**LIVING NURSING VALUES:
A COLLECTIVE CASE STUDY**

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ABSTRACT

Distinctive humanistic values are foundational in professional nursing practice, commonly shared by members of the profession and the mainstay of how nurses act. The foundational values of the nursing discipline are balanced with clinical knowledge and technical skill. Nursing values presuppose nurses' responsibility to nurture and protect, to heal, to cultivate healthy behaviours and attitudes, and to be present (physically and intellectually) during times of vulnerability, illness or injury.

The rationale for this study came from the recognition that nursing has changed, so too have the characteristics of patients and the way healthcare is operationalised. Nurses are challenged on a daily basis to negotiate between meeting the complex needs of patients whilst addressing healthcare priorities and attending to their own personal and professional requirements. There is a growing philosophical debate about whether the healthcare climate is dehumanising health care professionals' encounters with patients, including those of nurses, and creating a culture where enacted values are inconsistent with professionalism.

The purpose of the research was to explore the values of professional nurses practicing in medical ward environments and how these values are lived in day-to-day practice. Case Study methodology was used to capture the contextual conditions of nursing values in nurses' daily practice. Data collection was carried out in three medical wards in New Zealand; data were triangulated using observations, focus groups, interviews, burnout survey and theoretical application. The major theoretical and philosophical influences on the research, which were used to explore the data, were those of Isabel Menzies' defences against anxiety and Edith Stein's phenomenological theory of motivation and value.

Key findings indicate that healthcare environments obstruct the enactment of humanistic nursing values stimulating value dissonance for nurses between how they *want* to practice and how they *actually* practice. Conflict arises from nurses experiencing systems that foster managerialism and cultures of anxiety. In order to cope with value dissonance, nurses

enact unconscious defence mechanisms; resulting in constrained nursing practice, exhaustion, cynicism and burnout.

This thesis challenges the nursing profession to acknowledge and address the visibility of nursing values in contemporary practice, as well as acknowledge the dissonance that exists between the values of nursing and the values that drive healthcare delivery. Humanistic nursing values remain important to practicing nurses. This study identifies in detail the every-day difficulties nurses face in seeking to enact their values and the managerial challenges that confront them. This information offers a trustworthy analysis of the challenges the nursing profession faces in addressing this problem. It also offers a basis for developing approaches that could strengthen nurses' ability to enact the humanistic values they are professionally committed to provide.

It is critical that any attempt to embed nursing values into clinical nursing practice is founded on a strategy that recognises and mitigates against dysfunctional organisations and organisational constraints. Drawing on findings from this thesis, it is recommended that the articulation and development of nursing values in acute clinical environments is responsive to organisational factors. Through this, the nursing community can develop, articulate and operationalise nursing values.

Keywords: Professional nursing values, nursing, values, Isabel Menzies, defence mechanisms, managerialism, value dissonance, Edith Stein, medical wards, case study.

.

DEDICATION

To Mum and Dad for giving me roots and wings.

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I have never known a doctoral thesis to be plain sailing, I therefore set out on my journey with clear navigational charts and a survival kit, fully expecting to be tipped into the water at a moment's notice. That is exactly what happened many times. The choices that are made whilst bobbing in the ocean are the ones that make some swim for shore and others climb back on board. What helps make the latter decision are those who have also pinned their colours to the mast.

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I could not have put this better myself so I cautiously leave the last words to Sawicki (2000, p. XXIII) “Blessed as I have been with such abundant earthly assistance and heavenly surveillance, I beg the indulgence of critics from both planes for whatever shortcomings remain”.

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TABLE OF CONTENTS

ABSTRACT.....	I
DEDICATION.....	III
ACKNOWLEDGEMENTS	IV
TABLE OF CONTENTS	VII
LIST OF TABLES	XIII
LIST OF FIGURES	XIII
CHAPTER ONE: INTRODUCTION.....	1
1.1 Introduction.....	1
1.1.1 The image of nursing	1
1.1.2 Rationale and justification for the research	3
1.1.3 Research interest	4
1.1.4 Research question and objectives	6
1.2 Defining values	6
1.2.1 Axiology	7
1.2.2 Motivational values.....	8
1.2.3 The place of virtue and morality.....	9
1.3 Importance of healthcare values	11
1.3.1 New Zealand healthcare values	13
1.3.2 The impact of ‘productivity’ on healthcare values	15
1.4 Nursing values	17
1.4.1 Quality of nursing care and Codes of Conduct.....	19
1.4.2 Nursing values and Code of Conduct in New Zealand.....	22
1.5 Thesis overview	24
CHAPTER TWO: LITERATURE REVIEW.....	26
2.1 Introduction.....	26

2.2 Emerging areas of knowledge about nursing values.....	27
2.2.1 Professional socialisation of nurses	27
2.2.2 Measuring professional nursing values.....	31
2.2.3 Measuring professional nursing values in New Zealand	33
2.2.4 Teaching nursing values	35
2.2.5 Teaching nursing values in New Zealand.....	38
2.3 Effect of healthcare climate on nurses and nursing	39
2.3.1 Managerialism in healthcare	40
2.3.2 Quality of life for nurses	43
2.3.3 Compassion fatigue and burnout	44
2.4 Approaches to the organisation of nursing practice.....	49
2.4.1 Functional or task nursing.....	49
2.4.2 Primary nursing.....	50
2.4.3 Team nursing	51
2.5 Theoretical Influences.....	53
2.5.1 Isabel Menzies	53
2.5.1.1 Splitting up the nurse-patient relationship	56
2.5.1.2 Depersonalisation; categorisation and denial of the significance of the individual depersonalisation	56
2.5.1.3 Detachment and denial of feelings.....	56
2.5.1.4 Elimination of decisions by ritual task-performance	57
2.5.1.5 Reducing the weight of responsibility in decision-making.....	57
2.5.1.6 Collusive social redistribution	58
2.5.1.7 Purposeful obscurity in formal distribution of responsibility	58
2.5.1.8 The reduction of the impact of responsibility by delegation to superiors.	58
2.5.1.9 Idealisation and underestimation of personal development possibilities..	59
2.5.1.10 Avoidance of change.....	59
2.5.2 The adoption of Menzies thinking in nursing	59
2.5.3 Edith Stein.....	62
2.6 Summary	65
CHAPTER THREE: METHODOLOGY	67

3.1 Introduction.....	67
3.2 Constructivist epistemology and Case Study.....	68
3.2.1 Early history of Case Study methodology	71
3.2.2 Criticisms of Case Study methodology.....	72
3.2.3 Types of Case Study	73
3.2.4 Case boundaries	75
3.3 Triangulation.....	75
3.4 Research propositions	77
3.5 Chapter Summary	77
CHAPTER FOUR: METHODS.....	79
4.1 Introduction.....	79
4.2 Study setting.....	79
4.2.1 Access and gatekeeping	80
4.3 Participant recruitment.....	82
4.3.1 Nurse recruitment.....	82
4.3.2 Patient recruitment	83
4.3.3 Family/whānau recruitment	84
4.4 Data collection	85
4.4.1 Preparation for data collection	85
4.4.2 Data collection strategies	86
4.4.3 Interviewing (nurses, patients and family/whānau)	87
4.4.4 Focus groups	90
4.4.5 Observations	92
4.4.6 Documents as data	94
4.4.7 Burnout Scale.....	95
4.5 Data analysis	95
4.5.1 Focus group and individual interview data analysis	97
4.5.2. Burnout Scale data analysis	98
4.5.3 Document analysis	98
4.5.4 Cross-case analysis	99
4.5.5 The significance of triangulation	100

4.6 Ethical considerations	100
4.6.1 Informed consent	102
4.7 Reflexivity.....	104
4.7.1 The nurse ‘I’ judgment.....	106
4.7.2 The researcher ‘I’	107
4.8 Rigour and trustworthiness of the research process.....	108
4.8.1 Credibility	108
4.8.2 Transferability.....	110
4.8.3 Dependability	110
4.8.4 Conformity	110
4.9 Summary	111
CHAPTER FIVE: FINDINGS AND DISCUSSION: THE CHARACTERISTICS OF THE CASES.....	112
5.1 Introduction.....	112
5.2 Case characteristics	112
5.2.1 The physical layout and aesthetic of the ward	115
5.2.2 Patient handover.....	118
5.2.3 The model of nursing care	119
5.3 Nursing profile and participating nurse characteristics	120
5.4 Patient profile and family/whānau characteristics	122
5.5 Patient and family/whānau experiences with nurses	123
5.5.1 Needing to tell their story	124
5.5.2 The busyness of nurses	125
5.5.3 Patients caring for other patients.....	127
5.5.4 Experiences of physically being moved or discharged.....	128
5.5.5 Important nurse characteristics	130
5.5.6 Patients negative conceptions of nursing	131
5.6 Chapter summary	134
CHAPTER SIX: FINDINGS AND DISCUSSION: NURSING VALUES	135
6.1. Introduction.....	135

6.2 Values and motivation to enter nursing	136
6.2.1 Altruistic reasons for entering nursing.....	137
6.2.2 Socio-economic and cultural influences on entering nursing	139
6.3 Emergence of values	141
6.3.1 The influence of personal values on practice.....	142
6.3.2 Personal values and espoused professional values	143
6.4 Living and not living nursing values	145
6.4.1 Living nursing values.....	145
6.4.2 Not living nursing values: the impact of systems and situational context.....	147
6.4.3 Constrained practice and not living values	149
6.4.4 Value dissonance and not living nursing values	152
6.5 Defence mechanisms	154
6.5.1 Splitting up the nurse-patient relationship	155
6.5.2 Depersonalisation, categorisation and denial of the significance of the individual	156
6.5.3 Collusive social redistribution of responsibility and irresponsibility	157
6.5.4 Contemporary anxieties	162
6.6 Chapter summary	164
CHAPTER SEVEN: CONCLUSION	165
7.1 Introduction.....	165
7.2 Key findings and contribution to knowledge.....	165
7.3 Contribution to methodology.....	167
7.4 Propositions and reflexivity	168
7.5 Study limitations	169
7.6 Recommendations for future research	170
7.7 Implication for the nursing profession and healthcare.....	171
7.8 Dissemination	173
7.9 Conclusion	173
APPENDICES	174
Appendix 1 Letter of invitation.....	174

Appendix 2 Nurse information letter	176
Appendix 3 Invitation to participate	180
Appendix 4 Poster.....	182
Appendix 5 Letter of invitation for patient/family/whānau	183
Appendix 6 Nurse interview/focus group guide	187
Appendix 7 Patient/family interview guide	191
Appendix 8 Permission to use Maslach Burnout Inventory	194
Appendix 9 Initial coding - nurse focus group data Site 1	195
Appendix 10 Example of later coding	198
Appendix 11 Amended ethics approval.....	199
Appendix 12 Consent form.....	201
Appendix 13 Ward layouts	202
REFERENCES.....	204

LIST OF TABLES

Table 1: Examples of District Health Board value statements	14
Table 2: District Health Board value alignment	88
Table 3: Site-specific organisational values	113
Table 4: Profile of nursing and ancillary staff by no.(FTE) and study site	121
Table 5: Nurse participants by demographics, nursing characteristics and study site....	122
Table 6: Maslach Burnout Inventory by study site	148

LIST OF FIGURES

Figure 1: Flexible approach to data collection.....	87
Figure 2: Analytical approach to data analysis	96
Figure 3: Key themes and subthemes	136

CHAPTER ONE: INTRODUCTION

1.1 Introduction

The values of professional nurses are critical to nurses' attitudes and actions and directly impact on patient experiences. This research was undertaken to develop an understanding of the values of professional nurses practicing in medical ward environments. The introductory chapter provides a general outline and background to the research, beginning with a brief overview of how the image of nursing is negatively portrayed in the media and how this has evolved a social stereotype of the profession that may impact on recruitment and retention. This is followed by a rationale and justification for undertaking the research and how my personal philosophy in regard to my position as a professional nurse has influenced how I view the values embedded in the profession of nursing. I then provide a discussion on the nature of values, drawing primarily on the fields of philosophy, social psychology and sociology, addressing the historical development of values and the relationship between values and virtues. The importance of human values in healthcare is discussed in the context of systematic healthcare challenges and a failure to provide safe care and respect for human dignity. The centrality of professional nurses' values to their practice is discussed by examining international and national perspectives. The chapter concludes with an overview of the thesis.

1.1.1 The image of nursing

The professional identity of nurses is primarily linked with values, beliefs and attitudes that permeate nurses' behaviour (Hallam, 2012). However, this identity is also shaped by society, which in turn is influenced by media images such as those in movies, television, artistic representations, novels and social media outlets. In the film, *The English Patient*, the character of the Canadian army nurse, Amy, is portrayed as demure, dedicated, caring and putting the patient's needs first; in contrast with the image of Nurse Ratched, who in both the novel and film of *One Flew Over the Cuckoo's Nest*, is portrayed as a cold tyrannical battle-axe. Multiple depictions of nurses are presented on television, for example in *Getting On*, a British sitcom, Nurse Kim Wilde is portrayed as kind, but useless; she

does what she is told. In *Nurse Jackie*, an American comedy drama, Jackie Peyton is strong willed competent nurse with a flawed character; an unfaithful drug addict. Charles Dickens penned the character of the nurse Sairey Gamp, in his novel, *Martin Chuzzlewit*, as an unkempt, drunk. These representations of nurses are often at odds with each another; the caring competent ministering angel, willing to do anything for her patient, juxtaposed with the incompetent, tyrannical, drug addicted, promiscuous, battle-axe. Media representations of nursing are known to influence social perceptions of the profession (Price, 2009) and lead to stereotyping that impacts on recruitment and retention within the profession (Takase, Maude, & Manias, 2006). To redress the stereotype image of nurses Ten Hoeve, Jansen, and Roodbol (2014) argue that nurses must actively increase their visibility and their social and political voice.

Critiquing representations of nurses and nursing as presented in the media will help the profession to counter the serotyping discourse (Darbyshire, 2014b; Hallam, 2012). Kelly, Fealy, and Watson (2012) assert that, “what nursing is said to be constitutes what nursing is”. The basis for their assertion was a critical discourse analysis of the ten most viewed YouTube clips for the search terms ‘nurse’ and ‘nursing’. The discourse on nursing centred on the nurse as a “skilled knower and doer”, “a sexual plaything” and “a witless incompetent” (Kelly et al., 2012, p. 1810).

A positive image of nurses and nursing as well as the nursing voice is often ‘airbrushed’ from media representations (Darbyshire, 2014b) and in a number of television medical dramas (for example *Grey’s Anatomy* and *House*), nurses are invisible; when they do appear they are subservient to doctors (Summers & Summers, 2002, 2015). This invisibility suppresses the nursing profession because of old arguments situated in the historical roots of nursing, gender and latterly professionalisation (Rook & Coombs, 2016, p. 397).

It is argued that, because of the way nursing is presented in the media, society does not understand or value nurses (Summers & Summers, 2015). Yet nursing is repeatedly rated as one of the most trusted professions (Philpott, 2005). The image that society has of nurses and nursing may be conflicted, but most trust the profession (Roy Morgan Research, 2016). It is well documented that nurses are critical in improving patients’ experiences and

outcomes (Aiken, Rafferty, & Sermeus, 2014; Aiken et al., 2016; Aiken, Clarke, & Sloane, 2002; Francis, 2013; Francis & Lingard, 2013; Francis, 2010; Kutney-Lee et al., 2009; Rafferty et al., 2007).

1.1.2 Rationale and justification for the research

Nurses struggle with complying with economic healthcare priorities at the expense of meeting patients' human needs and their own personal needs. This has occurred due to a growing national and international focus on efficiency in healthcare (Davis et al., 2013; Dickson, Bulley, & Oliver, 2014; Pauly, 2012) that has resulted in humanistic values of care and compassion being side-lined, in favour of economic agendas. Yet it is understood that the role of the nurse is pivotal in delivering safe and effective care (Aiken et al., 2014, 2016). Understanding nurses' values and their ability to enact these values is essential to developing a professionally aware, responsive and mature nursing service. In their umbrella review of evidence about the factors that influence caring relationship between nurses and their patients, Wiechula et al. (2016, p. 731) argue that values such as "trust, sympathy, support and responsibility" are foundational in the nurse-patient relationship and should be reflected in the attitudes and actions of nurses. Negative nurse attitudes are understood to impede the nurse-patient relationship (Tay, Hegney, & Ang, 2011; Wiechula et al., 2016).

Nursing is caught between two opposing forces, that of health services and that of the profession. In the health service, efficiency is becoming the mantra and measure of good service outcomes. There is a growing philosophical debate that this type of culture is dehumanising patient encounters, and creating a culture devoid of compassion, where economic values are inconsistent with professional ways of being (Cribb, 2011; Georges, 2011). Despite the financial, as well as other pressures in healthcare, basic human dignity is an expectation within a civilised society and people expect to be respected irrespective of economic pressure within a system (McCullough, 2011). There have been a number of reports outlining the devastating failings in the provision of healthcare, and the role nurses played in those failings. The Mid-Staffordshire Report (Francis, 2010) and the more recent exposure of the poor care given at the Aras Attracta Care home in Ireland (Traynor, 2014a),

are two examples of these failings. Both present harrowing examples of a lack of care, compassion or clinical excellence within the healthcare system. These reports, and many others like them (Harding Clark, 2006; O'Donovan, 2009; The Patients Association, 2009, 2010, 2011, 2012), have led to a refocusing of healthcare and professional group agendas, in particular nursing, where there is now a call for a return to the core elements of compassionate care (Wiechula et al., 2016).

On examining these reports I was left asking questions about what is at the heart of nursing? For me it was not so much the issue of lack of care that was central to these questions. Rather, it was the place and influence of nursing values within the healthcare environment; as it is values that drive both attitudes and actions. Values espoused by Florence Nightingale included altruism (referred to by Nightingale as *motherly interest*), intellect, excellence, punctuality, cleanliness, and spirituality. Society has changed radically since the time of Florence Nightingale and the spiritually¹ bounded values of which she wrote are not explicit in the twenty first century.

1.1.3 Research interest

I have been a professional nurse for over 20 years and have always had an interest in, and advocated for, a compassionate and skilled professional nursing discipline. This has been both as a clinician and as an educator. My clinical career has been spent in acute settings in Ireland, the United Kingdom (UK) and New Zealand, primarily in the field of intensive care nursing. It was whilst working in intensive care that my career in education began; I now work as a nursing lecturer.

The values that were instilled in me growing up, both as a Catholic and an Irish woman, guide me in my life. The values I speak of are bound to Christian values derived from the theological virtues of faith, hope and charity (love and generosity of spirit) and the cardinal virtues of prudence, justice, temperance (restraint) and courage (fortitude). My values

¹ Nightingale spoke and wrote about spiritually bounded values as the nurses' earnest purpose for God, humanity, love, kindness, sympathy and goodness (Nash, 1914).

further developed when I became a nurse and the values of human dignity and empathy were emphasised. Who I am and what I believe shapes my worldview. These values are critiqued at various stages of this research through a reflexive lens (Day, 2012; Pickard, 2013; Primeau, 2003).

In my years as a lecturer I have never lost contact with the clinical environment; my teaching is clinically focused and I often visit students whilst they are on a clinical placement. I work in partnership with many students and nursing colleagues, planning nursing service evaluation, delivering bespoke education or supporting nurses to become nurse practitioners. It was during clinical visits and many conversations with both colleagues and students that I came to the conclusion that all was not well in nursing. I was also influenced by what I was reading, not only in the nursing literature but also in mainstream and social media posts by nurses, about how nurses were referred to as uncaring and lacking compassion, as depicted above in the media images of nurses and nursing. What I was witnessing and hearing was a focus on managerial imperatives, with economic pressures felt by nurses and patients.

On-going changes in healthcare pose challenges ahead for nursing and at the core of these challenges is the place of values, because, as argued in a recent position paper on values in nursing and midwifery, “values serve as the compass that sets the standards for making decisions and guiding individuals behaviour” (Office of the Chief Nursing Officer, June 2016, p. 3). In New Zealand, nurses are faced with new and extended scopes of practice, indirect effects of a shortage of doctors, an ageing nursing workforce (Clendon & Walker, 2016), as well as the impact of a global economic recession (National Nursing Organisations [NNO], 2014; New Zealand Nurses Organisation [NZNO], 2011). On the basis of gender, part-time working hours, retirement and migration, it is predicted that the health workforce will not have enough practitioners in 2021 to meet the needs of an ageing New Zealand population (Gorman, 2011). Nurses are expected to be in particularly short demand. The potential shortfall in the nursing workforce and the negative image of nursing means it is important to examine nurses’ values in New Zealand and understand how these influence nursing practice in contemporary healthcare environments.

1.1.4 Research question and objectives

The research question posed was: What are the values of professional nurses practicing in medical ward environments and how are these values lived in day-to-day practice?

The research objectives were to:

- Examine professional nurses' values and to determine whether there is congruence between personal, organisational and professional values;
- Explore how professional nurses express their values in nurse-patient interactions.

1.2 Defining values

Values are socially ubiquitous, everyone is expected to have values, know what they are, and understand how they motivate us (Pattison & Pill, 2004). However, defining values is challenging; there are definitions related to economics, where value (as a noun) is defined as desirability, importance, worth (often ascribed to financial value), principle or standards of behaviour (Stevenson & Waite, 2011); and there are definitions associated with human values, principles, standards, convictions and beliefs (Pattison & Pill, 2004). Generally the definitions associated with human values assume that values are the foundations of culture, and have an individual, as well as social aspect (Clegg, Kornberger, & Pitsis, 2009). Therefore values are used to construct positions and gain understanding of particular attitudes and behaviour (Hogg & Vaughan, 2005).

The assimilation of values into modern discourse is attributed to Nietzsche (Himmelfarb, 1995). Nietzsche, a German philosopher, saw new and different possibilities in modern society with the rise of science in the 19th century and the disenfranchisement of religion and the “metaphysical certainty (or death of God as Nietzsche famously puts it) leaves Man² in the open space of modern secularism...” (Drummond, 2000, p. 148). This ‘Enlightenment’ shifted the focus from rule bound unquestioning doctrine to questioning and rationalising empiricism. The Enlightenment, or the age of reason, was a movement

² When Nietzsche refers to Man he is referring to the human species, rather than gender (Drummond, 2000).

instigated by intellectuals, such as Voltaire and Newton, in the late 18th century (Shank, 2008). They were concerned with reforming society based on reason and logic. Nietzsche was not content with empiricism; as he saw it, man was capable of more. By ‘more’ Nietzsche (1969) was thinking about man not focusing on the goal (end point) but rather focusing on the journey; in fact he considered taking the journey the most important aspect for man; suggesting man is a bridge.

Nietzsche called for the transvaluation of values, which he argued would realign man from a position of weakness (apparent from the acceptance of classical virtues and Judaeo/Christian virtues) to a position of strength (de Huszar, 1945; Drummond, 2000). Classical virtues and associated vices and ideas of good and evil were redundant ideas for Nietzsche, who focused on values. After Nietzsche’s death the term values became more commonplace. Max Weber, a German sociologist, used the term matter-of-factly, which is why Himmelfarb (1995) believed it was absorbed so readily into vocabulary. Himmelfarb (1995, p. 11) was outraged at the assimilation and acceptance of values referring to them as; “subjective and relative, that they are mere customs and conventions that they have a purely instrumental, utilitarian purpose, and that they are peculiar to specific individuals and societies”. Himmelfarb was a historian and a self-declared Jewish conservative who argued for the re-introduction of traditional virtues (responsibility, chastity and self-reliance) into society (Himmelfarb, 1995). Her academic enquiry into life in Victorian Britain led her to identify with the virtues associated with the era, which may explain why she was so outraged by the assimilation of values.

1.2.1 Axiology

The question of values spawned a legitimate area of scholarly enquiry into values and value judgments, creating an axiology (Clawson & Vinson, 1978). Axiology is the philosophical study of value and is concerned with how values are experienced, the kinds of values that exist and the standards of value. The rise of axiology is associated with the rise of individuality, positivism and the division between science and philosophy. In contrast to this perspective, early Greek philosophers such as Socrates, Plato and Aristotle, believed

that virtue and morality were entwined and society ought to be guided by these principles (Barker, 2012).

All aspects of a person's life are influenced by human values (Pakizeh, Gebauer, & Maio, 2007). Values help people to determine their future direction, rationalise past actions, assess themselves against others, reinforce or reject the actions of themselves or others. When we think of values we think about what is important to us, for example; loyalty, security, kindness, success, and honesty. The importance of each value can fluctuate depending on the circumstances, and a particular value may be very significant to one person and totally irrelevant to another (Calman, 2004). Pattison (2004, p. 1) proposes that; "the concept of 'values' is one of those portmanteau concepts which chases after meaning", largely because the term is apparently seemingly simple yet it conceals secondary meanings.

1.2.2 Motivational values

Schwartz (1994, p. 21), a social psychologist and key influence in understanding human values, indicates that "values are desirable trans-situational goals, varying in importance, that serve as guiding principles in the life of a person or other social entity". Schwartz (1992) developed a model of 10 motivational value types founded on the assumption that values are based on human beings biosocial interactions, group effectiveness and endurance needs. Each value; power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, and security is defined and linked to related values. For example, benevolence (embedded in the need for social interaction) is defined as; "preservation and enhancement of the welfare of people with whom one is in frequent contact with" (p. 21). Schwartz (2012) in his overview of theoretical perspectives he concluded that values must be viewed as a circular structure reflecting the motivation that each value expresses.

The seminal work of Rokeach (1968, 1973, 1979) indicates that human values guide, not only actions (behaviour), but also judgements (attitude), and are important in setting desired goals, and or conditions for individuals and or society. Rokeach, a Polish-American

social psychologist, is best known for his exploration of dogmatism and human values. The definition of human values offered by Rokeach is, an “enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposed or converse mode of conduct of end-state of existence” (1973, p. 5). This definition transcends situational contexts, and focuses on personal and socially desirable constructs.

It is worth noting that values are defined essentially as being morally neutral, an influence of relativism. Values are almost always defined as positive, however it is also recognised that values can be viewed as negative, but this is not addressed in the literature on human values (Carney, 2006). MacIntyre (1984) takes a very different philosophical approach to those who subscribe to axiology: arguing that human persons are oriented to the good. Consequently values are rejected in favour of virtues, which he contrasts to, vices.

1.2.3 The place of virtue and morality

It has been argued by MacIntyre (1984) that modern philosophy and modern life are characterised by the absence of any coherent moral code, and that the vast majority of individuals living in this world lack any meaningful sense of purpose in their lives and also lack any genuine sense of community. MacIntyre draws on the ideal of the Greek polis and Aristotle’s philosophy to propose a different way of life in which people work together; ideally in small groups, so as to resist destructive forces of liberal capitalism. He takes a firm position; his goal is to transform society as he declares; “what matters at this stage is the construction of local forms of community within which civility and the intellect and moral life can be sustained through the new darks ages which are already upon us” (MacIntyre, 1984, p. 263). His argument, profoundly influenced by Aristotle and Aquinas, sought a return to a pre-Nietzschean world that was morally bound, as he believed that this older conception of morality is both superior to, and fundamentally hostile to the modern world. According to MacIntyre (1984) the modern world (the world post Enlightenment) is dominated by liberal capitalism, and a society that is made up of individuals who have little understanding of the human good, no way to come together to pursue the common good, and no way to persuade one another about what the common good might be. Sellman (2011) argues, that for professional nursing practice, a return to virtue would restore the

moral obligations of nursing, such as care, compassion, trustworthiness and the enabling of human flourishing.

Another element missing in modern life is 'practice' (MacIntyre, 1984). MacIntyre's idea of practice is positioned around internal and external goods, and goods of excellence and goods of effectiveness. These goods of excellence and effectiveness require the presence of virtue:

a virtue is an acquired human quality the possession and the exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively prevents us from achieving any such goods...we have to accept as necessary components of any practice with internal goods and standards of excellence the virtues of justice, courage and honesty. (MacIntyre, 1984, p. 191)

Like internal goods, goods of excellence are those goods that are only available to the individuals who participate in practice as a practice, whereas goods of effectiveness can be obtained elsewhere and relate, for example, to organisational or institutional goals.

Many nurses practice in liberal capitalist societies, where technology and efficiencies profoundly influence their practice (Sellman, 2011b). Sellman (2011a,b), considers MacIntyre's (1984) view on practice helpful in the pursuit of the moral aims of nursing because of its focus on internal rather than on the external goods. Sellman (2011b), who is strongly influenced by both MacIntyre and Aristotle, believes that nursing, as a practice, is intrinsically involved in enabling human flourishing. To enable flourishing, the nurse must protect those who are not only vulnerable (as humans we are all vulnerable), but also those who are more than ordinarily vulnerable (Sellman, 2005). To do this nurses are expected to be of good character. A nurse with good character has a disposition that fosters compassion, care, honesty and a sense of justice and fairness. (Sellman, 2011b). Sellman (2011b) is critical of contemporary nursing education for its lack of attention to developing good character - mental and moral qualities - of nurses. There is an inevitable tension between educational institutions on the one hand and practice that requires practitioners to be of 'good character' on the other; this invariably leads to dissonance between professional ways of being (as described in professional codes of conduct as well as being

dictated by healthcare organisations) and the moral practice of nursing (MacIntyre, 1984; Sellman, 2011b).

In summary, there is argument in support of values as a post enlightened way of thinking, but there is also a competing argument presented in favour of virtue. Modern healthcare does not embrace virtue in the way that MacIntyre recommends; healthcare organisations do however affirm values as guiding principles.

1.3 Importance of healthcare values

There is a proliferation of dialogue about the need for shared values in healthcare, most notably from the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), commonly known as the ‘Francis Report’. The report outlines a litany of poor standards of care, lack of professionalism, and complacency from healthcare providers. Of the 290 recommendations made, clarity of values and principles was one of the highest priorities. “We need common values, shared by all, putting patients and their safety first; a commitment by all to serve and protect patients and to support each other in that endeavour” (Francis, 2013, p. 4). This is not to say that values do not exist, value statements are rife throughout the National Health Service (NHS). Within the Francis Report there is an acknowledgement that professions have their own codes of conduct which include explicit values, but Francis recommends that there be shared values across the NHS and recommends the addition of the ‘Nolan Principles’ as described by The Committee on Standards in Public Life (Nolan & Nolan, 1995). These principles are selflessness, integrity, objectivity, accountability, openness, honesty, and leadership, and were expressly written to guide those working in public office.

There have been other reports that have cast doubt on standards of care and nursing’s ethical and moral footings (Abraham, 2011; Harding Clark, 2006; Williams, 2011). In the Irish Lourdes hospital inquiry (Harding Clark, 2006, p. 316), which investigated the high rates of postpartum hysterectomies, the authors found it difficult to understand; “why so few had the courage, insight, curiosity or integrity to say, ‘this is not right’”. In an integrative literature review of 14 studies from seven countries, Jackson et al. (2014)

proposed that for many nurses the repercussions of speaking out stops many from doing so. Despite nurses being best placed to raise concerns, speaking out or whistleblowing is viewed as having negative consequences, both mentally and physically, for the individual nurse (Jackson et al. 2014).

The Health Service Ombudsman in the UK reported a serious lack of care and compassion in the NHS and that nurses specifically were lacking in these qualities (Abraham, 2011). The Health Service Ombudsman report detailed the care of 10 older patients and revealed personal and institutional attitudes that failed to recognise and respond to patients as unique human persons or indeed respond to patients needs with sensitivity or compassion. The report is a harrowing account of insensitive, unprofessional care, where a patient's difficulties were not always about their condition; "but arose from the dismissive attitude of staff, a disregard for process and procedure and the apparent indifference of NHS staff to deplorable standards of care" (p. 9). In a follow up to this report the Secretary of State for Health in the UK asked the Care and Quality Commission to inspect NHS hospitals. The inspection teams visited 100 hospitals in England, and found 20 did not meet the standards expected (Williams, 2011).

In 2008 the Royal College of Nursing in the UK conducted a dignity survey of over 2,000 nurses, student nurses and healthcare assistants. The results revealed a workforce feeling distressed about not providing the care that it knew it should. This feeling, of not being able to do the right thing, can be linked to a "lack of virtues, such as moral courage, wisdom, and integrity" (Gallagher, 2011, p. 8). New graduate nurse respondents to the dignity survey said they were working in ways contrary to the values of the profession, and contrary to the reasons they entered into the profession to begin with.

The role of mass media (print and electronic formats) in highlighting concerns and dissatisfaction with healthcare has grown exponentially over the past 10 years (Antheunis, Tates, & Nieboer, 2013). There is a global awareness that the reporting of patients' dissatisfaction, and problems with the delivery of healthcare services increases public awareness and in turn accountability (Morrell, Forsyth, Lipworth, Kerridge, & Jordens, 2014). Often media stories lead to greater analysis of the issues and many have led to

significant public reports in a number of countries, resulting in a groundswell of reform and values clarification initiatives (Marshall, Romano, & Davies, 2004). These reports outline the extent of patient harm caused by poor healthcare and the gap between existing care and the care that the public expect (Francis & Lingard, 2013; Francis, 2010; Kohn, Corrigan, & Donaldson, 2000; Little, September 6th 2016; McCoy, 2016; Richardson et al., 2001). The Health Quality and Safety Commission are responsible for the monitoring and improving the safety and quality of healthcare (public and private) in New Zealand. The 2015 annual report of adverse events in New Zealand notes that patient falls, clinical management issues, and medication errors are consistently reported as the top areas for concern (Health Safety & Quality Commission, 2015).

1.3.1 New Zealand healthcare values

In New Zealand, healthcare values are conveyed in the approach taken to the health of New Zealanders and captured in the *New Zealand Health Strategy* (Minister of Health, 2016). The principle of partnership and acknowledging the special relationship between Māori and the Crown, under the principles of the Treaty of Waitangi, are paramount in the strategy (Belgrave, Kawharu, & Williams, 2004). Equally, the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights regulation, acts as a framework for healthcare service delivery (Health & Disability Commissioner, 2014). There are 20 District Health Boards (DHBs) in New Zealand; each is guided by Ministerial and legislative frameworks; however, individual DHBs have their own value statements (Table 1) and DHB's values are driven by the need to serve a community and adhere to government strategy.

Table 1: Examples of District Health Board value statements

District Health Board	Value Statements
<i>Auckland DHB</i>	<ul style="list-style-type: none"> • Welcome <i>Haere Mai</i> - We see you, we welcome you as a person • Respect <i>Manaaki</i> - We respect, nurture and care for each other • Together <i>Tuhono</i> - We are a high performing team • Aim High <i>Angamua</i> - We aspire to excellence and the safest care
<i>Waitemata DHB</i>	<ul style="list-style-type: none"> • Everyone matters: Every single person matters, whether a patient / client, family member or a staff member • With compassion: We see our work in health as a vocation and more than a job. We are aware of the suffering of those entrusted to our care. We are driven by a desire to relieve that suffering. This philosophy drives our caring approach and means we will strive to do everything we can to relieve suffering and promote wellness • Connected: We are connected with our community. We need to be connected within our organisation – across disciplines and teams. This is to ensure care is seamless and integrated to achieve the best possible health outcomes for our patients/clients and their families. • Better, best, brilliant: We seek continuous improvement in everything we do. We will become the national leader in healthcare delivery
<i>Canterbury DHB</i>	<ul style="list-style-type: none"> • Care and respect for others: <i>Manaaki me te whakaute i te tangata.</i> • Integrity in all we do: <i>Hāpai i ā mātou mahi katoa i runga i te pono.</i> • Responsibility for outcomes: <i>Te Takohanga i ngā hua.</i>
<i>Southern DHB</i>	<ul style="list-style-type: none"> • Putting people first • Well-being for everyone • Recovery • Affirming rights and autonomy • Building strengths and resilience • Responding early • Connectedness/<i>Te hononga</i> • Right responses • Collaboration • Services in communities

It is very common for healthcare organisations to publicly state their overall aims, visions and values (MacLeod, 2016; Nelson & Gardent, 2011). The values espoused by the New Zealand health services are repeated in a similar vein in most other countries that have similar healthcare models (see for example, Department of Health [UK], 2015; Health Canada, 2016). A significant difference between New Zealand and the Canadian healthcare values are how those for the indigenous populations are framed. The Canadians have a separate document specific to that group whereas New Zealand presents overarching values for the population (these values are framed with the context of the Treaty of Waitangi). In Australia values are articulated in a Customer Care Charter, and each health authority applies the Charter and articulates values for their own organisation and territory (Australian Commission on Safety and Quality in Health Care, 2008). It is not clear how the values of the indigenous population of the Australian Aboriginal and Torres Strait Islander peoples are articulated in this Charter. However, to augment the Charter the Australian government have a National Aboriginal Torres Strait Islanders Health Plan that articulates a vision and strategic plan for the indigenous population (Australian Government, 2013). Values talk in healthcare appears to be important; these declared values could be vital to the delivery of quality and equitable healthcare. Alternatively they can be meaningless platitudes where undeclared values like economic and productivity priorities are more meaningful (Giacomini, Hurley, Gold, Smith, & Abelson, 2004).

1.3.2 The impact of ‘productivity’ on healthcare values

Professional nursing practice is balancing between initiatives, imperatives, politically driven and financial motives, and the moral and ethical imperative to improve and promote health, prevent illness and alleviate suffering (Sellman, 2007, 2010b, 2011a, 2011b, 2012; Sellman & Snelling, 2016; Snelling & Sellman, 2016; Traynor, 1999, 2009, 2014b). However, organisational structures and imperatives do little to better the world of nursing (Sellman, 2011a). In the view of Sellman (2011a), organisational targets, such as emergency department waiting times, waiting list figures for various types of surgery, put pressure on departments because healthcare institutions are fearful of being at the top of non-compliance league tables. These targets force departments to be creative and even unscrupulous in ‘fiddling the figures’ to reflect better on them and their performance. The

example given by Sellman is the creation of virtual beds. A patient is physically in the emergency department but is technically admitted to a bed where another patient is physically residing and awaiting discharge. This gives the illusion that the emergency department episode has ended.

There is an explosion of new ideas in today's healthcare environment that can be viewed as inimical to the expression of human values in healthcare; the implementation of the Productive Ward - Releasing Time to Care TM (PW) is one such example. This initiative, developed by the NHS institute for innovation and improvement, has been adopted in countries outside the UK, including New Zealand, Australia and Canada (Avis, 2009). The impetus for implementation is based on the assumption that there is something wrong with healthcare and although not directly stated, with nursing. The philosophical underpinning of the initiative is 'lean' methodology (Wilson, 2009); a methodology associated more with Toyota car manufacturing than healthcare where Toyota was renowned for 'kaizen' or continuous quality improvement. Given the reputation for quality, it was remarkable that the company should in recent times have significant reputational damage based on substandard quality (Kissoon, 2010; Tubbs, Husby, & Jensen, 2011).

The PW initiative is actively supported and funded by the New Zealand Ministry of Health (MoH). The MoH notes, the "ongoing roll-out of hospital productivity initiatives is on track to achieve forecast labour productivity cost savings of \$81 million" (MoH, 2010, p. 2). Cost saving is becoming the mantra and measure of good outcomes. Much of the literature describes quality improvements as a result of the PW without empirical data, for example Wilson (2009) heralds the PW as a "golden ticket", without presenting any data about the positive impact on patient outcomes or nurse satisfaction. In an attempt to redress the balance, Robert, Morrow, Maben, Griffiths and Callard (2011) utilised a mixed method approach to determine how innovations like the PW are adopted, implemented and integrated into nursing practice. Their results demonstrated that the PW is being "rapidly adopted" (p. 1196) and there are multiple ways in which the innovation is being implemented. This variance in implementation may have an impact on the ways it is integrated into nursing practice. Figures published from the NHS Institute (2011) reported

an increase of 41.6% in direct patient care time. The inference is made that, because there is increased care time there will be better patient and staff satisfaction, and decreased rate of adverse events, including hospital acquired infection. However, one of the most obvious outcomes of implementing the PW is not satisfaction; it is financial savings (Randnor, Holweg, & Waring, 2012).

It is important to consider what effect the barrage of health service initiatives are having on nursing values, nursing practice, nursing as a discipline, its self-sufficiency and self-determination. Writing specifically about New Zealand, O'Connor (2010, p. 3) argues that productivity measures have weaknesses because of the "dichotomy between the fragmentation of measurement and holism inherent in nursing". Compliance with organisational initiatives essentially forces nurse to behave in ways that are contradictory to the philosophical principles and value system of the profession. Allowing nurses to self-determine their practice will, in O'Connor's (2010) opinion, give rise to efficient ways of providing care not motivated by cost saving but motivated by the delivery of effective and efficient care which ultimately is less of a financial burden.

In summary, there is considerable attention given to the expression of values in healthcare and this attention is not new. It is difficult to see how these values can be enacted in the presence of "financial squeezing" and the ensuing tension between cost and quality (Snelling & Sellman, 2016). Nurses are charged with the delivery of this cost effective quality care and must render a balance between costs, quality and espoused professional nursing values.

1.4 Nursing values

Nursing values are the beliefs and ideologies commonly shared by members of the profession and are the backbone of how nurses act (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Kim, 2010). The foundational values of the nursing discipline are balanced with clinical knowledge and technical skill. This balance between art and science, tenderness and technique, character and knowledge, of nurses and nursing is referred to repeatedly in the nursing literature as representing values central to the

profession (Conway, 1994; Jasmine, 2009; Meyer, 1960; Nightingale, 1856, 1969; Rafferty, 1995). Nightingale (1856, 1969) argued that nursing was more than a sum of tasks; that it required a deeper understanding of the need for air, warmth, light, cleanliness, diet and partnership with patients. Since the time of the Crimean War, nursing has undergone many stages in its search for a professional identity and in defining its domain (Meleis, 2012).

How nurses think about nursing practice, education, administration, research theory and philosophy has evolved over the centuries (Meleis, 2012). Nurse theorists have earnestly attempted to describe and explain the practice of nursing, and whilst there have been many different perspectives there are certain concepts that are central to nursing, notably meeting the needs of the person to enhance adaptation capability, self-care, and health and wellbeing (Henderson, 1960; Meleis, 2012; Roy, 1984; Watson, 1988). However, throughout these descriptions and explanations of the practice of nursing, nurse theorists with one exception have paid little attention to human values. The exception is Watson (1988), in her theory of Human Caring, that emphasises humanistic values and the centrality of the human person in the practice of nursing. Rassin (2008, p. 614) recommends that it is time to rethink the theoretical basis of nursing, arguing that the profession ought to be founded on human values, generating a balance between scientific knowledge and technical skills.

For centuries nurses have recognised the complexities and frailties of human beings; indeed loving kindness and service to humankind are deeply embedded in nursing. The values documented as being important to nurses have included: heroism (Lanara, 1991); love, kindness, niceness (Li, 2002); compassion, sensitivity (Sayers & de Vries, 2008); tenderness, care (Benner, 1994; Georges, 2011; Lanara, 1991; Li, 2002; Meehan, 2003; Nash, 1914; Sayers & de Vries, 2008; Watson, 1988); and humility (de Vries, 2004). Nursing values presuppose nurses' responsibility to nurture and protect, to heal, to cultivate healthy behaviours and attitudes, and to be present (physically and intellectually) during times of vulnerability, illness or injury. These values and professional attributes are largely embedded in nursing codes (Sellman, 2011).

1.4.1 Quality of nursing care and Codes of Conduct

The central role of the nursing profession is the provision of healthcare; values held by nurses have the potential to have a major influence on healthcare outcomes. The contribution of nursing to healthcare can be understood from the perspectives of patients and patient experiences, which are influenced by nurses values (Wiechula et al., 2016). Concerns from governments and the public about quality healthcare have focused attention on evaluating and measuring the quality of hospital nursing care (Montalvo, 2007). For example, nurse-sensitive quality indicators are used to assess how well departments and the wider hospitals perform using certain indicators specific to nursing such as: falls; incidence of pressure ulcers; infection rates; and nurse patient ratios (American Nurse Association, 2006). This gives nurses the ability “to describe and quantify their particular contribution to healthcare” (Muller-Staub, Lavin, Needham, & van Achterberg, 2006, p. 517).

Professional codes of conduct and professional codes of ethics hold the values that are explicit to the nursing profession (American Nurse Association, 2001; An Bord Altranais, 2000; An Bord Altranais agus Cnáinhseachais na hÉireann: Nursing and Midwifery Board of Ireland, 2014; Australian Nursing and Midwifery Council, 2008; Canadian Nurses Association, 2008; International Council of Nurses, 2006; Nursing and Midwifery Council, 2008, 2015; Nursing Council of New Zealand, 2009, 2012). However these values are expressed differently in each Code. For example, in the Canadian Code, although not expressly informed by a single philosophical perspective, has a very strong emphasis on relation ethics, ethic of care, feminist ethics, virtue ethics and values. In its first iterations the Canadian Code was influenced and developed by Roach³ (1984, 1992), a critical thinker in the field of nursing theory and nursing ethics, who was deeply influenced by Christian relational values. There are seven primary values expressed in the Canadian Code with associated responsibility statements. The value statements are “grounded in nurse

³ Roach is known for her theory of human caring and identified five elements of human caring, compassion, competence, confidence, conscience and commitment (Roach, 1984, 1992), comportment, a sixth element was later added (Roach, 2002).

professional relationships with individuals, families, groups, populations and communities as well as students, colleagues and other health-care professionals” (Canadian Nurses Association, 2008, p. 3).

In contrast to the Canadian Code, the International Council of Nurses (ICN) (2012) code of ethics contains four ‘so called’ principles; nurses and people, nurses and practice, nurses and the profession, and nurses and co-workers. There is no definition in ICN code for the term principle, therefore it is unclear what actual principles relate to each statement. The emphasis of the ICN Code is action orientated to social values such as social justice. However, nurses are also reminded that they should demonstrate professional nursing values “such as respectfulness, responsiveness, compassion, trustworthiness and integrity” (International Council of Nurses, 2012, p. 2). These values are found across the majority of international nursing codes although they are often expressed differently in each code.

The expression of values in nursing is heterogeneous and the expectation of nurses to enact values is not clearly articulated, although the assumption is made that values are necessary in the practice of nursing. Variations in understanding of values may explain why countries like the UK and Ireland are making attempts to clarify or augment nursing values with revised Codes of Conduct and values initiatives (An Bord Altranais agus Cnáinhseachais na hÉireann: Nursing and Midwifery Board of Ireland, 2014; Nursing and Midwifery Council, 2015). The revised Nursing and Midwifery Council (NMC) Code has been strongly influenced by the recommendations in the Francis report⁴. This is as a result of the systemic failures outlined in the Report (Francis & Lingard, 2013), including the large scale criticism of: nurses practice; nurse leadership; nursing education; monitoring by professional nursing bodies; as well as the toxic and dysfunctional culture of the healthcare environment.

⁴ Francis recommended that a duty of candour prevail in healthcare (Francis & Lingard, 2013), the revised code asserts, “you work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk” (Nursing and Midwifery Council, 2015, p. 11).

In light of the challenges facing healthcare in the UK the Chief Nursing Officers (CNOs) for England deemed it imperative to develop a vision strategy for nursing, midwifery and care staff (Cummings & Bennett, 2012). Nine thousand nurses, midwives, care staff and patients were consulted as part of the development of this strategy. The result of the consultation was the development of the '6Cs' (care, compassion, competence, communication courage and commitment) as "enduring values and behaviours in nursing, midwifery and care support" (Cummings & Bennett, 2012, p. 5). The CNOs then launched a national implementation of the 6Cs nursing values to all health service staff (Stephenson, 2014). This initiative has been met with mixed responses, both from within the profession and from other healthcare groups (Allied Health Solutions, 2015; Dewar & Christley, 2013; Sellman & Snelling, 2016).

Bradshaw (2016) reviewed the policy approach taken by the CNOs, exploring both the philosophical basis and evidence base used to support the 6Cs. Her critique focused on the lack of methodological clarity or acknowledgement of any theoretical underpinnings to 6Cs. The 6Cs mirror Roach's (1984, 1992, 2002) theoretical work yet this is not acknowledged (Bradshaw, 2016). Bradshaw highlights a dichotomy in the approach to values taken by the CNOs, who argue that nurses have "professional instincts for compassion" (Cummings & Bennett, 2012, p. 5) despite numerous reports indicating healthcare (and by implication, nurses) is lacking in care and compassion. A further dichotomy exists; that is, in spite of the government-backed 6Cs 'movement', there is no reference to this within the NMC Code (NMC, 2015). Without coherence between the NMC and the strategy of the CNOs the messages of one or both are weakened.

In Ireland the process of values identification for nurses and midwives has just begun with the recent publication of a position paper on values (Office of the Chief Nursing Officer, June 2016). Similar to the UK, the impetus for the initiative in Ireland was centred on patient safety following public reports of poor standards of care and a lack of compassion (Harding Clark, 2006; McCoy, 2016; O'Donovan, 2009). These reports challenged the values that underpin nursing and midwifery practice. Unlike the UK, the approach in

Ireland is a partnership between the Nursing and Midwifery Board (regulator) the Office of the Nursing and Midwifery Services Director and the Department of Health.

Values are central to the practice of nursing. The expression of nursing values varies from country to country and from professional organisation to regulating body. There has been considerable effort internationally to bring nursing values to the attention of nurses, primarily because of systematic failures in healthcare and in nursing. However, little attention is being paid to the meaning of professional nursing values and how these can be enacted in challenging economic climates. A similar pattern of values clarification has emerged in New Zealand.

1.4.2 Nursing values and Code of Conduct in New Zealand

Nursing practice in New Zealand is guided by the Nursing Council of New Zealand (NCNZ) Code of Conduct (NCNZ, 2012a); as stated earlier it is the professional codes that present the values of the profession. The NCNZ Code of Conduct was revised in 2012. The revisions in the Code were predominately updates in response to legislative, societal and practice changes. Prior iterations of the Code lacked clarity in relation to professional value, the 2009 Code, for example, was framed on principles (NZNC, 2009); however, it was not clear in the document what these principles were based on. The 2012 Code was written to replace the 2009 Code. The revision began after consultation with nurses, professional organisations, DHBs, consumer groups, education providers, government agencies and non-governmental organisations about nursing in New Zealand including ethical behaviour, professional boundaries, the maintenance of public trust and confident and nursing values. Consulting the community of nursing on its values is not unique to New Zealand and is a common approach taken by nursing regulators internationally (Bord Altranais agus Cnáinhseachais na hÉireann, 2014). The benefit of such consultation is a shared and agreed mandate from the profession on values and standards of behaviour for nurses.

The new Code is clearly underpinned by the values of respect, trust, partnership and integrity (these values were not articulated in the 2009 Code). The introduction of values

in the Code was strongly supported by the stakeholders who were consulted on the document. As asserted by one particular stakeholder “the four core values are fundamental to the overall integrity of the profession and set the platform for public confidence” (NCNZ, 2012c, p. 5). However, it is stated in Code of Conduct that the primary concern of the NCNZ is public safety, it does not “seek to describe all the ethical values of the profession” (NCNZ, 2011, p. 2). Therefore nurses look to other organisations in New Zealand to inform ethical values of the profession.

The New Zealand Nurses Organisation (NZNO) (a professional association and registered union) also proposes values of nursing (NZNO, 2010). The NZNO (2010) values are deeply embedded in an ethical framework and include concepts such as: autonomy; beneficence; non-maleficence; justice; confidentiality; veracity; fidelity; guardianship; and professionalism. The organisation has made explicit the value of professional nursing and set out a vision for its future (NZNO, 2011). An important aspect of this vision focuses on the nurse-patient relationship and professional nursing values (NZNO, 2011). The vision document produced by the NZNO makes numerous recommendations about nurse practitioner roles, changing models of care⁵ to better meet the needs of an ageing population, and educating nurses to work in community and primary healthcare sectors. The document states unequivocally that New Zealand nursing and its political discourse lacks any consideration of humanistic models of care or indeed person centred care, which may explain why the revisions to the New Zealand Code of Conduct in 2012 were welcome.

In New Zealand, both the NCNZ and the NZNO describe professional nursing values. Over time the articulation of values has become clearer. Internationally there is a move to, not only clarify but also enact nursing values, and a number of initiatives have been or are in the process of being developed to do this. The impetus for many countries to elevate and clarify nursing values has come about due to systemic healthcare failures. There is indeed

⁵ A model of care in the New Zealand context is a term used to describe how care is delivered across a District Health Board. It has nothing to do with nursing’s theoretical heritage.

national and international concern about the healthcare system dehumanising patient encounters and focusing of fiscal priorities (Youngson, 2012).

1.5 Thesis overview

This thesis is presented in seven chapters. In this first chapter I have provided a background to the study by discussing how values are essential within professional nursing and healthcare. This research was undertaken to develop an understanding of the values of professional nurses practicing in medical ward environments in New Zealand. The professional identity of nurses is primarily linked with values, beliefs and attitudes that permeate nurses' behaviour (Hallam, 2012). However, this identity is also shaped by society, which is why this chapter commenced with short overview of how nurses are depicted in the arts and media and the implications of these depictions for professional nursing practice. My research interest was sparked by a desire for compassionate and skilled professional nurses who can practice within challenging clinical settings. In light of personal values I outlined the critical need to maintain reflexivity through-out the research process. The research question and objectives were presented. Definitions of values are addressed and the challenge of defining values is outlined. Nursing values are primarily communicated to the profession via codes of conduct or codes of ethics. Whilst there is a variance between these codes there is a shared understanding that nurses ought to practice nursing with respect for human dignity and with care and compassion. A discussion on how values of professional nurses are critical to nurses' practice in the context of systematic healthcare failures and a failure to provide safe and dignified care is given.

The purpose of Chapter 2 is to present an overview of pertinent literature. The literature is presented using an iterative/nexus approach. Emerging areas of knowledge about values includes professional socialisation of nurses and the measuring and teaching of nursing values. The effects of the healthcare climate on nurses and nursing values is critiqued, this includes an exploration of managerialism, quality of life of nurses, compassion fatigue and burnout. Approaches to the organisation of nursing practice are examined. The chapter concludes with an exposition of the theoretical influences of Isabel Menzies and Edith Stein

whose ideas are pivotal in understanding defences against anxiety and the theory of motivation and values.

The methodological approach taken in the study is described in Chapter 3. The chapter begins with the motivation to take a constructivist epistemological approach using Case Study methodology. I present the rationale for my choices as well as an overview of the methodology. The research question, objectives and propositions are presented.

In Chapter 4, I present an in-depth description of the methods taken. The design of the study and recruitment strategy is outlined and ethical considerations are detailed. I describe the approach taken to data collection and analysis. A reflexive discussion is offered on how my position as both a nurse and researcher influenced my perspectives. Rigour and the trustworthiness of the research process are described.

The findings and discussion are offered in Chapters 5 and 6. In Chapter 5 the context and characteristics of the medical ward cases is described. This is followed by the nursing profile and participating nurse characteristics, patient profile and family/whānau characteristics. Patient and family/whānau experiences with nurses are also presented. Chapter 6 presents the descriptive themes that emerged from the data and discusses these in the context of nursing values, why nurses choose to enter the profession and the emergence of values. The challenges of living and not living nursing values are outlined. Unconscious defence mechanisms emerged as a significant factor in the study and these mechanisms are examined in light of the findings.

Chapter 7 concludes this thesis and this is where I make explicit my contribution to professional nursing practice, methodology and method. A methodological critique is offered and recommendations are made for future research. The thesis concludes with the implication of this study for the nursing profession and healthcare organisations.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In this chapter I extend the discussion laid out in Chapter 1 on how values influence healthcare and underpin professional nursing practice. This chapter begins with a discussion on emerging areas of knowledge about socialisation of nurses and development of nursing values. The development and socialisation of nursing values and an examination of the research undertaken in relation to emerging areas of knowledge about nursing values, focusing on measuring and teaching nursing values, is presented. The challenges that nurses face when practicing in contemporary healthcare climates are discussed, including managerialism, professional quality of life, compassion fatigue and burnout. The literature pertaining to the organisation of nursing practice is also critically discussed. The chapter concludes with a theoretical appraisal of the contribution of Isabel Menzies and Edith Stein.

The literature related to the research topic of this study is vast and because of this, and also due to the word limitations of the thesis, this review is limited to literature relevant to the main findings of this study, as such some logical decisions were taken toward literature included in the review. The review process followed an iterative or nexus approach advocated by Kwan (2008), who undertook a study to determine how reading for study and reading for the literature review was undertaken by 16 students from humanities and social science at various stages of their doctoral journeys. This iterative approach is particularly useful in doctoral thesis writing as it captures “complexities” and “textualises” information in qualitative research (Lee, 1998). The premise of the approach rests in the co-implications of reading, writing and researching taking place at various stages and for different purposes in doctoral research (Dong, 1996, 1998; Kwan, 2008; Lee, 1998). Writing a literature review using a nexus approach offers the opportunity to crystallise ideas that have been generated throughout the research process (Kwan, 2008). Doctoral students in the Kwan’s study articulated a flexible approach to reading for study and reading for the literature review; the stages of the research process determined the approach taken. This is unlike the standard approaches of reading, writing and researching recommended in many research

texts such as Torrance and Thomas (1994) and Hart (2001). Kwan (2008) argues that the standard approaches are counterproductive. The preliminary nexus model developed by Kwan represents the major steps in the research process as iterative and interconnected allowing greater understanding of the research. All participants in Kwan's (2008) study described the co-implication process (the interconnection and implications of reading, writing and researching) but felt that their experiences were anomalous.

My own experiences with the literature were similar to those of the students in Kwan's study. I conducted multiple searches at key stages of the research process. Search strategies were undertaken using bibliographic databases including CINAHL Complete (Cumulative Index Nursing and Allied Health), ProQuest Nursing and Allied Health Source, PsycInfo, grey literature included electronic data, websites, blogs, Facebook, Twitter and limited to the English language.

2.2 Emerging areas of knowledge about nursing values

There is an assumption that all nurses experience nursing in a similar way; that values are important in the practice of nursing (Martin, Yarbrough, & Alfred, 2003; Weis & Schank, 1997, 2000, 2002, 2009; Woodard Leners, Roehrs, & Piccone, 2006); and that nursing values are professionally socialised (Arnold & Boggs, 2015; Chitty & Black, 2011; Goldenberg & Iwasiw, 1993; Kilpatrick & Frunchak, 2006; Mooney, 2007; Shinyashiki, Mendes, Trevizan, & Day, 2006; Tradewell, 1996).

2.2.1 Professional socialisation of nurses

According to Norman (2015), positive professional socialisation instils fundamental nursing values in nurses. The process of socialisation involves individuals developing values, attitudes, and characteristics of a profession that allows them to identify with and internalise behaviours of the profession (Goldenberg & Iwasiw, 1993). Dinmohammadi et al. (2013) recommend that the foundations of professional socialisation in nursing rest in educational preparation, competent role models and good clinical experiences. In keeping with others who have examined professional socialisation, Norman (2015) in a discussion paper on professional socialisation, argued that mentors and nurse managers have a critical

role in socialisation. Specifically role models instil fundamental professional values and behaviours.

