings of empathy with their emotional responses to patients' situations. Empathy in this sense was about striving to see the patient as '*a person such as I*' (Scott 2000:128) much as the nurses spoke of understanding themselves to be 'on a level' with the patients in their care. Scott (2000) argued that empathy involves deliberation, attention and a certain character. This means that for the nurses in the study to feel empathy they had to work to achieve it. Good nurses were those who acted in a certain way with patients and had certain characteristics that they used intentionally to evoke feelings of being cared for in patients (Fagermoen 1997).

Scott (2000) pointed out that this kind of notion is in tune with the Aristotelian notions of the 'good man', whose actions transcend rules and blanket principles. In order to gain access to this moral sensitivity, the nurse must therefore give attention to the relevant, meaningful and salient aspects of practice (Gobbi 1998). The inevitable extraneous diversions that may present in contemporary patient care situations have to be put aside in order for attention to be given to the true problem (Higgins 2001). Giving this attention requires a human receptivity (Scott 2000) that is both cognitive and emotional

in nature. This includes not only the practical use that the emotional understandings held by the participants were put to, but how this influenced their wider professional knowledge, ethics and practical wisdom.

5.6.1 Intuitive Practice and Emotion Work

The crucial nature of compassion in nursing remains high on the contemporary agenda highlighting the tension between quality and quantity of care and how this impacts on nursing practice (Crawford *et al* 2014). Whilst conducting an in-depth study on the use of intuition with three nurses, Gobbi (1998) conceptualised what she saw and heard in terms of the *bricoleur* who uses the *shards and fragments* of the resources at hand to construct a way of acting in a certain situation. Gobbi's (1998) participants perceived intuition as being reliable with a strong level of determinism, but as lacking an objective rationale. Gobbi's conceptualisation of intuition was of a *'signifying process'* (Gobbi 1998:iii) that involved both nurse and patient as the nurse searches for clues as to how to act, and she argued that action is where intuition arises and operates. The participants in this study responded to situations at hand and were alert for the cues that signified the best path to take. Whether the term intuition is the correct one to describe this kind of behaviour, the essence is that the participants talked of something that existed inside themselves that caused them to react to certain cues apparently without conscious thought.

The participants in this study were searching for any shreds of understanding or support in order to fulfil the needs that they perceived, in a way that was also described by Gobbi (1998). This required them to use their senses, their bodies and their minds to identify cues from which to construct a plan of action, a process of which they were not at all times aware. Dewey (1991) talked of *signifying* in indicating the basis of a belief in a certain cue. This, Dewey (1991) argued, is a rational part of building up the evidence for a particular course of action that must be based, at least partly, on what cannot be seen. This idea was echoed in Gobbi's study, and she concluded that

'intuition is thus the action of striving to see upon/within' (Gobbi 1998:194) and that it orientates the nurse to either current and/or future action. This striving or quest for the essence of patients' needs might be embodied in the ways of acting that the participants in this study showed; it cannot be expressly attributed to a notion such as intuition, but rather it was talked of as a journey or a process of unpeeling the layers of patients' needs in an attempt to get to the heart of a problem and that this gradually became instinctive.

Striving to get to the heart of a problem despite the obstacles, was key to the demands of the nursing observed as the participants used their senses to try to pick up cues and to respond in the time available. Schön (1983) suggested that the two processes involved in intuition are *seeing-as* and *doing-as,* so that the knowledge used is *reflected in and informs the action taken*. The practitioner thus sees one situation as similar to another, and does as she did in the last occurrence. In these ways, the understandings reported by participants in this study were dynamic, operating *before and within* care episodes. This had to take place in the hectic and pressurised context of contemporary health care as described by Allan (2001), and thus it was coloured by the priorities of which the participants regularly spoke and required of them a set of highly refined professional skills. It was also frustrating and stressful at times.

Cheek and Porter (1997) debated the notion of the *clinical gaze* in a paper that discussed the possible meanings of Foucault's analysis in nursing and health care. Cheek and Porter (1997) defined the clinical gaze as a disciplinary technique represented in medicine by the ways in which clinical staff may view the human body as passive. This, in Foucauldian terms, would operate in the panopticon of surveillance by experts and is thus an expression of power. This constitutes a form of postmodernism that rejects the dominance of those in positions of power and allows for other possibilities in the practice of nursing in particular. Cheek and Porter (1997) argued both sides of this debate,

concluding that these debates should not be over-simplified but that possibilities should be considered openly.

