THE DOMAIN OF NURSING: DEVELOPING PRACTICE THROUGH ACTION RESEARCH IN THE INTENSIVE CARE UNIT

by

Mary Patricia La Pine

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Abstract

In the intensive care unit (ICU) the bedside nurse is the person who carries out the fundamental care to sustain life and comfort for that patient and is the conduit between the patient, their family/whanau, the doctors and the multi disciplinary team. Nursing practice has an indelible impact on that patient's life and future and for their family.

This thesis presents a project on the reconnaissance phase of a future critical action research project. The project involved ICU nurses collectively defining their practice within the context of ICU and identifying aspects which needed development and change. As this was the first time that the nurses had met to define and discuss their practice it was essential for them to take this time in order to focus on the reconnaissance phase as this will guide and inform all future action. The study is informed by Habermas' Theory of Communicative Action which has an emancipatory focus. The action research approach enabled the nurses to reach mutual understanding of their practice and reach consensus on areas of practice they wish to develop to enhance their care of the patient.

Mutual understanding and consensus have been achieved using focus groups and interviews involving self reflection as well as collective reflection. The reconnaissance phase as described in this thesis involves the nurse participants collectively identifying their ideals of ICU nursing, then defining where they are unable to meet these ideals in the reality of every day practice.

The themes emerging from the discussions are defined in terms of relationships; *nurse to patient, nurse to family/whanau, nurse to doctor and nurse to nurse*. These relationships are interconnected and all occur within the overarching theme of *professional standards of care.* Through the process of discussion and consensus the nurses identified nurse to nurse communication and support as the most important aspect of practice needing development.
Reconnaissance in this research defines the beginning of the change process as the transformation begins with the creation of the communicative space enabling the nurses to connect and together to look ahead at what changes might now be possible.

Key words: Action research, communicative action, nursing practice, intensive care.

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Table of Contents

Preliminary pages

List of Figures

List of Tables

Chapter One Introduction to the Study

The intensive care unit (ICU) is a specialised unit where critically ill patients are cared for by a team of highly skilled multidisciplinary health practitioners. These may include nurses, doctors, physiotherapists, pharmacists and dieticians. While each team member has a specific role in the care of these patients, the person who has the most contact with the patients is the nurse. The nurse at the bedside, on a one-to-one basis is the constant person with each patient for the duration of their ICU stay. As Diers (2004, p.205) states, "Intensive care is intensive nursing care." The role of the nurses in this intensive care setting and the care they give has provided the impetus for this thesis.

The focus of this thesis is the domain of nursing, the nurses within the domain and the care they provide in an intensive care unit. It is an exploration of the nursing lifeworld of an ICU and the relationships the nurses in the lifeworld have with each other within the micro and macro systems of the hospital. This thesis is the reconnaissance phase for a future critical action research project. It is informed by Habermas' Theory of Communicative Action, and introduces the beginnings of the change process. Reconnaissance is the crucial beginning process of action research which sets up the possibilities for action and change to take place. The thesis focuses on the reconnaissance phase as it was the first time these ICU nurses had come together as a group to discuss and define what is important in their practice of ICU nursing. Within this process of reconnaissance, transformation begins to take place as participants together define the core values which underpin their nursing care and reach agreement on fundamental issues, thus highlighting areas for future change (Morton-Cooper, 2000; Nolan & Grant, 1993). These core values identify nursing as a unique discipline within the multidisciplinary team of the ICU. It was essential to take time to get this right as this reconnaissance will now provide the foundation for future action and practice development.

The centrality of the nurse in ICU

The modern ICU is often a place of heightened activity (Lower, Bonsack & Guion, 2002). The environment is usually noisy, bright, with complex machinery, equipment and many people. During the day the continual parade of medical and surgical consultants with accompanying entourages, radiology technicians, physiotherapists, pharmacists, attendants, aides, and medical supply personnel are a source of almost ceaseless activity and movement.

In contrast to the continually mobile doctors and ancillary staff, at each patient's bed stands a nurse vigilant, guarding, guiding, intervening, reporting and being the one central constant for that patient (Almerud, Alapack, Fridlund & Ekeburgh, 2007; Fairman, 1992). The clinical bedside nurse is perhaps the single most important person in that patient's life at this particular time of illness or injury. This nurse is the conduit between the patient and their family, the doctors and the multidisciplinary team that constitutes the ICU. She or he manages the bed-space and access to the patient by family/whanau. The nurse is the person the doctors ask for information about the patient and the one person that multidisciplinary staff approach for information and access. Medical procedures and interventions to be conducted on the patient also rely on the knowledge, expertise and the physical presence of the nurse, to ensure the patient receives optimal treatment and care.

The nurse is the person who carries out the fundamental care to sustain life and comfort for that patient. They are the one person who has the potential to truly know the patient at that time (Tanner, Benner, Chesla & Gordon, 1993). How the nurse fulfils this role has indelible impact on that patient's life and future and for their family (Hupcey 1999; Russell, 1999). With this position of power and influence that these nurses hold, there also comes the responsibility and accountability to ensure this impact is as positive as possible within the context of caring for the critically ill patient. Therefore, it is essential that each nurse is able and willing to articulate and discuss with other nurses their perceived problems and difficulties when caring for patients requiring a high degree of technological support and intervention.