Early professional socialisation is influenced by multiple factors; values and beliefs of family members, personal values and beliefs, educational preparation, and the presence or absence of role models (Mariet, 2016; Dinmohammadi, Peyrovi, & Mehrdad, 2013). Student nurses are socialised through formal strategies, such as nursing education, and informal strategies, such as clinical immersion, that requires students to spend time with nurses in the clinical setting (Mariet, 2016). An early study in this field was by Goldenberg and Iwasiw (1993) who examined the effects of preceptorship on the professional socialisation of 242 student nurses. A pre and post-test descriptive design was used to survey the student nurses experiences before and after a preceptorship programme in the Unites States of America (USA). The results indicated that practicing alongside a preceptor was valuable for student nurse professional socialisation.

There are a number of models of professional socialisation (Bandura, 1977; Benner, 1984; Cohen, 1981; Throwe & Fought, 1987), which argue that student nurses sequentially progress through stages of socialisation. However, in a concept analysis on professional socialisation, Dinmohammadi et al. (2013) found that socialisation is not linear; it is dynamic and nurses at any stage of their professional career can adapt and change the way they view themselves or their role.

In keeping with Dinmohammadi et al. (2013) are results from a meta-analysis conducted by Price (2009) on early professional socialisation and career choice in nursing, Price found that role models, peers and nurse educators are critical to the development of professional behaviours of nurses. Price's study findings point to a level of cognitive dissonance that many new nurses face as they find that the reality of nursing is often at odds with their pre-held beliefs (usually idealistic beliefs about nursing). These studies together confirm the position that Kramer (1974) took in her seminal text, *Reality Shock*, where Kramer argues that if early socialisation is not successful, professional nursing values will not be embedded in nursing practice. The basis of Kramer's argument comes from findings from a research programme conducted over eight years that explored the role conception of 222

new graduate (degree qualified) nurses in the USA. Kramer's (1969) five major objectives of the research were: to explore education and socialisation; to understand the effect of organisational adaption; to explore and identify career patterns; to understand adaptive role strategies; and to explore and identify opportunities for new graduate nurses. The methodological approaches taken by Kramer are not well articulated, however, she employed multiple methods including survey, interviews (Kramer & Baker, 1971), and hypothetical propositional testing (Kramer, 1969). Reality, as described by Kramer (1974), is grounded in a belief that, as we are socialised into systems or groups, we have more in common than not. In nursing this commonality is founded in a shared values system with corresponding expected behaviours (Kramer, 1974). Reality shock refers to the emotional, physical and social response of a person (nurse) to the; unexpected, unwanted, undesirable, or the intolerable (Kramer, 1974). The unexpected or intolerable is experienced when "school-bred values" (the values developed in a school of nursing) conflict with "work-world values" (the values found in clinical practice) (Kramer, 1974, p. 4). Nursing turnover is a key consequence of such dissonance (Institute of Medicine, 2011).

A number of nurse researchers, drawing on the concepts of reality shock, offer strategies to positively integrate new graduate nurses into clinical practice. These include developing healthy work environments (Kramer, Brewer, & Maguire, 2013), a nursing curriculum that balances theory and practice (Hinton & Chirgwin, 2010), and structured preceptorship programmes (Clipper & Cherry, 2015; Haggerty, Holloway, & Wilson, 2013; Whitehead, Owen, Henshaw, Beddingham, & Simmons, 2016). In New Zealand the MoH commissioned an evaluation of a nurse entry to practice programme by Haggerty et al. (2013) and found that a culture of support was important for new graduate socialisation. The evaluation, which involved yearly questionnaires during 2007-2009, case studies of eight DHBs offering new graduate programmes and stakeholder interviews, found that new graduate nurses valued the support that they received from preceptors. Preceptors were accessible, except when there was high patient acuity or increased workload. Preceptors were well prepared and their support helped develop the new graduates professional self-confidence and socialisation.

The concern about new graduate role transition has been so great it has led to the establishment of formal programmes⁶ designed to support nurses in their first year of practice (Haggerty et al., 2013). These programmes are not universally found in nursing. In some countries the focus for new graduate nurses is on preceptorship support systems (Lalonde & Hall, 2017; Omer, Suliman, & Moola, 2016). In a cross sectional multi-site study in Canada, Lalonde and Hall (2017) explored the relationship between 41 preceptor characteristics (emotional intelligence, personality and cognitive intelligent) to 44 new graduates (generation Y or millennial) socialisation (intent to leave and job satisfaction). The findings demonstrate a relationship between preceptor characteristics, in particular, openness, conscientious and emotional stability and new graduate outcomes. The more open the preceptor the higher degree of job dissatisfaction of the new graduate. Similarly, the more conscientious the preceptor the greater the intent of the new graduate to leave; conscientious preceptors had higher expectations of new graduates. This study raises some questions that have yet to be answered, such as, when we consider professional socialisation, are the historically developed strategies for socialisation still suitable for millennial new graduates?

Much of the work that built on Kramer's (1969, 1974, 1971) research focuses on new graduate transitions; however very little attention has been paid to Kramer's ideas that nurses were practicing in industrial bureaucratic environments. These environments have a defined chain of command, policies, rules and guidelines to guide/manage clinical practice, they employ strategies of skill mix to manage care and performance based promotion (Kramer & Baker, 1971). The impetus for a bureaucratic system has changed little in 45 years; it is fundamentally the management of resources. This position is supported by Kramer where in a recent lecture she argued that little has changed for nurses in the intervening years (since her 1970 publication); bureaucratic models prevail over professional holistic models (Kramer, 2014). Holistic models allow nurses to enact

⁶ In New Zealand these programmes are called Nurse Entry to Practice Programmes.

autonomy, responsibility, self-evaluation, and teamwork. The challenge therefore is not just socialisation to professional practice, it is also understanding and adapting to the complex and adaptive healthcare organisations at the same time as living professional nursing values. Understanding what is meant by nursing values is critical and measuring nursing values is one way to do this.

2.2.2 Measuring professional nursing values

There is an extensive international literature on measuring nursing values (Eddy, Elfrink, Weis, & Schank, 1994; Hoyuelos et al., 2010; Jiménez-López, Roales-Nieto, Seco, & Preciado, 2016; LeDuc & Kotzer, 2009; Martin et al., 2003; Mazhindu et al., 2016; Weis & Schank, 1997, 2000, 2002, 2009; Woodard Leners et al., 2006; Yeong Ok & Eun, 2015). How nursing values are measured is variable and the development of tools have generally been country-specific; this is to be expected as values are considered to be socially and culturally constructed (Clegg et al., 2009; Hofstede, 1998, 2001; Hofstede, Hofstede, & Minkov, 2010; Martin et al., 2003; Pattison, 2004; Pattison & Pill, 2004; Stevenson & Waite, 2011). Historically, nurse researchers have used a variety of tools to measure nursing values and a significant amount of attention has been paid to the values of student nurses. Areas in which measurement of professional nursing values⁷ has been undertaken include: general life values of student nurses (Bloomquist, Cruise, & Cruise, 1980; Garvin, 1976; Garvin & Boyle, 1985; Waugh, Smith, Horsburgh, & Gray, 2014); nursing values of student nurses (Eddy et al., 1994; Kubsch, Hansen, & Huyser-Eatwell, 2008; Woodard Leners et al., 2006); and registered nurse values (Heidgerken, 1970; Schank, Weis, & Ancona, 1996; Shaw & Degazon, 2008; Weis & Schank, 1997, 2000, 2002, 2009).

The most referenced scale for measuring nursing values is the Nursing Professional Values Scale (NPVS) developed by Weis and Schank (2000). The NPVS was specifically designed to measure nursing values. Composed of 44 items, each with a 5-point Likert scale, scores range from one, not important, to five, most important. Each item is linked to statements

⁷ There are extensive literatures on other types of nursing values e.g. ethical; moral etc. values that have not been included in the review – the review was confined to ‘professional’ nursing values

in the American Nurses Association Code for Nurses (American Nurse Association, 2001). The alpha coefficient for the 44 items was 0.94 with a test-retest reliability of 0.94. The tool is therefore considered to have a high level of reliability and validity in measuring professional nursing values of student nurses in the USA (Weis & Schank, 2000), and has been revised for use in Turkey (GeÇKil, Ege, Akin, & GÖZ, 2012), Korea (Moon, Kim, Kim, Kim, & Lee, 2014) and Spain (Hoyuelos et al., 2010). LeDuc and Kotzer (2009) carried out one of the few studies where the NPVS was employed to include the measurement of professional nursing values. The values of 227 student nurses, new graduate nurses and what the LeDuc and Kotzer referred to as seasoned professional nurses had more similarities than differences. The results indicate that nurses have high levels of professional values and these values were similar across all groups of nurses and across generations. However, based on the job dissatisfaction of millennial new graduates, described earlier in relation to professional socialisation, it would be useful to see if there was congruence between nursing values in this group. LeDuc and Kotzer (2009) recommend that nursing values must be embedded in undergraduate education (teaching nursing values is discussed in section 2.1.1).

A recent addition to the instrumentation designed to measure nursing values is the Nurse Match Instrument (NMI) developed in the UK by Mazhindu et al. (2016). The NMI was developed from the combination of Identity Structure Analysis (ISA) and qualitative data that were collected to determine an individual's match to certain criteria. ISA is a software package, commercially available and developed from a theoretical framework of well-defined psychological concepts (Weinreich & Saunderson, 2005). The methodological approach taken by Mazhindu et al. (2016) was that of co-participatory action research which was used to determine professional nurse ideology in relation to the professional identity of nursing. The data led to the development and piloting of the NMI; a recruitment instrument to measure the professional identity and professional values of nurse recruits. The human values assessed in the instrument are commensurate with the NHS vision for nursing (Commissioning Board Chief Nursing Officer, 2012) encapsulated in the 6Cs (caring, compassion, communication, commitment, courage and competence) and with the principles of the NHS Constitution (DH, 2015). The NMI has been recommended for use

in the UK to assess potential nurses' suitability for the profession, however, the authors acknowledge that a larger scale study is required to standardise the tool (Mazhindu et al., 2016). In presenting the research Mazhindu et al. (2016) describe in detail the philosophical and theoretical influences on the development of the NMI, these included a psychodynamic approach, personal construct theory, symbolic interactionism, social construction, reference group theory and cognitive-affective theory. Their approach is unique as participants were co-participants in the construction of professional identity profiles. What the NMI offers the UK is a robust process that has been theoretically developed but now requires further testing before there can be widespread adoption. In particular, attention is needed to describe the reliability and validity measures of the NMI.

There is an extensive literature describing the measurement of nursing values. These tools are advocated for use in the recruitment, retention and socialisation of nurses. Understanding an individual's suitability or 'match' to the profession will go some way to ensuring that nurses are professionally prepared for their role in delivering safe, equitable person-centred care. Similarly, understanding nursing values enables employers to develop strategies to improve job satisfaction and nurse retention.

2.2.3 Measuring professional nursing values in New Zealand

There is a lack of research in New Zealand measuring professional nursing values; rather, researchers have focused on the exploration of concepts such as professionalism (Walker, Clendon, & Walton, 2015), burnout (Hall, 2001; Jasperse, Herst, & Dungey, 2014; Poghosyan, Clarke, Finlayson, & Aiken, 2010), moral distress (Woods, Rodgers, Towers, & La Grow, 2015), missed care (Winters & Neville, 2012) and workforce development (Clendon & Walker, 2012, 2016; Clendon & Gibbons, 2015). There has however been a significant amount of research on understanding the nursing workforce, specifically undertaken by the NZNO team (Clendon & Walker, 2012, 2016; Clendon & Gibbons, 2015; Clendon & Walker, 2015). This includes: understanding the challenges facing younger nurses (Clendon & Walker, 2012); the ageing nursing workforce (Clendon & Walker, 2016); the effects of shift work (Clendon & Gibbons, 2015); and professionalism (Walker et al., 2015). The latter small-scale study explored the concept of professionalism

with New Zealand nurses. Enabling and disabling factors for professional behaviour were explored with 245 nurses. The researchers explored personal attitudes, attributes and values that make up professionalism, yet professionalism was not defined. The methodological approach was not described, but survey and focus groups were conducted. A survey was conducted with 245 nurses and focus groups with 25 nurses were used to rank themes that emerged from the survey. The ability to deliver professionally appropriate care was key to nurses job satisfaction and choice to remain in nursing; lack of professionalism was fostered in climates that focused on financial priorities, had heavy workload and where emotional labour was high (Walker et al., 2015), although it is not clear if emotional labour was measured. This small-scale study has limitations (no definition of terms, no methodological detail, the survey tool was not described nor was there any detail of the validity of the tool, lack of detail about the focus groups, and the small scale) but does give some insight into professionalism in nursing within the New Zealand context.

Tuckett (2015) explored the value and meaning of the nursing profession to new graduate nurses in New Zealand and Australia. Tuckett's findings were extrapolated from a data set that was part of a larger multi country study. This larger study, the Graduate e-cohort study, is a longitudinal web-based workforce study examining the choices that new graduates nurses in Australia, New Zealand and the USA make in their first year of practice (Graduate e-cohort, 2016). Participants in the Graduate e-cohort study were asked an open-ended question "I love nursing and/or midwifery because", the answers to this question were the basis of Tuckett's (2015) findings. New Zealand and Australian graduate nurses reported that the healthcare climate (economic and organisational pressures) impacts on their nursing practice, but traditional/humanistic values (altruism and person centred care) are critically important to them (Tuckett, 2015). Tuckett did not measure values but this research does provide an opportunity to view professional nursing values in New Zealand.

A 20 year longitudinal survey being undertaken to explore the attitudes and values of New Zealanders (Duckitt & Sibley, 2009, 2010; Sibley, Harré, Hoverd, & Houkamau, 2011; Sibley & Liu, 2004; Sibley, Wilson, & Duckitt, 2007) is in its eighth year. This study seeks to understand how changing circumstances and experiences influence attitudes and values

over time; primarily the researchers track factors associated with health and social psychology. To date the following has been explored: support of euthanasia; material deprivation; cyber bullying; regional commute times; and support for Māori language. This work is important because it sheds light on levels of satisfaction with life and how this may change over time and in turn how values and attitudes change for New Zealanders (Milfont, Milojev, & Sibley, 2016). Whilst not directly related to nursing values, this study does offer some insights into the values of the New Zealand public and this is a useful consideration for the nursing profession given that values are socially constructed.

In summary there are a number of tools that are used to measure professional nursing values that have contributed towards developing an understanding of what is meant by values and how values impact on attitudes and actions of nurses. The reporting of these tools is not always clear and there are studies that fail to report strategies for ensuring validity and reliability. None of the tools presented have been adapted for use in New Zealand. It is difficult to get a sense of nursing values in New Zealand given the limited exploration.

2.2.4 Teaching nursing values

As with measuring nursing values, there is an extensive international literature on teaching values within nursing (Fahrenwald et al., 2005; Iacobucci, Daly, Lindell, & Griffin, 2013; Lynch, Hart, & Costa, 2014; McLean, 2012; Shaw & Degazon, 2008). Drawing on the American Nurse Association (2001) code of conduct values (human dignity, integrity, autonomy, altruism and social justice) Fahrenwald et al. (2005) describe how they integrated these values into a nursing curriculum, arguing that when values are carefully embedded into education the legacy of caring behaviour, personified by nurses, will ensure that the future nursing workforce is strengthened (Fahrenwald et al., 2005). Fahrenwald (2005) offers no evaluative evidence or any recommendations for a formal evaluation to support her assertions and leaves the reader to assume that because values are central to the curriculum these values will be enacted in clinical practice. However, Kramer's (1974, 2014) position may be more in keeping with the present environment where many nurses are repeatedly faced with reality shock and dissonance when they enter clinical practice.

Shaw and Degazon (2008) implemented core professional nursing values (CPNVs) (altruism, autonomy, human dignity, integrity and social justice) into a nursing curriculum in the USA. These authors were motivated to do so based on feedback from graduates of the programme; reporting they did not feel socialised to professional nursing. CPNVs were implemented as a mandatory element of the curriculum and students were required to attend a four-week intensive workshop to “acculturate students more readily into the profession” (Shaw & Degazon, 2008, p. 45). The 25 students who participated were enrolled in a nursing programme specifically for minority, disadvantaged, first nation nursing students. In follow up interviews, students reported that the programme was useful and helped to shape a shared culture of professional nursing practice. There has been no further, or long-term evaluation of this approach, consequentially there is no real evidence of CPNV having been integrated into practice and maintained.

The curricular approach to teaching nursing values has yet to yield positive outcomes (Iacobucci et al., 2013). In an attempt to redress this problem Iacobucci et al. (2013) explored the relationship between nursing values, self-esteem and ethical decision-making in 47 student nurses. In this correlation study, three scales were used to collect data. These were the NPVS (Weis & Schank, 2000), the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and a tool designed by the researchers, the Perceived Ethical Confidence Scale. The first two scales had well-established reliability and validity the third did not. The researchers noted that in any follow up study the third scale would need to be validated and tested. Overall findings showed a positive relationship between nursing values and self-esteem ($p < 0.05$). The higher the self-esteem the more embedded values and the more likely nurses were to act or say something when faced with a value conflict/dissonance, supporting the view that it is important that nurse educators (clinical and faculty) teach strategies to manage value dissonance (Iacobucci et al., 2013).

Building resilience and self-esteem may go some way to embed values in nursing behaviours (Cope, Jones, & Hendricks, 2016; Drury, Craigie, Francis, Aoun, & Hegney, 2014; Manzano García, & Ayala Calvo, 2012), but without understanding or addressing the healthcare climate it is difficult to see how nursing values can be systematically

applied. In the UK, like the USA, various strategies have been employed to embed values into the nursing curriculum. Recent initiatives, as described in Chapter 1, are central in this move to values based education. Steps taken by one University to not only emphasise nursing values but also place the concept of ‘good character’⁸ at the epicentre of their curriculum is one such initiative (McLean, 2012). A model of Values Based Enquiry (VBE) is presented as a curriculum framework. The impetus for VBE came from a review of education standards by the NMC (2010) prompting a review of the nursing curriculum. The theoretical foundation of VBE is virtue ethics and values based practice (being of good character). VBE emphasises self-awareness, the awareness of others, and care and compassion as critical professional nursing values (McLean, 2012). A metaphor of the characters in the *Wizard of Oz*; requiring a heart, a brain and a nerve, is used by McLean (2012) to demonstrate the journey of self-discovery that student nurses undertake before becoming registered nurses. The approach taken by McLean (2012) was innovative, however there is no evidence that the approach makes any difference in emphasising or prioritising nursing values or that these values will be steadfast when the students are faced with the reality of clinical practice. An evaluation of McLean’s approach is yet to be published.

There are examples of similar approaches taken in Australia. Lynch et al. (2014) argue that in spite of the requirement of the Nursing and Midwifery Board of Australia (2006 2016) for graduate nurse to be skilled in moral and ethical decision-making, there is little emphasis on developing student nurses values. These authors piloted the adoption of the *Giving Voice to Values* (GVV) curriculum designed by Gentile (2010). The curriculum was designed to assist students and professional alike to practice responses to specific situations so their responses reflect their values (Gentile, 2010). Lynch et al. (2014) reported that the method of rehearsal gave students a structured approach to speak about values as well as providing a framework to manage uncertainty or hesitation. They found that the outcomes of the pilot project supported the educational power of scenario-based learning suggesting that student nurses have greater levels of confident competence and

⁸ Nursing and midwifery graduates in the UK are expected to be of good character.

courage to voice their values when they are faced with conflict. Lynch et al. (2014) recommended that the GVV underpin the nursing curriculum in their institution. It is worth noting that GVV was designed for the world of commerce and focuses on communicating values and offers a framework to communicate values effectively (Gentile, 2010). It may be argued that a business framework is unsuitable for nursing because of the concerns over managerialism, however it may be useful in helping nurses to understand the business model and develop strategies to situate nursing values within this type of framework.

2.2.5 Teaching nursing values in New Zealand

The development of nursing values begins with formal education, yet in New Zealand there is no single or common nursing curriculum. Therefore a shared perspective on professional nursing values is unlikely, however, schools of nursing are guided by educational standards outlined by the Nursing Council of New Zealand (NCNZ). According to the NCNZ (2010, 2015) the curriculum should meet education standards and prepare student nurses to meet the competencies of a registered nurse (NCNZ, 2007, 2016). There is no definition of values within the NCNZ educational standards for registered nurse preparation. Nor is there reference made to the Code of Conduct, where the values of the profession are described. Consequently the place of values in the New Zealand nursing curriculum is not concrete and can vary throughout the country.

Teaching culturally appropriate values is important in New Zealand. A number of nursing education providers deliver programmes specifically for Māori nurses (NCNZ, 2013). These programmes account for different learning styles, family responsibilities as well as the fewer financial resources that these students have, compared to others (Simon, 2006). This approach is an attempt to redress the disparities in the nursing workforce and address issues of cultural safety. Guidelines for cultural safety have been developed in New Zealand (Ramsden, 1990, 2015) that challenge the nursing philosophy to move from a view of nurses caring irrespective of difference, to a position of caring with a perspective of difference, between gender, ethnicity, culture, age, politics and religious beliefs (Ramsden, 1990, 2015). Māori nurses report that they are challenged in delivering care that is

culturally appropriate, primarily because Māori models of care are not operationalised in the New Zealand healthcare system (Walker, 2015).

In summary, there is a body of literature indicating that nursing values are professionally socialised (Arnold & Boggs, 2015; Chitty & Black, 2011; Goldenberg & Iwasiw, 1993; Kilpatrick & Frunchak, 2006; Kramer, 1969, 1974; Kramer & Baker, 1971; McLean, 2012; Mooney, 2007; Shinyashiki et al., 2006; Tradewell, 1996). There is however no agreement on the best way to socialise nurses into nursing. Some countries embed nursing values into nursing curricula others do not. No matter the level of effort that is exerted in acculturating nursing values the climate that nurses practice in has a profound effect on the enactment of these values.

2.3 Effect of healthcare climate on nurses and nursing

As discussed in Chapter 1, the healthcare environment is complex, challenging, and has been highly criticised for not fostering the enactment of humanistic nursing values. Tension exists between the professional nursing practice and the healthcare climate (Zoboli & Schweitzer, 2013). In the view of Sellman (2011a), organisational targets put pressure on departments because they are fearful of reaching the top of non-compliance league tables. They force departments to be creative and even unscrupulous in fiddling the figures to reflect better on them and their performance. The example given by Sellman was the creation of virtual beds (discussed in Chapter 1). Sellman's research interest is largely focused on virtue ethics and the fostering of a clinical environment that allows for human flourishing (an Aristotelian principle) (Sellman, 2011b). The philosophical arguments presented by Sellman (2011a, b, 2012, 2016) rest on the premise that the idea of human flourishing implies that there is *something more* to nursing than mastering tasks or meeting targets. For nurses, being able to be *something more*, conflicts with the prevailing discourse of bureaucracy and managerialism in healthcare.

There is a current shortage of nurses worldwide and it is expected to increase (Buchan & Calman, 2004; Cain, 2005; Cowden, Cummings, & Profetto-Mcgrath, 2011; Cummings et al., 2010; Scott, 2014); in New Zealand it is projected that 50% of the current nursing

workforce will retire by 2035. This shortage of nurses, coupled with the impact of managerialism, constrained professional nursing practice (Traynor, 1999; Traynor, Bolland, & Buus, 2010), and a climate of distrust (Gilbert, 2005), can erode therapeutic environments that foster professional and compassionate nursing care (Goodman, 2014).

2.3.1 Managerialism in healthcare

The term managerialism first emerged in 1932 (Berle & Means, 1967), and was used to describe separation from ownership of organisations to managerial control, particularly in large public trading corporations. For these companies there were so many shareholders that decision-making was problematic, giving rise to management control over assets and shaping policies for the benefit of the majority shareholders (Currie, McElwee, & Somerville, 2012). There are a number of ways that managerialism can be conceptualised and defined and Currie et al. (2012) argue that this can be problematic because of the diversity in definitions and in some cases there is a lack of criticality in the definitions given. Managerialism can be a positive organisational characteristic or a negative conception, or a command and control hierarchical approach (Carlisle, 2011). The positive view of managerialism refers to it as effective practices that mitigate economic concerns (Pollitt, 1990). For the purpose of this study I draw on the following definition:

Managerialism combines management's generic tools and knowledge with ideology to establish itself systemically in organizations, public institutions, and society while depriving business owners (property), workers (organizational-economic) and civil society (social-political) of all decision-making powers. Managerialism justifies the application of its one-dimensional managerial techniques to all areas of work, society, and capitalism on the grounds of superior ideology, expert training, and the exclusiveness of managerial knowledge necessary to run public institutions and society as corporations. (Klikauer, 2015, p. 1104)

Internationally, governments are under pressure to provide more services at a lower financial cost but with the same level of quality and safety, this is particularly evident in healthcare, and managerialism is often seen as the answer. Nowhere was this clearer than in New Zealand in the 1980s, when healthcare was suffering from poor management, large budget overruns, large waiting lists, and reduced public confidence (Devlin, Maynard, & Mays, 2001). The overhaul of the health system was characterised by managerialism,

“radicalism, boldness, coherence, and innovate methods” (Boston, 1999, p. 3). Health system competition was advocated in a seminal report commissioned by the Minister of Health (Gibbs 1988). In what was considered an attempt to “unshackle the hospitals” the Gibbs Report (1988) recommended the creation of Area Health Boards. These Health Boards were led by Chief Executives who may or may not have had health system experience. The restructuring of the health system resulted in hospitals becoming publicly owned companies subject to normal company law and expected to perform like a business (Devlin et al., 2001). The approach did not have the desired outcomes of increased efficiency and cost effectiveness but resulted in (for example) longer rather than shorter waiting lists. For nursing the results were devastating: “from 1990-1994 nursing staffing levels dropped by 12.4% while inpatient numbers increased. Whole layers of nursing leadership were removed from hospitals and the numbers of general managers swelled” (Harre, 2003, p. 2). These consequences were primarily blamed on managerialism, however the lessons of this era were not learned as managerialism continued to rise both in New Zealand and around the world (Carlisle, 2011).

In the UK middle managers micromanage clinical care whilst attempting to meet performance measures, and in doing so they may actually be preventing excellent clinical care (Zigmond, 2009). Aiken et al. (2001) surveyed 43,000 nurses from 711 hospitals in five countries (USA, Canada, England, Scotland and Germany) to understand organisational climate, nurse staffing and patient outcomes. Findings indicate that nurses across each of the countries faced similar challenges in clinical practice (Aiken et al., 2001). Key areas of discontent across the five countries were related to burnout, poor job satisfaction, and inadequate support from managers. Owing to their discontent over 30-40% of nurses under the age of 30 reported that they were planning on leaving nursing in the next year. Aiken et al. (2001) argued that there are fundamental flaws in the management of hospitals and the nursing workforce and these flaws are not unique to a single country. These flaws are driven by managerialism and bureaucratic models and lead to a shortage of nurses, inequitable healthcare, medical errors and adverse patient outcomes (Aiken et al., 2001).

As well as being financially motivated, managerialism offers a way to increase efficacies, patient satisfaction and access to services (Beck & Melo, 2014). As discussed, managerialism has its roots in efficacy; the efficiency of services, staff, and resources, and is aligned with bureaucracy (Beck & Melo, 2014). Because professional nursing is the largest section of the healthcare workforce, managerialism has significant influence on how nursing is practiced (Traynor, 1999, 2013). Managerialism, bureaucracy and the context of clinical nursing practice is the focus of much of Traynor's work; he argues that the nursing profession ought to prepare its nurses for the reality of healthcare. This includes preparing them to practice with an understanding of managerialism and bureaucracy, thus reducing the risk of *reality shock* and value dissonance. Gilbert (2005) conducted a discourse analysis on trust and managerialism. The 17 participants in the study, who managed facilities that cared for people with intellectual disabilities, were torn between their professional autonomy and managerial controls. The managerial discourse was defined by managerial imperatives, trust and intimate social activity has been replaced with distrust associated with audit and quality monitoring. Although a small-scale study it highlights the tensions that healthcare professionals face on daily basis.

The significance of humanistic values is lost in healthcare environments that are centred on managerialism and the turnover of acutely unwell comorbid patients (Cope et al., 2016). A portraiture study was conducted by Cope et al. (2016) with the aim of understanding why nurses choose to stay in the healthcare workforce and describe their resilience qualities. Nine nurses participated in the study and described the strategies they used to overcome managerialism, these included optimism, hope, strength of purpose, and maintaining close relationships. The central tenet of Cope et al.'s methodological approach was to present the positive aspects of the participants' stories, focusing on strengths and successes. Portraiture blurs the lines between aesthetics and empiricism to capture complexity and human experiences (Lawrence-Lightfoot & Davis, 1997). Cope et al. (2016, p. 121) found that articulating resilience will help nurses to resist managerial forces, "to perform care, to advocate to teach even when overloaded [resilience] empowers their capacity to continue". However, if nurses are inadequately prepared, or fail to understand

the healthcare climate and the policy and political forces that they face, their quality of life will suffer and so too will their ability to enact professional nursing values.

2.3.2 Quality of life for nurses

In considering professional quality of life for nurses many researchers (Drury et al., 2014; Hegney et al., 2014; Hunsaker, Chen, Maughan, & Heaston, 2015; Kelly, Runge, & Spencer, 2015; Sacco, Ciurzynski, Harvey, & Ingersoll, 2015) have drawn on the work of Stamm (2002, 2009). Stamm (2002, 2009) developed the Professional Quality of Life Scale (ProQOL), a 30 item self-report measure of positive and negative aspects of caring. Stamm, a psychologist and researcher in the field of traumatic stress, determined that the professional quality of life for 'carers' is complex. Carer is a generic term used by Stamm and is not specific to registered nurses, however it is applicable in the context of nurse activity. Not only do carers become stressed by their exposure to illness or trauma, they also have resilience to it. There are three components to professional quality of life, compassion satisfaction, compassion fatigue and burnout (Stamm (2002, 2009). Compassion satisfaction manifests in a level of contentment with practice, the greater support from healthcare managers the greater the level of compassion satisfaction in nurses (Stamm, 2002, 2009).

In a three phase mixed method research programme the researchers attempted to understand compassion fatigue and compassion satisfaction in relation to anxiety, depression and stress in nurses (Hunsaker et al., 2015). The first phase explored the relationship between compassion satisfaction, secondary traumatic stress, and burnout (as described by Stamm, 2002, 2009), with anxiety and stress. Phase two explored work related factors that affect the development of compassion satisfaction, compassion fatigue and burnout, and collated strategies that could be used by nurses to develop resilience. Phase three (yet to be published) will draw on the findings from phase two to build a resilience framework, which will be implemented and then evaluated. This body of work is important in identifying the components of compassion fatigue and how these can be mitigated in clinical practice, by offering practical assessment frameworks that can be used by nurse

managers to identify potential anxiety and stress in the nursing workforce. Thus creating clinical practice environments that support the enactment of professional nursing values.

2.3.3 Compassion fatigue and burnout

A lack of congruence between nurses' values and organisational values leads to value dissonance, dissatisfaction, burnout and increased turnover (McNeese-Smith & Crook, 2003). There is a burgeoning nursing literature on compassion fatigue and burnout. Compassion fatigue is a syndrome that nurses and other health professionals can develop when they internalise the pain and suffering of their patients it is often related to repeated exposure to stressful situations (Drury et al., 2014; Drury, Francis, & Chapman, 2009; Hegney et al., 2014). It manifests when a nurse absorbs another's suffering, this can result from a single experience or a series of experiences (Todaro-Franceschi, 2013). Todaro-Franceschi argue that compassion fatigue manifests when individual's (referring specifically to psychotherapists) fail to care for themselves and instead focus on the needs of others. In a very early discussion on compassion fatigue in nursing, Figley (2002) argued that nurses are predisposed to compassion fatigue which is emotionally draining and unavoidable.

Compassion fatigue has been found to have three distinct stages; compassion discomfort, compassion stress and finally compassion fatigue (Joinson, 1992). Coetzee and Klopper (2010) carried out a concept analysis on compassion fatigue, and found that if compassion fatigue is not addressed in the early stages it may alter the nurse ability to be compassionate. Given the nature of nursing it is difficult to see how compassion fatigue could not exist in professional nursing practice (Coetzee & Klopper, 2010) and environmental factors such as: high workload; long hours; and the complexity of patients' needs can intensify compassion fatigue (Mendes, 2014). In the literature the terms compassion fatigue and burnout are often used interchangeably and it is unclear if they are synonymous with each other (Hevezi, 2016).

Burnout is similar to compassion fatigue and can be brought about by another's suffering, but more often than not there are other factors that contribute to burnout including: short

staffing; excessive workload; lack of management support; bullying; and conflict (Boyle, 2011). Burnout is defined as a state of physical, emotional and psychological exhaustion that occurs because of sustained work pressures (Maslach, 1976; Sorenson, Bolick, Wright, & Hamilton, 2016).

The Maslach Burnout Inventory (MBI) is widely used by researchers to assess for levels of burnout (Büssing & Glaser, 2000). The origins of the tool rest in the work of psychiatrist Freudenberger (1975) and social psychologist Maslach (1976), both of whom were interested in the challenges and difficulties that arise in work situations for people working in human services. Maslach (1976) interviewed human service workers asking them about the emotional stress of their jobs. The finding of this early work revealed that these workers developed coping strategies to alleviate emotional stress. Maslach found that coping strategies had implications for the professional identity and behaviour of the individual. It was Freudenberger (1976) who went on to describe emotional exhaustion, the loss of motivation and commitment, as burnout. The initial foray into the field of burnout led to an empirical exploration and development of a survey tool, the Maslach Burnout Inventory (MBI) by Maslach and Jackson (1981).

There are now three versions of the MBI; the original measure the Maslach Burnout Inventory-Human Services (HS) survey, an adapted version for use with educators, MBI-Educators survey and the MBI-General Survey (GS). The latter survey was developed to measure “burnout as a crisis in ones relationship with work, not necessarily as a crisis in ones relationship with people at work” (Maslach, Jackson, Leiter, Schaufeli, & Schwab, 1986, p. 20). The MBI-GS consists of 16-item scale, with a 7 point Likert scale from zero (never) to six (everyday).

There are three subscales in the MBI-GS that measure exhaustion, cynicism and personal efficacy. Exhaustion is a central element of burnout and is one of the most noticeable manifestations of burnout (Maslach, Schaufeli, & Leiter, 2001). Cynicism relates to an “indifference or a distance attitude towards work” and professional efficacy to encompass “social and non-social aspects of occupational accomplishment” and “explicitly assesses an individual’s expectations of continued effectiveness at work” (Maslach, Jackson et al.,

1986, p. 21). By examining these additional concepts there is a better likelihood that the phenomenon of burnout will be understood in its entirety (Maslach et al., 2001). Scores are reported with an average rating of each subscale divided by the total number of items responded to.

Nurse researchers have used the MBI-HS and MBI-GS widely to explore levels of burnout in the nursing population (Finlayson & Gower, 2002; Hall, 2001; Leiter, Jackson, & Shaughnessy, 2009; Leiter & Maslach, 2009b; Watson & Feld, 1996). Manzano García, Calvo, and Carlos (2012) explored the emotional exhaustion of nurses; of particular interest to the researchers were resilience and emotional annoyance. The researchers utilised the MBI-GS to measure cynicism, professional efficacy and emotional exhaustion of 200 nurses in Spain. The reported findings of the study were that nurses with increased levels of emotional exhaustion have reduced performance, particularly in relation to the provision of nursing care.

The effects of burnout are felt by nurses' and patients as well as having an impact on the wider healthcare organisations. For nurses burnout is associated with decreased job satisfaction (Graham, Davies, Woodend, Simpson, & Mantha, 2011; Kalliath & Morris, 2002; Önder & Basim, 2008) and poor physical health including insomnia and headaches (Jourdain & Chênevert, 2010; Piko, 2006). Nurses' thinking is also affected by burnout (Balevre, 2001; Balevre, Cassells, & Buzaianu, 2012). Survey methodology was employed by Balevre et al. (2012) in a pilot and replication study to explore nurses (N=648) irrational thinking and burnout. Their study found that nurses who are burnt out demonstrate maladaptive or irrational thinking and this in turn is manifested in their behaviours (for example disturbed sleep). Irrational thinking, according to Balevre et al. (2012), includes mistrust, where nurse feel they are being taken advantage of by others (including patients, managers and other nurses). Self-sacrifice (letting others have their way), control (limiting spontaneous action or emotion), entitlement (I should be respected), and negativity (nothing I do is good enough), were other elements of nurses irrational thinking described by Balevre et al. (2012). These *maladaptive thoughts* have all the hallmarks of organisation

anxiety and defence mechanisms described by Menzies (1960, 1988) as discussed later in this chapter, and also make it difficult for nurses to enact their nursing values.

The impact of burnout is not limited to nurses; patients also report poorer levels of satisfaction when nurses are burnt out (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). In a cross sectional survey of nurses (n=820) and patients (n=621) by Vahey et al. (2004), it was identified that when nurses had a high degree of burnout patients were dissatisfied with their care. These findings are similar to that of an earlier survey study by Leiter, Harvie, and Frizzell (1998) where 605 patients and 711 nurse participants revealed that in units where nurses were burnt out, dissatisfied or intent on leaving the professions, patients were also dissatisfied. In both these studies the MBI was used to measure nurse burnout.

In a South African longitudinal study Khamisa, Peltzer, Ilic, and Oldenburg (2016) attempted to determine the relationship between burnout, job satisfaction and nurses' general health. To do this they utilised five tools that are widely recognised as having good reliability and validity; these were the MBI-HS, Nursing Stress Inventory (NSI), Job Satisfaction Survey (JSS), General Health Questionnaire (GHQ-28) and a socio-demographic questionnaire (SDQ). Twelve hundred nurses were invited to participate, but only 277 agreed to participate in the follow up survey (the term follow up was used by the authors, but it is not clear what they were following up as the results presented were from an earlier survey). Khamisa et al. (2016) concluded that the turnover of nursing staff in South Africa was a key factor in the poor response rate and that a lack of support in the clinical area is associated with nursing burnout.

The impact of burnout on healthcare organisations can include absenteeism, high turnover and difficulties in recruiting and retaining registered nurse. A systematic review conducted by Davey, Cummings, Newburn-Cook, and Lo (2009) to identify the predictors for nurse absenteeism found that absenteeism is directly related to burnout and job dissatisfaction. There is a direct link between nurse burnout, absenteeism, turnover and an effective healthcare system (Daouk-Öyry, Anouze, Otaki, Dumit, & Osman, 2014). Nurses are critical to a successful healthcare system and their attendance or lack of attendance can seriously affect the quality of patient care, patient outcomes and safety, in addition to

financials outcomes (Ball, Murrells, Rafferty, Morrow, & Griffiths, 2013; Gaudine & Gregory, 2010; Hall, 2001; Spence Laschinger, Gilbert, & Smith, 2011; Spence Laschinger & Leiter, 2006; Spence Laschinger, Leiter, Day, & Gilin, 2009).

Along with compassion fatigue and burnout, emotional labour is considered to have a significant impact on nurse performance in practice (Cheng et al. 2013). Emotional labour is the suppression of feelings in order to convey confidence in another “the management of feeling to create a publically observable facial; and bodily display” (Smith, 2008; Wang & Epstein, 2015). A smile from a nurse, an act of compassion, has been conceptualised as a form of emotional labour (Hochschild, 2003). However, Smith, (2008) and Wang and Epstein (2015) argue that the problem with the imposition of emotional labour is increased levels of burnout and cynicism, rather than genuine expressions of emotion.

Hochschild (2003) coined the concept, ‘emotional labour’ and is regarded as the ‘founder’ of using the term to describe either the induction or suppression of feelings, giving an outward appearance that makes other feel as if they are being cared for and cared about. Her work has long focused on the human emotions which underlie moral action and care and there is a substantial body of research in nursing using this concept (Gray, 2009; Kean, 2010; Msiska, Smith, Fawcett, & Nyasulu, 2014; Sawbridge & Hewison, 2013) and a number of scales have also been developed that measure emotional labour (Brotheridge & Lee, 2003). DeLucia, Ott, and Palmieri (2009, p. 1) affirm that nurses practice in healthcare systems that “do not accommodate human limits and capabilities and that the nurses work under cognitive, perceptual and physical overloads”. Overload, short staffing and a culture of busyness are pervasive in healthcare and in nursing. This coupled with economic reform, cost cutting, downsizing and managerialism not only stifles nursing creativity and innovation but it puts patients at risk. Nurses get caught in the treadmill of stress, burnout and cynicism leading to decreased professional satisfaction, increased risk and poorer patient outcomes (Aiken et al., 2002; Francis, 2013; Francis & Lingard, 2013; Francis, 2010; Rafferty et al., 2007; Twigg, Duffield, Bremner, Rapley, & Finn, 2012).

Burnout is “a process in which the professional’s attitudes and behaviour change in negative ways in response to job strain” (Cherniss, 1980, p. 5). Similarly, compassion

fatigue and emotional labour have the potential to negatively impact on nurses and their patients. Humanistic values are difficult to enact in healthcare environments that are fraught with burnout, compassion fatigue and emotional labour. The clinical milieu becomes saturated with the emotional stress of nurses and their patients.

To summarise: the healthcare climate affects, the enactment of humanistic values, the delivery of nursing care, and patient outcomes. A cultural of managerialism fosters distrust and impacts on nurses' quality of life. The literature presented paints a picture of a nursing workforce that is struggling to adapt to this type of healthcare climate, resulting in high levels of compassion fatigue, burnout and emotional labour. This type of climate does not foster humanistic values. Given the complexity of healthcare and the profoundly challenging clinical environment the issues of how nurses approach the organisation of nursing practice must be considered.

2.4 Approaches to the organisation of nursing practice

There are a number of approaches to nursing practice, many of which have evolved over time and have been influenced by national and international security, financial priorities, and changing societal values. The most significant approaches to the organisation of nursing practice that have evolved and been recurred through cycles of change, restructuring and organisational priorities, and for which some level of evaluation has been undertaken are those of: functional or task nursing; team nursing; and primary nursing.

2.4.1 Functional or task nursing

During the formal beginnings of nursing Florence Nightingale was regarded as a “spiritual beacon of hope and compassion for all who suffered” (Dossey, 1998, p. 111). Nightingale was however critical of nursing, stating that the focus had been on functions such as the “administration of medicines and the application of poultices”, rather than on the, “the proper use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of diet- all at the least expense of vital power of the patient” (Nightingale, 1856, 1969, p. 8). Virginia Henderson, an early nurse theorist, also described her own nurse ‘training’ as being about functions such as “technical competence, speed of performance

and a 'professional' (actually impersonal) manner were stressed" (Henderson, 1964, p. 64). She spoke of a nursing system that was a series of procedures and a mechanistic approach to care (task nursing). Nurses in favour of partnership approaches, that emerged post World War II, rejected this ritual, routine and focused on task. However in spite of the universal rejection of functional/task nursing there were some nurse scholars who argued for the restoration of ritual, largely associated with task. Biley and Wright (1997) argue that there is meaning in both ritual and routine.

In their philosophical and theoretical paper Biley and Wright (1997) discuss the advances that have been made in healthcare in the 1990s. They argue that initiatives like primary nursing or the named nursing initiative were creating healthcare environments that were becoming more accessible (not as harsh or clinical) for patients. However, the cost of these new and modern approaches to practice was the elimination of ritual, which as they argue may not necessarily be a positive step. From their perspective the act of ritual may be part of the healing process for patients. Interestingly the failures of contemporary healthcare systems have led to a call for the return to 'basic' nursing care and the ritual and routine of the past (Francis, 2010, 2013; Francis & Lingard, 2013).

2.4.2 Primary nursing

Primary nursing is an approach to practice that is centred on the concept of one nurse having complete responsibility for one or a group of patients. The nurse is responsible for both the coordination and the delivery of care. The approach was first described by American nurse scholar Marie Manthey (1970b). In her early publications Manthey described a system where decision-making was decentralised thus recognising the value of individual nurses and empowering them to have authority over their actions (Manthey, 1980; Manthey, Ciske, Robertson, & Harris, 1970a; Manthey & Kramer, 1970). Primary nursing peaked in popularity during the 1970s and 1980s producing an enormous international literature on the integration and evaluation of this approach to nursing care across all areas of nursing practice (Gardner & Tilbury, 1990; Leach, 1993; MacGuire & Botting, 1990; Manthey, 2002; Webb & Pontin, 1996).

A key element of the success of primary nursing was managerial facilitation and support. In contemporary practice primary nursing is now known as individual patient allocation, and for many acute hospitals it is the principal model of care (Fairbrother, Jones, & Rivas, 2010). There is a paucity of contemporary literature on models or approaches to nursing practice. The literature that is available lacks clarity about individual patient allocation; on the one hand the approach is seen in a similar way to primary nursing, one nurse responsible for a cohort of patients (O'Connell, Duke, Bennett, Crawford, & Korfiatis, 2006; Tran, Johnson, Fernandez, & Jones, 2010). Conversely, Fairbrother et al. (2010) argue that unlike primary nursing, as described historically, individual patient allocation requires no one-nurse to be responsible for the on-going coordination of the care given throughout the patient journey.

2.4.3 Team nursing

Team nursing emerged to address the impersonal nature of task orientated or functional nursing care, as well as the shortage of registered nurses (Dobson & Tranter, 2008; Ferguson & Cioffi, 2011). Team nursing was proposed as an approach for increasing nurses' efficiency, managing healthcare cost, and responding to rapidly developing technologies in healthcare (Shukla, 1983). There was a collaborative element to team nursing founded on a philosophy of care and clinical excellence (O'Connell et al., 2006); harsh impersonal care was rejected in favour of partnership and human dignity (Fairbrother et al., 2010). Team nursing was and remains a collective approach to nursing care, where nurses practice cooperatively. The assumption is that the team's broad base of nursing knowledge is greater than that of a nurse working alone (Fairbrother et al., 2010). A key element in team nursing is the nurse team leader who coordinates the team and has oversight of patient care. Some authors consider this to be a traditional hierarchical approach to nursing care (Dobson & Tranter, 2008; Duffield, Roche, Diers, Catling-Paull, & Blay, 2010). These authors note that the aim of team nursing is to practice collaboratively with "shared responsibility and to some extent accountability for assessment, planning and delivery of patient care" (Tiedeman & Lookinland, 2004). Hayman, Wilkes, and Cioffi (2008) undertook a study with the aim of reporting a case study of a nursing practice redesign in a surgical ward in a large Australian hospital. The methodological approach

taken was descriptive Case Study. The study focused on the process of implementing change from patient allocation to team nursing. The results highlighted nurses' frustration with a lack of autonomy and what they saw as cost-cutting measure.

Humanistic societal values such as justice, kindness, respect and the value of individualised care, together with partnership, were embedded in team nursing (Fairbrother et al., 2010; Tiedeman & Lookinland, 2004). This approach to care fosters evidence, reason, morality, meaning and purpose, emphasising love, self-respect and respect for others (Shahriari, Mohammadi, Abbaszadeh, & Bahrani, 2013; Verpeet, Meulenbergs, & Gastmans, 2003). Tiedeman and Lookinland (2004) argue that a humanistic approach accounts for the needs of the whole person and their self-determination and it was these factors that influenced the move from functional nursing practice to team nursing. According to a number of writers, team nursing and good teamwork has the potential to increase nurse retention and improve patient outcomes and nursing satisfaction (Kalisch, Weaver, & Salas, 2009). Nurses who value collegiality (a key factor in developing nurses' resilience to burnout) view team nursing favourably (O'Connell et al., 2006). Collegiality improves job satisfaction for nurses and makes them more likely to stay in their roles; this is significant given the national and international shortage of nurses (Buchan & Calman, 2004; Cain, 2005; Drury et al., 2009; North, 2011; North et al., 2005). Equally nurses are better equipped to cope with challenging, complex and ever changing clinical environments when they feel that colleagues and management support them (Drury et al., 2014). Without this support, nurses can become stressed and burnt out (Büssing & Glaser, 2000), subject to compassion fatigue (Todaro-Franceschi, 2013) and unable to be attentively present with patients during clinical encounters (Kimble & Bamford-Wade, 2013).

In summary, approaches to the delivery of nursing care have evolved over time; rejecting old-fashioned practices in favour of modernity. The popularity of each approach has been influenced by a number of factors such as economic and societal pressures. All three approaches described have been enacted in clinical practice with varying degrees of success. The approaches do not stay long enough to be embedded or evaluated and Biley and Wright (1997) caution nurses that rejecting historical approaches to care may be

detrimental for contemporary nursing practice. In the following section I outline the theoretical perspectives and influences that informed this study; namely the work of Isabel Menzies and Edith Stein.

2.5 Theoretical Influences

During data analysis, and in keeping with Case Study methodology and triangulation processes, the work of Isabel Menzies (1969, 1988, 1989) and, to lesser degree, Edith Stein (1989, 2000) became instrumental in my understanding of nursing values in contemporary practice. These were the theoretical lenses through which I examined my data.

2.5.1 Isabel Menzies

Isabel Menzies⁹ was born in 1917 and raised in Scotland; one of four children of a protestant family. She studied economics and experimental psychology at St Andrews University. After graduating from University she worked alongside Eric Trist (a leading figure in organisational development) to help veterans returning from the World War I to resettle. She later moved to the Tavistock Institute and trained as psychoanalyst. The Tavistock Institute was established in 1947 and is still in existence today; the purpose of the Institute was to apply the social sciences, in particular the application of psychoanalytic and open systems, to groups and organisations. The Institute has been significant in understanding groups (1989, 2000), organisations (Bion, 1961), and the dynamics of change (Miller & Rice, 1967). Much of Menzies' work explored the functioning of organisations and the application of psychoanalysis to organisations.

Menzies work was profoundly influenced by the theories of Melanie Klein, and later by her contemporary Wilfred Bion (Bion and Menzies worked together at Tavistock). Klein also worked with the Tavistock Institute and was associated with the development of

⁹ After her marriage Isabel changed her name to Menzies Lyth. In this thesis she is referred to throughout as Isabel Menzies as her seminal work was conducted and published under her maiden name.

psychoanalysis and psychodynamic theories. Klein, a psychoanalyst, specialised in analysing children and was credited with providing, “an extraordinarily rich and complex picture of the inner life of the young child, and even of the baby” (Sher, 2013). For Klein, it was “the nature and quality of emotional relationships” (Waddell, 2002, p. xviii) that were at the forefront of her thinking. This approach became known as object relations and emphasised the significance and quality relationship between self and other (Waddell, 2002).

When Menzies began her psychoanalytic training Bion became her analyst. This analysis was something that Menzies undertook for herself, not something she was expected to do because of her training. Bion and Menzies became friends and colleagues and he influenced her greatly. For Bion, knowledge about oneself is always constituted within a group, group dynamics are inherent in individuals and are most evident when individuals are together in groups (Klein, 1997; Schneider, 2015; Waddell, 2002); In fact “no individual, however isolated in time and space, can be regarded as outside a group or lacking in active manifestations of group psychology” (Bion, 1961, p. 132).

Menzies drew on the works of Klein and Bion when undertaking her seminal study on hospital student nurse absenteeism and wastage; describing these environments as steeped in hierarchies, ritual and primarily task orientated practices (Menzies, 1960). Through her observations she noted that anxiety arose from nursing practice itself. Sources included the proximity to death and illness, as well as the necessity for intimate physical contact. She concluded that nursing care was instrumental (functional/task) in nature; for example one nurse would take the temperatures of all the patients, another all the fluid balances. Menzies postulated that this type of practice protected nurses from the anxiety of being too close to patients thus allowing the development of “socially structured defence mechanisms” (Bion, 1961, p. 168).

Anxiety is critical in understanding the unconscious mind, according to Menzies, anxiety, like phantasy, is at the core of deep and primitive thoughts. Fantasy is a term used to cover conscious and unconscious senses; phantasy refers to the unconscious senses (Menzies, 1960). Klein posits that phantasy underlies all mental process, as well as acting as a defence

mechanisms against those impulses (Jacques, 1955; Klein, 1997). In Menzies (1960) view, nurses unconsciously associate the pain and or distress of patients with their own phantasy worlds, thus the nurses' anxieties are added to those of others. Nurses also project their infantile phantasy (an unconscious state of mind of a child) into their practice thus allowing them to master anxiety (Klein, 1997). Menzies developed Jacques' (1955) notion of a social defence against anxiety. Jacques made the assumption that social defences cohesively bind individuals to institutions. Both Jacques and Menzies take a distinctly psychoanalytical point of view and both were profoundly influenced by work of Sigmund Freud. The unconscious, a central concept in psychoanalysis, is usually individually focused however both Jacques (1955) and Menzies (1988, p. 463) considered the unconscious in terms of organisations; "structure, sub-systems and culture".

Menzies (1960) described 10 specific interrelated defensive techniques: 1) splitting up the nurse patient relationship; 2) depersonalisation; categorisation and denial of the significance of the individual; 3) detachment and denial of feelings; 4) the attempt to eliminate decisions by ritual task performance; 5) reducing the weight of responsibility in decision-making by checks and counterchecks; 6) collusive social redistribution or responsibility and irresponsibility; 7) purposeful obscurity in formal distribution of responsibility; 8) the reduction of the impact of responsibility by delegation to superiors; 9) idealisation and underestimation of personal developmental possibilities and 10) avoidance of change. Each of these anxieties will be briefly (because of the constraints of the thesis) described. Although they are described separately they are however interconnected. These 10 defence mechanisms have been developed, largely unconsciously, by nurses to protect themselves from anxieties that they faced in clinical practice (Menzies, 1960). Cooper (2011) argues that the merits of Menzies' work have yet to be fully realised or explored. He commented that if Menzies were to conduct her study today, in addition to the anxieties she described, she is likely to identify additional anxieties in healthcare that might include "rationing anxiety", "performance anxiety" and "governance anxiety", thus better reflecting the managerial and economic rhetoric of contemporary healthcare.

2.5.1.1 Splitting up the nurse-patient relationship

At the core of nurses' anxiety is the nurse-patient relationship; the closer the relationship the greater the anxiety. To protect a nurse from such anxiety both the nurse and the organisation adopt strategies to split contact with patients, this is achieved in the breakdown of the nursing tasks. The protection that this approach offers is augmented by a number of other strategies. These strategies are situated in depersonalisation "or elimination of the distinctiveness in both nurse and patient" (Menzies, 1960, 1988). Allan (2016) argued that this type of defence mechanism means that nurses fail to acknowledge or experience an emotional connection with their patients.

2.5.1.2 Depersonalisation; categorisation and denial of the significance of the individual depersonalisation

The patient is depersonalised by the use of a bed number, illness, gender or ethnicity. The nurse is depersonalised by wearing a uniform, having a shared skill set with other nurses; similarly, the layout of the ward and the standardisation of equipment and procedures adds to uniformity (Menzies Lyth, 1988). Professional detachment is achieved when nurses control their feelings, do not overly identify with or become involved with patients and maintain a high degree of flexibility (a good nurse does not mind moving from one ward to another). A large number of nursing studies associate depersonalisation with burnout (Menzies, 1960, 1988).

2.5.1.3 Detachment and denial of feelings

The nurses in Menzies' (1960) study did not always accept detachment and denial of feelings, but it was reinforced by the organisation; the 'system'. Professional detachment was associated with controlling feelings; not getting overly involved with patients. Becoming psychologically detached is a defensive strategy that has been employed by nurses for decades (Gama, Barbosa, & Vieira, 2014; Gandi, Wai, Karick, & Dagona, 2011; Jesse, Abouljoud, Hogan, & Eshelman, 2015; Lang, Pfister, & Siemens, 2010; Wang, Liu, & Wang, 2015). This detachment is often a recovery strategy whereby nurses ending their clinical shift detach and leave it all behind (Sonnentag & Bayer, 2005; Sonnentag & Fritz, 2007). There are some similarities with work to emotional labour as presented earlier in

the chapter. Menzies was also referring to another type of detachment; a detachment demonstrated when nurses were in clinical practice. Msiska et al. (2014) examined the clinical learning experience of undergraduate nursing students in Malawi, with the aim of understanding their experience. A hermeneutic phenomenological study was undertaken with a purposively selected sample (N=30) of student nurses. Findings revealed that nurses demonstrated emotional detachment when caring for HIV positive patients; emotional detachment similar to that described by Menzies. These authors make the point that the nurses' detachment was a consequence of contextual factors such as being a novice nurse, insufficient preparation and insufficient support.

2.5.1.4 Elimination of decisions by ritual task-performance

Decision-making is necessary in nursing practice, however the uncertainty of the outcomes, particularly in the context of patient wellbeing, creates anxiety. To help eliminate this anxiety 'nursing services' try to standardise decision-making with protocols and guidelines that outline exactly what ought to happen and in what order; consequently ritual is reinforced. However, rituals in practice can also reduce nurse anxiety and can support social cohesion (Menzies, 1960, 1988). In contemporary practice we view protocols and guidelines as necessary elements of professional practice, they reinforce the evidence base in decision-making (Roberts-Turner, 2016). However there is a rigidity associated with protocols and guidelines that can foster ritual and routine and stifle autonomous decision-making (Nelson, 2014).

2.5.1.5 Reducing the weight of responsibility in decision-making

Martin (1998) found that committing to a decision by a single individual is diluted with checking and counter-checking. Double-checking is one of the strategies employed by nurses to reduce medication errors (Menzies, 1960, 1988). The habit of checking is not limited to 'dangerous' tasks, like medication administration, it is also apportioned to benign tasks such as what room to use for an interview; hence supportive decision-making and collaborative practice is encouraged in nursing (Alsulami, Choonara, & Conroy, 2014). Menzies recommends that wherever possible nurses involve others in decision-making and in reviewing actions. This is not unique to nursing, West and West (2002) propose that

doctors have similar challenges; uncertainty in decision-making generates anxiety. For doctors the reliance on protocols; and fear of admonishment may result in an anxiety so profound that they may abandon their patients (West & West, 2002).

2.5.1.6 Collusive social redistribution

Nursing practice requires individual nurses to be accountable and responsible for their actions. This burden is often heavy, and whilst nurses do bear the burden, Merrick, Fry, and Duffield (2014) argue that nurses often tend to reject responsibility; but describe themselves as responsible and other nurses as irresponsible. In her work Menzies showed that nurses habitually complained about the practice of other nurses and never admitted their own failings or frailties. These complainants rarely named an individual; the complaint was directed to a group of nurses, usually new nurses or student nurses. Menzies argued that this strategy is projection; nurses projecting their own irresponsibility or fear of irresponsibility onto others.

2.5.1.7 Purposeful obscurity in formal distribution of responsibility

Irresponsibility is further augmented by the lack of structure within the 'system', outlining who is responsible and for what (Menzies, 1960). This blurring of the lines is well reported and there have been a number of measures to address it. In the UK for example modern matrons were deployed to be the fulcrum of the healthcare team, as visible figures providing leadership and authority. In an evaluation of their roles Currie, Koteyko and Nerlich (2009) found that, with support, matrons can improve patient care, but in many instances these roles lack support and the ambiguity about who was responsible and for what remained. The lack of a stable responsible person makes it difficult to assign responsibility to anyone (Scott, Savage, Ashman, & Read, 2005).