The participants in this study talked constantly about how their feelings related to their practice; they did not attempt to put aside their emotions, but conversely valued their responses, using these feelings to guide their interventions. This was seen as a legitimate source of understanding of the situation at hand. Emotions, feelings and their role in nursing practice have been debated over the years in the nursing literature and remain a topic of debate. Smith (2012) continues to argue that nurses use a form of purposeful labour in using their emotions to achieve care goals.

The art of professional practice, according to Schön (1983), is situated in situations of *uncertainty, instability, uniqueness* and *value conflict.* In the context of nursing, these situations are unlikely to be without emotional content. As both Boud *et al* (1985) and Gustafsson *et al*. (2007) proposed reflection is often triggered by emotional experiences and the participants expressed emotional responses to situations in which they found themselves in practice using ordinary human ways to express their emotions: they cried, they were angry and they became frustrated. These might be considered to be the emotions that are engendered by working in an environment where one is sometimes at a loss as to how to help, or where resources or staff are reduced or removed so that one is constantly fighting against sub-standard care. In order to retain an ability to assist their patients, these emotions were not expressed in the patient's presence but often formed the rationale for actions and interventions.

The study findings suggest that emotions and feelings are inextricably bound up in practice, and in particular in contemporary nursing where priorities had to be juggled with restraints. The nurses accepted emotions in their work as part of *what they did*. Their feelings coloured everything, and often prompted

responses that were of a very ordinary and human type. These were not simply the emotions that led to reflecting on ones practice, and nor were they merely the emotions that a professional feels when a care intervention goes well or badly. The emotions that these nurses described were reflective of a fundamental common humanity with the people in their care and they were given a high value, accorded importance, shared freely and acted upon.

Reeves' (1992) account of Aristotle's Nicomachean Ethics was based on the achievement of moral good or *human flourishing* through the application of practical wisdom. *Practical wisdom,* like dialectical thinking (Brookfield 1995), attends to the particulars of a situation in the light of generalities and principles, giving primacy to the moral response. Flaming (2001) applied this to nursing as a reaction against the claimed overwhelming value given to research-based practice and in recognition of other forms of professional knowing. In pursuit of *eudaimonia* (or human flourishing) and because the achievement of flourishing for all patients is not realistic, Flaming suggested that the ultimate goal might really be *care*. The participants in this study seemed to have a clear vision of good practice that was articulated as being the outcome of doing good things, of intending to do good and to a shared understanding of what good is and this was expressed as *care.*

Boykin *et al*. (2003) explored the importance of shared values in a study undertaken in the United States, which aimed to re-focus the minds and hearts of nurses on caring. Boykin *et al.*'s study, based on a caring model of nursing, helped nurses and the wider team in a hospital setting through a journey of 'coming to know what really matters' and 'responding to that which really matters' in a bid to bring the team together in a vision of what they described as *exquisite nursing.* This notion, that nurses can rise above the challenges and frustrations of scarce resources and shortages of staff to focus on what really matters to their patients, was highly congruent with the findings in this study and with a community of practitioners who valued what their kind did and had a professional identity that was strongly attached to this. The participants tried

to keep their minds on what they felt was of utmost importance at any one time with a view to acting on the most pressing need and doing the greatest good that might be possible.

5.7 Summary

This study has found that the nurses in the two contexts were practising in a way that enabled them to retain their key values and shared understandings about patient care in a contemporary context. The original study aim was found to be too restrictive within which to address these findings and the discussion therefore has therefore encompassed a wider arena of understanding. The participants delivered care through use of their intuitive or instinctive responses to patient need, using their emotional reactions as valid sources of understanding. They prioritised action, desiring an ability to do something in a timely manner to help patients and in so doing, aimed to do 'good'. They recognised the importance of acting in a particular way, not just in a practical act, but also in a *way of being*. What they knew or did not know was mediated through the community, which embodied 'what our kind does' through communication, interaction and discourse. The shared values and understanding that they all held bonded them together. This body of knowledge was constructed with trusted others and served to enable the participants to deliver a highly refined, exquisite type of nursing. This study has argued that there are new understandings to be gained within the data collected that illuminate the nature of contemporary nursing and of why and how nurses practice in modern health care.