Conflict between technology and care

Many nurses in the ICU struggle with their desire to care for patients holistically and humanely, recognising the uniqueness of each patient's situation. However, the technological, mechanistic demands of the unit and institutional system can often reduce the human aspect to disease states, bed numbers and routines. The vital components of technology, invasive procedures and constant intervention are regarded as the most important aspects of ICU care when the patient is critically ill. While the technology and interventions are essential for the patient's survival, routine interventions based around this technology and the demands of the institution often reduce and objectify the patient as a body to be manipulated (Cooper, 1993; Walters, 1995b). Barnard's (2000) study of surgical nurses' perceptions of technology and nursing maintains that the demands of technology can interfere with the nurses' free will and their desire to care for the patient's individual needs. Nurses' perceptions of technology are explored in the ICU context by Wikstrom, Cederborg and Johanson (2007) who found that while it can complicate the nurses' everyday practice it is seen as decisive, good for the patient and as reducing workload. Tonuma and Winbolt (2000) argue that while nurses espouse the desire to care holistically for their patients as individuals, it is the rituals, routines and culture of nursing practice that act as barriers to this ideal of nursing care. These routines of care are organised to meet the needs of the medical/nursing staff and unit administration and do not focus on the individualised care of the patient. In Marck's (2000) study on nursing in a technological world the acute care nurse participants all agreed that "for the system a good nurse was a fast nurse" (p.75). When care becomes focused on the routines and needs of the system rather than on the individualised needs of the patient, dehumanisation of the intensive care unit occurs.

Rushton (1991) identifies ten factors responsible for the dehumanisation of the intensive care unit. They are: inconsistent philosophies in patient care and decision making, conflict in personal and professional values; poor communication; lack of professional skill in various dimensions of humane care; unresolved ethical dilemmas; increased technology and shortage of resources; inadequate support systems; poor administrative support and the physical environment of the unit. Factors concerning technology, the physical environment and administrative support may be beyond the nurses' resources to change but the other factors are nursing issues which are

within the nurses' domain and can only be changed by nurses. Philosophies of care and decision making, personal and professional values, communication and professional skill are all basic aspects of nursing practice which nurses can explore, develop and use to bring about change. Developing these aspects of care may have substantial impact on reducing the dehumanisation of the ICU. However, the functional needs of managing the ICU and the patients within the system are also important in the overall care of the patient. Management and administrative roles concerned with the operational dynamics of the institution and senior clinical positions concerned with patient care, are essentially daytime occupations. Thus, the functioning of the institution and care of the patients often revolves around a timetable that enables optimum facilitation of these management roles and clinical investigation and intervention. The needs of the institution often take precedent over the individual needs of the patient. These include interventions such as inserting intravenous lines (IV) lines, investigations such as CT scans and X-rays, consultation with relevant specialists within the hospital, or physiotherapy treatment. The timing of interventions for ICU patients must also be conducted with regard for the needs of other patients within the hospital system. During the night shift, staff are able to concentrate more on patient care without the interruptions inherent during the day shifts and for this reason the study was originally focused on the care nurses give during the night. All the nurses in the ICU either work night shift on a rostered basis or have some influence on the care that is given, such as a Nurse Educator or Clinical Nurse Manager (CNM).

Night shift - the nurses' domain

Night shift is traditionally a quieter time with only enough staff to care for sleeping patients, with other staff on call to provide emergency treatment and urgent investigations. This shift should therefore be a time when the needs of the patient take precedence over the demands of the institution. It is the time when nurses should be able to care for their patients as individuals without the pressure of the demands of members of the interdisciplinary team, all requiring access to the patient.

The night shift may be regarded as a unique lifeworld (Habermas, 1984; 1987a) within the larger social structure that makes up the institution of a hospital. It is a muffled, ceaseless, unseen activity that continues the work of the institution when the vast majority of the hospital staff are off duty and asleep. The uniqueness of this shift, certainly within the hospital structure, is that it can be regarded as the domain of nursing. Clinical nurses have responsibility for the care of the patients, with only a fraction of the support staff available during the daylight hours.

The ICU, to a certain extent, mirrors the night activity of the rest of the hospital, but mainly in the area of external intervention and procedures. There are fewer people around and most multidisciplinary interventions such as radiology investigations, physiotherapy and surgical operations are only conducted in urgent situations (Campbell, Nilsson & Pilhammar Andersson, 2008). The majority of interventions to the patient at night are likely to be carried out by a nurse. These interventions may include fundamental care such as suctioning, turning or washing the patient; administration of drugs such as antibiotics, sedation or analgesia, and continual assessment and reaction to any change in the patient's condition. The continual 2 hourly interventions, noise, light and nursing activities are also some of the factors that the nurses identify as issues. These all interfere with patients' sleep. This is evident in casual conversation, actual complaints and in discussion with nurses during study days.

Background to the study

As a clinical staff nurse and then Research Nurse in an intensive care unit for over 24 years, I had formed my own view of what I perceived to be problems in some aspects of the way we as nurses cared for our patients. As I worked permanent night shift prior to commencing the role of ICU Research Nurse, sleep for both patients and nurses has provided a very strong research interest for exploration. Looking at various aspects of this phenomenon as a special topic in my undergraduate degree, unit based research and nurse education, I had begun to explore the question of how nurses' actions impact on patients' sleep.