2.5.1.8 The reduction of the impact of responsibility by delegation to superiors

Delegation happens as a matter of routine and this form of delegation is upward so that nurses can disclaim responsibility, thus reducing the burden on the individual (Menzies, 1960, 1988). Menzies was struck by the lack of empowerment of nurses. She noticed that nurses were often assigned tasks and responsibilities that were well below what they were

capable of doing. Similarly nurses would take on tasks that they had no time for because they were the senior and did not fully trust their subordinates.

2.5.1.9 Idealisation and underestimation of personal development possibilities

In an attempt to reduce anxiety, nurses seek assurance that all nurses in their team are competent and responsible (Menzies, 1960, 1988). There is a classification of those who are deemed responsible and this results in an idealisation of the ‘good’ nurse. There was no evidence of a supportive culture toward junior of student nurses in Menzies study (1960, 1988). This is in contrast to the vast support that student nurses and new graduate nurses are afforded today.

2.5.1.10 Avoidance of change

Change is a certainty in healthcare. The nurses in Menzies study responded to change by avoiding it at all costs, they clung to the familiar. Only when the change was inevitable did they respond to it. The reason for the resistance rests in a social defence against anxiety. The anxiety was centred in the uncertainty of the outcomes of change and this inhibited the nurses’ ability to be constructive. In a recent study senior nurses were seen as key in mitigating the resistance to change because they acted as a buffer to the nurses anxiety (Belcher & Jones, 2009; Casey, Fink, Krugman, & Propst, 2004).

2.5.2 The adoption of Menzies thinking in nursing

There are very few studies in nursing that have employed Menzies theoretical perspectives¹⁰. Despite this, Hancock (2008, p. 33), in an obituary to Isabel Menzies, described her as “a great friend to nurses” and that her work continues to have relevance to contemporary practice. Allan (2016) in a recent editorial argued that nurses and nurse

¹⁰ The field of Social Work, particularly the area of child protection in the UK, has drawn a great deal on Menzies thinking. Lees, Meyer, and Rafferty (2013) argue that performance management, managerialism, risk mitigation that are pervasive in child protection, are all attempts to defend against anxiety. In this case the anxiety stems from making the wrong decision and facing public criticism. The source of Social Workers anxiety in child protection is the daily exposure to powerful emotions from, children, families and society (Taylor, Beckett, & McKeigue, 2008; Whittaker, 2011).

researchers neglect exploring defence mechanisms preferring to focus on technical aspects of care. The result of this lack of attention is what she considers to be a further devaluation of the nursing profession.

The literature review revealed a number of publications that employed, or referred to, Menzies. Drawing on Menzies' ideas, Holden (1991) composed a paper presenting a psychoanalytically informed conversation with a patient and her husband, informed by Menzies' defence against anxiety. The vignette was a distressing account of a patient and husband's anxiety; nurses became saturated by the patient's anxiety and favoured routine when nursing her. Holden argued that hospitals are permeated with anxiety that impedes the caring relationship and genuine caring. In a personal communication between Holden and Menzies, Menzies proposed that a way around the anxiety for nurses was to 'nature the task' rather than focus on the person, thus avoiding a dependency. Holden advocated for nurses to *practice anxiety* (in a simulated fashion) in undergraduate curricula to prepare students for the clinical reality. Holden believed that practicing anxiety would allow potential problems to be formally addressed, both psychologically and intellectually.

Based on previously conducted fieldwork in a Norwegian hospital, Ramvi (2011) utilised Menzies' social defence against anxiety to understand the development of empathy in student nurses. Ramvi (2011, p. 285) describes how she saw and heard student nurses' frustration as they entered clinical practice, and observed their "lack of naturalness" with patients and colleagues. The thesis presented by Ramvi (2011) is that it is difficult, if not impossible, for student nurses to develop empathy when facing anxiety. Critically, defence mechanisms neither contain anxiety nor do they foster the development of empathy.

In a discussion paper by Walsh, Crisp, and Moss (2011), exploring the psychodynamics of organisations, and drawing on the work of Menzies, the authors argue that behaviours in healthcare are profoundly influenced by interpersonal mechanism, in turn influencing organisational culture and organisational functioning. They argue that a better understanding of psychodynamics of organisations ensure educators are better able to develop strategies and achieve better success with practice development.

Evans, Glass, and Traynor (2014) conducted a focus group (no other detail is provided by the authors) and wrote a peer reviewed paper on two fragments of dialogue from the focus group. The authors wanted to understand how some nurses remain in nursing despite the challenges they face in daily practice. Menzies psychoanalytic theory and Lacan's (1988) theoretical perspectives were used to explore nurses' anxiety. There were two distinct discourses presented by Evans et al. (2014), one, nurses complained about surplus (this is articulated as wealth or what others had, for example doctors privilege), and two, nurses tolerated the surplus preferring to focus on nursing practice. In this latter position the nurse chose not to be distracted by privilege, preferring to focus on patient care instead. Evans et al. (2014) propose that the ability not to be distracted (in this case by surplus/privilege) is central to the practice of nursing. However, I argue that distraction is in itself a defence strategy to organisational anxiety.

In a particularly pointed review of Menzies it was argued that her theoretical assumptions are inaccurate because, in the reviewers opinion, the hospital in question was "incompetently run" and this was the root of the problem, it had nothing to do with anxiety or defence mechanisms (RMN, 1960). Menzies refuted this suggestion, arguing that any organisation subject to such an investigation is likely to show some failures but that the greater question ought to be situated on the unconscious defence mechanism that are employed.

This review of Menzies work highlights her particular view of the significance of anxiety and associated defence mechanisms for nurses, patients and healthcare systems. Her psychoanalytic training, and those who worked alongside her, profoundly influenced her ideas. There are few examples of the application of her work in nursing and dearth of research exploring each anxiety and organisational defence. Cooper (2011), also a member of the Tavistock Institute, argues that contemporary anxieties ought to be considered in any exploration of Menzies work in present day nursing practice. Menzies was profoundly influential in this study but the theoretical perspectives of Edith Stein also had relevance and will now be discussed.

2.5.3 Edith Stein

Edith Stein was a philosopher, teacher, writer, feminist, nurse,¹¹ and ultimately, a martyr. She was born in Breslau, Silesia (now Wroclaw, Poland)¹² in 1891 one of 11 children of a Jewish family. In her early life she was inquisitive and challenged the status quo, a rebellious teenager who rejected her faith (Stein, 2000). She studied under Edmund Husserl, the father of phenomenology (Baseheart, 1989; MacIntyre, 2007; Stein, 2000). The First World War interrupted her doctoral study and for a period of time she worked as a ‘nurse’ in a Red Cross field hospital in Austria. Once the field hospital was dissolved Stein returned to the University of Göttingen where she completed her doctoral thesis; *On the Problem of Empathy*, that may have been influenced by her experiences working for the Red Cross (Calcagno, 2015). Her academic career was hampered by the fact that she was a woman and she was unable to secure a postdoctoral faculty position (Ales Bello, 2015; Calcagno, 2015). This led her to take up a position as a schoolteacher where she focused much of her attention on developing strong female students (Ales Bello, 2015; Baseheart, 1989; Lebech, 2015b). At the age of 30 Stein converted to Catholicism and later became a cloistered Carmelite nun (Calcagno, 2015; MacIntyre, 2007). As the political climate changed in Europe her Jewish heritage made her a target for the Nazi regime. She was arrested by the Gestapo in 1942 and transported to Auschwitz where she was exterminated along with a million others (Baseheart, 1989; MacIntyre, 2007).

Stories have emerged detailing Stein’s kindness and compassion to others who travelled with her by train to the death camps (Baseheart, 1992). Her life and death are both shocking and inspirational. Stein (known by her religious name as Sister Theresa Benedicta of the Cross) was beatified in 1987 and canonised as a saint by the Catholic Church in 1998 (Määttä, 2006).

¹¹ Although many texts about Edith Stein affirm that she was a nurse I have found no evidence that she undertook any formal education in nursing; however she did train as a Red Cross nurses’ aid. She worked in a 4,000 bed military hospital in Austria for most of 1915. She describes her nursing work in detail in her autobiography, *Life in a Jewish Family: 1891-1916*

¹² Silesia was conquered by Prussia and later became part of the German empire.

Stein's phenomenological theory of motivation and value influenced the theoretical perspectives I took in this study. It was not only her views on values that influenced my thinking it was also her deep consideration to the concept of empathy. Empathy is discussed here because of its centrality to Stein's thinking and because understanding the relationship between empathy and values is important as empathy is a source of moral developmental (Persson & Kajonius, 2016). However, this is not the focus of the review which is why empathy is only presented in relation to thinking of Stein. Empathy and compassion are multidimensional constructs that sometimes have contradictory definitions (Mercer & Reynolds, 2002), and sometimes they are used interchangeably (Raab, 2014). For Stein there were three levels of empathy. First, we experience the other person as an object "when it arises before me all at once, it faces me as an object (such as sadness I 'read' in another's face)" (Stein, 1989, p. 10). Second, there is an attempt to clarify the object's emotional state and in doing so a personal experience occurs. This parallel experience does not mean that the same feelings are experienced but that, "the empathiser experiences that others state of mind as if it were his or her own" (Määttä, 2006, p. 6). The third level of empathy is concerned with separation, where affinity with the other ceases and we become ourselves again; because of the shared affinity we stand alongside the person.

Määttä (2006) (in one of the very few papers on Stein and nursing) argues that a Steinian approach to empathy can be particularly useful in healthcare as it can balance the tension between closeness and distance in nurse-patient relationships. In this discussion paper Määttä (2006) explores contrasting understandings of empathy and their relevance to nursing and healthcare; arguing that both Martin Buber, and Carl Rogers' perspectives on empathy are not as complete or as relevant as Stein's perspective. German philosopher Buber considers that empathy cannot be achieved as an act of will; Rogers, a psychologist, and the developer of the client-centred theory, presents empathy as identical with dialogue and an outcome of active listening. These rather linear perspectives fail to capture the true complexity of empathy as described by Stein (Määttä, 2006). Määttä, who is also a registered nurse, offers a unique perspective, asserting that Stein's approach will foster empathy that will not submerge nurses, however she also recognises that there is need for research in this area.

Empathy is experienced primordially and non-primordially, and through empathy a lived experience is recognised (Stein, 1989). Stein contends that when we experience something; pain as a result of an injury for example, we experience it primordially (personally), when we become pain free we reflect on the event but we do so non-primordially. We see someone else get hurt; we are not primordially affected by their pain but are drawn into their experience non-primordially. Stein (1989, p. 7) argues that “all our own experiences are primordial...but not all experiences are primordially given nor primordial in their content”. Lebech (2009), a philosopher, adds some clarification to Stein’s ideas by noting that inter-subjectivity is dependent on empathy, when a distinction can be made between ourselves and a foreign subject, allowing for a greater awareness of several subjects including ourselves, and this does not have an end. Further to Stein’s views on empathy, community and values were key considerations in her later scholarly activity.

In her phenomenological theory of motivation and value, Stein posits that values are constituted on the basis of what happens inside us, what we experience; the effects of our valuation impacts both our individual psyche and the wider community (Lebech, 2009; Stein, 1989). In Stein’s view, a community is made up of individuals who have shared values and the values help to coordinate their actions, offering a sense of unity as they work together to realise their actions (Lebech, 2009, 2015a; Stein, 1989, 2000). Stein recognised the hierarchy of values and those that are given a higher place (for example human dignity) the more deeply they are felt by the community. Values are explained in terms of how they motivate action, values explain feeling, values explain attitudes to feelings and values determine whether an action or not is required (Lebech, 2009). According to Stein there are three main factors that constitute values: what they are; what identifies them as values, for example the value of kindness, the value of family; and how deeply they are felt and thus acted upon.

Values are seen in a person’s character and the person’s character infers the value. The essence and the height of the values must be examined within the context of the individual’s makeup; their physical, psycho-spiritual nature (Lebech, 2009; Stein, 1989). Values can also be shared with a community and coordinate the actions of the community (nursing is

a good example of this). For each value there is a response that corresponds to the value and it is the response that is the motivating aspect of values (Lebech, 2009; Stein, 1989).

In order to perform the response to the value it is not always necessary to feel the value; the person may not have a grasp of it. Yet, in Stein's (1989) opinion, the response to a value that is completely fulfilled, that is, felt, means that the intention and the responses to the values are unified. If a person is to have an adequate response to a value it includes 'feeling' the value. When a value response is not adequate the value response is not fully realised and therefore does not motivate in the same way as those that are felt. The substance of a value response is when the feeling and motivation aligns with the value rationale (Lebech, 2009; Stein, 1989). Or as Tshudin (1992, p. 2) proposes; "values are closely related to meaning - the meaning of life. The inner meaning of action, an experience or an attitude gives us our values".

2.6 Summary

The literature review presented followed an iterative/nexus approach, thus capturing the complexities of the board literature base of the study. Emerging areas of knowledge about nursing values were presented. This included, both the international and national literature on professional socialisation, measuring values and teaching nursing values. The effects of the healthcare climate have been critiqued, including managerialism, and its impact on nurses' well-being, quality of life and the enactment of nursing values. Approaches to the delivery of nursing care; functional/task orientated, primary and team nursing are analysed. These approaches have developed over time with varying degrees of success. The chapter concludes with an overview of the theoretical lenses that were used in the analysis of this thesis.

Menzies seminal research on organisational anxiety and defence mechanisms was examined both in terms of its development and application to contemporary professional nursing practice. Nurses who experience anxiety in clinical practice develop defence mechanisms. These defences inhibit the enactment of nursing values. The defensive strategy of spitting up the nurse patient relationship, for example, is challenging for nurses

and patients. Human beings are relational beings and nursing is a relational practice. Acknowledging and moderating defensive strategies can help restore the split nurse-patient relationship. Stein conceptualises a way of understanding and experiencing relationship, which can be useful when relationships are encumbered with powerful and exhausting emotions/anxieties. Stein offers a perspective whereby the relationship can be therapeutic for the patient and not harmful to the nurses, this is mediated by empathy and empathy allows for values to motivate nurses' actions.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

The purpose of the study was to examine the values of professional nurses and to determine whether there is congruence between personal, organisational and professional values and examine how nurses express their values in nurse-patient interactions. The research question posed was: What are the values of professional nurses practicing in medical ward environments and how are these values lived in day-to-day practice?

Choosing the methodology best suited to capture knowledge about nursing values was the first step in designing this study. Thus this chapter concerns theories of knowledge and interpretive frameworks most appropriate for this study purpose. A key factor in determining both the philosophical and methodological approach was the ability to explore nursing values in the context of day-to-day nursing practice within complex healthcare organisations. To achieve a holistic understanding of nursing values I chose a constructivist epistemological approach utilising Case Study (CS) methodology.

The research question was constantly refined throughout the research process, from the writing of the proposal to the final iteration presented here. This refinement led to a clearer articulation of the aims of the research. In established research texts there is little written about constructing, formulating and reformulating research questions (Denzin & Lincoln, 2005; Hesse-Biber & Leavy, 2011; Silverman, 2013), and even less written in peer reviewed journal publications. I argue that in a constructivist paradigm it is an essential aspect of the research process to examine the research question through the course of a research study. This position is supported by Alvesson and Sandberg (2013, p. 10) who argue that rather than being rigid, research questions set “the somewhat broader intellectual motive of a study, whether it is empirical and/or theoretical, that is, the rationale and direction of a study”. Questions are the starting point of knowledge development and through questions we are able to generate knowledge (Alvesson & Sandberg, 2013).

In this chapter I address constructivist epistemology and how this study sat within a constructivist paradigm. This is followed by an outline of CS methodology, including a discussion on the history of this methodology and criticism of the approach. A discussion about the types of CS methodology is presented. Within CS methodology there is a need for a clear description of the boundaries (geographical, time period, definition, and context) of the case, as such, the geographic boundaries of the case are provided. As a key element of this methodology is triangulation, a critique of triangulation is also offered.

3.2 Constructivist epistemology and Case Study

Constructivism focuses on research participants' individual accounts reflecting their unique experiences and perspectives; knowledge is therefore constructed rather than discovered (Crotty, 1998; Stake, 1995). The constructivist worldview is commonly associated with naturalistic enquiry and qualitative research (Creswell, 2013b). Researchers using a constructivist approach aim "to generate the most sophisticated description or explanation...as a result of an interactive process between the researcher and participants" (Brown Wilson & Clissett, 2011, p. 678). As a paradigm, constructivism originated from the fields of psychology, and education, and was influenced by the work of Piaget and Vygotsky (Wadsworth, 1996). In more recent times constructivism has been expanded to include social constructivism (Berger & Luckmann, 1991) and naturalist enquiry (Lincoln & Guba, 1985).

Intrinsic to constructivism or indeed naturalistic enquiry are ethics and values; both are imperative to this paradigm. Lincoln (1992, p. 382) maintains that constructivism requires "an ethical posture that is diametrically opposed to that of positivism". Meaning researchers are honest with participants, they reveal rather than conceal and are concerned "for the values of various audiences" (Lincoln, 1992, p. 382). There is a refusal, in constructivist epistemology, to distance the researcher and the phenomenon of interest; this is why the approach is well suited to nursing research as; "Constructivist inquiry...has enormous power and subtlety when it is used for questions of human behaviours, interactivity, belief systems and meaning attribution" (Lincoln, 1992, p. 390).

CS methodology can take a positivist/post-positivist or an interpretive/constructivist stance. Yin's approach to CS is positivist/post-positivist (Lauckner, Paterson, & Krupa, 2012); in contrast, Stake (1994, 1995, 2013) seeks out multiple perspectives attempting to collate diverse interpretations of a specific phenomenon. Stake's ontological belief, or world view, is that reality is specific and unambiguously constructed which, according to Lauckner et al. (2012), positions Stake in an interpretive/constructivist paradigm. This study, on nursing values, required an exploration of multiple perspectives and my belief was that it logically sat within a constructivist paradigm as described by Stake (1994, 1995, 2013).

Nurses have different perspectives of the world they live in, the society they function in and the profession within which they practice; these perspectives can change over time. Nurses continually attempt to make sense of their experiences; these experiences shape their perspective, and they construct theories, and test and modify their theories on the basis of new experience (Heimann et al., 2013). Constructivism underpins this flexible approach to nursing practice and nurses clinical decision-making (Lim, Honey, North, & Shaw, 2015; Peters, 2000). For these reasons this study was conceptualised within a qualitative methodological approach that allowed data to be represented and analysed through a socially constructed theoretical lens. This philosophical position is in contrast to a positivist perspective of objectivity and neutrality. In constructivism the social context and personal values, attitudes and actions are of paramount importance; "At the heart of constructionist perspective is the belief that our categorizations are important because they *influence our behaviours*" (Loseke, 2011, p. 17, original emphasis). Therefore this approach is congruent with the study of nursing values. It was important for me that the research captured the contextual nature of nursing in a medical ward, allowing for the exploration of multiple dimensions of nursing values in that environment; when using CS methodology there is deliberate exploration of the "contextual conditions" (Yin, 2003, p. 13).

The choice of CS methodology was further determined by a number of factors including, the aspiration to holistically and meaningfully explore nursing values, to explore a nursing issue in the context of clinical practice, and to understanding nursing values from a number

of perspectives. A CS approach permits description, exploration and understanding of phenomena in the context of the real world and allows researchers to explore the experiences of individuals or a collective (Anthony & Jack, 2009; Stake, 1978).

The use of CS methodology in nursing research peaked in the 1960s and then declined rapidly until more recent times when its popularity has again risen; it is now used widely in nursing for studies (Anthony & Jack, 2009; Bourgeois et al., 2014; Kroezen, Mistiaen, van Dijk, Groenewegen, & Francke, 2014; Luck, Jackson, & Usher, 2006; Powell, 2013) and in the social sciences, because the merits of qualitative research approaches are now accepted (Cronin, 2014).

CS methodology is valuable when exploring a nursing issue in the context of clinical practice. Examples of the use of this methodology in nursing include a study on the role of Australian nurse practitioners (Bourgeois et al., 2014), the experiences of nurses working night shift (Powell, 2013), and negotiating the jurisdiction for nurse prescribing in hospital settings (Kroezen et al., 2014). In New Zealand CS methodology has also been used to examine complex clinical settings by Quirke (2011), who explored factors affecting the care of acutely unwell ward patients, and by Wilson and Barton (2012) in an intrinsic single case study to explore Māori experiences of hospitalisation.

The research on nursing values has predominantly used quantitative approaches, however there are a few exceptions that have used qualitative approaches. Zoboli and Schweitzer (2013), for example, wanted to understand which values frame and guide professional nursing practice. They conducted a meta-synthesis of works published in Spanish. Their results argue that nursing is a social and relational practice for Brazilian nurses and a tension exists between technical skills of nurses, healthcare organisations and ethics. In Australia, Drayton and Weston (2015) sought to understand and develop a shared vision for nursing. The aim of their study was to describe the experiences of nurses who employ professional development approaches in exploring values. Drayton and Weston (2015) employed a focus group design, 42 nurses from 14 hospitals participated in the research. The researchers found that emergent themes supported values based programmes, and exploring values with a group of nurses led to new perspectives on the nursing team and

on clinical practice. Much of the research on nursing values describes the development and validation of instruments to measure nurse values (Eddy, Elfrink, Weis, & Schank, 1994; Hoyuelos et al., 2010; Jiménez-López, Roales-Nieto, Seco, & Preciado, 2016; LeDuc & Kotzer, 2009; Martin et al., 2003; Mazhindu et al., 2016; Weis & Schank, 1997, 2000, 2002, 2009; Woodard Leners et al., 2006; Yeong Ok & Eun, 2015) (see Chapter 2, Literature Review). What quantitative approaches fail to take into account are the systems and situational context of clinical nursing practice. CS methodology was therefore considered an appropriate approach in which to capture contextual conditions of living nursing values in nurses' daily practice.

3.2.1 Early history of Case Study methodology

The history of CS methodology is rooted in the debate between the merits of quantitative and qualitative research (Daniel, 2007). Proponents of CS methodology contend that it is comprehensive, flexible and reliable (Simons, 1987, 2009; Stake, 1967a, b, 1978, 1994, 1995; Yin, 1993, 1994, 2003). The earliest forms of using case studies are associated with medicine, psychology and sociology. These case studies were used to explore individual patient cases and social conditions such as poverty, immigration, and unemployment (Freud, 1909; Tellis, 1997; Whyte, 1943). As researchers in the late 1960s early 1970s wanted to understand the effects of both social and education programmes, their research techniques relied on quantitative quasi-experimental and survey data (House, 1993). It became apparent that the results of these types of exploration failed to take into account the socio-political influences or the complexities of the programmes in practice, providing little evidence in support of, or change to, the particular programme (Norris, 1990; Simons, 1987, 2009). In the USA it was Robert Stake (1967b) who challenged education researchers, of the time, to broaden their thinking about research designed to evaluate, and to consider telling the story of the programme rather than discreet elements. Stake argued that little attention was given by researchers to describe “antecedent conditions and classroom transactions” (Stake, 1967a, p. 524). Naturalistic, ethnographic, phenomenological, holistic and biographic research methods influenced Stake's (1995) interpretation of CS methodology.

A classic example of the emerging field of CS research is MacDonald's (1971) work commissioned by the Nuffield Foundation (an independent trust fund) and the Schools Council (a non-profit organisation representing 1,2000 schools) to support schools teaching the humanities (as the United Kingdom [UK] prepared for raising the school leaving age from 15 to 16). MacDonald (1971) set out to explore how the humanities programme was implemented in each school. He did this by interviewing stakeholders, observing in classrooms, capturing images and exploring the general environment. He paid attention to the culture of the school, the staff turnover, staff experience and confidence, teaching methods, the relationship between staff and students and their engagement with the programme. It was the CS approach to the evaluation that gave MacDonald (1971) insight into the differences between schools and those working in them. He found that how the programme was enacted depended on the teachers' personal insights and how they perceived the programme priorities. MacDonald and Walker (1975, p. 2) assert that CS methodology portrays both the experience and milieu and "is the examination of an instance in action". Simons (2003) recognised Stake, MacDonald and later Walker as leaders in the development of CS methodology in the fields of evaluation and education and argues that their influence has permeated many professional fields. CS is now recognised as a study design that facilitates researchers to explore their interest in the particular case rather than on the methods of enquiry (Hyett, Kenny, & Dickson-Swift, 2014).

3.2.2 Criticisms of Case Study methodology

Critics of CS argue that small cases cannot be generalised and the findings from such studies lack reliability (McCurdy & Cleary, 1984; Tellis, 1997). Some authors question whether CS can be classified as a methodology (Meyer, 2001; Luck et al., 2006; Thomas, 2010). Flyvbjerg (2006, p. 219) notes that there are many sceptics of CS methodology in the field of social sciences, primarily because "social science is about generalising" and generalisations cannot be made from CS.

Hyett et al. (2014) critically analysed the methodological approaches of 34 published research projects using CS methodology. Their findings highlight that the flexibility of CS

design is a liability and can result in “haphazard reporting” therefore affecting the credibility of CS as a rigorous qualitative research approach (Hyett et al., 2014, p. 10). Choosing multiple cases may be a challenge; how do researchers decide for example how many cases are sufficient (Creswell, 2013). More than one case can potentially dilute the findings and provide less detail or depth of analysis. Rolls (2013) asserts that just because these types of studies can be uniquely bespoke and don’t necessarily lend themselves to replication it doesn’t invalidate them, in fact some of the most significant advances in psychology have come from one-off case studies.

Generally CS methodology is used to determine what is common and particular to the case, but it also highlights the prevailing uniqueness to each case. The individuality of the case is founded on the nature of the case, its distinctive history, the physical setting, and contextual influences such as, politics, culture and economics (Stake, 1994). To study the case fully a researcher may choose to gather data on all or some of the characteristics of the case as described above. Given the practical logistics of conducting research it is ultimately the researcher who will determine how long and what characteristics of the case need to be explored (Silverman, 2013; Simons, 2009; Stake, 1978, 1994, 1995; Yin, 1993, 1994, 2003, 2009). Stake (1994) argues that the individuality of the case is not universally appreciated and argues that there is a preference for theoretical development and generalisation that fails to acknowledge the value of the particular. It is, in Stake’s (1994, p. 238) opinion, a problem when theorisation and generalisation distract the researcher from focusing on the “features important for understanding the case itself”.

3.2.3 Types of Case Study

There are three types, or categories, of CS according to Stake (1995): *intrinsic*, to gain insight into a particular case; *instrumental*, to gain insight into an issue or refine a theory; and *collective*, where several cases are used to gain a collective understanding of the phenomenon or question. Stake makes these distinctions to assist in identifying the methods to be employed by researchers, however he recognises that rarely does research fit neatly into one category or another and in that sense he sees the categories as “heuristic” rather than “functional” (Stake, 1995, p. 238).

There have been other attempts to categorise CS type, for example Bassey (1999), Merriam (1998), Yin (2003) and Simons (2009). In the context of educational research Bassey (1999) categorises CS methodology as theory testing, storytelling, picture drawing and evaluative; whereas Merriam (1998) makes a distinction in relation to the presentation of the case, be it descriptive, interpretive or evaluative. In his early publications Yin (1994) described CS as descriptive, exploratory or explanatory. Over time Yin's ideas developed to take a broader approach to CS methodology, identifying two distinct elements. First the scope of the CS is concerned with investigating a phenomenon in a real world context, particularly where the boundaries between the phenomena and the context are not clear. Secondly, Yin (2003, p. 13) offers a technical definition, specifically stating that in the CS approach there are, "more variables of interest [to the researcher] than data points", therefore multiple sources of data need to converge in a triangulated fashion. As a result the case benefits from propositional development to guide both data collection and analysis. Simons (2009) proposes yet another categorisation of CS methodology, the ethnographic CS, with its origins in the fields of anthropology and sociology. This type of approach uses participant observation to achieve a close up description of the context. It differs from ethnographic research in that it can be conducted at different times in both familiar and unfamiliar cultures, whereas ethnographic research requires ethnographers to be immersed for sustained periods of time in the lives of their participants in the same culture so as to achieve meaningful and deep understanding (Vidich & Lyman, 1994). The ethnographic CS approach uses ethnographic methods, such as participant observation and interviewing. In using these methods this type of CS focuses on both the instance in action, as described above, whilst also gaining insight into the socio-cultural context (Simons, 2009).

The type of CS methodology used in this study was a collective case study as described by Stake (1995); that is essentially an instrumental case study (to gain insight into an issue) extended to several cases. The methods used (see Chapter 4) had ethnographic elements as described by Simons (2009). The cases provided insight into a phenomenon (nursing values). The cases (medical wards) play a supportive role and facilitate understanding of

nursing values and were examined in-depth to provide a comprehensive description of the phenomena of interest (nursing values) and the culture in which they were expressed.

3.2.4 Case boundaries

Stake contends that it was Louis Smith (an educational ethnographer) who first helped to define a case and he did so by arguing that a case is a ‘bounded system’, an object rather than a process (Stake, 1995). The idea of boundaries and a bounded system are considered to be one of the hallmarks of CS methodology (Merriam, 2009; Stake, 1995; Yin, 2009). The need for clear boundaries (geographical, time period, definition, and context) in case selection is also important in order to ensure that the study is practically achievable (Baxter & Jack, 2008; Miles & Huberman, 1994; Stake, 1995). Simons (2009) contends that it is wise to decide the boundaries of the case before the study commences and acknowledges that there may be a need to refine the boundaries once in the field, to reflect any unintended shifts. These shifts, as described by Simons (2009), could be politically influenced or simply undertaken because that the researcher needed to re-conceptualise.

The case boundaries for this study were geographical. Three medical wards, each in a different healthcare organisation, were identified as cases for the research. When designing the study there was much to consider in setting the boundaries. For example, whilst the general phenomena of interest was nursing values each case required a full and detailed exploration in order to fully understand nursing values in the context of the case, in this instance the medical ward (Patton, 2002). Thomas (2011) proposes that in many CS reports the researchers fail to adequately present their argument for the selection of the cases and the specified boundaries.

3.3 Triangulation

The term triangulation “has been used, abused, and misinterpreted” (Denzin, 2012, p. 85) since it was first advocated in qualitative research. Denzin proposed that triangulation was not merely the combination of qualitative and quantitative methods but was the use of multiple forms of evidence (Denzin, 1970). Sandelowski (1995) later argued that triangulation, as traditionally described, for example by Denzin (1970), is rigid and

meaningless. By this she meant the very notion of a triangle, the symbol of triangulation, is problematic. A triangle is two dimensional, flat and rigid and cannot capture complexities because, “what we see depends upon our angle of repose” (Richardson, 1994, p. 522). A crystal or kaleidoscope has been offered as alternative to the triangle because it offers ever-changing, complex and multiple perspectives (Flick, 1992; Richardson, 1994). Sandelowski (1995, p. 570) proposed that the term triangulation should be used only when “designating a technique for confirmation employed within paradigms in which convergent and consensual validity are valued and in which it is deemed appropriate to use information from one source to corroborate another”. I agree with Sandelowski’s perspective and took this approach to triangulation for this study.

There are four types of triangulation according to Denzin (1970, 1978) – data triangulation (the use of multiple sources of data); investigator triangulation (the use of several researchers); theory triangulation (the use of different perspectives to interpret or analyse data); and methodological triangulation (the use of multiple methods to study a single problem as in mixed method research¹³). Another type of triangulation described by Kimchi, Polivka, and Stevenson (1991) is data analysis triangulation where two or more approaches are taken to the analysis of the same data. Janesick (1994) added another type of triangulation; interdisciplinary triangulation, in an attempt to reduce disciplinary boundaries and advance both method and the substance of qualitative research. In undertaking this study I used, six sources of data, four methods of data collection, and different perspectives to interpret data. These are discussed in detail in Chapter 4.

The benefits associated with triangulation are increased confidence in data, and a “holistic and contextual portrayal” of the phenomenon of interest (Jick, 1979, p. 603). There is also the ability to present unique findings that may not be apparent when using one method of data collection; overcoming the scepticism associated with single method, single

¹³ There is a problem using the language of mixed methods and triangulation interchangeably as it risks rejecting mixed methods as a distinct research paradigm and diluting CS as a qualitative methodological approach. The advocates of mixed methods research (MMR) purport that the approach bridges two widely accepted methodological paradigms; that of qualitative and quantitative research (Johnson & Onwuegbuzie, 2004). Plano Clark, Creswell, O’Neil Green, and Shope (2008, p. 363) define MMR “as a design for collecting, analysing, and mixing both quantitative and qualitative data in a study in order to understand a research problem”.

perspective and lone analyst (Patton, 2002). The effectiveness of triangulation rests on the assumption that the weakness in any particular method is redressed by other approaches (Silverman, 2013). In fact different sorts of data may also yield different results which can be both “illuminative and important” (Patton, 2002, p. 556).

3.4 Research propositions

In line with CS methodology, as determined by Yin (2003, 2013), propositions are generally developed to help guide the research process. Propositions act much like hypotheses and offer statements of relationship and are often, but not always, present in CS methodology (Baxter & Jack, 2008). The discourse in the literature around the use of propositions is far from clear. For example, Yin (2003) argues that propositions direct the researcher to aspects of the study that require examination as part of the whole study, and that the propositions are generally how and why questions, as articulated by Morse and Field (1995) and do not convey what should be examined but lay out what interests the researcher. It is claimed that propositions increase the manageability of the research and therefore likelihood of completion (Baxter & Jack, 2008). In the early stages of this study I established four propositions that were derived, both from my exploration of the literature and my personal experiences as a nurse; these were intended to assist in the direction taken to data collection, the data collection itself, data analysis and possibly to form the foundation for a conceptual theoretical framework (Baxter & Jack, 2008). The propositions were: i) nurses’ personal values influence nursing practice; ii) there is minimal congruence between professional and organisational values, and those held by individual nurses; iii) healthcare organisations influence how nurses express their values in daily practice; and iv) nursing values have an impact on patient experiences. These propositions were highly influential in directing me to aspects of the study that required examination. They were used to guide early literature review and develop coding schemes.

3.5 Chapter Summary

Given my ambition to achieve a holistic understanding of nursing values, I chose to take a constructivist epistemological approach utilising CS methodology. It was determined that

a collective CS approach would provide comprehensive insight into nursing values. In this chapter attention was paid to the describing CS methodology, its history, strengths and weaknesses. Key elements of CS methodology were described; these included case boundaries and triangulation. This chapter established the rationale for the methods of data collection. The following chapter presents the methods that were employed on this study.

CHAPTER FOUR: METHODS

4.1 Introduction

In this chapter I first describe the study setting, preparation for data collection, challenges in gaining access, recruitment processes and sample selection. The data collection process is explained, with particular attention to the methods of triangulation. The approach taken to data analysis is presented and examples of the various stages of analysis are provided. Ethical considerations are critical to all research studies and the strategies I employed to achieve informed consent, confidentiality the protection of participants and adherence to ethical principles and professional codes of conduct are outlined. Reflexivity is critical in establishing rigour and I discuss strategies I employed to manage my dual role as researcher and nurse, along with the approaches taken toward establishing trustworthiness.

4.2 Study setting

The settings for this study were medical wards based in three different hospital sites in three different District Health Boards in the North Island of New Zealand. Site 1 was a major tertiary hospital, Site 2 was a secondary level hospital with no tertiary services, and Site 3 was a secondary level hospital with some tertiary services. The particular sites were chosen because managers were open and amenable to the study and to me as a researcher. The sites offered different perspectives because of the different levels: tertiary, secondary, and a mix of tertiary and secondary. The hospitals were also geographically distant, but not so distant that excessive time was taken up travelling. Stake (1995) recommends that a practical approach be taken to the selection of cases and advises selecting cases that are accessible and welcoming to the researcher and points out that, “case study does not depend on being able to defend the typology of the case” (Stake, 1995, p. 4).

On commencement of the study, I had planned for the inclusion of only two hospital sites. However, once data collection began at the first site, it became apparent that a third site would strengthen the study and offer further perspectives related to geography and culture

within New Zealand. Three sites provided an opportunity to learn and understand from multiple perspectives (Stake, 1995). In addition, as a consequence of my experience in the first hospital site, I elected to add a burnout survey¹⁴ to my data collection tools. The nurses in Site 1 were visibly tired, busy and stressed.

4.2.1 Access and gatekeeping

A number of steps were taken prior to gaining access to the sites. The process began by seeking institutional approval to undertake the study from each hospital Director of Nursing (DoN) or Chief Executive Officer (Appendix 1). Once approval was given, the DoNs from each site were asked to identify a suitable ward. Site 1 mandated separate approval from the hospital Māori Research Advisory Group, and Site 3 required locality agreement, which necessitated an additional ethical approval process. The additional approvals delayed the data collection process by four months. Once all approvals were achieved the DoN in each site presented my request to either, the Associate Director of Nursing for the area, or directly to the ward Nurse Manager (NM). Copies of the information letter were provided at each step in the process and I asked for these to be made available to the ward staff. The selection criteria stipulated that the ward be medical in nature and cater for a variety of patient groups and demographics with multiple levels of need and length of stay. Once suitable wards had been identified, the NM of each ward was contacted via email with regard to advertising the study and recruiting participants. All NMs were positive and supportive; I explained the data collection requirements and the predicted level of intrusion my study may have on the nursing team. Each NM showed me around the ward and invited me to attend a nursing team meeting to present the research to the staff.

The process, as described above, took nine months however this protracted length of time is not uncommon for this type of research design (Pereira de Melo, Sevilha Stofel, Gualda, & Antunes de Campos, 2014). Negotiating access concerns creating and building

¹⁴ The tool chosen was the Maslach Burnout Inventory a validated tool that has been used in a number of New Zealand nursing studies (Hall, 2001; Jasperse et al., 2014; Kumar, Fischer, Robinson, Hatcher, & Bhagat, 2007; Poghosyan, Aiken, & Sloane, 2009; Poghosyan et al., 2010).

relationships with gatekeepers and this is an “ill-defined unpredictable and uncontrollable process” (Wanat, 2008, p. 191). Wiles, Heath, Crow, and Charles (2005) argue that gatekeepers control and have power over the process of consent, therefore they can potentially influence participants’ involvement in the research. Gatekeepers have a critical role, can be formal and informal; both powerful positions that can either hinder or help the researcher (Lincoln & Guba, 1985). What is known from the gatekeeping literature is that there are two ways gatekeepers can influence a research study (Garrido, Zentner, & Busse, 2011). They can be purely facilitators of access (May, 2011; McGivern, 2013), or they can be critical players in establishing relationships that can shape a researchers understanding of the environment and the participants (Hennink, Hutter, & Bailey, 2011; Sanghera & Thapar-Björkert, 2008).

In this research gatekeepers included: district health boards; institutional ethics committees; hospital research committees; Māori consultation; directors of nursing; charge nurse managers; clinical coordinators; and senior nurses. These gatekeepers were critical players in forming relationships within the settings and highly facilitative in supporting access. I was required to go through several layers of gatekeepers in each hospital in order to gain access to patients and nurses. However, I was fortunate to have an established professional relationship with the DoNs in each site, hence their position as critical players in the process. Without established relationships, entering the field could have been excessively time-consuming with potential to end in failure (Silverman, 2013). The DoNs facilitated institutional approval; once formal approval to be on site was given, I then had to gain the trust and cooperation of the NMs and the nurses.

Organisational approval would have been meaningless without the support of the NMs who managed and organised the ward environment. I took a proactive approach and met with the NMs of each ward prior to the commencement of the study, to gain access and build relationships. Once I had an established relationship with the NMs they helped to facilitate access to the ward and introduced me and my study to the nursing team. I also attended nursing team meetings on each of the wards, where the team members were given the opportunity to ask questions about the study. The concept of access and consent are not

mutually exclusive therefore the principles of relational ethics guided my approach to both access and consent. These concepts will be discussed in detail later in this chapter.

4.3 Participant recruitment

The approach taken to identifying the participants for the study was purposive which is synonymous with qualitative research (Creswell, 2013b; Silverman, 2013). Purposive sampling, also known as judgmental, selective or subjective sampling, is the selection of research participants in a deliberative and non-random fashion to achieve a certain goal; it starts with a purpose in mind; the sample is selected to include people of interest and exclude those who do not suit the purpose (Suri, 2011). To enable me to understand nurses' values it was important to collect data from nurses and patients in a clinical setting, an environment where values are most likely to be enacted. The approach to sampling is dependent on the research context and research question. Denzin and Lincoln (2005) and Stake (1978, 1994, 1995) advocate for a pragmatic approach to sampling; Creswell (2013a) favours the inclusion of unusual cases in a collective case study because these allow for maximum variation; however my intent was to present nursing values in a 'real world context', in a highly complex and challenging clinical practice environment. Whilst there were differences between cases, the cases are typical; typical case sampling highlights what is normal or average and it is one of the distinctive typologies in purposive sampling (Miles & Huberman, 1994).

4.3.1 Nurse recruitment

As a nurse researcher I was familiar with acute clinical environments (as discussed in Chapter 1). I had a good understanding of the complexities nurses face in the clinical setting and the impact this could have on both recruitment and data collection. This knowledge was critical as I set about the recruitment of nurses.

All nurses on the ward were eligible to participate in the study. The only exclusion criteria were non-consent. This was particularly important in relation to observations; ensuring no observations took place where a nurse did not consent. Only one nurse declined to participate and she gave no reason for her decision. I made every attempt to recruit

participants who were representative of the nursing demographic, that is: newly qualified; experienced; New Zealand trained; overseas trained; and ethnically diverse nurses. However, I was limited to those nurses who were employed in the three wards; therefore any demographic representation was unique to the clinical area of medical nursing. At the presentation of the research nurses were given the research information package, which included details about the intent of the study and its relevance to nursing practice (Appendix 2), and an invitation to participate in the study (Appendix 3). My initial intention was to recruit nurses prior to observational data collection. However, this proved impractical, primarily because of nurse shift patterns. Therefore nurse recruitment took place prior to each period of observation (discussed in more detail in section 4.4).

4.3.2 Patient recruitment

All patients over the age of 18 were eligible to participate in the study. In order to participate patients were required to be cognitively able to give informed consent and if not, it was a requirement that they had a family/whānau member who were prepared to give assent (Black, Rabins, Sugarman, & Karlawish, 2010; Overton et al., 2013). It was my intention to achieve a broad sample representative of patients admitted to medical wards, including patients with acute and chronic diseases, mixed ethnicity, mixed gender and a wide age range. On admission to the ward patients were notified that a research study was taking place in the clinical environment. A number of strategies were used to notify patients, these included: a display of posters explaining the purpose of the study (Appendix 4); personally speaking to patients and family/whānau prior to and during each period of observation; and nurses informing patients about the study. Patients were given the research information package that included study details outlining the intent of the research and its relevance to nursing practice, along with an invitation to participate in the study (Appendix 5)

A number of factors made patient recruitment more difficult than was anticipated. These factors were the acuity of patients' medical condition, the proportion of patients with cognitive impairment, and the movement of patients either to another bed on the ward, to another ward or discharged home. Due to the nature of, and potential variation in, my ability to gain consent I adopted a strategy of process consent described by Dewing (2006,

2007). The process content method has five stages: background and preparation; establishing the basis for capacity; initial consent; on-going consent monitoring; and feedback and support (Dewing, 2007). Process consent was relevant to my patient recruitment because it identified the steps I took in my recruitment strategy and in turn consent strategy. Dewing (2006, 2007) rejects the traditional competency based approach to patient consent in favour of a situational approach that acknowledges a patient's capacity to consent. The day prior to observations I met with patients, spoke to them about my research, gave them consent forms and information sheets, (background and preparation). Prior to each period of observation I met with patients, established capacity, and reiterated what I was doing. If at that point patients didn't have study information (because they were recently admitted or transferred) I left information with them for a number of hours before returning to get initial consent. During the process of data collection I checked frequently with participants asking them; "*are you still okay for me to be here*" (on-going consent monitoring); and finally, feedback and support, where I offered feedback to the nursing team or NM on a patient's safety and or well-being.

Nine patients consented to observations only and 10 consented to both observations and interviews from across all sites. The primary reason for not consenting to be interviewed was the patients' clinical condition. Those patients who did not want to participate gave various reasons for this; some were feeling too unwell others, despite having had the study explained to them, stated that they didn't *want to get anyone into trouble*. No demographic data were collected from the observation only group; this observation data were recorded in field notes and used as part of data triangulation.

4.3.3 Family/whānau recruitment

Family/whānau members were also invited to participate in the study. In order to participate, the family/whānau member had to be over 18 years of age and consent to participate. When a patient was admitted to the ward, if present, family/whānau members were notified that a research study was taking place. Posters (as discussed above) were displayed in the waiting areas explaining the purpose of the study. Family/whānau received a research information package that was designed for both them and the patient.

I had anticipated that there would be a significant number of family/whānau who would want to participate in the study, however this did not eventuate and there were a number of reasons for this. Firstly, many patients' relatives were geographically distant and could not visit easily. Secondly, when a family/whānau member did visit they wanted to spend time with their relative, principally because of the acuity of the patient. Finally, due to the constant movement of patients it became problematic to find the family member who had consented to participate; as a result only two family/whānau members were finally recruited.

4.4 Data collection

4.4.1 Preparation for data collection

We are all participant observers in our own lives, what turns a normal life situation into qualitative data is the recording and analysis of it (Richards, 2009). On this premise, whilst I was waiting for institutional approvals, I prepared myself for observation data collection (which was a new research method for me) by sharpening my observation skills. I did this by paying attention to what was happening around me with particular emphasis on the interactions I had with service industries such as cafes and restaurants, and my personal experiences with nurses and doctors. For example I observed barista staff (coffee house employees) as they served coffee, the way they acknowledged or failed to acknowledge customers and how a simple smile related to a difference in a positive or negative customer interaction with them. Similarly I observed airline cabin crew interactions and the specific professionalism displayed within this service. Also, during personal encounters with health services I observed the differences between these and the commercial services. After each of the encounters I wrote my impressions in a journal as field note writing practice. What I found was with each encounter the focus of my observations changed which refined my observation and note taking techniques. I was mindful of my ethical and moral responsibilities to those who I 'practised' observing; this activity proved extremely valuable in preparing me for data collection and managing field-notes taken during observations.

4.4.2 Data collection strategies

The development of a robust research protocol is important in CS methodology as it helps define the data collection process and promote triangulation (Yin, 1993). However, as discussed earlier, even with a protocol the research design evolved and was modified over the course of the study¹⁵. When using CS methodology there is no set period of time when data collection should begin, it is during the researcher's preparation for undertaking the research that first impressions are created and these impressions are the foundations of the data (Stake, 1995). Stake proposes that as a researcher begins to formally explore the case(s) these first impressions are replaced with actual data, nevertheless, early observations and impressions were included in my study (Stake, 1995); that is my initial exposure to the clinical sites generated first impressions and these impressions were later developed in light of the data collected and became part of my field notes (see section 5.5.4).

Five discreet methods of data collection were undertaken: individual interviews; focus group interviews; field observations; documents as data; and survey. I had anticipated that the study would have three distinct stages: firstly observation of nurse-patient interactions and nursing activity; secondly focus groups and individual interviews with patients, family/whānau members and nurses; and thirdly document reviews. At Site 1 I set out to take this approach to data collection however, I soon realised that a more flexible approach was required to account for the reality of a complex clinical environment. This approach allowed me to enter into the data collection process and experience it in different combinations of ways as the circumstances of the settings allowed. This resulted in the linear three-stage approach to data collection described above becoming redundant. The actual data collection was highly fluid and flexible (Figure 1). For example, being present in the clinical environment was sometimes enough to prompt a nurse interview. This flexible approach allowed me to include the addition of a survey tool, *The Maslach Burnout Inventory – General Survey*, to capture burnout, cynicism and professional efficacy, when

¹⁵ Two amendments were made to the protocol; the inclusion of a third site and the addition of the Maslach Burnout Inventory.

I realised nurses were experiencing high levels of stress (the survey tool is discussed in greater depth later in this chapter).

Figure 1: Flexible approach to data collection

4.4.3 Interviewing (nurses, patients and family/whānau)

In preparation for the interviews I developed two guides, one for nurses and one for patients and for family/whānau members (Appendices 6 & 7). The interview guides were constructed after a critique of the Nursing Council of New Zealand (2012a) *Code of Conduct* the New Zealand Nurses Organisation (2010) *Code of Ethics* and the International Council of Nurses (2012) *Code of Ethics*. These documents were used as they share a common approach to the values that underpin professional nursing practice (Sellman, 2011b).

In the New Zealand codes there was an overarching principle, specific to the New Zealand context, Te Tiriti o Waitangi¹⁶ and the values of protection, partnership, and participation. I separated the values that were explicit or implicit in all three codes. Those that were

¹⁶ Te Tiriti o Waitangi (The Treaty of Waitangi) was an agreement between the indigenous population of New Zealand, the Māori people, and the British Crown (Theunissen, 2011). There remains clear social, economic and health disparities between Māori and European people in New Zealand (Ellison-Loschmann & Pearce, 2006). Professional nursing bodies in New Zealand are committed to addressing these disparities as evidenced in the fulcrum position of Te Tiriti in both codes.

common across codes were grouped under shared values. As an example, I initially decided the notion of being professional incorporated confidentiality (privacy), veracity (truthfulness), fidelity (faithfulness), responsiveness and compassion. Upon further reflection I felt it was more meaningful to align confidentiality (privacy), veracity (truthfulness), fidelity (faithfulness) to the concept of integrity and responsiveness and compassion to beneficence.

The alignment of the values that permeated all three professional documents are summarised in Table 2:

Table 2: District Health Board value alignment

-
- ***Respect***
 - ***Trust***
 - ***Partnership***
 - ***Being professional***
 - ***Justice*** (fairness)
 - ***Integrity*** to include confidentiality (privacy), veracity (truthfulness) and fidelity (faithfulness)
 - ***Autonomy*** to include human rights, culture, spirituality and self-determination
 - ***Beneficence*** to include active goodness or kindness, responsiveness and compassion
 - ***Non-Maleficence*** (doing no harm)
 - ***Guardianship*** of the environment and its resources
-

The one exception to alignment was guardianship of the environment and its resources, which was unique to NZNO (2010) *Code of Ethics*. The New Zealand guardianship of the environment rests with the Māori concept of Kaitiakitanga (Guardianship and sustainability). Following the identification of key values, questions were developed to enable exploration of participants' values in all three sites.

Interview guides (or protocols) provide a structured approach to assist the researcher to ask the same questions to participants (Kvale & Brinkman, 2009). However, the open-ended nature of questions allowed for individual responses from participants. There is a flexibility that can be applied to the interview process in determining the appropriateness of certain questions, as well as giving or seeking clarification and allowing for rewording as

necessary (Robson, 2004). This is considered to be a ‘semi-structured’ approach to interviewing. I had a predetermined set of questions but modified how I asked these depending on the context of the conversation and the engagement of the participant. This approach was not undertaken haphazardly; rather it was flexible and allowed me the freedom to probe participant responses. In many cases probes were unscheduled and improvisational, allowing participants to fully express their perspectives (McIntosh & Morse, 2015). Similar to Dearnley (2005), I valued the flexibility of the approach. Each interview was audio recorded and then transcribed.

“An interview is both the most ordinary and the most extraordinary of ways you can explore someone else’s experience” (Richards, 2009, p. 42). It is ordinary because it is nothing more than a conversation, and yet extraordinary because of the revelations that can ensue when someone shares their experience with the researcher. Richards (2009) cautions new researchers to be aware of thinking that interviewing is ‘primarily’ ordinary; if they do they will neglect extraordinary elements that surround interviewing, such as ethical approaches, good relevant questions and good note taking. The interviews with nurses took place where each nurse felt most comfortable; ranging from quiet nurses stations on a night shift to staff tearooms on the ward, to coffee shops. The nurse always determined the location. Many of the interviews took place on the ward (in staff tea rooms or designated interview rooms) where there were often interruptions; usually limited to a quick question from a colleague. When a nurse was being interviewed on the ward, colleagues facilitated the interview by caring for the interviewee’s patients or answering call bells or phones. Occasionally other nurses would come and sit near where the interview was taking place. These nurses were informed that there was an interview in progress but rather than leaving they often asked to join in the conversation/interview. Before the interview recommenced the matter of consent was raised with all those present. As written consent had been previously provided, those nurses who requested to join the discussion were asked for additional verbal consent.

A number of nurses thanked me for the opportunity to talk about and reflect on nursing, reporting that they found it therapeutic. Qualitative research is a “moral allegorical and

therapeutic project” (Denzin & Lincoln, 2005, p. xvi), the outcome of which might be therapeutic. Some researchers have reported on the therapeutic benefit of participating in qualitative research, but it is not common to do so (Lakeman, McAndrew, Macgabhann, & Warne, 2013; Russell, 2000). Therapeutic benefits were found as a result of the interviews with the patients and family/whānau, supporting Russell’s (2000) study that explored isolation of older people; she identified clear benefits for participants when they were able to make intimate disclosures during the interviews.

All patient interviews took place at the bedside. The patients wanted to talk about their health, family, worries and concerns, thus they were facilitated and as occurred in Russell’s (2000) study patients were empowered to attend to their personal agendas. In some instances their personal agendas dominated the conversation and it became apparent that some patients had little or no understanding of the research, but they were happy that someone was willing to listen to them. Rather than leaving these patients or stopping the interview (because they were pursuing a storyline that had little relevance to my study, for example, their thoughts about a particular family member and their choice of spouse, or moving incoherently from one topic to another), I continued to listen because it was what they wanted and I deemed it unethical to stop. These interviews were either not recorded or if they were they were later deleted. For these patients the interviews were wholly therapeutic.

It has been found that acting in a way that helps others has therapeutic benefit (Yalom, 1995) and helping others has been found to be more beneficial than being the recipient of help (Schwartz, Meisenhelder, Ma, & Reed, 2003), which may explain why one patient participant persisted with the interview despite being in severe pain. I stopped the interview a number of times but she urged me to continue; she said it helped her to help me; the desire to help was a powerful motivator for this patient (Russell, 2000).

4.4.4 Focus groups

Focus groups interviews have a long history in qualitative research, and were originally used by market researchers (Then, Rankin, & Ali, 2014). Interviews using this approach

allow researchers to gain insight into how people communicate with others and what people say in a particular context, producing data at individual, group and interactive levels (Cyr, 2016), and are particularly useful when used in a triangulated fashion (Hollander, 2004). Health researchers have increasingly adopted this technique as a means of understanding what a group of people think about a particular topic, be it chronic disease or nurses perceptions of their professional work (Burnham et al., 2014; Carlson, Rämgård, Bolmsjö, & Bengtsson, 2014).

Focus group interviews were conducted with nurses and senior nurses. I was particularly interested in nurses' individual thoughts and or any consensus on nursing values; interaction, whilst meaningful, was not the primary intent of the focus group interviews. One of the benefits of focus group interviews is that they are conversational in nature and help to reveal things about what and why participants think the way they do (Morgan, 1996).

I was conscious of the importance of giving all participants the freedom to express themselves away from any power hierarchy that may have had an inhibiting affect (Grønkjær, Curtis, de Crespigny, & Delmar, 2011; Krueger & Casey, 2000). It was for this reason that I conducted separate focus groups for registered nurses and senior nurses. The senior nurse focus group interviews were pre-arranged however, the nurse focus groups were not. It was more suitable to arrange a nurse focus group partway through a shift; this enabled both the shift coordinator and I to plan the best time to release staff.

There are many challenges to focus groups, not least of which is losing control and the purpose of the focus group because of the potential for strong personalities to clash (Pickard, 2013). I drew on my skills as an educator when facilitating the focus groups. I chose not to take an 'open' (Silverman, 2013) focus group approach, which allows for a flexible and free flow discussion. Rather I took a formal approach and used the interview guide to direct the discussion.

Each focus group was composed of a 'pre-existing' group that had shared experiences and familiarity with each other. This pre-existing nature of the groups provided a certain level

of comfort and an ability to overcome concerns about disclosure (Curtis & Redmond, 2007). However, disclosure was an issue for some and resulted in a restraint not to fully disclose because of those present. Gill, Stewart, Treasure, and Chadwick (2008, p. 293) note that disclosure may be more comfortable in groups where participants are strangers to each other; supporting the behaviour of participants in the nurse focus group where as a consequence of a level of 'cautious disclosure' some senior nurses and registered nurses followed up with me to clarify their point of view or indeed contradict what they said in front of their colleagues. There were also incidents in the focus groups where strong personalities attempted to dominate the conversation and cultural differences were apparent. I managed this in a number of ways: returning to the interview guide; thanking dominant personalities for input and opening up the conversation to others; and acknowledging cultural differences and diversity.

4.4.5 Observations

Observation data collection took place over a two-week period at each site. There are two main approaches to collecting observation data; participant and non-participant observation. In participant observation the researcher participates in the activity at the study site and is usually a member of the team which is being observed, the benefit of which provides an insider perspective (Creswell, 2013a). However, the participant role can also be distracting for the researcher and make it challenging to record data (Creswell, 2013a).

Non-participant observation was the approach I set out to use; and is defined as a technique where researchers observe consenting participants without any active participation with them in their field of activity/practice (Scott & Marshall, 2015). This approach is often criticised because of the Hawthorn Effect; the tendency for people to act differently because they know they are being studied (Chiesa & Hobbs, 2008). There are a number of commentators who argue that the Hawthorn effect is over emphasised, as most professionals are too busy to maintain a behaviour that is at odds with how they normally act (Chiesa & Hobbs, 2008; Mulhall, 2003; Parahoo, 2006). During my observation periods I found that once the shift started nurses were generally so busy that they were hardly aware

that I was observing them, they were more likely to treat me as one-of-them, unless reminded about the research.

As an outsider, who knew very little about the culture of medical wards, I felt non-participant observation was the best approach to take. However, there was a dichotomy in my role, as a researcher I was most definitely an outsider, nonetheless I was also a registered nurse. Because I was a nurse, participants actively engaged with me as a fellow nurse and treated me more like an insider. They did this by asking me clinical questions, in spite of my explanation of my role as a researcher; they all knew however, that I was an Intestine Care Nurse with a long career in nursing. Traditionally, an insider is considered to be part of the group under study; the researcher is already part of the group before the study commences (Bonner & Tohurst, 2002). An outsider, on the other hand, is not part of the group and is potentially free from bias that may be associated with group membership (Allen, 2004a). Given my encounters with participants I had to reconsider and vary my approach toward that of undertaking a combination of non-participant and participant observation, consisting of both an insider and outsider perspective. Creswell (2013a, p. 167) argues that as a “good quality observer, you may change your role during observation, such as starting as non-participant and then moving into the participant role and vice versa”. Taking this approach allowed me to observe nurses’ actions and interactions, including any antecedent or subsequent circumstances, and at the same time be recognised and accepted as one-of-them.

Observations are only as good as the field notes that are kept (Richards, 2009). Field notes are more than a chronological list of what has happened, they allow the recording of information in a systematic way that helps to develop understanding and analysis (Miles & Huberman, 1984). A number of authors offer various strategies to help synthesise field notes in order to improve their reliability (Miles & Huberman, 1984; Spradley, 1979). Factors that were taken into account included: the physical setting; the participants’ characteristics; the activity and interactions; frequency and duration of specific activities (for example time spent in drug rooms); triggering factors such as time of day or night; and factors that needed follow up (things that I did not understand, such as an acronym or

a process). For every period of observation I recorded both descriptive notes and reflective notes. My direct observations (Yin, 1999) captured events in real time as well as the context of the event.