Chapter 6: Conclusions

6.1 Introduction

As has been noted, the scope of this study changed following data collection as it became clear that to focus purely on the notion of reflective practice would be to exclude the broader and more striking data emerging. The discussion chapter has argued that what was seen and heard led me to a new understanding about contemporary nursing. This fresh understanding is about *what nurses do* and *how they do it* in a modern practice setting, this being orientated around how they communicate and interact both within and to some extent outside of their professional group. The notion used to explain this borrows from that of Wackerhausen (2009) in his discussion of professional identity and collaboration as 'what our kind does'.

The pressures brought to bear in a modern health care context and the organisational boundaries that existed for these nurses caused them to find support and validation for their practice within a community of practice. This community served to embody the shared values and meanings that the nurses held and enabled them to learn from each other. This learning was not passive but involved the open and honest sharing of their experiences and perspectives in order to devise new ways of solving patients' problems. Whilst they relied on some level of routine in their work, care was devised around each patient as a unique individual and they attempted to show that they cared *about* patients whilst caring *for* them. This chapter concludes the study, summarises the findings and considers the limitations of the study. The chapter also contains some indications of the implications of the study findings and a how these might be applied to other contexts.

6.2 Summary of Study Findings

Through a process of crystallisation (Ellingson 2009), observational, interview and reflective data were structured into themes: *communication, interaction and discourse* being the over-arching theme and three associate themes:

practical action, *being and caring*, and *knowing*. The study themes have been argued to relate to key theoretical sources in nursing on communities of practice and professional identity as well as how nurses create and validate their understandings through establishing within communities *what our kind do*es. This embodies some new insights into what nurses are doing in contemporary practice and how these actions are informed.

6.3 Reflections on the Study

The data collected relating to reflection may have not been fully integrated into the study themes because it was prompted by me and served to lead the participants' responses in a certain direction. In addition, this was limited to the initial interviews because the second interviews were designed individually around the practice that had been observed and the data at this stage served to indicate a much broader sense of contemporary practice than simply that which was reflective.

Porter (2007:81) noted that construction of the meaning of a research report falls to both the writer and the reader:

'A core part of the interpretative work of research report writing involves writers presenting reports in such a way that they hope will persuade readers of their veracity, while a large part of readers' interpretations of the reports will involve judging the degree to which they accept their veracity'

In this way, Porter argued that mutually accepted criteria for the assessment of rigour in qualitative research are essential. For this reason, criteria set by Lincoln and Guba (1985) were used to try to establish the value of this study, but other conceptualisations are acknowledged (see Porter 2007). Essentially the methodology used in this study was of an ethnographic type and the intentions within this frame were to enhance the applicability or transferability of the findings so that the chance of practitioners using it to enhance understanding of contemporary nursing might be maximised. Porter (2007) also noted that these criteria and the form of research reporting such as in a doctoral thesis, do not exclude the potential for a novel and unique content. This might be argued to be a limitation of the study but it may be countered by

the argument that the study only claimed to use ethnographic *methods* and not to constitute *ethnography.* The application of the Casebook or Combinative approach advocated by Baszanger and Dodier (2004) may have one that aided in the contextualisation of the findings but overall could not be said to have been very helpful perhaps due to the lack of practical guidance given by these authors.

The data collection therefore conformed to traditional ethnographic approaches with the importance of context and application reiterated by the work of Baszanger and Dodier (2004) on Combinative or Casebook Ethnography. The data analysis procedures as outlined by Spradley (1979 and 1980) and by Hammersley and Atkinson (2007) were rejected in favour of crystallisation (Ellingson 2009). The ability to use verbal, observational and reflective data to interpret the findings was of great value. It was also congruent with the decision to keep the interview data contextualised by listening, reflecting, re-listening and making notes rather than transcribing the interviews and working from typed data. This enabled me to recall the context of the interview along with ambient noise and distractions and thus to attempt to interpret meanings that retained contextual features (Appleton and King 1997).