I commenced this study with the idea of investigating nurses' actions on patients sleep. However, when I read further into the philosophy of Communicative Action and the principles of action research and with guidance from my supervisors, I began to question my own assumptions and perceptions of the problem. I realised that by focusing on sleep I was excluding a large proportion of patients who get little sleep for a variety of reasons. These include critically ill patients who require ongoing intervention or cardiac surgery patients where the emphasis is on waking and extubating as soon as possible post surgery to facilitate discharge to the ward in the morning. I was also assuming that what I saw as an important problem was of equal importance to other nurses. I was using my clinical experiences to define the problem for the participants, rather than facilitating the clinical nurses to define the problems in their practice. It is the clinical nurses who are best able to look at the nursing care they give to their patients and decide on what is relevant and feasible with regard to determining solutions.

Critical Action Research

Questions and issues nurses have relating to their nursing practice require exploration to enable solutions to be found. However, conventional scientific research using quantitative methods such as randomised controlled trials often fail to make sense of situations which involve human interaction dealing with the intricacies of failing health. Morton-Cooper (2000, p. 2) states that "practitioners deal in the end not with the masses, but with individuals and their families". Action research centres on people and their problems and has been described as "a philosophical approach to the study of human problems which helps groups to share and refine their understanding of their situations in a mutually supportive environment" (Morton-Cooper, 2000, p. 14). Reason and Bradbury (2001) define action research as:

> a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview…. It seeks to bring together, action and reflection, theory and practice in participation with others in pursuit of practical solutions to issues of pressing concern to people (p.1).

Action research is a cyclical process which begins with practitioners meeting together to find a starting point for the project. The next stage in the process involves clarifying the situation through group discussion, interviews and analysis of the information gained from these. This is the reconnaissance stage of the action research process. The following stage involves the development of action strategies, in response to the outcomes of the reconnaissance phase, which are then put into practice. The impact of these strategies is observed and evaluated. This begins another cycle of the research with the situation requiring more discussion and reflection before devising further strategies for change and action (Altrichter, Posch & Somekh, 1993). The practitioners become co-researchers in the project and endeavour to develop their practice with the aim of the bringing the real closer to the ideal of practice (Hart & Bond, 1995).

Critical action research is informed by an emancipatory philosophical position such as Critical Social Theory, and is an inherently political process which enables people to recognise the reality of their situation, freeing them from coercion by the dominant ideology (Bellman, 2003). This study has been informed by Jurgen Habermas' (1984; 1987a) Theory of Communicative Action, which sits within the critical social theory paradigm, and where the problems are defined in a situation based on values clarification. The philosophy has an emancipatory focus which has enabled and guided the nurse participants in this study to reach mutual understanding and consensus about areas of their practice they wish to change. Mutual understanding and consensus have been achieved using the qualitative methods of focus groups, modified nominal group processes, individual interviews, field notes and written guidance for self reflection as well as collective reflection (Morton-Cooper, 2000).

The reconnaissance phase as described in this thesis involves the nurse participants collectively identifying their core values and ideals of ICU nursing, then defining where they are unable to meet these ideals in the reality of everyday practice. This occurred in two separate series of focus groups; the clarification of core values first and then reforming into different groups to look at the reality of their practice in relation to the core values. Some individual interviews occurred for nurses unable to attend a focus group. Relevant information from these interviews was

introduced anonymously into the group discussion by the researcher when appropriate. The final stage of this reconnaissance is where the nurses were asked to prioritise the sub themes and then discuss which sub theme most required development and change. This was achieved through discussion and consensus (Table 1).

Table. 1 Outline of reconnaissance stages

STAGE 1	VALUES CLARIFICATION FOCUS GROUPS
Stage 2	Reality of practice focus groups
Stage 3	Individual interviews
Stage 4	Gaining consensus

These stages are an essential process of acknowledgement, discussion and agreement before the 'action' phase of action research can be realised. The action stage often receives more attention in the literature and may perhaps be regarded as the more important aspect of the study. However, reconnaissance is a crucial stage in action research as this is what guides and supports further action (Nolan & Grant, 1993). If the nurses are unable to fully define and discuss the core values which guide their practice and identify the barriers to achieving their ideal in the reality of practice, all future action is flawed. The action research project becomes unsustainable if the foundations underpinning the action have insufficient strength and depth to support the change. To this end the thesis concentrates on the reconnaissance stage ensuring the robustness and veracity of the process will be sufficient to support future actions. This robustness is evident in the depth of information yielded from the discussions and also with the change in focus by the nurse participants from night shift to encompass practice on all shifts. As researcher I became both facilitator and participant in the research, but it was the participants as practitioners who ultimately defined the most important aspect of practice to focus on.

Position of the researcher

My experience and knowledge in this area has ideally positioned me to undertake this research. I am neither insider nor outsider, neither a clinical bedside nurse nor manager, and yet in the role of Research Nurse I am able to walk in both worlds (Bonner & Tolhurst, 2002). I carry out research procedures and data collection with the nurses at the bedside and I also have overall management of research in the unit as well as a teaching role. I have no direct governance over the clinical nurses and am not part of the Clinical Nurse Manager team but have insight into both aspects of nursing practice. My clinical experience has given me the insight necessary to understand and acknowledge the difficulties the nurse is faced with when caring for a critically ill patient in a highly technical medicalised area (Fairman, 1992). My research experience and academic study has enabled me to look beyond the immediate and obvious difficulties, such as short staffing and a lack of resources and strive to recognise the underlying influences that govern our nursing practice. It is these influences which may be an underlying source of frustration and dissatisfaction that many nurses feel when caring for these patients within the constraints of the ICU.

