

THE HUMAN COST OF 'CARING' CARE FOR REGISTERED NURSES IN CLINICAL PRACTICE.

By: Sylvia Margaret Shona Blair.

RGON BA

A thesis submitted to the Victoria University of Wellington in partial fulfillment
of the requirements for the degree of Master of Arts (Applied) in Nursing / Midwifery.

Victoria University of Wellington

1999

ABSTRACT

This research utilised a focus group methodology to discover what nurses in clinical practice considered 'caring' care meant for them. Six registered nurses volunteered to participate in the project. They practised over a variety of clinical settings within a public hospital, which provided both acute and elective surgical and medical services to the community, including an extensive elderly population.

Taking these important 'caring' care statements, I then explored with the group what factors in their work environment hindered or enhanced their identified 'caring' care. New Zealand nurses identified similar themes and concepts important to their 'caring' in clinical practice as did their overseas counterparts.

This study also highlighted the impact the health reforms had on individual clinical practice at this hospital. The effects of the institutional changes in response to the health reforms were far reaching at both a personal and professional level.

Caring is an important concept found in nursing practice. It has been widely documented by nurse scholars, researchers and nurse authors that care is at the core of nursing practice. Some have even referred to care as being the heart of nursing. The findings from the present research indicates the importance nurses place on caring in their day to day encounters with patients. It also demonstrates how nurses express their care and their perceptions of the importance care has in their clinical practice.

ACKNOWLEDGMENTS

This thesis is the final requirement of four years part time study toward a Master of Arts (Applied) degree in Nursing. It would not have been possible without the combined effort and support of some dedicated family, friends and colleagues. I would express my appreciation to those who helped make my dream a reality by contributing to this work.

To those who willingly gave their time to be part of the focus groups and to share their 'caring' nursing practice in an open and reflective way, making the experience illuminating and rewarding for us all. As a nurse I say thank you for your honesty, openness and the tremendous support you gave one another, and for the challenges that arose for reflecting on my own practice and personal development. I respect your excellence in 'caring' and am privileged to have shared your experiences.

The Department of Nursing and Midwifery staff at Victoria University of Wellington for their guidance, support, assistance and professional direction over the four years of my study. I would also like to acknowledge the Otago Polytechnic Nursing and Midwifery Department for connecting with Victoria University. This affiliation enabled me to access postgraduate study at a reasonable and realistic cost. My sincere thanks for this initiative. Had this not transpired this thesis would never have been produced.

Professor Alison Dixon, my thesis supervisor, who gave me invaluable assistance, time and experience along with stimulating dialogue and challenging thought provoking episodes throughout the year. I thank you sincerely for your knowledge and expertise, and for yourself the person and the nurse. I appreciated the times we connected for conversation, guidance, support and direction.

A special thank you to my critical friend Isobel for sharing the joys and frustrations of this journey. Your support, friendship and encouragement have been stimulating and

humbling. Everyone who travels on this journey needs another who will challenge and probe the thinking process. This made my journey an invaluable experience for my nursing practice.

Finally, the most important people who have lived through this experience. My husband Rob, who has given tremendous support and assistance throughout my years of distance learning, and who has always been there in the background patiently waiting for all this study to end. A heart felt thanks for giving me the space and the time to pursue a special nursing goal. My daughter Loren, who proof-read everything, the final polish is due to your diligence and perfection. My son Dougal, always the good listener and the quiet deep thinking contributor, silently looking over my shoulder and occasionally giving advice. Finally to the memory of my Grandparents, Christina and Victor Baker, who raised me as their own child. By the warmth of the coal range and the light of a candle, taught me the value of reading and writing. Instilling in me an insight for caring, love, morals, values, ideals and dreams. Where I learned that riches were not to be found in material possessions, they were encountered in living and experiencing life to the fullest.

Caring and sharing in the joys and frustrations of life together are what living experiences are all about. Each one of us takes our own path and for a time shares that journey of our life with another in special ways. We then part to grow in another dimension, hopefully learning from the other and the experience. We are only alone if we so choose to be. Thank you to everyone for your caring and being.

This research has been supported by a Mary Lambie Memorial Scholarship Award, valued at \$813.20 and a travel grant of \$400.00 from the New Zealand Nursing Education and Research Foundation.

TABLE OF CONTENTS

ABSTRACT	ii
ACKNOWLEDGMENTS	iii
TABLE OF CONTENTS.....	v
TABLE OF FIGURES.....	vi
PREFACE	vii
CARING AND NURSING.....	1
1.1 INTRODUCTION	1
1.2 BACKGROUND TO THE STUDY	10
1.3 IS CARE WORTH RESEARCHING?	18
1.4 THINKING AROUND CARING IN PRACTICE	21
THE CARING LITERATURE.....	25
2.1 LITERATURE REVIEW	25
2.2 THE MAJOR WRITERS ON CARING.....	36
2.3 HUMANISTIC CARING	45
THE STUDY METHODOLOGY.....	51
3.1 METHODOLOGY	51
3.2 FOCUS GROUPS.....	53
3.3 ETHICAL ISSUES	59
3.4 ACCESS TO THE FIELD	62
3.5 DATA ANALYSIS INTERPRETATION AND RESULTS	71
3.6 RIGOR, TRUTH AND AUDITABILITY	77
THE CARING DISCUSSION.....	80
4.1 EMERGENT THEMES.....	80
4.2 THE CARING WAYS OF PRACTICE	112
4.3 ENHANCING AND INHIBITING CARING FACTORS	122

RESEARCH OUTCOMES	132
5.1 RELEVANCE OF THE STUDY.....	132
5.2 STATEMENT.....	133
5.3 LIMITATIONS OF THE STUDY	134
5.4 STRENGTHS OF THE STUDY	135
5.5 REFLECTIONS ON THE METHODOLOGY	136
5.6 RECOMMENDATIONS FOR PRACTICE.....	138
5.7 CONCLUSION.....	139
REFERENCES.....	141
APPENDIX 1	147
APPENDIX 2	148
APPENDIX 3	149
APPENDIX 4	151
APPENDIX 5	152
APPENDIX 6	153
APPENDIX 7	154
APPENDIX 8	155
APPENDIX 9	156

TABLE OF FIGURES

FIGURE I PERSONAL NURSING PHILOSOPHY.....	8
FIGURE 2 EMERGENT CARING THEMES.....	76

PREFACE

**.... caring,
ultimately the most powerful force in the world,
is the focus of all energy.**

(Simone Roach, 1987, p.121).

To stand on the threshold of your chosen career that stretches before you into the future, unseen, unenvisioned, just the hopes and dreams of what may be. In 1970 I stood with a group of newly registered nurses, our apprenticeship behind us, our future as registered nurses before us. There was no crystal ball wherein to gaze, to see which path along nursing's highway we each would take and where that individual road would lead.

To receive our new five pointed 'star' badge, and certificate of registration giving us our license to practice as a nurse. To read in front of your peers and relatives the pledge of the five pointed star (Appendix 1). To say these words with feeling and mean what you stated. That day reflected my commitment to nursing as my chosen profession. This study reflects that pledge which I gave to nursing in 1970.

To be entrusted with the challenging profession of nursing means there are times when the nurses must take responsibility for looking after themselves. I have always sought solace in the nature that surrounds me. The following composition is how I achieve this to ensure that I can continue to care for others. I have called this work self nurturance. Everyone needs to be able to restore their caring abilities, to refill the vessel when it becomes depleted. If nurses fail to look after themselves they have no hope of providing 'caring' care for another and will become withered and dry in their practice and in their personal life. For myself I return to nature to absorb and enjoy the natural views and sensations that are so readily accessible. The following was written to illustrate my self-nurturance which uses metaphor from nature to illustrate practice experiences.

Self nurturance

There are the rivers, lakes, mountains and valleys, all so different yet so completely together, a finished painting, expertly framed.

I watch and absorb their beauty, and reflect on my good fortune that I am able to do this in such a picturesque and peaceful country.

To see, feel, hear, touch, smell and enjoy the open space, tranquil and quiet with the sounds of nature surrounding and touching me.

The caring highs of practice are similar to the pinnacles of lofty mountains, these provide moments of elation that can be heady.

These are difficult to climb, however, the view from the top surpasses the effort involved in the ascent.

These reflect the difficult clinical experiences where the nurse invests tremendous effort to reap any small reward.

The dark and shaded valleys, gloomy and cool where you carefully watch you step.

There will always lurk in unseen places of clinical practice, dangers, to be wary of.

The rivers that meander, taking everything with their flow as they weave and ripple along.

Cutting their way through the earth, ever onward, ever forward journeying toward the sea.

This represents the nurses' everyday clinical practice that weaves through the hours of the day leading to some goal to be achieved before the shift is ended.

The lakes of reflection where you look back over what has been, and what may become.

Nurses reflect on their own practice to improve their care or their approach to situations.

Discarding what has not worked and making improvements for future care.

The hills that roll along, climbing gently up then down like the surges of daily nursing.

The coming and going, toing and froing, the heavy and the light of everyday working life.

The ebb and flow of the tide, sometimes crashing to shore, always constant and rhythmic.

The normal flow of nursing practice, the rhythm of activity continuous, constant that sometimes crashes on our senses with some demand and urgency or clinical emergency.

The wind that quietly tickles the grass, or stirs with force to rattle the leaves and branches.

The subtle challenges that breeze through our thoughts to stir our daily thinking.

The gentle rain that nourishes the land, or causes havoc and ruin when there is too much.

The sun always a welcome warmth, and a light to see, but overdone does dry and destroy.

The small successes that bring rewards or the constant pounding from the environment that eventually takes its' toll by depleting the nurse of enthusiasm and self confidence.

I am particularly fond of Autumn and Spring, perhaps the beginnings and endings of life

Spring beauty with that splash of vibrant colour, welcoming after the dull grey of winter.

The inspirational thoughts that light a troubled corner to help us through the storms of life.

Then after Summer, Autumn shows off in a brilliant finale of burnt amber and gold, then withers and falls to the earth, spent and completed, dead, the years work over.

Sometimes the earth shakes forcefully, as if to loosen our very foundations and beliefs.

This makes us realise we are mere mortals passing through this world, and one day we to will move on. Hopefully leaving behind some evidence of our passing through this world.

To show where we have been, where we have come from, and what we did while here.

There will be those who investigate and study our past lives as we have done to others.

Those ancestors who passed this way in years gone by, who are gone but not forgotten.

How we lived and worked, how we survived, and finally how we succumbed and died.

The on going cycle of life. From birth to death, there's joy and grief, dilemma and solutions, laughter and love, trauma and peace, mayhem and madness. This is one occupation that can have it all. Nursing is working the life cycles through the stages.

Nature is all around us, it makes us who and what we are, our future is shaped from our past. It gives us strength in times of turmoil to carry on over the path we chose to take.

This gives us reason for our own existence if we take the time to stop a while and listen.

We are then grounded and will flourish in the essence of our chosen profession.

The caring that is nursing.

(1998).

CHAPTER ONE

CARING AND NURSING

1.1 INTRODUCTION

Nursing and Caring

As I reflected on this work I kept coming back to the questions of, why caring? What is the significance of caring in nursing? Is it important to the practice and discipline of professional nursing? Why am I so passionate about writing on caring when there are endless other possibilities I could have pursued within my nursing practice? Is it possible to have nursing without caring? Can nursing and caring be separated or do they work parallel with each another? What sort of caring is identified within clinical nursing practice? Do all nurses in fact, care? As I confronted and pondered on these questions, I reasoned that at some point other nurses also may have possibly given some thought and reflection to these same questions. However, I am only able to tell my story and relate my journey of care through clinical practice, reflection and reading. The stories of my participants will be narrated in the language they used to portray their caring to me.

I do not propose to offer any answers to the above questions, I would be unable to make any statement that would encompass every nurses impression. Each nurse has his or her own opinions and ideas, this is a feature of practicing professionals, we each contribute differing views and perspectives to similar issues. My hope is that this work will stimulate some thought provoking ideas and discussion as the story of care as myself and the participants perceive it unfolds.

Nursing theory shaping practice

During my formative years of nursing practice, nursing theories as they are understood today, were not clearly visible. As a student I learnt about the work of Florence Nightingale and her contribution to nursing. However, recognition of Nightingale as a nurse theorist was not evident by nurse educators in the late 1960s. Instead she was referred to as the initiator of formal training for nurses and set the foundations for recognition of nursing as a profession. Two of her goals following the Crimean war were to gain national support for a need for nurses, and to achieve education for nurses (Meleis, 1991). From my recollection Florence Nightingale was not referred to as a nurse theorist until the 1980s when I undertook further study in nursing at an undergraduate level. Nurse theorists are a recent phenomenon and started to emanate from the 1950s to the 1980s (Meleis, 1991). Other nurses were now being exposed to these theories through undergraduate study, and were endeavoring to apply meaning and understanding to their nursing practice through further education and reading.

My early nursing knowledge reflected the medical model which worked within the framework of the disease mode of health care delivery and my early recollections were of studying the 'diseased' part of the human body. This diseased component did not appear to be related to an actual person. To me the medical model of care filled me with unease as it did not consider illness from the humanistic perspective of the person. Personally I struggled with this through my early years as a nurse. As I reflect back on my apprenticeship I respected at that early stage the importance of treating the person as a whole. They were either male or female, composed of a physical, mental and spiritual element, admitted to hospital because they were experiencing a health crisis.

From my experience, nursing in the past was an apprentice focused practice where nurses were trained at the bedside of the sick. Formal education occurred in a classroom

one day a week or in a one week study block. The rest of the time was spent giving service to the sick and dying, being rostered on an eight hour morning, afternoon or night shift, for a small wage. Many student nurses from the second year of their apprenticeship were frequently found to be 'in charge' of wards on the afternoon or night shift. This meant maintaining responsibility for delivering appropriate nursing care to all the patients in the ward, which could number between 25 and 30. These patients were in varying stages of their illness to near recovery. Included with this responsibility, the most senior student nurse supervised the more junior nurses on the ward. The back up for the student nurse was one other registered nurse, afternoon or night supervisor, who could be called on for advice. This supervisor usually had responsibility for a block of three to six wards. For some student nurses, that responsibility for the hospitalised patient proved to be very demanding. Some, unable to continue with this expected responsibility, left the profession. Throughout this period, gaining new nursing knowledge and acquiring further nursing skills to become more proficient was expected by the clinical tutor in charge of nursing education and the charge nurses of the ward where the student worked. There were times when the classroom education held no relevance to the clinical practice being experienced at the time. Frequently the student nurse was tired from the physical ward work. Some had to juggle night shift around their formal learning sessions. This was my personal experience and would reflect the experiences of many other registered nurses who trained around my era of the nineteen sixties.

Over the past twenty years, nursing education in New Zealand has undergone major change and restructuring. Nursing students are now offered a more formalised process of education delivery than their previous hospital trained colleagues. In 1973 two technical institutions set up a pilot scheme for the three year comprehensive nursing education. By 1986 the number of technical institutes offering nursing courses had

increased to 15. By 1988 all hospital based nursing programmes had been phased out except for one Obstetric programme at Auckland Hospital (Workforce Development Group, 1988). All student nurses were now receiving their education in a technical institution. The education or formal learning took place at the technical institute and the clinical practice components of the programme occurred in clinical placements which may or may not have included a hospital setting. In the hospital, the student was allocated total responsible for one or two patients and was always buddied alongside a registered nurse on the ward. A clinical tutor would check on the student's progress once or twice throughout the duty. The students who graduated from this programme attained a Diploma in Nursing. Over the last four years the programme has undergone further change with student nurses now able to graduate with an undergraduate degree in nursing.

There has also been the availability of progression to a university qualification after the nursing qualification. Nursing education has taken a big step in its evolution and some nurses who trained under the hospital apprenticeship have kept up with the challenges and change advancing their own personal educational development. This is how I, through my own personal study and understanding, became exposed to other ideas mainly from the North American Nurse theorists. It became important for me to understand how my nursing practice had developed.

Evolution of my Nursing Practice

The foundations of my nursing work and understanding of how I practice have evolved through reading widely the work produced by some nurse theorists. In particular, the work of Martha Rogers has provided insights into my clinical practice and how I believe I deliver my nursing care. Rogers (1970), stated that man was an irreducible whole, greater than and different from the sum of the parts. The characteristics of each

living person included their physical, mental, spiritual and social being, those factors which distinguish each of us as individual. These factors were of a human energy field that is open and constantly exchanging matter and energy with the environment. Humans not only have energy fields, they are energy fields interacting with other energy fields, whether they be living or non living. Everything has an energy field. This is dynamic, ever-changing, extends to infinity, and is maintained through patterning and organisation. Caring moments in nursing occur within the energy fields of two individuals interacting. At the time of the interaction they become as one energy field forming a new pattern and a new energy field. This is how I see my nursing practice, an ever-changing evolving field of energy that interacts in and on different levels throughout the working day. This then leads to my nursing goal for each individual and reflects similarities with Rogers (1970), who states nursing is:

[T]o assist people in achieving their maximum health potential. Maintenance and promotion of health, prevention of disease, nursing diagnosis, intervention, and rehabilitation encompass the scope of nursing's goals. Nursing is concerned with people - all people - well and sick, rich and poor, young and old. The arenas of nursing's services extend into all areas where there are people: at home, at school, at work, at play; in hospital, nursing home, and clinic; on this planet and now moving into outer space. Nursing is a humanistic science.

(pp. 86-87).

I firmly believe that nursing does not just occur where a nurse's place of physical work may be. It is an ongoing profession that is carried with the practitioner into all walks of life. There will always be opportunity to communicate health related issues wherever there are people.

Understandings of my caring have also been influenced through the writings of Jean Watson (1979; 1985), who identifies carative factors and the use of transpersonal caring moments as that time when specific caring encounters occur. Transpersonal caring moments are the shared consciousness that happens between the nurse and the patient at a

specific point in a nursing event. In my clinical practice I find the caring encounter with patients occurs in a partnership of understanding between two people. It is through having a self awareness and understanding of my own consciousness and the application of a knowledge base from which to work, that enables me to care for patients the way I do, realizing their energy patterns and my own. This acknowledgment between the nurse, the patient and the energy fields of the two that form into one complete energy field during that transpersonal moment, is what translates into what I consider and recognize as my caring.

Sara Fry (cited in Gaut & Leininger, 1991, pp. 162-165), identifies three traditional models of caring: The Cultural model, the Feminist model and the Humanistic model. The cultural model was developed from anthropological and sociological studies in various world cultures that investigated the caring behaviours evident in cultural caring practices, beliefs and survival. The Feminist model tends to work from the feminist perspective of caring which is related to ethical behaviour and choices. The Humanistic model works from the stance that caring is a mode of being committed to protecting human dignity and preserving humanity.

This thesis follows the Humanistic model of caring, taking the human to human stance. Jean Watson (1985) and Sr Simone Roach (1987), have identified the characteristics of humanistic caring as a will, a commitment, an intention and an ideal. As I understand it, caring is a way of being in the world. It is an essential component of being human. Fry (cited in Gaut & Leininger, 1991), states “Caring is simply a mode of being that calls for a philosophy of moral commitment toward protecting human dignity and preserving humanity” (p. 164). As a nurse there is an unwritten commitment to protect human dignity and preserve humanity.

Personal care statement

In this thesis I intend to investigate the caring that is inherent in the nurse and what the nurse really values in that 'caring' in their clinical practice. This work will be specific to the Humanistic model of caring, that is the will, the commitment and the intention with reflective reasoning, feeling and evaluation of the situations expressed by the participants. I believe that caring creates possibilities in nursing situations and occurs when something really matters to the nurse. It creates a personal concern that leads to some commitment in the nurse and generates some form of activity between two people, that of the patient and that of the nurse.

It is my hope that nursing's specific caring can be defined and recognised as an unique scientific quality that is realised, understood and accepted within professional nursing. The science which I am referring to is a science of care that can explain and describe the phenomenon of caring as it relates to humanity in the nursing context, in its continuity, wholeness and change. From there I trust more pertinent research can be conducted into nursing situations, accepting the care concepts specific to nursing, and researching more deeply into the work of the professional nurse.

I believe that care comes from within an individual and arises as a response to an individual requirement. The care encounter occurs as these two individuals respond to each other, respecting each others individuality. The encounter can occur either between a patient and a nurse or between two individuals and one does not necessarily need to be a nurse. I am stating the nursing stance as that is where I have focused for this thesis. However, I firmly believe that any individual is capable of humanistic caring, and experiencing a transpersonal caring moment as previously described.

I have included my own personal nursing philosophy as it may allow the reader to understand the essence of what I have explained about caring from my perspective more fully.

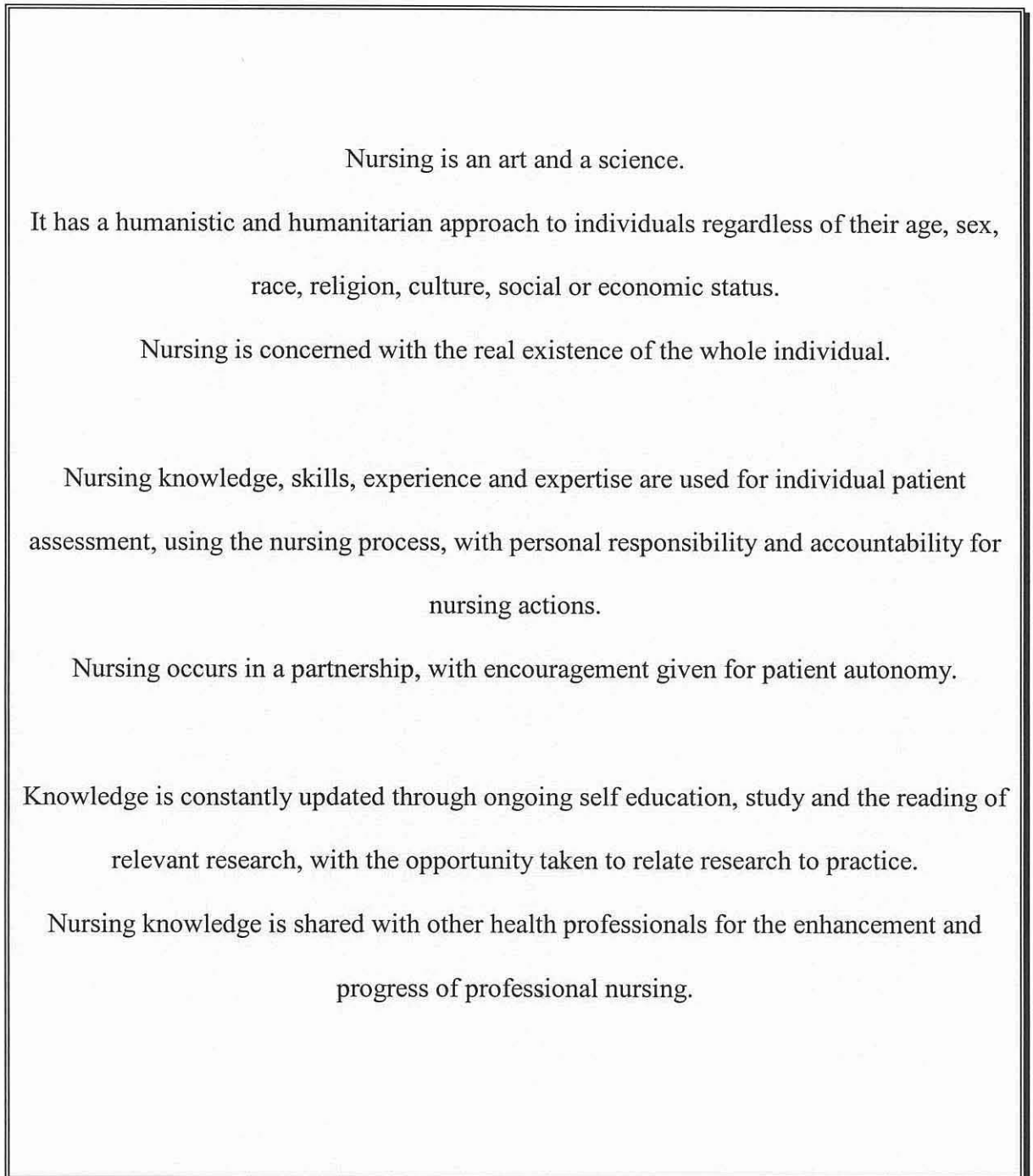


Figure 1

Personal Nursing Philosophy

Personal transparency

The research journey is one of interest and learning. I have furthermore found it to be most rewarding. As I embarked on an exploration of an area of interest I have had for some time, I have held three images in my mind throughout this journey. These were the participants data, my personal knowledge on caring, and the research methodology selected for exploring this phenomenon of nursing. As a researcher the set plan for the research does not necessarily flow smoothly. There are no markers along the way that inform the researcher that what they are doing is correct. The correctness evolves out of adhering to the rigor of the research and ensuring that you relay faithfully what the participants have stated. It also means keeping an accurate account of the method so others may follow the trail taken. There is no way to have all the answers. The process I found is one of learning, exploring, thinking and writing.

By writing this work I am exposing my innermost thoughts and feelings. Some may wish to question my beliefs and the position I have taken. This does fill me with some apprehension and can be personally quite frightening as I put myself, a practising nurse, up for critical judgment by my peers. I hope the stance of where I stand will be clearly revealed as the story of this thesis unfolds. It is important to place myself in the research and position myself within caring as it relates to nursing. I firmly believe that caring is an integral part of nursing and personally I could not practise this discipline if I did not have a deep desire and motivation to care for humanity. To care for people is part of my being, and to have that care guided by knowledge and understanding from nursing education and practice is humanly fulfilling and rewarding.

It is important to state that this work does recognize stress as an issue within the nursing profession. However, I have chosen not to include stress with this work, except for where the participants have raised it in relation to the inhibiting factors of their work. I

acknowledge also there are times when nurses do not care or are unable to care for patients for a multitude of personal and professional reasons. This will be referred to with the issues raised by the participants. This subject is worthy of a study in itself, and would involve a more lengthy investigation than time allows for within this research.

Why then, from my perspective as a nurse, was it important for me to investigate the care that occurs in clinical practice? I understand that care and nursing go together, I have never really questioned that it does not. For me, nursing and care are part of the whole that is professional nursing practice. This is how I understand it. I decided to investigate if my colleagues also understand it in this way. I set out on a journey of discovery to find out if this was so.

1.2 BACKGROUND TO THE STUDY

Why care?

Why research 'caring' care in nursing practice? Caring and nursing seem to have always been two words that have been linked together from my earliest experiences, even as a student nurse. As a clinical practitioner, with thirty years experience predominantly in operating theatre and recovery room nursing, there has always been an interest in the care nurses gave patients. Sometimes brief moments of care can hold much meaning in that moment of sharing between two people, the patient and the nurse. Personally, I have experienced times when what has taken place in the actual moment of caring does not appear significant to me, the nurse. However, the response from the patient can be quite profound and you the nurse are left to wonder what you actually did that was so meaningful and made such a difference.

Over the years I have found I cared in many different ways for patients. Some practices were creative and others very much on the spur of the moment when something

special had to be thought up for a challenging situation. This was often very dependent on the environment I was working in and the patient I was with at that time. Some experiences were very special as patients confided their inner most thoughts. Some experiences I still hold precious from patients who never regained consciousness following their surgery. Some died while undergoing surgery, but their faces and expressions I can still recall and these remain with me. I kept a record of instances from my practice in a personal diary and reflect back to encounters, both the memorable and the not so memorable. I use this as a way of sometimes addressing the painful episodes that occur. Through this reflective process I consider, could I or would I have achieved a different outcome if I had acted differently? I have written poetry as a form of reflection on my practice and will filter some of this poetry throughout this thesis. Some of this poetry was written at an earlier period from nursing experiences and other poetry has been written as part of this thesis journey. Reflective practice is a well documented activity used by nurses (Johns & Freshwater, 1998). Through reflection I assess myself and my caring of patients. The following poem was composed following an unexpected death in operating theatre. Writing this poem helped me accept and move forward from this traumatic event.

Unexpected death does happen

You hoped that surgery would improve your quality of life, you had difficulty walking.

There was pain in your lower legs when you walked and your feet were always cold.

I checked you in and spoke with you of your expectations of the proposed procedure.

I needed to make sure you were who I was expecting as I had never seen you before.

We had a little time together, you spoke of your wife and family waiting back in the ward.

You wanted to get into your garden with Spring now here, you were looking forward

to a life without pain, you had a lot you wanted to do, you had a holiday planned for later.

You spoke of your religion and faith in God, you appeared well informed and hopeful.

This was major surgery you were having, a lot of pre operative preparation and the next three or four hours on the operating table repairing your major artery, your life line.