The topic under investigation in this study was one that has created both debate and conflict in nursing and in other professions; reflective practice proved to be elusive in this study. Exploring topics like this has its challenges, not least the fact that the researcher's own perspectives on the notion of reflective practice, in particular its potential to enhance patient care, may well influence the study in a manner that some might term bias. Indeed there are some examples of this in the current body of knowledge in the area and the debate between authors shows this to be a controversial topic. Thus, constructing such a study, particularly one for the purposes of a doctoral award, was fraught with danger. As a past proponent of reflective practice in nursing, my personal challenge was to design and conduct a study that would

possess the *'confidence criterion'* of which Porter (2007:83) writes, without lending a positive or negative personal slant. The findings of the study, along with the methods employed, needed to evoke a sense of validity in the reader and required some caution in managing myself in the field. As well as a commitment to follow the data, the change in the study focus showed that there was an attempt to be true to the basic tenet of qualitative research, that is flexibility. Thus, the crucial process of research supervision was key to uncovering my own assumptions, and those of nursing in general about reflective practice.

6.4 Implications of the Study

The imperative on any research study is not only to have an impact on understanding in a certain area but also to generate new directions for further enquiry. This study has generated some implications in three main areas: the methods that might be used in the future to improve research into nursing practice; secondly the implications for the ways in which the findings of this study might influence the practice of individual nurses and their communities of practice, including implications for clinical leadership and thirdly for the continuing professional development of nurses. Finally there are further research questions that are generated by this study that may lead to a better understanding of contemporary nursing.

6.4.1 Implications for Nursing Research

Just as it is an informal agreement among those publishing in the British Medical Journal that they should not simply advocate 'more research needed', this will not be stated here. Further, having argued that there are implications arising from this study for professional collaboration, the research imperatives will not be restricted to nursing. As it stands, relatively little is yet known about what professionals do (and how) from an empirical perspective and yet great claims have been made and dedicated journals and conferences exist in this field. What is lacking is not more scholarly debates about this but a body

of situational and participatory enquiry that explores communities of professionals as they work across their own and others' professional boundaries in contemporary contexts.

The pursuit of understanding professional practice should not however, be restricted to descriptive accounts of their practice. Indeed the impact of research on clinical outcomes is what generates funding and resources for clinical and higher education bodies. Thus such research should be orientated around interventions and the empirical investigation of how these work and how they might be improved. How and why professionals do what they do will naturally be an essential part of this.

In my employing organisation, the need for research into nursing practice has been noted. This imperative, to understand better what nurses do and how they do it, is embedded in this study and is ripe for development. Nursing as a profession has borrowed research findings for many decades from many related disciplines and this has at times resulted in a few seminal studies about the nature of nursing itself. Yet the evidence base for many nursing interventions remains thin and thus arguments for resources and skill mix are largely unsubstantiated. The nature of research in nursing has for too long relied on self-report and has been decontextualised. That which has embedded data collection in practice has been accused of lack of transferability. Research methods that detail the context of exploration and collect data from multiple sources are needed in order to produce nursing research that is rigorous and transferable to other settings.

6.4.2 Implications for Nursing Practice

While it is not possible to make any extensive recommendations about reflective practice based on the findings of this study, some implications do exist. What the findings *do* show is that nursing practice is inherently creative and resourceful and is influenced strongly by the organisational context.

Contemporary nursing is fraught with targets, boundaries and limitations. Yet there is a way forward by investing in the instinctive desire of nurses to create and work within teams in which they can create a workable professional identity and do what they consider to be right. The participants in this study enable me to see what it is that nurses do and how they do it and thereby have generated some implications for how nursing practice might move forward.

The effective practice of nursing relies on sound clinical leadership and it is not the intention to place emphasis on that requirement here. However, the place of the clinical leader in motivating and inspiring nurses to maintain their communities of practice must receive greater attention in research and the literature. It is argued here that this role does not need to be fulfilled by an expert in the area; more that this person should be someone who can understand and value the role of a shared journey of knowing and should be able to guide nurses through the process of developing a notion of what their unique role is or *what our kind does.* As Wackerhausen (2009) pointed out, this includes the use of reflective knowledge gained through reflective practice but more than this it necessitates working in a multi-disciplinary arena, not just side by side with other professions. Knowledge and understandings that are shared only between nurses will never become meaningful in the wider community if they are not communicated outside of the nursing team. Thus, communities of practice can be key to inter-agency working (Lathlean and le May 2002).

Past research has shown that reflective practice alone is not sufficient to engage practitioners to make concrete changes if it is not based on shared values and understandings both across and within specialist communities (see Page and Meerabeau 2000 and Mantzoukas and Jasper 2004). If the practices of a single discipline community work with isolated values and beliefs, the patient or client receives fragmented care. All health professionals are on a quest for knowledge and understanding as they work in a world of uncertainty; this is one fact that is shared across all disciplines and specialities. Therefore

reflective practice in one profession fails to impact on holistic care as an endeavour and historical understandings of reflective practice have to be updated for contemporary health care.