Observation took place at various times over a 24-hour period during the two weeks spent at each site, and totalled 300 hours overall. Direct nurse-patient interactions were observed; this involved periods of observation in specific patient care areas as well as non-patient care areas, such as the nurses' station and other areas where nurses interact with patients and each other such as, medication administration or reading clinical notes. Initially I tried to keep the observation period to a defined set of time; this proved impractical as nurses, particularly on night shifts, wanted to talk to me about the study then and there, it was therefore logical to also conduct interviews as the opportunities arose and I took to carrying my digital recorder in my pocket ready to capture impromptu conversations/interviews. Withdrawing from the research field was challenging as I had developed relationships with the nursing teams; they became used to having me around and many nurses said they would miss me. In two of the sites I was offered a job on the nursing team.

4.4.6 Documents as data

Documentary analysis allows for a deeper understanding of organisational operations, priorities and the reality of the social world (Coffey, 2014). Whilst the analytical potential of documents has not always been recognised by qualitative researchers it does have a long history in both sociology and social sciences (Coffey, 2014). Early sociologists (e.g. Marx, Weber, and Durkheim) used documents "as part of empirical and theoretical practice", as did social scientists (e.g. Foucault and Bourdieu) (Coffey, 2014, p. 368). In nursing and health care, documents often capture interactions, actions, risk, performance and efficiencies. Nurse researchers have used documents to explore a multitude of areas such as: incontinence (Drennan, Norrie, Cole, & Donovan, 2013); cultural competence (Momeni, Jirwe, & Emami, 2008); risk (Higgins et al., 2016); and global nursing issues (Wong et al., 2015).

4.4.7 Burnout Scale

The decision to include a burnout scale was made following my first period of observation on Site 1. On this visit there was a palpable feeling of stress amongst the nurses, this feeling was validated when I attended a staff meeting and the nurses complained about how overworked and under-supported they felt. I sought and was granted an amendment of my ethics approval for the addition of The Maslach Burnout Inventory (MBI) scale (see Chapter 2 for a detailed discussion regarding the MBI). Chapter 2 also reported on considerable research using the MBI-HS. Given I was particularly interested in levels of cynicism and the nurses' relationship with the healthcare environment I opted to use the MBI-GS that measures exhaustion, cynicism and professional efficacy.

Permission to use the MBI was sought and granted by the publishers (Appendix 8). Nurses were asked to rank 16 statements of job-related feelings using a 7-point Likert scale from zero (never) to six (everyday). Once the nurses knew I was measuring burnout they were highly motivated to complete the survey and they actively encouraged others to do so and 43 nurses completed this. Nurses would seek me out to complete the survey and then would take the time to talk me through their answers, or ask me for their burnout score¹⁷.

4.5 Data analysis

Analysis of data, when using CS methodology, is complex and there are many pitfalls for a novice CS researcher. The process for analysis case studies is the least developed aspect of CS research (Yin, 2013). Yin (2003) maintains that analysis is dependent on the analytical approach/style of the researcher, and this is a skill that takes time and experience to develop. Furthermore, researchers are cautioned by Denzin (1994, p. 500) to remember; "there is only interpretation. Nothing speaks for itself", therefore it is up to the researcher to tell the story. "By handling the data records sensitively, managing them carefully and

¹⁷ Knowing their burnout score confirmed or rejected their felt belief about how burnt out or not they were.

exploring them skilfully, the researcher ‘emerges’ ideas, categories, concepts themes, hunches, and ways of relating them” (Richards, 2009, p. 74).

The process of data collection, data analysis and writing up are not discreet steps, each step is intertwined with the other (Creswell, 2013b) and the sheer volume of data generated in CS can be overwhelming (Patton, 1999). The data set from Site 1 were analysed initially; thematic analysis of individual and focus group interview data was carried out, descriptive statistics were used in the analysis of the demographics, that is, patient and staffing numbers, and the MBI field notes and documentary data were used to support emerging themes.

A coding scheme was developed following analysis of Site 1 (Richards, 2009; Saldaña 2015). According to Yin (2009) the analysis stage also relies on propositions and these were used to augment the coding scheme. Sites 2 and 3 were then analysed using the coding scheme, at the same time as reanalysis of Site 1. This enabled me to manage data without becoming overwhelmed by the sheer amount. The analysis of Sites 2 and 3 (and reanalysis of Site 1) were integrative with the application of the theoretical frameworks of Stein and Menzies (Figure 2).

Figure 2: Analytical approach to data analysis

4.5.1 Focus group and individual interview data analysis

Interviews and focus group data were audio-recorded, transcribed and thematically analysed following a combination of approaches as described by (Braun & Clarke, 2006; Creswell, 2013a, b; Creswell & Miller, 2000; Richards, 2009). Transcribed data were stored in word documents with all lines numbered to enable easy location of data extracts. To manage the volume of data my first step in data analysis was what Richards (2009) describes as descriptive coding. It is used as a categorisation technique for further qualitative data analysis. Descriptive coding summarises in a word or noun the basic topic of a passage of qualitative data. Prior to that initial coding was carried out using a word or short phrase taken from a section of the data; that is a word or short phrase from the actual language found in the transcribed qualitative data; that is thematic analysis started with analytical coding; aggregating data into small categories (Creswell, 2013b; Richards, 2009). To facilitate this I used colour coding as a means of identifying patterns and themes Appendix 9 provides an example of early coding using this approach. Following coding on hard copy I transferred these codes to my word document system (Appendix 10: example of later coding). In the reporting and naming the data sources a coding scheme was developed, for example Field Note S1D5 235. Field Note refers to the source, S1 refers to the site, D5 refers the Day 5 of observation and 235 refers to the line from notes. Other codes used were, N3 (nurse 3), P1 (patient 1), NFG (nurse focus group), SNFG (senior nurse focus group), NM (nurse manager) and NE (nurse educator).

The approach to analysis was iterative, initially inductive and later deductive. Inductive analysis was the process of coding data without trying to force data into a pre-existing coding framework of my own preconceptions (Braun & Clarke, 2006). I listened to and read all data, noting my thoughts in my research journal or on the transcript. I revisited the data multiple times and advanced my thinking from that's interesting, to why it was interesting, and then to why a study on nursing values benefits from the *interesting* thing; Richards (2009) describes this approach as reduction. As data patterns emerged I categorised and organised the information to make sense of the patterns and develop themes; then, as Simons (2009) advises, I judiciously selected the evidence to represent the emerging story. I then began to reflect, shape and test the developing coding scheme

deductively. This produced descriptive rather than interpretive themes (Vaismoradi et al., 2013) and was an intentional strategy. It was in the latter stage of analysis that Menzies theoretical perspective of defence against anxiety was applied.

Computer assisted analysis of qualitative data (CAQDAS) was considered as it is argued that this provides a robust audit trail (Shaw, 2013), however, regardless of the technique adopted for coding data (manual/word processing/CAQDAS), the process is time consuming (Creswell, 2013a). There is value in CAQDAS but the same integrity of the audit trail can be achieved by using word processing technology (Creswell, 2013a; Silverman, 2013). I did not employ CAQDAS and used a variety of other strategies as described above.

4.5.2. Burnout Scale data analysis

Survey data were analysed using descriptive statistics. There are three sub-scales in the survey, exhaustion (Ex), cynicism (Cy) and professional efficacy (PE). In measuring Ex there is reference to general fatigue, including the depletion of emotional energy. Cy reflects indifference or distancing attitudes. PE is similar to personal accomplishment, however additional aspects of social and non-social occupational accomplishments are also measured (Maslach et al., 1986). Together these three elements (Ex, Cy and PE) provide a three-dimensional view of burnout. I totalled each element using the coding scheme designed by Maslach et al. (1986). High total scores in Ex and Cy and a low score in PE reflect a high degree of burnout. No further statistical testing was undertaken on the burnout data. There were two reasons for this firstly, the descriptive approach was recommended by Maslach et al. (1986), and secondly the data were being used in the triangulation of data and not in their own right as in survey methodology or mixed method research.

4.5.3 Document analysis

Documents were used in the triangulation of data (Banik, 1993; Denzin, 2012; Flick, 1992; Jick, 1979; Kimchi et al., 1991; Mitchell, 1986; Shih, 1998; Thurmond, 2001). The document review included the following: hospital value statements and or vision/mission statements or philosophies; ward values statements and or vision/mission statements or

philosophies; models of care; ward communication books including ward demographic data; nurse patient ratios; nursing turnover; and nurse sensitive patient indicators. The professional body Code of Ethics and Codes of Conduct were also reviewed and, as discussed earlier, were used in the construction of interview guides.

Documents were examined in relation to their place within the organisational setting, the cultural values attached to them and the form that they take (Atkinson & Coffey, 1997). Documents reviewed in this study provided context, background information and insight. Reviewing nursing turnover for example helped to build and picture of the cultural stability of the wards. Information gleaned from the documents helped to focus the interview question. Documents were also used to supplement and verify other data; economic pressures were articulated by nurses and captured in written messages from management. This approach to document analysis is advocated by a number of authors (Atkinson & Coffey, 1997; Bowen, 2009; Coffey, 2014).

4.5.4 Cross-case analysis

Cross-case analysis was conducted early in the analysis stage of the study. Yin (2003) has argued that the benefit of multiple cases is that they add to the robustness of the study, however the process of undertaking cross-case analysis is not well documented. When a cross-case analysis is presented in the published literature it routinely presents the similarities or difference in emergent themes (Creswell, 2013a; Jack, Oldham, & Williams, 2003; Sandars, Langlois, & Waterman, 2007; Shiu, Lee, & Chau, 2012).

The analytical approach was multileveled (Figure 2 above) which demonstrates the iterative nature of the analysis. As patterns emerged Menzies (1960) social systems, as a defence against anxiety, was identified as the primary theoretical lens. Each defence mechanism described by Menzies was used to explore the data in a triangulated fashion. By this I mean I examined the initial coding for patterns and similarities in the data that were examples of defence mechanisms as described by Menzies. For example, one of the defence mechanisms identified by Menzies was splitting up the nurse-patient relationship;

I then examined the themes that had emerged during cross-case analysis for secondary anxieties (Menzies, 1960) and contemporary anxieties as described by Cooper, (2010).

4.5.5 The significance of triangulation

In order to develop a full and rich description of the phenomenon under study, CS methodology allows the researcher to draw on multiple sources of data (Gangness & Yurkovich, 2006; Patton, 2002) resulting in data triangulation, as described in Chapter 3 section 3.4. There were two particular ways triangulation was employed in this study; in the planning and design phase; and in the analysis phase. Method triangulation was utilised so that the situation and phenomenon could be fully explored and the strengths of one method could compensate for the other. Gangness and Yurkovich (2006) maintain that each source of data in isolation holds both positive and negative attributes but when used collectively they strengthen the case study significantly. In the analysis phase I employed cross-case data triangulation. As Baxter and Jack (2008, p. 554) note, data “convergence adds strength to the findings as the various strands of data are braided together to promote a greater understanding of the case(s)”. Data triangulation led to a detailed examination of both the phenomenon and the context under investigation and added to the overall rigour of the study.

4.6 Ethical considerations

Te Tiriti o Waitangi recognises the Māori people as tangata whenua (indigenous people) of New Zealand and Māori consultation was sought along with ethical approval, thus ensuring participation and partnership and protection of the pervasive principles of Te Tiriti. However, New Zealand has a diverse population, as does the nursing profession, and when taking a purposive sample it was important that Māori, as well as other cultural groups, were represented:

In the research context, to ignore the reality of inter-cultural difference is to live with outdated notions of scientific investigation. It is also likely to hamper the conduct of research, and limit the capacity of research to improve human development and wellbeing. (National Health and Medical Research Council, 2003, p. 3)

The New Zealand Health and Disability Ethics Committee (HDEC) (Appendix 11) granted ethical approval. Additionally, locality agreement¹⁸ was sought in one site, and in another site¹⁹ a Research Advisory Group Māori or representative was consulted. As part of the Māori approval process I attended approved cultural training with a District Health Board Whānau Care Services.

Particular detail was supplied to HDEC with regard to the challenges undertaking research in an acute clinical environment, the provisions taken to protect the anonymity of participants, and provisions to allow participants to withdraw. When I added a third site, and the MBI, permission for inclusion of these was sought and granted by the HDC, I also notified the University Ethics Committee of my updated HDEC approval.

It was my responsibility as a researcher to ensure participants gave their informed consent. The following were some of the ways that I did this:

- All participants were given detailed information about the study and its intended outcomes. Participants could withdraw from the study at any time without prejudice.
- All data gathered in the course of the study was stored securely, paper documents were locked securely in my office, all electronic data was password protected.
- No organisation or participants are identified in the research. The data has only been reviewed by myself and academic supervisors.
- The transcriber signed a confidentiality agreement.

As part of the observational phase of the study there was the possible risk of witnessing unethical behaviour in clinical practice. Observing unethical or unsafe care may require the

¹⁸ Locality agreement is a particular process to ascertain if all local governance issues have been address at the participating site.

¹⁹ One site had a Research Advisory Group Māori. To attend to the needs of Māori in the other sites I elected to consult with Toihuarewa the Māori academic forum within Victoria University of Wellington. Toihuarewa operates from a base of tikanga and kaupapa Māori, acknowledging partnerships with mana whenua, tangata whenua, staff and students. Toihuarewa offered their full support and I met with a leading academic to discuss the research and potential implications for Māori.

researcher to make decisions regarding possible intervention causing internal conflict between the researcher and clinician positions. This conflict was described in detail by Kayser-Jones, Beard, and Sharpp (2009) in their CS research on nursing home patients dying from stage IV pressure ulcers. These researchers witnessed inadequate delivery of care²⁰ that was so distressing that some of the research team had to withdraw from the data collection process. Others in the research team remained and felt it was important “to continue to collect and report data that could have a wide impact than to try to improve care on a case-by-case basis” (Kayser-Jones et al., 2009, p. 42). I understood the distress described by Kayser-Jones et al. (2009) as I too felt profound distress when I witnessed poor care. I intervened when I felt ethically there was no other option:

I'm at the nurse' station now and a patient with dementia has walked in with a walking stick and he banged it down on the station and is shouting. One of the nurses tried to wrestle the stick from him and the coordinator told her back off. The coordinator rang security "we need help up here there's a patient with a weapon". I spoke to him [patient] asking if he was okay. I told him that he was frightening some of the staff would he like to give his stick to me he said yes that's fine. I chatted to him and walked him back to bed. As I was walking him back I discovered that his wife had been admitted to hospital and he was quite concerned about some of his medication that he'd been on. (Field Note S3D5 25)

Had I not intervened in this situation the outcome may have been very different, as the security team arrived to restrain a patient with what she said was a weapon. My impression of the situation was that this man was frightened and needed to be listened to. In all circumstances I was guided by my professional and moral obligations as a nurse (International Council of Nurses, 2006; NCNZ, 2009, 2012). When necessary I sought the guidance from the NM on how best to proceed with a particular situation.

4.6.1 Informed consent

Since the Nuremberg Code (1949) obtaining informed consent is a fundamental requirement for all human research. Principle 1 of the Code affirms that “the voluntary

²⁰ Inadequate care consisted of patients not being assisted with meals, begging for water, left in soiled and wet bed linen, lying in bed for prolonged periods, not receiving oral hygiene or pain medication.

consent of the human subject is absolutely essential” and principle 9 relates to the right of the ‘subject’ to withdraw at any stage. These principles permeate all contemporary research practices. Consent is therefore voluntary in nature but must be given by people who have the capacity to understand whether they should participate or not (Schrems, 2014). This is not always possible due to clinical conditions of patients (Schrems, 2014). The nature of the acute health issues of patients admitted to medical wards means they are considered to be ‘vulnerable’. Defining what is meant as vulnerability is problematic (Hurst, 2008, Martin, Tavaglione, & Hurst, 2014; Ruof, 2004) however, based on my clinical knowledge I deemed all patients on these wards to be vulnerable and employed a process consent approach, as described earlier.

Relational ethics also guided the consenting process. A number of authors offer relational ethics as way forward for protecting vulnerable patients (Bergum & Dossetor, 2005; Gadow, 1999; Larkin, de Casterlé, & Schotsmans, 2008; MacDonald, 2007). Relational ethics accounts for the vulnerability of the person and the context they are in (Schrems, 2014), such as: mutual respect; engagement; embodiment; and environment, which are critical elements of relational ethics (Bergum & Dossetor, 2005). These elements offer a holistic approach to vulnerable patients and indicate a reciprocal relationship with the researcher (Schrems, 2014). Gjengedal et al. (2013) argue that vulnerability is an existential, contextual and a relational phenomenon, stating that way in which we meet people is critical in our understanding and experience of vulnerability. In relational ethics the ethical principles such as, beneficence, non-maleficence and autonomy are interwoven with principles of virtue, duty, rights and consequence; emphasis is placed on the integration of the principles but more importantly the enactment of the principles (Kunyk & Austin, 2012). The integration of ethical principles and virtues was the reason that relational ethics guided the consent and data collection process.

Prior to any data collection, participants were asked to sign a consent form (Appendix 12). The consent form had a clear statement on the voluntary nature of participation and the right to withdraw from the study at any time. It was vital to explicitly state the voluntary nature of the research as it maintained the integrity and transparency of the research process

(Richards, 2009). Nurses consented at various stages. Some consented after I presented the study at the staff meetings. However, this was problematic because of shift patterns and leave, which resulted in many of these nurses not being present during the observation phase of the data collection process. I therefore had to consent nurses at the beginning of their shift and prior to any observations taking place. These nurses already had prior knowledge of the study and had had time to consider their involvement.

As described in section 4.3.2 process consent was applied to the patient consenting process. There were a number of challenges in gaining patient consent. Where a patient was unable to consent to the observation phase of the research, due to mental or physical impairment or level of acuity, and if a family/whānau member was unable or unavailable to give assent, they were not observed. Patient turnover was high and this resulted in patients being moved frequently. For example, I could consent a patient one day and find the next day that they were transferred to another bed on the ward, to another ward or discharged. Reasons for patient movement varied from, requiring the bed for a new admission to a change in the patient's condition that meant they could or should be moved to a different area of the ward or out of the ward all together.

4.7 Reflexivity

Reflexivity refers to the researcher positioning and relates to the degree of researcher influence (deliberate or not) on the research findings. It is considered by many to be a vital aspect of rigorous and critical research (Cassidy, 2013; Darawsheh, 2014; Kingdom, 2005; Koch, 2006; Smith, 2006). It is a process that enhances the quality of research as it directs the researcher to extend their understanding of how their personal positions and interests affect all stages of the research process (Primeau, 2003). In order to be truly reflexive researchers must function on numerous levels (Pickard, 2013); and there is a balance that must be achieved between self-indulgence and an awareness of what the researcher brings to the field.

My position and role in the field (in each medical ward) was presented by the DoNs and NMs. They presented me as a researcher from “Victoria University” with a long career as

an Intensive Care Unit (ICU) nurse. This set up expectations from the nursing team and created a number of challenges for me, for example: a nurse and a new graduate nurse had taken an ECG [electrocardiograph] and they were unsure about reading it, there was nobody around for them to liaise with so they approached me for an opinion; another example was a nurse asking me to clarify the procedure for platelet administration. To manage these types of situations I adopted the position of a nurse who was new to the area of medical wards but someone with nursing experience. This allowed me the scope to say, “I think you should check with someone else”. It was fine line to walk between supporting nurses and wanting to stay detached as a research observer. My “dual practitioner-researcher identity” (Allen, 2004a, p. 15) was at the forefront of my mind throughout the fieldwork and there was a dissonance between my responsibilities as a researcher and those of my role as a professional nurse. Others have been similarly confronted with these conflicting roles and what to do when a patient is in need, or when witnessing poor care and how any potential intervention could influence the research (Kayser-Jones et al., 2009; Wilkes & Beale, 2005). There were times during the fieldwork where I witnessed unsafe practice and had to intervene. In these instances not intervening would have been unethical and potentially dangerous:

I’m in the drug room now with the staff and the new graduate wants to give medication attached to a chart. It’s attached in a transparent little plastic bag and she thinks its paracetamol. She asks another nurse who’s in there with her what she should do, the other nurse says “it’s up to you if you want to give it, are you comfortable that it’s paracetamol. It’s your decision but I would do it, I would give it”. She makes a move to leave the drug room with the unknown tables, I stop her and ask her “are you 100% sure you know what that drug is?” she says no, I tell her “you can’t give it then.”
(Field Note S2D2 190)

The work of Alan Peshkin (1988) was instrumental in my thinking about reflexivity. Peshkin (1988) articulated the need for the researcher to identify their subjectivity throughout the course of their study, searching for their subjective “I”. Many researchers claim that subjectivity is present in their research; however this is not necessarily a conscious process, relying on insinuation rather than clearly stating their position (Peshkin, 1988). Bradbury-Jones (2007) applied Peshkin’s ideas about subjectivity in a study exploring the meaning of empowerment of nursing students. She identified a number of

subjective positions, *the paladin I, the maverick I, the impatient I* and *the pragmatic I* and argued that this approach adds to the rigour of research; is applicable across multiple setting; and is a flexible approach for researchers to take.

The strategies I employed to manage my subjectivity was a conscious focus throughout the research process captured in my research journal and field notes. Meeting with my supervisors also helped to both identify and manage my subjectivity. I found, during the course of data collection (particularly the observation period) that I was judgmental about what I was witnessing. My judgment was framed in two ways, as a nurse and as a researcher. I was living simultaneously in two worlds, the ‘outsider’ (researcher) and the ‘insider’ (nurse).

4.7.1 The nurse ‘I’ judgment

I have been a nurse for over 20 years and have opinions about the professional appearance and comportment of nurses. My perspective is influenced by my values, nursing education, professional codes of conduct, and clinical role models (those nurses who I aspired to emulate). I therefore found it particularly challenging when I witnessed something that I thought did not reflect well on the profession:

Nurse X is sitting in a big chair [in the patient area] and I can’t say this in a gracious way but she’s not sitting in it, she’s slouching down in it and she has her feet up on another chair and despite my impressions of her as a professional nurse this is completely, in my opinion unacceptable and I’m trying not to be judgemental but I expect professional standards and this is just pure lazy. (Field Note S1 D1170)

I was not surprised about my judgement of this particular nurse, my ideas of professional appearance and professionalism are deeply held. However, I was a little shocked by how firmly these ideas were embedded in my views about what it means to be a professional nurse. Another example was when a nurse wore the same gloves between patients:

The nurse came out of a clinical area wearing her gloves and pushing a wound trolley and proceeded to assist with another patient. I couldn’t help noticing that she’s still wearing the gloves when she left the other clinical area, the same set of gloves she hasn’t changed them or washed her hands. I can’t believe it, what is she thinking. (Field Note S1D3)

I reflected on this particular incident many times before fully letting it go:

It's really frustrating, as I can't say anything. I have to remind myself that I'm an observer here. I am not here to judge anyone or change their practice. I am here to conduct a study about nursing values that is it. Let it go! (Reflective journal 7/7/2012)

I became aware of my judgments as the data collection progressed and commented on it to my supervisors who cautioned me on subjectively and objectively; I took some time to fully step back from my judgmental stance. Through a thoughtful awareness of my hypercritical positioning, I was able to acknowledge it and move forward with my research. When I came across what I considered poor professional standards I documented these (taking a reflexive position) and, if necessary, liaised with the NM. By taking such an approach, I was not distracted from my research focus.

4.7.2 The researcher 'I'

Another aspect of my subjectivity centred on my role as a researcher and my technical skills as an interviewer. My approach to patient interviews changed very quickly, I noted that:

I got consent for two patient interviews, what a disaster. The first interview lasted about 15 minutes with interruptions!! (Research journal 17/6/2012)

I could not understand why the interview had gone so terribly wrong, as a matter of urgency I met with my supervisor:

I met Kay for lunch and she gave me some ideas in how to open up the questioning, so I went back to my office and wrote up prompts. I then went back to the ward and interviewed a patient and her daughter using prompts. Wow what a difference, it was the break-through I needed as my confidence was beginning to go. (Research journal 17/6/2012)

This is an example of how I refined my skills by thinking through the issues and formulating a plan to rectify my mistakes, but also recognised the acuity and complexity of patients admitted to medical wards. During data collection, I reflected on how I was collecting data and began to think about how it could be analysed:

Thinking about frameworks! There are some basic assumptions about what is right, good, desirable and motivates professional behaviour. (Research journal 28/6/2012)

I also began to notice patterns in what I was seeing and it was these patterns that led to the approach taken to data analysis. However, I was cautious not to let early patterns direct the

study and achieved this by analysing each case separately before cross case analysis was conducted.

4.8 Rigour and trustworthiness of the research process

Rigour, validity and objectivity of the findings are critical elements of a positivist paradigm and in constructivism researchers look for the trustworthiness and authenticity of the findings (Lincoln, 1992). There is no universally accepted approach to the validation of qualitative research. There are multiple perspectives (Lather, 1993; LeCompte & Goetz, 1982; Lincoln & Guba, 1985, 1986) on rigour in qualitative research; these include definitions, descriptions and procedures for establishing rigour (Creswell, 2013a, p. 244). According to Morse (2015) the preeminent approaches to rigour (credibility, transferability, dependability and conformity), as described by Lincoln and Guba (1985), have changed minimally over subsequent years, apart from their operationalisation. Rolfe (2006) argues it is improbable that there can be any agreement on validation strategies in qualitative research because there is no single theory, method or methodology that has been established to support this. Creswell (2013a) and Rolfe (2006) offer some help in this regard by recommending that a minimum of two strategies be employed in a research study, arguing that researchers take a pragmatic and cost effective approach. A number of approaches to rigour described by Lincoln and Guba (1985) were applied in this study, these were: credibility; transferability; dependability; and conformity. These approaches are in keeping with naturalistic enquiry and appropriate when there has been an engagement in “the field” as well as the triangulation of data (Creswell, 2013a).

4.8.1 Credibility

Credibility refers to the extent that research claims are evidence based and can be trusted (Silverman, 2013) and paint an accurate picture of the phenomenon (Shenton, 2004). Lincoln and Guba (1985) maintain that credibility is a capstone in establishing the trustworthiness of a research study. Using methods that are well established and the correct operational measures for the concepts being studied help to ensure credibility (Yin, 1994). In achieving credibility when using CS methodology Yin (1994) advocates a number of

approaches. Including, using multiple sources of evidence, that is triangulation (as described earlier in this chapter and in Chapter 3); the evidence collated in this study was derived from individual interviews; focus group interviews; field observations, documents as data; and survey; establishing a chain of evidence. I did this by keeping detailed field notes as well as a research journal. Having key informants review findings was another approach I used; my relationship with nurse participants allowed an opportunity to discuss my interpretations with them. This process is often referred to as ‘member checking’, or ‘respondent validation’ (Richards, 2009) and I actively sought peer scrutiny throughout the research process. Provisional findings were presented to a number of nursing and non-nursing groups, their feedback supported the credibility of these, and many of the results resonated with them. I also asked an independent expert in medical nursing to review my findings chapter the content of which reflected their own experiences. Both my supervisors read transcripts of interview, focus group and field notes data and reviewed coding strategies and emergent themes in the early stages of the study. I also had frequent debriefing with my supervisory team who offered their own particular lens resulting in a widening of my own (Shenton, 2004).

A familiarity with the culture of the study site and establishing relationships can foster credibility (Shenton, 2004). There is a view that prolonged engagement with participants prior to data collection enhances co-operation and trust (Lincoln & Guba, 1985); but there is a risk that this approach will unduly influence and affect the researcher’s judgment (Lincoln & Guba, 1985). I did not have a ‘prolonged engagement’ with the sites, preferring to have a number of introductory meetings so as to not place undue time pressure on participants in each of the sites.

Thick description enhances credibility because it conveys the ‘actual situation’ and allows those who read the research to make decisions about its transferability to other settings (Creswell, 2013a; Lincoln & Guba, 1985; Merriam, 1998). Thick description requires a complete description that relays the actual phenomenon that has been investigated as well as the situational context in which it exists (Creswell, 2013a). Within this thesis I have given considerable attention to describing the cases, where in CS methodology thick

description encompasses looking at the rich details, complex layers, and the structure of the social world of the cases, therefore ensuring that readers can get a strong sense of how nursing values are enacted in medical ward settings.

4.8.2 Transferability

In a positivist paradigm there is a significant amount of attention given to the transferability of research findings and whether they can be applied to the wider population (Silverman, 2013). In CS research the focus is on the case or cases, and presenting the phenomenon in a real context. Although each case might be unique, Stake (1994) argues that it is also an example of a broader group, therefore transferability cannot be wholly rejected. The findings of this study do not claim to reflect how values are enacted or lived for all nurses practicing in medical ward environments. However, the degree of transferability lies in the similarities between the findings and other settings (Lincoln & Guba, 1985). Having explored the contextual representations, the responsibility to determine similarities rests with the reader (Fingeld-Connett, 2010; Shenton, 2004). To facilitate the reader I have provided considerable detail about the methodological approach, methods employed and findings that provide contextual information and rich description.

4.8.3 Dependability

Dependability refers to the ability to replicate the study, “if the work were repeated, in the same context, with the same methods and with the same participants, similar results would be obtained” (Shenton, 2004, p. 71). Other researchers may not share my interpretations, however they should be able to understand how I came to my decisions. A clear audit trail captures the rationale for methodological decisions, as well as contextual data (Ryan-Nicholls & Will, 2009). In explaining and describing my decision-making toward methodology and method others will be able to apply a similar approach should they choose to.

4.8.4 Conformity

Critical elements of conformity are credibility, transferability and dependability (Lincoln & Guba, 1985). Conformity refers to how interpretations have been arrived at and refers to

both neutrality and accuracy of the data (Houghton, Casey, Shaw, & Murphy, 2013; Koch, 2006). In ensuring conformity the researcher must make assurances that research findings reflect the participants and not the researcher (Shenton, 2004). To ensure there is no researcher bias the researcher must 'up front' their perspectives and world view and be mindful of their influence on the research. There were two particular ways I managed my bias, through reflexivity and the examination of the subjective I.

4.9 Summary

In this chapter, I have described the setting for the study and addressed the strategies taken to gain access and recruit participants. The study was conducted in complex rapidly changing medical ward environments; this required a flexible approach to both the recruitment of participants, methods of data collection and analysis. The influence of these circumstances on the rigour and trustworthiness of the study findings was discussed. The analysis of data was iterative and this process was reflected in the analytic approach taken. Examples have been given of each stage of the analysis and the process of triangulation has been explained. Thematic analysis was conducted across cases. Menzies' social systems as a defence against anxiety and Stein's phenomenological theory of motivation and value were identified as the theoretical lenses and applied in the cross-case analysis. Ethical compliance included informed consent and maintaining confidentiality, honesty, and integrity throughout the study. Reflexivity was a key strategy employed to ensuring rigour and trustworthiness.

CHAPTER FIVE: FINDINGS AND DISCUSSION: THE CHARACTERISTICS OF THE CASES

5.1 Introduction

This chapter is the first of two findings and discussion chapters; in keeping with CS methodology literature is interwoven with findings. In the first of these findings chapters I discuss the characteristics of the cases; in the second findings chapter I present the themes. Both chapters emerge from cross-case analysis. The key characteristic of the cases are presented in this chapter; these include: the physical layout and aesthetic of the wards; nursing handover processes; and the models of care used. In the second part of this chapter the patient profile, family/whānau characteristics and patient and family/whānau experiences are discussed. The themes that emerged from patient and family/whānau data include: needing to tell their story; the busyness of nurses; experiences of being moved; important nurse characteristics; and negative conceptions of nurses.

5.2 Case characteristics

Each case comprised one medical ward located at one of three hospital sites. Site 1 was a major tertiary hospital, Site 2 was a secondary level hospital with no tertiary services and Site 3 was a secondary level hospital with some tertiary services. Each participating hospital had explicit organisational values and these value statements were displayed on the ward and in the staff areas (coffee rooms and nurses' stations). The value statements held by each organisation were largely aspirational and many were shared across organisations, however some were unique; these are presented collectively (Table 3). Each site had implemented the principles of the productive ward as described in Chapter 2.

Table 3: Site-specific organisational values

<i>Shared values across organisations</i>	<i>Unique values in some organisation</i>
<ul style="list-style-type: none">• Innovation• Excellence• Professionalism• Cooperation• Trust• Commitment	<ul style="list-style-type: none">• Living the Treaty• Integrity• Social equality• Adaptability• Focus on patients

Ward size varied from 36 beds at Site 1, 35 beds at Site 2, and 52 beds at Site 3. All three sites were general medical wards, however Site 1 had two additional specialities, gastroenterology and respiratory medicine, and Site 3 included a stroke speciality. At Site 3 stroke patients were nursed in a designated area on the ward, unlike Site 1 where speciality patients were integrated with the general patient population.

The atmosphere at each site was immediately evident. Sites 1 and 3 were exceptionally busy and at times appeared chaotic. It was difficult to locate nurses²¹ and when they were visible, they moved quickly and with purpose. The environments at Sites 1 and 3 were also physically untidy:

The central nurses' station is messy. There are bits of paper and files everywhere. There's even a coffee plunger with old coffee in it that has mould growing on top. (Field Note S1D5 235)

The nurse coordinator asked nurses to tidy up after themselves in the central nurses' station as medical notes kept going missing and the place was a mess. (Field Note S3D1 80)

In contrast, Site 2 was calm, quiet, relaxed and physically tidy; nurses were visible; they also moved with purpose but not as quickly as those at Sites 1 and 3.

The physical appearance of nurses varied across all the sites. Nurses at Site 1 and 3 did not adhere to the hospital uniform policy; that is, nurses were wearing mismatched uniforms and a large range of types of shoes:

²¹ In all instances where nurses are referred to the reference is to Registered Nurses unless stated otherwise.

Registered nurses [RNs] and ENs²² are wearing the same uniform; however, there is a variety of styles there are dresses, tunics or t-shirts worn with long trousers, ¾ trousers, shorts, or skirts. There is no uniformity, the colours and quality of the uniforms varied, some tops were white, others were grey; bottoms were black, grey or navy. The Nurse Manager did not wear a uniform and the clinician coordinators wore the same uniform as the RN and EN. HCAs²³ wore a blue uniform. Very few members of staff worn a name badge, some wore handmade [pottery] badges listing their first names (Field Note S1D2 84) ... The nurse's trousers are black trousers the uniform is supposed to be navy trousers. So they wear their own trousers [not hospital issue]. All of the shoes are different varieties, trainers, pumps, lace ups, some black others blue and others brightly coloured. (Field Note S1D2 91)

Nurses and nursing assistants at Site 2 clearly adhered to hospital uniform policy and appeared professional:

In Site 2, the uniforms clearly differentiate between the RN (white with green piping), the EN (white with yellow piping) and the Nurse Manager (NM) and clinical coordinator (white with blue piping). The HCA's wore a green uniform. The nurse's shoes are all black. All members of staff wore their hospital ID badge. (Field Note S2D1 17)

The general appearance of nurses has been found to relay competency and quality assurance (Albert, Wocial, Meyer, Na, & Trochelman, 2008; Wocial et al., 2010; Wocial, Sego, Rager, Laubersheimer, & Everett, 2014), however there is a competing argument that a nurses appearance is not an indicator of clinical competence (Temara, 2015). In a recent integrated review Hatfield et al. (2013) confirmed that there is a dearth of research enquiry into the significance and impact of nurses appearance on patients perception of skills and judgments of the health professional caring for them, noting that extant research in this area supports the notion that a nurse's appearance increases the perception of professionalism and cultivating therapeutic relationships.

²² Enrolled nurses work under the direction and delegation of Registered Nurses and have a specific scope of practice (Nursing Council of New Zealand, 2012b).

²³ Healthcare assistants work under the direction and delegation of Registered Nurses or Enrolled Nurses (Nursing Council of New Zealand, 2012b).

5.2.1 The physical layout and aesthetic of the ward

Hospital design, the physical layout of hospital wards, the location of patient rooms, the nurses station, the entranceway, and the day room, are all historically and culturally dependent (Bromley, 2012). A hospital is a “concrete representation of the prerogatives, theories and preferences that prevail in the local context at a moment in time” (Bromley, 2012, p. 1057) and economic, technological, societal values, professional and demographic forces influence design trends for hospitals and wards; a good example of this is facility modifications for managing obese patients (Hignett & Griffiths, 2009; Porter & Catenacci, 2011; Rosenberg, 1987).

The layout of each ward varied (Appendix 13) and the layout had an impact on nurses, patients and the wider multidisciplinary team in a number of ways. Site 1 was a 36-bed ward which had three distinct areas (bays) each with their own nursing station; there was also a central nursing station. A ‘Patient Status at a Glance’ (PSAG) board was located in the central station. PSAG boards are large white boards with each patient’s name and a colour coded care trajectory. These boards have been reported to improved inter-professional communication and improve patient care (Lennard, 2012). The layout of the Site 1 ward meant that both patients and nurses were some distance from the central nursing station, drug and equipment rooms:

If nurses want to get medications for their patients they have go from where the medication charts are stored in the nurses station in the bay and they walk the length of the bay down outside to the drug room which is a controlled entry door, a swipe card is used to get in. There is a bell display monitor in the drug room so nurses can see if the bell ringing is from their bay, but they are quite a bit away from any of the activity within the bay. There are a number of times that I have noticed nurses leaving the bay to go and get medications or additional equipment. (Field Note S1 D2 53)

The layout of the wards affected how nurses practiced, nurses spent a lot of time moving from one place to another, searching for documentation, and equipment:

A lot of the days I feel I walk out of work and feel like I’ve been chasing my arse, excuse the language, for eight hours because it could be, being chased for unnecessary paperwork to be repeated, or I can’t find equipment or drug charts or patient notes. (S3N3 22)

Decentralisation of the nursing station isolated the nurses and impeded communication between them and other members of the multidisciplinary team (Tyson, Lambert, & Beattie, 2002). There is however a body of literature arguing that decentralisation of the nurses' station actually increases nurse-patient interactions and improves nursing communication with the multidisciplinary team (Bayramzadeh & Alkazemi, 2014; Gurascio-Howard & Malloch, 2007; Parker, Eisen, & Bell, 2012). However, enhanced communication referred to in the above studies was linked to the use of an electronic nurse locator system where a locator badge is worn by the nurse and picked up by ceiling sensors throughout the ward (Gurascio-Howard & Malloch, 2007). No such technology was utilised by the sites in this study and patients and family were frequently observed searching for nurses:

There are a number of bells ringing and lots of family with patients who look out the door from time to time searching for help. (Field Note S1 D7 45)

At Site 1 each 12-bed bay had its own nursing team, which was divided in two, six patients allocated to each smaller team. These small teams met regularly to support each other and communicate clinical updates. The allocation of patients within the teams was dependent on skill mix of the shift. Skill mix, as a key factor in patient allocation and patient outcomes, has been found in a number of nursing studies (Duffield et al., 2010; Rassin & Silner, 2007; Twigg et al., 2012). At the start of each shift, nurses were allocated patients who were acutely ill and requiring complex interventions; ENs and HCAs were allocated stable patients. This approach is widely supported (Aiken et al., 2002; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007; Twigg et al., 2012) as patient outcomes are significantly influenced when nurses care them for. Stable patients were those who did not require complex nursing or medical interventions, but still needed hospital care. This resulted in a system where a nurse's allocated patients were often spread across the bay(s). Consequently, nurses spent a considerable amount of time walking from one bay to another, supporting evidence that time spent walking lessens nurses time with patients (Hendrich, Fay, & Sorrells, 2004; Lu & Hyun-Bo, 2012; Welton, Decker, Adam, & Zone-Smith, 2006).

The physical layout of the ward and the distribution of nurse allocated patients also made it difficult for doctors, physiotherapists and others on the multidisciplinary team to locate nurses; a situation that is upheld in the literature where it has been shown that the poor design of hospital wards, including lack of space, frequent interruptions, and lack of privacy, has a significant negative effect on communication between nurses, patients and members of the multidisciplinary team (Gum et al., 2012; Liu, Manias, & Gerdtz, 2014):

There is a bit of activity now, one of the doctors is looking for some equipment and he can't find it or the nurse who is caring for the patient, the nurse educator has stopped what she's doing to go and help him to find the equipment. (Field Note S1 D2 142)

At Site 2 the nursing team were less isolated than at Site 1, primarily because there were no separate bays. Site 2 was a 35-bed ward. The layout of the ward facilitated multidisciplinary collaborative practice, as there were two central nursing stations, one for each end of the ward (Appendix 13). Each nursing station had a PSAG board. The nursing team at Site 2 was split; there were two teams who managed patient care at separate ends of the ward. Members of each team came together in much of the same way as at Site 1; they met for support and clinical updates. The only time the whole team met together was on a night shift.

Patient allocation in Site 2 was also dependent on the skill mix of the nursing team and resulted in nurse allocated patients spread across each end of the ward. The distance between patients did not have the same impact as at Site 1 because the ward was 'open plan' and nurses were visible as they moved from one patient to another. The few instances when nurses were not visible were when they were attending to a specific patient behind closed curtains, in the drug room, clinical preparation room or sluice room.

Site 3 had the largest of the three wards, with 52 beds. The ward was H shaped with a large central nursing station that was split in two, one side for each end of the ward. The central nursing station had two PSAG boards, one for each end. There were 26 patient beds on 'side one' and 26 on 'side two'. Each side of the ward had its own equipment, treatment, sluice and medication rooms and small nursing station. There was also a separate a staff room and patient TV room at each end of the ward. The nursing teams on side one and side

two never came together. They operated as two distinct wards each with a separate Clinical Nurse Coordinator (CNC) (responsible for managing the day-to-day running of the shift). Each side of the ward divided their nursing team into two sub-teams, and each sub-team was responsible for 13 patients. The nursing team on each side did not meet together regularly, preferring to liaise with the CNC throughout both day shift and night shift. Similar to Site 1 and 2, patient allocation was determined by skill mix and resulted in nurse allocated patients being spread out. The nurses were less visible at Site 3, than Site 2. Attending to individual patient need, attending to nursing responsibilities in a drug, sluice or clinical preparation room resulted in a lack of nursing visibility. The ward also had multiple side and isolation rooms, further impacting on the visibility of nurses.

5.2.2 Patient handover

The way the nurses communicated with each other, particularly during handover²⁴ varied across the sites. At Site 1 the morning nurse handover was conducted in each individual bay. As mentioned earlier nurses in each bay met regularly throughout the shift for support and clinical progress updates on their allocated patients. Because of the smaller numbers of nurses on night shift at Site 1, a full ward report was given to allow the night nurses a comprehensive overview of patient status across the ward, not only those in their allocated bay. On a day shift however a nurse in bay 1 would have no insight into the patients in bay 2 or 3 as the handover was specific to their small group of patients.

There are a number of types of handover described in the literature, these include verbal (at a designated location), tape recorded, written and bedside (Sexton et al., 2004). Bedside handover was the delivery preference at Site 2. This approach is associated with patient-centred care as it allows patients and families to participate in the handover process, avoiding what some consider paternalistic one-way communication (Anderson & Mangino, 2006; Liu, Manias, & Gerdztz, 2012; Lu, Kerr, & McKinlay, 2014). However,

²⁴ The handover is the formal transfer of responsibility and accountability from one nurse or healthcare professional to another (Evans et al., 2010; Hopkinson, 2002) and nursing handover is a “time honoured tradition and staff on every incoming shift must receive a report of patients status before they commence care” (Scovell, 2010, p. 35).

fieldwork observations revealed that handover was conducted both at the bedside and in the corridor with little to no patient or family/whānau engagement. Nurses gave a number of reasons why handover took place in the corridor. These included patient confusion or lack of cognitive ability, sleeping patients, patients in clinical isolation and patient confidentiality. Chaboyer, McMurray, and Wallis (2010) reported that less than half of the 500 bedside handovers observed in their study included patient involvement, confirming the evidence, from fieldwork observations, of little interaction between nurses and patients or families at handover.

The handover at Site 3 took place in the tearooms located at each end of the ward. All members of the nursing team, including ENs and HCAs were present for the full handover report, a practice across all shift patterns. The atmosphere for the handover was relaxed; nurses and their assistants sat at a table with handover sheets provided by the outgoing nurse in charge. Throughout the shift, at Site 3, nurses liaised frequently with the nurse in charge (CNC) but rarely came together as a team to discuss patient progress. Nurses relied heavily on the CNC to coordinate workload and assist with clinical care when the need arose.

5.2.3 The model of nursing care

The model of nursing care followed in all sites was that of team nursing (Chapter 2 section 2.4) which is a collaborative and cooperative approach to nursing care (Duffield et al., 2010). The teams comprised RNs, ENs and HCAs, each with a variety of experience and educational preparation.

The team nursing model of care enacted in each site was not obviously rooted in humanistic values (Chapter 2 section 2.4.3). Rather a pragmatic approach was taken to patient allocation influenced by the level of clinical practice skills that the nursing and ancillary team had; decisions at all sites were made on a shift-by-shift basis. Task-orientated care was a significant element of team nursing at all sites and overwhelmingly guided patient allocation:

The allocation of patients was based on skill mix or on the tasks that nurses could do. Nurses asked each other if they could administer IV fluids or IV

drugs and if they could, they were allocated to that patient, if not they were allocated to other patients. (Field Note S3D1 149)

They're [nurses] sitting at the nurses station and again allocating patients based on who can administer IV drugs. (Field Note S1D2 15)

Although the model of care in each site was reported to be that of team nursing, the reality of the clinical environment meant that the philosophical premise of team nursing was not overtly present. A functional/task orientated approach to nursing care was taken in each site. Partnership and individualised care were not the driving forces in decision-making and there was no ownership²⁵ by nurses of the team nursing model of care, or indeed ownership of functional/task orientated care.

5.3 Nursing profile and participating nurse characteristics

The staff profile varied across the three sites (Table 4); the significance of the staffing numbers is discussed in Chapter 6. Site 2 had a stable nursing workforce and well-staffed ward. Both Sites 1 and 3 had staff vacancies, specifically at the senior nurse position. In all sites, it was the senior nurse on duty or the CNC, who was responsible for the daily allocation of nursing and ancillary staff. Each ward had an appointed Nurse Managers (NM) who had varying degrees of management experience.

²⁵ Ownership relates to a theoretical and professional understanding of and philosophical agreement with the model of care.

Table 4: Profile of nursing and ancillary staff by no.(FTE) and study site

	Site 1	Site 2	Site 3
Beds	36	35	52
Nurse Manager	1 (1.0 FTE)	1 (1.0 FTE)	1 (1.0 FTE)
Nurse Educator	1 (1.0 FTE)	-	1 (0.6 FTE)
Clinical Nurse Coordinator	2 (1.5 FTE)	4 (3.7 FTE)	1 (1.0 FTE)
Clinical Nurse Specialist	-	-	2 (2.0 FTE)
Registered Nurse	32 (28.4 FTE)	26 (23.3 FTE)	60 (48.0 FTE)
Enrolled Nurse	5 (4.7 FTE)	2 (1.4 FTE)	1 (0.6 FTE)
New Graduate Nurse	3 (2.4 FTE)	3 (2.4 FTE)	4 (3.2 FTE)
Health Care Assistant	7 (6.0 FTE)	9 (5.4 FTE)	14 (9.8 FTE)

The nursing and ancillary team in each site provided a 24 hour 7 day a week service; the shift patterns were the same across all sites: 0700-1530, 1445-2315 and 2245-0715. Both Sites 1 and 3 were short-staffed and were actively recruiting nursing staff. Each site facilitated New Graduate Nurses. These nurses were in their first year of practice and had an appointed nurse acting as a clinical mentor/preceptor. A number of ENs were employed at each site; Site 1 had the highest number, with five ENs. HCAs were a vital part of the nursing teams at all sites and attended to the majority of patients' hygiene needs and supported patients with their nutritional intake across all sites. The nurse participants in all sites were experienced and the mean time they had been practicing in their clinical area was 4-8 years, range 22 years to one week (Table 5). The majority were female (96%), degree prepared (75%), and all were competent on the Nursing Council of New Zealand (NCNZ) accredited Professional Recognition Programme (PDRP)²⁶ (Table 5).

²⁶ The PDRP is a competency-based programme that exempts nurses from NCNZ competency assessment audit. It is used as a way to recognise and reward a nurse's practice and innovation (New Zealand Nurses Organisation, 2015).

Table 5: Nurse participants by demographics, nursing characteristics and study site

	Site 1	Site 2	Site 3
	n=11	n=18	n=19
Mean Age	37.4	38.41	42.6
Gender			
Male	0	1	1
Female	11	17	18
Ethnicity			
NZ Euro	4	13	7
NZ Maori	0	2	2
Samoan	0	0	1
Niuean	1	0	0
Other Pacific	0	0	2
Sth East Asian	3	2	4
Indian	2	0	1
Other Euro	1	1	2
Qualifications			
Hosp training	4	2	4
Bachelors	7	16	13
Grad Cert	0	1	0
Grad Dip	0	0	1
PG Cert	1	3	1
PDRP Level			
Competent	11	18	19
Mean Yrs. Qualified	13 (39yrs-6mts)	8 (39yrs-2weeks)	16 (40yrs-7mts)
Mean Yrs. on Ward	8 (22yrs-6mts)	4 (15yrs-1week)	6 (20yrs-2weeks)

5.4 Patient profile and family/whānau characteristics

The patient profile at each site consisted of mixed gender and ethnically diverse adult patients (over the age of 16). At Sites 1 and 3, most patients had been admitted because of an acute recurrence or acute exacerbation of an underlying condition such as diabetes, chronic obstructive pulmonary disease, cancer, congestive heart failure, or stroke. There were less acute patient admissions at Site 2. Whilst the type of medical conditions were similar in all three sites, at Site 2 the treatment plans were targeted toward patient self-

management and rehabilitation, reflecting the regional nature of the hospital. At Site 2, if a patient was acutely unwell they were, as a rule, referred to a larger tertiary centre.

The process of patient admission was similar in all sites. Patients were admitted via the Emergency Department or a General Practitioner referral. Each site followed an internal hospital referral process as well as accepting external referrals from other hospitals within New Zealand. In each site there were instances where patients who did not have a medical diagnosis, such as a general surgery patient, were admitted to the ward. These patients were referred to as 'outliers'. There was a similar average length of stay for all patients of between 4 to 5 days in each site.

All of the 10 patients who participated in both observations and interviews had recovered from their acute episode, were generally well and expecting to be discharged home. The decision to discharge patients rested with a medical practitioner. Seven patients were of New Zealand European ethnicity, one Maori, one Samoan, and one Greek. The age of patient participants in each of the sites ranged from 61-71 years, averaging 67.2 years. The average length of stay for participating patients was 6.6 days, higher than cross-site average of 4-5 days. Two family members, a spouse and a daughter, participated in the research.

5.5 Patient and family/whānau experiences with nurses

There has been a reported decline in trust and confidence of patients in healthcare and in those who deliver it, particularly in the western world (Brown, 2008; Gilson, 2003; Ward et al., 2015). When trust and confidence are absent patient outcomes are affected and there is an increase in psychological distress experienced by patients (Ahnquist, Wamala, & Lindström, 2010). A number of themes emerged from patient and family/whānau²⁷ interviews, these were: wanting to tell their story, awareness of the busyness of nurses; feeling responsible for others; being moved and positive or negative experience with

²⁷ As only two family members participated in the study their thoughts are presented alongside those of the patients. Both family members were interviewed at the same time at their relative.

nurses.

5.5.1 Needing to tell their story

There is a therapeutic benefit in research participants telling their stories (Lakeman et al., 2013; Russell, 2000). The stories related by patients and family/whānau, while individually different, had two similarities, these were concerned with: the patient's personal health history and current clinical presentation, including fears that they had about their health; and who they were, where they lived, their family, friends, occupation, life before hospital.

The desire to be a help is a strong motivator to participate in research, for example over half the participants in Fry and Dwyer's (2001) study stated that others would benefit because of their participation. For the participants in this study, wanting to help me (the researcher) was a motivator, but being listened to was also a motivation, "*it was nice to have someone to talk to*" (P4S1 565). All had a chronic condition; renal failure, chronic obstructive airway disease, diabetes, asthma and two had cancer. A patient at Site 3 was very concerned about being recently prescribed Morphine to manage pain. For this patient his primary story was about his fear about Morphine a theme he returned to time and time again repeatedly:

Putting me on Morphine for the first time in my life you know it's a scary experience...it's scary I am not a drug person... I know the local druggies line up for it at the chemist...I don't want to become a robbery victim in my own house. (P2S3 92)

For other patients their stories were about who they once were, a nurse, a psychologist, a wife, a husband; or who they are, a mother, grandmother, a father or grandfather. The majority of participants were widowed and each talked about their late partner. These stories were interwoven with views about nursing and their experiences with nurses:

A little two bedroom flat. I own it, nobody can turf me out I own it. My husband and I bought it; he was alive when I went in there. I was born right here [name of town], in the sitting room, my Mum always reckoned I'd come in a rush and I've been rushing ever since. [The narrative then moved to her hospital admission] I think it's fabulous. I've been well looked after; I've got no complaints [about nurses]. (P3S2 21)

These stories raised questions about who was engaging with these patients and their individual needs (mental physical, social and spiritual). Telling personal stories gives voice to patients who may feel powerless and legitimises sharing their feelings (Holloway & Freshwater, 2007). Similarly, coming to terms with vulnerability is another reason people wish to tell their stories, helping them cope and adapt to their situation (Holloway & Freshwater, 2007). Patient stories should be taken seriously as they provide understanding and an evidence base for nursing about patient experience that can lead to improved nursing care (Bradshaw, 2014). Patient stories have been at the heart of reports on inadequate nursing care, and have enlivened debate about nursing care in the 21st century (Care Quality Commission, 2012; Francis, 2010, 2013; Francis & Lingard, 2013; The Patients Association, 2009, 2011, 2012).

5.5.2 The busyness of nurses

A culture of busyness can preclude deep and meaningful interactions and therapeutic engagement between nurses and patients (Carr, 2010; Cavendish et al., 2000; Watson, Dossey, & Dossey, 1999). As mentioned earlier the wards were busy places. Patients and family/whānau, at all sites, noticed the workload and the demands placed on nurses in daily practice:

They've been so busy and sometimes they're running around as if they're on wheels. (P1S1 104)

Sometimes when I'm walking round I see them go from room to room to bring patients out, take them for bathing and elsewhere you know. They're generally pretty busy. (P1S1 115)

Busyness, as a concept, is well documented as a concern for patients and is significantly evidenced in the voices of family members of relatives who have died when in hospital care (Francis, 2010, 2013; Francis & Lingard, 2013). Their accounts are inundated with examples of busyness; nurses were too busy to care, to walk patients to the toilet, administer pain medication or change soiled bed linen (The Patients Association, 2009, 2010, 2011, 2012). Participants in this study acknowledged the busyness of nurses, and that they were only one of a number of patients that a nurse had responsibility for:

She's up and down [referring to another patient] in here and out of here and down there to the nurses...annoy her [the nurse] you know and I felt so sorry

for the nurse...I thought she [the nurse] actually went a long way. It was exceptional. (P1S3 260)

Patient recognition of the demands on nurses time has been described in other research studies (Griscti, Aston, Martin-Misener, Mcleod, & Warner, 2016; Hickman, Davidson, Chang, & Chenoweth, 2011). In keeping with Hickman et al.'s (2011, p. 83) sequential mixed method study, a patient participant "admired their [nurses] ability to cope with often competing demands: *"I think they do the best they can do...given the circumstances that they work within"*". Patient participants in this study had similar responses:

...I appreciate the time they do give. I think within the timeframe of what they've got to get through in a day. (S2P1 151)

The busyness of nurses has been perceived as preventing intimate patient encounters or positive therapeutic relationships, by inhibiting the connection between nurses and patients (Richards, 2015). Some participants felt that at times nurses: *"didn't want to know"* (P3S2 260); were rushing because they *"didn't want to speak or answer"* (P2S1 27); or they were *"ignored"* (P5S1 52) by nurses. These characteristics were associated with 'some' nurses and these nurses were the ones who participants felt lacked compassion and acted as *"Sergeant Majors"* (P2S2 291) or were *"lazy bitches"* (P2S3 197). This commentary from patients demonstrated a link between busyness and the façade of busyness (busyness as an excuse for a lack of care and compassion). "Growing numbers of patients are complaining of a sharp difference between that nursing ideal and the shoddy, perfunctory reality that they experience on the wards" (McCartney, 2008). Patients in Richards (2015) study reported that nurses who gave their time were compassionate, implying that those who did not were lacking compassion. However, giving time and compassion are not mutually exclusive, it is possible to give a little amount of time and demonstrate compassion. The Patients Association in the UK has published numerous reports describing patients suffering because of a lack of care and attention, in many cases attributed to a lack of compassion, busyness and the prioritisation of financial imperatives (The Patients Association, 2009, 2011, 2012) supporting a comment by one patient participant:

To me it's [lack of care] cost accounting, cost saving to send me home after three or four days. (P2S3 22)

5.5.3 Patients caring for other patients

On a number of occasions patients expressed a sense of responsibility for other patients, these were expressed in various ways; sometimes this was a general concern about others, for example a comment about the needs of older more infirm patients. Where there were a number of patients together in a room they would often call across to each other, asking one another if they were all right. Mobile patients would move call bells or drinks to within reach of their fellow patients. The most frequent way patients helped each other was ringing a call bell for a fellow patient:

I was quite helpful for Clare [pseudonym] when I was in bed 33 and she's about 92 and she sort of had difficulty getting the bell through the night to ring for the nurse. I heard her in distress so I rang the bell for her and called the nurse in you know. (P2S1 124)

A hospital ward is “a public place where the boundaries of private and public affairs are blurred” (Porock, Pollock, & Jurgens, 2009, p. 16). However, Larsen, Larsen and Birkelund's (2014) found that patients in their study had difficulty finding refuge from fellow patients because of the layout and public nature of hospital wards; similarly patients in this study were regularly exposed to the pain, distress and suffering of others. In many instances, across all study sites, patients were in close proximity to each other with only a curtain acting as a barrier against noises, smells and conversations. In some cases even the curtain did not provide visual privacy as silhouettes could be seen when lights were used, in keeping with other studies (Larsen et al., 2014; Larsen, Larsen, & Birkelund, 2015; Porock et al., 2009), thus making others distress difficult to avoid and compelling them to come to the aid of one another. However, going to the aid of another patient was not always acceptable to nursing staff:

I got told off for asking for help for one of my friends over there today. This woman [referring to a nurse] she said no, no I spoke to him and he's alright and I said well have you got eyes in the back of your head because he's coming up and he's slouched over his bed and all she was intent on was going crook at me, mind your own business. (P2S3 183)

Early last week, the same person, I'd saved his life actually because he, you know, he had to have the red bell rang and they brought him back from what the doctor said the day before was falling off the perch, because I thought to ring the red bell you know. (P2S3 188)

These patients felt excluded and unimportant in a similar way to patients in Attree's (2001) study that explored the good and not so good of quality care showing that both the nature of and interpersonal aspects of nursing care were important concerns for patients. The nurse in this instance may have viewed the patient as an outsider, without adequate medical knowledge, it is the nurse who knows best and questioning the nurse was a challenge to the nurses authority (Henderson, 2003).