The Anaesthetist inserted a needle in your vein and some saline was infused, soon the anaesthetic was started. I held your hand as the anaesthetising drug started to flow.

You gripped my hand tight and looked straight at me and said, “ Please stay with me won’t you?” I said as you were drifting off we were all there with you and would look after you.

I do not know if you heard me or not. Did you suddenly have a premonition of what was to come? Did you know you would not wake up? This is something we will never know.

Yes you died on the operating table, we the team worked so hard to keep you here but it was not to be. You arrested two hours into the surgery and your heart stopped beating.

Once the machines were turned off and the trolleys removed, it was so quiet, such a contrast to the business and bustle when we were working hard to shock you back to life.

I stayed with you until the police came, any sudden death being notifiable to the coroner.

I thought back to what you said before you went to sleep. The memories you had shared, the way you spoke so caring, of your wife who was so worried for you, and your family waiting for you to return home. Then I started to wonder did you know what would be?

I transferred you back to the ward on a bed, I had you draped in such a way that no one looking would realise. Your wife and primary nurse were waiting and we all went to the

side room. We stayed awhile and stood in silence around your bed. The air was heavy with the unspoken words. I could feel the support in the room for your grieving wife.

Your daughter arrived and we had a cuddle and a cry. You looked at peace, so serene. I left you in the care of your family. I felt I had carried out my commitment as you went to sleep. I sometimes still reflect back on what has passed and wonder in these situations.

But I could never leave someone alone once I had made that commitment to stay.

(1992).

From my current position

Over the past few years of my clinical practice many things have changed within the nurse's working environment. Nursing is constantly changing, reshaping and refocusing as new ways of treating patients are introduced. The clinical environment has also changed as technology has evolved and in most instances, improved patient outcomes and shortened their length of stay in hospital. Since the mid 1980s, the whole health system in New Zealand has come under the Government's focus as the allocated health money appears not to be delivering quality care to patients. Public hospitals have had to carefully scrutinize where the money has been spent on health care delivery, and nurses have found themselves often at the cutting edge of some of the changes that have been implemented.

I moved to a Charge nurse position at the onset of major changes to health care delivery with the introduction of the health reforms in 1993. It was from this unique middle management position that I became interested in the dynamics that were occurring with the Government driven directive to contain costs. The hospital management team attempted to retain the same services while implementing costs savings. The impetus was

to provide a cost effective quality health care service for the patient. My personal experience over these last few years has been implementing change which has been followed closely by introducing further change on the clinical environment. Through these changes, nurses who are at the edge of the effects from these cost driven efficiencies, appear to be adaptable, resilient and still remain focused on providing a caring centred service for the patients. This stimulated my thinking around nursing care and what it is that holds nurses together in these times of constant change. What is the important 'caring' care that still occurs and what hinders or enhances that caring in the working environment of these clinical nurses?

Working environment of the present study

In 1987 Arthur Anderson and Company put forward a document on "Public Hospital Performance Assessment." The objective of this report "was to review the performance and operations of New Zealand public hospitals, to quantify the expected improvements that could be achieved through better methods of clinical, patient and administrative management" (Arthur Anderson & Co, 1987, p. 1). The findings of this report were that higher productivity and greater efficiency could occur while working simultaneously with better equity, access, and a high quality public hospital system. The resultant efficiencies were mostly reflected in monetary terms. This report became known as the "White Paper."

The White Paper preceded a report of the Hospital and Related Services Taskforce, chaired by Mr Alan Gibbs. Mr Gibbs was Chairman of a number of New Zealand public companies which were engaged in a wide range of industries. He was appointed by Government to investigate the public health system. This publication, "Unshackling the Hospitals" (1988) looked at the entire public health system in New Zealand. The aim was

to ensure that hospitals contributed to the Government's broad health goals and that they assisted in achieving an improved health status for all New Zealanders. One suggestion made was that General Managers should be introduced to manage the health systems at a local level. It was proposed that this would provide clear lines of accountability and develop leadership. There would be a single point of reference for strategic planning, setting objectives, decision making, action and information. "This report drew attention to the fact that there was an appalling absence of relevant management information and costing throughout the present system" (Report of the Hospital and Related Services Taskforce, 1988, p. 40).

In 1989, under the leadership of the Labour Party, the Health Minister Helen Clark oversaw the transition from locally elected Hospital Boards to Area Health Boards, each with a government appointed general manager. This introduced a more business minded approach to the provision of health and health care services. Tighter controls were introduced on budget spending and areas had to furnish a list of items they wished to purchase over the following year. This was a change from previous years where areas asked for equipment and it was purchased for them with little renegotiation.

In 1991 Simon Upton's "Green and White" Paper was published which became the benchmark for the future health reforms in New Zealand. February 1992 saw the disestablishment of Area Health Boards. Commissioners were appointed by the Government to each organisation that previously had an Area Health Board. These Commissioners were to remain in that position until the transition from Area Health Boards to Crown Health Enterprises was completed which occurred on July 1st 1993.

The introduction of Crown Health Enterprises saw funding of hospitals moved from local control to regional control as four Regional Health Authorities were set up by government. Their function was to purchase health care and monitor performance in the

provision of health care services. Each individual Crown Health Enterprise had to contract to their controlling Regional Health Authority for the services that they wished to provide in their area. Hospitals, in effect, started competing for services and funding.

There has been much change throughout the local hospital environment with the impact of these health reforms. Day surgery was introduced and had its own dedicated area. However, some day surgery patients were still filtering through the wards. Another service originally run from the outskirts of town was relocated to a completely new site and building closer to the base hospital. Other wards which were used to specialising in similar classification of surgery were now completely mixed. Orthopaedic, Ear, Nose, Throat and Urology were together, General Surgery and General Medicine, then Paediatrics and Adult Surgery. The square footage of the hospital area was reducing as services were contracted out or eliminated. There was a general move to condense the patient services closer together and close areas of the old hospital building that were no longer required. Some services relocated or moved in to share office space or areas with others. Change was happening methodically, in an orderly coordinated fashion and was occurring in line with the funding available and the contracted services.

Flexibedding was introduced which meant patients sometimes did not have an allocated bed on arrival. Prior to or following surgery, a bed was arranged in the ward which had one available. This led to mixed feelings among nurses. Some had to upskill to cope with the different mixes of patients' conditions. Some felt the need to multiskill and there was an advantage for nurses who did this. There was now no straight surgical, orthopaedic, medical or children's ward. The wards were totally mixed, both with sexes and complexity of patients. Nurses on the floor were heard to say that they now felt they could not give the kind of care to patients that they would ideally like to. The patients were more acutely sick and day cases were admitted and discharged from another area. This

meant there were no simple case mixes to care for and the daily work load increased with the complexity of the ward mixes. Nurses were having difficulty meeting these extra demands and felt some patients were missing out on 'care'. There was added pressure on nurses to complete their work within the timeframes of their working day. They frequently felt exhausted following their shift.

I decided to look at the 'caring' care that nurses felt was really important to them as a professional nurse. By professional I understand this to mean a nurse who has undergone a formal nursing education and is registered, and who is able to put into practice those principles, theories and concepts of the discipline of nursing. I then wanted to take the project a step further and attempt to find out if there were issues with the nurses providing the 'caring' care that they had identified as important to their clinical practice. What helped or hindered that important 'caring' care? I really wanted to ascertain what was transpiring in clinical nurses' practice at the bedside of the patient. Were there issues that confirmed the underlying basis of these comments? Had I made a realistic assumption from what I had heard? I assumed nurses were experiencing frustration at being unable to deliver the kind of care to patients that they felt the patient should receive. Were nurses unable to deliver care to the patient in the clinical environment? If this was so, then what was preventing this happening? Were there enhancing factors occurring in the clinical environment? I really wanted to pursue these issues.

1.3 IS CARE WORTH RESEARCHING?

One thing leads to another

A decision was made to pursue care and look at the New Zealand perspective on the caring practices of clinical nurses in a public hospital. The subject of caring was raised among friends and work colleagues and ideas were discussed. This discussion helped formulate a research question and it was out of this process that the present research emerged. As I talked about my intending study with other friends who did not work in the health system, they asked why was I looking at something the public already knew?

The general impression I gained from my non-nursing friends was that nurses take care of sick people. They assist people who are unable to look after themselves and they look after people who have had an operation and need some specialised treatment. These are the doing or activity components of the profession frequently commented on by the public. This made me even more committed to my research in that there was definitely a need to make the 'caring' of nursing more visible and to define that 'caring' if at all possible. In this way I could ensure that people did understand the profession and be more informed about its focus.

I also felt that sometimes nurses themselves were unable to define what nursing is. However, in this instance perhaps it is because of the complexity of nursing, looking at nursing from within the profession. There are many different guises that professional nursing can take: cancer nursing, intensive care nursing, theatre nursing, psychiatric nursing, paediatric nursing, etc. They all have a different focus and discipline expertise of what and who they care about. There is, at their central focus or core, however, 'care' for another human being.

I support the notion that as a profession nursing should have a realistic and relevant definition for its focus. We have many nursing theories available which provide an

understanding of what it is we do, or how nursing is interpreted. The profession needs to progress forward, state what the focus of nursing reflects and proceed with that focus into the future. Research needs to be generated in clinical practice that reflects the central focus of the profession. Theories heighten our awareness of ways to think about individual practice and nurses are individuals in their approach to their practice. It is not sufficient to say that nursing is a caring profession and that nurses care. This then started me thinking around caring in clinical practice. What does happen in a moment of caring?

The following poem was written following a painful episode with a young female child who had been burnt and the burns had been skin grafted. The doctor requested a soak in a warm bath to allow the flaking skin and dead tissue to fall away. I was the one that had assisted most times when she required treatment in the unit and the one who she would look for and allow to care for her. We trusted each other. I never once said that the things we had to do would not hurt. I believe in honesty with children. I always stated what would happen, how I was going to go about whatever I was going to do and how I wanted her to assist me. Writing about this episode went some way in helping me accept the pain I had inflicted on this child along with her fear of soaking herself in water.

Your Pain Hurts me too

The day I first saw your legs
 my heart felt sick at what I saw,
 Your tender flesh so smooth and young
 Patched, blotchy, bleeding, lumpy, raw.

We cleaned your wounds to help them heal,
 it was just so painful for you to bear.
 The Anaesthetist gave you a “twilight” sleep
 your legs were redressed with extra care.

When you came back it was not so good,
 the Doctor took your dressings off.
 You screamed and screamed and screamed,
 was it the air or was it the thought.

I had to wash your legs with water
 in a shower or a bath.
 We filled the bath and striped you down.
 You screamed directly from your heart.

We tried to stand you in the bath
 you wanted, but did not want to,
 “Just a minute, don’t rush me” “O God
 why can’t I just die, I really really do want to.”

I tried to humor you. “You don’t have time”
 I said as you stood in the tub.
 “Not for long, Please don’t make it long”
 “OK Straighten your legs and I’ll give them a rub.”

“Don’t touch them!” “Then you touch them, look,
 see your old skin falling off in bits.”
 “Can I get out now?” “Just a little longer!”
 “I Don’t want this, **I don’t want this.**”

Suddenly your voice changed pitch,
 it didn’t feel so bad now.
 You did not want to be there, I know.

But you did it. Now it was time to get out.

I Lifted you out. "What do I do now?"

You said "How do I get dry?"

I gave a chuckle as we had both realised
we were in this together you and I.

As I gently dried you down

I talked you through, touching your legs.

Encouraging you all the way
to accept the changing you.

As your legs improve, and confidence returns

I hope your memory of the pain will fade
and be replaced by feelings of love and compassion
in our shared moments of a nurse's care.

(1998).

1.4 THINKING AROUND CARING IN PRACTICE

Thesis thinking and caring

It is not enough to say that nurses care. It is also evident that care is not a concept solely confined to the nursing profession. Other professions and individuals demonstrate care and this is realised, recognised and accepted. However, nursing has a particular style of caring and the way this caring is expressed within the profession is important. I also believe it is unique to nursing. It is this particular form of caring that I wish to research. The focus of this research is to identify the caring that is nursing, the caring that can be found in professional nursing situations.

When this thesis was commenced I particularly wanted to look at 'caring' care. This seems a double use of the same word. However, I will attempt to explain my

reasoning. I wanted the nurse participants to really think about the care situations that they practised, the care they enacted or provided to individual patients, the caring that really mattered to them and the response that emanated from the patient who was the recipient of their care. I wanted to stimulate some intense thinking around the care they identified as important. I wanted the participants to think and reflect on their practice with patients and to identify the more emotive perspective or the more internalised feelings each registered nurse experienced with each caring situation. Care by itself did not put the emphasis on what I wanted to research, and the use of the double care, I felt, emphasised and isolated that identified care a little more. It identifies particular perspectives of specific professional nursing care that nurses prescribe and practice individually with each patient.

Care and professional nursing practice

I personally do not believe that the word 'care' is used loosely within the practice of nursing, but it can and does take on different meanings. I believe that nurses communicate between each other and in the 'nurse talk' a particular reference to care immediately reflects meaning and understanding to the other nurse. I do feel that the inability to define the care that is specific to nursing has not assisted the profession. It has in some instances been detrimental as other professionals do not understand the underlying meanings of nurses' expressions of care. Care is a simple word that can have multiple meanings which perhaps is one of the reasons nurses have difficulty defining what care is. I believe nurses can and do define care. The meaning of care, however, does not connote shared understanding across occupations. I wish to move forward from this position and with this work attempt to identify nursing's specific 'caring' and attempt to create some shared understandings about what 'caring' care means.

Care: so simple to define

Caring was not easy to define, I discovered, when I went to put down a definition of care. There are diverse definitions and conceptualisations on caring. Therefore, it was important to take a stance and reflect this through the research. I had to settle on a definition that fitted with how I positioned caring in the practice of nursing. At this point it is important to state my personal definition, evolved through my nursing knowledge and assumptions, on what I perceive to be caring nursing in clinical practice. Caring for another is a commitment on the part of the professional nurse and this commitment has a professional basis and understanding. It has to be a contract between two people that has respect as a foundation that both parties work from. It is a sharing of a moment that respects both people in the caring encounter.

At the commencement of this study I was thinking about care in practice and wrote the following poem. This in some small way reflects my care in nursing and this will lead into focusing on the available literature on care.

All in a Day

There are times to care with times to share,
 a smile, a laugh, or silent tear,
 with someone who we never knew,
 when something shared does link us, two.

Every day there unfolds a different plan,
 we have no idea what each day could hold,
 as we start our shift and plan our work
 in anticipation of the patient's own health goal.

There is no other job that is quite like this
 with shared special thoughts and dreaded fears,

the hopes, the dreams, and the despair
and the grief when suspicions are finally real.

The unique, special times that nurses share
with patients, is very precious and rare,
the confidante, counsellor, and reassurer
that touches others in their moment of fear.

Each nurse embraces “caring”, and with
each new situation reaches out to share,
and embrace with knowledge and understanding
the core, and the essence of Nursing,

Care.

(1998).

CHAPTER TWO

THE CARING LITERATURE

2.1 LITERATURE REVIEW

Introduction

This literature review on care will initially demonstrate how I planned and then decided which literature would be most useful for this research study. The process I used to access then proceed through the available literature was firstly one of interest in the work readily available on caring. The general thoughts on care, which had initiated my first question, “What do registered nurses identify as caring care,” was an attempt for me to look at what other nurses had written on the subject. I realised that care was certainly not easily definable and this became obvious in the way others approached the topic. As background reading I located the work of Roach (1987) and Watson (1979; 1985). I found these publications most beneficial. This I would call ‘getting a feel’ for the subject, to discover what major nurse theorists and authorities had written about care. It was not until after the data analysis that I concentrated more on work that had been published on and around care and caring in other nursing publications.

There are many ways that nurse theorists and researchers have demonstrated how care occurs, as they have tried to define care that is unique to nursing practice. The first section of this review contains an introduction on how the search was initiated and how it proceeded. Following this will be a section on caring literature which looks at what other nurses have produced as their contribution to this ongoing and continuing body of knowledge on care. New Zealand nurses have also contributed to this developing body of knowledge and these contributions will also be reviewed in this section.

This will then be followed by a look at the work of a selection of the major contributors to the caring literature, who have published major works and are considered authorities on the concept of care. These include such world renowned authors as Sr Simone Roach, who made a profound impact in the literature on care with her publication "The human act of caring: A blueprint for the Health Professionals" (1987). Professor Jean Watson initiated the Center of Human Caring at the Nursing School in Denver Colorado, to study the phenomena of human care and caring in nursing. Watson published two books on the theory of caring in nursing (1979 and 1985) and has contributed many articles on care for other nursing publications. Dolores Gaut and Madeline Leininger published presentations from the twelfth and thirteenth World Caring conferences. Finally I will introduce those authors who have focused their work on understanding humanistic caring. This reflects on the human to human approach in nursing by exploring and expanding this relationship in its human context.

Literature search

Caring is widely considered to be central to, or the 'core', of nursing practice (Fry, 1988; Forrest, 1989; Bottorff, 1991; Kurtz & Wang, 1991; Swanson, 1991; Mckenna, 1993; Wilkes & Wallis, 1993; Fealy, 1995). Allmark (1998), refers to care as the heart of nursing. It became apparent as I started to search through the literature on care, that caring in nursing has only been evident in the research literature since the 1970s. Over the past decade caring has gathered considerable momentum as a subject of research. As there were many publications available on care in nursing, it was not possible to look up every available source. Therefore, I had to define early what literature I was going to pursue. I had my own ideas of what aspects of care I wanted to centre my research on. Broadly speaking, this was care in relation to registered nurses working in a public hospital

environment. I did, however, remain open minded about the care that had been researched and as I read the literature I asked myself if this article would be relevant for my study. This restriction of the field was important as it enabled me to negotiate the literature in a manageable way.

As I continued reading the literature, I discovered that some authors were stating that care in fact had been poorly researched. Forrest (1989), stated there was a lack of research on what the experiences of caring were for nurses. However, in my experience of reading the available literature, more articles were appearing in the 1990s looking into the phenomenon of care from the perspective of the nurse (Bottorff, 1991; Clarke & Wheeler, 1992; Dyson, 1996). Where in-depth qualitative and quantitative research has been conducted, the research is still relatively scarce considering there has been a ground swell of understanding that recognises that care is in fact at the heart of nursing practice. However, despite its central function in nursing, care remains a poorly researched area in nursing practice (Morrison, 1989). More recently Warelow (1996), raised a similar concern when he inferred that care in nursing was still “ill-defined, narrowly focused and incomplete” (p. 655).

What nurses say

Care articles do permeate the nursing literature and from the 1970s the literature on caring has gathered momentum as nurses have attempted to label the care that is nursing. Some nurse authors have tried to define what it is that nurses do when they ‘care’ for patients. Others have attempted to explain the caring situation. There are other nurses and nurse researchers who have written about what care involves. Others speak of caring attitudes, caring behaviours, caring tasks and what it means to care for patients. Nurse

theorists have also made contributions related to cultural care, environmental care and human care.

McCance, McKenna and Boore (1997), attempted to clarify the meaning of caring in nursing using a method of concept analysis. They stated that, “caring is a difficult concept to define and has been viewed from varying perspectives within the literature” (p. 241). The final outcome of the concept analysis was to make clear the meaning of caring in nursing. This resulted in, “the identification of four critical attributes of caring - ‘serious attention’, ‘concern’, ‘providing for’, and ‘getting to know the patient’. Furthermore, ‘amount of time’, ‘respect for persons’ and ‘an intention to care’ were identified as the antecedents of caring” (p. 247). All these attributes are vital for any caring encounter between nurses and patients.

Swanson (1993), writes on nursing as informed caring for the well being of others and uses the work of Benner (1984) to explain informed caring. In essence caring is informed from nursing knowledge and past experiences and becomes embedded in the nurse’s response to caring situations. Swanson also infers that in fact all nursing situations may be characterised by caring. This is how I understand care to be, an informed care that is a response to a caring situation. Swanson attempts to set out a structure of caring which reflects back to her earlier work when she wrote about a middle range theory of caring in 1991. She states that:

[M]aintaining belief is at the base of nurse caring, knowing is the anchor that moors the beliefs of nurse/nursing to the lived realities of those served. Knowing is striving to understand events as they have meaning in the life of the other. It involves avoiding assumptions, centering on the one(s) cared for, thoroughly assessing all aspects of the client’s condition and reality, and ultimately engaging the self or personhood of the nurse and client in a caring transaction.

(p. 355).

The nurse must maintain a belief in care which is at the base or foundation of nurse caring. Knowing and understanding that caring is the anchor or weight that holds fast that belief as the nurse and the patient live the realities of the caring experience. Nurses must believe in their caring to be able to fully access and engage in a caring transaction.

Two caring reviews

Two major literature reviews were accessed on caring (Kyle, 1995; Lea & Watson, 1996). Both determined that there was considerable written material available on caring in nursing. Kyle (1995), looked at the concept of caring in the literature and stated in her introduction, "Despite the strong association between nursing and caring, relatively little attention has been directed toward the study of care" (p. 506).

As I reviewed the available literature I too found little evidence into the actual study of care as it pertains to nursing practice. Her review highlighted caring as a complex phenomenon involving more than a set of caring behaviours. In my opinion the literature on caring can be quite confusing, as different authors take different stances and different aspects of care are considered important. It is dependent on where the researchers have directed their focus as to whether they understand care to be a behavioural trait, a task, an action or a relationship. Kyle also found that researchers had used qualitative approaches which have been criticised for the subjectiveness of the methods, mainly due to the researcher as instrument. Kyle suggests that qualitative method should be the preferred method when investigating care to enrich the descriptions of the phenomenon of caring.

Lea and Watson (1996), reviewed a selection of the literature on caring research and concepts. The purpose of their review was, "to provide a theoretical background for the development of an inventory which could be used to investigate perceptions of caring among nurses" (p. 72). These researchers found that the literature on the history of caring

dates back 30 years. I assume that nurses were starting to become more informed and to do further study into their practice as they gained undergraduate and postgraduate university education around this time. This resultant change in focus on nursing education and the availability of nurse educators, I believe, has encouraged student nurses to utilise research. Nurses began to write about their caring in practice and started to research nursing issues which were relative to their practice. Nursing research began to gather momentum. Nurses attempted to qualify care and demonstrate how care happened in the practice environment. These explanations considered caring behaviours, actions, relationships and commitments. Lea and Watson (1996), state in their writing that caring is a complex phenomenon that lacks clear definition and which can be conceptualised in a number of ways. There was also no consensus about the place of caring in nursing and the different perceptions of caring have encouraged the application of a wide range of qualitative and quantitative research methods.

A more recent study by Lea, Watson and Deary (1998), looked at caring in nursing through a multivariate analysis. This work stated that caring and nursing defy precise description and this undoubtedly contributes to the difficulties in defining the relationship between them. Fealy attempts to characterise professional care by explaining the moral aspect of caring. He states, “caring as *Praxis* guided by *phronesis*” (1995, p. 1137). Here Fealy infers that praxis is a form of ‘doing action’ which is morally committed.

The Aristotlian concept of praxis is one in which deliberation, practical wisdom (the Aristotlian notion of phronesis) and action are linked by judgement (ie reasoned action) in a way that seeks to pursue the human good (Carr, 1987) and it offers a useful way of characterizing contemporary nursing as expressed in professional caring. Professional caring differs from everyday relationships in that the relationships are established on a more formal basis....professional caring shares many of the characteristics of caring in the generic sense and of non professional caring, yet it's moral dimension renders it a separate, specific and identifiable form of caring.

(p. 1140).

There are times when the dynamics within hospitals act as counterproductive forces to caring. Holden (1991), raises this issue in her publication when the issue is raised about who cares for the carers? “The hospital environment is unequal to the task of caring for the caregivers, because it is permeated with ontological, spiritual and moral anxiety, yet all of which act as serious impediments to the caring enterprise” (p. 893). I was drawn to this statement that refers to caring for those who care for others and although I will raise this here, it will be further referred to in the discussion chapter. As previously discussed, the health reforms did impact on the clinical practice of these registered nurses. For Holden to say that the hospital is unequalled to the task of caring for the carer made me realise that perhaps the hospital environment is unable to provide a caring workplace for nurses in which to function. Therefore, how do nurses working in the hospital setting care?

Further literature contributions to caring in nursing

Kathryn Gardner (1992), affirms that a major factor that has influenced nursing’s progress toward professionalisation is its association with caring. Gardner also remarks “that nurses who were attracted to emphasizing caring quietly implemented these practice activities, turned to other non traditional settings to practice nursing or left the profession entirely” (p. 241). I believe this may have always been the case with nurses in that when they perceived they were unable to provide care the way they wanted, they left the profession. Lysaught, (cited in Gardner, 1992):

[V]iews caring as the epitome of nursing also points out how quickly it is stifled by other demands on nursing. The increased use of technology, the bureaucratic institutional constraints, the force of cost saving in health, the subservience of nursing to medicine, and, at times, the lack of accountability in nursing are several pressures which threaten the placement of caring as a priority in nursing.

(p. 246).

It would appear that sometimes the cost saving in health does take priority over care and care can be stifled by other seemingly more important demands on their nursing. It appears that other authors have also viewed the institutional constraints as a threat to the provision of care. Gardner (1992), proclaims “Nurses need to reestablish caring as a central characteristic of professional nursing and place it in a scientific perspective or they need to disassociate themselves from their previous embodiment as a profession” (p. 247). It is clear that Gardner would prefer caring to become a central characteristic of professional nursing. I would prefer that care is placed as a scientific perspective central to the focus of the nursing profession. She further goes on to say, “until recently caring has not been seen as a field for scientific inquiry. There has been little professional incentive to study caring” (p. 249). I consider that this has possibly led to the absence of a field of scientific inquiry in caring and the lack of professional incentive to study care. However, Watson in 1985 set down a theory of care in nursing and has referred to this as a human science of care. As Gardner does not refer to the work of Watson does she not perceive it to be a field of scientific inquiry? I support the theory of Watson. As a theory of human science it may not adhere to the rigid rules of a hard science. However, I believe Watsons theory does reflect a naturalistic inquiry. Gardner does however, realise caring is important when she states “if it is accepted that caring is essential and central to nursing, then it follows that nursings’ primary attention should be focused on the practice, study and teaching of caring within the nursing content” (1992, p. 251).

Clifford (1995), speaks of formalized caring in a paper she titled “Caring: fitting the concept to nursing practice.” She suggests it may be more appropriate to define caring in nursing as formalized caring.

In acknowledging a formalized caring role it is recognised that nurses will be personally involved in helping those for whom they are responsible. Within that role nurses will endeavour to meet the needs of the whole person from a humanistic perspective with compassion and empathy. In

such a role, however, claims will not be made for a unique caring role that cannot be fulfilled in the reality of everyday practice in nursing. In a formalized caring role nurses are seen as fulfilling a social role in society, responding to an identified need for health care.

(p. 40).

Nelms (1996), believes that nursing research is a caring act, because nurses choose to study and understand those things about which they care. Nealm's research methodology used the narratives of nurses to understand the truth about caring. This study utilized a Heideggerian hermeneutical analysis to interpret various nurses stories of practice. In this research, the essence of nursing was revealed in the being and doing of nursing and concluded that "nursing's provenance, its origin and source, is caring and as such is its own reason for being" (p. 373). This, as explained earlier, has been the central thrust of my own belief about nursing and I found the following statement by Hawthorne and Yurkovich (1994) reinforced this notion:

When nurses know who they are and where they are going, they will be clear about their purpose. They will acknowledge caring as the essence of professional nursing. They will acknowledge caring as essential to humanity. They will understand that caring is a way of giving meaning to life, theirs and the people they help.

(p. 51).

It is imperative that caring needs to be a priority in nursing research. Research methodologies need to study the many facets of caring as an art and a science. There are diverse definitions and conceptualisations on caring. Therefore, it was important for me to take a stance and reflect this through my research. After looking at the writings of international authors I pursued the New Zealand literature only to discover that within the local scene there were not many contributions to the literature. I too would ask that if care in nursing is a central component and the core of nursing then why is there not more writing about it and contribution to the refinement of this most important concept? Do nurses understand that caring is a way of giving meaning to life as Hawthorne and

Yurkovich state? Does it give meaning to the life of the nurse and the patients that they help? It was as I continued to read the literature and ask myself these questions that I identified there was a need to recognize the caring in nursing.