The findings of the Francis Report (2013) have shown how a lack of clinical leadership and shared values can lead to a community of practitioners who lack direction and basic empathy. In particular, Recommendation 10 states that the leadership in the nursing workforce should be the focus of development. The culture of the workforce at the NHS Trust under review in the Francis Report shows how the shared values and priorities are crucial in directing the practice of health care workers. This seems to provide evidence that attention must be paid to the influence of the community on standards of care and that the promotion of ideas such as reflective practice must be understood in the light of the context.

6.4.3 Implications for Nursing Education

As noted in Chapter Two, the professional socialisation of nurses is a difficult area as this relies upon sound and ethical conduct in the wider arena of practice. It is on education at undergraduate, pre-registration, post-registration and postgraduate levels that the focus lays. This is where educators get to influence practice and to help to form nurses, at an early or late stage in their careers, into the kinds of practitioners that the profession needs. Curricula need to address the issues of inter-professional collaboration, of the development of professional identity so that nurses may explore for themselves what it is that they do and how they do it. This will require the introduction of the skills of critical reflection early in the curriculum and the use of student-centered methods to enable nurses to gain confidence in their understandings of what nursing is. Once settled into the culture of nursing, some contexts may not empower nurses to articulate their practice values as Units A and B did.

The relevance of these issues for the continuing professional development (CPD) of nurses lies in the recognition of the evidence that indicates culture change to be key in changing practice. Problems with sustained change may be attributable to the predominant influence of the culture or community in which the nurse works which can overwhelm any good intentions. If practice change is to occur then CPD needs to be based on and situated in, the real world of practice and efforts need to be made to develop and sustain the values and beliefs in the community of practice in order for change to become permanent. This is the key to realising the *professional capital* (leMay 2009) that is needed to avoid future crises in nursing. Gobbi (2009:69-70) defines this as:

'intrinsically associated with the self-concept of the individual professional and their relationship with others.'

Thus any attempt to sustain and release this capital would require the education and continued professional development of nurses to be framed by and situated in, practice.

6.4.4 Implications for Professional Bodies

Inevitably the findings of research will not impact on nursing practice unless there is support at the level of professional bodies. The statutory bodies in British nursing, the United Kingdom Central Council (UKCC) and the Nursing and Midwifery Council (NMC) are the leaders in professional nursing for the setting of standards of practice. This includes both pre-registration training for first level qualification and professional development of qualified nurses. In order to respond to the findings of this study, it is recommended that these bodies consider the nature of what nurses do as well as their current concerns with safety and the scope of practice. Whilst the protection of the public is clearly a major concern, this goes further than rules and regulations.

In order to maximise the impact of the findings of this study it would be recommended that these bodies explore what nurses do and how in order to protect the public and the profession from the constant pressures of a

dynamic and bounded environment of care. Nurses are by far the largest workforce in the NHS in Britain yet the role of regulatory bodies is concerned more with the failings of the profession than the development of a clear understanding of it. With patient complaints about nurses always present, responding to these should be more than simply punitive measures against those at fault. Guidance for nurses tends to be generalised and decontextualised, with little apparent understanding of the pressures under which nurses practice. A more proactive approach to understand and embed the values embodied by the nurses in this study would be of value. A commitment to the importance of nurses' values, understandings and the need for collaboration would be a useful starting point in equipping them to be resilient against the pressures in the real world.

6.5 Summary

This chapter has concluded the study and the findings have been summarised and the wider resonance reiterated. The limitations of the study have been acknowledged. Despite these limitations, I have argued that the research has been sufficiently robust for a doctoral course of study. The implications of the findings of the study have been discussed with regard to nursing research, nursing practice and nursing education. Key recommendations leading on from the study have been identified. The study findings will be disseminated through two major channels. First through seeking the publication of a research report of the study. Secondly, the study will be presented at conferences. The overall objectives of disseminating the study are to influence nurses in their own practice and to aid in the wider understanding of contemporary nursing.

Appendix A

Invitation to Nurse Participants

REC No: 07/Q1603/8

An Exploration of Reflective Practice In Adult Nursing.