The role of patients helping other patients and nurses reaction to this is not well documented in the published literature. However, it is noted that timely recognition of patient deterioration can prevent adverse events (Bogert, Ferrell, & Rutledge, 2010) and there is growing body of literature about the role of patients, families and visitors in activating medical emergency calls (Brady et al., 2015). Recognising patient deterioration in the absence of a health professional has become a central element in managing risk. A number of authors advocate "Condition H" (or condition help), a formal process where patients and families are actively taught how to recognise deterioration in a patient's condition and are instructed on how to activate a medical emergency call (Durkin, 2006; Jolley, Bendyk, Holaday, Lombardozzi, & Harmon, 2007; Kirk, 2006). Condition H, or patient/family activated medical emergency calls like those described above, were not accepted practices in any of the sites in this study.

5.5.4 Experiences of physically being moved or discharged

Moving patients to facilitate new admissions is common practice in hospitals, the consequences of which are "bad for patients and bad for healthcare" (McMurdo & Witham, 2013, p. 555). Historically, 'boarding' (moving a patient from their specialist ward to accommodate others) or moving patients within wards was largely seen in winter months when there is increased hospital occupancy, however, this is no longer the case (George & Wilkinson, 2016). Patient movement is now a year-round occurrence and is linked to negative patient outcomes including patient falls, medication errors and increased nursing workload (Blay, Duffield, & Gallagher, 2012; Blay, Duffield, Gallagher, & Roche, 2014; Sprivulis, Da Silva, Jacobs, Frazer, & Jelinek, 2006; Weissman et al., 2007). Being moved around the ward or to other wards was a major concern for patients and their

families/whānau. This often occurred multiple times, sometime within one day:

She was quite stationary for a while but round here she's moved and moved and moved because she was so delirious they had her in that four bedroom, one that you saw, and talked to us and yesterday where there's a nurse aide who monitors everybody and keeps an eye on her but she's obviously not that delirious at the moment so they brought [her] in here this morning. (P3S1D1 190)

Relatives reported how they would come to visit and find another patient in the bed space where their family member should have been, or had been very recently. Other patients commented on how many times they were moved and how it left them feeling disappointed and disempowered, particularly if the reason for the move had not been explained:

They just come and moved me out. Move out man. You are gone. (P5S1 153).

I just get all comfortable in position and everything where I can reach it and plug in my phone for charging overnight and I got shifted. I was shifted from 27 down to 25 I think it was then across to 33 and [then] to here. (P2S1 124)

In Site 3 every available space was used for patients, overflow was normal; many patients admitted were 'boarders' from other services. This was particularly problematic for vulnerable and immunosuppressed patients:

Every patient bed is full, because there are no beds left a patient with cystic fibrosis is admitted to the treatment room. This young patient and his mother are very distressed about being in a treatment room and are speaking with the CNC to see if there is any other room, there isn't; the hospital is full. (Field Note S3D4 213)

Although the patients were medically cleared for discharge, five of them felt that they were not ready for discharge and worried about what would happen to them once they were home. Their worry focused on the possibility of readmission due to their condition deteriorating and their ability to cope with daily activities, such as cooking and caring for themselves. They were also concerned about being alone, having been surrounded by care and attention during the admission, "*I will be lonely when I go home*" (P3S2 88).

5.5.5 Important nurse characteristics

Patients noted a number of characteristics and values that they felt were important for nurses to possess:

Oh they were all, they were all being warm and compassionate, yeah. That's the biggest thing with the nurses, they've got to be compassionate to be in nursing these days. (P1S2 12)

Have a calming, listening ear. Never be in a rush. Have a caring heart. Have an average IQ, be able to put yourself in other people's shoes. (P2S1 20)

A significant nursing characteristic was smiling, both the nurse smiling spontaneously; “just they go past and give you a nice smile you know” (P2S2 365); and the nurse responding to a smile from a patient. If there was no response to the patient's smile it was viewed as disappointing and to some extent dismissive:

I gave her a smile and she didn't even acknowledge me you know, I just, I'm trying to say hello I hope you're having a good day with a smile. (S1P2D1 286)

Smiling, being kind and caring have been found to be considered characteristics of a ‘good nurse’ by patients in a number of studies (Catlett & Lovan, 2011; Chen & Hsu, 2015; Davis, Hershberger, Chun Ghan, & Ymg Lin, 1990; Fealy, 2004). Non-verbal communication, such as a smile, can have a profound effect on individuals (Hall & Roter, 2006) and a nurse's personality, approach and understanding are important to patients (Ersser, 1997). Smiling is an easily recognised facial expression that has been found to have a positive impact on well-being (Fredrickson & Joiner, 2002). Researchers in the field of psychology argue the cultural context and function of smiling and the relationship to positive and negative emotions is not fully understood (Gervais & Wilson, 2005; Papa & Bonanno, 2008). However, patient and family member participants understood a nurses' smile to mean attention and care.

It was clear that smiling was important to patients, but more that this was part of making a connection with the nurse. Connectedness between nurses and patients has the potential to enhance patient participation in decision-making (Cooper-Patrick et al., 1997) and increase compliance with medical treatments (Schneider, Kaplan, Greenfield, Li, & Wilson, 2004).

The concept of connectedness in healthcare is inadequately defined in the literature (Phillips-Salimi, Haase, & Kookan, 2012). However, Miner-Williams (2007) argues that connectedness in the nurse-patient relationship is more than the nurse meeting the patients' biophysical needs; it is a meaningful engagement with another and has the potential to have a positive impact on both the nurse and patient. Another perspective on connectedness is that of 'symbiotic niceness' where nurses and patients are nice to each other, thus constructing a climate of friendliness, respect and understanding (Li, 2002, 2004). The discourse from patients about smiling is a small element in a bigger picture of nurse-patient relationships that are enhanced by connectedness and niceness and connectedness and niceness are central elements of compassion (Bramley & Matiti, 2014). Patients have reported that compassion is the nurse knowing them and giving time to them (this need only be fleeting), understanding what it is like in their shoes and communicating with them (Bramley & Matiti, 2014). The appreciation and gratitude of patients, family and friends was publically displayed in all sites. These included thank you cards, which were displayed in public spaces:

The ward had thank you cards from patients on display, the comments on the cards were about dedication, professionalism, caring, compassionate, cheerfulness, attention, kindness, expertise and patience. (Field Note S2D4 281)

5.5.6 Patients negative conceptions of nursing

Chapter 1 referred to the numerous examples in public reports and research of patients' negative experiences with nurses and the impact this has had on patients and their families. An important element in assessing overall satisfaction with healthcare is patient satisfaction with nursing care (Akhtari-Zavare, Abdullah, Hassan, Said, & Kamali, 2010; Mrayyan, 2006). Measuring patient satisfaction with nursing is often conducted using Likert scale surveys' distributed to patients on behalf of the health care provider (Kutney-Lee et al., 2009). Junewicz and Youngner (2015) argue that these surveys have the potential to derail a quality service because there is no clear definition of patient satisfaction and results are subjective and unique to the individual. However as a nurse sensitive indicator²⁸, patient

²⁸ Nurse sensitive indicators have been described as 'those outcomes that are relevant, based on nurses' scope and domain of practice, and for which there is empirical evidence linking nursing inputs and interventions to the outcome for patients' (Doran, 2011, p. vii). There is no consistent agreement on what constitutes a nurse

satisfaction (comprising of effective care delivery, patient perceptions of competent care, and patients involvement in decision-making) is directly linked to the quality of nursing care (Spence Laschinger et al., 2011). When patients are not satisfied, their dissatisfaction often revolves around a lack of communication and lack of participation in their care (Coughlin, 2013; Dawood & Gallini, 2010). For patient participants their dissatisfaction presented in a number of ways, for example when call bells were not answered:

[A nurse] just told me you're not meant to ring [the bell] twice. Once is enough we will come for you when we're ready. And I was getting a bit panicky because I didn't have my oxygen on you see, I waited quarter of an hour in there. A whole quarter of an hour, ooh that's a bit long. [His wife responded] Too bad if you carked out. (S2 P2F 484)

Being treated compassionately was, for this patient, dependant on the nurse's background and values:

It comes down to the nurses' background and compassion and where they're coming from. At what stage they're at in their nursing if they're new enthusiastic beginners or getting long in the tooth and burnt out you know. (S2P1 114)

There were a number of excuses put forward by patients as to why some nurses were compassionate, and others were not. Overall, patient and family/whānau negative comments about their care were couched with positive commentary or an explanation. In many instances, poor care was directly related to an individual nurse, not all nurses. As a way of directing criticism away from an individual nurse one patient used the analogy of “a few bad apples²⁹” (P1S2 56), by this she meant that not all nurses were ‘bad’. According to patient and family/whānau participants there was a range in the quality of nurses; some were good others not so good. However, for Zimbardo (2007) the concept of a few bad apples is a disproportional view that fails to take into account the vessel that houses the apples (if apples are nurses then the vessel is the ward). The argument presented by

sensitive indicator however, Needleman, Buerhaus, Mattke, Stewart, and Zelevinsky (2002) argue that they include, central nervous system complications, deep vein thrombosis, pressure ulcers, upper gastrointestinal bleeding, hospital acquired phenomena, hospital acquired sepsis, shock/cardiac arrest, urinary tract infection, failure to rescue, metabolic derangement, pulmonary failure, wound infections, mortality and length of stay.

²⁹ A bad apple is an idiom for a person who impacts the entire group taken from the proverb a bad apple spoils the bunch (Nunberg, 2011).

Zimbardo is that by only viewing the bad apple there is a failure to consider the big picture, the system and situational context (system and situation context will be addressed in Chapter 6).

Three of the participating patients were ex-nurses, and each discussed their own experiences and commented in a general sense about poor nursing care. These ex-nurses felt that, on the whole, nurses were good and like other patients they too tried to explain why some nursing care was inadequate.

[One ex-nurse stated that contemporary nurses do] *not have the time with the patients and that's the thing with the doctor too. They don't have time with the patients. And the self-analysis and the analysis of the patient overall hasn't been what it used to be you know.* (S2P1 142)

Other patients who had recurrent hospital admissions remembered such instances of poor care and recalled those nurses who were responsible for what they considered to be poor care:

I had a run in with one [nurse] well she's out there [pointing to the nurse], last time. (S2P2 51)

The run in the patient was referring to, was primarily related to not been spoken to politely and being left to fend for himself.

I've probably been in here four admittance and you know [you get] to the point where you actually feel guilty...you're not treated with any disdain or such but you know sort of familiarity oh what's wrong [with you] this time. (S3P2 5)

Reflecting on past experiences was very powerful for the participating patients similar to findings by John (1992), who noted that patients tend to think of current hospital experience in light of previous experience which has an impact on patients trust of healthcare professionals (Tarrant, Colman, & Stokes, 2008). Trust is developed in the context of the nurses' clinical competence, caring attributes and nurses as human beings (Dinc & Gastmans, 2012). Dinç and Gastmans (2013) found that there were a number of factors that impact on the trust, including depersonalisation of the patient and a lack of nursing skill and knowledge.

5.6 Chapter summary

In this chapter I have provided a comprehensive overview of the characteristics across the three cases. The aesthetics of the ward, atmosphere and nursing visibility challenged the way nurses practiced and the model of nursing care was predominantly functional/task orientated, under the guise of team nursing. Patients wanted to tell their story, particularly relating to their concerns and worries. When patients provided care and ‘looked out’ for one another this was not always appreciated or accepted by the nursing staff. Patients and family/whānau valued nurses who smiled and attended to them with kindness and compassion and negative perceptions of nursing were primarily directed to individuals not toward the profession as a whole. In the following chapter I discuss the challenges nurses faced in their attempts to enact nursing values.

CHAPTER SIX: FINDINGS AND DISCUSSION: NURSING VALUES

6.1. Introduction

The first findings chapter set the context of the environments in which the study was conducted. In this chapter I focus on nursing values with specific consideration to the research question: “What are the values of nurses practicing in medical ward environments and how are these values expressed in day-to-day practice? Five themes were uncovered that express how values were enacted by the nurses in this study (Figure 3). The first theme; values and motivation to enter nursing, addresses how nurses chose nursing as a profession and what influenced their decision. The sub themes; altruistic reasons for entering nursing and socio-economic and cultural influences for entering nursing, articulate how their values influenced the decision they made. The second theme; the emergence of values has two sub themes, the influence of personal values on practice and personal values and espoused personal and professional values. Within these themes the significance of personal values are expressed. Living and not living nursing values is the third theme. The sub themes revealed what it means to live and not live values. Living and not living values are described in the context of systems and situations, value dissonance and constrained professional nursing practice. The final theme is defence mechanisms; three defence mechanisms are explored in detail; splitting up the nurse patient relationship; depersonalisation, categorisation and denial; and collusive redistribution or responsibility and irresponsibility. The chapter concludes with an exploration of contemporary anxieties of governance, rationing and performance.

Figure 3: Key themes and subthemes

6.2 Values and motivation to enter nursing

The decision to choose any career, not just nursing, is not made in isolation of an individual's personal circumstances, rather the decision is made with cognisance of what matters in people's lives (Chope, 2005). The participant's beliefs about why they chose nursing and what influenced their decision was congruent with research literature in this field. Numerous studies have reported that nurses enter the profession for a variety of reasons including, but not limited to: caring for others (Eley, Eley, Bertello, & Rogers-Clark, 2012; Eley, Eley, & Rogers-Clark, 2010; Jirwe & Rudman, 2012; Mooney, Glacken, & O'Brien, 2008); a rewarding career (Eley et al., 2010; Price, 2009; Price, McGillis Hall, Angus, & Peter, 2013); job security and career progression (Jirwe & Rudman, 2012; Mooney et al., 2008); family influences (Mooney et al., 2008); and job satisfaction (Eley et al., 2010, 2012; Jirwe & Rudman, 2012; Price et al., 2013). The main reasons for choosing a nursing career demonstrated in this study were: altruism, and socio-economic and cultural factors.

6.2.1 Altruistic reasons for entering nursing

Nursing is a physically and emotionally challenging endeavour (Clendon & Walker, 2012) yet nurses are still motivated to enter the profession. In keeping with the literature (Aiken et al., 2014; Duffield, Pallas, & Aitken, 2004; Gordon, 2005) across all sites there were nurses who were motivated by wanting to be of: “*some kind of value*” (N3S2 28), as well as wanting to “*help people*” (NFGS1 78). Being of value and wanting to help are altruistic intentions and are a core value of the nursing profession (Fahrenwald et al., 2005). The term altruism is used to describe unselfish concern for another’s welfare, and is inherently associated with action (Carter, 2014). Participants in Duffield, et al.’s (2004) cohort study reported that altruism was the most important reason for entering nursing; the researchers concluded that altruism as a motivation strengthened nurse retention.

The French philosopher Augusta Comte is reported as the first to present the term altruism, an antonym of egoism (egoism refers to those who are always motivated by self-interest) (Carbonnier, 2015). For Comte, altruism was giving priority to others, a form of self-sacrifice (Andreski, 1974). However, this view of altruism is rejected by some who believe it is in fact self-interest (Rand, 1964). Rand was not alone when she questioned the meaning of the term altruism; Carter (2014, p. 703) states, in relation to nursing that the term is limiting and “does not really explain the complexity and contradictions that exist for a well-intentioned profession”. In contemporary society, altruism is comprised of both self-interest and compassion (Wuthnow, 2012). Therefore motivation to care for another human being can be viewed as “a metaphor for our self-identity” (Wuthnow, 2012, p. 83). Taking the concept of motivation further, Lebech (2015a, p. 28) in her presentation of Edith Stein’s philosophy, notes that “motivatedness reveals to us the entire inner world of persons”. Values in turn are what shape our motivation (Lebech, 2015a). The motivation to enter nursing for some participants clearly embodied altruism:

Something that would help people, I could give back to the community. I wanted to kind of feel some kind of value in my work. (N2S2 8)

It’s the knowing that you’ve actually made or done something different for somebody else. It may be something as minute as making them laugh, it may be as massive as saving their life, who knows. Who knows because it’s not a glamorous job and it’s not, there’s just something in my makeup or

personality that just needs to be here and needs to do what I'm doing. (N3S3 41)

This desire to 'help people', as a reason for choosing nursing, is not new, it has been referred to more generally in the nursing literature as wanting to 'give back' and to make a difference for the better in people's lives (Chapman, 1983; Eley et al., 2012; Gallagher, 2004; Price, 2009; Price et al., 2013; Sellman, 2011a, b; Watson, 1988). It was apparent that making a difference in people's lives was an important motivating factor for choosing nursing; however personal experience was also a key influence. These personal experiences related to pre-existing relationships with nurses or the experience of caring for an ill family member:

I think from the very beginning I have been a very caring person and supportive, as a boy, my Mum used to be quite sick and I'd be looking after her and that probably gave me the incentive that if I could try and be a qualified nurse probably I could do a lot of good to other people, so that's probably what brought me in I think. (FGS2 11)

I went into nursing my friend with diabetes you know what I mean. That's why I went into nursing....probably look after my family as well. (N3S1 5/54)

I come from a background where my two brothers and my son and my grandson, they all have [a chronic illness] so and very severe, so I've always been brought up around hospitals. (N2S3 159)

I had some family members doing the job so I thought that looks really awesome. So I just did it. (FG2S3 40)

Findings from a number of nursing studies found that significant others, families, friends and teachers are very influential on career choice, as is a history of caring for relatives or friends (Al-Kandari & Ajao, 1998; Dockery & Barns, 2005; McLaughlin, Moutray, & Moore, 2010). Altruism and having a caring disposition were important elements in choosing a career in nursing however, for many participants these motivating factors were combined with other influences, for example the influences of family and pragmatic social, cultural and economic factors.

6.2.2 Socio-economic and cultural influences on entering nursing

Most of the nurses, in realising their professional aspirations, faced challenges and these primarily related to meeting entry requirements, self-doubt and marital/family status. Social and economic factors have been found to influence the choice of a nursing career across all nursing generations: 'Baby Boomers' born from 1946-1961; 'Generation Xers' born between 1960 and 1980; and 'Generation Nexters' born between 1980 and 2000 (Stuenkel, Cohen, & de la Cuesta, 2005). For those nurses who were Baby Boomers, nursing was a natural step, given the career opportunities open to women of their generation, that is, teaching, secretarial work or nursing (Twenge, 2001). For some of the Baby Boomer participants, nursing offered freedom from families and their living arrangements at the time of entering nursing:

Mine was a subtle way of leaving home really. It's like you move out of home into the nurses home so it's not obvious that you're leaving home is it because you know your mother thinks you're still quite safe and in a safe environment. (FG1S3 13)

Pragmatic motivations to enter nursing were described by Duffield et al. (2004) as default choices and, like altruism, were associated with a long tenure in the profession. Financial or economic motivation was not a finding captured by Duffield et al. (2004). However 'Generation X' and 'Generation Nexter' nurse participants in my study tended to have chosen their career based on economic stability, as they were sole providers or the main income earner:

I'd been a personal assistant like a secretary up till then and then for about 11 years I was at home with the kids. He was a carpet layer, started getting sore backs and we thought well what, you know what's probably the best option for me, maybe to try a new career, got a sister who's a nurse who said go nursing so that's what I did. (N6S2 6)

The reason I kept on doing it [was] because I guess with family situation you know it was easier for me to have the steady job and that's why I've stayed on the medical ward. (NFG2S1 92)

Economic pressures, in particular, resonated with 'Generation X' and 'Generation Nexter' nurses. The majority of nurse participants were 'Generation X' with an average age across all three cases of 39 years (Table 5), which is slightly lower than the national average of 47 (Nursing Council of New Zealand, 2014). There was a different average age within the

cases; Site 3 had the highest average age of 42 years, Sites 1 and 2 had a similar average age. Longevity and career stability are important for all generations of nurses (Chen et al., 2016; Duffield et al., 2004; Halfer & Graf, 2006; Zeller, Doutrich, Guido, & Hoeksel, 2011) and was reflected in the demographics of the nurses working in the three medical wards. Site 1 had the most established nursing workforce with an eight-year average length of time working on the ward. Site 2 and 3 had four and six year average length of time working on the ward respectively.

Becoming a nurse was difficult for some nurses who described experiencing barriers they had to overcome in order to undertake their nurse education. Barriers to nursing are often considered with reference to new graduate nurses (Casey et al., 2004), and men in nursing (Casey et al., 2004; Meadus, 2000; Roth & Coleman, 2007). In this study participant barriers ranged from; entry difficulties due to educational entry requirements:

I applied at the age of 16 to do general nursing and got declined because I left school at the end of the fifth form and didn't go into sixth form and missed out because the matron at that stage believed that I should have stayed at school so she thought that I should do my community nurse programme first and then go on and do my general nursing. (N3S3 93)

To self-doubt regarding intellectual abilities:

Well I didn't really think I could do the academic side. (N3S2 23)

Baby Boomers experienced a female nursing service in the 1950s embedded in hierarchy. Nurses lived in nurses' homes, the matron instructed on all aspects of their lives, from how late they could stay out, to the suitability of partners. Getting married meant that nurses had to leave the profession (O'Dowd, 2007); *"If you got married that was the end of your career"* (FG2S1 180). Similar to the students in Pool's study, nurses demonstrated "self-confidence to not be deterred from striving for an ambitious [nursing] career" (Pool, 2012, p. 33). However, educational factors (success or failure) were significant in making career decisions (Pool, 2012).

As was presented in Chapter 5 (Table 5) nurses came from a variety of ethnic and cultural backgrounds. There were cultural differences in how they talked about their motivation to enter nursing. Twenty (42%) of the nurses were emigrants to New Zealand and there were

strong economic considerations in their choice of career. The South East Asian, Indian and Pacific Island nurses tended to send money home to their families as they had financial obligations in their home country. This activity is supported by other research where, for example Humphries, Brugha, and McGee (2009) found that 85% of their participants sent money back to their home country on a regular basis. This money made a significant difference on the lives of their families.

Māori nurses were unique in how they spoke about their motivation to enter nursing. They talked at length about their responsibility to give back to their family/whānau. All of the Māori nurse participants were trailblazers, the first ones in their family to be awarded a degree. One participant talked about her life as a sheep rouser³⁰ her poor literacy skills, and how she wanted to make a change for her family/whānau:

It was really hard I left school when I was 15 so I had to pretty much start right from you know ABCs...I couldn't spell, I couldn't even speak sentences properly. (S2N3 27)

For this participant, similar to the other Māori participants, the academic side of nursing was challenging and they needed a high degree of determination to succeed:

I applied and they said to me, because they said to me oh no, something to do with my education. And I come home and I'm thinking to myself how yeah then I pushed for it and I pushed and I went to nursing and at that stage it was only five Māori students and at the end of it there was only two of us that got through it. (N3S1 36)

The reasons nurses enter nursing are complex and can be largely understood as altruistic, however socioeconomic and cultural influences also have a role to play. In keeping with Stein's position, that values motivate action (Lebech, 2015a), the personal values of participants strongly influenced their motivation to enter nursing.

6.3 Emergence of values

Participants struggled to describe nursing values in general and were unable to articulate (specifically) what nursing values were. There was no explicit articulation of values: nurses

³⁰ A sheep rouser works in shearing sheds and picks up the fleece.

described how they practiced; how they felt; and what they did not like about their practice and the practice of others; rather than describe particular values. Values such as: intelligence “*they have to be intelligent, think on their feet*”; confidence, courage, advocacy “*not frightened of authority...be for the patient*”; and a belief in empathy “*you’re the next person out from the patient so you’ve got to be empathetic*”, respect “*mine [values] definitely are empathy, respect and valuing each individual*” were evident. Primarily personal values influenced nurses’ practice; however these personal values were positioned and enacted in relation to shared professional values.

6.3.1 The influence of personal values on practice

Respect, patience, kindness, independence, and compassion resonated as emerging from participants’ personal values. Personal values mediate how individuals balance intra-personal, inter-personal and extra-personal interests, to make prudent decisions (Sternberg, 1998) and personal values can strongly influence a nurse’s practice. Stein’s perspective, that the things we experience are interpreted by us, and “our motivation is in turn reflected in what we experience” (Lebech, 2015a, p. 31) prevailed. For the participants, values were generated from experience and experience motivated their actions (Stein, 1989)

All participants stated that personal values guided their practice. Personal values were identified as those that the nurses grew up with and those rooted in their culture. Values were generated from their experiences. Personal values held by the nurses influenced how they felt they practiced. In the quote below the nurse initially found it difficult to describe what she meant, but then linked who she believed she was to how she practiced:

It’s a little bit hard to explain I guess but of course you bring in who you are into your practice, bring that into your practice. So yeah and on some level it is who you are, yes. Bringing your values, you know your upbringing and everything. (N2S2 782)

When asked to elaborate on what she meant by values the nurse responded thus:

Just the values you were taught as a kid I guess to be kind to others and being respectful and patient isn’t always a big thing but I try and be as patient as I can. Yeah those kinds of values and just having respect for others. (N2S2 789)

Nurses' personal values are derived from a combination of their attitudes and perspectives and these values support all nurses to create a shared perspective or a shared approach to practice (Meleis, 2012). A shared perspective could be considered as what is unique to nursing, or it could, as Allen (2004b) and Watson (1988) argue, reflect a mandate to care for people. Most of the participants noted their role in caring for others: *"I chose to be a nurse"; "I'm interested in nursing"; "I care for people"*, where the shared perspective, or the common goal of nursing (in which the caring for others exists), was acknowledged:

I think we have a common goal of what the nurses should be doing but then because of our own personal values sometimes we disagree. (SNFG S1 543)

For this participant, like many of the others, there was a distinction made between a common goal (a shared perspective) and personal values. The common goal superseded personal values. This reflects a hierarchy of values (Stein, 1989) within the community of nursing. For a community of nurses (there has to be a shared understanding of values because it is that shared understanding that helps the community to work together for a unified goal, "any community unites a plurality of subjects within itself" (Stein, 2000, p. 197). In the quote above there was an acceptance of the shared values (represented by a common goal), but personal values were acknowledged as also having an influence on the nurses practice and possibly leading to disagreements as to the 'common goal'.

6.3.2 Personal values and espoused professional values

The values that are espoused by the profession (the community of nursing) are respect, trust, partnership and integrity (Nursing Council of New Zealand, 2012). These values were articulated by the nurses, however, in many instances, they did not relate these values to the Nursing Council of New Zealand Code of Conduct, but there was an assumption that the Code resonated nurses personal perspectives:

I don't know off the top of my head but I just go by my own core values which seems to keep me safe and I'm sure is worded differently but the same as what's in there. Well I try to, I try to comply with all of their codes of conduct and policies and procedures but I don't know them all off by heart, I just know how to work safely and within my scope. (N3S2 505)

As discussed in the introduction chapter of this thesis, Codes of Conduct are derived from the opinions of the profession; therefore it can be assumed that the Nursing Council of New

Zealand's code was a reflection of the nurses' personal values. The sharing of values and the adherence to these values shapes professional culture in much the same way as they shape organisational culture (Suar & Khuntia, 2010). Professional nursing values were accepted by both the nurses and the professional body and act as a "framework for evaluating beliefs and attitudes that influence behaviour" (Eddy et al., 1994, p. 257), however, despite this the nurses repeatedly returned to the position that their own personal values fundamentally shaped their practice:

It's my own values, my recognition of people's rights to their own life and their own choices, so yes even though I read all this [referring to the New Zealand Nursing Council Code of Conduct] and I agree with it, it's lovely but actually it's my beliefs and personally I think that's what we all do ultimately if you think about it, it is yours. (N1S2 197)

My daily practice is about who I am and my values, my values of my job and my understanding of where I'm working, it's not guided by a Code, yeah the Code presumably agrees with me. (N1S2 203)

Shared values (Rokeach, 1973) remind nurses how they ought or ought not to act. The need to be reminded of the content of the Codes was raised by a number of nurses, demonstrating a sense of responsibility and ownership for these Codes:

We need to have it shoved up our noses every now and again just to refresh us and I have printed it out because sometimes we do forget and sometimes we do get slack and slippery and time management issues and all the rest that happens on the floor we take short cuts. (N3S3 854)

Discussions about values with participants focused on personal values, however another element to the discussions was the acknowledgement that standards slip and nurses need to reaffirm professional values. Whilst it was clear that, primarily, personal values influenced their practice there was also a pattern of nurses articulating their values parallel to the values of others; however these parallel views were often at odds with one another. For example, one nurse reported that her values were empathy and respect, then questioned if her colleagues held these values:

Yeah I know what mine [values] are. Mine definitely are empathy, respect and valuing each individual and also valuing the input that I have whether it's right or wrong that input. But I don't know that I can always say that about my colleagues. I can say that generally as an overall umbrella for nursing but I don't know that I can say that about some of my colleagues. (S3N3 188)

This led to participants both implicitly and explicitly judging the values of others (the concept of othering will be discussed later in the chapter in the context of defence mechanisms).

6.4 Living and not living nursing values

There were circumstances where nurses *lived their values*; and many circumstances when they did not or felt they could not *live their values*. Living values is demonstrating behaviours (actions) and attitudes that express those values or as Edge and Groves (1994, p. 3) argue living values gives rise to an “understanding of what ought to be in regard to human behaviour” and values become meaningful when they were demonstrated in nurses behaviour (Murphy, Canales, Norton, & DeFilippis, 2005). Not living nursing values was influenced by the situational contexts of being burnt-out, exhausted and cynical. Nursing practice was constrained and a dissonance existed between how nurses wanted to practice and how they actually practiced.

6.4.1 Living nursing values

Living nursing values was more than a practical activity, more than attending to the body physical; it was the enactment of values:

She sat down with him and he'd been vomiting. One of the first things she said to him was oh you poor thing you've been sick. She asked him if he was cold and he said he was so she went and she got him a blanket. She was gentle and kind. (Field Note S2D4 281)

There was both an active and passive aspect to the nurse's actions. Both skilled compassion and skilled companionship have been depicted as the “nurses active listening to the patients concerns, suggesting strategies to move patients forward, while at the same time, providing space for them to move at their own pace” (Lally, 2014, p. ii). In Ersser's (1997, p. 302) exploration of the therapeutic activity of nursing he reported that patients believed in both the therapeutic importance of nurses actions and their presence, arguing that nurses ought to be mindful of the subtlety of their actions because the impact of their actions has yet to be fully understood. Expressions of skilled compassion were observed more often on night

shift than on day shift; primarily because the night shift was quieter and allowed nurses more time to be with and attend to patient needs:

As she moves about to give her midnight medication she approaches the patient very gently and almost whispers you know I have tablets for you. And as she does that then she says I'm going to take your observations while I'm here. So the conversation goes on have you had much sleep and the patient says no. The nurse tries to find out is there any reason why. No, the patient says no. The nurse says sometimes it's hard to sleep when you've been in bed all day. The nurse does her best to reassure her and then tells her to have sweet dreams and tries to make her comfortable again. (Field Note S2D4 35)

Although not well researched there have been a small number of studies that found nurses provide greater levels of psychological support for patients on night shifts as opposed to day shifts (Hanson, 1994; Hanson, McClement, & Kristjanson, 1995). Nurse participants in Hanson's (1994) study sat with patients, listened to them and answered their questions. It was during the night when patients' felt they could voice concerns and be heard by the nurses (Hanson, 1994; Hanson et al., 1995).

Compassion and kindness were also manifested in the nonverbal communication and facial expressions of nurses; smiling was a good example of this:

...sometimes I'll just wave, communication that gets me out of the shit [referring to not missing critical elements of patient care or being reprimanded by the nurse manger] all the time. You know even though I'm there just acknowledging I'll be there running like crazy and I smile and run. (N3 S2 580)

Nonverbal communications such as a smile or wave are critical in establishing rapport, trust, warmth and support and can have a profound effect on individuals (Hall & Roter, 2006). It has been estimated that non-verbal cues, like smiling, make up 55-95% of communication (Gross, 1990) and is central in conveying emotional and relational information during patient interactions (Hall & Roter, 2006; Hall, Roter, Blanch, & Frankel, 2009; Roter, Frankel, Hall, & Sluyter, 2006). Nonverbal communication, in particular a smile was also shown to be important to patients (discussed earlier in section 5.5.5).

There were very few examples of both the articulation and enactment of nursing values. The observed actions of the majority of nurses in all sites were incongruent with the values they espoused and incongruence between espoused values and enacted values was demonstrated in all sites, the only difference was the level of incongruence. Site 2 had less incongruence overall; nurses were able to action their values to a higher degree than the other two sites due to less acute patient presentations and a more supportive and stable nursing team (a community of nursing) and clinical environment. More nurses were observed spending time with patients and supporting each other than was apparent in Site 1 and Site 3. Some examples included making beds “*to make life easier for the next shift*” (S2N5 307), and answering call bells for each other:

A patient’s bell is ringing and the nurse goes to see the patient even though he is not her allocated patient, “what can I do for you, can I make you comfortable”. (Field Note S2D3 312)

And assisting with clinical procedures:

One of the nurses has only been allocated one patient so she offers to help others, a 12 lead ECG [electrocardiograph] needed to be taken so she said she’d take it. (Field Note S2D3 312)

6.4.2 Not living nursing values: the impact of systems and situational context

Nurses could not consistently live their values because they practiced in environments that fostered burnout and cynicism and where they felt, for the most part exhausted, as one nurse recounted, she was “*so burnt-out that there’s only ash left*” (recorded in Field Note S3D1 53). As discussed earlier (Chapter 2 section 2.3), burnout is a psychological syndrome related to prolonged exposure to chronic interpersonal stressors (Leiter & Maslach, 2009a). The Maslach Burnout Inventory (MBI-GS) was used to measure the levels of burnout in the three sites. Forty-three surveys were completed (Table 6). There were three key dimensions of participant responses; overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment (Maslach 1993). High levels of burnout have been linked to negative attitudes, poor performance and inadequate patient care (Spence Laschinger & Leiter, 2006; Spence Laschinger, Leiter, Day, & Gilin, 2009; Poghosyan et al., 2009, 2010). High levels of burnout were reported at Site 1 and Site 3. Site 2 had an average level of overall

burnout. Professional efficacy (which is concerned with job satisfaction) was average across all sites.

Table 6: Maslach Burnout Inventory by study site

	Site 1 n=10	Site 2 n=12	Site 3 n=21
	$\bar{x}$ (SD)	$\bar{x}$ (SD)	$\bar{x}$ (SD)
Overall Level of Burnout	High	Average	High
Professional Efficacy	27.80 (6.03)	28.01 (4.50)	27.04 (4.68)
Cynicism	13.30 (6.44)	7.16 (7.70)	14.00 (6.48)
Exhaustion	13.40 (4.14)	9.41 (5.90)	17.90 (6.22)

*Colour code:

High score	Average score	Low score
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Site 2 had the lowest level of exhaustion, which could be explained by the fact that it was the smallest of the three sites and had a lower patient acuity. Site 3 had a high level of exhaustion; this site was in an intense period of change with a temporary leadership structure in place. For Site 1 the level of exhaustion recorded on the MBI was average; however, my observational field notes indicated a nursing team with high levels exhaustion:

Nurses came into the room and slumped back in the chairs, some closed their eyes others rubbed their faces, they took the tea offered to them with thanks, one stated I can't think straight. (NFG2 S1 3)

Only 10 nurses in Site 1 completed the MBI; the reason given for not completing the survey was that they had too much else to do. One of the events that created high stress levels was the number of patient deaths at Site 1. At this site the average patient deaths per ward across the hospital was 30 over a 10-month period and on the medical ward, there were 173 patient deaths over the same period. The ward had no specialist nursing palliative care services to support the management of dying patients. This alone, according the NM, caused a significant amount of stress for the staff (Gardiner, Gott, & Ingleton, 2012; Gardiner et al., 2013).

Some of the reasons given by patients for nurse burnout were, “*short staffing and bad management*” (S2N5 123). A suggestion was made by one of the ex-nurse patients that

“sometimes what happens in our [their] personal lives is reflected in our [their] professional life” (S2P1 129). This blurring of professional boundaries was challenging for this participant, as she was educated to be a nurse in the 1940s where the boundaries between nurse and patient were very clear. Participants in a study conducted by Belcher and Jones (2009, p. 148) confirmed that there are times when a nurse’s personal life influences their state of mind impacting in their ability to effectively communicate.

Systems, along with situational forces of the environment (Zimbardo, 2007) in which nurses practice, can influence individual nurses behaviour and ability to live their values (see Chapter 2 section 2.3). The system (in this case is the organisational activity embedded in District Health Board and to a lesser degree the ward) was a powerful force in the context of this study. When things go wrong in healthcare it is convenient to blame an individual rather than the system; it deflects attention from those who may be actually responsible for a lack of oversight or poor working conditions (Scott, 2014; Wright, 2011). Nationally and internationally there are examples of individual nurses being blamed for the failings of healthcare in meeting the need of patients (Carville, 2014; Cummings, 2013)³¹; however, blaming the individual fails to account for the situational context. For many of the nurses in this study, the environment in which they practiced was both burnt out and cynical.

6.4.3 Constrained practice and not living values

Constrained practice, as described by Aiken et al. (2014), was demonstrated in all sites, particularly in requests from management to ration care. Rationing care is considered a legitimate strategy employed by the ‘system’ to manage health care costs (Manning & Paterson, 2005) and is positioned in a managerialist approach to healthcare (Beck & Melo, 2014; Traynor, 1999, 2013). When rationing, nurses are expected to prioritise tasks such as clinical observations, medication administration and fluid balance charts, thus reinforcing task orientated nursing. At Site 3, the communication book³² had written directions for the nursing team to follow, for example, *“hygiene needs were limited to*

³¹ “Nurses who don’t care about patients must leave the NHS” according to Cummings (2013) in an emotive newspaper article.

³² Communication books were used across all sites. These books were hard covered daily diaries, and were used to communicate messages from the NM and between the members of the nursing team.

application of a wet cloth to face and hands and to genitalia for incontinent patients” (Field NoteS3 114). The implications of such care rationing on nurses are feelings of guilt (not providing a standard of care that they feel is acceptable) and the prevention of enactment of professional nursing values (Vryonides, Papastavrou, Charalambous, Andreou, & Merkouris, 2014).

The impact on patients was also deeply significant, as critical elements of care that are rationed included: emotional support, turning patients, hygiene needs (oral and hand hygiene) and patient teaching (Papastavrou, Charalambous, Vryonides, Eleftheriou, & Merkouris, 2016). The lack of prioritisation of emotional support was clearly demonstrated in all sites. Even Site 2, which for the most part was calm and quiet, there were examples where patients felt alone:

He said to me that he didn't feel listened to about his health and that he's been told what to do, go to sleep, do this, do that. He said to me that they [referring to nurses] say that they care but they don't love. He said it's paternalistic. He desperately needed someone to speak to and I felt that he desperately needed to be heard. When I left he kissed my hand and I think that he felt listened to. (Field NoteS2D6 181)

Maben, Latter and Clark (2007) point to the impact of professional constraints on nurses and the corpus of their Maben et al. (2007) study reflected participating nurses comments and actions of; hurried physical care, not getting involved with patients and intensification and routinisation of care. Nurses felt “*stretched to the max*” (FG3S1 133), feelings that are congruent with the Maben et al. (2007) study. At times they felt incapable of providing the level of care that they would like. This resulted in decision-making that was pragmatic, based on the practicalities facing them on a daily basis, what was realistically achievable, and what was unlikely to result in harm to patients or to themselves.

As mentioned above organisational constraints are positioned around “intensification and routinisation of nursing work” (Maben et al., 2007, p. 104). Intensification is defined as: staff shortages and patient turnover/throughput, and routinisation is predicated on task-oriented care (Allen, 2004b; Maben et al., 2007; Wong, 2004). Habitual task oriented care is a “direct consequence” of organisational constraints (Maben et al., 2007, p. 104):

They [Management] don't care, they don't care [about] the situation and the environment that we work in, it just doesn't make you feel like...that you're a valuable team member, you're just here to do a job and tick boxes. You know just do as you're told and do it properly but at the end of the day if you make an error or [have inaccurate] documentation you're accountable but even though you're under all this pressure to look after so many patients, you know, during the shift so much has gone on. (N3S2 154)

Nurses were juggling: medical and multidisciplinary needs; the needs and requirements of the organisation to discharge the patient; the needs of the patient and family; as well as their own physical and emotional capability and capacity. Using tasks, as a way to cope in clinical practice is well described by Menzies (1960) and is an example of secondary anxiety and the threat of crisis and operational breakdown. Because of the environment that the nurses practiced in tasks and timetables were used as a means to eliminate decision-making by establishing ritual (Roth, 1963). The rituals in each site were well established and pivoted primarily around medication administration, clinical procedures, admission and discharge. When the tasks in the ritual were not performed and the timetable was not met it caused further anxiety for nurses:

...sometimes I am nowhere to be seen and that's really, and that cripples my practice some days, it's because families want to talk to me and I have to run around and do other jobs because medication's the biggest you know. Making sure they get their meds on time, their blood pressure, because we're acute you know we can change just like that, yep. And the family wants to talk to me about their Mum, their loved one, the one that they care for and I know sometimes that they do but I just can't get them, I'll be there when I can. I'll be there when I can, I'm over here. I'm going to run away because I've got to go and get medication or do something else. (N3S2 245)

Constrained practice was further demonstrated in the very systems that were put in place to support nurses' practice, specifically patient acuity measures. Patient acuity was measured at Site 2 and Site 3 using TrendCare³³. Site 1 relied on a patient acuity score determined by the shift coordinator. There were contrasting feelings about the usefulness of TrendCare in recognising patient acuity and therefore nurses work load:

³³ In an attempt to support safe staffing District Heath Board in New Zealand and the NZNO agreed to implement safe staffing strategies. TrendCare and Care Capacity and Demand where the two strategies that were agreed upon. These strategies either have been or are in the process of being rolled out across New Zealand (Hunt, 2014).

It's hard to try and deliver a good standard of care when your acuity's based from a computer. Because I don't think it incorporates a lot of things. (N2S2 239)

They're not consistent that's the thing, it's not consistent. Yeah one minute, I think they change it sometimes, like we could escalate our TrendCare and then the person who oversees it might come into the ward and say no, no, no this needs to be changed and she'll change it and she's not even taking care of the patients. (N2S2 247)

The integration of technology into healthcare provision is essential, and when it works and is well resourced it can help establish safe and effective care outcomes (Barnard, 2016).

This was recognised by those nurses who supported the use of TrendCare:

But since the TrendCare has kicked in I think it is throwing a fair amount of load off us. And it shows our true acuity of the patients I would say. Before they were going on numbers and they were saying on you have three patients so you can have three more or four more. But they didn't know how heavy those three patients were but since TrendCare... (FGS2 243)

As a tool, TrendCare is used to measure patient acuity, and is supported by the biggest nursing union in New Zealand the New Zealand Nurses Organisation (NZNO, 2016), however there is a dearth of literature in New Zealand on the benefit and impact of TrendCare. What was clear from participants was that, whilst there may indeed be benefit there was a degree of scepticism that the tool gave nurses more time with their patients, particularly as the new approaches brought with them increased administration activity:

Sometimes with the amount of paperwork it keeps us away from our patients. We want to do the caring but we get too much care with lots of paperwork, which is quite huge at times. (FFS2 234)

Managerialism and bureaucracy were at odds with how nurses wanted to practice and there was a large degree of scepticism toward health service management from nurses across all sites. Nurses felt pressurised to meet organisational demands. This resulted in the rationing of care, constrained nursing practice and nursing values not being lived.

6.4.4 Value dissonance and not living nursing values

Not living nursing values was manifested in disrespect and value dissonance. Value dissonance is a term used to describe the conflict between the attitude and actions. It is a

term that is well documented in the nursing literature (Bendall, 1976; Houghton, 2014; Koerner, 1996; Lipscomb & Snelling, 2010) and is often conceptualised as what ‘is’ and what ‘should be’ (Clark, 1997, p. 446). Nurses articulated respect as an important nursing value, however there was conflict in how respect was enacted and articulated, a dissonance. Disrespect was exemplified in a number of ways and in many situations the nurses did not appear to be aware that they were being disrespectful:

The nurse goes into the room where the patient is and says Mrs A “what is your problem? I just have to keep ignoring you. You’re not weak and feeble, I’ve been polite to you, why do you have to be rude, if you’re going to be rude I will be equally rude to you. I expect you to treat me properly”. Mrs A says “I was calling for help”. The nurse walks out of the room and says to another nurse “she’s going to drive me nuts”. The nurse went back into the room and shut the door. I could hear her, I could hear what she was saying. “I can’t clean you while you’re flat on your back”. Her communication with the patient was loud and forceful. The shift went on in this manner. (Field Note D24 86)³⁴

When trying to understand or explain why someone has behaved in a particular way we often concentrate on the individual and ignore the context or the situation (Harman, 1999). This however, fails to take into account that behaviour is influenced by situational context (as previously mentioned) the fundamental attribution error (Paley, 2014). Fundamental attribution error occurs when the internal factors are overestimated and the external factors are underestimated when explaining behaviour (Ross, 1977). The nurse referred to above clearly wanted to provide a good standard of care; however she practiced in an environment and situational context that was profoundly influenced by managerial imperatives and a workforce that was burnt-out and highly cynical. A person’s ability to demonstrate helping behaviours is contextual and has little to do with compassion deficits or character traits (Paley, 2013). Fundamental attribution is not an excuse for bad behaviour, as some would argue (Darbyshire, 2014a), rather it helps to add context to the situation and not solely blame the character of the individual. In situations where the nurses were aware that their values were not met they felt deflated, dissatisfied “*shocking*”; “*frustrated*”; feeling like

³⁴ To protect the participants’ confidentiality no identifying features are used in this quote.

“crap”; “wasted”; and in some cases reported that they found it “hard to sleep eh you’re thinking all the time” (NFG3 S1 154):

...because our values are not met because if our values aren’t met we go home dissatisfied, we go home yeah not happy. And, and [this] affects us at home because we keep thinking. (NFG3 S1 299).

Value dissonance caused profound mental distress (Bruhn, 2008) for the nurses at all sites and deprived them of personal satisfaction (a secondary anxiety as described by Menzies). Each site had particular issues to contend with: Site 1 had high patient acuity and high patient mortality; Site 2, whilst the most settled of the three wards, still had a relatively new manager and was in the middle of the implementation of TrendCare; Site 3 had significant upheaval because of temporary nursing leadership and the pressure to rollout new projects including TrendCare. Some of the nursing staff felt the pressure acutely:

I’m sitting in the office bawling my eyes out that’s not me because you know events forms are going to be done against you and I had enough of those as a new grad. So no I just thought oh I can’t stand this, I hate it so much...I’ll nurse how they want me to. I don’t care if it’s different from one day to the next I will be the nurse that they want me to that day which is really unsettling, really unsettling. (N1S3 90)

Values dissonance felt by the nurses was linked to the influence of external factors, factors out of their control and was emotionally exhausting. To cope with this nurses employed a number of unconscious defence mechanisms.

6.5 Defence mechanisms

In an attempt to protect themselves from the system, and situational contexts in which they practice, the nurses at all sites demonstrated defence mechanisms as described by Menzies (1960). Menzies outlined 10 primary defensive mechanisms (see Chapter 2 section 2.5.1) three of which were dominant defence mechanisms of the nurses in this study. These were: splitting up the nurse-patient relationship; depersonalisation, categorisation and denial of the significance of the individual; and collusive social redistribution of responsibility and irresponsibility. These dominant defence mechanisms did not mean that the other six mechanisms were not demonstrated; they were, but to a lesser degree. Contemporary anxieties, rationing anxiety, performance anxiety and governance anxiety (Cooper, 2010)

were also present. A sense of operational breakdown and a deprivation of personal satisfaction were also elements of Menzies research. In this study these were viewed in the context of value dissonance and constrained practice as presented above.

6.5.1 Splitting up the nurse-patient relationship

Splitting up the nurse patient relationship (Menzies (1960) could be seen when nurses restricted their contact with patients, sometimes overtly: “*don’t go into her*” (Field Note S1D34 135); and other times unconsciously, such as nurses spending a significant length of time in medicine dispensing rooms, reading notes, or inputting data into the computer system. At certain periods of time, usually medication times (0800, 1000, 1200, 1400), the entire nursing team was sometimes in the drug room.

The nurses’ split up the nurse-patient relationship by restricting their contact with patients (Cooper, 2010; Menzies, 1960) and task orientated care was the predominant feature of nursing care. Focusing on the task was the nurses attempt to cope with the anxiety of not practicing at a level and in a way that they wanted to. Functional/task orientated care was used to cope with the demands that nurses faced in daily practice and splitting up the nurse-patient relationship, that is, not providing what they believed was ‘quality care’, was one method used:

I haven’t got the time for that quality care, I haven’t got the time to do it, it’s rushed, it’s yeah it’s rushed and there’s pressure to get that discharge out the door, you know and get them seen by all these people with MDT [multi-disciplinary team] and it’s a lot of the time, it’s like task orientated, yeah. (N3S2 356)

The entire nursing team is sitting at the station reading notes and working out their job list for the shift, who needs medication, who need washes. There’s an alarm ringing but it’s at the other side of the ward so nobody in this team gets up to answer it. They are checking in with each other a little bit and just clarifying some of the points about what needs to happen for the day. (Field NoteS2 101)

This focus on planning, and not responding to immediate needs (call bells), was sometimes done overtly, and other times unconsciously. The few nurses on each site who were observed to attend to their patients before reading notes were observed to demonstrate professional values to a higher degree than other nurses. These nurses were the ones who

greeted patients at the start of their shift; gave their patients recourse to freshen up before breakfast:

The nurse greets the patients in a very warm and friendly manner and gives them a warm flannel and face cloth to wash their hands and face before their breakfast. (Field NoteS2D1 25)

The nurse is going to each patient and greeting them and she asks them how they are and she makes them physically comfortable and she adjusts the blinds to make sure it's not too bright for them. (Field NoteS1D3 18)

These nurses were an exception rather than a rule and created a calm and relaxed environment.

The majority of nurses in all sites attended to the task before extending any courtesy to patients. According to Menzies (1960) the closer the relationship to the patient the more anxiety the nurse can experience therefore restricting the contact with patients protects the nurse:

The nurse is working with a patient who's just woken up and is just a little bit confused. She's doing her best to find the patient's slippers and is concentrating hard on what's going on for this patient and she's taking her clinical observations. The patient is talking and talking but she's getting very little back from the nurse. The nurse seems to be locked into doing what needs to be done and she made sure that the patient's bell was next to her and then she moves onto the next patient. (Field NoteS1D3 57)

This nurse was demonstrating splitting the nurse-patient relationship, she was present yet absent. This mechanism of being present but absent is sometimes referred to as emotional numbness. It can reduce the nurses' stress by providing "an exit from overwhelming distress that allows a person to remain physically present" (Hochschild, 2003, p. 188).

6.5.2 Depersonalisation, categorisation and denial of the significance of the individual

Depersonalisation of the individual was observed when nurses made comments about a patient being a bell pusher or referring to patients more generally as 'the bell', or 'the discharge' or when they focused on documentation or 'tasks'. Patient classification or describing a patient by how they fit into a diagnostic system, or labelled in anyway fails to take into account their uniqueness and humanity (Todres, Galvin, & Holloway, 2009). The

type of language used to describe patients represented their dehumanisation and objectification.

Keeping a distance, a manifestation of depersonalisation, was a defence mechanism advocated by one NM where she believed that she was acting in a manner that protected her staff from stress:

I'll get the nurse educator, the healthcare assistant, make sure that they are delegating appropriately, make sure that they get their breaks. Sometimes a lot of nurses they get so focused on their workload they can't see what's actually around, the resources that are around them. Prioritise their care. What is actually important, remind them that there is a shift coming on after them. You know of the fact that they can hand over, yes so it's just really just reprioritising with them, yes because you can get stressed when you can't see what's most important, they just see so much that they have to do.
(NMS1 170)

This support offered by the NM was not appreciated by the nursing team and they described it as a punitive approach where nurses were, “*pulled into the office*” (N3S1 433) by the NM, who concentrated on meeting targets such as reducing medication errors or falls.

Distancing was also manifested in the length of time nurses spent in the drug room. Sites 1 and 2 both had a Pyxis Medstation³⁵, this is an automated drug-dispensing device located on the ward in a controlled entry room (a drug room). At these sites the nurses spent longer in the drug room than they did at Site 3. The reason for this was that at Site 3 multiple nurses could work simultaneously to prepare medications. At Sites 1 and 2 nurses had to wait for the availability of the Pyxis machine, similar to the findings of Liu, Manias, and Gerditz (2014) who showed that nurses queuing to use the Pyxis machine were spending a significant amount of time in the drug room.

6.5.3 Collusive social redistribution of responsibility and irresponsibility

Nurses in all sites felt that they were under scrutiny from management and even asked me when I was observing: “*are you going to tell us off?*” (Field NoteS2D1 31). The notion of

³⁵ Pyxis Medstation is a “medication distribution systems that provide computer-controlled storage, dispensing, and tracking of medicines” (Zaidan et al., 2016, p. 1) implemented to reduce drug errors.

‘telling off’ was an example of collusive social redistribution of responsibility and irresponsibility. In Menzies study nurses identify some nurses as being more responsible or irresponsible than others and when things go wrong there was a tendency to blame whoever was closest without much effort being placed in finding the actual culprit. Specifically Menzies (1960, p. 105) mentions how “nurses complained about being reprimanded”. Fifty-four years after Menzies’ study, nurses are still complaining about being reprimanded. However, the NM at Site 2 made little apology for “*coming down on*” nurses as she sees it:

You know and there’s probably times when nurses are really a bit snappy but there is a standard of care that is expected and if that’s not happening I do come down on that smartly, yep and they know that. I hope they know it, they should know it because they’re told often enough. (NMS2 239)

Another example of collusive social redistribution of responsibility and irresponsibility was demonstrated when nurses carried out procedures or actions that were out of their scope of practice or against hospital policy. Examples of this included writing out medication charts for doctors; dispensing multiple medications instead of the one patient at a time policy; and manipulating patient acuity (so nurses would not be pulled from the ward). The reasons for these breaches were not to make nurses lives easier; they were undertaken with the patient’s interests in mind:

So she knows there’s something not right about that [writing out the chart] but then she’s saying that we have to improvise because the systems maybe are not in place to get things done quickly. She said to me that because she’s being watched, basically because I was there she was writing out the charts but ordinarily she would give the medication [without it being written up so that the patient didn’t have to wait and suffer for longer than was necessary]. (Field NoteS1D2 18)

This type of subversive activity is documented in the nursing literature by Sellman (2010a) and Hutchinson (1990) who both argue that “nurses bend the rules for the sake of the patient” (Hutchinson, 1990, p. 3) but they do so in a responsible way.

Menzies (1960) found that nurses habitually complained about the practices of others and these complaints were collective rather than directed toward a specific individual. Nurses in Menzies study described others as being irresponsible and demonstrating unprofessional

behaviours, never did they equate the behaviour to themselves. This is in accord with the findings in this study where nurses made frequent comments about the behaviour of others but never their own behaviour. No nurses disclosed negative personal values, although they did attribute negative personal values to ‘others’ and to ‘management’. Menzies found that nurses split aspects of their conscious self in order to project onto other nurses as a defence mechanism. Othering was a defence mechanism that nurses in this study used to protect themselves from anxiety.

Nurse values were frequently viewed parallel to the values of others. Parallel positions (either comparing oneself to others, or viewing others different to self) is othering and “is a process that identifies those that are thought to be different from oneself or the mainstream” (Johnson et al., 2004, p. 253). A number of authors argue that it is through others that we see ourselves, or that through others we know ourselves (Canales, 2000; Charon, 1992; Weis, 1995). I argue that to truly see ourselves we have to have an awareness and insight to our othering of others. The consequence of othering is a distancing between individuals; the other is different, and reinforces apparent differences from oneself (Johnson et al., 2004). Even when othering is unintentional it can augment and cement positions of dominance and subordination; I am better than you (Fine, 1994). The process of othering in nursing can therefore have a negative effect on the profession because when nurses other each other shared professional values are challenged.

Participants made judgements on the values both demonstrated and articulated by their colleagues making numerous references to the ‘poor practice’ of others. Othering separated the participant from what was considered the poor practice of others and nurses in all sites othered nursing colleagues ‘lack of values’ such as those of: autonomy; independence; respect; kindness; preserving dignity; integrity; partnership; and compassion. In making these judgements the participants referred to (other) nurses, for example, doing things for the patient that the patient could have done for himself or herself:

Promoting independence is a big one for me. For some of them [referring to other nurses] I think it's, this is going to sound horrible, making life easier for themselves as nurses. By bed panning you know by not by not assisting them up, by locking them in their beds and rolling them for cleaning them and rolling them for washing them and instead of taking that time to [help

them up for a shower], *I mean you don't always get the time but if you do I think promoting independence so that they can either get back to base line or whatever their new base line is due to whatever their illness it is a really important thing so they can either move on home again or back into the community.* (N1S3 189)

The nurse says she valued independence but (according to her) her colleagues were different and wanted to get the task done quickly to make their lives easier. This nurse's perception of the other had the potential to be stigmatising and a threat to the existing social order (Canales, 2000) of nursing mores.

According to Stein (1989), when an individual's values are challenged they are in turn challenged to reconsider their own values hierarchy. However, nurses frequently considered their own values hierarchy in relation to how they perceived the values of other nurses, sometimes judgementally but often with understanding of the challenges faced in clinical practice:

So a value that I might have is, you know, they have to have their hair brushed after their shower, half of the nurses on the ward wouldn't value that. I mean I accept that, that's fine it doesn't make them, you know, a bad nurse and I know that. (SNFGS1 577)

The values of the nurse (quoted above) were that of maintaining human dignity and were based on a presumption of shared values within the community of nursing. In this case, according to the nurse, all those in the community do not share her values, however the nurse was willing to accept that her colleagues were not 'bad', they just didn't share this particular value:

But I think we work like, patient focused. It's more patient focused but you know we [nurse community] have different ways of showing or applying that but I think at the end of the day it's working [in a] patient focused [way]. (SNFGS1 581)

Even with good intention nurses' willingness to accept a variance in a values hierarchy has the potential to reinforce negative feeling toward colleagues and the wider health care system (Johnson et al., 2004). Variance in a values hierarchy led participants to have a lack of a shared perspective. For example, some nurses understood patient focused care as "getting the task accomplished". Tasks included, but were not limited to, medication administration, the taking of clinical observations, or completing documentation such as a

discharge plan. These tasks mediated around the immediate treatment needs and were given priority over, for example, patient hygiene needs.