Rationale and significance of study

During my years of clinical experience in the ICU and now in my current role, my interest with how the routines, rituals and tasks govern our nursing practice remains strong. I have observed this frustration amongst my colleagues and it has been the topic frequently discussed informally by many nurses who work in this clinical area. This dissatisfaction on how the perceived routines and rituals govern their practice was expressed by the nurses within the workplace and provided the impetus and justification to conduct this study. Intensive care is about nursing with the patient always as the main focus. It was the nurses who defined what is important in their practice, the values and beliefs which guide their care and they also defined the areas of practice which needed development and change. Action research guided by the Theory of Communicative Action enabled them to collectively define their philosophy of nursing practice in the ICU and through discussion to reach consensus on which aspects of their practice they wished to change. The contribution of this study to ICU nursing practice is that the participants have increased awareness and knowledge of their collective values and beliefs and also an awareness of what influences and coerces their practice. This process of reconnaissance has

already initiated the change process by providing the participants with a space which enabled them to discuss their practice with a common purpose. This common purpose is providing optimum care for the critically ill patient.

The research question and aims

As many of the nurses' voiced frustrations focused on the routines and what was seen as often unnecessary ritualised care such washing the patient, suctioning and turning the patient, night shift seemed the optimal shift on which to concentrate the change process. This was due to the reduced requirement to consider the needs of other members of the multidisciplinary team and the nurses were better able to focus on the needs of the patients and how they delivered care.

The original research questions were: What do nurses do on night shift, what effect does it have on the patients and what needs to be changed?

The purpose and aims of the entire action research project as defined in the ethics submission and protocol are as follows:

To understand and define how nurses care for patients on night shift in the ICU.

To understand and acknowledge what influences and guides the nursing care.

To understand the effect this care has on the patients.

To acknowledge and define where there is need for practice development.

To define barriers to the proposed development.

To form strategies – methods which will facilitate the practice development.

To conduct, observe and evaluate the development, replan in a cyclical process of continual practice development and evaluation.

However, as the nurses in this unit either work rostered day/night shifts, permanent night shift or have influence on nursing care on night shift, all nurses were eligible to participate in the project. A total of 35 nurses of all levels of seniority participated in the reconnaissance phase of the study. Their participation and their responses to the aims of the study ultimately changed the focus of the thesis from night shift to encompass nurses' practice on all shifts. It was the clinical nurses who defined which areas of practice presented the most challenges and refocused the original question and aims to better reflect the difficulties and problems they were experiencing

in practice. These issues included difficulties with staff and relatives which in turn impacted on patient care. These problems occurred on all shifts, not just night shift. This change will be discussed in Chapter 5 which describes the values and reality focus groups.

The research question was altered and became twofold: How do ICU nurses wish to care for their patients and what are the tensions that exist between their stated values and beliefs and the reality of clinical practice within the context of the intensive care setting?
How can the nurses develop their practice to reduce these tensions and improve patient care?
The aims essentially remained the same, except the focus broadened from night shift to all shifts within the 24 hour period.

Overview

This thesis is an account of the reconnaissance phase of an ongoing project which will continue to evolve and develop indefinitely. Critical action research should be sustainable and able to be continued by the nurse participants/co-researchers guided by the reconnaissance data. It needs to become something the nurses are doing with their practice for their sake and the patients' benefit rather than for a researcher's qualification. However, I have an ethical duty to continue offering guidance and support as needed to ensure the nurses are able to continue with this project. I am an ICU nurse, a participant/co-researcher in this study as well as facilitator and thus will work with the group to devise and carry out strategies towards achieving the defined goals.

There is no literature review as a complete and separate chapter, but the literature will be part of an ongoing discussion as the thesis unfolds and develops. Throughout the document I have used the terms participant, co-researcher and nurse interchangeably. Nurses may also be described as senior or junior. Senior refers to nurses who hold senior positions such as a CNM role or who have been working in the ICU for many years. Medical personnel will be referred to as doctors regardless of seniority.

Chapter Two discusses the background of the ICU in this research and the advent of formalised nursing education as an ICU nursing specialty. The concepts of subordination, empowerment and cohesiveness will also be discussed in relation to the literature. This is also related to the nurses

in the ICU having management of their practice with nursing directed guidelines and leadership, critically resisting the status quo through questioning and discussing their practice.

Chapter Three will outline Jurgen Habermas's Theory of Communicative Action and how it is relevant as a theoretical framework for this critical action research. The action research approach as a design and its congruency with Communicative Action and the ICU context will be discussed. This will include the history and development of Action Research and its relevance for nursing research.

Chapter Four is the research design and the process of introducing the research into the ICU and the hospital. It includes discussion of the ethical issues inherent in this type of research and will discuss validity and rigour in Communicative Action and action research with regard to this project and how it was safeguarded. This chapter will also include the insider–outsider aspect of conducting this type of research within the unit I work in and how it relates to reflexivity, validity and rigour. Management and safety of the data will be included as will the requirements of the ethics submission, consultation with Maori, institutional requirements and the process of introducing the project to ICU management.

Chapter Five presents the beginning of the project with the commencement of the values focus groups, and the use of a modified nominal group process. The core values derived from these groups are the foundational values for a philosophy of nursing for this ICU.
This chapter continues with the reformation of the focus groups and individual interviews to look at the reality of ICU nursing and where the nurse participants are unable to meet their stated values of practice. It also discusses the many difficulties encountered with conducting action research in this reality. My role as researcher and participant with regard to the data collected and also in coping with the difficulties encountered will be discussed. The thematic analysis process and the development of the sub themes is described.