Dear Colleague,

I am a student at the University of Southampton and I am carrying out a research project looking at an approach to nursing called reflective practice. You are being invited to participate in the research project, which is being carried out for the award of PhD. Attached to this letter is an information sheet that is yours to keep whether you decide to take part or not. You have been invited to this informal meeting at which I will be able to give further information about the study and answer any questions that you may have. Following this, I will be asking each of you to consider taking part in the study. I will ask you to indicate your agreement or to decline within two weeks. This is to allow the study to get started. Prior to the meeting, I would be most grateful if you could read the information sheet. Thank you for your time.

Yours sincerely,

Sue Schutz

Appendix B

Information Sheet for Nurse Participants

Study Title: An Exploration of Reflective Practice in Adult Nursing

REC Study number: 07/Q1603/8

Version number: 2.0

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. Talk to others about the study if you wish.

- Part one tells you about the purpose of the study and what will happen to you if you take part.

- Part two gives you more detailed information about the conduct of the study.

Please ask me if there is anything that is not clear or if you would like more information. Take time to decide if you wish to take part.

Part One

What is the purpose of the study?

The study is a student research project for the award of PhD. It intends to find out whether there are adult nurses who demonstrate in their practice the characteristics of reflective practice.

Why have I been chosen?

The unit in which you work has been chosen as an appropriate place in which to look for nurses who may demonstrate the characteristics of reflective practice. All of the other qualified nurses within the team will be asked to take part too. Some of you will be asked also to allow me to work more directly with you for agreed periods of time and also to one or two interviews.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. If you decide at any time to withdraw from the project, this will not affect your employment rights in any way.

What will happen to me if I do take part?

If you decide to take part you will be asked to agree to my presence at periodic intervals in your place of work, over a period of about nine months. As a qualified nurse, I would attend some of the ward meetings and handovers. I may ask you to allow me to participate in the care of those of your patients who agree, this is called participant observation. I may also ask you to agree to two interviews with me. The interviews are likely to be about an hour each in duration and would be arranged at a time and place to suit you. You would not be expected to make any extra journeys to you place of work, nor to spend any extra time at work in order to participate.

What do I have to do?

You would be expected to go about your work as normal. You may be one of a number of unit staff who are asked to agree to participant observation and interview.

What are the possible disadvantages and risks of taking part?

There are no specific disadvantages of taking part. You may, however, find that I will want to ask you questions or discuss events with you. I have no intention of making any judgements about the care that you give to your patients or the ways in which you work. It is possible that distressing or sensitive issues may arise during discussion or interviews and, if this occurs, I will offer outside sources of support for you should you wish it.

What are the possible benefits of taking part?

There are no intended benefits to you as a professional from this study. You may however, find talking about your work helpful and enjoyable. The study hopes to contribute to the wider understanding of reflective practice in nursing and you may wish to request a copy of the final report which I would be happy to supply.

What happens if the study stops?

If the study stops for any reason you will be thanked for your time and no further approach will be made.

What if there is a problem?

Sometimes during studies of this sort, the researcher may become party to practice or professional behaviour that appears to contravene local protocols or professional codes. The researcher, as a qualified nurse, is bound by her professional code of conduct and therefore must report to the unit manager any incidents that constitute negligence or incompetence.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The details of how this is done are in part two.

Contact details.

If you have any questions about the study, please feel free to contact me at any time now or during the study on:

E mail:

Tel:

This completes part one of the information sheet. If the information in part one has interested you and you are considering participation, please continue to read the additional information in part two before making a decision.

Part Two

Complaints

If you have any concern about any aspect of the study, you should speak with myself. I will do my best to answer your questions. You can contact me on the number above. If you remain unhappy, you can speak to my supervisors at the University of Southampton, Dr …… or Dr…… on:

You may also contact the Research and Development Department of the….. NHS Trust.

Harm

In the event that something does go wrong and you feel that you have been harmed by the study there are no special compensation arrangements. If this harm is due to the researcher's negligence then you may have grounds for a legal action for compensation against the University of Southampton or the NHS Trust, but you may have to pay for your legal costs. Professional complaints procedures will also be open to you.

Will my taking part in the study be kept confidential?