Stein (1989) maintains that a community is made up of individuals who have shared values and the values help to coordinate their actions, offering a sense of unity as they work together to realise their actions; in the presence of othering this is challenging. Stein recognised the hierarchy of values and those that are given a higher place, for example human dignity; the higher placed the value the more deeply they are felt by the community (Lebech, 2009; Stein, 1989). However, task nursing (as described in Chapter 5) was the prevailing model of care in all sites and data demonstrates that (for some participants) human dignity was lower on the hierarchy of values:

We can't say to anybody that you haven't cared about that patient because you haven't brushed their hair and it's like well actually brushing hair is not big on the scale of things you know. (SNFGS1 532)

When criticising other nurses, participants described how colleagues were unwilling to deliver comprehensive nursing care. These nurses were accused of “*picking and choosing; cutting corners; lacking knowledge, being ignorant, only there for the money, or selective practice*” as to what they did or did not do, resulting in missed care. Missed care (also referred to as care undone) refers to any aspect of required care that is omitted (partly or completely) or delayed (Ball et al. 2016; Kalisch & Williams, 2009). The criticisms of other nurses were often given with consideration to the system and situational context and in what way it affected how nurses practiced their values, resulting in value dissonance.

She basically handed over that he hadn't been incontinent and yet he was absolutely filthy. But the nurse that handed him over to her is one of the ones that on a personal level I'm quite happy, you know, get on with her absolutely fine but she does cut corners...she gets all of her work done very quickly and very efficiently, makes it look like she's very, you know very efficient but she does, she's selective. (N4S2 128)

Another example of collusive social redistribution of responsibility and irresponsibility and othering was a nurse who was particularly critical of her colleagues calling them “*dud*” nurses, a synonym for calling them useless:

A dud nurse would be someone that doesn't check in on them [referring to patients] regularly, doesn't talk to, communicate properly, doesn't ask if they're in pain, just rushes, talks over them, talks through them, talks to the

other patient. If they're asking for too many things you know too many requests. (N3S2 245)

Dud nurses added to the pressure of the working environment because others had to pick up the pieces of work not done or repair relationships that had been damaged:

I'm the fifth nurse [to look after the patient]. There have been a couple of duds before me you know so in that instance I have to build up a rapport because you know, which is fair enough because sometimes they [the patients] lose a bit of trust in the care that they receive. (N3S2 238)

6.5.4 Contemporary anxieties

Cooper argues that the merits of Menzies work have not been fully realised or explored. He maintains that contemporary anxieties in health care might include “governance anxiety”, “rationing anxiety”, and “performance anxiety” (Cooper, 2010, pp. 222, 223). These additional anxieties shift the discourse of organisational anxiety and defences against anxiety to better reflect the economic and quality rhetoric from governments and health boards. The process of making this shift illustrates that anxieties are not simple but extremely complex and politically, socially and situationally motivated (Cooper, 2010).

In the context of governance anxiety, participants in all sites were aware of the organisational value statements but viewed them with scepticism. Gallagher (2013) contends that nurses are likely to have difficulty making sense of the proliferation of value statements that pervade health care and educational institutions. She makes the argument that organisational values statements can be a good thing but the meaning and role of such statements is not always clear. Nursing is a value-based profession and at its core is a “wide range of moral and intellectual values” (Gallagher, 2013, p. 616). These nursing values may be at odds with organisational and political values of productivity and cost effectiveness (Krol & Lavoie, 2014; Maben, Latter, & Clark, 2007; Sellman, 2011a, 2012) as is evidenced in the following quote when a participant was asked if personal values and organisational values align:

No. No because my values are to care for the patient. Their value is to...[have] feet on the floor and numbers in their books. (N2S3 209)

There was a perception, particularly at Sites 1 and 3, that management did not understand the realities of clinical practice:

It seems like it's very heavy on the management side and that's all well and good for them to sit there and develop policies and things but when it actually comes to the coalface they're not, they're not always practical things. And you sort of think, you know it's like the extra paperwork that we keep getting all these new assessments and forms and things to go in and pass through. And I know that in the long run it's all patient safety but we spend more time sitting here doing all of that paperwork which detracts from being with the patient which kind of negates the whole purpose yeah. (N4S2 5)

The NE at Site 1 recounted a conversation where she had tried to explain to senior hospital management why sick leave for nurses was so high. The distress on her face, when she recounted this experience, was clearly obvious as the manager responded by saying, “*tell me anything but don't tell me it has to do with acuity*”:

We [management] don't want to hear that it's the high acuity, why are the staff sick, why are they calling in sick. [The nurse educators says] It's just like well they are, they're burnt out, [The manager says] well that's not good enough what else is going on? [Reflecting on the manager's line of argument the nurse educator says] It's like you're [the manager] a frigging monkey seriously, like how can you fight against that, that kind of mentality. It's all paper pushing and dollars. It's not sick people in hospital. (NES1 D5400)

A number of research studies show an association between high patient acuity and higher rates of both long and short-term sick leave among nurses (Baydoun, Dumit, & Daouk-Öyry, 2016; Mudaly & Nkosi, 2015; Rauhala et al., 2007). The environment described by the NE was one of managerialism (Aiken, Rafferty, & Sermeus, 2014; Beck & Melo, 2014; Traynor, 1999, 2013). A defining characteristic of managerialism is the achievement of organisational goals or meeting strategic targets. It is a worldview that is different to the nurses who in many instances take “on this rationality ‘as a given’, this might result in cognitive dissonance as they struggle to reconcile humanistic care with technico-rationality, feelings of disempowerment, rendering them unable to criticise or posit an alternative” (Goodman, 2014, p. 1266):

Saving money for the organisation they don't care about what we are doing, what we are going through. (FG2S3 284)

One of the nurses is looking for tissues and asking does anyone have tissues. And the day staff are saying oh you're going to have to go home and get your own tissues we don't even give patients tissues here. The night nurse went and got some and there's an absolute amazement by the day staff

saying where did you get those from? You know as they said earlier you can't even get tissues for patients. (Field Note S3D1 64)

Performance anxiety manifested in nurses doing as they were told and was exemplified in constrained practice. Working in an environment where there is a perception that money and bureaucracy comes before patient care made it difficult for the nurses, in all sites, to enact their values and caused them to prioritise managerial imperatives above patient care, thus constraining their practice.

6.6 Chapter summary

The findings in this chapter highlighted a number of key issues which were concerned with the motivation and barriers to enter the nursing profession, the influence of personal values on professional practice, living and not living nursing values and defence mechanisms. The nurses were largely guided by their personal values, and the community values of nursing, as described in professional codes, aligned with the nurse personal values. There were examples of nurses living their values but also many instances when they did not. Not living values was profoundly influenced by the system and situational context and resulted in constrained practice and value dissonance. Nurses demonstrated defence mechanisms as a way to cope with the constraints they faced in daily nursing practice.

CHAPTER SEVEN: CONCLUSION

7.1 Introduction

In this chapter I outline the significance and contribution this study makes to professional nursing practice in medical ward environments as well as the implications for healthcare. Key findings and the contribution to knowledge are presented. A critique of methodology is offered and both the contribution to methodology and method are discussed. The propositions of the study are revisited, as is my reflexive awareness. The chapter concludes with recommendations for future research and the implications for the nursing profession and healthcare.

7.2 Key findings and contribution to knowledge

This study makes a unique contribution to nursing knowledge as the first doctoral study in New Zealand exploring contemporary nursing values within the clinical environment of acute medical nursing. The key finding is that nurses do not live their values despite having the motivation to do so. This primary research into nursing values has demonstrated that the current climate of healthcare does not foster the enactment of humanistic values that are fundamental to how nurses perceive the practice of nursing. Nurses are conflicted in how they want to practice nursing, and how they actually practice nursing. The conflict arises from nurses experiencing systems and situational contexts that foster managerialism, anxiety (such as governance, rationing, and performance anxiety), burnout, cynicism and exhaustion. This in turn, leads to a values dissonance resulting in a constrained nursing practice. Nurses use unconscious defence mechanisms to cope with the dissonant environment in which they are practising. These include: splitting up the nurse-patient relationship; depersonalisation, categorisation and denial of the significance of the individual; and collusive social redistribution of responsibility and irresponsibility. In using these defence mechanisms, nurses are able to deliver care but this is not in a way that allows them to live their personal and professional values.

Nurses in this study perceive the values that are identified by healthcare organisations, as platitudes. The real values of healthcare organisations are implied, and these values favour managerialism, efficiencies and cost savings. It is these hidden values that constrain the practice of nursing in medical wards and obstruct nurses on a daily basis to live their values. The system and situational context of care, as described by nurse and patient participants, identified significant barriers to the enactment of nursing values, for example economic priorities (managerialism) and the busyness of clinical areas. Previous research has described such constraints in clinical practice. However, this study has brought to the fore the significance of, and expanded understanding about the resultant anxiety and associated value dissonance experienced by nurses

One-way nurses cope with the challenges of daily practice is to engage in functional/task orientated care. This approach has its benefits, protecting the nurse from anxiety and meeting the health needs of patients. However, findings from this research offer the nursing profession an opportunity to revisit functional/task orientated approaches in the delivery of professional nursing care. Enlivening this approach to care with careful attention to human dignity may offer nurses a way to resolve value dissonance, and practice within managerial constraints. Equally, understanding the experiences of patients and family/whānau is important to not only determine the level of trust and confidence in healthcare, but also, and more significantly for this study, their thoughts about, and experiences with, nurses and nursing values.

In the professional arena, traditional humanistic values of nursing remain important to nurses and their patients. These values are firmly held personal attitudes about nursing and many nurses are altruistically motivated to enter the profession. To date, values have been used to shape and construct professional nursing practice through discrete nursing policies, or within professional codes. Despite these efforts, nurses do not relate to these initiatives. This study has highlighted how nurses draw on their personal values to inform practice, resulting in individual, rather than collective perspectives of practice being held. This is a significant finding, as shared values within a community of nursing, as described by Stein, provide a normative framework to guide and shape nursing practice.

Menzies (1960) theoretical considerations about anxiety in institutions shines light on the challenges faced by nurses in acute practice environments. Through an exploration of her work in this thesis, the relevance of defence mechanisms to the attitudes and actions of nurses has been made clear. Whilst Menzies (1960) described anxieties that were internal to nurses, the addition of contemporary anxieties (external anxieties) provides new understanding of the nature of anxiety in organisations. This original contribution has implications for how we think about the nursing profession, the delivery of nursing care and manage health services.

By identifying specific unconscious defence mechanisms that nurses use in clinical practice, the associated actions and behaviours of these mechanisms have been explicitly detailed. This knowledge can be used to develop theoretical and practical frameworks to inform thinking behind value-informed practice. This work therefore offers a new way of thinking about, engaging with, and reflecting on nurses own, and others, 'values in practice'. Such an approach will enable the discipline of nursing to see 'values' as having "genuine relevance to our conception of a social structure and to what is happening within it" (Wright Mills, 1967, p. 73).

These findings challenge any assumption that nurses can live their values in acute medical clinical practice environments.

7.3 Contribution to methodology

One of the strengths of this thesis is the use of collective Case Study (CS) methodology that enabled exploration of nursing values in the real world. Previous research on nursing values has been primarily quantitative in nature, using professional codes to inform development of survey tools, largely with the student nurse population. Whilst this has developed a platform for our understanding it has focused on a one-dimensional perspective of professionally constructed values. This study has presented professional nursing values from multiple perspectives, that is several case study sites, several sample populations (nurses and patients), using multiple data collection methods, those being observation, interview, focus group and the Maslach Burnout Inventory survey, in a real

world context. Triangulation of these data sources has added to the rigour of the research, and developed rich detail to fully illuminate nursing values in practice.

Furthermore, the flexible integration of theoretical perspectives in this work contributes to the rigour of CS methodology. Whilst theoretical integration is not uncommon in CS research, the place of theory in this thesis is uniquely innovative. No other research on nursing has drawn strongly on the theoretical and philosophical perspectives of Edith Stein or Isabel Menzies as part of data analysis. Using these theoretical lenses allowed the processes during data analysis to be both inductive to deductive.

As discussed in Chapter 3 Constructivism underpinned the flexible approach I took to undertaking this research allowing data to be represented and analysed through a socially constructed theoretical lens. It was important that the research captured the contextual nature of nursing in a medical ward, allowing for a holistic and meaningful exploration of nursing values.

7.4 Propositions and reflexivity

In keeping with CS I generated four propositions based on my personal perspectives of healthcare, observations of nursing practice and my reading of the literature. These propositions were non-judgmental statements developed to direct attention to what ought to be examined and reflected important theoretical concerns:

- nurses' personal values influence nursing practice;
- there is minimal congruence between professional and organisational values, and those held by individual nurses;
- healthcare organisations influence how nurses express their values in daily practice; and
- nursing values have an impact on patient experiences.

These propositional statements act much like hypotheses that can be accepted or rejected; findings from this study have supported each of the propositional statements.

As discussed in the introduction to this thesis my professional nursing values are founded on my life values that have been influenced by my Irish Catholic background. These values derived from my faith emphasise love, kindness, justice, courage, respect, human dignity and empathy. There were times during the research process when I was observing care or practices that were the antithesis of my personal values. This was exceptionally challenging for me personally however through rigorous reflexivity and in particular the use of Peshkin's ideas about subjectivity I believe I maintained my objectivity and consequently the integrity of the research.

7.5 Study limitations

Whilst this study has many strengths, there are also limitations that require acknowledgement. One of the propositional intentions at the outset of this study was to understand the impact of nursing values on patients' perceived experiences. However, the acuity and the complexity of the patients' conditions and capacity to consent impacted on recruitment to the study. This resulted in a small patient sample group and the data gathered does not give full representation of the views of medical ward patients. A further limitation could be considered to be the small sample size of nurses who completed the MBI burnout survey. However, as was described within the thesis, the MBI was used in the triangulation of data, statistical significance therefore was not a requirement.

The study is culturally bound in the context of medical ward environments in the New Zealand context. The findings may be useful for wider audiences in other acute medical clinical settings in different geographical locations. However, another clinical setting or geographic location may uncover different nursing values, dissonance, anxieties and defence mechanisms. It is not an aim of CS methodology to generate generalisable findings; sufficient contextual information regarding the study sites and methodology has been provided to allow others to determine the transferability of findings to their own practice.

7.6 Recommendations for future research

Further work is required to bring greater insight and understanding on the existence of contemporary anxieties, values dissonance and unconscious defence mechanisms in health care. Research that re-instates values as a legitimate focus for empirical work needs to gain profile in the nursing research agenda. Currently, this research has been subsumed within the burnout, compassion fatigue, and emotional labour literature. Findings from this study identify that there is need for values clarification in nursing.

This could begin with a grounded theory of nursing values, or nursing anxiety and defence mechanisms. Allowing for the building and testing of theory, no such work has been undertaken to date; the findings from this study could be re-examined with this in mind. Another approach could be the development of a framework that clearly identifies behaviours associated with key defence mechanisms and dominant contemporary anxieties. This could be explored using statements from this thesis to inform a consensus methodology, for example the Delphi process, to gain expert agreement on whether statements from the findings of this thesis resonate with nurses. Results from this could then be used to develop a survey tool that asks specific questions about the developed framework on contemporary anxieties and defence mechanisms to a wider group of nurses. This would generate on-going understanding about attitudes and behaviours in this area.

A further area of inquiry that would be of interest would be to compare how nurses are enabled to live their values across different nursing environments; for example extant literature (although not examined in this thesis) indicates that burnout is low for nurses working in hospice settings. This would also offer the opportunity to compare the management approaches and philosophies of the two environments; hospice with acute hospital. Further measurement of nurse burnout across all areas of nursing practice could be undertaken which could be augmented by the use of additional scales for example compassion satisfaction and emotional labour scales.

Following this work, there would be opportunity to develop an evaluation of specific interventions to address, for example, dominant defence mechanisms, and the associated

behaviours associated with depersonalisation, categorisation and denial of the significance of the individual.

It is also timely to explore contemporary anxieties and defence mechanisms and how these are operationalised within the broader healthcare organisation. Further case studies could be undertaken to see if these are transferable to other contexts.

7.7 Implication for the nursing profession and healthcare

There are a number of implications for the profession resulting from this study. Firstly this thesis challenges the nursing profession to acknowledge and address the visibility of nursing values in contemporary practice, as well as acknowledge the dissonance that exists between the values of nursing and the values that drive healthcare delivery. Humanistic nursing values remain important to practicing nurses. This study identifies in detail the every-day difficulties nurses face in seeking to enact their values and the managerial challenges that confront them. This information offers a trustworthy analysis of the challenges the nursing profession faces in addressing this problem. It also offers a basis for developing approaches that could strengthen nurses' ability to enact the humanistic values to which they are professionally committed.

It is critical that any attempt to embed nursing values into clinical nursing practice is founded on a strategy that recognises and mitigates against dysfunctional organisations and organisational constraints. Drawing on findings from this thesis, it is recommended that the articulation and development of nursing values in acute clinical environments is responsive to organisational factors. Through this, the nursing community can develop, rigorously articulate and operationalise nursing values. Furthermore, it is essential that there are strong credible nursing leaders to participate in these processes and foster collaborative, collegial and communicative teams. Nurse leaders at all levels of the healthcare system must be cognisant of, and address situations where value dissonance, contemporary anxieties and defence mechanisms manifest. This is imperative in order to develop professionally satisfied nurses. One strategy to address this would be to foster a collective responsibility within nursing teams to *name* defence mechanisms, anxieties and

value dissonance when identified and to challenge and support nursing colleagues in this. For example in the context of depersonalisation, current behaviours and language used to depersonalise patients, nurses and other team members could be identified and alternative language and supportive behaviours could be offered. Another example focuses on how nurses split and relegate the nurse-patient relationship by focusing on task. A solution to this could be the recognition that tasks are often associated with quality judgements, for example, the task of feeding a patient can also be viewed as an opportunity to spend quality time engaging and interacting with patients. Such an approach would allow nurses to be fully present with their patients, creating compassionate and humanistic clinical environments.

This study describes how medical wards are challenging practice environments that make the demonstration of values incongruent with professional nursing, difficult. Therefore the nursing profession must be critical about what values are, how values are enacted, and how values can be evaluated in clinical practice. Nursing values ought to be present in every aspect of professional nursing practice, from recruitment, curriculum development, and socialisation into the nursing profession, and in every element of daily nursing practice.

Healthcare organisations need to understand the impact on the nursing workforce where nurses cannot live their values, and where managerialism is the driving force. This thesis has demonstrated that constrained practice is associated with contemporary anxieties, dissonance and burnout. Empirical research has shown that burnout is associated with high turnover and this has significant impact on nursing recruitment and patient outcomes. Healthcare organisations therefore need to foster open debate, from the bedside to the Executive Board level, about how organisational cultures can be developed where nurses deliver care that is embedded in humanistic values. This will be important in order to: improve patient experience and outcome; develop professionally content nurses who can deliver humanistic care; and retain a stable and committed nursing workforce within the organisation.

7.8 Dissemination

Translating and sharing the findings of this research is critical for the nursing profession. Dissemination is planned in consideration of the target audience, allowing for communication and interaction with national and international nursing leadership. Three conference presentations were given during the doctoral journey, these were on various aspects of the findings: *Are Patient Care Technologies Impeding the Therapeutic Quality of Nurse-patient Relationships?* (Rook et al., 2014a), *Compassion: a Contemporary Nursing Practice Value?* (Rook et al., 2014b) and *The Redundancy of Team Nursing: The Revival of 'Task'* (Rook et al., 2016). These conference presentations form the basis of a publication strategy for postdoctoral work.

7.9 Conclusion

This research makes an original contribution to understanding how humanistic values, central to the practice of nurses in the past, remain important to the practice of nurses in the present. However, nurses are currently unable to live their values when caring for patients in the acute medical care environment where managerial and capitalist agendas prevail. Experiencing the resultant distress and anxiety, has a profound effect on nurses and further impacts on patient experiences. For successful healthcare environments to prevail it is imperative that humanistic values are central in all conversations about healthcare and at all levels of health service provision.

APPENDICES

Appendix 1 Letter of invitation

Graduate School of Nursing, Midwifery and Health

██████████
Director of Nursing and Midwifery
██████████ District Health Board,
Private Bag 7902, ██████████

4th May 2012

Dear ██████████,

I am a registered nurse, lecturer, and PhD student in Victoria University of Wellington. I would like to invite you (your hospital) to participate in my study designed to investigating the values of nurses in New Zealand medical ward environments. I am a beginning researcher with a strong supervisory team consisting of Dr Kay de Vries (Victoria University of Wellington) and Dr Therese Meehan (University College Dunlin, Ireland).

The overall aims of this study are to:

- 1) Examine the importance of values in nursing to determine whether these values are congruent with personal, organisational, disciplinary, patient and family/whānau values and
- 2) Examine how values are enacted in nurses daily work.

Participation in the study would involve giving me access to the a medical ward in your hospital to conduct a two week period of observation, to staff and patients being approached to participate in focus group interviews and single interviews, and access to hospital and ward documentation (for example, models of care, mission and vision statements, job descriptions, nurse patient ratios, nursing turnover etc.).

This study has received ethical approval on the 27th February 2012 from the Central Regional Ethics Committee; ethics reference number CEN/12/Exp/012 . Attached are the study protocol and the information letters that would be provided to participants in the study. I am also available to meet and discuss the study in more detail if this is required.

Yours truly,

Helen Rook
Lecturer / PhD student
Graduate School of Nursing, Midwifery and Health
Victoria University of Wellington
PO Box 7625, Newtown
Wellington 6242

Appendix 2 Nurse information letter

Graduate School of Nursing, Midwifery and Health

NURSE INFORMATION SHEET

Principal investigator:	Contact Details:
Helen Rook PhD student/researcher Registered Nurse DipN, B.Sc.(Hons), PG Dip ICU/CCU, MN	Graduate School of Nursing, Midwifery & Health Victoria University of Wellington PO Box 7625, Newtown, Wellington 6242 [REDACTED]

Title: The values of nurses in New Zealand medical ward environments

INTRODUCTION:

You are invited to take part in a study which looks at the values of nurses working in a New Zealand hospital environment. If you would like to take part in the study, I will discuss the details with you prior to commencement of the study. You are under no obligation to take part and as such your employment or future employment opportunities will not be affected.

ABOUT THE STUDY:

The aim of the study is to examine the importance of values in nursing and explore how nursing values are expressed in interactions with patients, and others. This exploration will help to understand what values are important to nurses, patients and whānau members.

All patients over the age of 18 admitted to [REDACTED] Medical Ward are eligible to participate in the study. Family/whānau member of patients admitted to [REDACTED] Medical Ward will be invited to participate in the study. The study will involve a period of observation; where I will observe nurses interacting and caring for patients. I am looking at the way nurses communicate with, and respond to patients and also how they interact with other nurses and members of the health care team. During this time you will see me writing notes. These notes will be about what I see. No private conversations heard during the period of observation will be recorded or used in the study. All of my notes will be coded so that you will be unidentifiable.

Additionally you will be invited to participate in a focus group; a focus group is like an interview with a group of nurses. During the focus group we will discuss nursing values as you see them and what you consider to be important nursing values. The focus group will be audio recorded and then transcribed (written out exactly as it was said). After transcription the information will again be coded, so your anonymity will be protected. Following the focus group I may go on to invite you to participate in a single interview.

I will also be reading a selection of ward and hospital documents. Any information taken from these documents will be coded so that hospital or department is not identifiable.

BENEFITS RISKS AND SAFETY:

There are no direct or immediate benefits of taking part in the study as the study is focusing on how nursing values are manifested verbally, nonverbally and in written documents. However your participation and the knowledge gained from your participation has the potential to influence the discipline of nursing, and nursing practices within hospital environments.

A potential risk of the study is that it may make you feel self-conscious and this may influence how you interact with the patients who you are caring for. I will make every effort to remain inconspicuous however, if you feel the observation is impacting on your ability to do your work you may withdraw from the study.

Participating in the focus group, and follow up single interview, which will take approximately one hour, may impact on you. However every effort will be made to offer a variety of times so that you can choose the time that best suits you.

As part of the observation phase of the study there is a risk of witnessing unethical behaviour or poor clinical practice. I will be guided in all instances by my professional code of conduct.

PARTICIPATION:

Your participation in this study is voluntary (your choice). If you do agree to participate you may withdraw from the study at any time without explanation and this will in no way affect your continuing or future employment.

You may have friend, family or whānau support to help you understand the risks and/or benefits of this study and any other explanation you may require. During the focus group activity and interview you do not have to answer all the questions, and you may stop and withdraw at any time.

GENERAL:

Should you require further information about the study this can be provided by me or Dr Kay de Vries (research supervisor).

Dr de Vries contact details are:

Phone: [REDACTED]

E-mail: [REDACTED]

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050

Free fax: 0800 2 SUPPORT (0800 2787 76 78)

E-mail: advocay@hdc.org.nz

CONFIDENTIALITY:

No material that could personally identify you will be used in any reports on this study. All observations, audio recordings and notes will be stored in a secure and locked environment. After the study has been completed and the results have been published the data collected will be stored for ten years in a secure locked environment and then destroyed.

Persons identified as having access to confidential information are:

1. Helen Rook
Principal investigator
2. Dr Kay de Vries
Primary research supervisor
Senior Lecturer
Graduate School of Nursing Midwifery & Health, Victoria University of Wellington, New Zealand
3. Dr Therese Meehan
Secondary research supervisor
Senior Lecturer
School of Nursing, Midwifery & Health Systems, University College Dublin, Ireland
Adjunct Professor
Graduate School of Nursing Midwifery & Health, Victoria University of Wellington, New Zealand
4. Confidential typist to transcribe data

RESULTS:

A significant delay may occur between data collection and publication of the results due to the nature of the research. However should you wish to receive information about the results you can contact me directly. It is anticipated that the results of this study will be published in a peer reviewed academic journal and/or presented at a professional conference(s). The results will also be submitted as part of a PhD thesis to Victoria University of Wellington.

STATEMENT OF APPROVAL:

This study has received ethical approval from the Central Regional Ethics Committee, ethics reference number CEN/12/EXP/012

Please feel free to contact me if you have any questions about this study

Appendix 3 Invitation to participate

Graduate School of Nursing, Midwifery and Health

INVITATION AND AGREEMENT FOR OBSERVATION, FOCUS GROUP AND SINGLE INTERVIEW

The values of nurses in New Zealand medical ward environments

I am a registered nurse, lecturer, and PhD student in Victoria University of Wellington and am investigating the values of nurses in New Zealand medical ward environments. I would like to invite you to take part in observation, focus group and single interview about the values of nurses in New Zealand medical wards.

I am an experienced nurse and beginning researcher with a strong supervisory team consisting of Dr Kay deVries (Victoria University of Wellington) and Dr Therese Meehan (University College Dunlin, Ireland).

The overall aims of this study are to 1) examine the importance of values in nursing to determine whether these values are congruent with personal, organisational, disciplinary, patients and family/whānau and 2) examine how values are enacted in nurses daily work.

Attached is the information letter providing details of the study. If you are interested in participating in this study please write your contact details below and return this sheet to me or place the sealed box provided on your ward.

Thank you

Helen Rook
PhD student/researcher
Graduate School of Nursing, Midwifery & Health
Victoria University of Wellington
PO Box 7625, Newtown, Wellington 6242
Phone: [REDACTED]
E-mail: [REDACTED]

I would like to participate
in observation, focus group and single interview about the values of nurses in New Zealand
medical wards.

Name:

Contact details:

Telephone Number:

Email Address:

Date:

Appendix 4 Poster

Graduate School of Nursing, Midwifery and Health

The values of nurses in New Zealand medical ward environments

My name is Helen Rook I am a registered nurse, lecturer, and PhD student in Victoria University of Wellington and am investigating the values of nurses in New Zealand medical ward environments.

I would like to invite nurses, patients and their family/whānau members in ward [redacted] to take part in observation, focus group and/or single interview about the values of nurses in New Zealand medical wards.

The overall aims of this study are to:

1. Examine the importance of values in nursing to determine whether these values are congruent with personal, organisational, disciplinary and societal values and
2. Examine how values are enacted in nurses' daily practice.

If you would like to participate, please contact:

Helen Rook
PhD student/researcher
Graduate School of Nursing, Midwifery & Health
Victoria University of Wellington
PO Box 7625, Newtown, Wellington 6242
Phone: [redacted]
E-mail: [redacted]

[redacted] Helen Rook	[redacted] Helen Rook	[redacted] Helen Rook	[redacted] Helen Rook	[redacted] Helen Rook	[redacted] Helen Rook	[redacted] Helen Rook	[redacted] Helen Rook	[redacted] Helen Rook	[redacted] Helen Rook
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Appendix 5 Letter of invitation for patient/family/whānau

Graduate School of Nursing, Midwifery and Health

PATIENT, FAMILY/ WHĀNAU INFORMATION SHEET

Principal investigator:	Contact Details:
Helen Rook PhD student/researcher Registered Nurse DipN, B.Sc.(Hons), PG Dip ICU/CCU, MN	Graduate School of Nursing, Midwifery & Health Victoria University of Wellington PO Box 7625, Newtown, Wellington 6242 Phone: [REDACTED] E-mail: [REDACTED]

Title: **The values of nurses in New Zealand medical ward environments**

INTRODUCTION:

You are invited to take part in a study which looks at nursing values in a New Zealand hospital environment. If you would like to take part in the study, I will discuss the details with you prior to commencement of the study. You are under no obligation to take part and as such your care will not differ from that of other participants.

ABOUT THE STUDY:

The aim of the study is to examine the importance of values in nursing and explore how nursing values are expressed in their interactions with patients, and others. This exploration will help to understand what values are important to both patients and nurses.

All patients over the age of 18 admitted to [REDACTED] Medical Ward are eligible to participate in the study. Your family/whānau members will be invited to participate in the study. The study will involve a period of observation; where I will observe nurses interacting and caring for you. I am looking at the way nurses communicate with, and respond to you and also how they interact with other nurses and members of the health care team. During this time you will see me writing notes. These notes will be about what I see. No private conversations heard during the period of observation will be recorded or used in the study. All of my notes will be coded so that you will be unidentifiable.

Additionally you will be invited to participate in a focus group. A focus group is like an interview with a group of people. During the focus group we will discuss nursing values as you see them and what you consider to be important nursing values. The focus group

will be audio recorded and then transcribed (written out exactly as it was said). After transcription the information will again be coded, so your anonymity will be protected. Following the focus group I may go on to invite you to participate in a single interview.

As part of the study your family/whānau will be also be invited to participate in an interview. This is so that they can provide insight into the values that they feel are important for nurses when they are caring for a relative of friend. The interviews will be audio recorded and then transcribed. After transcription the information will again be coded, so anonymity will be protected.

Nurses who are caring for you will be also be invited to participate in a focus group. Again focus groups will be audio recorded and then transcribed. After transcription the information will be coded, so anonymity will be protected.

BENEFITS RISKS AND SAFTEY:

There are no direct or immediate benefits to your or your family/whānau of taking part in the study as the study is focusing on how nursing values are manifested verbally, nonverbally and in written documents. The study has no therapeutic benefit to you. However your participation and the knowledge gained from your participation has the potential to influence the discipline of nursing, and nursing practices within hospital environments.

A potential risk of the study is that it may make you feel self-conscious this may and influence how you interact with the nurses who are caring for you. Participating in the focus group and follow up single interview will take approximately one hour, and may impact on you and your family/whānau. However every effort will be made to offer a variety of times so that you and your family/whānau can choose the time that best suits you both.

As part of the observation phase of the study there is a risk of witnessing unethical behaviour or poor clinical practice. I will be guided in all instances by my professional code of conduct and act accordingly.

PARTICIPATION:

Your participation in this study is voluntary (your choice). You do not have to participate in the study, and if you choose not to participate your current or future care will not be affected in any way.

If you do agree to participate you may withdraw from the study at any time without explanation and this will in no way affect your continuing or future health care.

GENERAL:

Should you require further information about the study this can be provided by me or Dr Kay de Vries (research supervisor). Dr de Vries contact details are:

Phone:

E-mail:

If you need an interpreter, one can be provided for you by the hospital for the duration of your stay. Please let me know if you would like me to arrange an interpreter for you.

You may have friend, family or whānau support to help you understand the risks and/or benefits of this study and any other explanation you may require.

During the focus group activity and interview you do not have to answer all the questions, and you may stop and withdraw from the focus group at any time.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050

Free fax: 0800 2 SUPPORT (0800 2787 76 78)

E-mail: advocay@hdc.org.nz

CONFIDENTIALITY:

No material that could personally identify you will be used in any reports on this study. All observations, audio recordings and notes will be stored in a secure and locked environment. After the study has been completed and the results have been published the data collected will be stored for ten years in a secure locked environment and then destroyed.

Persons identified as having access to confidential information are:

Helen Rook

Principle investigator

Dr Kay de Vries

Primary research supervisor

Senior Lecturer

Graduate School of Nursing Midwifery & Health, Victoria University of Wellington,
New Zealand

Dr Therese Meehan

Secondary research supervisor

Senior Lecturer

School of Nursing, Midwifery & Health Systems, University College Dublin, Ireland
Adjunct Professor

Graduate School of Nursing Midwifery & Health, Victoria University of Wellington,
New Zealand

Confidential typist to transcribe data

RESULTS:

A significant delay may occur between data collection and publication of the results due to the nature of the research. However should you wish to receive information about the results you can contact me directly. It is anticipated that the results of this study will be published in a peer reviewed academic journal and/or presented at a professional conference(s). The results will also be submitted as part of a PhD thesis to Victoria University of Wellington.

STATEMENT OF APPROVAL:

This study has received ethical approval from the Central Regional Ethics Committee, ethics reference number CEN/12/EXP/012

Please feel free to contact me if you have any questions about this study

Appendix 6 Nurse interview/focus group guide

Introduction

- Many thanks for coming to this focus group/interview today.
- My name is Helen Rook and I am a nurse and a PhD student.
- This meeting will last for about one hour.
- Does anyone have any question or concerns before we begin?

Confidentiality

- Each of you has signed a consent form to participate in the study.
- The focus group/interview will be audio recorded and then transcribed (written out exactly as it was said).
- After transcription the information will be coded, so your anonymity will be protected.
- No material that could personally identify you will be used in any reports on this study.
- During the focus group activity and interview you do not have to answer all the questions, and you may stop and withdraw at any time.

The purpose

- The purpose of this focus group/interview is to get your views on professional nursing values.
- I want you to do the talking; I am here to facilitate the discussion.
- It is important to get as many viewpoints as possible.
- Rest assured there is no right or wrong answer.

Process

- Participants already know each other.
- Before commencing the focus group get the participants to complete a burnout survey.

Questions

Background

- Why did you go into nursing?
- Was there any one in the family a nurse?
- What do you think are the core values of professional nursing?

Respect

- To what extent do you feel respected as a nurse?

- To what extent do you respect your nursing colleagues?
- Do the nursing team respect each other?
- To what extent do you listen to your patients and ask for and respect their views about their health?
- To what extent do you facilitate patient's participation in decisions about their care and involve them and their families/whānau in planning care?

Trust

- To what extent do you think your patients trust you?
- To what extent do you trust your nursing leadership?
- To what extent do you trust your nursing colleagues?
- To what extent do you trust the wider MDT?

Partnership (Teamwork)

- What does working partnership/as part of a team mean to you?
- To what extent do you think you work in partnership with your patients?
- Do you feel supported by your manager/nursing leadership, can you give an example?
- To what extent do you (the nurses in this ward) support each other?
- To what extent do you support new nurses?
- To what extent do you work in partnership/as a team with your nursing colleagues?
- To what extent do you work in partnership/as a team with your colleagues in the MDT?

Integrity (honest and having strong moral principles) includes confidentiality (privacy), veracity (truthfulness), fidelity (faithfulness)

- To what extent do you think that nurses on this ward act with integrity?
- How would you describe a nurse who acts with integrity?
- Are you able to protect vulnerable patients from exploitation and harm?

Autonomy (Human Rights, culture, spirituality, self-determination)

- Are your patients treated as individuals?
- To what extent do you think that their human dignity is respected?
- To what extent do you feel that you are treated like a human being by the nurse management?
- What is it like to work with such a cultural/ethnic mix?

Beneficence (active goodness or kindness) including responsiveness and compassion

- Are you able to provide the nursing care you want?
- To what extent do you feel that you are accessible to health consumers and colleagues when you are on duty?
- Is kindness a value that is important to you in your nursing practice?
- Do you see kindness in your daily practice?

Non-Maleficence (doing no harm)

- Do you feel that your care is to the safety standard that you or the profession expect?
- How do you keep your professional knowledge and skills up to date?
- Are there any ways in which you think that the ward environment compromises patient safety?

Justice (Fairness)

- Do all patients get treated the same?
- To what extent do you feel that you are treated fairly by nurse management?
- To what extent do you feel that you/colleagues treat each other with respect?
- Have you experienced poor (e.g. bullying, harassment) behaviour from colleagues?

Guardianship of the environment and its resources

- To what extent do you think that you have a responsibility as a nurse to protect the environment and its resources?

Being professional

- What does 'being a professional' nurse mean to you?
- Do you wish to continue to practicing as a professional nurse?
- Are you happy with the direction of professional nursing practice?
- What is your wish for professional nursing practice?
- What do you think are the core values of professional nursing?
- To what extent do you think the members of your team share the same values?
- To what extent do you think that your professional nursing values are shared with the organisations values?
- To what extent do you think that your professional nursing values are shared with the ward values?
- Do you reflect on your own practice and the practice generally on the ward?
- To what extent do you think that you deliver care based on best available evidence and best practice?
- How do you use the NCNZ Code of conduct?

Probes for all questions

- Can you give me an example?
- How is this demonstrated?
- Would you explain that further?
- Would you tell me more about that?
- What were your feelings about that?
- What was that like for you?
- What else happened?
- Can you elaborate on that idea?
- I'm not sure I understand what you are saying
- Would you give me an example?
- Is there anything else?
- Is there anything more that you would like to say?

Appendix 7 Patient/family interview guide

Introduction

- Many thanks for coming to this interview today.
- My name is Helen Rook and I am a nurse and a PhD student.
- This meeting will last for about one hour.
- Do you/anyone have any question or concerns before we begin?

Confidentiality

- You have signed a consent form to participate in the study.
- The interview will be audio recorded and then transcribed (written out exactly as it was said).
- After transcription the information will be coded, so your anonymity will be protected.
- No material that could personally identify you will be used in any reports on this study.
- During the interview you do not have to answer all the questions, and you may stop and withdraw at any time.

The purpose

- The purpose of this interview is to get your views on professional nursing values.
- I am very interested in nursing and what kinds of things you think make a good nurse.
- I want you to do the talking; I am here to facilitate the discussion.
- Rest assured there is no right or wrong answer.

Process

- Nurses are particularly responsible for helping and protecting people when they are in hospital and I would like to ask you a few questions about your experiences with nurses and nursing care.
- Start with a warm up question, can you tell me how you came to be on this ward?
- What happened when you arrived?
- How were you feeling when you arrived?

Questions

Respect

- Do you feel that nurses have respect for you as a patient/family member?
- Do you feel that nurses listen to your concerns about your needs for comfort, rest and safety and any questions you had about your care?

- Do you participate in decisions about your care? Is your families/whānau involved in planning your care

Trust

- Do you trust the nurses who care for you?

Partnership

- Do you think the nurses work in partnership with you to identify your nursing needs and plan your nursing care?

Integrity (honest and having strong moral principles) Confidentiality (Privacy), Veracity (Truthfulness), Fidelity (Faithfulness)

- Do you think the nurse on this ward act with integrity?
- How do you think a nurse with integrity acts?
- Do you feel safe and protected in this ward?
- Is your privacy protected on this ward?

Autonomy (Human Rights, culture, spirituality, self-determination)

- Are you treated as individual, unique human being?
- Is your human dignity respected?

Beneficence (active goodness or kindness) Responsiveness, Compassion

- Do you feel that you are getting the level of care that you need?
- What do you think makes a good nurse?
- Do you feel that the nurses are accessible to you?
- Do you see kindness and compassion on this ward?

Non-Maleficence (doing no harm)

- Do you feel that your care is to the standard that you would expect? Can you give me an example? Do you feel that the nurses are skilled and knowledgeable?

Justice (Fairness)

- Do you think all patients get treated the same? Can you give me an example? Do you feel that you are treated fairly by nurses? Can you give me an example?
- Have you experienced poor care?
- Can you give me an example?

Guardianship of the environment and its resources

- Leave out of patient interviews

Being professional

- What has impressed you?
- Has anything upset you?
- Do you know who the nurses are?
- What do you think makes a good nurse?

Appendix 8 Permission to use Maslach Burnout Inventory

www.mindgarden.com

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material;

Instrument: *Maslach Burnout Inventory, Forms: General Survey, Human Services Survey & Educators Survey*

Authors

MBI-General Survey: Wilmar B. Schaufeli, Michael P. Leiter, Christina Maslach & Susan E. Jackson

MBI-Human Services Survey: Christina Maslach & Susan E. Jackson

MBI-Educators Survey: Christina Maslach, Susan E. Jackson & Richard L. Schwab

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for his/her thesis research.

Three sample items from a single form of this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com

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Published by Mind Garden, Inc., www.mindgarden.com

Appendix 9 Initial coding - nurse focus group data Site 1

Themes	Indicators
Nursing a job	<ul style="list-style-type: none"> • <i>“Because I was always told I would be a good nurse right from when I was a little kid”(NFG2 S1 52)</i> • <i>“There was nursing, there was secretarial, there was teaching. I became a nurse” (NFG2 S1 54)</i> • <i>“I want to do nursing because I like to look after and always care for my sisters and family and friends so I just feel like I give more care to our people in the family”(NFG3 S1 61)</i> • <i>Freedom from parental influence</i> • <i>Always want to travel</i> • <i>Only choice</i>
Poor care	<ul style="list-style-type: none"> • <i>“There’s too much paperwork, not enough hands on time” (NFG2 S1 264)</i> • <i>“It’s just really hard, it’s un-copeable even with three staff members” .(NFG2 S1 274)</i> • <i>“Well if you’re a little old lady with dementia in a rest-home and cannot speak out for themselves you may not get any help or very minimal care” .(NFG2 S1 307)</i> • <i>“not getting fed or getting fed cold meals” .(NFG2 S1 313)</i> • <i>“Maybe not getting a pad change” (NFG2 S1 317).</i> • <i>“With nursing in this day and age here because there’s so much staff issues going on and money involved, if there’s no budget the nurse staff numbers will be you know low and patient care will compromise. It’s all the issues that come into it, yeah the situation at that point in time. And it mainly to do with our work, we nurses concerned about each other when they’re short of staff but sometimes we were stretched to the max” (NFG3 S1 128).</i> • <i>“We are here to do the look after the patients. If we are pushing from job to do things like that at the end of the day we feel like we have not fully done all the cares to the patient yeah” (NFG3 S1 230)</i> • <i>Stuff gets missed</i> • <i>Not satisfied with the level of care</i> • <i>“un-copeable”</i> • <i>Overloaded</i> • <i>Poor care</i> • <i>Bare minimum</i> • <i>Some nurses are better equipped to cope with increased nurse patient ratio</i>

	<ul style="list-style-type: none"> • <i>“So we looked after forty patients back home. That’s the thing, yeah but they are not doing that now, the showers and washes by ourselves because they can, but we can manage that’s what I’m telling you” (NFG3 S1 170)</i>
Dedication	<ul style="list-style-type: none"> • <i>I know most of the staff do half an hour or more overtime on most shifts simply trying to catch up ”(NFG2 S1 276)</i> • <i>“It’s all unpaid. It’s not on the time sheet because you’re not going to get paid for it so why bother. You work through your lunch or your morning tea” (NFG2 S1 281).</i> • <i>Unpaid catch up</i> • <i>Stay late to write notes</i> • <i>Don’t take breaks</i> • <i>No energy</i> • <i>No food</i> • <i>Not toilet breaks “8 hours without going to the toilet”. Can’t stretch and their own health is being compromised</i>
Feel like crap	<ul style="list-style-type: none"> • <i>Feeling like “Crap, Crap, makes you feel like you’re just doing the bare minimum”(NFG2 S1 326).</i> • <i>Feeling “frustrated sometimes and angry because we are stretched to the max and our health is compromised as well and not only that the patient we care for don’t get what they, they should get and it’s, it’s disheartening for us nurses because there’s only so much we can do. Yeah so that’s, that’s the situation. Like emergency the other day, you know when there’s an emergency going oh lord on top of that we need to attend that emergency bell and to complete that emergency it’s going to take you an hour and a half, eh. And that hour and a half if it happens on that time that your other patient needs medication, oh my god” (NFG3 S1 273).</i> • <i>“It eats up in you because you know your job, you did not complete your job properly and that is one of the most difficult things because the pressure is there” (NFG3 497)</i> • <i>“That is the kind of things that we find very difficult to cope with is, is when we don’t really meet all the needs of our patients. And that’s, and that’s you know we look at ourselves, we are not catering for the needs of our patients which is yeah, yeah it makes you think that you know it could be better, could be better” (NFG3 504)</i> • <i>No one to pick up the slack</i> • <i>No helping and no help</i>

Movement of patients	<ul style="list-style-type: none"> • <i>“Even though you’ve tucked your patient into bed for the night obviously they’re still moving them at ten or eleven o’clock at night” (NFG2 344)</i> • <i>And if you’ve got someone with dementia or an older patient and they wake up in another ward in the morning. They have no idea where they are. No they don't know what the hell happened. They don't remember that you’ve moved them (NFG2 347)</i> • <i>Patient moved a lot and just when you think they are settled for the night you get a call to move them.</i>
Not supported	<ul style="list-style-type: none"> • <i>“I’d be happy if they’re put somebody on the floor to do the care plans and bookwork and everything so that I can go back to being a nurse (NFG2 S1 829)</i> • <i>“but we learn to, we learn to cope and we learn to do what we need to do and we support, we support one another but I only wish sometimes that they stop saying there’s no money to do this” (NFG3 S1 518)</i> • <i>Talk about ‘them’ and ‘us’</i> • <i>Nurses stuck in the middle</i> • <i>Not supported by senior nurses – let them come and work for a week on the floor</i> • <i>Hit with the document stick</i> • <i>Financial pressure</i>
Commitment to nursing	<ul style="list-style-type: none"> • <i>Will not stay in nursing</i> • <i>No other choice</i>
Summary	<ul style="list-style-type: none"> • feeling put upon • not being understood • not being able to practice the way they want to • not meeting minimal standards • scraping by or in survival mode • nurses are vulnerable • despite the influences and the pressure they remain dedicated

Appendix 10 Example of later coding

Theme	Sub-themes	Emerging themes – descriptive	Early codes using participant terms	Data extracts
Motivation to enter nursing	Altruism	Something in them	Some kind of values	<i>I could give back to the community, I want to feel some kind of value</i>
			Need to do what I am doing	<i>Not a glamorous job and it not, there is just something in my make up or personality that just needs to be here needs to do what I am doing</i>
		Helping others	Looking after others	<i>My Mum used to be quite sick and I'd be looking after her.</i>
		Giving something back		<i>To look after my family. My friend with diabetes</i>
			Caring person	<i>I have always been a caring person. I could do a lot of good</i>
	Socio-economic and cultural influences	Influence of others	Friends and family nursing	<i>I had some friends and family members doing to job so I thought that it looked really awesome</i>
		Limited options	Leaving home	<i>It's was a subtitle way of leaving home really. I could be a teacher be a secretary or be a nurse</i>
		Financial security	Best option	<i>My husband started getting sore back and we thought well what, you know it's probably the best option for me, maybe to try a new career, got a sister who is a nurse who said go nursing that is what I did</i>
			Steady job	<i>It's easier for me to have a steady job</i>
		Important to culture	Give back to whānau	<i>I want to give something back to the whānau</i>

Appendix 11 Amended ethics approval

Health and Disability Ethics Committees

1 the Terrace
PO Box 5013
Wellington
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hdec@mh.govt.nz

17 July 2012

Ms Helen Rook
Graduate School of Nursing Midwifery and Health
Victoria University of Wellington
PO Box 7625
Newtown, Wellington

Dear Ms Helen Rook

Re: Ethics ref:	CEN/12/EXP/012
Study title:	The values of nurse working in New Zealand medical ward

I am pleased to advise that this application has been approved by the Central Health and Disability Ethics Committee.

The main issue considered by the HDEC in giving approval was as follows.

- Please formally advise the Committee of the additional site once this site has been selected.

Please don't hesitate to contact the HDEC secretariat for further information. We wish you all the best for your study.

Yours sincerely,

Dr Dean Quinn
Deputy Chairperson
Central Health and Disability Ethics Committee

Encl: appendix A: document submitted

Appendix A

Document submitted

Document	Version number	Date
Burnout Inventory	No Version Number	No date

Appendix 12 Consent form

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wānanga o Te Upoko o Te Ika a Maui

Graduate School of Nursing, Midwifery and Health

CONSENT FORM

Title: The Values of Nurses in New Zealand Medical Ward Environments

Principal Investigator: Helen Rook

English	I wish to have an interpreter	Yes	No
Deaf	I wish to have a NZ Sign language interpreter	Yes	No
Māori	E hiahia ana ahau ki te tahi kaiwhaka Māori/kaiwhaka pakeha korero	Ae	Kao
Cook Island Māori	Ka nāgaro au i te taiāngata ʻuri teo	Ae	Kare
Fijian	Au ʻgadrevame ʻdua ʻvaka dewa ʻvosa ʻvei au	Io	Sega
Niuean	Fia ʻmanako au ke ʻfaka aoga ʻe taha ʻagata ʻfakahoko hoko ʻkupu	E	Nakai
Sāmoan	Ou ʻe ʻmana ʻo ʻa ʻi ʻse ʻa ʻamatala ʻupu	Io e	Leai
Tokelaun	Ko au ʻe ʻfou ki ʻe ʻino ke ʻakalili i ʻe ʻgagana ʻe ʻletania ki ʻa ʻgagana ʻa ʻa motu ʻe ʻe Pahefika	Io e	Leai
Tongan	Oku ʻu ʻiema ʻu ʻa ʻakatonulea	Io	Ikai

I have read and understand the information sheet dated _____ for volunteers taking part in the study designed to explore the values of nurses in New Zealand medical ward environments.

I have had the opportunity to discuss this study. I am satisfied with the answers I have been given. I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice), and that I may withdraw from the study at any time.

I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.

I have had time to consider whether to take part in the study. YES/NO
I consent to any interview being audiotaped. YES/NO [circle as appropriate]
I wish to receive a copy of the results. YES/NO

I have been advised that a significant delay may occur between data collection and publication of the results.

_____ (full name) hereby consent to take part in this study.

Signature: _____ Date: _____
Project explained by: _____
Signature: _____ Date: _____

Appendix 13 Ward layouts

Drawings are not to scale, but are proportionally representative

Legend:

Represents a patient room with the number of patient-beds

Represents a Nurses Station

Ward layout - Site 1

Ward layout - Site 2

Ward layout - Site 3

REFERENCES

- Abraham, A. (2011). *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. (Fourth report of the Health Service Commissioner for England). London: Parliamentary and Health Service Ombudsman.
- Adler, P. A., & Adler, P. (1994). Observational techniques. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 377-392). Thousand Oaks: Sage Publications.
- Ahnquist, J., Wamala, S., & Lindström, M. (2010). What has trust in the health-care system got to do with psychological distress? Analyses from the national Swedish survey of public health. *International Journal for Quality in Health Care*, 22(4), 250-258. doi: 10.1093/intqhc/mzq024
- Aiken, L., Clarke, S., Sloane, D., Sochalski, J., Busse, R., Clarke, H., . . . Shamian, J. (2001). Nurses' reports on hospital care in five countries. *Health Affairs*, 20(3), 43-53.
- Aiken, L., Rafferty, A., & Sermeus, W. (2014). Caring nurses hit by a quality storm: Low investment and excessive workloads, not uncaring attitudes, are damaging the image of NHS trusts, argue the authors of ground breaking research into Europe's nurse workforce. *Nursing Standard*, 28(35), 22-25.
- Aiken, L., Sloane, D., Griffiths, P., Rafferty, A. L., Bruyneel, McHugh, M., . . . Sermeus, W. (2016). Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care. *BMJ Quality & Safety, Published Online First: 15th November 2016*. doi: /10.1136/bmjqs-2016-005567
- Aiken, L.H., Clarke, S.P., & Sloane, D.M. (2002). Hospital staffing, organization, and quality of care: Cross-national findings. *International Journal for Quality in Health Care*, 14(1), 5.
- Akhtari-Zavare, M., Abdullah, M., Hassan, S., Said, S., & Kamali, M. (2010). Patient satisfaction: evaluating nursing care for patients hospitalized with cancer in Tehran teaching hospitals, Iran. *Global Journal of Health Science*, 2(1), 117.

- Al-Kandari, F. H., & Ajao, E. (1998). Recruitment and retention of nursing students in Kuwait. *International Journal of Nursing Studies*, 35(5), 245-251.
- Albert, N. M., Wocial, L., Meyer, K. H., Na, J., & Trochelman, K. (2008). Impact of nurses' uniforms on patient and family perceptions of nurse professionalism. *Applied Nursing Research*, 21(4), 181-190. doi: <http://dx.doi.org/10.1016/j.apnr.2007.04.008>
- Ales Bello, A. (2015). From the “neutral” human being to gender difference: Phenomenological and dual anthropology in Edith Stein. In A. Calcagno (Ed.), *Edith Stein: Women, social-political philosophy, theology, metaphysics and public history: New approaches and applications* (Vol. 4) (pp.11-23). London: Springer.
- Allan, H. (2016). Editorial: The anxiety of caring and the devaluing of nursing. *Journal of Clinical Nursing*. doi: 10.1111/jocn.13380
- Allen, D. (2004a). Ethnomethodological insights into insider-outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry*, 11(1), 14-24.
- Allen, D. (2004b). Re-reading nursing and re-writing practice: Towards an empirically based reformulation of the nursing mandate. *Nursing Inquiry*, 11(4), 271-283. doi: 10.1111/j.1440-1800.2004.00234.x
- Allied Health Solutions. (2015). Pre-nursing degree care experience pilot: End of evaluation report. London: Health Education England.
- Alsulami, Z., Choonara, I., & Conroy, S. (2014). Paediatric nurses' adherence to the double-checking process during medication administration in a children's hospital: an observational study. *Journal of Advanced Nursing*, 70(6), 1404-1413. doi: 10.1111/jan.12303
- Alvesson, M., & Sandberg, J. (2013). *Constructing research questions: Doing interesting research*. London: Sage.
- American Nurse Association. (2001). *Code of ethics for nurses with interpretive statements*. Washington, DC.
- American Nurse Association. (2006). National Database of nursing quality indicators. Retrieved 20th November, 2011, from <https://http://www.nursingquality.org/>

- An Bord Altranais. (2000). *The code of professional conduct for each nurse and midwife*. Dublin: Author.
- An Bord Altranais agus Cnáinhseachais na hÉireann: Nursing and Midwifery Board of Ireland. (2014). Code of professional conduct and ethics for registered nurses and registered midwives. Dublin: Nursing and Midwifery Board of Ireland.
- Anderson, C. D., & Mangino, R. R. (2006). Nurse shift report: who says you can't talk in front of the patient? *Nursing Administration Quarterly*, 30(2), 112-122 111p.
- Andreski, A (Ed.). (1974). *The Essential Comte*. London: Croom Helm.
- Antheunis, M., Bates, K., & Nieboer, T. (2013). Patients' and health professionals' use of social media in health care: Motives, barriers and expectations. *Patient Education and Counselling*, 92(3), 426-431. doi: <http://dx.doi.org/10.1016/j.pec.2013.06.020>
- Anthony, S., & Jack, S. (2009). Qualitative case study methodology in nursing research: An integrative review. *Journal of Advanced Nursing*, 65(6), 1171-1181. doi: 10.1111/j.1365-2648.2009.04998.x
- Arnold, E., & Boggs, K. (2015). *Interpersonal relationships: Professional communication skills for nurses* (7th ed.). St Louis: Elsevier Health Sciences.
- Atkinson, P, & Coffey, A. (1997). Analysing documentary realities. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice*, (pp. 45-62). London: SAGE.
- Attree, M. (2001). Patients' and relatives' experiences and perspectives of 'good' and 'not so good' quality care. *Journal of Advanced Nursing*, 33(4), 456-466. doi: 10.1046/j.1365-2648.2001.01689.x
- Australian Commission on Safety and Quality in Health Care. (2008). Australian Charter of Healthcare Rights. Retrieved 29th December, 2016, from <https://http://www.safetyandquality.gov.au/publications/the-australian-charter-of-healthcare-rights/>
- Australian Government. (2013). *Closing the gap: National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. Canberra: Commonwealth of Australia.
- Australian Nursing and Midwifery Council. (2008). *Code of professional conduct for nurses in Australia*. Dikson ACT.

- Avis, K. (2009). Releasing time to care© in Saskatchewan: Promising signs that program engages clinicians: Saskatchewan Health Quality Council.
- Balevre, P. (2001). Professional nursing burnout and irrational thinking. *Journal for Nurses in Professional Development*, 17(5), 264-271.
- Balevre, P, Cassells, J, & Buzaianu, E. (2012). Professional nursing burnout and irrational thinking: A replication study. *Journal for Nurses in Professional Development*, 28(1), 2-8.
- Ball, J, Griffiths, P, Rafferty, A, Lindqvist, R, Murrells, T, & Tishelman, C. (2016). A cross- sectional study of 'care left undone' on nursing shifts in hospitals. *Journal of Advanced Nursing*, 72(9), 2086-2097. doi: 10.1111/jan.12976
- Ball, J, Murrells, T, Rafferty, A, Morrow, E, & Griffiths, P. (2013). 'Care left undone' during nursing shifts: Associations with workload and perceived quality of care. *BMJ Quality & Safety*, bmjqs-2012-001767.
- Bandura, A. (1977) Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review*, 84(2), 191-215.
- Banik, B. J. (1993). Applying triangulation in nursing research. *Applied Nursing Research*, 6(1), 47-52.
- Barnard, A. (2016). Radical nursing and the emergence of technique as healthcare technology. *Nursing Philosophy*, 17(1), 8-18. doi: 10.1111/nup.12103
- Barker, E. (2012). *The political thought of Plato and Aristotle*. New York: Dover Publications.
- Baseheart, M. C. (1989). Edith Stein's philosophy of woman and of women's education. *Hypatia*, 4(1), 120-131.
- Baseheart, M. C. (1992). Edith Stein's philosophy of community. *The Personalist Forum*, 8(1), 163-173.
- Bassey, M. (1999). *Case study research in educational settings*. Buckingham: Open University Press.
- Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, 13(4), 544-559.