New Zealand nurses contribution to the literature

Euswas (1991), a nurse from Thailand studying in New Zealand at Massey University, researched caring in nursing practice using a grounded theory study. The actualised caring moment was explained as “the nurse and the patient’s peak experience of real caring which occurs at a specific point in time” (p. 142). At a given point the nurse and the patient recognise the giving and receiving of care. Euswas primarily researched patients with a terminal illness. The research outcome produced a conceptual framework which explained the holistic dynamic process whereby nurses translated caring into nursing action. These actions assisted the patient to potential well-being or peaceful death. The theory described the human lived experiences of caring. This research aligned with some of my thoughts around caring in nursing practice.

Other published papers were not in-depth research projects from the field, but were written as exploring the issues of care. Hodge (1993), listened to and talked with nurses about caring practices and the ethical issues they faced. This work concentrated around the work of Watson and focused on an ethic of care. It also included the ethical perspective and understanding of nursing ethical dilemmas of practice. “Uncovering the ethic of care,” as this paper was titled, concluded by stating, “Nurses must be able to articulate their position on moral issues, and it seems that nurses will be most able to do this if situations are considered in a context of care” (p. 22). Nurses do have to confront moral and ethical positions in their working environments and I support this statement. I will discuss some of these moral issues in chapter four.

Squires (1994), wrote on “Defining care” and concluded her presentation by stating that nurses “must take pride in knowing that caring binds us together in this society and that human beings, by caring, are linked together as one great culture in this world” (p. 22). Society must be a caring culture and when we care we are invisibly bound and take pride in the combined achievements and successes of the profession.

Wilson (1994), asks if care is a superior ideal for nursing? This paper investigates care in the literature firstly by asking the above question followed by asking if care is a womanly virtue? Wilson then looks at care as an integrated ethic and then caring in practice. She states that “the caring theorists have done nursing an immense service in raising these issues but the journey to delineate nursing continues” (p. 10).

Dyson (1997), explores the concept of an ethic of care. Dyson recognises that caring has long been associated with and important to nursing practice, and in this research she uses the literature and her own personal perspective to demonstrate meaning of an ethic of care. She also concludes that further research and dialogue are required to clarify the meaning of an ethic of care. I have used an ethic of care in clinical practice and will refer to this later in the chapter.

Making a directional choice

I have had an interest in caring for some time and have read extensively in the literature around this topic. I chose for the purposes of this study to put my thoughts on caring to one side as I did not want to commence my research with this knowledge to the forefront. Instead, I wanted to focus on what the nurses involved in this study considered important to their clinical practice. Once this was identified, I then planned to undertake a literature search around the ‘caring’ care they identified, to find if similar or dissimilar factors had been recognised nationally or internationally. I did not want to influence the

findings in any way and wanted to limit the extent to which the participants could be influenced by any preconceived thoughts I had on caring. However, my research question was influenced by nurse theorists who have focused on caring. In order to track with these influences throughout the research process, I recorded my personal thoughts on caring by writing in my journal and composing poetry. I found that this process clearly identified the participants' voices and my own voice had its own place. My reflections in poetry are used in this thesis. In the next section of this chapter I will introduce the nurse theorists who have influenced my thinking on caring in nursing.

2.2 THE MAJOR WRITERS ON CARING

Major contributors to the 'care' literature

The most influential literature that I have found helpful to look at caring in nursing has been the work of Benner and Wrubel (1989), Roach (1987), and Watson (1979), and the material that has come out of the Human Caring Conferences edited by Gaut and Leininger (1991), and Gaut (1992). I have also included Van Hooft (1987) as a valuable contributor to my work.

Benner and Wrubel (1989), claimed that caring was primary in the relationship between caring, stress and coping, and health. Benner and Wrubel speak of caring as a basic way of being in the world. Their work uses nurses stories from practice to demonstrate care situations and the relationships that occur in practice. The authors wanted to illustrate the power, challenge and stunning human victory when the difficulties of practice are met with a caring intent. The stories told are too lengthy to include here, so it is better they be read in their fullest context to maintain meaning. However, I have selected one small example to demonstrate one of the caring situations.

This nurse, concerned for the patient for whom she was caring, continued to persist in questioning the physician's treatment and assessment of this patient. The patient's condition appeared to demonstrate signs of a classic case of pulmonary emboli. The nurse relayed her story;

Some patients complain a lot. He didn't. He was just very hopeful that something would be found, that he would feel better. I don't know what engaged me, but I got very engaged. I think that I got engaged in his struggle to be independent. His determination not to be dependent even in the face of these terrible surgeries and having to be tube fed. He wanted someone there. He kept pulling me back. So I decided to stay.

(p. 95).

Benner and Wrubel (1989), go on to say that,

[C]oncern is a way of caring about patients. Concern determines salience and is the basis for gaining knowledge that is both generalizable and specific. Concern is caring, and without caring there can be neither cure nor comfort.

(p. 96).

Their work illustrates some powerful situations that allow nurses to demonstrate their caring work. Such examples were captured from nurses describing special caring moments experienced with patients in challenging situations, similar to the given example.

Roach (1987), is one of the recognised authorities on care. She states:

There are obligations which are not experienced as forced on us ... devotion is a convergence between what one wants to do, and what one is supposed to do. Caring seems to place such value on the other, the task at hand, the challenge ahead, the immediate demand on time and energy, that the dividing line between wanting to and being obligated to tends to disappear.

(p. 14).

This occurs in nursing situations where it may be preparing someone for theatre, or preparing them for discharge home following surgery. The obligations are not forced on the nurse as the nurse knows what must be done for the patient to cover safety and ethical requirements. Caring does place a value on the other, the patient, which the nurse meets by

ensuring that the patient is provided with the nurse's time and energy. The line between wanting to, and being obligated to, does disappear in addressing the requirements of that individual patient with the resources that the nurse has. The nurse provides that patient with the optimum care that is possible to provide. This is related to a further statement by Roach who describes the relationship of the importance of nursing theory and the practice of nursing:

Theory development was perceived as a process by which nursing becomes a science and a special way of human caring. From psychoanalytical and philosophical points of view, caring is called forth and necessitated by the natural state of the human person; caring is considered an essential ingredient in human development and survival. Caring suggests a place, providing meaning and order to our life qualifying relationships with the other and subsuming the characteristic of devotion - a convergence between desire and ought.To be is to care.

(p. 19).

Roach further refers to care and affirms that "the capacity to care needs to be nurtured, and such nurturing is critically dependent on its being called forth by others" (p. 5). I believe this to be necessary and that the specific care inherent in nursing does need to be nurtured with other nurses and health professionals recognising and valuing that caring. This then ensures that it has primacy in the clinical setting. The capacity to care is critically dependent on it being respected and accepted by others, because if it is not nurtured, and considered valuable and recognised as such, it will become meaningless. Roach (1987), makes a further statement about nursing and caring, in which she makes clear how care is considered unique to nursing, when she states that:

Caring, rather may be considered unique in nursing. Within nursing itself, the concept caring is unique in that it alone embodies certain qualities, or it exists as the sole example of specific characteristics. ... the attributes used to describe nursing have their locus in caring.

(p. 47).

Roach is inferring that there are single examples of caring in nursing that have specific characteristics that will only be found in nursing situations. This caring is therefore unique to nursing and she follows through on that to professionalise caring in nursing as an essential duty and a challenge for professional nursing. To professionalise the unique caring in nursing would mean that it is then understood that nursing is aligned to the human mode of being and a profession of human caring. "The essential task and essential challenge is to professionalize caring. The professionalization of human caring entails as its first imperative the affirmation that caring is indeed the human mode of being" (Roach, 1987, p. 48). The work of Roach reflects the Humanistic approach to care which will be further referred to in chapter two on Humanistic care (p. 45) and in the discussion in chapter four.

Gaut (1992), edited the papers presented at the thirteenth annual caring research conference. Two presentations in this work especially made an impact on my thinking. Firstly Eriksson (1992), in her research into "Nursing: The Caring practice "Being There"" speaks of caring communion. Eriksson found that caring arose "from an emotional ability, an ethical motive, and a willingness to do something special" (cited in Gaut, 1992, p. 208). The second author Dietrich (1992) stated that "little attention has been placed on understanding the concept of caring in nurse - nurse interactions in the work environment, the settings where the art of nursing is practiced" (cited in Gaut, 1992, p. 69). There has in the past been little understanding placed on the interactions of caring in the working environment. Therefore, I hope to heighten some awareness of some of the issues with the present research.

Gaut and Leininger (1991), published as editors the papers which emerged out of the twelfth annual caring conference. They state:

Human care as the essence of nursing and the distinct, central focus, and coherent dimension of nursing has, at last, become our major focus. The

importance of this development cannot be overlooked. In helping nurses to discover and value the significance of care, it has also helped in establishing and maintaining care as central to the discipline and profession of nursing.

(p. xiii).

This statement reflects the way I consider care in nursing and it does reflect care at the central core of the discipline. It follows on to a statement by Roach (1991), who was a contributor at this conference. She states:

As a human mode of being, caring is not unique to nursing in the sense that it distinguishes nursing from other professions, Rather, caring is, unique in nursing as the concept which subsumes all the attributes descriptive of nursing as a human, helping discipline. Nursing is no more and no less than the professionalization of the human capacity to care through the acquisition and application of the knowledge, attitudes, and skills appropriate to nursing's prescribed roles.

(cited in Gaut & Leininger, 1991, p. 9).

The care in nursing is unique and it has attributes that are descriptive and identify nursing as a human, helping discipline. Nursing's prescribed role of specialised knowledge, skills and attitudes identifies professional nursing to have the human capacity of a humanly caring profession.

Dombeck (1991), another contributor in this publication looks at "Conscience and Consciousness" and her presentation reflects how nurses frequently find themselves in practice situations. Nurses want to practice holistically but must realise that humans frequently work by different rules and everyone has a different perspective of priorities and values. Therefore, nurses need to be conscious of the desires of each patient for whom they are caring and must not impose personal ideas of care on the other if it is not what the other wants. She makes the following statement:

It is our emic reality, and one that we, as nurses, have to contend with constantly. Even though as human beings we experience ourselves as whole, and as nurses we want to practice holistically, as persons in Western or industrialized societies we find ourselves with persons and systems, including our very thoughts and linguistic processes, that make us engage in dualistic, mechanistic, objectivistic or subjectivistic ways of seeing others

and ourselves. While we proclaim our holism, we often experience ourselves as fragmented in our own contexts.

(Dombeck, cited in Gaut & Leininger, 1991, p. 23).

This I believe to be very much a part of the nurses clinical practice and the reality of the current working environment. Patients are valued for their individuality and treated holistically. However, sometimes the nurse may perceive the experience of the care given as disjointed and fragmented leaving the nurse with feelings of personal dissatisfaction.

Watson (1985), constructed a theory of caring which attempted to fit caring in nursing into the realms of a science. Her work demonstrates and explains this theory which is valued as a nursing resource. It has provided nurses with a dimension of their reality in practice, legitimising the acceptance of a seemingly simple concept not readily understood outside the profession. Human caring is very much part of the care of nursing. Watson infers it to be the moral ideal, whereby the end product is protection, enhancement and preservation of human dignity. "Human caring involves values, a will and a commitment to care, knowledge, caring actions, and consequences" (Watson, 1985, p. 29). Watson identifies a deeper more intense caring that is involved in a caring encounter and proposed a Transpersonal care theory. She states:

Transpersonal human care and caring transactions are those scientific, professional, ethical, yet aesthetic, creative and personalized giving - receiving behaviors and responses between two people (nurse and other) that allow for contact between the subjective world of experiencing persons (through physical, mental or spiritual routes or some combination thereof). The human care transactions include the nurses unique use of self through movements, senses, touching, sounds, words, colour and forms in which he or she transmits and reflects the persons condition back to that person.

(p. 58).

As a practising nurse I do believe there are instances where this caring is possible. It cannot, I believe, be accepted as a way that nurses can approach each caring moment. There has to be a deep understanding relationship that makes this caring a possibility.

Watson (1985), in her theory of caring proposed ten carative factor for nursing which are:

1. *The formation of a humanistic - altruistic system of values.*
2. *The instillation of faith - hope.*
3. *The cultivation of sensitivity to one's self and to others.*
4. *The development of helping - trusting, human care relationships.*
5. *The promotion and acceptance of the expression of positive and negative feelings.*
6. *The systematic use of the scientific problem - solving method for decision making.*
7. *The promotion of interpersonal teaching - learning.*
8. *The provision for a supportive, protective, and / or corrective mental, physical, sociocultural and spiritual environment.*
9. *Assistance with gratification of human needs.*
10. *The allowance of existential - phenomenological forces.*

(pp. 9 & 10).

Watson's carative factors are all presupposed by a knowledge base and clinical competence. These factors were developed from humanistic philosophy, central to caring for another human being and founded on a growing scientific base.

Watson has made a major contribution to the understanding of the phenomenon of caring in nursing. Her original work published in 1979, set down a foundation where nurses could now relate to their practical work, and begin to understand the caring that is inherent in the diverse fields of clinical nursing. As Watson (1979), stated at the beginning of her original publication:

Professional nursing requires a grounding in a humanistic value system that the nurse continues to cultivate. The humanistic value system must be combined with the scientific knowledge base that guides the nurse's actions. That humanistic - scientific combination underlies the science of caring.
(p. 7).

I agree with this statement and believe that the science of caring does have a scientific and humanistic knowledge base that guides each nurse's actions.

One other author whose work influenced my thinking, was Taylor (1994), who looked at nursing practice and although this work did not specifically focus on care as such,

care was referred to as part of the ordinariness of nursing. The humanness of personal encounters are what makes nursing therapeutic.

Those nurses who are able to acknowledge and value their own humanness in their own professional lives bring a special gift to people in caring contexts, because they bring themselves as knowledgeable and skillful humans who are able to transcend the professional inhibitions of their roles to be 'just themselves'.

(p. 4).

There are nurses who display their clinical practice as effortless, although to other nurses it would appear stressful and demanding. These nurses choose to work in selected practice areas and are comfortable within their working environment, for example intensive care, coronary care, paediatrics, neonatal, operating theatre and oncology nursing specialties to name a few. These are the nurses who I believe accept their own humanness and are totally committed and comfortable with their chosen profession and although it may be stressful and demanding the nurse enjoys the clinical challenges. I will refer more to the work of Taylor in chapter four.

Other publishers who have contributed to the literature

Two authors who have contributed to my understanding of care, although their work is not specific to the nursing context, are Van Hooft and Mayeroff. Van Hooft (1987) in the opening pages of his work states:

Though the roots of civilization and modern medicine were founded upon caring as a means for both survival and treatments, there is increasing uncertainty as to whether logic, moral reason, or science can relieve us of the dilemmas our world now faces.

(p. ix).

There is a moral obligation that professional nurses do perhaps unconsciously relate to when they care for patients. I personally believe in a nursing ethic of care and have published an exemplar from my own practice relating to this concept (Blair, 1998). In this

work I referred to the eight essential components of care that have been described by Mayeroff (cited in Carper, 1979).

1. *Knowledge that is both general and specific.*
2. *Alternating rhythms....being able to maintain or modify behavior.*
3. *Patiencein which there is a sense of the other's own time and style.*
4. *Honesty.... being open to oneself and to the other.*
5. *Trust involves the appreciation of the independent existence of the other includes an element of risk and a dose of courage.*
6. *Humility....involves continuous learning and an awareness of the uniqueness of each new situation. It includes an acceptance of dependence and an awareness of personal limitations.*
7. *Hope as an expression of a present alive with possibilities and plenitude..... Hope implies that there is or could be something that is worthy of commitment.*
8. *Courage makes risk taking possible, which carries one beyond safety and security. But it is not blind. It is a courage informed by knowledge, by past experiences and by a trust in one's own and in another's ability to grow.*

(pp. 14-15).

When I related these components of care to clinical practice, I was attempting to understand my actions in the given situation. I had retrieved an intact foetus from a kidney dish of blood. I cleaned and placed the foetus in a gamgee square for the surgeon to show the parents. The ruptured ectopic pregnancy had almost cost the young woman her life and I understood the young couple were grieving for the loss of this pregnancy. I believe I was behaving in a caring way to benefit the young couple. Van Hooft (1987), relates:

To find something important is to make it apt to be acted upon. If caring, in turn, is linked to finding something important, then it follows that caring is inherently practical. If we care for someone or about something, then we are apt to act, as occasion demands, in pursuit of the benefit of that which is cared for. Merely being affected by the well being of those objects is not sufficient. One must be inclined to act. This is the significance of my calling caring, a motivation or a motivational orientation.

(p. 36.)

A commitment is essential to another who has need of some assistance. As a nurse I responded to that identified need by motivating myself into some form of action. As Van Hooft (1987), says "It follows that caring and commitment are intertwined. Just as the test

of commitment is action, so the test of caring is action.” Of the person caring he states that “one must be practically committed” (p. 37). Nursing is a practical profession that focuses on people with a need of some assistance. These people are human therefore I assume that the commitment to care for another is presented in a humanistic way.

2.3 HUMANISTIC CARING

What is humanistic care?

It is sometimes difficult to put into succinct words what it means to provide humanistic care. It was therefore better to set it out in the words of an expert from the field. Caring is an essential expression of a human to human connectedness. Boykin and Schoenhofer (1993), who published “Nursing as Caring; A model for transforming practice,” discuss the humanness of caring in nursing:

Nursing knowledge is knowledge of nurturing persons living caring and growing in caring within shared lived experiences in which the caring between nurse and nursed enhances personhood. Furthering nursing knowledge requires methods that can illuminate the central phenomenon of the discipline.

(p. 96).

Nurses do share lived experiences with those they care for. Nursing is informed by nursing knowledge that does nurture care and through the experience there is the potential to grow with the shared caring experience. In this work Boykin and Schoenhofer speak of developing a theory of nursing as caring and define this as:

[A]n understanding that the focus of nursing, both as a discipline and as a profession, involves nurturing of persons living caring and growing in caring. In this statement of focus, we recognize the unique human need to which nursing is the response as a desire to be recognised as caring person and to be supported in caring.

(p. 22).

They do say that to practice within this framework the nurse has to make a deliberate commitment to develop this knowledge of Nursing as Caring. They suggest ways to achieve this and offer the following advice:

[A] methodology that would permit the study of nursing meaning as it is being co-created in the lived experience of the nursing situation. The developments of methods of nursing inquiry appropriate to the study of the theory, Nursing as Caring, is in a formative stage.

(p. 97).

It would be ideal to focus research around the lived experiences of nurses working in nursing situations. For those that believe that nursing is a caring profession and has caring as its central focus, this research would be welcomed.

Of nurses, Roach (1987), states that there is a challenge to education for the caring professions. Her belief being that people choose certain professions because they want to help or care for people. Professionals exist because a need is perceived by society for those types of services. Roach speaks of professional nursing as:

[T]he premise that caring is intrinsic to humanness; that caring is the human mode of being. The challenge involves the task of professionalizing the desire and the human capacity to care ... what the professional does for him or herself is to become authentically human through the human act of caring.

(p. 131).

It is imperative that when a caring theory emerges that focuses on the shared experience, that is the moment of care between two individuals in clinical practice, it should then be taught to future professional nurses. This way the essence of professional nursing permeates the nurses knowledge from the commencement of their education. The acceptance of a theory of care as pertaining to nursing would then provide a more defined focus. There would be consistency on what caring in nursing is. If there were to be an acceptable theory of caring specific to the discipline of nursing it would then be less confusing for nurses to explain the care that is inherent in nursing.

Humanistic caring reflects my way of understanding the care that is specific to nursing and how I understand care. Watson's writings on caring came out of a humanistic framework and a humanistic framework of caring resonates with how I distinguish caring in nursing. Watson (1985) states that:

Human care and caring requires a personal, social, moral and spiritual engagement of the nurse and a commitment to oneself and other humans, nursing offers the promise of human preservation in society. Caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity. Human caring involves values, a will and a commitment to care, knowledge, caring actions, and consequences. All of human caring is related to intersubjective human responses.

(p. 29).

I maintain there has to be a commitment to respond to another in a human way. Through the literature were other authors who in their work have reflected humanistic care.

Literature on Humanistic care

From what I have read on the concept of care there is no doubt that the concept of caring does have a profound effect on nursing practice, education, philosophy and research. I believe that the majority of nurses would be humanistic in their care and as supporting evidence I have selected comments that have been written by some nurse authors to demonstrate this.

Squires (1994), a New Zealand nurse concludes her paper with "Nurses must take pride in knowing that caring binds us together in this society and that human beings, by caring are linked together as one great culture in this world" (p. 22). I would understand that in this statement Squires is demonstrating the principle of humanistic care for all world societies.

Swanson (1993), who proposes a structure for a theory of caring, states "caring as grounded in maintenance of a basic belief in persons, anchored by knowing that the others

reality, conveyed through being with, and enacted through doing for and enabling” (p. 357). With this statement of caring, Swanson believes it is important that caring be established in persevering a belief in people. By believing in people, which is believing in another human, you get to know the reality of that other person. To have achieved this it is important to have established a relationship of knowing and trust with the other. Believing in people is to have an understanding of human nature and the importance of relationships to any concept of caring in a human way. Griffen (1983), states that “caring is a fundamental concept both in the philosophy of human nature and that of personal relationships” (p. 289). This brings me to a comment made in Benner and Wrubel (1989):

Nursing is a metaphor for intimacy. Nurses are involved in the most private aspects of people's lives, and they cannot hide behind technology or a veil of omniscience as other practitioners or technicians in hospital may do. Nurses do for others publicly what healthy persons do for themselves behind closed doors. Nurses as trusted peers, are there to hear secrets, especially the ones born of vulnerability. Nurses are treasured when these interchanges are successfully, but most often people do not wish to remember their vulnerability or loss of control, and nurses are indelibly identified with those terribly personal times.

(Fagin & Diers, cited in Benner & Wrubel, 1989. p. 257).

How true this statement is and how appropriate. This is a reflection of humanistic nursing. Nurses are trusted by patients and in the formation of these relationships the nurse is unable to hide. The nurse is exposed more frequently to the patients than any other health professional. Nursing is the only health service that is available on demand at the patient's bedside 24 hours a day. Often patients do not wish to remember their most vulnerable moments and nurses choose not to remind patients of these times.

Caring is done by humans who are subject to the range of human feelings and failings. Nurses should be encouraged to speak about all, not just some, of these thoughts and feelings about nursing. When they are allowed the inward pleasure of being honest, individuals grow and contribute to the collective maturity and wisdom of their profession.

(Macdonald, 1993, p. 30).

Macdonald has made an important statement here. How many times do nurses repress their feelings and emotions? Nursing is a profession that covers the lifespan from birth to death. It is a human occupation of life experiences for both the nurse and the patient. There are good experiences and there are traumatic experiences. Nurses should be encouraged to experience the inward pleasures of being honest. This would provide maturity and wisdom to the profession. Is this not an attribute of being human?

Hodge (1993), reflects on the human caring in nursing and states “human caring in nursing is not only an emotion, concern, attitude or benevolent desire, caring is the moral ideal of nursing where by the end is protection, enhancement and preservation of human dignity” (p. 15). This statement follows on from Macdonald and speaks of the range of emotions associated with caring. After all as Hodge states, in the end it is the protection, enhancement and preservation of human dignity that is the moral ideal of nursing. This to me, as I understand humanistic care, means the human dignity of the nurse as well. Humanistic nursing for me is very much to the front of professional nursing. The following statement has an element of truth as it states that “when nurses know who they are and where they are going they will be clear about their purpose. They will acknowledge caring as the essence of Professional nursing. They will acknowledge caring as essential to humanity” (Hawthorne & Yurkovich, 1994, p. 51).

Summary

To conclude this section I feel these few words sum up the care that is nursing: “caring is the roar that lies on the other side of silence. When the mist lifts, nurses can find new images of caring” (Watson, 1987, cited in Swanson, 1993, p. 16).

In doing this research I recognise the human care that is inherent in professional nursing. Before starting this study I believed that human care was occurring. However, I

had no grounds on which to rest my assumptions and beliefs and this is what focused my research. The following chapter will illustrate the methodology used to investigate the 'caring care' of registered nurses actively practising in a public hospital.

The aim of the present study is to investigate what registered nurses working in a public hospital perceive as 'caring' care in their clinical practice. Once that important aspect of caring is identified, the 'care' theme will then be focused on discovering what the factors are in the nurses' working environment that enhance or hinder that significant identified 'caring' care. It is hoped this study will contribute to the nursing literature some New Zealand registered nurses' perspectives of 'caring' from within their public hospital clinical practice.

The broader aims of the study are to advance the understanding of 'caring' in nursing and to make it more identified and recognised, with an attempt being made to recognize the caring that nurses value in their practice. It may also influence political change in that the hospital environment has experienced continual change as a result of the health reforms. Ultimately this constant change is likely to have an effect on the nurse-patient relationship, the patient in need of care and the nurse who wants to provide that care. This study also intends to explore what these effects have been.

CHAPTER THREE

THE STUDY METHODOLOGY

3.1 METHODOLOGY

Starting the thinking

As I was considering which method of data collection to use, I thought back to what it was I really wanted to investigate. What was the driving force behind the topic in professional nursing practice that I wished to investigate. As stated earlier I really wanted to research the 'caring' nurses identified as important in their everyday clinical practice. I then considered the possible participants I could recruit for this research, and decided I would focus on registered nurses currently employed in clinical practice in a hospital environment.

Once I decided on potential participants I then considered how I would gather my data. After careful consideration of the available methods I could use to investigate hospital nursing practices, I made a decision to use a focus group. As this was to be a two paper thesis it was important to get some boundaries around the size and scope of the research project. I had to make the best use of my time, the participants time, and fit this research around my current full-time employment as a charge nurse of an active clinical area. I decided not to include patient's views in this research project as it would then become too large. A focus group would allow me to ask registered nurses about their practice and would be appropriate and supportive for gathering information.

Initial ideas

A focus group technique is one method used for collecting qualitative narrative data. Krueger (1994), is considered an authority on the use of focus group methodology

and the current research has been informed by his work. His publication focused on planning the group meeting, asking questions in the group, selecting participants and how to facilitate the group. A checklist was also included to ensure that all possibilities were considered by the researcher. As I read the work of Krueger, I kept asking myself if this method could be applied to my research. In particular I reflected on his comments about selecting participants for a group, where he states, “the most overlooked and underestimated aspect is the recruitment of the right people” (p. 74). I sat with this chapter for a couple of days, reading and reflecting on the proposed research and thinking about the suitability of the method for my research question. There was also the purpose of the study, which in effect should guide the decision of who should be invited to be a participant. Krueger says that one of the characteristics to consider in the group is homogeneity. I had already decided to have a group of registered nurses who worked in a hospital setting. “The guiding principle is the degree to which these factors will influence sharing within the group discussion” (Krueger, 1994, p. 77).

Krueger (1994), also states:

It is important to keep in mind that the intent of focus groups is not to infer but to understand, not to generalize but to determine the range, not to make statements about the population but to provide insights about how people perceive a situation. As a result, focus groups require a flexible research design, and although a degree of randomization may be used, it is not the primary factor in selection.

(p. 87).

This was one of the deciding factors for me as I was looking for insights about how nurses perceived a situation. I wanted the registered nurses to inform me of what they considered important caring in their clinical practice. I wanted to gain some understanding about their caring practice. I also wanted to remain flexible in my research methodology. The focus group methodology was selected for this research for the following three reasons:

- Firstly, insights were needed to explore nurses ‘caring’ care as an initial or first study.

- Secondly, the intended members of the focus group were to be registered nurses working within a hospital setting.
- Thirdly, the researcher wanted the ideas to emerge from the group and the purpose of setting up the focus group in this way was to uncover factors relating to the nurses behaviours or their motivations. The researcher felt the focus group environment was more conducive to motivate the thought processes of the other participants in a sharing collegial way.

3.2 FOCUS GROUPS

The Focus Group methodology

Focus group interviews, as previously stated, do differ from individual interviews in that the focus groups explore and stimulate ideas based on the participants shared perceptions (Holloway & Wheeler, 1996). Interviewing individuals would have required a huge time commitment on my part as more than one interview would have been required. I was very aware of the value placed on nurses' private time and did not wish my study to impinge on this. With a focus group I could have more participants involved than individual interviews and collect a lot of data in a short space of time.

That the value of the group discussion as opposed to a one on one interview I considered would provide good quality data. Also at this point I had no idea of how many participants would be involved. The group can consist of any number of participants. However, the recommended number is between 6 and 12 people (Krueger, 1994; Holloway & Wheeler, 1996; Morgan, 1997). It was suggested by Holloway and Wheeler (1996), that a small group can generate a great deal of information. I found this comment rather attractive in that I realised by holding two or three focus group sessions I could collect a substantial quantity of information quickly. There would also be group support and I

hoped that some of the registered nurses would know each other which would provide a friendly environment. I had decided from reading the research of others that I would not exceed nine for one focus group and if more than nine approached me I would form two groups.