All information that is collected about you during the research will be kept strictly confidential. Information will be collected informally by verbal discussion and visual observation. This will include daily practice in the unit and one to one participant observation and interview. The observational data will be recorded in hand-written field notes and stored in a locked cabinet at the researcher's home address. Interview data will be recorded electronically and transcribed by a professional transcriber, employed for the purpose. Transcriptions will be kept both on a password-protected computer and in a locked cabinet, both at the researcher's home address. All material will be coded and anonymised in accordance with the guidance on personal information issued by the Medical Research Council, so that participants may be identified only by the researcher. Only the researcher and her supervisors

will have access to raw data. The University of Southampton, NHS Trust and the researcher's employers, Oxford Brookes University will have access to analysed data for monitoring purposes only. All will have a duty to you as a research participant and nothing that could reveal your identity will be disclosed outside of the research site. No data will be used for any purposes other than the study and transcripts and field notes will be disposed of securely after a period of five years in accordance with the Data Protection Act.

What will happen to the results of the research study?

The results of the research will be made available to participants at the completion of the study. During the study, you have right to check that any data held about you is correct. I will share my initial findings with participants at times throughout the study in order to check my understanding. You will not be identified in any publications made of the results of the study.

Who is organising and funding the research?

As a student study, the research is organised by the student (researcher) under the direct supervision of the University of Southampton. There is no external funding for the study, all direct costs are met by the researcher and indirect costs, including your time, by the Trust.

Who has reviewed the study?

The study has been given a favourable ethical opinion for conduct in the NHS by Milton Keynes Local Research Ethics Committee. It has also been approved by Trust Research and Development, the Finance Director and Directors of the research sites. As a student project, it has received favourable Peer Review from the School of Nursing and Midwifery, University of Southampton.

Date:

Susan E. Schutz

This information sheet is for you to keep whether or not you decide to take part in the study.

If you wish to participate, you will be asked to sign a consent form and also be given a copy of this to keep.

Thank you for taking the time to read this information sheet.

. . . . . .

Tear/cut

I would be willing to participate in the study entitled:

'An Exploration of Reflective Practice in Adult Nursing'

Please contact me to arrange a meeting where I can sign a consent form.

Signed: ……

Date: ……

Print name: ……

Contact details:

Telephone:……

Email:……

Appendix C

Invitation to Patients

REC No: 07/Q1603/8

An Exploration of Reflective Practice In Adult Nursing.

Dear Patient,

I am a student at the University of Southampton, and also a qualified nurse and I am carrying out a research project looking at an approach to nursing called reflective practice. You are being invited to participate in the research project, which is being carried out for the award of PhD. Attached to this letter is an information sheet that is yours to keep whether you decide to take part or not. The project will involve you for a very short period of time and requires no direct action from yourself. If the nurse who is helping with my study is caring for you on the day that I am on the unit, you will be asked whether or not you would like to participate. If you wish to participate, you will be asked to sign a consent form. Please take time to read the attached information and ask any member of the nursing team to contact me if you wish to talk with me about the study further.

Yours sincerely,

Sue Schutz

Doctoral Student

University of Southampton

Appendix D

Information Sheet for Patients

Study Title: An Exploration of Reflective Practice in Adult Nursing

REC Study number: 07/Q1603/8

Version number: 2.0

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. Talk to others about the study if you wish.

Part one tells you about the purpose of the study and what will happen to you if you take part.

Part two gives you more detailed information about the conduct of the study.

Please ask me if there is anything that is not clear or if you would like more information. Take time to decide if you wish to take part.

Part One

What is the purpose of the study?

The study is a student research project for the award of PhD. It intends to find out whether qualified nurses demonstrate in their practice the characteristics of a concept called reflective practice. Reflective practice is a way of going about nursing that is thought to help nurses learn from the experience of caring for patients. The project is only studying the nurses, it is not in any way a study of yourself.

Why have I been chosen?

The ward in which you are currently a patient has agreed to allow me to study nurses who may demonstrate the characteristics of reflective practice. All of the qualified nurses within the ward team will be asked to take part. Some of the nurses will be asked also to allow me to work more directly with them for agreed periods of time and also to an interview. You are only being approached because you are being cared for by one of the nurses that I am studying.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I do take part?

If you decide to take part you will be asked to agree to my presence at periodic intervals whilst the nurse that I am studying is caring for you. As a qualified nurse myself, I would take part in the care that you receive, although your nurse would always lead this. You would not be asked to take part in any other way, it is only the nurse who is being studied.