- Baydoun, M., Dumit, N., & Daouk-Öyry, L. (2016). What do nurse managers say about nurses' sickness absenteeism? A new perspective. *Journal of Nursing Management*, 24(1), 97-104. doi: 10.1111/jonm.12277
- Bayramzadeh, S., & Alkazemi, M. (2014). Centralized vs. decentralized nursing stations: An evaluation of the implications of communication technologies in healthcare. *HERD: Health Environments Research & Design Journal*, 7(4), 62-80. doi: 10.1177/193758671400700406
- Beck, M., & Melo, S. (2014). *Quality management and managerialism in healthcare: A critical historical survey*. Retrieved from <http://www.palgraveconnect.com.helicon.vuw.ac.nz/pc/doifinder/10.1057/9781137351999.0004>
- Belcher, M., & Jones, L. (2009). Graduate nurses experiences of developing trust in the nurse-patient relationship. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 31(2), 142-152.
- Belgrave, M., Kawharu, M., & Williams, D. (Eds.). (2004). *Waitangi revisited: Perspectives on the Treaty of Waitangi* (2nd ed.). Auckland: Oxford University Press.
- Bendall, E. (1976). Learning for reality. *Journal of Advanced Nursing*, 1(1), 3-9. doi: 10.1111/j.1365-2648.1976.tb00423.x
- Benner, P. (1984). *From novice to expert, excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley Publishing Company
- Benner, P. (1994). Caring as ways of knowing and not knowing. In S. Phillips & P. Benner (Eds.), *The crisis of care: Affirming and restoring caring practices in the helping professions* (pp. 42-62). Washington, D.C: Georgetown University Press.
- Berger, P. L., & Luckmann, T. (1991). *The social construction of reality: A treatise in the sociology of knowledge*: Penguin UK.
- Bergum, V., & Dossetor, J. B. (2005). *Relational ethics: The full meaning of respect*: University Publishing Group Hagerstown, MD.
- Berle, A., & Means, G. (1967). *The modern corporation and private property* (revised ed.). New York: Harcourt.

- Biley, F, & Wright, S. (1997). Towards a defence of nursing routine and ritual. *Journal of Clinical Nursing*, 6(2), 115-119.
- Bion, W. R. (1961). *Experiences in groups*. London: Tavistock Publications.
- Black, B, Rabins, P, Sugarman, J, & Karlawish, J. (2010). Seeking assent and respecting dissent in dementia research. *The American Journal of Geriatric Psychiatry*, 18(1), 77-85.
- Blay, N., Duffield, C., & Gallagher, R. (2012). Patient transfers in Australia: Implications for nursing workload and patient outcomes. *Journal of Nursing Management*, 20(3), 302-310.
- Blay, N., Duffield, C., Gallagher, R., & Roche, M. (2014). A systematic review of time studies to assess the impact of patient transfers on nurse workload. *International Journal of Nursing Practice*, 20(6), 662-673. doi: 10.1111/ijn.12290
- Bloomquist, B. L., Cruise, P. D., & Cruise, R. J. (1980). Values of baccalaureate nursing students in secular and religious schools. *Nursing Research*, 29(6), 379-383.
- Bogert, S., Ferrell, C., & Rutledge, D. N. (2010). Experience with family activation of rapid response teams. *MEDSURG Nursing*, 19(4), 215-222.
- Bonner, A., & Tohurst, G. (2002). Insider-outsider perspectives of participant observation. *Nurse Researcher*, 9(4), 7-19.
- Boston, J. (1999). *The New Zealand model of public management: A brief assessment*. . Paper presented at the Process of Governance and the Role of the Individual, Community and Markets, Wellington.
- Bourgeois, S, Blanchard, D, Doldissen, R, Maher, L, Stoddart, K, Johnston, N, & Hungerford, C. (2014). Nurse practitioner work: A case study. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 47(1/2), 61-68. doi: 10.5172/conu.2014.47.1-2.61
- Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, 9(2), 27-40. doi: 10.3316/QRJ0902027
- Boyle, D. (2011). Countering compassion fatigue: A requisite nursing agenda. *The Online Journal of Issues in Nursing*, 16(1).

- Bradbury- Jones, C. (2007). Enhancing rigour in qualitative health research: Exploring subjectivity through Peshkin's I's. *Journal of Advanced Nursing*, 59(3), 290-298. doi: 10.1111/j.1365-2648.2007.04306.x
- Bradshaw, A. (2014). Listening to the patient's self- reported testimony: The authentic hermeneutical witness to the compassionate nurse? *Journal of Advanced Nursing*, 70(1), 60-67. doi: 10.1111/jan.12170
- Bradshaw, A. (2016). An analysis of England's nursing policy on compassion and the 6Cs: The hidden presence of M. Simone Roach's model of caring. *Nursing Inquiry*, 23(1), 78-85. doi: 10.1111/nin.12107
- Brady, P. W., Zix, J., Brilli, R., Wheeler, D. S., Griffith, K., Giaccone, M. J., . . . Tegtmeier, K. (2015). Developing and evaluating the success of a family activated medical emergency team: A quality improvement report. *BMJ Quality & Safety*, 24(3), 203-211. doi: 10.1136/bmjqs-2014-003001
- Bramley, L., & Matiti, M. (2014). How does it really feel to be in my shoes? Patients' experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *Journal of Clinical Nursing*, 23(19/20), 2790-2799 2710p. doi: 10.1111/jocn.12537
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi: 10.1191/1478088706qp063oa
- Bromley, E. (2012). Building patient-centeredness: Hospital design as an interpretive act. *Social Science & Medicine*, 75(6), 1057-1066.
- Brotheridge, C., & Lee, R. (2003). Development and validation of the emotional labour scale. *Journal of Occupational and Organizational Psychology*, 76(3), 365-379.
- Brown, P. (2008). Trusting in the new NHS: Instrumental versus communicative action. *Sociology of Health & Illness*, 30(3), 349-363.
- Brown Wilson, C., & Clissett, P. (2011). Involving older people in research: practical considerations when using the authenticity criteria in constructivist inquiry. *Journal of Advanced Nursing*, 67(3), 677-686. doi: 10.1111/j.1365-2648.2010.05500.x
- Bruhn, J. (2008). Value dissonance and ethics failure in academia: A causal connection? *Journal of Academic Ethics*, 6(1), 17-32.

- Buchan, J., & Calman, L. (2004). *The global shortage of registered nurses: An overview of issues and actions*. Geneva: International Council of Nurses.
- Burnham, B., Wallington, S., Jillson, I., Trandafili, H., Shetty, K., Wang, J., & Loffredo, C. (2014). Knowledge, attitudes, and beliefs of patients with chronic liver disease. *American Journal of Health Behaviour*, 38(5), 737-744. doi: 10.5993/ajhb.38.5.11
- Büssing, A., & Glaser, J. (2000). Four-stage process model of the core factors of burnout: The role of work stressors and work-related resources. *Work & Stress*, 14(4), 329-346. doi: 10.1080/02678370110041884
- Cain, M. (2005). Highlighting concerns and about staffing shortages. *Kai Taiki Nursing New Zealand*, March, 24.
- Calcagno, A. (Ed.). (2015). *Edith Stein: Women, social-political philosophy, theology, metaphysics and public history: New approaches and applications* (Vol. 4). London: Springer.
- Calman, K. C. (2004). Evolutionary ethics: Can values change. *Journal of Medical Ethics*, 30(4), 366-370.
- Canadian Nurses Association. (2008). *Code of ethics for registered nurses*. Ottawa: Author.
- Canales, M. K. (2000). Othering: Toward an understanding of difference. *Advances in Nursing Science*, 22(4), 16-31.
- Carbonnier, G. (2015). Reason, emotion, compassion: Can altruism survive professionalisation in the humanitarian sector? *Disasters*, 39(2), 189-207. doi: 10.1111/disa.12096
- Care Quality Commission. (2012). *The state of health care and adult social care in England in 2011/12* (Vol. 763): The Stationery Office.
- Carlisle, Y. (2011). Complexity dynamics: Managerialism and undesirable emergence in healthcare organizations. *Journal of Medical Marketing: Device, Diagnostic and Pharmaceutical Marketing*, 11(4), 284-293.
- Carlson, E., Rämgård, M., Bolmsjö, I., & Bengtsson, M. (2014). Registered nurses' perceptions of their professional work in nursing homes and home-based care: A focus group study. *International Journal of Nursing Studies*, 51(5), 761-767. doi: 10.1016/j.ijnurstu.2013.10.002

- Carney, M. (2006). Positive and negative outcomes from values and beliefs held by healthcare clinician and non- clinician managers. *Journal of Advanced Nursing*, 54(1), 111-119. doi: 10.1111/j.1365-2648.2006.03795.x
- Carr, T. J. (2010). Facing existential realities: Exploring barriers and challenges to spiritual nursing care. *Qualitative Health Research*, 20(10), 1379-1392. doi: 10.1177/1049732310372377
- Carter, M. (2014). Vocation and altruism in nursing: The habits of practice. *Nursing Ethics*, 21(6), 695-706. doi: 10.1177/0969733013516159
- Carville, O. (2014, 27th May). Overworked nurses ration patient care, *The Press*.
- Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration*, 34(6), 303-311.
- Cassidy, S. (2013). Acknowledging hubris in interpretative data analysis. *Nurse Researcher*, 20(6), 27.
- Catlett, S., & Lovan, S. R. (2011). Being a good nurse and doing the right thing: A replication study. *Nursing Ethics*, 18(1), 54-63. doi: 10.1177/0969733010386162
- Cavendish, R., Luise, B., Horne, K., Bauer, M., Medefindt, J., Gallo, M., . . . Kutza, T. (2000). Opportunities for enhanced spirituality relevant to well adults. *International Journal of Nursing Terminologies and Classifications*, 11(4), 151-163. doi: 10.1111/j.1744-618X.2000.tb00422.x
- Chaboyer, W., McMurray, A., & Wallis, M. (2010). Bedside nursing handover: A case study. *International Journal of Nursing Practice*, 16(1), 27-34 28p. doi: 10.1111/j.1440-172X.2009.01809.x
- Chapman, C. M. (1983). The paradox of nursing. *Journal of Advanced Nursing*, 8(4), 269-272. doi: 10.1111/j.1365-2648.1983.tb00325.x
- Charon, J. M. (1992). *Symbolic interactionism: An introduction, an interpretation, an integration* (4th ed.). Englewood Cliffs, NY: Prentice Hall, Inc.
- Chen, M., Ho, C., Lin, C., Chung, M., Chao, W., Chou, H., & Li, C. (2016). Organisation- based self- esteem mediates the effects of social support and job satisfaction on intention to stay in nurses. *Journal of Nursing Management*, 24(1), 88-96.

- Chen, S., & Hsu, H. (2015). Nurses' reflections on good nurse traits. *Nursing Ethics*, 22(7), 790-802. doi: 10.1177/0969733014547973
- Cherniss, C. (1980). *Professional burnout in human service organisations*. New York: Praeger.
- Chiesa, M., & Hobbs, S. (2008). Making sense of social research: How useful is the Hawthorne Effect? *European Journal of Social Psychology*, 38(1), 67-74.
- Chitty, K., & Black, B. (2011). *Professional nursing: Concepts & challenges*. Maryland Heights: Elsevier.
- Chope, Robert C. (2005). Qualitatively assessing family influence in career decision-making. *Journal of Career Assessment*, 13(4), 395-414. doi: 10.1177/1069072705277913
- Clark, P. (1997). Values in health care professional socialization: Implications for geriatric education in interdisciplinary teamwork. *The Gerontologist*, 37(4), 441-451.
- Clawson, C.J., & Vinson, D.E. (1978). Human values: A historical and interdisciplinary analysis. *Advances in Consumer Research*, 5(1), 396-402.
- Clegg, S., Kornberger, M., & Pitsis, T. (2009). *Managing and organizations: An introduction to theory and practice* (2nd ed.). Los Angeles: Sage.
- Clendon, J., & Walker, L. (2012). 'Being young': A qualitative study of younger nurses' experiences in the workplace. *International Nursing Review*, 59(4), 555-561.
- Clendon, J., & Gibbons, V. (2015). 12h shifts and rates of error among nurses: a systematic review. *International Journal of Nursing Studies*, 52(7), 1231-1242.
- Clendon, J., & Walker, L. (2016). The juxtaposition of ageing and nursing: The challenges and enablers of continuing to work in the latter stages of a nursing career. *Journal of Advanced Nursing*, 72(5), 1065-1074. doi: 10.1111/jan.12896
- Clipper, B., & Cherry, B. (2015). From transition shock to competent practice: Developing preceptors to support new nurse transition. *The Journal of Continuing Education in Nursing*, 46(10), 448-454. doi:10.3928/00220124-20150918-02
- Coetzee, S., & Klopper, H. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing & Health Sciences*, 12(2), 235-243. doi: 10.1111/j.1442-2018.2010.00526.x

- Coffey, A. (2014). Analysing documents. In U. Flick (Ed.), *The SAGE handbook of qualitative data analysis*. London: SAGE Publications Ltd.
- Cohen, H. (1981). *The nurse's quest for professional identity*. Menlo Park, CA: Addison-Wesley Publishing Co.
- Commissioning Board Chief Nursing Officer. (2012). Compassion in practice: Nursing, midwifery and care staff our vision and strategy: Crown copyright.
- Conway, J. (1994). Reflection, the art and science of nursing and the theory-practice gap. *British Journal of Nursing (BJN)*, 3(3), 114-118.
- Cooper, A. (2010). Legend, myth and idea: On the fate of a great paper. *British Journal of Psychotherapy*, 26(2), 219-227. doi: 10.1111/j.1752-0118.2010.01176.x
- Cooper-Patrick, L., Powe, N., Jenckes, M., Gonzales, J., Levine, D., & Ford, D. (1997). Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine*, 12(7), 431-438.
- Cope, V., Jones, B., & Hendricks, J. (2016). Resilience as resistance to the new managerialism: Portraits that reframe nursing through quotes from the field. *Journal of Nursing Management*, 24(1), 115-122. doi: 10.1111/jonm.12279
- Coughlin, C. (2013). An ethnographic study of main events during hospitalisation: Perceptions of nurses and patients. *Journal of Clinical Nursing*, 22(15-16), 2327-2337. doi: 10.1111/j.1365-2702.2012.04083.x
- Cowden, T., Cummings, G., & Profetto-Mcgrath, J. (2011). Leadership practices and staff nurses' intent to stay: A systematic review. *Journal of Nursing Management*, 19(4), 461-477 417p. doi: 10.1111/j.1365-2834.2011.01209.x
- Cheng, C, Bartram, T, Karimi, L, & Leggat, S. (2013). The role of team climate in the management of emotional labour: Implications for nurse retention. *Journal of Advanced Nursing*, 69(12), 2812-2825. doi: 10.1111/jan.12202
- Creswell, J. W. (2013a). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Los Angeles: Sage.
- Creswell, J. W. (2013b). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Los Angeles: Sage.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice*, 39(3), 124-130.

- Cribb, Alan. (2011). Integrity at work: Managing routine moral stress in professional roles. *Nursing Philosophy*, 12(2), 119-127. doi: 10.1111/j.1466-769X.2011.00484.x
- Cronin, Camille. (2014). Using case study research as a rigorous form of inquiry. *Nurse Researcher*, 21(5), 19-27. doi: 10.7748/nr.21.5.19.e1240
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*: Sage.
- Cummings, G., MacGregor, T., Davey, M., Lee, H., Wong, C. A., Lo, E., . . . Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies*, 47(3), 363-385 323p. doi: 10.1016/j.ijnurstu.2009.08.006
- Cummings, J. (2013, 7th February). Nurses who don't care about patients must leave the NHS, *The Telegraph*.
- Cummings, J., & Bennett, V. (Producer). (2012). Compassion in practice: Nursing, midwifery and care staff. Our vision and strategy. Retrieved from <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>
- Currie, D., McElwee, G., & Somerville, P. (2012). Managerialism and nihilism. *Tamara Journal for Critical Organization Inquiry*, 10(4), 61-72.
- Currie, G., Koteyko, N., & Nerlich, B. (2009). The dynamics of professions and development of new roles in public services organizations: The case of modern matrons in the English NHS. *Public Administration*, 87(2), 295-311.
- Curtis, E., & Redmond, R. (2007). Focus groups in nursing research. *Nurse Researcher*, 14(2), 25-37.
- Cyr, J. (2016). The pitfalls and promise of focus groups as a data collection method. *Sociological Methods & Research*, 45(2), 231-259. doi: 10.1177/0049124115570065
- Daniel, D. (2007). Case study methodology: Fundamentals and critical analysis. *Cognition, Brain, Behaviour*, 11(2), 299-317.

- Daouk-Öyry, L, Anouze, A, Otaki, F, Dumit, N, & Osman, I. (2014). The JOINT model of nurse absenteeism and turnover: A systematic review. *International Journal of Nursing Studies*, 51(1), 93-110. doi: 10.1016/j.ijnurstu.2013.06.018
- Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy & Rehabilitation*, 21(12).
- Darbyshire, P. (2014a). Character assassination? Response to John Paley, "social psychology and the compassion deficit". *Nurse Education Today*, 34(6), 887-889.
- Darbyshire, P. (2014b). Heroines, hookers and harridans: Exploring popular images and representations of nurses and nursing. In J. Daly, S. Speedy & D. Jackson (Eds.), *Contexts of nursing* (pp. 53-69). Sydney: Churchill Livingstone Elsevier
- Davey, M. M., Cummings, G., Newburn-Cook, C. V., & Lo, E. A. (2009). Predictors of nurse absenteeism in hospitals: A systematic review. *Journal of Nursing Management*, 17(3), 312-330. doi: 10.1111/j.1365-2834.2008.00958.x
- Davis, A. J., Hershberger, A, Chun Ghan, L, & Ymg Lin, J. (1990). The good nurse: descriptions from the People's Republic of China. *Journal of Advanced Nursing*, 15(7), 829-834. doi: 10.1111/j.1365-2648.1990.tb01914.x
- Davis, P., Milne, B., Parker, K., Hider, P., Lay-Yee, R., Cumming, J., & Graham, P. (2013). Efficiency, effectiveness, equity (E3). Evaluating hospital performance in three dimensions. *Health Policy*, 112(1-2), 19-27. doi: <http://dx.doi.org/10.1016/j.healthpol.2013.02.008>
- Dawood, M., & Gallini, A. (2010). Using discovery interviews to understand the patient experience. *Nursing Management - UK*, 17(1), 26-31.
- Day, S. (2012). A reflexive lens: Exploring dilemmas of qualitative methodology through the concept of reflexivity. *Qualitative Sociology Review*, 8(1).
- de Huszar, G. (1945). Nietzsche's theory of decadence and the transvaluation of all values. *Journal of the History of Ideas*, 6(3), 259-272.
- de Vries, Kay. (2004). Humility and its practice in nursing. *Nursing Ethics*, 11(6), 577-586. doi: 10.1191/0969733004ne740oa
- Dearnley, C. (2005). A reflection on the use of semi-structured interviews. *Nurse Researcher*, 13(1), 19-28.

- DeLucia, P, Ott, T, & Palmieri, P. (2009). Performance in nursing. *Review of Human Factors and Ergonomics*, 5, 1-40.
- Denzin, N. K, & Lincoln, Y. S. (Eds.). (2005). *The Sage handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Denzin, N. K. (1970). *The research act: A theoretical introduction to sociological methods*. New Brunswick, USA: Transaction publishers.
- Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York, USA: McGraw Hill.
- Denzin, N. K. (1994). The art and politics of interpretation. In N. Denzin & Y. Lincoln (Eds.), *The handbook of qualitative research* (pp. 500-505). Thousand Oaks, CA: Sage.
- Denzin, N. K. (2012). Triangulation 2.0. *Journal of Mixed Methods Research*, 6(2), 80-88. doi: 10.1177/1558689812437186
- Department of Health. (2015). *The NHS Constitution for England*. Crown copyright.
- Devlin, N, Maynard, A, & Mays, N (2001). New Zealand's new health sector reforms: Back to the future. *British Medical Journal*, 322, 1171-1174.
- Dewar, B., & Christley, Y. (2013). A critical analysis of compassion in practice. *Nursing Standard*, 28(10), 46-50.
- Dickson, J., Bulley, S., & Oliver, D. (2014). Efficiency and perceptions of cost in healthcare. *British Journal of Healthcare Management*, 20(5), 222-226.
- Dinc, L., & Gastmans, C. (2012). Trust and trustworthiness in nursing: an argument-based literature review. *Nursing Inquiry*, 19(3), 223-237.
- Dinç, L., & Gastmans, C. (2013). Trust in nurse–patient relationships: A literature review. *Nursing Ethics*, 20(5), 501-516. doi: 10.1177/0969733012468463
- Dinmohammadi, M., Peyrovi, H., & Mehrdad, N. (2013). Concept analysis of professional socialization in nursing. *Nursing Forum*, 48(1), 26-34. doi: 10.1111/nuf.12006.
- Dobson, S., & Tranter, S. (2008). Organising the work: choosing the most effective way to deliver nursing care in a hospital haemodialysis unit. *Renal Society of Australasia Journal*, 4(2), 59-63.

- Dockery, A. M., & Barns, A. (2005). Who'd be a nurse?: Some evidence on career choice in Australia. *Australian Bulletin of Labour*, 31(4), 350.
- Dong, Y. (1996). Learning how to use citations for knowledge transformation: Non-native doctoral students' dissertation writing in science. *Research in the Teaching of English*, 30(4), 428-457.
- Dong, Y. (1998). Non-native graduate students' thesis/dissertation writing in science: Self-reports by students and their advisors from two US institutions. *English for Specific Purposes*, 17(4), 369-390.
- Doran, D. (Ed.). (2011). *Nursing outcomes: state of the science* (2nd ed.). London: Jones & Bartlett Learning.
- Drennan, V., Norrie, C., Cole, L., & Donovan, S. (2013). Addressing incontinence for people with dementia living at home: A documentary analysis of local English community nursing service continence policies and clinical guidance. *Journal of Clinical Nursing*, 22(3-4), 339-346. doi: 10.1111/j.1365-2702.2012.04125.x
- Drummond, J. (2000). Nietzsche for nurses: Caring for the Übermensch. *Nursing Philosophy*, 1(2), 147-157. doi: 10.1046/j.1466-769x.2000.00021.x
- Drury, V., Craigie, M., Francis, K., Aoun, S., & Hegney, D. (2014). Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: Phase 2 results. *Journal of Nursing Management*, 22(4), 519-531. doi: 10.1111/jonm.12168
- Drury, V., Francis, K., & Chapman, Y. (2009). Where have all the young ones gone: Implications for the nursing workforce. *The Online Journal of Issues in Nursing*, 14(1), 1-12.
- Duckitt, J., & Sibley, C. (2009). A dual process motivational model of ideological attitudes and system justification. In J. Jost, A. Kay, & H. Thorisdottir (Eds). *Social and psychological bases of ideology and system justification* (pp. 292-313). Oxford: Oxford University Press.
- Duckitt, J., & Sibley, C. G. (2010). Personality, ideology, prejudice, and politics: A dual- process motivational model. *Journal of Personality*, 78(6), 1861-1894.

- Duffield, C., Pallas, L. O., & Aitken, L. M. (2004). Nurses who work outside nursing. *Journal of Advanced Nursing*, 47(6), 664-671. doi: 10.1111/j.1365-2648.2004.03155.x
- Duffield, C., Roche, M., Diers, D., Catling-Paull, C., & Blay, N. (2010). Staffing, skill mix and the model of care. *Journal of Clinical Nursing*, 19(15/16), 2242-2251 2210p. doi: 10.1111/j.1365-2702.2010.03225.x
- Durkin, S. E. (2006). Emergency. Implementing a rapid response team: In-hospital intervention before a critical event occurs can save lives. *American Journal of Nursing*, 106(10), 50-53.
- Eddy, D.M., Elfrink, V., Weis, D., & Schank, M.J. (1994). Importance of professional nursing values: A national study of baccalaureate programs. *The Journal of Nursing Education*, 33(6), 257.
- Edge, R., & Groves, J. (1994). *The ethics of health care: A guide for clinical practice*. Albany, NY: Delmar Publishers.
- Eisner, E. W. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice*. Toronto: Collier Macmillan Canada.
- Eley, D, Eley, R, Bertello, M, & Rogers-Clark, C. (2012). Why did I become a nurse? Personality traits and reasons for entering nursing. *Journal of Advanced Nursing*, 68(7), 1546-1555. doi: 10.1111/j.1365-2648.2012.05955.x
- Eley, D, Eley, R, & Rogers-Clark, C. (2010). Reasons for entering and leaving nursing: An Australian regional study. *Australian Journal of Advanced Nursing*, 28(1), 6-13.
- Ellison-Loschmann, L, & Pearce, N. (2006). Improving access to health care among New Zealand's Maori population. *American Journal of Public Health*, 96(4), 612-617. doi: 10.2105/ajph.2005.070680
- Ersser, S. J. (1997). *Nursing as a therapeutic activity: An ethnography*. Aldershot: Avebury.
- Evans, A, Glass, N, & Traynor, M. (2014). Anxiety and surplus in nursing practice: Lessons from Lacan and Bataille. *Nursing Philosophy*, 15(3), 183-191. doi: 10.1111/nup.12049

- Evans, S., Murray, A., Patrick, I., Fitzgerald, M., Smith, S., & Cameron, P. (2010). Clinical handover in the trauma setting: A qualitative study of paramedics and trauma team members. *Quality and Safety in Health care*, 19(6), 1-6.
- Fahrenwald, N., Bassett, S., Tschetter, L., Carson, P., White, L., & Winterboer, V. (2005). Teaching core nursing values. *Journal of Professional Nursing*, 21(1), 46-51. doi: <http://dx.doi.org/10.1016/j.profnurs.2004.11.001>
- Fairbrother, G., Jones, A., & Rivas, K. (2010). Changing model of nursing care from individual patient allocation to team nursing in the acute inpatient environment. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 35(2), 202-220 219p. doi: 10.5172/conu.2010.35.2.202
- Fealy, G. M. (2004). 'The good nurse': visions and values in images of the nurse. *Journal of Advanced Nursing*, 46(6), 649-656.
- Ferguson, L., & Cioffi, J. (2011). Team nursing: experiences of nurse managers in acute care settings. *Australian Journal of Advanced Nursing*, 28(4), 5-11 17p.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology*, 58(11), 1433-1441.
- Fine, M. (1994). Working the hyphens: Reinventing self and other in qualitative research. In K. N. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 70-82). Thousand Oaks, CA: Sage.
- Finfgeld- Connett, D. (2010). Generalizability and transferability of meta- synthesis research findings. *Journal of Advanced Nursing*, 66(2), 246-254. doi: 10.1111/j.1365-2648.2009.05250.x
- Finlayson, MP, & Gower, SE. (2002). Hospital restructuring: Identifying the impact on patients and nurses. *Nursing Praxis in New Zealand inc*, 18(1), 27-35.
- Flick, U. (1992). Triangulation revisited: Strategy of validation or alternative? *Journal for the Theory of Social Behaviour*, 22(2), 175-197.
- Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, 12(2), 219-245.
- Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery Office.

- Francis, R., & Lingard, H. (2013). *Final report. Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery Office.
- Francis, R. (2010). *Independent inquiry into care provided by mid Staffordshire NHS Foundation Trust January 2005-March 2009* (Vol. 375): London: The Stationery Office.
- Fredrickson, B. L., & Joiner, T. (2002). Positive emotions trigger upward spirals toward emotional well-being. *Psychological Science*, 13(2), 172-175.
- Freud, S. (1909). Analysis of a phobia in a five-year-old boy. *Standard Edition*, 10(3).
- Freudenberger, H. (1975). The staff burn-out syndrome in alternative institutions. *Psychotherapy: Theory, Research & Practice*, 12(1), 73.
- Fry, C., & Dwyer, R. (2001). For love or money? An exploratory study of why injecting drug users participate in research. *Addiction*, 96(9), 1319-1325.
- Gadow, S. (1999). Relational narrative: the postmodern turn in nursing ethics. *Research and Theory for Nursing Practice*, 13(1), 57-70.
- Gallagher, A. (2004). Dignity and respect for dignity - Two key health professional values: Implications for nursing practice. *Nursing Ethics*, 11(6), 587-599. doi: 10.1191/0969733004ne744oa
- Gallagher, A. (2011). Moral distress and moral courage in everyday nursing practice. *OJIN: The Online Journal of Issues in Nursing*, 16(2). doi: 10.3912/OJIN.Vol16No02PPT03
- Gama, G, Barbosa, F, & Vieira, M. (2014). Personal determinants of nurses' burnout in end of life care. *European Journal of Oncology Nursing*, 18(5), 527-533. doi: 10.1016/j.ejon.2014.04.005
- Gandi, J, Wai, P, Karick, H, & Dagona, Z. (2011). The role of stress and level of burnout in job performance among nurses. *Mental Health in Family Medicine*, 8(3), 181-194.
- Gangeness, J. E., & Yurkovich, E. (2006). Revisiting case study as a nursing research design. *Nurse Researcher*, 13(4), 7-18.
- Gardiner, C., Gott, M., & Ingleton, C. (2012). Factors supporting good partnership working between generalist and specialist palliative care services: A systematic

- review. *British Journal of General Practice*, 62(598), e353-e362. doi: 10.3399/bjgp12X641474
- Gardiner, C., Gott, M., Ingleton, C., Seymour, J., Cobb, M., Noble, B., . . . Ryan, T. (2013). Extent of palliative care need in the acute hospital setting: A survey of two acute hospitals in the UK. *Palliative Medicine*, 27(1), 76-83. doi: 10.1177/0269216312447592
- Gardner, K. G., & Tilbury, M. (1990). A longitudinal cost analysis of primary and team nursing. *Nursing Economics*, 9(2), 97-104.
- Garrido, M. V., Zentner, A., & Busse, R. (2011). The effects of gatekeeping: A systematic review of the literature. *Scandinavian Journal of Primary Health Care*, 29(1), 28-38. doi: 10.2109/02813432.2010.537015
- Garvin, B.J. (1976). Values of male nursing students. *Nursing Research*, 25, 352-357.
- Garvin, B.J., & Boyle, K.K. (1985). Values of entering nursing students: Changes over 10 years. *Research in Nursing and Health*, (8), 235-241.
- Gaudine, A., & Gregory, C. (2010). The accuracy of nurses' estimates of their absenteeism. *Journal of Nursing Management*, 18(5), 599-605. doi: 10.1111/j.1365-2834.2010.01107.x
- GeÇKil, E, Ege, E, Akin, B, & GÖZ, F. (2012). Turkish version of the revised nursing professional values scale: Validity and reliability assessment. *Japan Journal of Nursing Science*, 9(2), 195-200. doi: 10.1111/j.1742-7924.2011.00202.x
- Gentile, M. (2010). *Giving voice to values: How to speak your mind when you know what's right*. London: Yale University Press.
- George, J., & Wilkinson, I. (2016). Moving patients to create bed capacity. *Journal of The Royal Society of Medicine*, 109(5), 172-173. doi: 10.1177/0141076816646944
- Georges, J.M. (2011). Evidence of the unspeakable: Biopower, compassion, and nursing. *Advances in Nursing Science*, 34(2), 130. doi: 10.1097/ANS.0b013e3182186cd8
- Gervais, M., & Wilson, D. (2005). The evolution and functions of laughter and humor: A synthetic approach. *The Quarterly Review of Biology*, 80(4), 395-430.
- Giacomini, M, Hurley, J, Gold, I, Smith, P, & Abelson, J. (2004). The policy analysis of 'values talk': Lessons from Canadian health reform. *Health Policy*, 67(1), 15-24.

- Gibbs, A. (1988). *Unshackling the hospitals: Report of the hospital and related services taskforce*. Wellington: Ministry of Health
- Gilbert, T. P. (2005). Trust and managerialism: exploring discourses of care. *Journal of Advanced Nursing*, 52(4), 454-463. doi: 10.1111/j.1365-2648.2005.03611.x
- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal*, 204(6), 291-295.
- Gilson, L. (2003). Trust and the development of health care as a social institution. *Social Science & Medicine*, 56(7), 1453-1468.
- Gjengedal, E., Ekra, E., Hol, H., Kjelsvik, M., Lykkeslet, E., Michaelsen, R., . . . Wogn-Henriksen, K. (2013). Vulnerability in health care – reflections on encounters in every day practice. *Nursing Philosophy*, 14(2), 127-138. doi: 10.1111/j.1466-769X.2012.00558.x
- Glaser, B. & Strauss, A. (1967). The discovery of grounded theory. *London: Weidenfield & Nicolson*.
- Goldenberg, D. & Iwasiw, C. (1993). Professional socialisation of nursing students as an outcome of a senior clinical preceptorship experience. *Nurse Education Today*, 13(1), 3-15.
- Goodman, B. (2014). Risk, rationality and learning for compassionate care; The link between management practices and the 'lifeworld' of nursing. *Nurse Education Today*, 34(9), 1265-1268. doi: 10.1016/j.nedt.2014.04.009
- Gordon, S. (2005). *Nursing against the odds: How health care cost cutting, media stereotypes, and medical hubris undermine nurses and patient care*. New York: Cornell University Press.
- Gorman, D. (2011, 28th April). Mission to heal the health system, *The New Zealand Herald*.
- Graduate e-cohort. (2016). Retrieved 28th December, from <https://graduates.e-cohort.net/default.cfm>
- Graham, K., Davies, B., Woodend, A., Simpson, J., & Mantha, S. (2011). Impacting Canadian public health nurses' job satisfaction. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, 427-431.

- Gray, B. (2009). The emotional labour of nursing – Defining and managing emotions in nursing work. *Nurse Education Today*, 29(2), 168-175. doi: <http://dx.doi.org/10.1016/j.nedt.2008.08.003>
- Griscti, O., Aston, M., Martin-Misener, R., Mcleod, D., & Warner, G. (2016). The experiences of chronically ill patients and registered nurses when they negotiate patient care in hospital settings: A feminist poststructural approach. *Journal of Clinical Nursing*, 25, 2028-2039. doi: 10.1111/jocn.13250
- Grønkjær, M., Curtis, T., de Crespigny, C., & Delmar, C. (2011). Analysing group interaction in focus group research: Impact on content and the role of the moderator. *Qualitative Studies*, 2(1), 16-30.
- Gross, D. (1990). Communication and the elderly. *Physical and Occupational Therapy in Geriatrics*, 9(1), 49-64.
- Gurascio-Howard, L., & Malloch, K. (2007). Centralized and decentralized nurse station design: An examination of caregiver communication, work activities, and technology. *HERD: Health Environments Research & Design Journal*, 1(1), 44-57. doi: 10.1177/193758670700100114
- Haggerty, C., Holloway, K., & Wilson, D. (2013). How to grow our own: An evaluation of preceptorship in New Zealand graduate nurse programmes. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 43(2), 162-171. doi: 10.5172/conu.2013.43.2.162
- Halfer, D., & Graf, E. (2006). Graduate nurse perceptions of the work experience. *Nursing Economics*, 24(3), 150.
- Hall, J. A., Roter, D. L., Blanch, D. C., & Frankel, R. M. (2009). Nonverbal sensitivity in medical students: Implications for clinical interactions. *Journal of General Internal Medicine*, 24(11), 1217-1222.
- Hall, J. A., & Roter, D. L. (2006). Physician-patient communication. In H. Friedman & R. Cohen Silver (Eds.), *Foundations of health psychology* (pp. 325-357). Cary, NC: Oxford University Press.
- Hall, L. (2001). Burnout: results of an empirical study of New Zealand nurses. *Contemporary Nurse*, 11(1), 71-83.

- Hallam, J. (2012). *Nursing the image: media, culture and professional identity*. London: Routledge.
- Hanson, E. J. (1994). Psychological support at night: A pilot study. *Cancer Nursing*, 17(5), 379-384.
- Hanson, E. J., McClement, S., & Kristjanson, L. J. (1995). Psychological support role of night nursing staff on an acute care oncology unit. *Cancer Nursing*, 18(3), 237-246.
- Harding Clark, M. (2006). The Lourdes hospital inquiry: An inquiry into postpartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda. Dublin: The Stationary Office.
- Hart, C. (2001). *Doing a literature review*. Sage: London
- Harman, G. (1999). Moral philosophy meets social psychology: Virtue ethics and the fundamental attribution error. *Proceedings of the Aristotelian Society*, 315-331. doi: 10.2307/4545312
- Harre, L. (2003). *Has the sun set on New Zealand's health reforms*. Paper presented at the Experience Conference on Health Reforms, Norway.
- Hatfield, L. A., Pearce, M., Del Guidice, M., Cassidy, C., Samoyan, J., & Polomano, R. C. (2013). The professional appearance of registered nurses: An integrative review of peer-refereed studies. *Journal of Nursing Administration*, 43(2), 108-112.
- Hayman, B., Wilkes, L., & Cioffi, J. (2008). Change process during redesign of a model of nursing practice in a surgical ward. *Journal of Nursing Management*, 16(3), 257-265. doi: 10.1111/j.1365-2834.2007.00774.x
- Health & Disability Commissioner. (2014). Code of Health and Disability Services: Consumer Rights. Wellington: Author.
- Health Safety & Quality Commission. (2015). Adverse events reported to the Health Quality & Safety Commission. Wellington: Author.
- Hegney, D., Craigie, M., Hemsworth, D., Osseiran-Moisson, R., Aoun, S., Francis, K., & Drury, V. (2014). Compassion satisfaction, compassion fatigue, anxiety, depression and stress in registered nurses in Australia: Study 1 results. *Journal of Nursing Management*, 22(4), 506-518. doi: 10.1111/jonm.12160

- Heidgerken, L.E. (1970). Work values and career preferences of nurses for teaching and clinical practice. *Nursing Research*, 19(3), 219-230.
- Heimann, C., Prado, C., Moraes, R., Vidal, G., Liberal, D., Oliveira, G., & Barata, M. (2013). Acquiring nursing knowledge through the constructivist method. *Revista da Escola de Enfermagem da USP*, 47(4), 997-1000.
- Henderson, S. (2003). Power imbalance between nurses and patients: A potential inhibitor of partnership in care. *Journal of Clinical Nursing*, 12(4), 501-508.
- Henderson, V. (1960). *Basic principles of nursing care*. London: International Council of Nurses.
- Henderson, V. (1964). The nature of nursing. *The American Journal of Nursing*, 64(8), 62-68.
- Hendrich, A. L., Fay, J., & Sorrells, A. K. (2004). Effects of acuity-adaptable rooms on flow of patients and delivery of care. *American Journal of Critical Care*, 13(1), 35-45.
- Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative research methods*. London: Sage.
- Hesse-Biber, S. N., & Leavy, P. L. (2011). *The practice of qualitative research* (2nd ed.). Los Angeles: Sage.
- Hevezi, J. (2016). Evaluation of a meditation intervention to deduce the effects of stressors associated with compassion fatigue among nurses. *Journal of Holistic Nursing*, 34(4), 343-350. doi: 10.1177/0898010115615981
- Hickman, L., Davidson, P., Chang, E., & Chenoweth, L. (2011). In Hospital Study: Do older people, carers and nurses share the same priorities of care in the acute aged care setting? *International Journal of Multiple Research Approaches*, 5(1), 76-88.
- Higgins, A., Doyle, L., Morrissey, J., Downes, C., Gill, A., & Bailey, S. (2016). Documentary analysis of risk- assessment and safety- planning policies and tools in a mental health context. *International Journal of Mental Health Nursing*. doi: 10.1111/inm.12186
- Hignett, S., & Griffiths, P. (2009). Manual handling risks in the bariatric (obese) patient pathway in acute sector, community and ambulance care and treatment. *Work*, 33(2), 175-180.

- Himmelfarb, G. (1995). *The demoralization of society: From Victorian virtues to modern values*. New York: Random House.
- Hinton, A., & Chirgwin, S. (2010). Nursing education: reducing reality shock for graduate Indigenous nurses - it's all about time. *Australian Journal of Advanced Nursing*, 28(1), 60-66.
- Hochschild, A. R. (2003). *The managed heart: Commercialization of human feeling* (20th Anniversary ed.). Berkeley: University of California Press.
- Hofstede, G. (1998). Attitudes, values and organizational culture: Disentangling the concepts. *Organization Studies*, 19(3), 477-493.
- Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviours, institutions and organizations across nations* (2nd ed.). London: Sage.
- Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations: Software of the mind* (3rd ed.). New York: McGraw-Hill.
- Holden, R. J. (1991). An analysis of caring: Attributions, contributions and resolutions. *Journal of Advanced Nursing*, 16(8), 893-898. doi: 10.1111/j.1365-2648.1991.tb01793.x
- Hollander, J. A. (2004). The social contexts of focus groups. *Journal of Contemporary Ethnography*, 33(5), 602-637. doi: 10.1177/0891241604266988
- Holloway, I., & Freshwater, D. (2007). Vulnerable story telling: Narrative research in nursing. *Journal of Research in Nursing*, 12(6), 703-711.
- Hopkinson, J. B. (2002). The hidden benefit: the supportive function of the nursing handover for qualified nurses caring for dying people in hospital. *Journal of Clinical Nursing*, 11(2), 168-175 168p. doi: 10.1046/j.1365-2702.2002.00576.x
- Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher*, 20(4), 12-17.
- Houghton, C. E. (2014). 'Newcomer adaptation': A lens through which to understand how nursing students fit in with the real world of practice. *Journal of Clinical Nursing*, 23(15-16), 2367-2375. doi: 10.1111/jocn.12451
- House, E. R. (1993). *Professional evaluation: Social impact and political consequences*. Newbury Park, CA: Sage

- Hoyuelos, S. B., Fraile, C., Weis, D., Urien, E., Elsdén, C., & Schank, M. (2010). Nursing professional values: Validation of a scale in a Spanish context. *Nurse Education Today*, 30(2), 107-112. doi: 10.1016/j.nedt.2009.05.010
- Humphries, N., Brugha, R., & McGee, H. (2009). Sending money home: A mixed-methods study of remittances by migrant nurses in Ireland. *Human Resources for Health*, 7(1), 1-12. doi: 10.1186/1478-4491-7-66
- Hunsaker, S., Chen, H., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship*, 47(2), 186-194. doi: 10.1111/jnu.12122
- Hutchinson, S. A. (1990). Responsible subversion: A study of rule-bending among nurses. *Research and Theory for Nursing Practice*, 4(1), 3-17.
- Hyett, N., Kenny, A., & Dickson-Swift, V. (2014). Methodology or method? A critical review of qualitative case study reports. *International Journal of Qualitative Studies on Health and Well-being*, 9. doi:10.3402/qhw.v9.23606
- Iacobucci, T., Daly, B., Lindell, D., & Griffin, M. (2013). Professional values, self-esteem, and ethical confidence of baccalaureate nursing students. *Nursing Ethics*, 20(4), 479-490.
- Institute of Medicine. (2011). The future of nursing: Leading change, advancing health *committee on the Robert Wood Johnson Foundation initiative on the future of nursing*. Washington, DC: National Academies Press.
- International Council of Nurses. (2006). The ICN code of ethics for nurses. Geneva: Author.
- International Council of Nurses. (2012). The ICN code of ethics for nurses. Geneva: Author.
- Jack, B., Oldham, J., & Williams, A. (2003). A stakeholder evaluation of the impact of the palliative care clinical nurse specialist upon doctors and nurses, within an acute hospital setting. *Palliative Medicine*, 17(3), 283-288. doi: 10.1191/0269216303pm697oa
- Jackson, D., Hickman, L., Hutchinson, M., Andrew, S., Smith, J., Potgieter, I, . . . Peters, K. (2014). Whistleblowing: An integrative literature review of data-based studies

- involving nurses. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 48(2), 240-252. doi: 10.5172/conu.2014.48.2.240
- Jacques, E. (1955). Social systems as a defence against persecutory and depressive anxiety. In M. Klein (Ed.), *New directions in psychoanalysis*. London: Tavistock Publications.
- Janesick, V. J. (1994). The dance of qualitative research design: Metaphor, methodolatry, and meaning. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. London: Sage Publications.
- Jasmine, T. (2009). Art, science, or both? Keeping the care in nursing. *Nursing Clinics of North America*, 44(4), 415-421. doi: 10.1016/j.cnur.2009.07.003
- Jasperse, M., Herst, P., & Dungey, G. (2014). Evaluating stress, burnout and job satisfaction in New Zealand radiation oncology departments. *European Journal of Cancer Care*, 23(1), 82-88. doi: 10.1111/ecc.12098
- Jesse, M, Abouljoud, M, Hogan, K, & Eshelman, A. (2015). Burnout in transplant nurses. *Progress in Transplantation*, 25(3), 196-202. doi: 10.7182/pit2015213
- Jick, D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly*, 24(4), 602-611. doi: 10.2307/2392366
- Jiménez-López, F, Roales-Nieto, J, Seco, G, & Preciado, J. (2016). Values in nursing students and professionals. *Nursing Ethics*, 23(1), 79-91. doi: 10.1177/0969733014557135
- Jirwe, Maria, & Rudman, Ann. (2012). Why choose a career in nursing? *Journal of Advanced Nursing*, 68(7), 1615-1623. doi: 10.1111/j.1365-2648.2012.05991.x
- John, J. (1992). Patient satisfaction: The impact of past. *Journal of Health Care Marketing*, 12(3), 56-64.
- Johnson, J., Bottorff, J., Browne, A., Grewal, S., Hilton, B. A., & Clarke, H. (2004). Othering and being othered in the context of health care services. *Health Communication*, 16(2), 255-271. doi: 10.1207/S15327027HC1602_7
- Johnson, R.B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33(7), 14-26. doi: 10.3102/0013189x033007014
- Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22(4), 116-121.

- Jolley, J., Bendyk, H., Holaday, B., Lombardozzi, K. A. K., & Harmon, C. (2007). Rapid response teams: Do they make a difference? *Dimensions of Critical Care Nursing*, 26(6), 253-262.
- Jourdain, G., & Chênevert, D. (2010). Job demands–resources, burnout and intention to leave the nursing profession: A questionnaire survey. *International Journal of Nursing Studies*, 47(6), 709-722.
- Junewicz, A., & Youngner, S. (2015). Patient- satisfaction surveys on a scale of 0 to 10: improving health care, or leading it astray? *Hastings Centre Report*, 45(3), 43-51.
- Kalisch, B. J., Weaver, S. J., & Salas, E. (2009). What does nursing teamwork look like? A qualitative study. *Journal of Nursing Care Quality*, 24(4), 298-307 210p. doi: 10.1097/NCQ.0b013e3181a001c0
- Kalisch, B. J., & Williams, R. A. (2009). Development and psychometric testing of a tool to measure missed nursing care. *Journal of Nursing Administration*, 39(5), 211-219.
- Kalliath, T., & Morris, R. (2002). Job satisfaction among nurses: A predictor of burnout levels. *Journal of Nursing Administration*, 32(12), 648-654.
- Kälvemark, Sofia, Höglund, Anna T., Hansson, Mats G., Westerholm, Peter, & Arnetz, Bengt. (2004). Living with conflicts-ethical dilemmas and moral distress in the health care system. *Social Science & Medicine*, 58(6), 1075-1084. doi: 10.1016/s0277-9536(03)00279-x
- Kane, R. L., Shamliyan, T., Mueller, C., Duval, S., & Wilt, T. J. (2007). *Nurse staffing and quality of patient care: evidence report technology assessment* (Vol. 151, pp. 1-115). Rockville: Agency for Healthcare Research and Quality.
- Kayser-Jones, J., Beard, R., & Sharpp, T. (2009). Case study: Dying with a Stage IV pressure ulcer. *American Journal of Nursing*, 109(1), 40-48. doi: 10.1097/01.NAJ.0000344036.26898.e3
- Kean, S. (2010). Emotional labour within community nursing leadership. *Community Practitioner*, 83, 24-27.
- Kelly, J., Fealy, G., & Watson, R. (2012). The image of you: Constructing nursing identities in YouTube. *Journal of Advanced Nursing*, 68(8), 1804-1813. doi: 10.1111/j.1365-2648.2011.05872.x

- Kelly, L., Runge, J., & Spencer, C. (2015). Predictors of compassion fatigue and compassion satisfaction in acute care nurses. *Journal of Nursing Scholarship*, 47(6), 522-528. doi: 10.1111/jnu.12162
- Khamisa, N, Peltzer, K, Ilic, D, & Oldenburg, B. (2016). Work related stress, burnout, job satisfaction and general health of nurses: A follow- up study. *International Journal of Nursing Practice*, 22(6), 538-545. doi: 10.1111/ijn.12455
- Kilpatrick, K., & Frunchak, V. (2006). The nursing extern program: Innovative strategies for students in transition. *The Health Care Manager*, 25(3), 236-242.
- Kim, H. S. (2010). *The nature of theoretical thinking in nursing* (3rd ed.). New York: Springer Publishing Company.
- Kimble, P., & Bamford-Wade, A. (2013). The journey of discovering compassionate listening. *Journal of Holistic Nursing*, 31(4), 285-290.
- Kimchi, J., Polivka, B., & Stevenson, J, S. (1991). Triangulation: Operational definitions. *Nursing Research*, 40(6), 364-366.
- Kingdon, C. (2005). Reflexivity: Not just a qualitative methodological research tool. *British Journal of Midwifery*, 13(10).
- Kirk, T. (2006). Rapid response teams in hospitals: improving quality of care for patients and quality of the work environment for nursing staff. *Holistic Nursing Practice*, 20(6), 293-298.
- Kissoon, N. (2010). The Toyota way... or not? New lessons for health care. *Physician Executive*, 36(6), 40.
- Klein, M. (1997). *Envy and gratitude and other works 1946-1963*. Wiltshire: Random House.
- Klikauer, T. (2015). What is managerialism? *Critical Sociology*, 41(7-8), 1103-1119. doi: 10.1177/0896920513501351
- Koch, T. (2006). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, 53(1), 91-100. doi: 10.1111/j.1365-2648.2006.03681.x
- Koerner, J. G. (1996). Congruency between nurses' values and job requirements: A call for integrity. *Holistic Nursing Practice*, 10(2), 69-77.
- Kohn, L., Corrigan, J., & Donaldson, M. (Eds.). (2000). *To err is human: building a safer health system* (Vol. 6). Washington DC: National Academies Press.

- Kramer, M. (1969). Collegiate graduate nurses in medical centre hospitals: mutual challenge or duel. *Nursing Research*, 18(3), 196-209.
- Kramer, M. (1974). *Reality shock; why nurses leave nursing*. Saint Louis: Mosby.
- Kramer, M. (2014). AONE 2014 Nursing Thought Leader: A conversation with Marlene Kramer [Video File]. Retrieved 11th September, 2016, from <http://www.youtube.com/watch?v=7fOX1Y-tlPw>
- Kramer, M., & Baker, C. (1971). The exodus: Can we prevent it? *Journal of Nursing Administration*, 1(3), 15-30.
- Kramer, M., Brewer, B., & Maguire, P. (2013). Impact of healthy work environments on new graduate nurses' environmental reality shock. *Western Journal of Nursing Research*, 35(3), 348-383. doi: 10.1177/0193945911403939
- Kroezen, M., Mistiaen, P., van Dijk, L., Groenewegen, P. P., & Francke, A. L. (2014). Negotiating jurisdiction in the workplace: A multiple-case study of nurse prescribing in hospital settings. *Social Science & Medicine*, 117, 107-115. doi: 10.1016/j.socscimed.2014.07.042
- Krueger, R., & Casey, M. (2000). *Focus groups: A practical guide for applied research* (3 ed.). Thousand Oaks, CA.: Sage Publications.
- Kubsch, S, Hansen, G, & Huyser-Eatwell, V. (2008). Professional values: The case for RN-BSN completion education. *The Journal of Continuing Education in Nursing*, 39(8), 375-384.
- Kumar, S., Fischer, J., Robinson, E., Hatcher, S., & Bhagat, R. N. (2007). Burnout and job satisfaction in New Zealand psychiatrists: A national study. *International Journal of Social Psychiatry*, 53(4), 306-316.
- Kunyk, D., & Austin, W. (2012). Nursing under the influence: A relational ethics perspective. *Nursing Ethics*, 19(3), 380-389. doi: 10.1177/0969733011406767
- Kutney-Lee, A., McHugh, M., Sloane, D., Cimiotti, J., Flynn, L., Neff, D., & Aiken, L. H. (2009). Nursing: A key to patient satisfaction. *Health Affairs*, 28(4), w669-w677. doi: 10.1377/hlthaff.28.4.w669
- Kvale, S., & Brinkman, S. (2009). *Interviews: Learning the craft of qualitative interviewing*. London: Sage.

- Kwan, B. S. (2008). The nexus of reading, writing and researching in the doctoral undertaking of humanities and social sciences: Implications for literature reviewing. *English for Specific Purposes*, 27(1), 42-56. doi: 10.1016/j.esp.2007.05.002
- Lacan, J. (1988). *The seminar of Jacques Lacan: Book II: The ego in Freud's theory and in the technique of psychoanalysis 1954-1955*. Cambridge: Cambridge University Press.
- Lakeman, R, McAndrew, S, Macgabhann, L, & Warne, T. (2013). 'That was helpful ... no one has talked to me about that before': Research participation as a therapeutic activity. *International Journal of Mental Health Nursing*, 22(1), 76-84. doi: 10.1111/j.1447-0349.2012.00842.x
- Lalonde, M., & Hall, L. (2017). Preceptor characteristics and the socialization outcomes of new graduate nurses during a preceptorship programme. *Nursing Open*, 4(1), 24-31. doi: 10.1002/nop2.58
- Lanara, V.A. (1991). *Heroism as a nursing value: A philosophical perspective*. Athens.
- Lang, G. M., Pfister, E. A., & Siemens, M. J. (2010). Nursing burnout: Cross-sectional study at a large Army hospital. *Military Medicine*, 175(6), 435-441.
- Larkin, P. J., de Casterlé, B., & Schotsmans, P. (2008). A relational ethical dialogue with research ethics committees. *Nursing Ethics*, 15(2), 234-242.
- Larsen, L., Larsen, B., & Birkelund, R. (2014). A companionship between strangers—the hospital environment as a challenge in patient–patient interaction in oncology wards. *Journal of Advanced Nursing*, 70(2), 395-404. doi: 10.1111/jan12204
- Larsen, L., Larsen, B., & Birkelund, R. (2015). A companionship between strangers. *Journal of Advanced Nursing*, 71(2), 271-280. doi: 10.1111/jan.12490
- Lather, P. (1993). Fertile obsession: Validity after post structuralism. *The Sociological Quarterly*, 34(4), 673-693. doi: 10.1111/j.1533-8525.1993.tb00112.x
- Lauckner, H., Paterson, M., & Krupa, T. (2012). Using constructivist case study methodology to understand community development processes: Proposed methodological questions to guide the research process. *Qualitative Report*, 17, 25.

- Lawrence-Lightfoot, S., & Davis, J. (1997). *The art and science of portraiture*. San Francisco: Jossey-Bass
- Leach, M. K. (1993). Primary nursing: autonomy or autocracy? *Journal of Advanced Nursing*, 18(3), 394-400. doi: 10.1046/j.1365-2648.1993.18030394.x
- Lebech, M. (2009). *On the problem of human dignity: a hermeneutical and phenomenological Investigation* (Vol. 18): Königshausen & Neumann.
- Lebech, M. (2015a). *The Philosophy of Edith Stein: From phenomenology to metaphysics* (1st ed.). Oxford: Peter Lang.
- Lebech, M. (2015b). Women in society: The critical potential of Stein's feminism for our understanding of the state. In A. Calcagno (Ed.), *Edith Stein: Woman, social political philosophy, theology, metaphysics and public history*. London: Springer.
- Lees, A., Meyer, E., & Rafferty, J. (2013). From Menzies Lyth to Munro: The problem of managerialism. *British Journal of Social Work*, 43(3), 542-558.
- LeCompte, M., & Goetz, J. (1982). Problems of reliability and validity in ethnographic research. *Review of Educational Research*, 52(1), 31-60.
- LeDuc, K., & Kotzer, A. M. (2009). Bridging the gap: a comparison of the professional nursing values of students, new graduates, and seasoned professionals. *Nursing Education Perspectives (National League for Nursing)*, 30(5), 279-284.
- Lee, A. (1998). Doctoral research as writing. In J. Higgs (Ed.), *Writing qualitative research* (pp. 121-136). Sydney: Hampden Press.
- Leiter, M., Harvie, P., & Frizzell, C. (1998). The correspondence of patient satisfaction and nurse burnout. *Social Science and Medicine*, 47(10), 1611-1617. doi: 10.1016/S0277-9536(98)00207-X
- Leiter, M., & Maslach, C. (2009a). Nurse turnover: The mediating role of burnout. *Journal of Nursing Management*, 17(3), 331-339. doi: 10.1111/j.1365-2834.2009.01004.x
- Leiter, M., Jackson, N., & Shaughnessy, K. (2009). Contrasting burnout, turnover intention, control, value congruence and knowledge sharing between Baby Boomers and Generation X. *Journal of Nursing Management*, 17(1), 100-109. doi: 10.1111/j.1365-2834.2008.00884.x

- Leiter, M., & Maslach, C. (2009b). Nurse turnover: the mediating role of burnout. *Journal of Nursing Management*, 17(3), 331-339.
- Lennard, C. (2012). How the productive ward scheme gives staff more time to care. *Mental Health Practice*, 15(5), 30-33.
- Li, S. (2002). *Symbiotic niceness: A study of psychosocial care in palliative care settings*. (Doctor of Philosophy), University of London, London.
- Li, S. (2004). 'Symbiotic niceness': constructing a therapeutic relationship in psychosocial palliative care. *Social Science & Medicine*, 58(12), 2571-2583.
- Lim, A., Honey, M., North, N., & Shaw, J. (2015). Learning to become a nurse prescriber in New Zealand using a constructivist approach: A narrative case study. *Nursing Praxis in New Zealand*, 31(3), 27-36.
- Lincoln, Y. S. (1992). Sympathetic connections between qualitative methods and health research. *Qualitative Health Research*, 2(4), 375-391.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Lincoln, Y. S., & Guba, E. G. (Eds.). (1986). *But is it rigorous? trustworthiness and authenticity in naturalistic evaluation*. San Francisco: Jossey-Bass.
- Lipscomb, M., & Snelling, P. C. (2010). Value dissonance in nursing: Making sense of disparate literature. *Nurse Education Today*, 30(7), 595-597.
- Little, J. (September 6th 2016). 'Widespread control' of residents at Aras Attracta, says report. <http://www.rte.ie/news/2016/0906/814467-aras-attracta-report/>
- Liu, W., Manias, E., & Gerdtz, M. (2012). Medication communication between nurses and patients during nursing handovers on medical wards: A critical ethnographic study. *International Journal of Nursing Studies*, 49(8), 941-952 912p. doi: 10.1016/j.ijnurstu.2012.02.008
- Liu, W., Manias, E., & Gerdtz, M. (2014). The effects of physical environments in medical wards on medication communication processes affecting patient safety. *Health & Place*, 26, 188-198. doi: 10.1016/j.healthplace.2013.12.017
- Loseke, D. R. (2011). *Thinking about social problems: An introduction to constructionist perspectives* (2nd ed). New Brunswick: Transaction Publishers.