Focus group interviews differ from interviews with individuals in that they explore and stimulate ideas based on shared perceptions of the world, especially when participants share the same specialty or occupation (Holloway & Wheeler, 1996). As my participants would be all registered nurses working in a hospital, I decided they would have shared meanings and understandings of the health environment in which they worked. Issues raised would have some commonality to them and time would not have to be spent explaining issues. They would be able to stimulate each other and discuss issues without too much prompting from me, the researcher.

Krueger (1994), states that focus groups should be considered when:

Insights are needed in exploratory or preliminary studies.

There is a communication or understanding gap between groups or categories of people.

The purpose is to uncover factors relating to complex behaviour or motivation.

The researcher desires ideas to emerge from the group.

(pp. 44-45).

These were the qualities that I was looking to emerge from my group process.

I decided to pose two questions only to the group. My first question was, “could you please tell me what ‘caring’ care means to you in your nursing practice?” I wanted them to identify their caring and to give it greater emphasis I added the second ‘care’ into this question. To further emphasis ‘care’ I then planned to pose a second question around “considering what you have just identified as important to your ‘caring’ care, what enhances or hinders that caring where you work?” I remained confident that with these two questions I would obtain data on caring from these nurses in clinical practice. My role

would be one of ensuring that the issues raised were relevant to the subject of the research. I would not contribute any information to the discussion from my nursing perspective the issues would be generated from the group.

Supportive literature on focus group methods

Initially I did not find a great deal in nursing publications on focus groups as this style of researching had only in latter years become a popular method of data gathering for nurses to utilise. Much of what I gleaned and have since used as resource material has been published since 1990. I then reviewed other research that used a focus group methodology and found two articles that had used the technique for nursing research. MacIntosh (1993), used the methodology via teleconference using 32 students in total at different teleconference sites distributed over a number of locations. Each site had a group of up to eight students. The researcher stated they found this number of participants was not a barrier. Nyamathi and Shuler (1990), used their focus group along the lines of how I wished to undertake with my research. Their research was a useful resource in that they discussed and explained clearly how their focus group functioned. They also discussed the process and usefulness of this methodology as an interviewing technique and suggested that, “the hallmark for the focus group is the quality in which spontaneity and candor is obtained” (Nyamathi & Shuler, 1990, p. 1283). I found this statement most encouraging in light of how I was intending to proceed with my group. I was hoping the group would be spontaneous and would include some candid statements. I intended the group to be relaxed and as informal as possible.

Kingry, Tiedje and Friedman (1990), discussed this style of research as an efficient method for nurses undertaking research. They touched on issues raised by Krueger (1994), and stated that usually the greatest amount of information comes from the first two groups.

Thomas, MacMillan, McColl, Hale and Bond (1995), compared focus group methodology with individual interviews. In their examination of the depth of data generated they, in effect, found no differences between the two methods. However, they did state that the concepts probably could have been generated with a smaller number of focus groups compared to individual interviews. Lankshear, (1990); Nyamathi and Shuler, (1990); MacIntosh, (1993); Torn and McNichol, (1998), and Twinn, (1998), have all used the methodology in their research. From the research it appeared that focus group methodology was an efficient way of data collection and these researchers had collected substantial information using this method. Reed and Payton (1997), discussed the analysis and interpretation of focus group results and how they attempted to utilise a computer assisted package. They found the computer package did not interpret the data efficiently and was too rigid in its interpretation. When they attempted the analysis they found they were unable to make sense of some of the information. They found that manually interpreting the data gave a richer picture.

Issues related to this method

Krueger (1994), suggested having a moderator and assistant moderator who was in charge of audio taping and keeping notes. This allowed the researcher (as moderator) some freedom from the pressure of running the group. I gave this a lot of thought. It was important for the moderator to keep control of the group and guide the group back on target if they wavered. I realised I would be collecting the information by audio taping and writing, controlling the group and managing to hold the discussion. After much deliberation I decided against a second neutral person. It would mean introducing another into the group. If that person was not a nurse some issues may not be discussed. If they were a nurse they may well be tempted to speak which would have been inappropriate.

Finally, I considered whether having only two key questions was sufficient. Krueger (1994), had stated that the questions were the heart of the focus group interview. Kingry, Tiedje, and Friedman (1990), suggested carefully structured, sequenced questions based on the purpose of the study, would elicit a wide range of responses. Other focus group research I had read discussed the importance of the questions. One researcher Lankshear (1993), had given her focus group a set of trigger questions. From what I could find through my reading it appeared that no researcher had gone into their research with only two questions. However, I decided I would still utilise the two question approach but also write down three or four prompt words in case the group became stuck at some point.

Advantages of focus group methodology

There are advantages to collecting data in a group method. The most appealing one being that more than one person can respond to an issue and all comments are collected at one time. By collecting data in a group I remained confident the issues raised would be relatively focused as each person would hear what the other said then build on that information. I considered the group process and dynamics of the group would be conducive to collecting rich information.

I saw an advantage in that the participants were all registered nurses, employed at the same hospital, and likely to have had similar experiences around issues that the focus group raised. I felt this would be supportive to the discussion and would keep the process moving. While I understood the one to one interview to be more personal and therefore likely to raise sensitive information, I hoped that the focus group would provide a supportive safe environment for similar sensitive issues to be aired. The data in this style of interview is usually rich and narrative by nature.

The group method is a social interaction and as facilitator of the group I saw a distinct advantage to capitalise on that interaction to elicit rich data. The created synergism from the group interaction should stimulate ideas and produce a high level of energy in the group discussion. The group approach would mean less pressure on individuals if they at some point felt unable to contribute to the discussion.

Limitations of using this methodology

There are always limitations to every methodology and with help from Krueger (1994), I had anticipated some before starting. The first issue related to the participants actually turning up at the right time and place. I decided to phone each of the participants the night before to ensure they remembered the group meeting. This way I would confirm their attendance and the time and place of the meeting. It would also be an opportunity to answer any last minute questions.

I also wondered if I would reach saturation point by choosing this form of data collection. I even wondered if I would manage to collect enough data from the focus group sessions. I projected that I would need to have probably three focus group sessions to elicit the information required. However, the final choice would remain with the participants. They would decide if they had provided enough information or if they felt there was more to discuss. The other issue related to the participants finding group discussion too intimidating. In this instance I decided that nurses work from a compassionate understanding and I remained confident these issues would be resolved with the group dynamics.

Transcribing the collected data was an issue raised by both Krueger (1994) and Twinn (1998), especially when voices spoke over others in the group making it difficult to decipher information (Lankshear, 1993). This may result in losing two conversations as it

is difficult to transcribe either conversation. There were also the personal issues of participants who dominated in group discussions. This occurred in research undertaken by Twinn (1998). She found in both her focus groups, one homogenous and one non-homogenous, that each group contained one member who dominated the group. I decided to deal with this issue as nursing still maintains a hierarchical structure even if unconsciously, as frequently there is one dominant group member. Realising the potential pitfalls and weighing these with the advantages of using this methodology I structured the subsequent ethical approval process. For this reason ground rules were set and each group member would read these before the group met. I decided they would be displayed at the meeting and would be read and agreed to before starting.

3.3 ETHICAL ISSUES

The ethical necessities of research

There are ethical rules and regulations in any research that must be strictly adhered to. It is important for the governing bodies who oversee research to know that an individual's rights are being upheld and protected by those undertaking research. Research participants need protection from exploitation and potential harm. This is an important objective for the ethics committee to consider when approving human research.

Application for approval was made to the local Health Ethics Committee before this research could commence. An ethics form with the required information and in the proper format was accessed on computer disc. Every section of this form had to be completed clearly, accurately and concisely. I found completing the form an excellent way to focus on the intended research. I thought I had a clear understanding of how I wanted to progress through this study. However, it was only by writing it out and having to think about what I intended to do that I realised I had to have ideas clearly worked through.

At this point in the process there were issues to think through regarding the focus group methodology that required meticulous consideration. One issue was to consider the identity of the participants. I had to ensure they remained anonymous to other people and the information they discussed remained confidential. I decided to address this with the informed consent (Appendix 2), and the information sheet for participants (Appendix 3). Each participant would read these before the group interview and the consent would be signed in front of the other participants in the group on the day. I decided each participant should call themselves by a pseudonym so they retained anonymity.

I also had to ensure my integrity as a neutral participant as some of the participants could possibly be colleagues and co-workers. I did not want to jeopardise my working relationships. I did this by stating in the information sheet (Appendix 3), that the information collected would be the participants' own personal and professional opinions. I decided that I would state at the initial focus group meeting that this was to be the participants' "caring" and this was to be their story of care. To ensure participants did not speak while others were speaking, I decided to address this by setting ground rules (Appendix 4) which would be circulated to the participants with the consent and information sheet and read before the group meeting. I would reinforce the ground rules before the focus group commenced.

I decided to audiotape the sessions and store this data in a locked cupboard at my own home. As I anticipated requiring the services of a transcriber I decided to include a transcriber consent in the ethics application form (Appendix 5). I would store the transcripts on a computer disc in the locked cupboard with the recorded tapes. Having worked through the ethics form it was submitted to the Ethics Committee.

Approval

The committee duly met and I rang the secretary to enquire about the outcome. My application was passed first time with two typing errors and a small adjustment to the cultural safety section (Appendix 6) as the committee requested that the cultural aspect be raised in the focus group. This had previously been discussed with my supervisor in light of how the focus group was to proceed. I had intended that only two questions be asked and the discussion kept to the issues raised by the group. It was my intention to keep the group focused on the original questions. Once this was clarified with the Ethics Committee, I was able to commence my study. There was only one letter received from the Ethics Committee which gave approval subject to the required changes being made (Appendix 7).

Negotiating access to participants

As this work would be focused on the practice of hospital nurses I approached the Director of Nursing Services for approval to conduct the study. The Chief Executive Officer of the Crown Health Enterprise was informed of the study by the Director of Nursing. Anyone who wished to talk about the intended study with me was informed that ethical approval was being sought from the local ethics committee, and if they were interested an advertisement would be placed in the hospital newsletter after which they could approach me if they wished to take part.

An advertisement was placed in the local hospital circular which had a wide distribution throughout the CHE (Appendix 8). This advertisement stated the intent of the study and how much time the participants may be required to invest in the focus group. After placing the advertisement I then set about preparing the participant's information packages for these perspective participants. Each envelope included the consent

(Appendix 2), information sheet (Appendix 3), letter of introduction (Appendix 9) and ground rules for the group meeting (Appendix 4). I did not have a suitable venue for the meeting and decided to put this to the participants to see if they could identify an appropriate venue.

Three colleagues responded immediately, then another three the following day. It took another week for three more to make contact. These respondents received the information on the study three weeks prior to the first focus group meeting. As nine participants had approached me I had decided to allocate them to one group, the recommended number for a focus group being between six and twelve participants (Krueger, 1994). The date was then set for the first meeting. One participant located an appropriate venue away from the hospital. This was discussed when each participant recontacted me after they had read the information. All agreed on this venue which was then confirmed. This venue had a white board available. I decided to use this for recording key statements the participants made. It would help keep the group focused on the topic without my interrupting the process.

Of the original nine expressions of interest, there were four participants who instantly responded with their agreement to be a part of the study. Two decided not to proceed after reading the information. One decided that her practice was not completely clinically focused and the other, although keen to take part, was unable to organize childcare for the scheduled morning.

3.4 ACCESS TO THE FIELD

Progressing with trepidation

It was an interesting position to be in, just before the data collection and the week that led up to this. Last minute checks were made on my supplies. I felt like an early

explorer about to embark on an expedition. Ringing the participants the night before to remind them of the group meeting the next day revealed that two participants were unable to come. For one participant her rostered shift could not be changed and the other had an unwell family member. I decided to proceed with the five remaining participants.

On the morning of the study one other participant received unexpected visitors and rang as I was leaving home. I decided to proceed with the remaining four participants. However, I would put this to the group for their consideration. Although I was eager to commence the process I figured that perhaps four participants may not be enough. I decided to discuss the options with the participants and let them decide if they wanted to proceed.

Getting Started

The group met and the seats were arranged in a semi circle so the participants could all see each other clearly, and the kettle was turned on. Once the participants arrived they were introduced to each other and offered a cup of tea or coffee. They were informed of what had transpired with the absent participants. The group decided that they would rather proceed on that day as they had planned. They were willing to come back in the afternoon if the others could be brought into the group. However, I knew from speaking with the absent participants that this was not possible and the hall was unavailable in the afternoon. The group were as keen to commence the process as I was, so it was decided that the group of four plus myself would generate some initial data. They decided that with four participants quality information could be raised.

I introduced the topic, and the format of the session was discussed. The ground rules for the focus group, which I had circulated with the original information to the participants, were discussed, understood, agreed on and accepted. The participants were

given the opportunity for questions which were answered and then consent forms were signed and witnessed. We were ready to begin. I lit a candle and placed it directly in front of the tape deck on the floor so people could focus on the light while discussing issues and while they were talking and reflecting on their caring practice. I consider the candle to be a symbol of illumination that reflects light on a discussion, as well as having a calming influence. Once all the relevant checks were made and the group felt at ease, the audio tape was started and the topic introduced. Everything appeared to be flowing smoothly and the group appeared relaxed and comfortable.

The First Question

The tape was started and the first question was asked: **“Could you please tell me what ‘caring’ care means to you in your nursing practice?”** It took a few moments for the participants to warm to the process. I stated that what was wanted was for the nurses to tell “their story,” and what they felt was important to them when they were caring for patients. The first item that was recorded on the white board was the importance of looking at the “whole” person. Considering their individuality, sex, age, spirituality, nationality, culture, physical and mental health, family, support, their sexual orientation, and whether they were male or female. The group felt this was a really important starting point and the discussion flowed on from there. The participants conversed freely with each other and were extremely attentive to ensure that nobody spoke over another who was speaking. During this process I wrote down key words on the white board. This was also how I kept the group focused on what was being discussed. I found it a good process for keeping the conversations focused on the original question.

Approximately one hour was spent on discussion of the ‘caring’ care important to these four nurses. The discussion then started to raise issues of inhibiting and enhancing

factors. At this stage I asked the group to stop and consider if there was anything else they wished to add to their ideas about ‘caring’ care before the discussion moved on. It was obvious that the discussion was changing and it appeared the group had raised all the obvious issues that they felt were important.

The Second Question

“Considering what you have just identified as important to your ‘caring’ care what enhances or hinders that ‘caring’ where you work?” The group then discussed very openly and freely what they considered important factors in their working environment. The discussion went for over an hour and again the white board was used to record trigger words. The factors in this section were being spoken about as a narrative story and one person led on where the other left off in the discussion. It was interesting to note similarities of experiences even with the nurses working in different areas of expertise, across different modes of illness and age ranges. It was evident that the group had made many adjustments in their personal and professional lives and still remained happy and productive in their work choices.

Finally no further new information was forth coming. The group was asked if they wished for anything further to be included. I was aware that the group had been together for over two hours and while they were comfortable in the discussion which they stated could proceed all day, it was time to close the session.

Believe it or not

There is always a sobering thought when these sessions are finished as you wonder how good the recording is. I decided to check the audio tape, it was rewound and turned on. There was a deafening silence. ‘I don’t believe this’ I said as a cold reality struck me.

The tapes were all blank. The microphone switch had not been flicked down after the initial check. The participants were really supportive and suggested they come back. They were aware of the other three who also wanted to be part of the group, and could not make it. A date was then set two weeks out. I was to clarify with my supervisor if another session was an option. I would then contact the rest of the group and invite them to the next meeting.

I was really heartened to discover such enthusiasm in the group and the continuing and ongoing support for me and my research. They were as keen on the project as I was and I wondered if it was because someone was attentively listening to their stories from practice. I asked if they were sure about including the others as this had to be mutually agreed upon by the group members. It was stated that it was important for the original group to be present at the next meeting which meant another two hours of their time. They all agreed saying it was time to get more fresh information.

The group was told I would write a report from what could be remembered from the discussion and from my notes. These would be given to them to read over before the next group meeting. They were asked to make changes as I would not remember all of the discussion. I felt total and absolute frustration having sat in on such wonderfully rich and open discussion on their stories from practice and had lost most of it. Thankfully a hand written report of all the important facts had been recorded on the white board and notes had been taken by me throughout the process to ensure the discussion remained focused. Fortunately not all was lost.

Retrieval at a gallop

I was more than thankful that I had recorded notes on the first question. However, it was the valuable information from the second question that was missing. Only brief

notes were taken as the narrated information was so rich with wonderful examples from practice I had become engrossed in listening. For the next nine hours I shut out everything around me. It was important to get information that I could recall down on paper.

I sat at the word processor and typed. The notes taken on the identified 'caring' care were set out on two pages with the words identified and a brief comment. The second part of the discussion was definitely not as easy to recall. However, I could remember issues raised and a paragraph explaining what was identified had to be added for clarity of comment. In some instances the issue had two or three discussions around it and I tried to get down as much as could be recalled. Finally it was completed and a line was inserted for each participant to sign that they had read and agreed with what was written. They were also invited to add or delete information.

Wow how did you do it!

One of the participants made this comment on her initial reading of the report. At the second focus group meeting the three original participants (one unfortunately was held up at work and did not make the meeting), said that it was a good recall with not much information being left out. They complemented me on my memory recall.

The original group had the data for two weeks to review and write comments on before the second focus group meeting. Interestingly, not many comments were recorded on the sheets of paper nor was much information deleted. I asked a couple of times if the group was sure that they did not wish to add more, and the comment was "no it is just fine". I kept having an uneasy feeling that perhaps I had forgotten something vitally important as I knew the discussion had contained some rich examples from clinical practice. Running a second focus group offered another opportunity to capture some stories to illustrate this richness.

Another focus group meeting was arranged. As the church hall was unavailable the group met at a school. The participants who were unable to make the initial group meeting because of family and work commitments were invited to join in with the second meeting. The three new participants were willing to join in this way. They were given the two questions to reflect on before the meeting and had a week to think over their 'caring' care. They were told that the 'caring' care points raised in the initial group would be on a white board and they would have first say at adding to them with what they identified as important from their perspectives.

It was a dark and stormy night

One problem I found was the difficulty of directing traffic in a dark coat when you are on your own and your participants are unsure of where to go. School grounds have limited lighting and the library we were to meet in was not in an obvious location. The caretaker decided at the last minute because the night was so cold that the library would be warmer than a classroom.

One of the new participants sent an apology that she was unable to make this meeting because of a very busy week with a sick family member being admitted to hospital. As a group we waited a further fifteen minutes for one of the original participants to arrive before we decided to commence. We discovered later she had been held up at work and had not got away until after 6:30 p.m. The focus group had been timed for 7 p.m.

The group introduced themselves to each other and the two new participants were welcomed. I went over the focus group ground rules and after checking whether there were any questions the two new participants' consents were signed and witnessed. I set out how the evening was to progress and it was stated that once no new discussion was forthcoming the group meeting would close. The tape recorder was checked, started and rechecked after

a few minutes. The participants did not want a rerun of the previous group meeting and were all eagle eyed watching the recording. This time the recording occurred and there were no further equipment problems.

The Questions Revisited

“Could you please tell me what ‘caring’ care means to you in your nursing practice?” The white board already had caring words written on it, identified from the original group meeting. The new participants added more words to this which the other participants agreed with. The ‘caring’ care issues were saturated after 45 minutes and as there were no new issues raised the group progressed onto the second question.

“Considering what you have identified as important to your ‘Caring’ care, what enhances or hinders that ‘Caring’ where you work?” This time there were different factors raised and after the discussion had progressed for 30 minutes the group wanted to look over the factors raised in the previous meeting. They wanted to make sure that nothing was omitted. Interestingly, this discussion reached saturation point after a further fifty minutes. As no new information was being raised the group decided to end the discussion. They left with the promise that I would transcribe the tapes and write a report. This I would get to them as soon as possible for verification. I thanked the group for their support and for coming out on such a blustery wet night. I packed up my valuable recordings and made for home where I immediately made a second copy of the recorded tapes.

Demographics of the focus group

The final composition of the two groups were six females, whose ages ranged from 30 to 50 years. There were 4 participants in the first group and the second group had 3 of

the original group plus 2 new members. They had varying years of service. The shortest length of clinical experience, including training, was 8 years with the top range being 28 years of service to the profession. There were three participants who identified as European and two with the 'smallest spattering' (as these participants put it) of Maori heritage.

The participants all worked in a clinical environment. One held a charge position and the others were considered senior staff nurses within the organization. All had worked in their current areas of practice for some time. One had been redeployed in the last year as the staffing in her previous clinical area was reduced and in the past six months one other had selected a different clinical area of practice. I felt with these participants I had covered a wide area of clinical practice and had nurses with varied clinical experience. The participating nurses worked in the areas of elderly health, specialised clinical areas, medical and surgical day procedures. All of these areas had been affected in recent ward reconfigurations and mix of surgical and medical patients, along with experiencing the impact of reduced hospital length of stay and flexi bedding. I felt with this mix of participants I could not have made a better choice if I had selected them myself. The first group of four plus the researcher met for a total of two and a half hours and the second group met for two hours in total.

Transcribing and report writing

The reports, firstly the one on the caring factors then the inhibiting and enhancing factors were hand delivered to each participant a week apart. I did not want to overwhelm the participants with a large quantity of data to read. I wanted them to look over the 'caring' issues while the information was fresh in their minds. This gave ample opportunity to transcribe the second question while they were reading the first report and

meant I could focus on the caring factors as soon as the signed sheets were returned. This process gave me the opportunity to distribute accurate information as soon as possible following the interviews.

These second reports were signed by all the participants and additional information was added to the sheets. These returned sheets were read over and the additions put into the master copy of the report. All the information thus far collected had been verified by each participant in their own time. They took the reports away and read them before signing. This took between one and two weeks.

3.5 DATA ANALYSIS INTERPRETATION AND RESULTS

Working with the data

Once the raw data had been collected I needed to organise it into some workable form. The following is how I proceeded with the data and how I finally moved to the themes that emerged from the participants' contribution in the two focus groups. The process of filtering the data and attempting to put some analysis on it I liken to swimming through a lily pond thick with plant. All the words and sentences were similar to fine threads holding onto each other firmly and it was extremely difficult to separate the themes.

As I continued to swim through this data I tried to draw the strands of the groups into a trail that flowed behind with the hope that some semblance of order would come out at the other end. Sometimes there were single words. More frequently there were groups of words and care had to be taken so that nothing was left out. The swimming at the start was hard going as the plant resisted progress. As I continued to find a way through, the going became easier as order fell into place.

The Process

Once the data had been verified I went through each transcript individually and highlighted words and sentences that stated or reflected instances of care. When I had completed this I went through each transcript again and wrote out each word or sentence onto sheets of A4 paper, which I then highlighted in different colours or used symbols to identify similar words or sentences. I then transposed the words or sentences that reflected similarity onto individual sheets of A4 paper. For example, grouped under nursing knowledge was: ground roots of care, need reinforcement skills, researched based practice, good expert knowledge base to make sound clinical decisions, confidence in practice, and nurses have a pool of life experiences to call on. Once I had completed this process I attempted to give each piece of paper a heading that in two words reflected the essence of the collective meaning of each sheet. I ended up with seven headings; Organisational factors, Tangible actions, Interpersonal relationships, Mindful thoughts, Nursing knowledge, Internalised feelings, and Professional conduct.

I was trying to formulate the data I had into some type of structured format that could be worked with. I found that this did not appear to be working all that successfully and I was having difficulty structuring the data in this rigid way. I then separated it again and reworked it. The data was left for approximately a week as I thought about the reworked analysis. I realised what I really wanted to achieve was to hear the participants' words and statements and to get the order of importance as they prioritised it in relation to their caring.

I then put all the data onto a large sheet of paper and regrouped it into similar themes and groups of similar words and sentences. Once I had this laid out I saw linkages across the paper. Somehow what had been separated out was still linked up with words in other groups. I started to get myself really confused and had a sudden overwhelming

feeling of doubt that perhaps this research was not going to progress from here. I had in effect found my way through the lily pond but it still looked like the threads did not want to be separated out.

What is the problem ?

The most paralyzing moment in conducting qualitative analysis is simply getting started.

(Sandelowski, 1995, p 371.)

Never was a more honest statement made. I had been enthusiastic in planning the project, writing the proposal for the Ethics Committee and collecting and getting the data transcribed. All this appeared relatively straight forward. I could not believe that now I had reached a state of paralysed stagnation. What was I doing that was proving to be so difficult? At this point of the research process I found myself immobilised.

Sandelowski (1995), states that, “data analysis involves breaking the data up or down” (p. 372). Not only did I break the data down, I put it back together. I reworked it. I had it in groups then I ungrouped it. I had it on many pieces of paper, then I set it all out onto a larger sheet of paper. I became very familiar with the words used by the participants. They became part of my thought process during this time. It seemed I was eating, sleeping and working and all the time this data kept knocking at my thoughts.

Helpful advice

It was at this stage I decided it was time to speak with my supervisor. It was also at this time I received two very good pearls of advice which were recorded on tape from the Spring research school. Firstly my supervisor advised me to relisten to the data and the themes would emerge. Just sit with it and it will come. Secondly another experienced research lecturer advised that it was like kneading the dough, working with it, reworking it

and that was what I was currently doing. Come at the data differently and eventually it will come to you.

I felt like, 'oh yee of very little faith' how long was I to sit and wait for this great coming? I knew I had been wandering around with the data for well on a month with no sudden flash of inspiration. I was beginning to think that there was no way I was going to come out the other end with something relevant. I had certainly been kneading the dough and nothing at all was rising, or was it? On reflection I think this was one of the most vital aspects of the analysis because when I took the next important step I knew my data very well. I had been living with it and I found it was easy to relate to.

Coming at the data differently

What I did next was really very important to the process. I did revisit the data. I decided to go back to the tapes and sit with my eyes shut and just listen. I listened uninterrupted to the tapes. I heard what care words or sentences were stated and I was listening to hear where the participants' emphasis lay in their conversations. What was it that they were saying, repeating and validating as a group? Then I rewound the tapes and this time I sat with the transcript in front of me. I wrote out a care word each time it was said then put a mark beside that word each time it was restated. I then counted up each time a word was used by counting the ticks. I then ranked them in importance of how the participants had perceived their care. The important words were placed in a line, those with the most ticks at the top and tapering down to the words with the least ticks. I also considered where they had placed their emphasis when relating issues.

This is when I decided on the emergent caring themes and their order of importance to the participants. One of the difficulties I had was to ensure that the words I selected did reflect the essence of the participants' expressed ideas. While I was working with the data,

I talked about the themes that were emerging from the data with other nurses and the participants. Once I had these printed (see Figure 2 p. 76) I wanted to ask the participants if they considered these words stated the essence of the group discussion. Was this how they saw the importance of their caring?

On reflection I feel this was a check on myself to ensure that what I had was their reflection and not my interpretation of their reflection. I was able to easily contact five participants and ask them to validate what I thought I had perceived as important and in which order they would place these words. The five agreed and were very pleased with what had arisen as they felt I had captured 'caring' care exactly. The participants agreed that the individual took priority with consideration being given for the whole person. Any caring must be individualised and tailored to that person.

The individual took central focus and the importance of touch, talk and time evidently came next followed by holism, honesty, humour, courage, confidence, determination and dedication (see Figure 2 p. 76). Throughout the discussion there was reflection back through the narration to a holistic approach to nursing. These words were the thrust of the 'caring' care expressed by the participants. As the participants went about the business of care they saw their caring focused on a partnership with each individual, practising from a professional and personal knowledge base accompanied by a professional commitment to care. For all this to occur there needed to be between the nurse and the patient a response, a reciprocal understanding, a receptiveness, and an underlying respect for each other. Participants reflected on care for enhancement and improvement of their caring practice. I felt excited at this point, I had emergent themes and had validated these with five of the six participants. I was now ready to start writing.