What do I have to do?

You do not having to do anything. You will simply notice that I am assisting the nurse who is caring for you.

What are the possible disadvantages and risks of taking part?

There are no specific disadvantages of taking part. I have no intention of making any judgements about the care that you receive. It is possible that at times, you may wish me not to be present and you should indicate this to the nurse caring for you on that particular day or time. I will withdraw immediately. The study has no effect on the care that you receive now or in the future.

What are the possible benefits of taking part?

There are no intended benefits to you from this study. The study hopes to contribute to the wider understanding of reflective practice in nursing.

What happens of the study stops?

If the study stops for any reason you will be thanked and no further approach will be made.

What if there is a problem?

If you feel that there are any problems during the study, please ask to talk to me or to a member of the nursing staff, who will be happy to answer your questions.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. No information about your identity will be collected or used in any way. The details of how this is done are in part two.

Contact details.

If you have any questions about the study, please feel free to contact me at any time now or during the study by asking a member of the nursing staff to contact me or on:

E-mail:

Tel:

This completes part one of the information sheet. If the information in part one has interested you and you are considering participation, please continue to read the additional information in part two before making a decision.

Part Two

Complaints

If you have any concern about any aspect of the study, you should speak with myself. I will do my best to answer your questions. You can contact me on the number above. If you remain unhappy, you can speak to my supervisors at the University of Southampton: Please contact a member of the nursing staff who will assist you to contact me. You may also contact the Research and Development Department of the NHS Trust on:.

Harm

In the event that something does go wrong and you feel that you have been harmed by the study there are no special compensation arrangements. If this harm is due to the researcher's negligence then you may have grounds for a legal action for compensation against the University of Southampton or the NHS Trust, but you may have to pay for your legal costs. Professional complaints procedures will also be open to you.

Will my taking part in the study be kept confidential?

All information that is collected during the research will be kept strictly confidential. No information that would allow you to be identified will be collected or kept. Material collected about the nurse caring for you will be recorded in hand-written field notes and stored in a locked cabinet at the researcher's home address. Only the researcher and her supervisors will have access to this material. The University of Southampton, NHS Trust and the researcher's employers, Oxford Brookes University will have access to some material for monitoring purposes only. No data will be used for any purposes other than the study and notes will be disposed of securely after a period of five years in accordance with the Data Protection Act.

What will happen to the results of the research study?

The results of the research will be made available to nurse participants at the completion of the study. You will not be identified in any publications made of the results of the study.

Who is organising and funding the research?

As a student study, the research is organised by the student under the direct supervision of the University of Southampton. There is no external funding for the study; all direct costs are met by the researcher and indirect costs.

Who has reviewed the study?

The study has been given a favourable ethical opinion for conduct in the NHS by Milton Keynes Local Research Ethics Committee, Trust Research and Development, the Finance Director and Directors of the research sites have also approved it. As a student project, it has received favourable Peer Review from the School of Nursing and Midwifery, University of Southampton.

Date:

Version 1.0

Susan E. Schutz

This information sheet is for you to keep whether or not you decide to take part in the study.

If you wish to participate, you will be asked to sign a consent form and also be given a copy of this to keep.

Thank you for taking the time to read this information sheet.

. . . . . .

Tear/cut

I would be willing to participate in the study entitled:

Appendix E

Consent Form - Nurse Participants

REC Study Number: 07/Q1603/8

An Exploration of Reflective Practice In Adult Nursing.

Please initial box.

I confirm that I have read and understand the information sheet (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without affecting my legal or employment rights. ☐

I agree to the use of electronic recording equipment for the purpose of the accurate recording of interview data. ☐

I agree to the use of anonymised direct quotations. ☐

I agree to take part in the above study. ☐

Name of nurse: Signature:

Name of researcher: Signature

Date:

When completed, one copy for nurse, one for researcher.

Appendix F

Consent Form – Patients

REC Study Number: 07/Q1603/8

Title: An Exploration of Reflective Practice In Adult Nursing.

Please initial box.

I confirm that I have read and understand the information sheet dated…… (version…….) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without my legal rights being affected. ☐

I agree to the consultant in charge of my medical care being informed of my participation in the study. ☐

I agree to take part in the above study. ☐

Name of patient: Signature:

_____ _____

Name of researcher: Signature:

_____ _____

Date:

_____

When completed, one copy for patient, one for researcher