Chapter Six discusses the process of re-engaging the participants in the study and the process of achieving consensus with regard to further action. This process informed the further analysis of

the sub themes to define the core themes and overarching theme of the study. The themes are discussed with reference to the data and with supporting literature.

Chapter Seven concludes the thesis with reflections and discussion on the overarching theme and the agreed issues for change. These issues will also be discussed in relation to the Theory of Communicative Action and some ideas for bringing about this change will be posited. The study and processes will be revisited with discussion on how the thesis is relevant to nursing in ICU and also for future action of the study. The concept of reconnaissance as change will also be discussed, highlighting its importance in the action research process and as a change agent in its own right.

Chapter Two The Environment of Intensive Care

This chapter discusses the background of the ICU in this research and the advent of formalised nursing education as an ICU nursing specialty. The concepts of subordination, empowerment and cohesiveness will also be discussed in relation to the literature. This is also related to the nurses in the ICU having management of their practice with nursing directed guidelines and leadership, critically resisting the status quo through questioning and discussing their practice. This focus on change is being embraced both nationally and internationally through nurse-led action research and practice development across all nursing specialties.

Intensive care as a nursing specialty

Intensive care units developed in the 1950s with the advent of positive pressure ventilation and in recognition of the growing need for seriously ill patients to have specialised care. Prior to this, nurses with no extra training had cared for these patients on the wards. (Crocker, 2007; Hilberman, 1975; Intensive Care Society, 2003; Society of Critical Care Medicine, 2001). Working in these organised ICUs provided nurses with the opportunity to develop their skills and knowledge to form their own specialty practice. The value of these skills was recognised early especially for patients following cardiac surgery, where it was acknowledged that the patient's outcome correlated with the nurse's skill and experience (Crocker, 2007; Hilberman, 1975). While much of the medical literature on the development of ICUs has focused on the medical contribution, authors such as Hilberman (1975) acknowledged nurses' early contribution. In the contemporary medical literature the main focus is on doctors training, technological advances and mortality rates with little mention about the impact nursing care has on patient outcomes. However, Fisher (1997) acknowledges the importance of nursing in ICU, stating:

> The nurses are the life blood of the intensive care unit. It is here that collaboration and integration must be optimal. Changes in the role of woman and nursing dictate that the old patronising and controlling roles are no longer valid. Nurses solve nursing problems best, and the role of the medical unit leader is to facilitate and assist when requested... nurses should be involved in the managing body and have input in all aspects of decision making (p.241).

Fairman (1992) maintains that in order to cope with caring for unstable critically ill patients, nurses strove to increase their knowledge. They were acutely aware their nursing education had focused on the functional aspects of nursing work and they needed to understand what was happening with these patients. Nurses learnt on the job, often taught by ICU doctors, accumulating knowledge and skills previously only the domain of medicine. During the late 1970's and early 1980's several unit based intensive care courses were established in New Zealand. In New Zealand and Australia many of these are now affiliated with universities, being offered at postgraduate level (Aitken, Currey, Marshall & Elliott, 2006; Dobbs, 1997).

Context of the ICU

The ICU in which this research was conducted was established in 1975 as an 8 bed closed unit in a metropolitan hospital in New Zealand. The definition of a closed unit is that the patients are under the care of ICU specialists, not the doctor under whom the patient was admitted to in the hospital. The unit was staffed by one full-time consultant/Clinical Director, 2 part-time consultants, 2 registrars, one charge nurse and approximately 30 registered nurses. The initial protocols and guidelines for nursing practice were written by the Clinical Director. A year-long unit-based critical care course was introduced in 1981, initially coordinated by the ICU Charge Nurse and later the ICU Nurse Educator. The lectures were given by doctors and senior nurses and as the years progressed, also by nurses who had completed the course. In 2004 the course became affiliated with a tertiary institution offering postgraduate level nursing education and by 2005 became a Postgraduate Certificate in Critical Care. A requirement of this course is that the student investigates an aspect of practice which requires improvement and devises strategies to achieve this. This course no longer simply educates ICU nurses on patient physiology, treatment and care, but commences them on the pathway of advanced clinical practitioner by teaching them to formally question current nursing practice. Nurses are also encouraged to review the ICU specific nursing protocols and guidelines using evidence based practice.

By 2007 the unit was staffed by 6 rotational consultants, one of whom is Clinical Director, 9 registrars, 1 Senior Registrar, 5 Clinical Nurse Managers (CNMs), one of whom works part time night shift, 2 Nurse Educators, 1 Research Coordinator (part time) and approximately 70 staff

nurses including full time and part time. The Unit now consists of two separate areas, one 4 bedded cardiac surgery unit and an 11 bed general adult and paediatric unit. Overall governance of the unit is by the Clinical Director and an Operations Manager but the management team meets monthly for operational discussion and decision making. This team consists of the Consultants, Operations Manager, CNMs, Nurse Educators, Research Coordinator, Charge Technician and CNMs of the High Dependency Unit (HDU), aligned with the ICU. The HDU, which cares for less critically ill patients, is under the same management as ICU but is staffed by a separate team of nurses. The majority of clinical and management decisions and changes are made by this team, unless it is directly a medical domain. Nurses who wish to change some aspect of ICU care are required to present their ideas, rationale and evidence to this team. This is regardless of whether the proposed change is nursing care or may involve some aspect of the medical domain. By adhering to this format doctors continue to have direct influence on nursing care, whether they wish to or not. It is not necessarily the doctors who require this, more perhaps that as nurses we are used to working so closely with medicine and feel it should be a team decision.