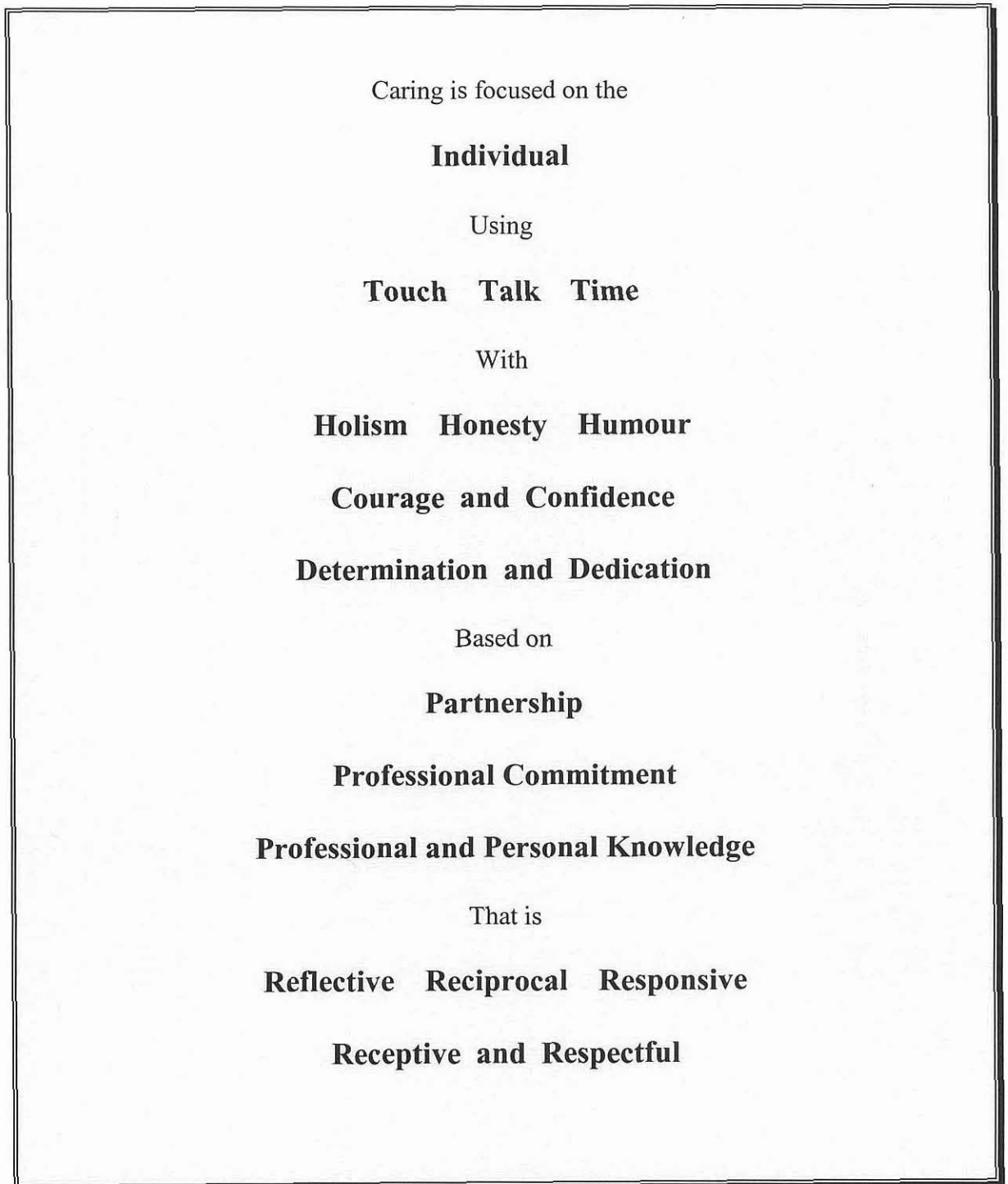


Figure 2

Emergent Caring Themes

3.6 RIGOR, TRUTH AND AUDITABILITY

Attention to rigor and paralysis

It is vital that any researcher taking part in qualitative research leaves an audit trail that can be traced by another on how the methodology of the research occurred. The researcher needs to portray the research in a true and accurate way, reflecting the ideas and thoughts of their participants. The one most important question that has kept me on track was one from my supervisor very early in the process “How can I trust you?” I have thought on this question often throughout the process of this research to ensure that I have laid down a transparent trail so trust and truth can be visible. This question ensured I continually reflected the truth of what the participants and the literature stated. But how can others trust my findings when I am working in relative isolation on this project? Working with a critical friend throughout the process and having colleagues to bounce ideas off helped tremendously.

The truth trail

To help me follow a research trail of truth I used the work of more experienced researchers who had trialed the method. Krueger (1994), was invaluable with issues related to the focus group. Sandelowski (1986; 1995) and Koch (1993), were two nurses who used the work of Guba and Lincoln and made this work more accessible to the realms of nursing research. Guba and Lincoln (cited in Koch, 1993), put forward the criteria of credibility, transferability, and dependability for establishing trustworthiness in qualitative research.

Koch (1993), claims that “credibility is enhanced when researchers describe and interpret their experiences as researchers” (p. 976). The researcher’s self awareness is essential throughout the research and can be recorded in a journal. I found this process of

recording extremely useful especially when I experienced periods of frustration. For example, when I encountered difficulties working through the data. Another way of ensuring credibility is consulting with participants and asking them to read and discuss the content of what is being written. This process was also used in this research. As I worked through sections of the data I would ask one or two of the participants about what I had written, both to ensure I had captured their essence of the discussion and to ensure I was reflecting the participants' story of caring. This was my approach to ensuring accurate portrayal of the participants' information. Sandelowski (1993), supports this approach stating "member checking exemplifies the practical and deeply theoretical, representational, and even moral problems involved in using such techniques. Indeed, practical problems are frequently theoretical, and representational problems are frequently both theoretical and moral" (p. 7).

"Transferability is dependent upon the degree of similarity between two contexts" (Guba & Lincoln, cited in Koch, 1993). Sandelowski (1986), suggests the following for meeting the transferability criterion and suggests a fittingness of the information: "A study meets the criterion of fittingness when it's findings can "fit" into contexts outside the study situation and when it's audience views it's findings as meaningful and applicable in terms of their own experience" (p. 32). Other nurses can relate meaning in the emergent themes selected as these words will have shared meaning and understanding in the context of other nursing situations. Therefore, I see this study meeting the criterion of transferability or fittingness. I have held the descriptions under the emergent themes which focused around one aspect of the nursing situation. This preserves contextual meaning and understanding.

Dependability is the process when another researcher can follow the audit trail used by the investigator in the study. This addresses the process of auditability of the research. An audit trail provides the means to establish linkages and why decisions were taken.

Finally any research has to be confirmable. Confirmability requires that the person conducting the research is able to show the way in which interpretations have been made. Confirmability is established when credibility, transferability and dependability are achieved. There are clear markers throughout the research indicating where research decisions have been made and what influenced those decisions.

Every human experience is viewed as unique, and truth is viewed as relative. The artistic integrity, rather than the scientific objectivity, of the research is achieved when the researcher communicates the richness and diversity of human experience in an engaging and even poetic manner.
(Sandelowski, 1986, p. 29).

Throughout this research I have filtered poetry from personal experiences of my clinical practice. As Sandelowski (1986) states: “The truth value of qualitative investigation generally resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects. Significantly, truth is subject - oriented rather than researcher - defined.” (p. 30). This relates to how I have conducted this research. The truth from the lived experience of registered nurses currently working in a public hospital environment were sought. Findings from this study emanated from their descriptions of their lived experiences.

CHAPTER FOUR

THE CARING DISCUSSION

4.1 EMERGENT THEMES

Introduction

It became evident to me as I was progressing through the data analysis that the two research questions posed in the focus groups were inextricably linked. Therefore it seemed pertinent to combine these two questions within this discussion. Examples will be used from the identified 'caring care' question and from the 'inhibiting and enhancing' question, that will reflect the essence of the selected emergent themes. (Refer to figure 2, Pg. 76). These emergent caring themes will then be illustrated with the participants' stated words, using double speech marks. My words to clarify intent, will be shown in square brackets. I will give examples of how the participants' articulated their care within an identified theme which will illustrate the particular themes inclusion in the analysis. The literature will either support or not support these emergent themes and where possible I will reflect on how other researchers and writers have articulated these themes.

I will present the ideas and thoughts of the participants in their emphasised caring and discuss what has impacted on that caring in the clinical environment. I accept the reality that some of the focused issues have had a profound effect on the nursing service. These issues will be referred to only in the enhancing and inhibiting factors section. The participants recognised that some issues were impossible for them to change. However, by identifying issues they were able to contemplate solutions for enhancing their nursing practice.

As a process I intend to give a dictionary definition, or a definition from the nursing literature where it has been found, that best reflects the understanding of each selected

emergent theme. I will then discuss how each theme reflects caring. The participants' contribution will then illustrate how they dialogued the essence of this theme through their discussion in the focus groups. This will be followed by other writers' experiences on this specific theme. Where specific issues relate to actual patient experiences I have used a pseudonym to maintain patient confidentiality.

Caring themes

The participants collectively agreed upon a definition of caring. The group unanimously decided that caring "was hard to define as it arose from within the self." This was stated at the first focus group meeting and reinforced at the second focus group. It was decided "caring is learnt." "There are a pool of life experiences that develop your care as you gain experience" as a registered nurse. This aligns with the novice to expert experience described in the work of Benner (1984). The registered nurse progresses along a continuum of clinical expertise, with some never achieving expert status. This aligns with my beliefs about how nurses care in clinical practice. The concept of care progresses along a similar continuum where nurses build on their abilities and gain confidence with their caring practices. It is out of this context of care that I have identified the emergent themes that were reinforced by the experiences of the participants. They identified individual humanistic caring concepts which used touch, talk and time with holism, honesty, humour, courage and confidence with dedication and determination. These concepts were based on partnership and professional commitment using professional and personal knowledge that was reflective, reciprocal, responsive, receptive and respectful.

Care was identified as "individual." "Caring is that depth of feeling" that comes through as you develop as a nurse. "You do care, but become better at it as you practice." You "learn by watching other good role models," and you take on that expertise as part of

your nursing persona. There are “times when you need to stand back from situations so you can continue to care for yourself and others.” The importance and need to care for colleagues was considered significant to the caring nurse. Some situations that nurses find themselves in can be demanding and emotionally draining. However, nurses can often recognise when other nurses need to be cared for. They support their nurse colleagues, “you never know when you can find yourself in a similar situation.” “It could well be me next time.” The importance of support for colleagues was highlighted by the writings of Boykin and Schoenhofer (1993) who say “caring is living in the context of relational responsibility. A relationship experienced through caring holds at its heart the importance of person-as-person” (p. 8).

There was discussion on the important role the charge nurse has in caring for the staff. There are expected obligations for the charge nurse to identify and confidently address the staffs’ coping abilities in given situations. The group felt they recognised a supportive charge nurse. They also recognised the tremendous pressures the charge nurses worked under. Johns (1994) cites the situation of a caring charge nurse who had experienced organizational changes with health restructuring:

I have tried so hard on this ward - to be caring, to spend time with patients...but it has become impossible. They hit you with one thing after another and before you have time to deal with the first issue along comes another.

(p. 158).

This charge nurse was leaving the profession, as she felt unable to manage the situation any longer. As Johns explains:

She could no longer manage the contradictions but neither could she give up her hope to care. When nurses go to work each day in the face of conditions that do not permit human caring, and where satisfaction with work becomes just getting through the list of tasks to do, then human caring and nursing itself is in dire straits.

(p. 158).

This statement reflects one participant's experience who had previously been a charge nurse and left that position. She stated "frustration at not feeling able to fill either the management or clinical aspects fully, never felt completion, so [the] job satisfaction level [was] very low. I decided it was time I took steps to care for *me*." From my experience I believe there are nurses who experience this two way pull on their 'caring' and the human cost of caring eventually takes its toll. They either leave the profession or move to where they feel more comfortable in providing their 'caring' care. Another participant said, "The job is mostly learning by default...there is a blurring of the roles between clinical and management." Of charge nurses it was stated:

They are the meat in the sandwich. As a student nurse the pinnacle of your career was to aspire to this position, but now, it is not worth it. The job has a nasty habit of changing once you are in it, and it is not what you went out to do.

(Participant statement).

The participants stated, "Caring can take place in a moment to moment transaction or interaction." "In the here and now, this space, this time, spirit to spirit." "Sometimes the [caring] moment is created." Euswas (1991), defines the 'actualized caring moment' to be:

At a given point in time within the ongoing interaction process, the nurse and the patient know, and recognise the giving and receiving of care. It is a connection from feeling and knowing each other as human beings. It is the moment of interhuman unity in transforming healing and growing between the nurse and the patient and it occurs in a specific situation in an episode or series of episodes of the nurse patient encounter. Once the nurse and the patient have experienced the actualized caring moment, it is more likely that such a moment will occur again.

(p. 143).

I consider statements made by the participants in my study would refer to this description as the moment of care and believe this paragraph succinctly captures when caring occurs.

A phenomenological study which looked at the lived experience of caring (Forrest, 1989), discovered during the data collection that the meaning of caring fell into two broad themes. What is caring, and what affects caring? Under 'what is caring', Forrest had nine theme clusters set under two categories. The first category, Involvement, had four theme clusters: being there, respect, feeling with and for, and closeness. The second category, Interacting, included touching and holding, picking up cues, being firm, teaching, and knowing them well. Under 'what affects caring' were thirty theme clusters. Interestingly Forrest's research raised similar issues to what my participants had raised. My participants had issues with putting the patient first, taking opportunities, valuing relationships, looking for cues, telling the patient what they need to know, and allowing the patient to be involved in their care. The caring was affected by their own confidence, lack of time, the physical environment, talking, unwinding, protecting yourself, teamwork, and unit supervisors. There appeared to be commonalities in the working environments of Forrest's research participants and my study participants.

The emergent caring themes my participants raised will follow in order of where they placed the most emphasis as they were speaking or referring to the issues. (Refer to Figure two, p. 76). The individual was paramount, and care revolved around individualised assessment of the patient while the other emergent themes emanated from an individualised humanistic perspective. As stated in chapter two, I believed nurses provided humanistic care. However, I had no evidence to support that assumption. It is out of the analysis that I discovered examples of individual humanistic care. The analysis supports my belief that humanistic care is provided by nurses. The characteristics of humanistic caring as identified in chapter one (p. 7) are a will, a commitment, an intention and an ideal. The following examples demonstrate the first emergent theme, the individual, within a Humanistic framework.

Participants' humanistic examples

Nurses in charge of the wards often have to work with managers who are more focused on the financial aspect of running 'the business'. Frequently the nurse can find his or herself in a dilemma with regards to what is the best response in a given situation. For example, one manager wanted to remove a dying teenager from a ward and clearly the charge nurse felt it was more important that this patient stay with the staff who knew her and where the parents would be able to have ongoing support. There was a lengthy discussion when the charge nurse asked the manager, "what are we going to do with [Emily], what *are* we going to do with [Emily]?" This charge nurse felt that by personalising the problem the issue was brought back to a human understanding between all parties. [Emily] was a human being who was dying of a terminal condition. She was with staff who knew and understood her and above all really cared about [Emily] the human person.

Another example arose in a ward where an elderly lady in need of much assistance to care for her daily activity needs, had been admitted for care now that her son was unable to care for her at home. This lady verbalised to the nursing staff who were looking after her how good her son was to her and what a wonderful person he was. This son had recently raped and suffocated an elderly lady. "I don't know of anyone who wasn't disgusted in what he did and totally disagreed with her. We worked through it mainly through talking with each other and getting it sorted. So now it's not a problem to nurse her anymore." In this instance the nursing staff talked through the issues of the rape and murder that had been committed by the son. The patient clearly loved her son and the staff had to maintain that relationship between mother and son. They also had to accept that she was a human being in her own right with her own identified needs to be addressed. To

care, the nurses needed to clearly discuss the issues openly so they could continue to progress with her care.

Another example occurred when there was a murder in town, and the patient who had murdered their partner was admitted to hospital. “You had to go on, you still had to look after him. You can’t just, ... you can’t just stop [caring].” This participant spoke of the internal turmoil of the nurses who looked after this patient and the atmosphere of fear that was evident in the ward. The main problem appeared to be the level of junior nursing staff on the ward with a lack of senior nursing support backup. The participant spoke of the ongoing support from the other nurses working on the ward at the time for the nurses who were caring for this patient. This shows the human side of caring, the care of the other nurses supporting and assisting their colleagues through a difficult nursing situation.

These human care examples are supported by the words of Boykin and Schoenhofer (1993), who say:

Through entering, experiencing, and appreciating the world of other, the nature of being is more fully understood. The notion of person as whole or complete expresses an important value. As such the respect for the total person - all that is in the moment - is communicated.

(p. 9).

These three examples from the present study show the human nature of nursing and when these issues were raised in the group there was general agreement that you still care for these patients. They need a nurse’s care no more or no less than any other patient. However, the nurse is more acutely aware that these patients may require some extra time and attention paid to them.

Individual

The New Collins Concise English dictionary (New Zealand version), refers to the definition of individual as “Relating to, characteristic of, or meant for a single person.

Separate or distinct from others of its kind. Characterized by unusual and striking qualities; distinctive, indivisible, inseparable” (Gordon, 1982, p. 572).

Individual is relative to caring in that each person has a different and singular need, requirement or desire, and it is important for nurses to respect that position and care for the person completely. This was an important emergent theme and was stated as the opening comment at the initial focus group. The other emergent themes were focused around the individual. The group vocalised the importance of individualised care which was reflected throughout the discussion, as the participants spoke about their care for patients.

“A caring practice alters with peoples’ ages, their sexes, their nationality, their spirituality, as well as their physical and mental health and their family support.” “All these factors influence care, their social economic individual way of how they do things,” stated one participant. Nurses must “value patient individuality and their own personal individuality.” Patients deserve a nurse’s full “undivided attention,” and caring is when “a patient can feel heard”. The participants were in full agreement of individual care being tailored specifically for that person. The care as expressed by the participants was a total individual process for each patient.

McNamara (1995), in her qualitative descriptive research with perioperative nurses, looked at what perioperative nurses considered important caring practices in the operating theatre. Interestingly they considered showing concern for the patients as “unique human beings” (p. 381) a priority, followed by communication, then touch. McNamara considered that these perioperative nurses placed great emphasis on establishing relationships with patients which they considered part of the healing process. Jean Watson’s carative factors were proposed as a framework to consider the findings of this study. This emphasises the humanistic caring stance and shows the human to human encounter of the theatre nurse and the patient. Examples of the questions asked and a description of the collective answers

were given to demonstrate the humanistic caring. It appears there is a perception that the perioperative nursing environment is often viewed as being technically centered with a limited emphasis on caring and that caring in this setting is often invisible. This was a small study with five perioperative nurse participants.

Individualised care is an important aspect of nursing practice. All patients want to feel important and it has to be remembered that regardless of the issue the patient has, this issue is the patient's reality and for them is genuine. This issue is of sole importance. It requires the nurses ultimate consideration and the patient has no idea that the nurse has other issues of equal importance for all the other patients he/she is caring for. This is the secret of providing individualised care. As one participant in the present study stated, "a minor procedure is not minor to the patient, it is their experience and very real." Nurses treat the whole patient and their presenting problem and work on the best outcome for that patient. Ideally, nurses are taught not to judge nor put a value on any problem as they look after their allocated patients, each with their important and critical problem or concerns. As Bottorff (1991) stated, "clearly there are some "oughts" related to caring in nursing. For example, treating the patient as an individual is one principle that seems to pervade the nursing literature and does not appear to be antithetical to caring" (p. 33).

Caring and nursing are comparative and clearly there are some obligations in nursing related to caring that do have the principle of treating patients as individuals. This clearly was the directive given from the participants in the present study. They combined individualised and holistic care together, that the individualised care incorporated the holistic demeanor for patients. It was apparent that all nursing care had to be individualised to give any meaning for the patient. The nurse with the formation of an understanding between the two, the patient and their prescribed care, provides specific care to that individual.

Touch

The New Collins Concise English dictionary (New Zealand version), refers to the definition of touch as, “the sense by which the texture and other qualities of objects can be experienced when they come in contact with a part of the body surface especially the tips of the fingers” (Gordon, 1982, p. 1237).

Touch is a tactile expression of caring, usually portrayed by the arms and hands of one person, the nurse, administered to the body of the other. It conveys a person’s desire to help another through some perceived personal crisis. This occurs in a close personal space.

“Appropriate touch is learned.” How touch is learnt was discussed in the focus group along with how some nurses were able to use touch better than others in their practice. It was decided by the group that touch was certainly a “learnt skill.” “Touch is caring, it might only be just a gentle touch, but then it is appropriate.” “Touch is just so important but it is something you have got to learn to do properly.” Nurses also needed to be aware when not to touch and there was discussion concerning, where out of cultural respect for individuals, it was important not to touch the patient’s head. This referred to both Maori and Indian cultures. Discussion then followed on how “appropriate touch” came into the cultural aspects of care and how it was important to recognise and read the feedback from patients.

Taylor (1994), says that “touch is integral to nursing care and in it’s various forms can mean different things to patients. Touch and touching can facilitate human connections” (p. 23). Another study conducted by Wolf, Giardino, Osborne and Ambrose (1994), used a Caring Behaviours Inventory (CBI), a 43 factor instrument, to research five dimensions of nurse caring. The five dimensions were: respectful deference to others, assurance of human presence, positive connectedness, professional knowledge and skill, and attentiveness to the others experience. This study demonstrated that patients and

nurses had scored 'Touching patients to communicate caring' as important (p. 109). What this study failed to demonstrate clearly was which factor number related to which description. I could not find any reference to the 6th dimension yet there were clearly six columns of factors. For this reason this paper was confusing and unclear.

Hawthorne and Yurkovich (1994), described touch as a comfort to patients. "Through their presence, their touch and their reassurance, nurses bring comfort to patients. Caring is their way of connecting with others. *Through caring they make a difference - through caring, they receive their reward*" (p. 36). This article focused on professional nurses' reasoning processes. It associated the caring of nursing in the professional sense and the relationships that arise with patients. The human aspect of nursing was discussed providing a definition of being professional and accountable for self practice.

Other articles that focus on the importance of touch in nursing include Forrest (1989); Clarke and Wheeler (1992); and Tutton (cited in Hogg, 1994). Nurses and patients consider touch to be therapeutic and promote healing. Tutton (cited in Hogg, 1994), discussed touch being used in an intensive care unit where nurses used high levels of touch in patient care. This article suggested intensive care nursing provided excellent possibilities to develop touch as nurses have more frequent and constant hand to body contact with patients.

Clarke and Wheeler (1992), state that "touching and hugging patients [are] expressions of caring, when considered appropriate by the nurse within the constraints of respect and a patient's need" (p. 1287). This study, like the present study, considered the caring experience and the interpersonal aspects more than the tasks that a nurse may perform. The study found the quality of care was affected when nursing staff experienced pressures in their clinical practice such as "dealing with lack of resources, poor skill mix and staff shortages" (p. 1289).

The participants of the present research considered touch an important aspect of their provision of caring. Touch was raised early within the focus group discussion, and continued to be raised at various stages throughout. An example of this will be illustrated during the discussion on pets, where the participants found their animals to be therapeutic when coping with the stress and unhappy aspects of the profession.

Talk

The New Collins Concise English dictionary (New Zealand version), refers to the definition of talk as, “to express one’s thoughts feelings or desires by means of words, to communicate by other means. To know how to communicate” (Gordon, 1982, p. 1192).

Talk is related to caring in the following way It is important to be able to talk with a patient in a language that they understand and have them comprehend the meaning you are conveying. It relates also to how nurses communicate with each other, to learn how to care in situations. This talk relates to aspects that convey care behaviour, relationships, physical activities and health information sharing.

I refer to “**Nurse talk**” as one way of communicating. The question, “Where do we get the time to do nurse talk?” arose out of the group discussion when the group was raising the issue of how they use talk with other nurses. It appeared that nurses readily communicate together using commonly understood words that hold common meaning in the profession. Statements can be made and colleagues will pick up on the essence of the statement very quickly without getting into a lengthy discussion of explanation. Ideas can then be shared and solutions sought by having a discussion on the spot. As one participant stated “actually nurse talk, it is different from anything else.” This phenomenon is not only a characteristic in nursing but also reflects other professions’ specific use of language which is reflective of the specific knowledge pertinent to that profession.

“You talk about the problems you are having, you talk them out at hand-over, you work and talk out your [clinical] problems without them getting out of hand,” said one of the participants. They felt that the talk that occurred at “the change over and hand over” of staff was an excellent time for sharing nursing information about patients.

It can be a very good problem solving time, and a sharing time for something that someone else has tried, might be with a wound, or doing something with a patient. Like this worked really well yesterday. Or I did that yesterday and didn't find it good. That's the nice thing about hand over if they're run properly.

(Participant statement).

Baker and Diekelmann (1994), discuss the necessity for all members of the health team to share their stories of caring and suggest in this presentation that shared decision making can provide optimal patient outcomes. From a statement by a participant in the present study, it would appear that this hand over time is a time for assessing individual practice and care that each nurse is providing. Speaking about caring practices, or relaying difficult decisions and dilemmas in the group, helps the knowledge of both the individual and the other group members. Nursing has historically valued oral communication.

How you talk to patients is also very important. The pitch of your voice can speak volumes. One participant described a patient who relayed “you know nurses are so unique, they are the only ones he knows that say, ‘I’m coming’, and they are walking in the opposite direction.” It is difficult to walk past a problem or leave it for the next nurse to clean up. “By the time someone throws up around the corner, you can’t really walk past them can you?” There are times that patients and the situation the nurse is working in can be unpredictable and when something does happen it has to be addressed promptly. Nurses have found that by walking past a problem they can compound an issue. It is important for the nurse to keep the working environment safe for other patients.

Saying you will “be back in just a minute,” I now tell patients “I will be back but I’m not sure when.” I have observed this phenomenon and was unable to find any

literature to support or refute it. The language used to convey a message, how that message is interpreted by another, and what transpires in the activity surrounding the whole activity, would be worthy of a study in itself.

The participants talked about the issues of having to care for the murderer and rapist's mother, and how they each in their respective wards assisted the nurses who were doing the hands-on caring for the patient and their relatives. They talked about supporting their colleagues who each had to come to terms with accepting these people as someone needing care. This talking in the group at the time helped each group of nurses in the ward deal with the issues that affected them. These nurses were still able to care for the patient as an individual, accepting the situation, but not having it affect their caring for others in the ward.

Time

The New Collins Concise English dictionary (New Zealand version), refers to the definition of time as "the continuous passage of existence in which events pass from a state of potentiality in the future, through the present, to a state of finality in the past. The expected interval in which something is done, an unspecified interval, a while" (Gordon, 1982, p. 1226).

Time as it relates to care takes on the normal definition that everyone uses. It is used as the interval of initiating and concluding a specific period with a patient and is a frequent measurement used in nursing to convey how long something may take. However, in nursing situations time can be open ended, frequently dependent on other environmental impingements that interrupt the nurse-patient relationship. Time as hours and minutes is less relevant in some instances than the progress patients achieve over a day. There are other instances when timing is absolute and precise, for example the medication time or the

time a patient was anaesthetically induced. For the most part, time as it is commonly defined has no relevance in the majority of nursing situations. It is the quality of the time spent that should be measured and not the actual time itself.

This theme relates back to talk in that time facilitates talk and there needs to be time to work issues through. These two themes are reciprocal. The lunch time is considered by some as a sharing time “you sit down at lunch time and you talk.” “Taking time,” the group decided, was something important that nurses need to do for their clinical practice. Many issues could be worked through by talking them out with another. “Because you can actually have a difference of opinion without coming to blows. At the end you are both resolved, just a different perspective.” Dietrich (cited in Gaut, 1992) states that “being broad minded enough to listen to a co-workers view and to convey to another co-worker that you are listening is perceived as caring” (p. 73). She further says that “the lack of time and space to interact away from direct patient care can inhibit nurses caring” (p. 80).

The participants in the present study raised other issues related to time. To be able to “spend the time to help patients raise areas of concern.” To be able to provide “exclusive time” with the patient in a close person to person interaction. Eriksson (cited in Gaut, 1992), states “as a quantity, time is of no great significance, but the quality of sharing time with somebody is important” (p. 208). This issue was also expressed by the participants in the present study, in that sometimes they would like to “spend more time” when in fact they all felt the pressure of the working environment on their time. This “spending of quality sharing time” relates to the participants stating the need for “exclusive time.” These two statements support each other, as does the nurses making time to do the work of another. This was expressed when a patient died and “it was a busy time” at nine o’clock in the morning. The other nurses on duty allowed this nurse time to attend to a

patient's last rights. Hawthorne and Yurkovich (1994), talk of the nurses that value caring.

They state:

[A] nurse, who spends "extra" time listening to patient's concerns instead of "getting her work done," may be viewed by some of her colleagues as not carrying her load, wasting her time or not "being part of the team. They are challenged to maintain their commitment to human caring.

(p. 39).