- Lu, S., Kerr, D., & McKinlay, L. (2014). Bedside nursing handover: Patients' opinions. *International Journal of Nursing Practice*, 20(5), 451-459 459p. doi: 10.1111/ijn.12158
- Lu, Y., & Hyun-Bo, S. (2012). The effect of hospital unit layout on nurse walking behaviour. *Health Environments Research & Design Journal*, 6(1), 66-82.
- Luck, L., Jackson, D., & Usher, K. (2006). Case study: A bridge across the paradigms. *Nursing Inquiry*, 13(2), 103-109. doi: 10.1111/j.1440-1800.2006.00309.x
- Lynch, S., Hart, B., & Costa, C. (2014). Giving voice to values: An undergraduate nursing curriculum project. *Collegian*, 21(4), 367-373. doi: 10.1016/j.colegn.2013.09.004
- Määttä, S. M. (2006). Closeness and distance in the nurse-patient relation. The relevance of Edith Stein's concept of empathy. *Nursing Philosophy*, 7(1), 3-10.
- Maben, J., Latter, S., & Clark, J.M. (2007). The sustainability of ideals, values and the nursing mandate: Evidence from a longitudinal qualitative study. *Nursing Inquiry*, 14(2), 99-113.
- MacDonald, B. (1971). The evaluation of the Humanities Curriculum Project: a holistic approach. *Theory into Practice*, 10(3), 163-167.
- MacDonald, B., & Walker, R. (1975). Case study and the social philosophy of educational research. *Cambridge Journal of Education*, 5(1), 2-11.
- MacDonald, H. (2007). Relational ethics and advocacy in nursing: Literature review. *Journal of Advanced Nursing*, 57(2), 119-126.
- MacGuire, J. M., & Botting, D. A. (1990). The use of the Ethnography program to identify the perceptions of nursing staff following the introduction of primary nursing in an acute medical ward for elderly people. *Journal of Advanced Nursing*, 15(10), 1120-1127. doi: 10.1111/j.1365-2648.1990.tb01702.x
- MacIntyre, A. C. (2007). *Edith Stein: A philosophical prologue 1913-1922*. Plymouth, UK: Rowman and Littlefield publishers INC.
- MacIntyre, A.C. (1984). *After virtue: A study of moral theory* (Vol. 99) London: Harpercollins Publishers.
- MacLeod, L. (2016). Mission, vision, and values statements: The physician leaders role. *Physician Leadership Journal*, 3(5), 18-25.

- Manning, J., & Paterson, R. (2005). "Prioritization": rationing health care in New Zealand. *The Journal of Law, Medicine & Ethics*, 33(4), 681-697.
- Manthey, M. (1980). A theoretical framework for primary nursing. *Journal of Nursing Administration*, 10(6), 11-15.
- Manthey, M., Ciske, K., Robertson, P., & Harris, I. (1970a). *Primary nursing: A return to the concept of "my nurse" and "my patient"*. Paper presented at the Nursing Forum.
- Manthey, M., Ciske, K., Robertson, P., & Harris, I. (1970b). Primary nursing: A return to the concept of "my nurse" and "my patient". *Nursing Forum*, 9(1), 65-84.
- Manthey, M., & Kramer, M. (1970). A dialogue on primary nursing. *Nursing Forum*, 9(4), 356-379.
- Manthey, M. (2002). *The practice of primary nursing*. Creative Health Care Management, Inc. Place
- Manzano García, G., & Ayala Calvo, J. (2012). Emotional exhaustion of nursing staff: influence of emotional annoyance and resilience. *International Nursing Review*, 59(1), 101-107. doi: 10.1111/j.1466-7657.2011.00927.x
- Manzano García, G., Calvo, A., & Carlos, J. (2012). Emotional exhaustion of nursing staff: Influence of emotional annoyance and resilience. *International Nursing Review*, 59(1), 101-107.
- Mariet, J. (2016). Professional socialization models in nursing. *International Journal of Nursing Education*, 8(3), 143-148. doi: 10.5958/0974-9357.2016.00107.0
- Marshall, M., Romano, P., & Davies, H. (2004). How do we maximize the impact of the public reporting of quality of care? *International Journal for Quality in Health Care*, 16(suppl 1), i57-i63. doi: 10.1093/intqhc/mzh013
- Martin, G. W. (1998). Ritual action and its effect on the role of the nurse as advocate. *Journal of Advanced Nursing*, 27(1), 189-194. doi: 10.1046/j.1365-2648.1998.00492.x
- Martin, P., Yarbrough, S., & Alfred, D. (2003). Professional values held by baccalaureate and associate degree nursing students. *Journal of Nursing Scholarship*, 35(3), 291-296. doi: 10.1111/j.1547-5069.2003.00291.x
- Maslach, C. (1976). Burnout. *Human behaviour*, 5(9), 16-22.

- Maslach, C., & Jackson, S. (1981). The measurement of experienced burnout. *Journal of Organizational Behaviour*, 2(2), 99-113.
- Maslach, C., Jackson, S., Leiter, M., Schaufeli, W., & Schwab, R. (1986). *Maslach burnout inventory manual general survey, human services survey, educators survey, & scoring guides* (3rd ed.): Mind Garden.
- Maslach, C., Schaufeli, W., & Leiter, M. (2001). Job burnout. *Annual Review of Psychology*, 52(1), 397-422.
- May, T. (2011). *Social research: issues, methods and process* (4th ed.). Maidenhead: Open University Press.
- Mazhindu, D. M., Griffiths, L., Pook, C., Erskine, A., Ellis, R., & Smith, F. (2016). The nurse match instrument: Exploring professional nursing identity and professional nursing values for future nurse recruitment. *Nurse Education in Practice*, 18, 36-45. doi: 10.1016/j.nepr.2016.03.006
- McCartney, J. (2008, 2nd March). Nurses: The angels who fell from grace? *The Telegraph*. Retrieved from <http://www.telegraph.co.uk/news/uknews/1580463/Nurses-the-angels-who-fell-from-grace.html>
- McCoy, K. (2016). What matters most: Report of the Aras Attracta Swinford review group. Dublin: Feidhmeannacht na Seirbhíse Sláinte / Health Service Executive.
- McCurdy, H. E., & Cleary, R. E. (1984). Why can't we resolve the research issue in public administration? *Public Administration Review*, 49-55.
- McGivern, Y. (2013). *The practice of market research: an introduction* (4th ed.). Harlow: Pearson Higher Ed.
- McIntosh, M. J., & Morse, J. M. (2015). Situating and constructing diversity in semi-structured interviews. *Global Qualitative Nursing Research*, 1-12. doi: 10.1177/2333393615597674
- McLaughlin, K., Moutray, M., & Moore, C. (2010). Career motivation in nursing students and the perceived influence of significant others. *Journal of Advanced Nursing*, 66(2), 404-412. doi: 10.1111/j.1365-2648.2009.05147.x
- McLean, C. (2012). The yellow brick road: a values based curriculum model. *Nurse Education in Practice*, 12(3), 159-163. doi: 10.1016/j.nepr.2011.11.002

- McMurdo, M., & Witham, M. (2013). Unnecessary ward moves. *Age & Ageing*, 42(5), 555-556. doi: ageing/aft079
- McNeese-Smith, D., & Crook, M. (2003). Nursing values and a changing nurse workforce: values, age, and job stages. *Journal of Nursing Administration*, 33(5), 260-270.
- Meadus, R. J. (2000). *Men in nursing: Barriers to recruitment*. Paper presented at the Nursing Forum.
- Meehan, T. (2003). Careful nursing: A model for contemporary nursing practice. *Journal of Advanced Nursing*, 44(1), 99-107. doi: 10.1046/j.1365-2648.2003.02772.x
- Meleis, A. I. (2012). *Theoretical nursing: Development and progress* (5th ed.). Philadelphia: Wolter Kluwer | Lippincott Williams & Wilkins.
- Mendes, A. (2014). Recognising and combating compassion fatigue in nursing. *British Journal of Nursing*, 23(21), 1146-1146. doi: 10.12968/bjon.2014.23.21.1146
- Menzies, I. (1960). A Case-study in the functioning of social systems as a defence against anxiety: A report on a study of the nursing service of a general hospital. *Human Relations*, 13, 95-121. doi: 10.1177/001872676001300201
- Menzies, I. (1989). A personal review of group experiences. In I. Menzies Lyth (Ed.), *The dynamics of the social: Selected essays*. London: Free Association Books.
- Menzies Lyth, I. (1988). *Containing anxiety in institutions* (Vol. 1). London: Free Association Books.
- Merriam, S. B. (1998). *Case study research in education: A qualitative approach*. San Francisco, CA: Jossey-Bass.
- Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation* (3rd ed.). San Francisco: John Wiley & Sons.
- Merrick, E., Fry, M., & Duffield, C. (2014). Australian practice nursing: Collaboration in context. *Journal of Clinical Nursing*, 23(23/24), 3525-3532. doi: 10.1111/jocn.12605
- Meyer, C. B. (2001). A case in case study methodology. *Field Methods*, 13(4), 329-352.
- Meyer, G. R. (1960). *Tenderness and technique: Nursing values in transition*. Los Angeles: University of California, Los Angeles: Institute for Research on Labor and Employment

- Miles, M., & Huberman, A. (1984). *Qualitative data analysis*. London: Sage.
- Miles, M., & Huberman, A. (1994). *Qualitative data analysis: A sourcebook of new methods* (2nd ed.). Thousand Oaks, CA: Sage.
- Milfont, T., Milojev, P., & Sibley, C. G. (2016). Values stability and change in adulthood. *Personality and Social Psychology Bulletin*, 42(5), 572-588. doi: doi:10.1177/0146167216639245
- Miller, E. J., & Rice, A. K. (1967). *Systems of organisation*. London: Tavistock Publications.
- Miner-Williams, D. (2007). Connectedness in the nurse-patient relationship: A grounded theory study. *Issues in Mental Health Nursing*, 28(11), 1215-1234. doi: 10.1080/01612840701651462
- Minister of Health. (2016). *New Zealand health strategy: Future direction*. Wellington: Author.
- Ministry of Health. (2010). *Implementing the New Zealand health strategy 2010*. Wellington: Author.
- Mitchell, E. S. (1986). Multiple triangulation: A methodology for nursing science. *Advances in Nursing Science*, 8(3), 18-26.
- Momeni, P., Jirwe, M., & Emami, A. (2008). Enabling nursing students to become culturally competent—a documentary analysis of curricula in all Swedish nursing programs. *Scandinavian Journal of Caring Sciences*, 22(4), 499-506. doi: 10.1111/j.1471-6712.2007.00554.x
- Montalvo, I. (2007). The National Database of Nursing Quality Indicators TM (NDNQI®). *OJIN: The Online Journal of Issues in Nursing*, 12(3), Manuscript 2.
- Montani, F., Courcy, F., Giorgi, G., & Boilard, A. (2015). Enhancing nurses' empowerment: The role of supervisors' empowering management practices. *Journal of Advanced Nursing*, 71(9), 2129-2141. doi: 10.1111/jan.12665
- Moon, S., Kim, D., Kim, E., Kim, Y., & Lee, S. (2014). Evaluation of the validity and reliability of the Korean version of the nursing professional values scale—revised. *Nurse Education Today*, 34(3), 325-330. doi: 10.1016/j.nedt.2013.06.014
- Mooney, M. (2007). Professional socialization: The key to survival as a newly qualified nurse. *International Journal of Nursing Practice*, 13(2), 75-80.

- Mooney, M., Glacken, M., & O'Brien, F. (2008). Choosing nursing as a career: A qualitative study. *Nurse Education Today*, 28(3), 385-392. doi: 10.1016/j.nedt.2007.07.006
- Morgan, D. (1996). Focus groups. *Annual Review of Sociology*, 22, 129-152.
- Morrell, B., Forsyth, R., Lipworth, W., Kerridge, I., & Jordens, C. (2014). Rules of engagement: Journalists' attitudes to industry influence in health news reporting. *Journalism*, 16(5), 596-614. doi: 10.1177/1464884914525705
- Morse, J. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, 25(9), 1212-1222. doi: 10.1177/1049732315588501
- Morse, J.M., & Field, P. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks: Sage Publications.
- Mrayyan, M. (2006). Jordanian nurses' job satisfaction, patients' satisfaction and quality of nursing care. *International Nursing Review*, 53(3), 224-230.
- Msiska, G., Smith, P., Fawcett, T., & Nyasulu, B. (2014). Emotional labour and compassionate care: What's the relationship? *Nurse Education Today*, 34(9), 1246-1252.
- Mudaly, P., & Nkosi, Z. Z. (2015). Factors influencing nurse absenteeism in a general hospital in Durban, South Africa. *Journal of Nursing Management*, 23(5), 623-631. doi: 10.1111/jonm.12189
- Mulhall, A. (2003). In the field: notes on observation in qualitative research. *Journal of Advanced Nursing*, 41(3), 306-313. doi: 10.1046/j.1365-2648.2003.02514.x
- Muller-Staub, M., Lavin, M. A., Needham, I., & van Achterberg, T. (2006). Nursing diagnoses, interventions and outcomes application and impact on nursing practice: systematic review. *Journal of Advanced Nursing*, 56(5), 514-531.
- Murphy, N., Canales, M., Norton, S., & DeFilippis, J. (2005). Striving for congruence: the interconnection between values, practice, and political action. *Policy, Politics, & Nursing Practice*, 6(1), 20-29.
- Nash, R (Ed.). (1914). *Florence Nightingale to her nurses*. London: Macmillan & Co.

- National Health and Medical Research Council. (2003). Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research. Canberra ACT.
- National Nursing Organisations (NNO). (2014). Report from the National Nursing Organisations to Health Workforce New Zealand: Author.
- Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine*, 346(22), 1715-1722.
- Nelson, A. (2014). Best practice in nursing: A concept analysis. *International Journal of Nursing Studies*, 51(11), 1507-1516. doi: 10.1016/j.ijnurstu.2014.05.003
- Nelson, W., & Gardent, P. (2011). Organizational values statements. *Healthcare Executive*, 26(2), 56-59.
- New Zealand Nurses Organisation. (2010). *Code of ethics*. Wellington: Author.
- New Zealand Nurses Organisation. (2011). 2020 and beyond: A vision for nursing. Wellington: Author
- New Zealand Nurses Organisation. (2016). What is care capacity demand management? Retrieved 29th September, 2016, from http://www.nzno.org.nz/get_involved/campaigns/care_point/what_is_ccdm
- Nietzsche, F. (1969). *Thus Spoke Zarathustra* (R. J. Hollingdale, Trans.), London: Penguin.
- Nightingale, F. (1856, 1969). *Notes on nursing: What it is and what it is not*. New York: Dover Publications, Inc.
- Nolan, M., & Nolan, B. (1995). *Standards in public life: first report of the committee on standards in public life*: HM Stationery Office.
- Norman, K. (2015). How mentors can influence the values, behaviours and attitudes of nursing staff through positive professional socialisation. *Nursing Management*, 22(8), 33-38.
- Norris, N. (1990). *Understanding educational evaluation*. London: Kogan Page
- North, N. (2011). Can New Zealand achieve self-sufficiency in its nursing workforce? *Journal of Clinical Nursing*, 20(1-2), 40-49. doi: 10.1111/j.1365-2702.2010.03380.x

- North, N., Rasmussen, E., Hughes, F., Finlayson, M., Ashton, T., Campbell, T., & Tomkins, S. (2005). Nursing turnover and staffing practices in New Zealand's District Health Boards: A national survey. *New Zealand Journal of Employment Relations*, 30, 49-62.
- Nunberg, G. (2011). Bad apple proverbs: There's one in every bunch. Retrieved September 19th, 2016, from <http://www.npr.org/2011/05/09/136017612/bad-apple-proverbs-theres-one-in-every-bunch>
- Nuremberg Code. (1949). Trials of war criminals before the Nuremberg military tribunals under control council law number 10 (pp. 181-182). Washington DC: U.S. Government Printing Office.
- Nursing and Midwifery Board of Australia. (2006). Registered nurse competency standards. Melbourne: Author.
- Nursing and Midwifery Board of Australia. (2016). Registered nurse standards for practice. Melbourne: Author.
- Nursing and Midwifery Council. (2008). *The Code Standards of conduct, performance and ethics for nurses and midwives*. London: Author.
- Nursing and Midwifery Council. (2010). Standards for Pre-Registration Nursing Education. London: Author.
- Nursing and Midwifery Council. (2015). The Code: Professional standards of practice and behaviour for nurses and midwives. London: Author.
- Nursing Council of New Zealand. (2007, 2016). Competencies for registered nurses. Wellington: Author.
- Nursing Council of New Zealand. (2009). Code of conduct for nurses. Wellington: Author.
- Nursing Council of New Zealand. (2010, 2015). Education programme standards for the registered nurse scope of practice. Wellington: Author.
- Nursing Council of New Zealand. (2012a). Code of conduct for nurses. Wellington: Author.
- Nursing Council of New Zealand. (2012b). Competencies for enrolled nurses. Wellington: Author.

- Nursing Council of New Zealand. (2012c). Draft code of conduct: Analysis of submissions. Wellington: Author.
- Nursing Council of New Zealand. (2012d). Guidelines: professional boundaries, a nurse's guide to the importance of appropriate professional boundaries. Wellington: Author.
- Nursing Council of New Zealand. (2014). The New Zealand nursing workforce: A profile of nurse practitioners, registered nurses and enrolled nurses 2012-2013. Wellington: Author.
- O'Connell, B., Duke, M., Bennett, P., Crawford, S., & Korfiatis, V. (2006). The trials and tribulations of team-nursing. *Collegian*, 13(3), 11-17.
- O'Donovan, D. (2009). *The commission of investigation (Leas Cross Nursing Home): Final report*. Dublin: An Roinn Slainte: Department of Health.
- O'Dowd, A. (2007). NHS nursing in the 1950s. *Nursing Times*, 104(1), 20-22.
- O'Connor, T. (2010). Productivity: Nursing's contribution (pp. 1-6). Wellington: New Zealand Nurses Organisation.
- Office of the Chief Nursing Officer. (June 2016). *Position paper one: Values for nurses and midwives in Ireland*. Dublin: An Rionn Slante: Department of Health
- Omer, T, Suliman, W, & Moola, S. (2016). Roles and responsibilities of nurse preceptors: Perception of preceptors and preceptees. *Nurse Education in Practice*, 16(1), 54-59. doi:10.1016/j.nepr.2015.07.005
- Önder, Ç., & Basim, N. (2008). Examination of developmental models of occupational burnout using burnout profiles of nurses. *Journal of Advanced Nursing*, 64(5), 514-523.
- Overton, E., Appelbaum, P., Fisher, S., Dohan, D., Roberts, L., & Dunn, L. (2013). Alternative decision-makers' perspectives on assent and dissent for dementia research. *The American Journal of Geriatric Psychiatry*, 21(4), 346-354.
- Pakizeh, A., Gebauer, J. E., & Maio, G. R. (2007). Basic human values: Inter-value structure in memory. *Journal of Experimental Social Psychology*, 43(3), 458-465. doi: 10.1016/j.jesp.2006.04.007
- Paley, J. (2013). Social psychology and the compassion deficit. *Nurse Education Today*, 33(12), 1451-1452.

- Paley, J. (2014). Compassion and the fundamental attribution error: A reply to Rolfe & Gardner. *Nurse Education Today*, 35(3), 474-479. doi: 10.1016/j.nest.2014.08.013
- Papa, A., & Bonanno, G. (2008). Smiling in the face of adversity: the interpersonal and intrapersonal functions of smiling. *Emotion*, 8(1), 1.
- Papastavrou, E., Charalambous, A., Vryonides, S., Eleftheriou, C., & Merkouris, A. (2016). To what extent are patients' needs met on oncology units? The phenomenon of care rationing. *European Journal of Oncology Nursing*, 21, 48-56. doi: 10.1016/j.ejon.2016.01.002
- Parahoo, K. (2006). *Nursing research: Principles, process and issues*. New York: Palgrave MacMillan.
- Parker, F., Eisen, S., & Bell, J. (2012). Comparing centralized vs. decentralized nursing unit design as a determinant of stress and job satisfaction. *Journal of Nursing Education and Practice*, 2(4), 66.
- Pattison, S. (2004). Understanding values. In S. Pattison & R. Pill (Eds.), *Values in professional practice: lessons for health, social care, and other professionals*. Oxford: Radcliffe Medical Press.
- Pattison, S., & Pill, R. (Eds.). (2004). *Values in professional practice: Lessons for health, social care and other professionals*. Oxford: Radcliff medical Press.
- Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, 34(5 Pt 2), 1189-1208.
- Patton, M.Q. (2002). *Qualitative research and evaluation methods*: Sage Publications, Inc.
- Pauly, M. (2012). Lessons to improve the efficiency and equity of health reform. *Hastings Centre Report*, 42(5), 21-24. doi: 10.1002/hast.71
- Pereira de Melo, L., Sevilha Stofel, N., Gualda, D., & Antunes de Campos, E. (2014). Nurses' experiences of ethnographic fieldwork. *Nurse Researcher*, 22(1), 14-19.
- Persson, B., & Kajonius, P. (2016) Empathy and universal values explicated by the empathy-altruism hypothesis. *The Journal of Social Psychology*, 156(6), 610-619, doi: 10.1080/00224545.2016.1152212
- Peshkin, A. (1988). In search of subjectivity—one's own. *Educational Researcher*, 17(7), 17-21.

- Peters, M. (2000). Does constructivist epistemology have a place in nurse education? *Journal of Nursing Education*, 39(4), 166-172.
- Phillips- Salimi, C., Haase, J., & Kookan, W. (2012). Connectedness in the context of patient–provider relationships: A concept analysis. *Journal of Advanced Nursing*, 68(1), 230-245.
- Philpott, S. (2005). The truth, the whole truth and nothing but the truth? *Kai Tiaki Nursing New Zealand*, 11(4), 16-18.
- Pickard, A. (2013). *Research methods in information*. London: Facet Publishing.
- Piko, B. (2006). Burnout, role conflict, job satisfaction and psychosocial health among Hungarian health care staff: A questionnaire survey. *International Journal of Nursing Studies*, 43(3), 311-318.
- Plano Clark, V., Creswell, J. W., O'Neil Green, D., & Shope, R. J. (2008). Mixing quantitative and qualitative approaches: An introduction to emergent mixed methods research. In S. N. Hesse-Biber & P. L. Leavy (Eds.), *Handbook of emergent methods* (2nd ed., pp. 923-948). New York: Guilford Press.
- Poghosyan, L., Aiken, L. H., & Sloane, D. M. (2009). Factor structure of the Maslach burnout inventory: An analysis of data from large-scale cross-sectional surveys of nurses from eight countries. *International Journal of Nursing Studies*, 46(7), 894-902. doi: 10.1016/j.ijnurstu.2009.03.004
- Poghosyan, L., Clarke, S., Finlayson, M., & Aiken, L. H. (2010). Nurse burnout and quality of care: Cross- national investigation in six countries. *Research in Nursing & Health*, 33(4), 288-298.
- Pollitt, C. (1990). *Managerialism and the Public Services: The Anglo-American Experience*. Oxford: Basil Blackwell.
- Pool, L. (2012). How culture influences choosing nursing as a career. *Whitireia Nursing Journal* (19), 27-42.
- Porock, D., Pollock, K., & Jurgens, F. (2009). Dying in public: The nature of dying in an acute hospital setting. *Journal of Housing for the Elderly*, 23(1-2), 10-28. doi: 10.1080/02763890802664521
- Porter, S., & Catenacci, V. (2011). Office and hospital needs. *Orthopaedic Clinics of North America*, 42(1), 1-9 9p. doi: 10.1016/j.ocl.2010.07.005

- Powell, I. (2013). Can you see me? Experiences of nurses working night shift in Australian regional hospitals: A qualitative case study. *Journal of Advanced Nursing*, 69(10), 2172-2184. doi: 10.1111/jan.12079
- Price, S. (2009). Becoming a nurse: a meta-study of early professional socialization and career choice in nursing. *Journal of Advanced Nursing*, 65(1), 11-19. doi: 10.1111/j.1365-2648.2008.04839.x
- Price, S., McGillis Hall, L., Angus, J. E., & Peter, E. (2013). Choosing nursing as a career: a narrative analysis of millennial nurses' career choice of virtue. *Nursing Inquiry*, 20(4), 305-316. doi: 10.1111/nin.12027
- Quirke, S. (2011). *Factors affecting the care of acutely unwell ward patients: A multiple case study*. Victoria University of Wellington, Wellington.
- Raab, K. (2014). Mindfulness, self-compassion, and empathy among health care professionals: A review of the literature. *Journal of Health Care Chaplaincy*, 20(3), 95-108. doi: 10.1080/08854726.2014.913876
- Radnor, Z. J., Holweg, M., & Waring, J. (2012). Lean in healthcare: the unfilled promise?. *Social Science & Medicine*, 74(3), 364-371.
- Rafferty, A. M. (1995). Art, science and social science in nursing: occupational origins and disciplinary identity. *Nursing Inquiry*, 2(3), 141-148.
- Rafferty, A. M., Clarke, S., Coles, J., Ball, J., James, P., McKee, M., & Aiken, L. H. (2007). Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional analysis of survey data and discharge records. *International Journal of Nursing Studies*, 44(2), 175-182.
- Ramsden, I. (1990). *Kawa whakaruruhau: Cultural safety in nursing education in Aotearoa*. Wellington.
- Ramsden, I. (2015). Towards cultural safety. In D. Wepa (Ed.), *Cultural Safety in Aotearoa New Zealand* (2nd ed.). Melbourne: Cambridge University Press.
- Ramvi, E. (2011). The risk of entering relationships: experiences from a Norwegian hospital. *Journal of Social Work Practice*, 25(3), 285-296. doi: 10.1080/02650533.2011.59717
- Rand, A. (1964). *The virtue of selfishness*. New York: Penguin

- Rassin, M., & Silner, D. (2007). Trends in nursing staff allocation: the nurse-to-patient ratio and skill mix issues in Israel. *International Nursing Review*, 54(1), 63-69.
- Rassin, M. (2008). Nurses' professional and personal values. *Nursing Ethics*, 15(5), 614-630.
- Rauhala, A., Kivimäki, M., Fagerström, L., Elovainio, M., Virtanen, M., Vahtera, J., . . . Kinnunen, J. (2007). What degree of work overload is likely to cause increased sickness absenteeism among nurses? Evidence from the RAFAELA patient classification system. *Journal of Advanced Nursing*, 57(3), 286-295. doi: 10.1111/j.1365-2648.2006.04118.x
- Richards, K. (2015). The disease of 'busyness'. *Nursing Economics*, 33(2), 117-119.
- Richards, L. (2009). *Handling qualitative data: A practical guide*: Sage Publications.
- Richardson, L. (1994). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 516-529). Thousand Oaks. CA: Sage Publications.
- Richardson, W., Berwick, D., Bisgard, J., Bristow, L., Buck, C., & Cassel, C. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: Institute of Medicine, National Academy Press.
- RMN. (1960). Defence mechanisms in nursing: a review by a registered Mental Nurse. *Nursing Times*. [Reprinted in Menzies—Lyth (1988), pp 89—94].
- Roach, M. S. (1984, 1992). *Caring: The human mode of being*. Toronto ON: University of Toronto Press.
- Roach, M. S. (2002). *Caring, the human mode of being: A blueprint for the health professions* (2nd ed.). Ottawa: CHA Press.
- Robert, G., Morrow, E., Maben, J., Griffiths, P., & Callard, L. (2011). The adoption, local implementation and assimilation into routine nursing practice of a national quality improvement programme: The productive ward in England. *Journal of Clinical Nursing*, 20, 1196–1207. doi: 10.1111/j.1365-2702.2010.03480.x
- Roberts-Turner, R. (2016). Rethink rituals. *Nursing Management*, 47(4), 36-41. doi: 10.1097/01.NUMA.0000481785.14320.5C
- Robson, C. (2004). *Real world research* (2nd ed.). Malden, MA: Blackwell Publishing.

- Rokeach, M. (1968). *Beliefs, attitudes and values: A theory of organization and change*. San Francisco: Jossey-Bass.
- Rokeach, M. (1973). *The nature of human values*. New York: Free Press.
- Rokeach, M. (1979). *Understanding human values: Individual and societal*. New York: Free Press.
- Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53(3), 304-310.
- Rolls, G. (2013). *Classic case studies in psychology* (2nd ed.). New York: Routledge.
- Rook, H., & Coombs, M. A. (2016). Giving voice to optimism and hope for the future of nursing. *Collegian*, 23(4), 397-398. doi: dx.doi.org/10.1016/j.colegn.2016.11.002
- Rook, H., de Vries, L. K., & Meehan, T. (2014a). *Are patient care technologies impeding the therapeutic quality of nurse-patient relationships?* Paper presented at the 18th Annual International Philosophy of Nursing Conference in association with the International Philosophy of Nursing Society (IPONS), Nottingham, England.
- Rook, H., de Vries, L. K., & Meehan, T. (2014b). *Compassion: A contemporary nursing practice value?* Paper presented at the 3rd Asia-Pacific International Conference on Qualitative Research in Nursing, Midwifery and Health, Newcastle, NSW Australia.
- Rook, H., de Vries, L. K., & Meehan, T. (2016). *The redundancy of team nursing: The revival of 'task'*. Paper presented at The 8th International Congress on Innovations in Nursing, Perth, Australia.
- Rosenberg, C. (1987). *The care of strangers: The rise of America's hospital system*. New York: Basic Books.
- Rosenberg, M. (1965). *Society and self image* (Vol. 61). Princeton, NJ: Princeton University Press.
- Ross, L. (1977). The intuitive psychologist and his shortcomings: Distortions in the attribution process. *Advances in Experimental Social Psychology*, 10, 173-220.
- Roter, D. L., Frankel, R., Hall, J. A., & Sluyter, D. (2006). The expression of emotion through nonverbal behaviour in medical visits. *Journal of General Internal Medicine*, 21(S1), S28-S34.

- Roth, J. E., & Coleman, C. L. (2007). Perceived and real barriers for men entering nursing: Implications for gender diversity. *Journal of Cultural Diversity*, 15(3), 148-152.
- Roy, C. (1984). *Introduction to nursing: An adaptation model*. Englewood Cliffs, NJ: Prentice-Hall.
- Roy Morgan Research. (2016). Roy Morgan image of professions survey 2016: Nurses still easily most highly regarded – followed by Doctors, Pharmacists & Engineers. Retrieved 1st September, 2016, from <http://www.roymorgan.com/findings/6797-image-of-professions-2016-201605110031>
- Russell, C. (2000). Interviewing vulnerable old people: Ethical and methodological implications of imagining our subjects. *Journal of Aging Studies*, 13(4), 403-417.
- Ryan-Nicholls, K., & Will, C. (2009). Rigour in qualitative research: mechanisms for control. *Nurse Researcher*, 16(3), 70-85.
- Sacco, T., Ciurzynski, S., Harvey, M., & Ingersoll, G. (2015). Compassion satisfaction and compassion fatigue among critical care nurses. *Critical Care Nurse*, 35(4), 32-44. doi: 10.4037/ccn2015392
- Saldaña, J. (2015). *The coding manual for qualitative researchers* (3rd ed.). London: Sage.
- Sandars, J., Langlois, M., & Waterman, H. (2007). Online collaborative learning for healthcare continuing professional development: A cross-case analysis of three case studies. *Medical Teacher*, 29(1), e9-17.
- Sandelowski, M. (1995). Triangles and crystals: On the geometry of qualitative research. *Research in Nursing & Health*, 18(6), 569-574.
- Sanghera, G. S., & Thapar-Björkert, S. (2008). Methodological dilemmas: Gatekeepers and positionality in Bradford. *Ethnic and Racial Studies*, 31(3), 543-562. doi: 10.1080/01419870701491952
- Sawbridge, Y., & Hewison, A. (2013). Thinking about the emotional labour of nursing-supporting nurses to care. *Journal of Health Organization and Management*, 27(1), 127-133.
- Sawicki, M. (2000). Editor's Introduction (M. C. Baseheart & M. Sawicki, Trans.). In Stein, E., *Philosophy of psychology and the humanities*. Washington: ICS Publications.

- Sayers, K.L., & de Vries, K. (2008). A concept development of 'being sensitive' in nursing. *Nursing Ethics*, 15(3), 289.
- Schank, M.J., Weis, D., & Ancona, J. (1996). Reflecting professional values in the philosophy of nursing. *Journal of Nursing Administration*, 26(7/8), 55.
- Schneider, J. A. (2015). Bion's thinking about groups: A study of influence and originality. *The Psychoanalytic Quarterly*, 84(2), 415-440.
- Schneider, J., Kaplan, S., Greenfield, S., Li, W., & Wilson, I. (2004). Better physician-patient relationships are associated with higher reported adherence to antiretroviral therapy in patients with HIV infection. *Journal of General Internal Medicine*, 19(11), 1096-1103.
- Schrems, B. M. (2014). Informed consent, vulnerability and the risks of group-specific attribution. *Nursing Ethics*, 21(7), 829-843. doi: 10.1177/0969733013518448
- Schwartz, C., Meisenhelder, J. B., Ma, Y., & Reed, G. (2003). Altruistic social interest behaviours are associated with better mental health. *Psychosomatic Medicine*, 65(5), 778-785.
- Schwartz, S. H. (2012). An overview of the Schwartz theory of basic values. *Online Readings in Psychology and Culture*, 2(1), 11.
- Schwartz, S. H. (1994). Are there universal aspects in the structure and contents of human values? *Journal of Social Issues*, 50(4), 19-45. doi: 10.1111/j.1540-4560.1994.tb01196.x
- Schwartz, S.H. (1992). Universals in the content and structure of values: Theoretical advances and empirical tests in 20 countries. *Advances in Experimental Social Psychology*, 25(1), 1-65.
- Scott, C., Savage, J., Ashman, M., & Read, S. (2005). Evaluating the role of modern matrons. *Nursing Management*, 12(2), 22-26.
- Scott, G. (2014). Don't blame nurses for poor patient satisfaction, blame staff shortages. *Nursing Standard*, 29(6), 10-10.
- Scott, J., & Marshall, G. (2015). *A dictionary of sociology* (Online ed.): Oxford University Press.
- Scovell, S. (2010). Role of the nurse-to-nurse handover in patient care. *Nursing Standard*, 24(20), 35-39 35p.

- Sellman, D. (2005). Towards an understanding of nursing as a response to human vulnerability. *Nursing Philosophy*, 6(1), 2-10.
- Sellman, D. (2007). On being of good character: Nurse education and the assessment of good character. *Nurse Education Today*, 27(7), 762-767.
- Sellman, D. (2010a). Mind the gap: Philosophy, theory, and practice. *Nursing Philosophy*, 11(2), 85-87. doi: 10.1111/j.1466-769X.2010.00438.x
- Sellman, D. (2010b). Values and adult general nursing. In S. Pattison, B. Hannigan & R. Pill (Eds.), *Emerging values in health care: the challenge for professionals* (pp. 129-144). London: Jessica Kingsley Publishers.
- Sellman, D. (2011a). Professional values and nursing. *Medicine Health Care and Philosophy*, 14(2), 203–208. doi:10.1007/s11019-010-9295-7
- Sellman, D. (2011b). *What makes a good nurse: Why the virtues are important for nurses?* London: Jessica Kingsley Publishers.
- Sellman, D. (2012). A shortage of caring in British nursing? *Nursing Philosophy*, 13(3), 159-160. doi: 10.1111/j.1466-769X.2012.00548.x
- Sellman, D., & Snelling, P. (Eds.). (2016). *Becoming a nurse: Fundamentals of professional practice for nursing* (2nd ed.). New York: Routledge.
- Sexton, A., Chan, C., Elliott, M., Stuart, J., Jayasuriya, R., & Crookes, P. (2004). Nursing handovers: Do we really need them? *Journal of Nursing Management*, 12(1), 37-42. doi: 10.1111/j.1365-2834.2004.00415.x
- Shahriari, M., Mohammadi, E., Abbaszadeh, A., & Bahrani, M. (2013). Nursing ethical values and definitions: A literature review. *Iranian Journal of Nursing and Midwifery Research*, 18(1), 1-8.
- Shank, J. B. (2008). *The Newton wars and the beginning of the French enlightenment*. Chicago: University of Chicago press.
- Shaw, D. (2013). Rigour in qualitative case-study research. *Nurse Researcher*, 20(4), 12.
- Shaw, H., & Degazon, C. (2008). Integrating the core professional values of nursing: A profession, not just a career. *Journal of Cultural Diversity*, 15(1), 44-50.
- Shenton, A. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63-75.

- Sher, M. (2013). *The dynamics of change: Tavistock approaches to improving social systems*. London: Karnac Books.
- Shih, F. (1998). Triangulation in nursing research: Issues of conceptual clarity and purpose. *Journal of Advanced Nursing*, 28(3), 631-641.
- Shinyashiki, G., Mendes, I., Trevizan, M., & Day, R. (2006). Professional socialization: Students becoming nurses. *Revista latino-americana de enfermagem*, 14(4), 601-607.
- Shiu, A., Lee, D., & Chau, J. (2012). Exploring the scope of expanding advanced nursing practice in nurse-led clinics: A multiple-case study. *Journal of Advanced Nursing*, 68(8), 1780-1792. doi: 10.1111/j.1365-2648.2011.05868.x
- Shukla, R. (1983). Technical and structural support systems and nurse utilization: Systems model. *Inquiry*, 381-389.
- Sibley, C. G., Harré, N., Hoverd, W., & Houkamau, C. (2011). The gap in the subjective wellbeing of Māori and New Zealand Europeans widened between 2005 and 2009. *Social Indicators Research*, 104(1), 103-115.
- Sibley, C. G., & Liu, J. (2004). Attitudes towards biculturalism in New Zealand: Social dominance and Pakeha attitudes towards the general principles and resource-specific aspects of bicultural policy. *New Zealand Journal of Psychology*, 33(2).
- Sibley, C. G., Wilson, M. S., & Duckitt, J. (2007). Antecedents of men's hostile and benevolent sexism: The dual roles of social dominance orientation and right-wing authoritarianism. *Personality and Social Psychology Bulletin*, 33(2), 160-172.
- Silverman, D. (2013). *Doing qualitative research: A practical handbook (3rd ed.)*. Los Angeles: Sage Publications Limited.
- Simons, H. (1987). *Getting to know schools in a democracy: The politics and process of evaluation* (Vol. 5): Psychology Press.
- Simons, H. (2009). *Case study research in practice*. London: Sage.
- Smith, P. (2008). Compassion and smiles: What's the evidence? *Journal of Research in Nursing*, 13(5), 367-370. doi: 10.1177/1744987108096012
- Smith, S. (2006). Encouraging the use of reflexivity in the writing up of qualitative research. *International Journal of Therapy & Rehabilitation*, 13(5), 209-215

- Snelling, P., & Sellman, D. (2016). The state of UK nursing. In D. Sellman & P. Snelling (Eds.), *Becoming a nurse: Fundamentals of professional practice for nursing* (2nd ed.). New York: Routledge.
- Sonnentag, S., & Bayer, U. (2005). Switching off mentally: predictors and consequences of psychological detachment from work during off-job time. *Journal of Occupational Health Psychology*, 10(4), 393.
- Sonnentag, S., & Fritz, C. (2007). The recovery experience questionnaire: Development and validation of a measure for assessing recuperation and unwinding from work. *Journal of Occupational Health Psychology*, 12(3), 204.
- Sorenson, C., Bolick, B., Wright, K., & Hamilton, R. (2016). Understanding compassion fatigue in healthcare providers: A review of current literature. *Journal of Nursing Scholarship*, 48(5), 456-465. doi: 10.1111/jnu.12229
- Spence Laschinger, H., Gilbert, S., & Smith, L. (2011). Patient satisfaction as a nurse sensitive outcome. In D. Doran (Ed.), *Nursing outcomes: State of the science* (2nd ed.) (pp. 359-400). London: Jones & Bartlett Learning.
- Spence Laschinger, H., & Leiter, M. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout engagement. *Journal of Nursing Administration*, 36(5), 259-267.
- Spence Laschinger, H., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management*, 17(3), 302-311. doi: 10.1111/j.1365-2834.2009.00999.x
- Spradley, J. (1979). *The ethnographic interview*. New York: Holt, Rinehart and Winston.
- Sprivulis, P., Da Silva, J., Jacobs, I., Frazer, A., & Jelinek, G. (2006). The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments. *Medical Journal of Australia*, 184(5), 208.
- Stake, R. E. (1967a). The countenance of educational evaluation. *The Teachers College Record*, 68(7), 523-540.

- Stake, R. E. (1967b). Toward a technology for the evaluation of educational programs. In R. W. Tyler, R. M. Gagne & M. Scriven (Eds.), *Perspectives of curriculum evaluation*. Chicago: Rand McNally.
- Stake, R. E. (1978). The case study method in social inquiry. *Educational Researcher*, 7(2), 5-8.
- Stake, R. E. (1994). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (pp. 236-247). Thousand Oaks, CA: Sage.
- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage Publications.
- Stake, R. E. (2013). *Multiple case study analysis*. New York: Guilford Press.
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 107-119). New York: Brunner-Routledge.
- Stamm, B. H. (2009). Professional quality of life: Compassion satisfaction and fatigue version 5 (ProQOL). Retrieved 1st August, 2016, from <http://www.proqol.org>.
- Stein, E. (1989). On the problem of empathy [1917]. *Trans. Waltraut Stein. Washington: ICS Publications*.
- Stein, E. (2000). *Philosophy of psychology and the humanities* (M. C. Baseheart & M. Sawicki, Trans. Vol. 7). Washington: ICS Publications.
- Stephenson, J. (2014). NHS England to rollout '6Cs' nursing values to all health service staff. *Nursing times*. <https://www.nursingtimes.net/roles/nurse-managers/exclusive-6cs-nursing-values-to-be-rolled-out-to-all-nhs-staff/5070102.article>
- Sternberg, R. J. (1998). A balance theory of wisdom. *Review of General Psychology*, 2(4), 347.
- Stevenson, A., & Waite, M. (Eds.). (2011). *Concise Oxford English Dictionary: Book & CD-ROM Set* (3rd ed.). Oxford: Oxford University Press.
- Stuenkel, D. L, Cohen, J., & de la Cuesta, K. (2005). The multigenerational nursing work force: Essential differences in perception of work environment. *Journal of Nursing Administration*, 35(6), 283-285.

- Suar, D., & Khuntia, R. (2010). Influence of personal values and value congruence on unethical practices and work behaviour. *Journal of Business Ethics*, 97(3), 443-460.
- Summers, S., & Summers, H. J. (2002). Is the media image of nursing damaging the profession? *BBC News Health*. Retrieved 1 Sep, 2016, from <http://news.bbc.co.uk/2/hi/health/8708041.stm>
- Summers, S., & Summers, H. J. (2015). *Saving lives: Why the medias portrayal of nurses puts us all at risk* (2nd Ed.). New York: Oxford University Press.
- Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, 11(2), 63-75.
- Takase, M., Maude, P., & Manias, E. (2006). Impact of the perceived public image of nursing on nurses' work behaviour. *Journal of Advanced Nursing*, 53(3), 333-343. doi: 10.1111/j.1365-2648.2006.03729.x
- Tarrant, C., Colman, A., & Stokes, T. (2008). Past experience, 'shadow of the future', and patient trust: A cross-sectional survey. *British Journal of General Practice*, 58(556), 780-783. doi: 10.3399/bjgp08X342615
- Tay, L., Hegney, D., & Ang, E. (2011). Factors affecting effective communication between registered nurses and adult cancer patients in an inpatient setting: A systematic review. *International Journal of Evidence- Based Healthcare*, 9(2), 151-164.
- Taylor, H, Beckett, C, & McKeigue, B. (2008). Judgements of Solomon: anxieties and defences of social workers involved in care proceedings. *Child & Family Social Work*, 13, 23-31. doi: 10.1111/j.1365-2206.2007.00507.x
- Tellis, W. (1997). Introduction to case study. *The Qualitative Report*, 3(2).
- Temara, L. (2015). Judging in looks v's competency. *Kai Tiaki Nursing New Zealand*, 21(9), 3.
- Ten Hoeve, Y., Jansen, G., & Roodbol, P. (2014). The nursing profession: public image, self- concept and professional identity. A discussion paper. *Journal of Advanced Nursing*, 70(2), 295-309. doi: 10.1111/jan.12177
- The Patients Association. (2009). Patients not numbers: People not statistics. London: Author.

- The Patients Association. (2010). Listen to patients: Speak up for change. London: Author.
- The Patients Association. (2011). We have been listening: Have you been learning. London: Author.
- The Patients Association. (2012). Stories from present: Lessons for the future. London: Author.
- Then, K., Rankin, J., & Ali, E. (2014). Focus group research: What is it and how can it be used? *Canadian Journal of Cardiovascular Nursing*, 24(1), 16-22.
- Theunissen, K. E. (2011). The nurse's role in improving health disparities experienced by the indigenous Māori of New Zealand. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 39(2), 281-286.
- Thomas, G. (2010). Doing case study: Abduction not induction, phronesis not theory. *Qualitative Inquiry*, 16(7), 575-582.
- Throwe, A. N., & Fought, S. G. (1987). Landmarks in the socialization process from RN to BSN. *Nurse Educator*, 12(6), 15-18.
- Thurmond, V. A. (2001). The point of triangulation. *Journal of Nursing Scholarship*, 33(3), 253-258. doi: 10.1111/j.1547-5069.2001.00253.x
- Tiedeman, M., & Lookinland, S. (2004). Traditional models of care delivery: What have we learned? *Journal of Nursing Administration*, 34(6), 291-297.
- Todaro-Franceschi, V. (2013). *Compassion fatigue and burnout in nursing: Enhancing professional quality of life*. New York: Springer Publishing Company.
- Todres, L., Galvin, K. T., & Holloway, I. (2009). The humanization of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies on Health and Well-being*, 4(2), 68-77.
- Tompkins, E. S. (1992). Nurse/client values congruence. *Western Journal of Nursing Research*, 14(2), 225-236.
- Torrance, M. S., & Thomas, G. V. (1994). The development of writing skills in doctoral research students. In R. G. Burgess (Ed.), *Postgraduate education and training in the social sciences: Processes and products*. London: Jessica Kingsley Publishers.
- Tradewell, G. (1996). Rites of passage adaptation of nursing graduates to a hospital setting. *Journal for Nurses in Professional Development*, 12(4), 183-190.

- Tran, D. T., Johnson, M., Fernandez, R., & Jones, S. (2010). A shared care model vs. a patient allocation model of nursing care delivery: Comparing nursing staff satisfaction and stress outcomes. *International Journal of Nursing Practice*, 16(2), 148-158. doi: 10.1111/j.1440-172X.2010.01823.x
- Traynor, J. (2014). Inside bungalow 3: RTE Investigations Unit, *Prime Time*. Dublin: RTE.
- Traynor, M. (1999). *Managerialism and nursing: Beyond oppression and profession*. London: Routledge.
- Traynor, M. (2009). Humanism and its critiques in nursing research literature. *Journal of Advanced Nursing*, 65(7), 1560-1567. doi: 10.1111/j.1365-2648.2008.04956.x
- Traynor, M. (2013). *Nursing in context: Policy, politics, profession*. New York: Palgrave Macmillan.
- Traynor, M. (2014b). Caring after Francis: Moral failure in nursing reconsidered. *Journal of Research in Nursing*, 19(7-8), 546-556. doi: 10.1177/1744987114557106
- Traynor, M., Boland, M., & Buus, N. (2010). Professional autonomy in 21st century healthcare: Nurses' accounts of clinical decision-making. *Social Science & Medicine*, 71(8), 1506-1512.
- Tubbs, S., Husby, B., & Jensen, L. (2011). Ten common misconceptions about implementing continuous improvement efforts in health care organizations. *The Business Review, Cambridge*, 17(2), 21-27.
- Tuckett, A. (2015). Speaking with one voice: A study of the values of new nursing graduates and the implications for educators. *Nurse Education in Practice*, 15(4), 258-264. doi: 10.1016/j.nepr.2015.02.004
- Twenge, J. (2001). Changes in women's assertiveness in response to status and roles: A cross-temporal meta-analysis, 1931–1993. *Journal of Personality and Social Psychology*, 81(1), 133.
- Twigg, D., Duffield, C., Bremner, A., Rapley, P., & Finn, J. (2012). Impact of skill mix variations on patient outcomes following implementation of nursing hours per patient day staffing: A retrospective study. *Journal of Advanced Nursing*, 68(12), 2710-2718. doi: 10.1111/j.1365-2648.2012.05971.x

- Tyson, G. A., Lambert, G., & Beattie, L. (2002). The impact of ward design on the behaviour, occupational satisfaction and well-being of psychiatric nurses. *International Journal of Mental Health Nursing*, 11(2), 94-102 109p.
- Vahey, D., Aiken, L., Sloane, D., Clarke, S., & Vargas, D. (2004). Nurse burnout and patient satisfaction. *Medical Care*, 42(2), 1157-1166.
- Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, 15(3), 398-405.
- Verpeet, E., Meulenbergs, T., & Gastmans, C. (2003). Professional values and norms for nurses in Belgium. *Nursing Ethics*, 10(6), 654-665. doi: 10.1191/0969733003ne654oa
- Vidich, A. J., & Lyman, S. M. (1994). Qualitative methods: Their history in sociology and anthropology. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 23-59). Thousand Oaks: Sage Publications.
- Vryonides, S., Papastavrou, E., Charalambous, A., Andreou, P., & Merkouris, A. (2014). The ethical dimension of nursing care rationing: A thematic synthesis of qualitative studies. *Nursing Ethics*, 22(2), 881-900. doi: 10.1177/0969733014551377
- Waddell, M. (2002). *Inside lives: Psychoanalysis and the growth of the personality*. London: Karnac Books.
- Wadsworth, B. J. (1996). *Piaget's theory of cognitive and affective development: Foundations of constructivism*. New York: Longman Publishing.
- Walker, L. (2015). Walking in two worlds. *Kai Tiaki Nursing New Zealand*, 21(5), 34-35.
- Walker, L., Clendon, J., & Walton, J. (2015). What nurses think about professionalism. *Kai Tiaki Nursing New Zealand*, 21(1), 12-13.
- Walsh, K., Crisp, J., & Moss, C. (2011). Psychodynamic perspectives on organizational change and their relevance to transformational practice development. *International Journal of Nursing Practice*, 17(2), 205-212. doi: 10.1111/j.1440-172X.2011.01926.x

- Wanat, C. L. (2008). Getting past the gatekeepers: Differences between access and cooperation in public school research. *Field Methods*, 20(2), 191-208. doi: 10.1177/1525822X073138811
- Wang, S, Liu, Y, & Wang, L. (2015). Nurse burnout: Personal and environmental factors as predictors. *International Journal of Nursing Practice*, 21(1), 78-86. doi: 10.1111/ijn.12216
- Wang, Y., & Epstein, M. (2015). Smiling through clenched teeth: Why compassion cannot be written into the rules. *Journal of Medical Ethics*, 42(1), 7.
- Ward, P., Rokkas, P., Cenko, C., Pulvirenti, M., Dean, N., Carney, S., . . . Meyer, S. (2015). A qualitative study of patient (dis)trust in public and private hospitals: the importance of choice and pragmatic acceptance for trust considerations in South Australia. *BMC Health Services Research*, 15(1), 297. doi: 10.1186/s12913-015-0967-0
- Watson, J., Dossey, B. M., & Dossey, L. (1999). *Postmodern nursing and beyond*. Toronto: Churchill Livingstone.
- Watson, M. J. (1988). New dimensions of human caring theory. *Nursing Science Quarterly*, 1(4), 175.
- Watson, P, & Feld, A. (1996). Factors in stress and burnout among paediatric nurses in a general hospital. *Nursing Praxis in New Zealand inc*, 11(3), 38-46.
- Waugh, A, Smith, D, Horsburgh, D, & Gray, M. (2014). Towards a values-based person specification for recruitment of compassionate nursing and midwifery candidates: A study of registered and student nurses' and midwives' perceptions of prerequisite attributes and key skills. *Nurse Education Today*, 34(9), 1190-1195. doi: 10.1016/j.nedt.2013.12.009
- Webb, C., & Pontin, D. (1996). Introducing primary nursing: Nurses' opinions. *Journal of Clinical Nursing*, 5(6), 351-358. doi: 10.1111/j.1365-2702.1996.tb00267.x
- Weinreich, P., & Saunderson, W. (2005). *Analysing identity: Cross-cultural, societal and clinical contexts*. Sussex: Routledge.
- Weis, D., & Schank, M.J. (1997). Toward building an international consensus in professional values. *Nurse Education Today*, 17(5), 366-369. doi: 10.1016/s0260-6917(97)80096-2

- Weis, D., & Schank, M.J. (2000). An instrument to measure professional nursing values. *Journal of Nursing Scholarship*, 32(2), 201-204.
- Weis, D., & Schank, M.J. (2002). Professional values: Key to professional development. *Journal of Professional Nursing*, 18(5), 271-275. doi: 10.1053/jpnu.2002.129224
- Weis, D., & Schank, M.J. (2009). Development and psychometric evaluation of the nurses professional values scale revised. *Journal of Nursing Measurement*, 17(3), 221-231.
- Weis, L. (1995). Identity formation and the processes of "othering": unravelling sexual threads. *The Journal of Educational Foundations*, 9(1), 17.
- Weissman, J., Rothschild, J., Bendavid, E., Sprivulis, P., Cook, E., Evans, R., . . . Haug, P. (2007). Hospital workload and adverse events. *Medical Care*, 45(5), 448-455.
- Welton, J. M., Decker, M., Adam, J., & Zone-Smith, L. (2006). How far do nurses walk? *Medsurg Nursing*, 15(4), 213-216.
- West, A. F., & West, R. R. (2002). Clinical decision-making: Coping with uncertainty. *Postgraduate Medical Journal*, 78(920), 319-321.
- Whitehead, B., Owen, P., Henshaw, L., Beddingham, E., & Simmons, M. (2016). Supporting newly qualified nurse transition: A case study in a UK hospital. *Nurse Education Today*, 36, 58-63. doi:10.1016/j.nedt.2015.07.008
- Whittaker, A. (2011). Social defences and organisational culture in a local authority child protection setting: Challenges for the Munro Review? *Journal of Social Work Practice*, 25(4), 481-495. doi: 10.1080/02650533.2011.626654
- Whyte, W. F. (1943). *Street corner society: The social structure of an Italian slum*. Illinois: University of Chicago Press.
- Wiechula, R., Conroy, T., Kitson, A., Marshall, R., Whitaker, N., & Rasmussen, P. (2016). Umbrella review of the evidence: What factors influence the caring relationship between a nurse and patient? *Journal of Advanced Nursing*, 72(4), 723-734. doi: 10.1111/jan.12862
- Wiles, R., Heath, S., Crow, G., & Charles, V. (2005). Informed consent in social research: A literature review *NCRM Methods Review Papers* (Vol. 1): ESRC National Centre for Research Methods.

- Wilkes, L., & Beale, B. (2005). Role conflict: Appropriateness of a nurse researcher's actions in the clinical field. *Nurse Researcher*, 12(4), 57-70.
- Wilkinson, J. E., Nutley, S. M., & Davies, H. T. (2011). An exploration of the roles of nurse managers in evidence-based practice implementation. *Worldviews on evidence-based nursing / Sigma Theta Tau International, Honor Society of Nursing*. doi: 10.1111/j.1741-6787.2011.00225.x
- Williams, J. (2011). Dignity and nutrition inspection programme: National overview. Newcastle upon Tyne: Care Quality Commission.
- Wilson, D., & Barton, P. (2012). Indigenous hospital experiences: A New Zealand case study. *Journal of Clinical Nursing*, 21(15- 16), 2316-2326.
- Wilson, G. (2009). Implementation of releasing time to care – the productive ward. *Journal of Nursing Management*, 17, 647–654. doi: 10.1111/j.1365-2834.2009.01026.x
- Winters, R., & Neville, S. (2012). Registered nurse perspectives on delayed or missed nursing cares in a New Zealand hospital. *Nursing Praxis in New Zealand*, 28(1), 19-28.
- Wocial, L., Albert, N. M., Fettes, S., Birch, S., Howey, K., Jie, Na, & Trochelman, K. (2010). Impact of pediatric nurses' uniforms on perceptions of nurse professionalism. *Pediatric Nursing*, 36(6), 320-326 327p.
- Wocial, L., Sego, K., Rager, C., Laubersheimer, S., & Everett, L. (2014). Image is more than a uniform: The promise of assurance. *Journal of Nursing Administration*, 44(5), 298-302.
- Wong, F., Liu, H., Wang, H., Anderson, D., Seib, C., & Molasiotis, A. (2015). Global nursing issues and development: Analysis of World Health Organization documents. *Journal of Nursing Scholarship*, 47(6), 574-583. doi: 10.1111/jnu.12174
- Wong, W. (2004). Caring holistically within new managerialism. *Nursing Inquiry*, 11(1), 2-13.
- Woodard Leners, D, Roehrs, C., & Piccone, A. V. (2006). Tracking the development of professional values in undergraduate nursing students. *Journal of Nursing Education*, 45(12), 504-511. doi: 10.1053/jpnu.2001.21116.

- Woods, M., Rodgers, V., Towers, A., & La Grow, S. (2015). Researching moral distress among New Zealand nurses: A national survey. *Nursing Ethics*, 22(1), 117-130 114p. doi: 10.1177/0969733014542679
- Wright, K. (2011). Many factors can lead to drug errors, so stop blaming nurses. *Nursing Standard*, 26(12), 33-33.
- Wright Mills, C. (1967). *The sociological imagination*. London: Oxford University Press.
- Wu, M., Courtney, M., & Berger, G. (2000). Models of nursing care: A comparative study of patient satisfaction on two orthopaedic wards in Brisbane. *Australian Journal of Advanced Nursing*, 17(4), 29-34.
- Wuthnow, R. (2012). *Acts of compassion: Caring for others and helping ourselves*: Princeton University Press.
- Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.
- Yeong Ok, R., & Eun, K. (2015). Influence of emotional labor and nursing professional values on job satisfaction in small and medium-sized hospital nurses. *Journal of Korean Academy of Fundamentals of Nursing*, 22(1), 7-15. doi: 10.7739/jkafn.2015.22.1.7
- Yin, R. (1993). Applications of case study research *Applied Social Research Methods Series*. Newbury Park: Sage Publications.
- Yin, R. (1994). *Case study research: Design and methods*. California: Sage Publications.
- Yin, R. (1999). Enhancing the quality of case studies in health services research. *Health Services Research*, 34(5 Pt 2), 1209-1224.
- Yin, R. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Yin, R. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks CA: Sage Publications.
- Yin, R. (2013). *Case study research: Design and methods* (5th ed.). Thousand Oaks CA: Sage Publications
- Youngson, R. (2012). *Time to care: How to love your patients and your job*. Raglan: Rebelheart Publishers.

- Zaidan, M., Rustom, F., Kassem, N., Al Yafei, S., Peters, L., & Ibrahim, M. (2016). Nurses' perceptions of and satisfaction with the use of automated dispensing cabinets at the heart and cancer centres in Qatar: A cross-sectional study. *BMC Nursing*, 15(1), 1-8. doi: 10.1186/s12912-015-012107
- Zeller, E., Doutrich, D., Guido, G., & Hoeksel, R. (2011). A culture of mutual support: Discovering why new nurses stay in nursing. *The Journal of Continuing Education in Nursing*, 42(9), 409-414.
- Zigmond, D. (2009). No country for old men: The rise of managerialism and the new cultural vacuum. *Public Policy Research*, 16(2), 133-137. doi: 10.1111/j.1744-540X.2009.00569.x
- Zimbardo, P. (2007). *Lucifer Effect: How good people turn evil*. London: Rider.
- Zoboli, E., & Schweitzer, M. (2013). Nursing values as social practice: A qualitative meta-synthesis. *Revista latino-americana de enfermagem*, 21(3), 695-703. doi: 10.1590/S0104-11692013000300007