If the quotation by Fisher (1997) is indicative of contemporary medical attitudes, as opposed to historically patriarchal attitudes, then why have nurses not wholeheartedly embraced the statement, “Nurses solve nursing problems best” (p. 241)? Why are nurses in ICU not addressing nursing questions about care in their own way? Is it a lack of confidence in their own knowledge to address and solve these issues without medical approval? Or is it because many nurses feel they are subordinate to medicine and as such, lack the power to effectively manage their own practice? A lack of cohesiveness may be one reason why the nurses in the ICU have failed to actively address issues that are a cause of dissatisfaction in their practice. Although many of the historical barriers are no longer relevant nurses perhaps still regard themselves as being subsumed by medicine, especially in the technologically demanding environment of the ICU. The ICU environment demands that nurses and doctors work closely together with a small number of critically ill patients, providing the opportunity for doctors to have more influence over the nursing care than would happen in the wards. This close working relationship may also accentuate the dominant/subordinate aspects of the relationship between nurses and doctors especially when there are differing ideologies governing the care and treatment.

The concepts of subordination, lack of empowerment and cohesiveness continue to be reported in the contemporary literature as still relevant to nurses and nursing (Allan, Tschudin & Horton, 2008; Brown, 2002; Deppoliti, 2008; Fletcher, 2006; Gutierrez, 2005; Manojlovich, 2007; Nedd, 2006; Paliadelis, 2008; Randle, 2003; Sheridan-Leos, 2008; Sunderland & Hunt, 2001; Thupayagale-Tshweneagae & Dithole, 2007; Woelfle & McCaffrey, 2007). Nurses continue to feel devalued and powerless when excluded from the decision making process regarding the care of their patients, despite their advanced knowledge of the patients and their families (Gutierrez, 2005). Nursing unit managers in Paliadelis' (2008) study maintain that they have all the responsibility but lacked the power commensurate with this responsibility. Nedd (2006) links perceptions of access to workplace empowerment structures with the nurses' intent to stay in the organisation. Thupayagale-Tshweneagae and Dithole (2007) contend that if nurses could unite, their numerical strength would give them power over other health professionals. An example of how this unity can be used in a position of power is when the New Zealand nurses joined together in 2006 and successfully negotiated a multi-employer contract agreement.

There are many situations where nurses are resisting external control of their practice. Action research has been embraced by nurses looking at improving multidisciplinary teamwork and introducing new practice initiatives such as family focused nursing in intensive care (Blanchard, 2006; Brown, Ohlinger, Rusk, Delmore & Ittmann, 2003; Coyer, Courtney & O'Sullivan, 2007. Action research is a political process which may be considered to be subversive and undertaking it in the area or hospital where the nurses' work can be described as resistance (Coghlan & Casey, 2001; Meyer, 1993; Williams, 1995; Williamson & Prosser, 2002). McEldowney (2003) introduces the notion of a critical resistance pathway which is a knowing political act intended to bring about social change. It is speaking out against the status quo sharing stories of oppression so that "we may discover connections among us and ways to resist and transform our oppressions" (p.195). Practice development is another way nurses are looking at bringing about emancipatory change in their practice, enabling nurses and health care teams to transform their culture and context of care. Practice development is being undertaken in a wide variety of nursing areas to bring about change, both internationally and in New Zealand (Fitzgerald & Armitage, 2005; McCormack, Manley, Kitson, Titchen & Harvey, 1999; Pryor & Forbes, 2007;

Walsh, Lawless, Moss & Allbon, 2005; Walsh, Moss & Fitzgerald, 2006; Ward, Titchen, Morrell, McCormack & Kitson 1998).

The intensive care environment

In the highly technical environment of the ICU, nursing care is governed by a dominant medical focus where intervention, procedures and invasive monitoring take precedence. However, it is short-sighted to rest with the overt medical dominance of the ICU and assume that all the power influencing nursing practice comes from the hierarchical system. The existence of the multi-disciplinary team within the ICU enables the exercise of power to emanate from a variety of sources and not necessarily leaders. Kuokkanen and Leino-Kilpi (2000) maintain that "the exercise of power is not so much action, domination or control, but the real exercise of power turns out to consist of the manipulation of thoughts, attitudes and social relationships" (p.237). Street (1991) describes Foucault's (1979) concept of disciplinary power as habitual, familiar actions which produce a docile workforce, that is efficient, fast and has technical expertise. The exercise of power at micro-level occurs where nurses are taught tasks and processes, with efficiency and speed to serve the needs of the institution. These myriad processes, arising out of responses to needs and crises, become embodied within the nursing culture, and combine to form disciplinary power relationships. It is nurses' lack of awareness of these forces and processes, coupled with historical subservience to the medical profession that allows nursing practice to be manipulated. Nurses are also struggling to keep up with high workloads, staff shortages and increasing professional and career expectations, which further increases their vulnerability and lowers their desire to self reflect and question the status quo. Within the stressful ICU environment it is often easier for nurses to concentrate on doing familiar clinical tasks than to delve into the unfamiliar situation of reflecting on their own performance and how it affects the patient and their family. Currey and Worrall-Carter (2001) note that nurses in an Australian critical care unit found that not knowing the patient and the family made decision making more difficult, and communicating with the family and other staff was regarded as much more difficult than making clinical care decisions. Cooper (1993), in describing the paradoxical nature of the relationship between technology and care in the ICU, cites a nurse as stating:

> the machines are actually fundamental for us in terms of caring for our patients in this kind of unit, but they can also be used as a means of not having to face the patient, not having to deal with the patient's emotional needs (p.26-27).