This leads on to a comment made in the focus group that provided intense discussion. This was "**a nurse's minute.**" There was a lot of discussion around the definition of the nurse's minute and what it means. It was inferred that the nurse's minute had no ending, it is open-ended time. Nurses are "time travellers," a minute can be more like an hour. The issue appeared to relate to the comment "I will be back in a minute." The discussion then circled around the fact that you do intend to return to the patient. However, the ward situation is not always predictable. Someone rings a bell, or someone falls, "it can take you about half an hour to get up the ward, someone wants drugs checked, who's got the key?" These are what interrupt the nurse's intended minute.

Milne and McWilliam (1996), considered nursing resource as caring time. This resource I found most enlightening. They used a phenomenological inductive research methodology, asking patients and nursing staff of a neuroscience and chest surgery unit respectively, the nature of the nursing resource. This research was undertaken in a 600 bed teaching hospital during a time of change. The reason they undertook this research was to investigate what and how nursing was occurring in the working environment, and to increase the understanding of the use of nurses as a resource. This study aligned with similar statements from my participants on time, relating the importance of how time is comparable for both the nurse and the patient. Both placed value on the time spent with patients. The Milne and McWilliam study raised the issue of nurses being on the ward 24 hours a day, so when the patient had a problem a nurse was there to talk with them. This

was reinforced by the participants in the present research who stated that nursing “is a 24 hour perspective isn’t it”.

Milne and McWilliam (1996), demonstrated how nursing should be understood as a health service resource that can be “inextricably linked to both quantitative and qualitative expressions of nursing” (p. 810). Their research explored this concept and concluded that the nursing resource be interpreted as “Caring Time” (Milne & McWilliam, 1996). The elements of caring time included: being with, sharing humanness, connecting, doing to and doing for, being technical, and integrating services. They also found an overarching structure of spending time, inadequate time, and struggle with time. The researchers then went into more detail using the participants’ words to demonstrate the meaning of the element selected. At the hospital under study, there was pressure to determine the outcomes of nursing care relative to cost. They highlighted the importance that Nurse Administrators, Nurse Managers and bedside nurses must have and continue to be involved in leadership roles to achieve recognition, allocation, and promotion of nursing’s contribution of “Caring time.” Caring as a component of nursing needs to flourish despite the workplace pressures that have the potential to reduce nursing to a collection of tasks and procedures. Nurse managers need to promote ‘caring time’ within the institutional culture so it does not go unvalued. Certainly in times of economic restructuring, nurses are at the cutting edge of most of the changes in the health system. They frequently are required to implement and be proactive with the containment and control of spending. They also work closely with the patient, the receiver of health care. Consequently many of the financial changes do affect both the nurse and the patient.

There are times in the working environment that can be emotionally draining for the nurse. Therefore, it is important for the nurse to take time for him/herself, whether it be taking time away from the worries of the workplace or enjoying some physical activity or

hobby. Sometimes nurses need to verbalise what has happened to them with their colleagues. This is one way nurses can accept whatever the concern is for them and move on from painful and emotional experiences encountered in their clinical practice. One participant related that “sometimes after work we will all go out for coffee and that can be the most heart wrenching time out. Afterwards you feel really good.” Oberle and Davies (1993), conducted research in Canada among nurses using a model of supportive care that they had introduced in an earlier research project. The supportive care model could “be used to demonstrate the foundational relationship between an ethic of care and nursing practice” (p. 70). Their study focused specifically on those nurses working in acute settings to explore reasons of dissatisfaction among nurses. In the concluding statement it was found that if nurses were “prevented from providing the kind of care they believe in, they experience a betrayal of personal values” (p. 74). This, it appeared, resulted in nurses who were disillusioned and dissatisfied.

Holism

The New Collins Concise English dictionary (New Zealand version), refers to the definition of holism as, “the idea that the whole is greater than the sum of its parts” (Gordon, 1982, p. 534).

Holism interacts with caring in the following way. the whole patient is treated as unique with their own individual bodies, minds, spirits and their presenting health problems. Each brings their own specific social, cultural and environmental individuality and stipulations to the encounter. To nurse each person holistically the nurse must recognise these individualities and respond within a partnership with the patient, reaching for their individual health goal and providing all relevant possible information for optimum

decision making for their health outcome. The statement made by Rogers (1970), defines holism as the state that:

The science of man cannot be reduced to systems, organs and cells. Man's humanness is not the product of a machine. The wholeness of life cannot be identified in the laws of physics and biology....Human beings are characterized by mass, structure, function and feelings....They are identifiable in their totality. They behave as a totality.

(p. 46.).

This aligns with my belief on holism a person is a totality that cannot be reduced to parts. Human beings are not as machines. They are not mechanical nor do they have pieces that can be separated. Human beings are characterised by mass, structure, function and feeling. That is what makes us human. Owen (1995), investigating nurses interpretation of holism, makes the following statement:

[T]here is a growing acceptance of holism as a central and organising concept for the discipline, an ichor; indeed the term is becoming idiomatic in nursing language. However its general usage makes it difficult for nurses to determine an exact meaning.

(p. 4).

I too have found the concept of holism difficult to define. It is however, widely used, accepted and understood in nursing circles. The participants reflect holism as "You have got to get to the bottom of the problem to find out what it is to be able to help them fix it." This goes back to treating the patient holistically, taking into account that there is more to the issue than what is being presented on the surface. In some instances the patient is unaware of what the problem may be, they may have repressed the issue. Therefore, the nurse does need to take the time and talk it through with them. "You can dig and you can often find it and bring that awareness out," then you can deal to the whole issue, this in turn helps the patient accept and ultimately leads to the overall healing process.

This aligns with the words of Wadas (1993), who asserts that: " Helping a patient to achieve a sense of harmony with mind, body and soul is one of nursing's goals. This

harmony, in turn, generates self-healing processes and gives meaning to one's existence" (p. 40). Wadas argues that Watson's ten carative factors would provide achievable goals through the human care process. Wadas developed a case management model that had the patient and family in the centre of a circle. Additional circles radiated out to include Ambulatory care, Home care, Cardiac rehabilitation, Inpatient services and Long care services. The next circle consisted of the Primary Physician while the outer circle contained the Nurse as case manager. The nurse case manager "co-ordinates patient services, evaluates patient outcomes, collaborates with multi - disciplinary health care team members, utilizes community resources, and functions as a risk manager and patient advocate" (p. 40). This model would provide holistic patient care, with a nurse directing the caring service.

The participants spoke of "an individual's way, of how they do things." "Especially when it comes to culture, it can really make a mark on the type of nursing that you do. I don't just mean colour." Here participants were alluding to such aspects as the social networks the patients may or may not have or the economic situation that the patients may find themselves in. It was like nurses had to really do their best for the patient and consider all these other aspects as well. This I consider is an example of thinking holistically about the patient's total care. This also reflects back to the three examples provided in the human care section of this discussion (p.85). These examples portray the nurse's ability to look beyond the immediate problem confronting them and consider further issues and the other colleagues they work with.

Watson (1994), looked at the competency statements in perioperating nursing arising from the American Operating Room Nursing standards and recommended practices and related these to her ten carative factors. She took the stance that the operating theatre can be considered a highly technical environment for nurses to practice patient centred

caring. She relayed that “nursing should build its epistemological foundation on the holistic view of caring” (p. 268). Her suggestion was perioperative nurses should develop creative ways to enhance patient care delivery. In the present study there was a participant who did consider the total picture of staffing in the operating theatre when a trauma was eminent. “You have to be aware of it [who has children around the same age] when you know you have a six year old coming in with major trauma. You look at who you’ve got on with you.” “That’s right, it is your support and your caring” for your colleagues, a second participant continued and the group agreed.

Nurses found they became personally distressed when they were unable to provide holistic care. This was one of the findings from the Oberle and Davis (1993) study. With the enhancing and inhibiting factors raised by the participants in this present study, I consider this a reality of the current nursing environment. In the first focus group, when there was talk of moving a dying teenager from the ward, you could hear how frustrated the senior nurse had felt when she realised the teenager would be moved away to another area to die. When issues similar to this occur, it affects the total staff on the ward not just the nurse involved in the patient’s care. This too is the essence of holism and holistic nursing having a wide concern and caring for the whole.

Honesty

The New Collins Concise English dictionary (New Zealand version), refers to the definition of honesty as, “the condition of being honest, virtue or respect” (Gordon, 1982, p. 537).

How honesty relates to caring is by being open, clear and precise with information conveyed to the patient in a language that is readily understood. Medical terminology should be translated clearly into common lay language. While the information is being

conveyed, the nurse should try to understand how the patient receiving the information is feeling and relate sensitively and tactfully what needs to be said. The nurse should conduct themselves with integrity respecting the moral and ethical boundaries of their practice, though I realise this is a value judgement.

“Keeping promises, don’t make promises you can’t keep.” This revolved around a discussion on Emlar cream which is required to achieve a localised skin anaesthesia applied mostly to the back of children’s hands when an intravenous line is to be inserted. This practice ensures there is no pain associated with the needle. However, “if there was only five minutes before a child went into theatre, then don’t put the cream on, as it will not have time to work, and the needle will hurt. Tell the child there will be pain, they may not like it but they will be aware.”

For nurses it was apparent that telling patients the truth about clinical experiences was vitally important and again there was quite a discussion involved around the issue of “truth telling.” Much of this has already been raised in the time section where the participants were discussing the nurses’ minute and saying to the patient when they will be back. “If it is going to be sore tell them it is going to be sore.” Taylor (1994), has eluded to ‘straight talking’ and talks about “speaking messages frankly and clearly between nurses and patients”(p. 196). The participants in the present study raised the issue of nurses preparing a patient to be discharged home. The nurse had given the patient good pain control following surgery and had other medication prescribed for picking up at a pharmacy on the way home. The patient was ready for discharge home when the doctor arrived and said, “of course you realise that when you go home in 3 hours you’re going to be in writhing agony! Why did he not arrange for the patient [to stay in hospital] if he thought that. You just don’t do things like that,” continued the participant. The nurse felt

as though this patient had lost trust in her with the doctor coming and undermining what information she had already given the patient.

If for any reason the nurse may feel unable to look after someone then it is being honest to say, “Look I would rather not have this patient.” “You have got to learn to take a step back sometimes and that takes strength.” “It takes guts really and honesty from the start.” This discussion revolved from the humanistic examples given on page 85.

Situations and experiences do challenge the nurses personal belief system. Sometimes the nurse may become emotionally involved and be unable to be objective in given situations.

Therefore, it is honest to face these practice realities and challenges. As stated in the introduction of this study, issues such as this would be raised in this discussion section.

However, I would not pursue the theme of not caring. It is worthy of a study in itself.

Humour

The New Collins Concise English dictionary (New Zealand version), refers to the definition of humour as, “the quality of being funny. The ability to appreciate or express that which is humorous” (Gordon, 1982, p. 545).

The relationship of humour with care means the nurse can make light of some intense situations while still respecting the integrity of the patient. It means that nurses are able to keep a balance in their lives and assist patients through challenging situations by making humor work for nursing practice.

One participant stated, “nurses need to retain a sense of humour in caring, this is more prevalent in smaller team focused units. It helps retain a sense of balance.” There was discussion on how therapeutic humour can be and when a unit is happy, even though the work may be hard or stressful, it can be fun and the time goes by more quickly. One participant decided “the camaraderie between nurses, I think, is really important.

[Including good] peer support and humour.” Dietrich (cited in Gaut, 1992), mentions that “*esprit de corps* [comaraderie] develops as a nurse becomes part of a unique nursing community. Respecting this sense of community *esprit de corps* is a way of showing caring” (p. 75). As the researcher I could not help but observe the group on both occasions. Once the first focus group participants became familiar with each other they displayed a camaraderie in the group. The second focus group that contained three of the original focus group settled more quickly into a group of ‘friends’ who appeared to be getting on really well. It was heard on the recording as joviality that occurred spontaneously. When it occurred it was appropriate and not destructive to the focus group process.

The participants then discussed the talk over lunch and “how you would not be saying this if you were sitting down in a fine restaurant.” The discussion then moved to going out socially with a group of family and friends, and how sometimes it is one of the partners who will start a humorous discussion around the nurse’s work. “But it is important to have those times when there’s other people involved,” said one participant. “Families in general?” asked another participant to clarify what was intended. “I think families can be just really special,” continued the participant.

Although there was not much articulation of humour it was evident throughout the focus group discussion on the tape. There were frequent periods of laughter filtered through the data. There was one part where the group was speaking on how they had been physically hurt by patients pinching, punching and head butting them. All members had experienced some episodes of violence from patients at some time in their careers and the comments were, “we keep going back for more? What does that tell you about us!” (laughter then a second or two of silence) “We need the money.” (more laughter). “We get paid for this?” asked one participant. As I listened closely to the tape there were periods when laughter was spontaneous and related to a discussed issue, or something that had

occurred, like an unscheduled sneeze. One unfortunate participant had a coughing episode that prompted light humorous discussion and laughter.

As Taylor (1994), states:

Humor can soften the hard realities of people's circumstances and provide a means of levity, even temporarily, above the inevitable of certain ultimate tragedies. When humor is shared and sensitive to the other's situation, it can make people feel less lonely and connect them on lighter levels. An awareness of the benefits of humor as a therapy in itself, can be a modality of care for nurses to explore and apply in their daily nursing practice.
(p. 228).

Nursing can be a solemn and stressful profession at times with nurses supporting patients at some of the most vulnerable moments in their lives. If a nurse can use humour to facilitate the humanistic caring of nursing then surely this is one of nursing's reality and purpose.

Courage and Confidence

The New Collins Concise English dictionary (New Zealand version), refers to the definition of courage as, "the power or quality of dealing with or facing danger. The confidence to act in accordance with one's beliefs" (Gordon, 1982, p. 256). The New Collins Concise English dictionary (New Zealand version), refers to the definition of confidence as "trust in a person or thing. Belief in one's own abilities, self assurance. Something confided, secret" (Gordon, 1982, p. 233).

The relationship of courage with care means that nurses, with their vast clinical knowledge, sometimes have to use that knowledge and advocate for patients when they may not have a full understanding of their health problem. The nurse has to speak up for the patient and ask the doctor to explain something more fully. This is no easy situation and it means the nurse has to draw on many personal resources.

The relationship of confidence to care is the knowledge the nurse has gained through their practice and being able to portray that honestly and accurately to patients. It

means also that the nurse has the ability to perform in this professional role and when nurses are unsure of issues they enquire for answers. I have chosen to put these two emergent themes together as it was difficult to separate them out in the discussion of the participants. There were times when they merged in the discussion.

“With time and experience you have that sort of self confidence to ask people what they want.” Building the relationship with the patient and instilling them with confidence in your ability to do right by them. “If you do not understand, or there is something you’re unsure of give me a nod and I will pick up on that, you don’t have to say anything.” This participant’s statement reflects a caring way of considering the patient’s individual needs. The patient can give a nod to the nurse when they do not understand what the doctor is saying and the nurse will ensure the patient gets that information either by asking the doctor there and then, or by talking with the patient to clarify issues once the doctor has left. Hogg (1994), raises the issue of the unique role that the nurse plays in meeting the patient’s needs. The paper Hogg wrote was titled, “Don’t let cure be at the expense of care.” She states, “until the 1980s, nurse education was based on the medical model” which it is believed led to an emphasis being placed on curing. The situation is now with the emphasis placed on caring. The focus the participant demonstrated with the patient giving a nod if they did not understand the doctor’s explanation shows nursing as caring. As Miller (1995), points out in “Keeping the care in nursing care,” “More than any other profession, nursing has the distinction of being responsible for the caring that patients receive in our health care system” (p. 29).

The participants discussed the patients access to medical personnel and how they were being forced to make clinical decisions when the doctor would not come over to the area.

There is a lot of pressure on staff nurses because you are making the decisions that the doctor should be making up to a point. Like, will we ring

the doctor now or will we wait? You're going to be held accountable if you get them over there and their opinion does not agree with yours. We have got to have a pretty good [reason] to get them to come in.

(Participant statement).

It appeared that with some of the contracting in of services which had been previously provided for by the hospital were causing some difficulties. Doctors were experiencing problems meeting the demands of each clinical area they were responsible to. It was found that doctors were having to cover more in their daily work practice and that nurses were being forced to pick up more of the clinical decision making on the floor.

We were absolutely promised that we would have better doctor cover when we shifted [to the new hospital]. We have doctors rounds two days a week, we're lucky if they come one day a week. We had a list a mile long, [and the Doctor said] we're not going, we just haven't got the time.

(Participant statement).

It appeared this issue was causing stress and pressure on the registered nurses working in this area and it was still occurring a year after this unit moved on to the hospital site.

Over the past year, some nurses in the environment of the study had acquired further skills. Nurses were running off ECG readings and some were inserting intra venous cannulae in patients. It was now becoming accepted that nurses would do these activities. One doctor rang and asked if "next time [could the nurse] put a bigger line in." He was informed he was "lucky to have it in at all." There was a lot of discussion on how good it was that nurses were "upskilling," the term the participants used. However, they saw a down side to this in that if the nurse could do these things they were more likely to be called away from their own work to put in lines or do ECGs for other staff.

There are confidence and courage issues sometimes that the nurse perceives need to be raised with patients. Sometimes the nurse picks this up by the look on a patient's face and then they need to pick the right time to discuss this issue with them. One participant

took an opportunity in the shower, "I hope this is an okay time to mention to you, but I saw your face yesterday." "Can't I have intercourse?" asked the patient. The nurse explained how he could but needed to take care for a while with his new hip replacement. It is having confidence in your ability and the courage to share sensitive, personal and private information that the patients need. The nurse is often the one that finds themselves in situations quite unexpectedly when patients divulge private, personal and sensitive information. It is having the confidence to truly nurse when these situations arise. Nursing has a social contract with the public which states "Nursing is a specialised expression of caring concerned primarily with enhancing the abilities of individuals and groups to achieve their health potential within the realities of their life situation" (NZNO, 1993, p .2). Nurses have access to health information which can be acquired on the job, or they are able to find out where that information can be found. They can either access it for patients or tell the patient how they can access the health information themselves.

This raised a point with another participant who said "It's picking up on those things. I remember dishing out Beta Blockers. With a lot of guys you know, it affects their whole sexual performance. And doctors aren't necessarily telling them, 'look we are going to prescribe this for you and you may be affected in this way.'" The participants felt they needed to have the courage to raise these issues with the patients if it was suspected the patient was unaware of the side effects of medication. This raised the dilemma where in fact the doctor should be the one to ensure the patient is informed of all the risks at consultation. Nurses did not know if the patient had been informed or not, or if they had been informed and had not taken the information on board when they had the consultation. Often the nurse found themselves relaying important information the patient should have been told.

The participants in the present study had all experienced violent physical outbursts from patients. Their response to these experiences demonstrates courage which is needed when nurses go into situations not knowing if they will be injured. Clarke and Wheeler (1992), raise the issue of “pressures in nursing as a natural consequence of caring for others” (p. 1286), and raise the point of aggressive and angry outbursts nurses experience. They state, “understanding for such individuals was expressed with recognition of there usually being underlying concerns within such patients.” As one participant in the present study stated, “a lot of your angry ones have got no respect, they are really verbally abusive, it’s really hard to cope with.” It was inferred that it is sometimes the hospital system the patient is frustrated with that has led to the outburst. This may include having to wait for treatment, waiting to see a doctor, or just waiting for an operation that has been cancelled. The discussion continued around physical and verbal abusive experiences of the participants. As one participant spoke of a young man who had:

[B]een in before and he had caused so many problems. He’d discharged himself and ended up back in, no one wanted to look after him. A lot fell to me. I just sat and listened to him and recognised all his outbursts were not about me personally. He had alienated himself from most of the medical staff by his attitude and ended up being termed a difficult patient.

(Participant statement).

Unfortunately this can happen with some patients and the nurse must use courage to care for them. The discussion around violence from patients in the work place was not considered trivia. “Goodness, we have all had experiences of pain and we keep going back for more” one participant stated. I would describe this as how the nurse anticipates a need to provide care no matter what. They do continue to go back. As one participant stated, “we are glad to be nurses.” From the discussion, these participants did on the whole enjoy their profession.

Determination and Dedication

The New Collins Concise English dictionary (New Zealand version), refers to the definition of determination as “the act of making a decision. The condition of being determined, resoluteness” (Gordon, 1982, p. 304). The New Collins Concise English dictionary (New Zealand version), refers to the definition of dedication as “the act of dedicating or being dedicated. Wholehearted devotion, especially to a career” (Gordon, 1982, p. 290).

Again I have chosen to put these two emergent themes together, for the same reason in that they merged in the focus group discussion. To separate them would have lost their meaning. The relationship of determination to care is having the tenacity of character to follow through on your convictions. To be able to make decisions for patients, their relatives, and other health professionals, and be able to make things happen. It also means accepting when you are wrong and making the appropriate changes. The relationship of dedication to care is more aligned to the commitment the nurse makes to carry out care no matter what. Sometimes it can be hampered by the environment or the patient themselves when they do not fully understand what is happening to them. It can mean putting yourself out, or going that little bit further when the situation dictates. It means always putting the professional responsibilities before anything else when you are working with patients. Some would go as far as to say this would be considered a duty to care. Reverby (1986), analysed the consequence for nursing as a ‘caring’ dilemma. She proclaims through reviewing the historical evolvement of nursing in early colonial America that ‘nursing’ took place in the home. It was usually taught by the mother to the daughter as a type of female apprenticeship. Thus nursing then became embedded in the character of women. It then further evolved to be considered as the duty of women to take responsibility to care

for the sick. Reverby (1986), then further goes on to state about the relationship of care with nursing that:

[W]as organised under the expectation that its practitioners would accept a duty to care rather than demand a right to determine how they would satisfy this duty. Nurses were expected to act out an obligation to care, taking on caring more as an identity than as work, and expressing altruism without thought of autonomy either at the bedside or in their profession. Nurses have had to contend with what appears as a dichotomy between the duty to care for others and the right to control their own activities in the name of caring.

(p. 5).

Even in the current working environment this statement would have relevance. This consequently leads to the issue where nurses are trying to fit everything into their day as they view their responsibilities to care highly. Reverby (1987), moves on to say: “Nursing continues to struggle with the basis for, and the value of caring. Hospitals, seeking to cut costs, have forced nurses to play ‘beat the clock’ as they run from task to task in an increasingly fragmented setting”(p. 10). This would echo the participants as they have kept up with the pace of the changing system that becomes fragmented around them.

Your values effect your caring and the patient’s values effect your caring.

“Sometimes the family don’t represent what the person feels.” One participant was referring to long term care where patients are in care for long periods, sometimes this being permanent. “Quite often the patients cannot speak, so we go by assessment usually over long term.” This shows dedication to the patient the nurse is caring for, respecting them as an individual with their personal values and beliefs.

There was the issue with [Adrienne] the 6 year old child with burns who was having the dressings removed. The child obviously felt traumatised and said “it’s sore,” with tears flowing down her cheeks as proof. The doctor demanded she “get up and walk, it’s not sore.” The nurse who had managed to administer the charted Panadol prior to this said “the child will not be moving until the child is comfortable, and then she will get off

the bed and maybe go for a walk...in her time.” This nurse demonstrated determination by asserting herself to provide the best care possible for this patient in the most comfortable way possible. It is understanding that what the patient says is what the patient feels. It is the patient’s reality. Nurses are not there to judge if the patient is sore or not. The patient is the one in the situation and the nurse is dedicated to provide the best care possible for the patient in the situation.

I found in the analysis there was complexity when trying to separate issues. Frequently there was an interweaving of the themes, a linking of courage and determination. It takes courage to confront issues in the workplace. This was raised in the research of DeMarco (1998). This focus group study explored phenomenologically the experiences of staff nurse interactions. The analysis found nurses tended to seek “an avoidance of direct communication with co workers regarding the type of care they were giving to patients. The participants emphasised that they chose to not confront because they valued connectedness as reciprocal care in and of itself” (p. 131). I would agree with DeMarco. However, there are times when nurses will confront, especially when a nurse does something that challenges the normal procedures. For example as quoted in chapter two (p. 44), I wrote about retrieving a foetus from an ectopic pregnancy to show the grieving parents. It took courage to take this risk in practice. However, “courage makes risk taking possible and carries one beyond safety and security. It is not blind, it is a courage informed by knowledge and by past experiences and by a trust in one’s own ability to grow” (Blair, 1998, p. 19). It must strengthen the knowledge base of each nurse to have colleagues question individual clinical practices.

There will always be personal challenges to the nurse from the patients who move in and out of nurse’s care. Those whose life styles are abusive and self inflicted, those who self mutilate or mutilate and abuse others, those who want to commit suicide and those

who want to be put to sleep to be out of their pain and suffering. Then there are the other challenges of murder, rape, and the drunk driver who causes death. “It is giving care to that person. Giving them 100 percent through it, and it’s non judgmental. With some nurses there’s a bit of an attitude, and I think that is really quite sad because you know it carries over into their care” said a participant.

4.2 THE CARING WAYS OF PRACTICE

Partnership

The New Collins Concise English dictionary (New Zealand version), refers to the definition of partnership as “a contractual relationship between two or more persons carrying on a joint business venture. The deed creating such a relationship” (Gordon, 1982, p. 824).

Partnership in care means that decisions made occur between the patient and the nurse. It is an unwritten agreement that the two will work together, considering the other and making the best decisions together for the patient’s best health outcome.

“We quite often have patients that cannot speak and sometimes the family doesn’t represent what the person feels.” “We go by assessment over a long period of time,” stated one participant in the present study. Griffen (1983), informs that “the helping activities of caring are of innumerable kinds, simple, complex, more or less technical. They are grounded in a nurse’s perception and judgment of the patient’s needs at a particular time” (p. 292). One participant in the present study demonstrated how she engages a patient in talking about their health issue or illness and involving patients with their own care. “I have had a look at your notes and I am unclear about this [an issue in the patients file], can you help me.” This participant encourages patient involvement and initiates this by drawing the patient into a discussion. Hawthorne and Yurkovich (1994), remind nurses

that: “Nursing textbooks are written to remind nurses to focus on the emotional needs of their patients as well as the biological ones. This information is intended to help nurses to communicate more effectively and to establish an atmosphere of trust with their patients” (p. 41).

Clearly, the participants’ focus was one of working partnerships of caring with their patients. The following are some examples the participants gave of working in partnership with their patients. In the discussion of the angry young man ‘who alienated everyone’, the nurse sat with him and discussed what his problems were. The participant who allowed the relative to wash her sister after she had died, worked in a partnership of caring and understanding of how the relative must have felt. The story of the nurse who did not want the dying patient to be removed from those who knew and cared for her. Throughout the discussion there were clear examples to demonstrate the nurse working in partnership with patients, relatives, their nurse colleagues and other health workers.

Professional commitment

The New Collins Concise English dictionary (New Zealand version), refers to the definition of commitment as “the act of committing or pledging. An obligation or promise” (Gordon, 1998, p. 224). The definition of professional is “of suitable for, or engaged in as a profession. Engaging in an activity as a means of livelihood. Extremely competent in a job” (Gordon, 1998, p. 908).

The relationship of the professional obligation of the nurse to care is the unspoken duty to care for patients, the commitment that the nurse engages in in clinical practice. There is loyalty to both the profession with its rules and regulations, and to the organization. It is related to the moral and ethical issues that abound within the profession. As one participant said, sometimes there is a conflict of interest:

You have got someone who wants to die...you know, who wants to be snowballed, or you have got someone who wants an abortion, and you don't believe in it. You struggle with that. You've got 'that conflict.' But it's giving that care to that person isn't it. Giving them 100 percent through it, and its 'non judgmental.' We do face some big conflicts.

(Participant statement).

Nurses face many controversial issues in practice that need to be addressed immediately. In most instances the nurse is not able to put the issue out of their immediate focus and wait for a more appropriate time to deal with it. Most practice issues require immediate attention and demand to be solved quickly, whether it be the right time for the nurse or not.

Nurses find they are usually never totally alone in the hospital environment, some other nurse will notice and may support or help the other. As one of the present participants stated, "You just never know, it could be you the next time." Griffen (1983), raises an interesting point about nurses, "If he or she [the nurse] is an active participant in an important human experience, it is necessary that she is able and willing to understand the features of the situation and that the nurse is 'a mind in possession of its own experience'" (p. 292). Sometimes the nurse finds themselves in situations before they comprehend what is happening. Patients will raise the most interesting issue when it is least expected. As one participant stated, a young nurse was preparing a patient for theatre for a prostatectomy, when the patient asked, "will I be able to have sex again?" This nurse had to leave the room to find the answer, she had never been confronted with that question before. This demonstrates how the nurse learns by relating to the patients lived concerns, then making a commitment to find the knowledge for the patient. It also adds to the nurse's knowledge.

Hawthorne and Yurkovich (1994) state, "when a nurse loses sight of her central purpose that is crucial to her existence as a professional, then she also loses her

commitment to the essence of nursing - the caring relationship” (p. 41). This statement is one that I fully agree with and support.

Professional and personal knowledge

The New Collins Concise English dictionary (New Zealand version), refers to the definition of knowledge as “the facts or experience known by a person or a group of people. The state of knowing. Conscious or familiarity gained by experience or learning. Erudition of informed learning” (Gordon, 1982, p. 623).

The relationship with care is the reading, learning and understanding that the nurse adds to their personal traits as they work in the profession. It is what is built on over the years as the nurse matures through the milestones of life and experience. It means being able to share that knowledge with patients and colleagues in a clear, concise and easily understood way.

Sharing “what you know [with your patients] and advising them.” “Being the patients advocate.” “Knowing when the doctor wants to talk to the patient and you know that the news is not good, you set the scene and are there for the patient once the doctor has gone.” These comments were all made by the participants in the current study and demonstrate the application of professional and personal knowledge to the situation being confronted. Swanson (1991), raised the issue of a theory of caring when, “the desire is to understand the personal reality of the one cared for. Integral to knowing is the provider’s philosophy of personhood and the willingness to recognise the other as a significant being” (p. 163). These sentiments were clearly filtered throughout the focus group discussion in the present study.

Hand-over can be a very good time for nurses to share clinical problems they have encountered. There was a willingness to share clinical expertise with colleagues. Nurses

add to their personal and professional knowledge by sharing information and may change their practice for a better method that another nurse has used. This is supported by a comment from McFarlane (1976), in the “Charter for Caring.” “Knowledge forms the basis of the judgments which nurses should be making in assessing needs and planning action” (p. 193).

Nurses watch for subtle changes in the patient’s general condition. Kitson (1993), infers when she talks about caring in nursing that nurses refine and clarify their own concepts of nursing and caring. “When workable aspects of the concepts are identified and relationships predicted, and particularly when events can be anticipated and controlled through an understanding of these relationships, then one can talk about a theory of nursing and caring”(p. 30). Boykin and Schoenhofer (1991), add that the aspect of:

Personal knowledge is essential to ‘being’ in a nursing situation. Nursing cannot occur from the exterior. It only occurs through entering the world of the person(s) being cared for, understanding that world and the calls emerging from it, and responding to them.

(p. 247).

Professional and personal knowledge provide an essential ingredient that helps make up the whole of that individual nurse. Clinical knowledge is frequently updated on the job from reading other nurses research into clinical issues. This enables current research and trends in the clinical field to be applied to practice and provides the best possible care with the resources that are available to treat the patients.

Reflective

The New Collins Concise English dictionary (New Zealand version), refers to the definition of reflective as “characterised by quiet thought or contemplation. Capable of reflecting” (Gordon, 1982, p. 964).

The relationship of reflection to care is the nurse thinking back over what they have accomplished or not accomplished and accepting it as it happened or looking at ways to improve the encounter. This can create or clarify the meaning of what occurred for the nurse as either a good or bad experience. It is acceptable for a nurse to create her own diary of experiences.

From the stories told in the focus group discussion I could hear how a nurse would reflect over their practice and the other group members would draw out the experience. The participants were reflecting on holistic and individualised nurse 'caring'.

"Sometimes we'd go to the funerals of our patients and your presence there is really treasured by the family". This participant was completing the care she provided in life for the now deceased patient by providing holistic caring for the individual and their family.

The present study could be considered a reflection on the lived experience of practice. The participants recalled experiences from their practice within the focus group. Johns (1996) states, "caring can only be realised through reflection on, the lived experience of caring. Reflection offers practitioners a window for them to look inside and know who they are as they strive towards understanding and realizing the meaning of desirable work in their everyday practice (p. 1137). He further states "failure to work in desired ways is unacceptable to the practitioner committed to caring" (p. 1137). I fully support this statement and feel nurses who reflect on their practice are able to monitor their own actions in caring and enhance their own clinical practice by personal evaluation.

Reciprocal

The New Collins Concise English dictionary (New Zealand version), refers to the definition of reciprocal as "relating to, or designating something given by each of two

people etc., to the other, mutual. Given or done in return, indicating that action is given by each subject” (Gordon, 1982, p. 956).

The reciprocal relationship with care is the shared understanding that portrays meaning. There is mutual sharing of information between two people.

Patients who drop in two or three months later to say thank you. “You see them hobbling back on their crutches, with something under their arm.” “I’ve never forgotten you ones here. And that is worth more than money can ever buy.” These examples from the participant in the present study give a shared understanding between the nurse and the patient. The nurse cares for the patient when they need care and the patient responds in the way they feel most able to, and say “thank you for caring for me.” Boykin and Schoenhofer (1989), say that “through interpersonal human care transactions, there is a reciprocity between persons that allow for a unique and authentic quality of presence in the world of the other” (p. 149). Taylor (1994), presents the therapeutic nature of relationships when she states, “Something more than nurses’ knowledge and skills accounts for the healing effects, because the therapeutic effects are reciprocated between nurses and patients, that is, nurses and patients alike can experience the various benefits of their relationship” (p. 22). Reciprocity nourishes relationships and adds value to the experience of the encounter. Taylor states “the apparently small and insignificant nature of everyday human qualities can take on a larger and more significant character, when they are seen as mutually enhancing forces in human life” (p. 233). These are usually ordinary, common aspects of the job, not the highly technical and sophisticated aspects, yet this aspect of nurses caring is largely invisible to other people.

Responsive, Receptive and Respectful

I have put these last three concepts together as in the analysis I found they were interchangeable. This reflects the intergratedness of holistic nursing. The New Collins Concise English dictionary (New Zealand version), refers to the definition of responsive as “reacting or replying quickly or favorably, as to a suggestion, initiative etc. Reacting to a stimulus” (Gordon, 1982, p. 981). The dictionary definition of receptive is given as “able to apprehend quickly, tending to receive new ideas or suggestions favorably” (Gordon, 1982, p. 956). The dictionary definition of respectful refers to “full of, showing or giving respect” (Gordon, 1982, p. 980).

Responsiveness is related to care in that a situation evokes some action to take place from the nurse. The nurse has to physically, emotionally or spiritually be present with the patient. The response is initiated by a desire to provide a service to another in need of a service. Boykin and Schoenhofer (1989), relate the meaning of response succinctly when they say, “the importance of authentic presence and connectedness with the other. Caring in Nursing is viewed as a mutual human process in which the nurse responds with authentic presence to a call from another” (p. 150).

One family relative washed her sister after she had died. I asked her if she would like to do it. She seemed so grateful at the time, to be able to do this, spending your life with someone, it is nice to spend the last of their life, the last thing that you can do for them. Her sister sat with her for hours a couple of days on end until she passed away, I felt the least I could do was to offer her the choice.

(Participant statement).

This participant was responding to a need for the sister to spend time with her recently deceased sister. The nurse was also responsible for the last rights being performed. It gave time for the nurse and sister to be together, to talk and to perform a caring act. The other nurses allowed this nurse the time to do this. While the nurse assisted in the last rights for this patient, the other nurses were quite happy to carry on with the nurse's work so she

could be there for this relative. This demonstrates how other staff responded to another nurse's caring situation. In the study of Clarke and Wheeler (1992) "caring was identified as responding to a continuous process of need, with the ability to care related to personal supportive networks and their own coping strategies" (p. 1287). This statement reflects the essence of the example given.

The relationship of receptive to care means being open to different ideas, cultures, and responses and to not feel personally challenged by that difference. To realise there are other views and opinions and to be able to consider another's opinions and beliefs and remain unthreatened by this.

When a person who has experienced trauma arrives in theatre the nurse always takes note of those on duty especially staff with children of a similar age. This is "your supporting and [you personally] caring for your colleagues." Forrest (1989), relates through her research the support of colleagues. "Only a nurse with whom one works can understand the emotional burden that arises as a result of caring for acutely ill patients and anxious families. It is possible for the nurse to continue to feel and to be caring when this support is available" (p. 822). There were further examples of nurses supporting colleagues which were discussed in the focus group.

Receptive is being open minded about care and being amenable to other ideas and the ways of other nurse's practice. It is the acceptance of the team spirit all working together for a common cause, the patient. It is also being open and appreciating the patient's ways, personal beliefs, lifestyle, their needs and their desires. Nodding (cited in Hanford, 1994) uses the term 'engrossment' to describe the internal feelings of the one giving the care. In this, it is not overwhelming, or over-indulging. It is being fully present and attentive to the one being cared for. It is having the patient realise that they are being cared for without having anything special added to that care. The discussion referred to

instances of the nurse crying with the patient, observing body language and facial expressions. Emotional presence was raised by Swanson (1993) when she stated: “Emotional presence is a way of sharing in the meanings, feelings and lived experience of the one-cared for. Being with assures clients that their reality is appreciated and that the nurse is ready and willing to be there for them” (p. 355). These examples all state the desire to be receptive to the patient’s reality. It is impossible to give and receive care if there is not some acceptance of the two in the caring encounter. There needs to be mutual receptiveness of the two in the caring encounter. This leads to respectfulness, which receptiveness is tightly aligned with. To be receptive there is a need to consider respect for the patient, the situation and the issue at hand. This total discussion has reflected a respectfulness by the participants for their patients and their nursing experiences. Respecting individuality and the holistic stance of humanistic nursing.

Summary

In summary it was found from the results of this section that the participants were focused on the importance of the individual and the provision of humanistic care. The three most important themes that rated highly were touch, talk and time followed by holism, honesty and humour. Nursing required courage and confidence followed closely by dedication and determination. This all happened in an environment of partnership, professional commitment and personal and professional knowledge and it was reflective, reciprocal, responsive, receptive and respectful. As I discovered with my data analysis, I experienced difficulty separating the data as it was found to be linked and interwoven. This was also the case with the experiences relayed by the participants in the focus group. It was difficult to decide which statements would best represent the emergent themes. This reflects the nature of holistic nursing. The participants were referring to a humanistic

provision of nursing care when they were discussing issues in the focus group. I recognised humanistic care was inherent within their professional nursing practice. As stated before, starting this study I believed humanistic care was being provided by nurses but had no evidence to prove that. With this research I discovered the evidence on which to place my beliefs.

4.3 ENHANCING AND INHIBITING CARING FACTORS

In relation to the emergent caring themes

There were instances throughout this discussion where the concepts of care and the enhancing and inhibiting factors overlapped. This is where I found it difficult to separate out the themes, which appeared to all interrelate in some way. Perhaps this is how care is structured in practice. Components of care are interrelated and unable to be neatly separated.

As stated earlier factors that enhanced or inhibited the caring experiences of these participants in addition to those already mentioned would be briefly summarised in this section. These factors demonstrate that the clinical working environment does impact on the caring of these participants. It goes beyond the actual moment of the caring encounter experienced in the clinical environment. The nurse can encounter long lasting and frustrating effects of the experience of the inhibited caring experience.

High level communication

This is the level of communication that occurs both in verbal and written form. It includes those in the hospital hierarchy who have authority over the practising nurse. The communication that occurs at a management level for any service change when

restructuring the organisation has an impact on nurses. From the participants' discussions, open and relevant information communicated in a timely manner was valued. It was evident this made nurses feel affirmed and informed thereby enhancing care. The current Chief Executive Officer (CEO) was appreciated for their ability to frequently communicate with staff. The CEO was frequently seen walking the wards, being visible and talking to staff. Communication occurred regularly by newsletter where significant events in the life of the organisation were communicated to the staff. This was really appreciated. When this person was not there it was noted how communication did not happen. This evoked a feeling of not being valued and the organisation not caring for their workforce. Clearly an inhibitor to caring.

Doctor mix

A common issue related to non New Zealand doctors, for whom English was not their first language. Patients often commented they did not understand what the doctor said yet they were too afraid to ask for clarification. It was also found that there were doctors whose knowledge base was out of date. Participants also spoke of inappropriate behaviour toward them as women. "Most of us don't mind the odd pat on the back, but it is this being mauled."

Nurse voice

"A good charge nurse is an invaluable asset to the staff, how she deals with the staff and how they are treated is important." There is a good "nursing family support" in some areas, nurses feel needed, wanted, and are part of a productive team. With good team building and debriefing and offering support for each other. "All nurses have been through the fire of late, sometimes staff feel helpless and out of control."

The participants felt nurses need to get onto committees to have input and be heard. “It takes time to write submissions and it takes time to put it all together to present.” Frequently the nurse felt exhausted once they finished their shift. “There is a lot of stress in the job.” Though one outcome of all this is that nurses are becoming more politically aware than previously.

There is great motivation and satisfaction in a job well done, nurses need to feel good about achieving. Caring for someone is something you can see through to completion and this is satisfying.

The telephone

The telephone, although considered an enhancer to care, can also be one of the biggest inhibitors to care. The telephone can save nurse’s time in walking to locate people. By paging a doctor they can get an instant reply to their question and do not have to wait for hours for a doctor to arrive.

However it also has a down side. For example, The telephone call can go directly through to operating theatre and when the nurse answers it can be someone asking about a relative. “The switch board does not query why the call is going through to theatre, they should be screened.” This same participant stated that the telephone puts a lot of pressure on the nurse especially when relatives ask about a patient. “The night call system causes some amazing problems.” “When you try to explain to people you cannot put them through because you’re on night alarm, they don’t understand.” Night alarm is when the call can be picked up from any extension by accessing two numbers to retrieve the call however the call is unable to be transferred to another extension. “We have a problem with the rest of the hospital as well, when they want a registrar and they are scrubbed, you say they may be a few more hours, you actually get verbal abuse from nurses.”

At the weekend there is no unit or ward receptionist to answer the phone. It appeared interruptions by the telephone interfered with continuity of care for patient. Clearly from the discussion, the telephone was considered an “object of distress.”

Then there was the added problem with the media probing for patient information, “they will try anything to get information.” These calls should be screened. Clearly if nurses are to care for their patients they cannot be hindered by the constant interruption of the telephone.

Confidentiality

With the services and areas shrinking there is “no place to have a conversation without being overheard.” As one participant stated, “it has a lot to do with down sizing into other areas and making it more cramped for space. This is a daily problem.” “We try to find a space then get interrupted by the doctor.”

There was the mother who phoned theatre to ask “how is my daughter?” The daughter was over the age of consent and clearly did not want her mother to know. “You can’t give out information to relatives, and they get very cross at you.”

You cannot even tell your partner you saw their best mate in hospital today unless you have that person’s permission to do so. Some people will ask straight out “is so and so in hospital.” Some people can put you in an awkward situation. You have to be careful that you do not breach confidentiality.

Pets for care and care for pets

Pets are valued as important to care. They are something the nurse can speak to confidentially and know the information won’t be repeated. “I often go home at night and talk to my cat, or my dog. They never answer back.” “I will sit with my cat in my lap and

sometimes at night be reflecting back on the day and have a 'blub,' they don't understand what is wrong and they don't ask you, just cuddle them." It was felt that relaxing with their animals after work was considered therapeutic and enhanced how the nurses felt about themselves. "it does make you feel better." "You go home and give your dog a cuddle, and be sitting there at 9 o'clock at night, just feeling a bit bad about something. They [pets] don't get into all complicated questions" reflected one participant.

Animals are known to be therapeutic. Pets bring a balance to the nurses life, they are a great releaser of stress and can bring pleasure and comfort to the caring nurse.

Change

Change can be positive or it can be negative. Change is inevitable and is always occurring. To change, the group suggested nurses need to build on their strengths and need to grow with the change. Some in the group had made adjustments in both their professional and personal lives for success. Change in the New Zealand health system is not unique. The health sectors of other countries have also been affected. Internationally, nurses have also been affected in some way with restructuring of hospital services and the following comments are what international authors have said.

From London, Sourial (1997), writes on the cost cutting environment, "perhaps caring within major bureaucratic health care systems, especially business orientated ones, better facilitate the delivery of physical rather than effective care" (p. 1190).

Ray, Didominic, Dittman, Hurst, Seaver, Sorbello and Stankes-Ross (1995), write from Florida :

As the forces of economics and the need for human caring escalate, the dissension and disequilibrium between them steadily heighten. At the edge of chaos, where the turbulence exists, the system can either evolve to a higher level of complexity or collapse. The current health care environment with its emphasis on the 'bottom line' is at this point. If caring were to evolve as the dominant order, the economic structure would

disintegrate. On the other hand, if economics were to prevail, the system would also fail.

(p. 49).

In respect to this statement, would it not be reasonable to heed the cautionary note? That clearly running an economic system and a caring system together are unsustainable. This led to the Canadian author Boon (1998), who in her focus group study looked at caring and the financial bottom line by asking for nurses clinical experiences. She started by saying that the measures implemented to instigate savings were working. However, they were putting caring at a great risk. Boon (1998), in summing up the findings decided “Management needs to learn to appreciate and reward caring values in nursing” (p. 32). She further states, “nurses voices within the organisation must be heard and responded to by management. Nurse executives and unit managers must work to remain connected with nursing staff and to foster shared work values trust and communication” (p. 32).

The participants in the present study stated that nurses were having input into some of the changes that were happening. This was starting to have an effect at the local level. However, the participants raised issues where nurses’ voices were not being heard. Their solution was for nurses to be elected onto Boards where these decisions were made to ensure the interest of nursing was maintained. Time needed to be made for the nurses on the floor to achieve this.

Flexibedding, Flexi nursing and Upskilling

Flexibedding meant patients scheduled for surgery with no pre-allocated bed put pressure on the admitting nurse to “find a bed” before surgery. “Sometimes the call is too close, the patient is having surgery and there is no bed. Reducing the length of patient’s overnight stay in hospital, and flexibedding, have created their own problems.”

Discharging patients earlier and having day surgery patients away from the general

wards means the patients are sicker than years ago and require more nursing. Through changes in surgical technology a patient having a gall bladder operation for instance, used to stay in hospital four to six weeks. Now they stay overnight and instead of a major surgical wound they have five puncture holes in their abdomen. The surgery is performed through a laparoscope.

“Flexi financing, Flexi options, Flexi nursing and Flexi skilling we are all just getting flexible,” this was one statement made by the same participant who raised the point of upskilling. Upskilling of staff does take longer and there is no formal help. One participant was very vocal in her work area. She kept asking about what she did not know, and felt at times her questions were stupid. She kept asking until she found the answer. This was stated as flexi skilling.

There had been stress experienced that was related to the nurses who had left the work force. It was felt there was a complete level of nursing experience now missing from the nursing workforce at this hospital. There is no one with the depth of nursing knowledge left. There were a lot of junior staff on the wards and casual nurses taking on more and more responsibility. One participant referred to a ward being staffed totally by casual staff. This left one permanent ward nurse in charge on the shift. Unable to cope any longer with the stress, this nurse eventually left nursing.

Boykin and Schoenhofer (1989), state “the caring nurse is living the personal commitment of service to human-kind, sending forth through caring an affirmation of personhood within the rubic of the nursing relationship” (p. 152). The participants discussed the cutting back of staff and the staffing levels. This created issues at the weekend in specialised areas such as operating theatre. When someone called in sick the staff on duty had to ring around and find a replacement from someone on their day off at home. It created problems when the area was really busy.

This led to a discussion on recognition for on going learning being valued by the organisation. There were no rewards for on going learning nor the financial involvement incurred by the nurse continuing their education. However, further education had good spin offs for the organisation who gained from the nurses' additional education, but provided little incentive for the nurses effort. "It is personal enthusiasm [to continue with further nursing education], and using up your time and your leave for study." Some did their own fund raising for participating in conferences related to their areas of expertise in nursing. As one participant stated, "there's no rewards." This was also related to the budget savings that were being made in areas related to the implemented changes. "There's no reward for savings that you can see." It appeared from the discussion nurses were making all the effort at their own personal expense and the organisation was reaping the benefits with little reimbursement.

Discussion conclusion

Caring in nursing is an expression that has been frequently used over many years. However, it has only been in the last 20 years that any research of significance has been generated. Nevertheless, there appears to be much work needed to investigate what happens when nurses deliver 'caring' care. I do believe this is the core of nursing and this has been reinforced by other nurse researchers. It is now time to delve deeper into what caring means in nursing practise and why nurses need to state more fluently what is happening when they are caring. This study has illuminated one small aspect in an attempt to look at the New Zealand perspective. Do we need to study nursing's purpose more than the essence of nursing? This was asked by Salsberry (1992). I believe that we do, and consider that we need to claim the important caring aspects that are unique to the caring care of nursing.

Purpose of the study

As previously stated the purpose of this research was to discover what registered nurses considered important when they were caring for patients. I asked registered nurses to identify those important caring care moments so I could discover just what those important moments related to. To place a greater emphasis on the caring I then asked these participants what enhanced or hindered that care that they had identified was so important to their practice.

Were the aims of the study met?

I did discover what was important 'caring' care for these nurse participants. This study will contribute to New Zealand nurses' perspectives of 'care' in the nursing literature. It has captured what a group of colleagues in a public hospital consider 'caring' care to be, and what factors enhanced or hindered that care.

Other nurses will be able to read this study and decide what resonates for them and what might be different in their practice at this time of major health reform. Health organisations will always be in the public eye. In the provision of a health service there is no option but to be governed by the forces of the political environment and the current economic position that faces the nation. These variables will always have some impact on the availability of health services in a community. Public hospitals are government funded, nurses are employed in these government funded hospitals, and patients who use the services want to feel cared for in the publicly funded system that they have contributed to through their taxes.

It is timely to consider the impact the health reforms have had on these services. Evaluating the health organisations more regularly would surely be a reasonable request, especially considering the impact these reforms have had on the ability of nurses to practise

with a caring focus. Then the impact of all these changes on nursing care delivery could be more closely monitored.

CHAPTER FIVE

RESEARCH OUTCOMES

5.1 RELEVANCE OF THE STUDY

This study identified the ‘caring’ care registered nurses working in a public hospital considered important. The identified emergent themes arose from a focus group discussion the participants had reflecting on their clinical working environment. In addition, there were factors that enhanced and hindered their ‘caring’ care. This study supports my contention that ‘caring’ care should be fostered, nourished and allowed the time and space to be practised without any hindrances or restrictions. It is evident from the literature that caring nurses do get frustrated and leave the system when they no longer feel able to provide the care which they identify as important to their clinical practice. The participants identified that many experienced registered nurses had already taken this option. It is imperative that policy makers and budget controllers, who do not provide care, really understand the importance of caring practice in nursing. Do administrators want nurses to merely perform a series of tasks throughout an eight or twelve hour day? I would caution anyone wanting to entertain this direction for nursing as this approach is likely to lead to a nursing workforce shortage.

It is time for the care to continue. It is time for the caring nurse to be recognised and affirmed, and who better to identify this than the nurse managers who are in charge of clinical areas. Nurses also must value what they have and keep the care at the bedside of the patient; to not let the caring slip away and be replaced by other so called ‘more important’ factors. Patients want nurses that care, and nurses must know, recognise, and value what this means in practice. For nurses to know what they mean by care is equally

important as is their ability to articulate what ‘care’ in nursing means. This is vital to keeping the heart of the profession alive.

5.2 STATEMENT

This study has contributed to the New Zealand nursing literature and supports and adds to the growing body of research on ‘care’ in nursing practice. It gives a New Zealand perspective that emphasizes what nurses in New Zealand consider important when they care in their clinical practice. It also shows the importance of politics in health care and recognises that politics and health are interrelated. I have faithfully related the participants’ contribution to this study and have given their perspective of important ‘caring’ care. I have relayed those factors which have enhanced or inhibited care in the nurse’s working environment. It is hoped that this thesis will be used to stimulate discussion for other nurses to reflect on what is important in their clinical practice and to discover the truth for themselves. If this work inspires just one other nurse to research caring, then I consider this to be the most valuable contribution I can make to my profession.

Future research

I lay claim to two themes for future research. Firstly **“Nurse talk”** (refer to p. 91) that is, nursing’s unique language used in everyday clinical practice. Nurses use ‘nurse talk’ in their narration with their nurse colleagues in daily communication. It has shared meaning and understanding. What language is used in ‘nurse talk’ and how do the nurses take meaning from these words? Is ‘nurse talk’ a commonly accepted phenomenon?

Secondly, the **“Nurse’s minute”** (refer to p. 95). This is another common statement used in nursing. How long is a nurses’ minute? Does the nurse’s minute have an end? What do nurses do in that space of time, the minute they tell the patient they will be?

These two themes I believe are interrelated as illustrated by a statement from the present research that demonstrates the themes of time and language. A common saying when recounting examples from practice in the focus group was “I’m coming” when in fact the nurse was actually going in the opposite direction. Investigation to detect meaning and interpretation of the language may provide a window in which to further view the clinical nurses world.

Nurses must continue to investigate and research their practice and the essence of their profession. Researching practice demonstrates that nurses care about what it is they do. It is no longer acceptable to take for granted clinical decisions that are not grounded in research based evidence from clinical practice. The future for nursing is as vulnerable to the winds of change as is any people related service. I would say very firmly that nothing is assured with no guarantee for the future. Research strengthens the profession, adds to its growth and maturity and strengthens its knowledge base. Consider changes, accept the challenge and progress the profession into the new century.

5.3 LIMITATIONS OF THE STUDY

This study was conducted in an acute base hospital that does not provide for extensive major surgery or some of the other specialist services available in larger hospitals. It did however, provide an extensive service for Orthopaedic, General Surgery, Gynaecology and Obstetric procedures, and did cater for a high ratio of elderly patients within the community. The small sample size of participants and the geographical area in which the study was conducted, limits the generalisability of these results.

This was a small study with six registered nurse participants which means the findings from this study cannot be generalised to the whole of New Zealand’s nursing workforce. The participants were all female which may have provided some gender bias in

the results. Nurses will read and decide for themselves whether the themes of this thesis have relevance for their practice. The problems which faced these nurses with the enhancing and inhibiting factors may be specific to the public hospital they are working in.

Within the limitations of this two paper thesis, the inhibiting and enhancing factors were not discussed in any depth. Therefore it is difficult to argue how broad an issue they were compared to other research findings. Qualitative studies may not have quantity. They do, however, provide rich descriptions of practise thereby increasing the trustworthiness of the results. I did exhaust the literature on care pertaining to the public hospital environments. However, it was difficult to find pertinent research that I could relate to the present study.

5.4 STRENGTHS OF THE STUDY

I attended to issues of rigor for this research throughout. I kept a journal and recorded my experiences and recounted my reflections on the method (refer to p. 77) at certain points in the process to address credibility. Transferability has been demonstrated by the fittingness of the findings. The narrated examples from practice demonstrate each emergent theme which may have shared meaning and understanding for other nurses who read this thesis. A clear trail of how I progressed this study has been written so another researcher can follow the audit trail and be able to replicate the study, thereby addressing dependability. Finally, confirmability has been demonstrated by including the participants quotes to enable the reader to see where my interpretation came from. As Sandelowski (1986) stated, “the truth value of qualitative research generally resides in the discovery of human phenomena or experiences as they are lived” (p. 95). This increases the trustworthiness of the findings. Throughout the process the participants were asked to

verify the data, they also considered the emergent themes to consider their relevance and reflectiveness relating to the focus group discussion.

5.5 REFLECTIONS ON THE METHODOLOGY

Using focus groups

The focus group methodology I found to be an excellent method of gathering information. I enjoyed working in the group situation. Making the data visible to the participants kept the process moving with minimal involvement from me to prompt the discussion. The information shared during both group sessions reflected mutual support and understanding, with the participants ensuring that everyone participated in the sessions. In general, the participants were prompt with their meeting times and returning any information. I would emphasize the need for these sessions to be well planned and for the researcher to ensure communication is kept open with the participants. This guarantees they are well informed before the meeting. I took the added precaution of communicating with each participant on the evening before the group met. I did this on both occasions to ensure the participants had remembered the meeting.

The participants used each other in the group process, in that when one participant raised an issue another would remember a similar incident or a totally different one with similar characteristics. Having a homogenous group of like minded participants working in different areas of nursing elicited enough quantity and quality of data for this thesis. The group functioned well together and some members did know others in the group. Transcribing the audio tapes was accomplished relatively easily. The participants did not speak over one another and the group dynamics were conducive to collecting the relevant information. Establishing clear ground rules was important to the process.