ICU nurses often equate work satisfaction with technical competence and being busy, that is, doing things to the patient that yields immediate results. The technology and technical competence become part of the caring aspect of the ICU and balancing technology with caring becomes a challenge for the ICU nurse (Walters, 1995b). This incorporates the potential for the paradoxical nature of ICU 'busyness' to conflict with the patients' need for rest and healing sleep. Clinical and technical expertise are essential components for nurses working in the ICU and is perhaps regarded as of greater importance than the caring, nurturing attributes. Nurses within the ICU are said to have greater autonomy of practice than other areas but this pertains to medically orientated clinical tasks rather than the traditional nursing domain (Bowler & Mallik, 1998). Many studies into nurses' decision making and role expansion in the ICU have concentrated on ethical, life and death decisions or decisions involving clinical or technical tasks (Baumann & Bourbonnais, 1982; Bucknall and Thomas 1995, 1997; Bunch, 2000, 2002; Bowler & Mallik, 1998; Coombes, 2003). These decisions often encompass tasks that have traditionally been the domain of doctors.

Bucknall and Thomas (1995; 1997) explain that there is routinely a need for ICU nurses to make rapid, complex diagnostic and interventional decisions, to prevent negative outcomes for their patients. This requires the focus of their role to lie between traditional nursing and medical domains. ICU nurses regard the extended/expanded practice domain as enabling them to have high levels of autonomy, responsibility and accountability (Bowler & Mallik, 1998; Bucknall & Thomas, 1997). However, Bowler and Mallik's study showed that the autonomy of the expanded role is not extended to junior nurses by the senior nursing staff who have adopted an elitist position. The senior nurses become marginalised by annexing the extended role for themselves and demonstrate horizontal hostility towards more junior staff, by their gate-keeping stance. Yet these nurses are still not regarded as equals by the medical staff, as they do not regard the permitted extended practice as added responsibilities, merely tasks any nurse could perform. Nurses are still excluded from actively participating in the ethical treatment decisions for

critically ill patients despite having the most contact with the patient and family (Bucknall & Thomas, 1997; Bunch, 2000; Gutierrez, 2005).

ICU nurses often measure their autonomy by the degree of extended practice they are permitted to undertake by the medical staff, who are willing to allow nurses to take over the less important tasks regarded as part of their domain. These tasks may include titration of medication within defined parameters, initiation of intravenous fluids, interpretation of arterial blood gases and the subsequent adjustments to ventilation and weaning of ventilation. Yet ICU nurses often seem to be unaware of the level of constraints and influences that govern their everyday nursing care and the inequality of the interactions between individuals that form the basis of power play within the ICU. Manias and Street (2000) focused on the power relationships in the ICU associated with nurses and doctors use of policies and protocols. While doctors preferred to rely on scientific knowledge and previous experiences, the nurses regarded the policies and protocols as vital knowledge sources that legitimized their decision-making and offered formal support for nurses to confidently justify their claims. Nurses used these protocols to resist doctor's orders that breeched the accepted standards of the unit and/or institution and to self monitor nurses compliance to these standards. This self monitoring, such as quality assurance and nursing handover processes, has been referred to as the 'nursing gaze' and has the effect of developing conformity in nurses (Cheek & Gibson, 1996). Nurses also exercise power over each other by using their knowledge of the protocol and policies and also any changes in the guidelines. While nurses use the guidelines to legitimise their actions and practice safely, they also constrain their practice by relying on limited and relatively inflexible sources of knowledge (Manias & Street, 2000). Nurses also have the responsibility to look beyond the protocols and guidelines that govern practice and begin to nurse reflectively and with insight and depth. It is no longer possible or acceptable to adhere strictly to set rules without question. Sandelowski (1994, p.56) states that, "We refuse the art in our science when we forget that rules of method serve us, but only to a point, after which they enslave us". The New Zealand Health Practitioners Competence Assurance Act (2003) requires registered nurses to work within their scope of practice and also be responsible and legally accountable for their actions. This Act has made it even more imperative for nurses to question their practice, the care they give and to examine the underlying influences that guide or coerce their decisions regarding patient care. McEldowny's (2003)

concept of critical resistance involves nurses talking to each other, telling their stories, breaking their silence on the oppressive influences and together transforming their workplace culture. Kritek (2001) also advocates breaking the silence and maintains that speaking out in itself becomes a "call to excellence" (p.336). The action research approach provides a social space for these nurses to define their ideals and realities of practice and work towards changing aspects of practice they agree are issues (Habermas, 1996; Kemmis, 2001).

The communicative action framework informing this thesis provided each nurse participant the opportunity and responsibility to speak freely, without constraint, on the reality of their practice. Nursing is regarded as an oral culture in which nurses have sophisticated oral and expressive skills with regard to communicating and storytelling (Street, 1991). Brown (2002) maintains that power is a complex process that occurs over time through relating and communicating. She states:

> Each individual nurse whether administrator or direct caregiver participates in a number of relationships, all leading to the ultimate outcome of individuals experiencing overpowering or empowering…The qualities of each dyadic relationship …are important as these are the basic building blocks for the climates of teams, groups care units…(p. 25).