I suggested the participants select a venue to meet. I had a strong preference not to hold the focus group meetings within the hospital environment as I felt this could hinder the flow of information. On reflection this was an excellent decision as the discussion was open, honest and uninterrupted by the noise associated with a hospital environment. This decision also contributed to participant confidentiality as work colleagues were aware of my impending research. A group gathered for discussion at the hospital would have invited interest and questions from those not participating. Both selected venues were central and readily accessible to the participants.

Group support and collegiality were evident. Ideas were spontaneous and issues discussed openly. The ideas raised were frequently reinforced by one another in the group. One participant stated she enjoyed the sessions and had learnt so much about herself and her own practice. The data was rich in description with the group showing interest in capitalising on group interaction.

There were many gestures made by the participants which were not recorded. With hindsight, if their facial expressions and hand gestures could have been recorded against key words it may have made the data analysis easier.

I chose not to lead the discussion, the participants held the floor. Would the focus group have produced different information if I had taken a more active part? I feel, however, I have the participants stories of practice for this research and these stories were given spontaneously without any prompting.

Would I use this methodology again for research?

In answer to the above question, yes I would and I would recommend this method for the following reasons. From my experience I found the methodology conducive to investigating nursing phenomena. The methodology was flexible. It could be used, as I

did, with the participants totally leading the discussion or alternatively the researcher could ask a set of questions to narrow the field of inquiry. For naturalistic inquiry where nurses want to study the stories of nursing this is an excellent way to generate rich stories from practice. I did ask the participants to write down issues on the day or following the session. However, they choose not to contribute any written material to this study. Next time I would ask that participants do take notes on the day and write their reflections on the session. This would give another dimension to the group methodology and would reinforce issues of relevance for each participant.

Having used the methodology I would however, make some changes. Next time I would not build on information from a previous session. I would commence the discussion with new items being raised because I found when reading the transcripts from the second focus group that the group would be discussing one issue, there would be a pause and one participant would then state "I see we discussed ... last time." This then started a new direction and a new focus. In some instances the previous discussion had not been concluded. I did not realise this had occurred until I was reading the transcripts.

I experienced no problems in conducting both group sessions, but I would reconsider using a second person as suggested by Krueger (1994) (refer to p. 56) to take responsibility for any recording equipment. I had no problems controlling the group but feel in hindsight I would have the participants observed next time by a second person. Then observations of participants gestures could be included in the research to add greater clarity to the study.

5.6 RECOMMENDATIONS FOR PRACTICE

Further research should be conducted into nurses 'care' in other hospital environments, to discover if these findings cross different contexts. Would other New

Zealand nurses identify the same important aspects of their care as the participants in this study? It would be timely for nurses to have a period of stability in their working environments. There has been constant change occurring in the health and nursing education systems. I consider this has produced an air of uncertainty in the working environment. It is time to affirm what nursing has to offer in terms of quality in the health service before the 'care' that is nursing is lost. Nursing care will be moved to the side and under valued if change keeps occurring on top of earlier change with no evaluation of the effects of the change occurring. Nurses will become entrenched in trying to keep up with the changes, along with all the other ongoing effects that follow any introduced change. This, from experience, tends to deplete any energy the nurse has left for nursing issues. Will that special and unique 'caring' that is nursing disappear? So far nurses have managed to provide 'caring' care but its invisibility makes this type of nursing practice vulnerable.

5.7 CONCLUSION

Publication of research into nursing practice is the only way to let those in power know what in actuality is happening in the clinical environment. It allows the Government of the day to see what impact their policies are having on the patient-nurse relationship. Nurses need to get behind policy changes and hold to their social contract to provide care in return for a mandate from the public to regulate our own profession. This is nursing's responsibility to society. Where there are patients, will there always be nurses? I would hope this is so. However, it will not happen if nurses do not work to make it so. Thinking about care vanishing prompted me to write a final poem to bring this thesis to an end.

Where oh where

Did you see that caring care, as it went from here to there,
As it went from there to yon, oh where has all that caring gone!

It has gone to you know where. Who thought that caring was never there?
'Twas never there, so they did say. So caring care just went away.

It went away and was replaced, by high tech care that took it's place,
that cures and heals and keeps a stance, the technology of the medical dance.

The cost of caring was far far more, than Government and hospitals could ever wish for
the nurses left to give their care away from here, and moved elsewhere.

And one day soon it will be told. "The care has gone!" "The place grows cold!"
So if you're sick and in some need, of nursing assistance, please take heed.

It may be you that will need a hand to wash, or dress, or walk, as planned
with a caring nurse there by your side. Don't let care disappear on that retreating tide!

Reforms will come, and reforms will go. Restructuring is part of the efficiency flow.
But in the future let us hope that there will be, a caring nurse to look after you or me.

Into the future it is hoped that we still will see, a nurse looking out for you and me.
A nurse that cares with compassion and pride, for a patient who needs that care, "inside."

It will not be the money for gain, or the cost that will stifle such care, you wait and see.
For the nurse who cares is the nurse that will be in the front of the nursing fraternity.

(1998).

REFERENCES

- Allmark, P. (1998). Is caring a Virtue? *Journal of Advanced Nursing*. 28, (3) 466 - 472.
- Anderson, A. (1987). *New Zealand Department of Health. Public Hospital Performance Assessment*. Wellington. New Zealand Department of Health.
- Baker, C. & Diekelmann, N. (1994). Connecting Conversations of Caring: Recalling the Narrative to Clinical Practice. *Nursing Outlook*. 42, 65 - 70.
- Benner, P. (1984). *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park. Addison-Wesley.
- Benner, P. & Wrubel, J. (1989). *The Primacy of Caring. Stress and coping in Health and Illness*. Menlo Park. Addison - Wesley Publishing Co.
- Blair, S. (1998). An Ethic of Care in Practice. *Star of the South. Nursing and Midwifery Publication*. 1, 16 - 22.
- Boon, L. (1998). Caring Practices and the Financial Bottom Line. *The Canadian Nurse*. 94, (3) 27 - 32.
- Bottorff, J. L. (1991). Nursing: A practical science of caring. *Advances in Nursing Science*. 14, (1) 26 - 39.
- Boykin, A. & Schoenhofer, S. (1989). Caring in Nursing: Analysis of Extant Theory. *Nursing Science Quarterly*. 149 - 155.
- Boykin, A. & Schoenhofer, S. O. (1991). Story as Link Between Nursing Practice, Ontology, Epistemology. *IMAGE Journal of Nursing Scholarship*. 23, (4) 245 - 248.
- Boykin, A. & Schoenhofer, S. (1993). *Nursing as Caring A Model for Transforming Practice*. New York. National League for Nursing Press.
- Carper, B. A. (1979). The ethics of caring. *Advances in Nursing Science*. 1, (3) 11 - 20.
- Clarke, J. B. & Wheeler, S. J. (1992). A view of the phenomenon of caring in nursing practice. *Journal of Advanced Nursing*. 17, (11) 1283 - 1290.
- Clifford, C. (1995). Caring: fitting the concept to nursing practice. *Journal of Clinical Nursing*. 4, 37 - 41.
- DeMarco, R. F. (1998). Caring to Confront in the Workplace: An Ethical Perspective for Nurses. *Nursing Outlook*. 46, (3) 130 - 135.
- Dyson, J. (1996). Nurses' conceptualizations of caring attitudes and behaviours. *Journal of Advanced Nursing*. 23, 1263 - 1269.

- Dyson, L. (1997). An Ethic of caring: conceptual and practical issues. *Nursing Inquiry*. 4, 196 - 201.
- Euswas, P. (1991). *The Actualized Caring Moment: A Grounded Theory of Caring in Nursing Practice*. Palmerston North. PhD. Thesis. Massey University.
- Fealy, G. M. (1995). Professional caring: the moral dimension. *Journal of Advanced Nursing*. 22, 1135 - 1140.
- Forrest, D. (1989). The Experience of Caring. *Journal of Advanced Nursing*. 14, 815 - 823.
- Fry, S. (1988). Response to "Virtue, ethics, caring and nursing." *Scholarly Inquiry for Nursing Practice*. 2, (2) 97 - 101.
- Gardner, K. (1992). The Historical conflict between caring and professionalization: A dilemma for nursing. In *The Presence of Caring in nursing*. (Ed D. A. Gaut) p. 241 - 255. New York. National League for Nursing.
- Gaut, D. & Leininger, M. M. (1991). (Eds). *Caring: The Compassionate Healer*. New York. National League for Nursing Press.
- Gaut, D. A. (1992). *The Presence of Caring in Nursing*. New York. National League for Nursing.
- Gordon, I. A. (1982). (Ed). *The New Collins Concise English Dictionary. New Zealand Edition.*) Auckland. Collins.
- Griffin, A. P. (1983). A philosophical analysis of caring in nursing. *Journal of Advanced Nursing*. 8, 289 - 295.
- Guba, E. G. & Lincoln, Y. S. (1995). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln. (Eds.). *Handbook of qualitative research*. p. 105 - 117. Thousand Oaks, Ca. Sage.
- Hanford, L. (1994). Nursing and the Concept of Care. In *Ethical Issues in Nursing*. (Ed. G. Hunt, p. 181- 197.) London. Routledge.
- Hawthorne, D. & Yurkovich, N. (1994). Caring: The Raison d'être of the Professional Nurse. *Canadian Journal of Nursing Administration*. Nov - Dec. 35 - 55.
- Hodge, B. (1993). Uncovering the Ethic of Care. *Nursing Praxis in New Zealand*. 8, (2) 13 - 22.
- Hogg, K. (1994). Don't let cure be at the expense of care. *Professional Nurse*. April. 465 - 470.
- Holden, R. J. (1991). An analysis of caring: attributions, contributions and resolutions. *Journal of Advanced Nursing*. 16, 893 - 898.

- Holloway, I. & Wheeler, S. (1996). *Qualitative Research for Nurses*. Bournemouth. Blackwell Science.
- Hospital Related Services Task Force. (1988). *Unshackling the Hospitals*. Wellington. Ministry of Health.
- Johns, C. (1994). Can Human caring in practice be an everyday reality for nurses? *Journal of Nursing Management*. **2**, 157 - 159.
- Johns, C. (1996). Visualizing and realizing caring in practice through guided reflection. *Journal of Advanced Nursing*. **24**, 1135 - 1143.
- Johns, C. & Freshwater, D. (1998). (Eds). *Transforming nursing through Reflective practice*. Oxford. Blackwell Science.
- Kingry, M., Tiedje, L. B. & Friedman, L. L. (1990). Focus Groups: A Research Technique for Nursing. *Nursing Research*. **39**, (2) 124 - 125.
- Kitson, A. (1993). (Ed). *Nursing Art and science*. London. Chapman Hall.
- Koch, T. (1993). Establishing Rigor in qualitative research: The decision trail. *Journal of Advanced Nursing*. **19**, 976 - 986.
- Krueger, R. A. (1994). *Focus Groups. A Practical Guide for Applied Research*. 2nd Ed. London. Sage Publications.
- Kurtz, R. J. & Wang, J. (1991). The Caring Ethic: More than Kindness, the Core of Nursing Science. *Nursing Forum*. **26**, (1) 4 - 8.
- Kyle, T. V. (1995). The concept of caring: a review of the literature. *Journal of Advanced Nursing*. **21**, 506 - 514
- Lankshear, A. J. (1993). The use of focus groups in a study of attitudes to student nurse assessment. *Journal of Advanced Nursing*. **18**, 1986 - 1989.
- Lea, A. & Watson, R. (1996). Caring research and concepts: a selected review of the literature. *Journal of Clinical Nursing*. **5**, 71 - 77.
- Lea, A., Watson, R. & Deary, I. (1998). Caring in Nursing: A Multivariate analysis. *Journal of Advanced Nursing*. **28**, (3) 662 - 671.
- Macdonald, J. (1993). The Caring imperative: A must? *Australian Journal of Advanced Nursing*. **11**, (1) 26 - 30.
- MacIntosh, J. A. (1993). Focus groups in distance nursing education. *Journal of Advanced Nursing*. **18**, 1981 - 1985.
- McCance, T. V., McKenna, H. P. & Boore, J. R. P. (1997). Caring: dealing with a difficult concept. *International Journal of Nursing Studies*. **34**, (4) 241 - 248.

- McFarlane, J. K. (1976). A charter for caring. *Journal of Advanced Nursing*. **1**, 187 - 196.
- McKenna, G. (1993). Caring is the essence of nursing practice. *British Journal of Nursing*. **2**, (1) 72 - 75.
- McNamara, S. A. (1995). Perioperative Nurses' Perceptions of Caring Practices. *AORN Journal*. **61**, (2) 377 - 388.
- Meleis, A. I. (1991). *Theoretical Nursing. Development and Progress*. 2nd. Ed. Philadelphia. J. B. Lippincott.
- Miller, K. L. (1995). Keeping the care in nursing care. Our biggest challenge. *Journal of Nursing Administration*. **25**, 11 29 - 32.
- Milne, H. A., & McWilliam, C. L. (1996). Considering nursing resource as "caring time". *Journal of Advanced Nursing*. **23**, 810 - 819.
- Morgan, D. L. (1997). *Focus Groups as Qualitative Research*. 2nd. Ed. Thousand Oaks. Sage Publication.
- Morrison, P. (1989). The caring attitude; Nurses self perceptions. *Nursing Times*. **85**, (4) 56.
- Nelms, T. P. (1996). Living a caring presence in nursing: a Heideggerian hermeneutical analysis. *Journal of Advanced Nursing*. **24**, 368 - 374.
- New Zealand Nurses Organisation. (1993). *Social Policy Statement*. Wellington. New Zealand Nurses Organisation.
- New Zealand Nurses Organisation. (1995). *Code of Ethics*. Wellington. New Zealand Nurses Organisation.
- Nyamathi, A. & Shuler, P. (1990). Focus group interview: a research technique for informed nursing practice. *Journal of Advanced Nursing*. **15**, 1281 - 1288.
- Oberle, K. & Davies, B. (1993). An Exploration of Nursing Disillusionment. *The Canadian Journal of Nursing Research*. **25**, (1) 67 - 76.
- Owen, M. J. (1995). Challenges to Caring. Nurses interpretation of holism. *Australian Journal of Holistic Nursing*. **2**, (2) 4 - 14.
- Ray, M. A., Didominic, V. A., Dittman, P. W., Hurst, P. A., Seaver, J. B., Sorbello, B. C. & Stankes-Ross, M. A. (1995). The edge of Chaos. *Nursing Management*. **26**, (9) 48 - 50.
- Reed, J. & Payton, V. (1997). Focus Groups: Issues of analysis and interpretation. *Journal of Advanced Nursing*. **26**, 765 - 771.
- Reverby, S. (1986). A Caring Dilemma: Womanhood and Nursing in Historical perspective. *Nursing Research*. **36**, (1) 5 - 11.

- Roach, M. S. (1987). *The Human Act of Caring: A Blueprint for the Health Professions*. Ottawa. Canadian Hospitals Association.
- Rogers, M. (1970). *An Introduction to the Theoretical Basis of Nursing*. Philadelphia. Davis Co.
- Salsberry, P. J. (1992). Caring, Virtue Theory, and a Foundation for Nursing Ethics. *Scholarly Inquiry for Nursing Practice*. 6, (2) 155 - 167.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*. 8, (3), 27 - 37.
- Sandelowski, M. (1993). Rigor or Rigormortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*. 16, (2), 1 - 8.
- Sandelowski, M. (1995). Focus on qualitative methods. Qualitative analysis: What it is and how to begin. *Research in Nursing and Health*. 18, 371 - 375.
- Sourial, S. (1997). An Analysis of caring. *Journal of Advanced Nursing*. 26, 1189-1192.
- Squires, K. (1994). Defining Caring. *Nursing New Zealand*. July 20 - 22.
- Swanson, K. M. (1991). Empirical Development of a Middle Range Theory of Caring. *Nursing Research*. 40, (3) 161 - 166.
- Swanson, K. M. (1993). Nursing as Informed Caring for the well-being of Others. *IMAGE Journal of Nursing Scholarship*. 25, (4) 352 - 357.
- Taylor, B. J. (1994). *Being Human Ordinarity in nursing*. Melbourne. Churchill Livingstone.
- Thomas, L., MacMillan, J., McColl, E., Hale, C. & Bond, S. (1995). Comparison of Focus Group and Individual Interview Methodology in Examining Patient Satisfaction with Nursing Care. *Social Science in Health*. 1, (4) 206 - 220.
- Torn, A. & McNichol, E. (1998). A qualitative study utilizing a focus group to explore the role and concept of the nurse practitioner. *Journal of Advanced Nursing*. 27, 1202 - 1211.
- Twinn, S. (1998). An analysis of the effectiveness of focus groups as a method of qualitative data collection with Chinese populations in nursing research. *Journal of Advanced Nursing*. 28, (3) 654 - 661.
- Upton, S. (1991). *Your Health and the Public Health*. Minister of Health. Wellington.
- Van Hooft, S. (1987). Caring and professional commitment. *Australian Journal of Advanced Nursing*. 4, (4) 29 - 38.
- Wadas, T. M. (1993). Case Management and Caring Behaviour. *Nursing Management*. 24, (9) 40 - 46.

Warelow, P. J. (1996). Is Caring the ethical ideal? *Journal of Advanced Nursing*. 24, 655 - 661.

Watson, D. S. (1994). Technology in the perioperative environment. *AORN Journal*. 59, (1) 268 - 277.

Watson, J. (1979). *Nursing the Philosophy and Science of Caring*. Boston. Little Brown and Company.

Watson, J. (1985). *Nursing: Human Science and Human Care. A Theory of Nursing*. New York. National League for Nursing.

Wilkes, L. & Wallis, M. (1993). The five C's of caring: The lived experiences of student nurses. *Australian Journal of Advanced Nursing*. 11, (1) 19 - 25.

Wilson, C. (1994). A Superior Ideal for Nursing. *Nursing Praxis in New Zealand*. 9, (3) 5 - 11.

Wolf, Z. R., Giardino, E. R., Osborne, P. A., & Ambrose, M. S. (1994). Dimensions of Nurse Caring. *IMAGE. Journal of Nursing Scholarship*. 26, (2) 107 - 111.

Workforce Development Group. (1988). *Nursing Education in Transition. The transfer of nursing education to the general system of education. 1973 - 1988: the Department of Health's perspective*. Wellington. Department of Health.

Appendix 1



The Hand . . .

That my hand shall ever extend to help, comfort and relieve the sick and suffering.

The Foot . . .

That my feet not falter, loiter nor linger when journeying to alleviate the sick.

The Knee . . .

That my knee shall bow to the Almighty Creator in asking for guidance and aid in my endeavour to relieve the suffering of the sick.

The Breast . . .

That my breast shall be a safe and sacred repository for any secret entrusted to me or divulged through sickness or delirium or otherwise obtained.

The Head . . .

That I will constantly pursue and study the secret arts ; that I will exercise my knowledge to the benefit of those suffering bodily or mental distress, and will disseminate such knowledge amongst others as my preceptors authorise and direct.

Appendix 2

What do Registered Nurses identify as “Caring” Care.

What enhances or inhibits that “caring” care in their clinical practice.

Consent Form for Participants

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I understand that:

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. I agree to participate in a focus group interview with five or six other Registered nurses plus the researcher;
4. I agree to retain confidentially any information disclosed within the focus group and agree not to discuss any issues raised with anyone, apart from the researcher;
5. I will have access to a report of this interview to review and change at my discretion; and sign to verify that what I have read is considered an accurate statement of the interview;
6. The audiotapes will be wiped at the conclusion of the project but any raw data on which the results of the project depend will be retained on a computer disc in secure storage for five years, after which they will be cleared;
7. There is no anticipated risk, harm or discomfort involved, and I am aware some sensitive issues may arise within the focus group interview;
8. I am aware there is Employee Assistance Programme available for counselling available should it be required;
9. The results of the project will be published in a thesis however my anonymity will be preserved at all times.

I agree to take part in this project

(Signature of Participant)

(Researcher)

(Date)

This project has been reviewed and approved by the Southern Regional Health Authority and Victoria University Ethics Committee.

Appendix 3

What do Registered Nurses identify as “Caring” Care.

What Enhances or Inhibits that “Caring” Care in their clinical practice.

Information Sheet For Participants

Thank you for showing an interest in the project. Please read this information sheet carefully before deciding whether or not to participate as it is important to make this decision before you meet with the other participants in a focus group. If you decide to participate, I thank you. If you decide not to take part there will be no disadvantage to you of any kind and I thank you for considering my request.

This project is being undertaken as part of my requirement for a Master’s Degree in Nursing at Victoria University of Wellington. The major aim of the project is to identify the “caring” care that nurses identify is important to them when they are caring for patients in a hospital, setting and to establish whether there are factors that inhibit or enhance that “caring” care. These are the two questions the group will focus on.

Should you consent to be involved in this project you will be required to participate in a focus group interview with the researcher and five to six other nurses from your work environment. This interview will take a maximum of three hours, the interview will be audiotaped and the tapes transcribed. A report of the interview will be compiled and returned to you for validation, and you will be able to comment on the report, sign it and return it to me. It is not expected there be any potential harm or discomfort experienced by yourself, however some sensitive issues could be raised and every attempt will be made to assure your needs will be met by the group. Should it be necessary the hospital does provide an Employee Assistance Programme that is available for all employed staff. You are assured of the right to refuse to answer any questions as you see fit. You may withdraw from participation in the project at any time without any disadvantage to yourself. Confidentiality will be maintained within the group and it will be every participants responsibility to ensure they remain faithful to this. Every effort will be made by me to ensure the information shared remains anonymous however you will be known to the other participants in your focus group. In addition, the study will state that the research has been conducted within an Acute Base Hospital which also services a wider rural community. No material which could personally identify you will be used in any reports in this study.

The information that will be collected will be your own personal and professional opinion related to nurses “caring” care in the hospital setting. All information disclosed will only be accessed by Shona Blair (the researcher) and Alison Dixon (supervisor at Victoria University of Wellington) and possibly another transcriber. Results of this project will be published in a thesis. Any data included will in no way be linked to any specific participant unless that participant expresses otherwise in writing to the researcher.

The data collected will be securely stored in such a way that only Shona Blair will be able to gain access to. At the completion of this project any personal information will be destroyed immediately except as required by the Victoria University of Wellington’s

research policy that any raw data on which the results of the project depend will be retained in secure storage for five years after which it will be destroyed.

I would also like to be able to access you should it be necessary to clarify any information during the transcribing of the data and the data analysis.

If you have any questions about the project either now or in the future please feel free to contact:

Researcher.

Shona Blair
25 Kinmont Crescent
Newfield
Invercargill
Southland

Phone (03) 216 6292

Supervisor.

Professor Alison Dixon
Department of Nursing & Midwifery
University of Wellington
P. O. Box 600
Wellington

Phone (0800) 108 005

The Principal investigator of this research is ;

Shona Blair, R G O N. B A (Nursing Studies).
Peri operative Nurse Clinician (N Z N O)
Masters Candidate (Victoria University of Wellington)

This project has been reviewed and approved by the Southern Regional Health Authority and Victoria University Ethics Committee.

Appendix 4

GROUND RULES FOR THE FOCUS GROUP

1. Approximately 15 minutes will be allowed at the start of the session for all focus group members to meet each other informally and prepare for the interview. A light refreshment will be offered.
2. This area is a safe place for you to explore your “caring” care and to discuss what hinders or enhances your caring care in your work environment.
3. You will know other people in the group, their confidentiality must be maintained. Any information raised and commented on in this group must remain here with this group. Once you leave this group there can be no further discussion about anything raised at the focus group interview.
4. You may feel personally challenged or feel some personal hurt when other participants are talking. Please feel you are supported within this group and likewise offer support for your colleagues.
5. Please remember everyone in the group must be given the space to speak and contribute.
6. If you so wish time will be allowed at the completion of taping for any debriefing before participants leave.
7. I thank you for giving your precious off duty time, and being a contributor to my project.

Thank you.

Shona Blair.

Appendix 5

Consent for transcriber

I _____ of _____
(name) (address)

have been asked by Shona Blair to transcribe the data from the tapes that recorded the nurses voices from the focus groups.

I understand that the information on these tapes is confidential, and must not be discussed by me to anyone apart from the researcher, Shona Blair. Issues of clarification may be required and I will ask the researcher if any words or statements are unclear.

The tapes will be transcribed by me at the researchers house and I will ensure they are stored securely while they are in my care.

I have signed this in the presence of the researcher and a witness and do solemnly declare to abide by the conditions stated.

Signed

Researcher

Witness

Date

Appendix 6

25 Kinmont Cres
Newfield
Invercargill

20 May 1998

Secretary Southland Ethics Committee
Barbara Roff
P O Box 116
Invercargill

Dear Barbara,

re: Application - Registered Nurses "Caring" care and their clinical practice.

I have noted the comment the ethics committee made that:
"Cultural and diverse issues should be a topic in focus groups, in order that opportunities be created for cultural issues to be raised." I gave this issue specific consideration when I was developing my research proposal for ethical approval, and discussed it at the time with my supervisor, in light of my particular methodology. I wanted the nurses to lead the discussion with minimal direction from me, apart from my keeping the discussion focused on the research question.

I would refer the committee to page 13 of my application where it does say that if the focus group introduces cultural issues related to the research question they will be addressed. If any issues are raised that are outside the groups' ability to deal with I intend to contact my supervisor and the hospital's cultural advisor for guidance.

The purpose of a focus group is to start with the research question that is before them, and to then follow the issues that are raised by the group in relation to the question. It is not appropriate for the researcher to direct the focus group process as has been suggested.

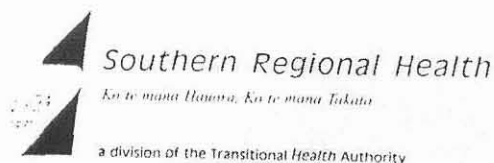
Could you please table my response for noting at the next meeting of the ethics committee.

Thank you in anticipation.

Yours sincerely,

Shona Blair
RGON BA
Perioperative Nurse Clinician
Masters Candidate Victoria University of Wellington

Appendix 7



DSJH-DH
229 Gray Place
P.O. Box 444
Invercargill
New Zealand
Telephone: 03-477 4222
Facsimile: 03-474 0088

ETHICS COMMITTEE SOUTHLAND

Secretary: Barbara Roff
PO Box 116
Invercargill
Phone/Fax:
03 2188 778

23 April 1998

Shona Blair
25 Kinmont Crescent
Invercargill

Dear Shona

re: Application - Registered Nurses "Caring" Care and their clinical practice

Thank you for your application. As you know, it was considered at the Committee's April meeting.

In general, the Committee thought that the application was well presented, but asked that the following points be noted:

- a) Cultural and diverse issues should be a topic in focus groups, in order that opportunities be created for cultural issues to be raised
- b) Page 11 - 11.3 needs the word "form" added after the word "consent"
- c) Page 27 - the word "minuet" should be corrected to read "minute"

We would appreciate a copy of your Curriculum Vitae for our records, please.

The Committee approved the study, subject to the above comments, and asked that I compliment you on its presentation.

Our approval is for one year. It is a condition of the approval that a report is provided at the completion of the study and that the Committee is notified if the study is changed in any way or abandoned.

Yours sincerely

Barbara Roff
Secretary

Appendix 8

NURSES CAN YOU HELP ME?

As part of my Masters study this year, I am required to complete a major research project. The study will be conducted with ethical approval from the Southern Regional Health Authority and the Victoria University of Wellington Ethic's Committee.

I want to ask nurses what "Caring" care means for them, and what enhances or hinders that care in their clinical practice.

At this stage I am asking for six to twelve registered nurse volunteers who want to explore what "caring" care means for them, in a focus group along with five other Registered Nurses including myself. I am asking for a maximum of 3 hrs of your time.

If you are interested in taking part in this study, please contact me on extension 8564, or drop a note to myself C/- Day Surgery Unit.

I look forward to hearing from you.

Many thanks.

Shona Blair

Appendix 9

4 : 5 : 1998



Dear Participants,

Thank you for making contact with me for my research project.

I have enclosed for you an information sheet and a consent form which I would like you to read over the next week. Please **do not** sign the consent form until we meet and I can witness it with you prior to the focus group meeting.

I do not want you to talk about being in this project as I have undertaken to ensure that your identity will remain anonymous.

I would like to organise the focus group meeting for Saturday 23rd May, could you please let me know if you prefer to meet in the morning, between 9:30 am and 12 am or afternoon between 1:30 pm and 3pm. I do not see the group lasting longer than two hours. Please ring me at home with your decision and a phone number that I can make contact with you away from the work environment.

The focus group will meet in a church or school hall, if you know of a place let me know that also.

I am really looking forward to meeting and sharing with you.

Thank you for your consideration.

Yours in nursing

Shona Blair