Empowering communication is clear, open and authentic while overpowering communication is distorted and deceitful (Brown, 2002). Fletcher (2006) contends that dialogue as suggested by Freire (1972) is the essence of leadership and political action. Dialogue or communication with others coupled with self-awareness enables nurses to work together with a mutual understanding of their nursing practice and a common purpose.

(Habermas' (1984) Theory of Communicative Action enables empowerment or emancipation through communicative competence; speaking truthfully, using reason, autonomy and responsibility. Communicative Action within the action research approach enabled the nurses in this research an equal autonomy of voice towards mutual understanding of the revealed problems,

acknowledging the underlying influences of their practice and the exploration of options towards an identified goal. It enabled ICU nurses to become aware of the realities of their practice and the underlying influences that guide their practice decisions. In the next chapter I will discuss more fully the theory of Communicative Action and how it informs this research as the reconnaissance phase of a future action research project.

Chapter Three Theory of Communicative Action as a philosophical frame work for Action Research

This chapter discusses Jurgen Habermas' Theory of Communicative Action (1984; 1987a) which sits with the paradigm of Critical Social Theory. Habermas' early work on knowledge and rationality and the three knowledge interests of technical, practical and emancipatory domains also provided the basis for the development of Communicative Action (1984). The second part of Communicative Action introduces the theory of the System and the Lifeworld (1987a). This focuses on the tensions and interconnections between the lifeworld and system in a society as a whole. In the context of this thesis the lifeworld is nursing practice within the system of the ICU and the wider institution as a society. The research uncovers and explores the tensions between the nurses' values of practice and the reality of everyday clinical practice within this society and how these tensions and interconnections impact on the care they give to their patients.

Action research, particularly the reconnaissance phase, as an appropriate approach to this research within the Communicative Action framework will be discussed, and will include the history and development of action research and its relevance within the nursing context.

The Critical Social Theory approach of Jurgen Habermas

Habermas' theory had its beginnings in the 'Frankfurt School which is credited with developing the early critical theorists (e.g. Max Horkheimer, Theodor Adorno and Herbert Marcuse). Critical Social Theory (CST) is defined by Leonardo (2004, p. 11) as "a multidisciplinary framework with the implicit goal of advancing the emancipatory function of knowledge". The work of these early critical theorists as well as the work of Kant, Mead, Durkheim, Parsons, Weber and Marx, informed the refinement, reconstruction and development of critical social theory by Habermas (Habermas, 1984; Crotty, 1998; Ray, 1999). Porter (1998) combines these stances to define critical theory as:

> looking beneath the surface of knowledge and reason (Kant) in order to see how that knowledge and reason is distorted in an unequal and exploitive society (Marx) and, in doing so, to point the way to less distorted forms of knowledge and reason (Hegel) (p.131).

Habermas developed his view of rationality through the critique of Weber's theory of Western rationalism. Purposive-rational action is regarded as the technological goal directed action, or as Porter (1998) explains, purposive-rational action involves the most efficient way to achieve an end, based on technical aspects, not ethics. Value-rational action is defined by Weber (cited in Habermas, 1984) as when people act purely on their convictions of what they feel is required, according to, either, their cause, duty, piety, honour or religion, despite the foreseeable consequences. The rationality of the values are measured by how generalisable or fundamental they are so that "they can ground a mode of life based on principles" (Habermas, 1984, p.171). The first stage of this research is to collectively discuss and define the fundamental values of nursing care which 'ground the mode' of the lifeworld of ICU nursing practice. Collective agreement will validate the rationality of these values which will guide the ongoing process of the research.

Knowledge and Rationality

Habermas defines rationality as looking more at how subjects acquire and use knowledge than the actual possession of knowledge. The close relationship between knowledge and rationality indicates that the reliability of a statement depends on how reliable the knowledge is that informs that statement (Habermas, 1984). Habermas defines a want or expression as rational if it is supported by an acceptable reason for wanting or expressing it. Therefore for knowledge to be reliable it must be supported by an acceptable reason or argument. He uses the term argumentation for the type of speech where participants attempt to vindicate or criticise contested validity of an expression. The strength of the argument is measured through the soundness of the reasons and also how the participants behave. A participant who is open to reason and either acknowledges the force of those reasons or is able to refute them is said to be rational, while the participant who dogmatically ignores opposing reasons is said to be irrational. Rational argument also enables mistakes to be identified and learnt from when controversial expressions or truth claims are discussed and consensus is reached. Practical discourse is where norms of actions in

everyday life can be recognised and impartially justified with the approval of everyone affected, i.e. negotiated social agreement (Habermas, 1984; Crotty, 1998).

A central assumption for CST is based on the premise that truth (knowledge) is based on negotiated social agreement. Truth is determined through rational, uncoerced agreement within a social group following the central values of autonomy and responsibility. The ideal society would base its decisions on the premise that each person felt free to speak without coercion or fear of authority and that each person is responsible for creating that society to enable others that same freedom (Allen, Benner & Diekelmann, 1986).

Habermas developed a positive concept of reason (rationality), which he published in 1968 in *Knowledge and Human Interests.* Habermas disagreed that humanity's capacity for labour and production alone defined and guided social thought and society. He maintained that humanity's ability to think, understand and communicate rationally through language also defined social thought and human freedom (Crotty, 1998; Habermas, 1971; Porter, 1998). By positing labour as instrumental action and social interaction as communicative action, and combining with the exercise of power and domination he formed the basis of three cognitive domains of human interest related to the constitution of knowledge (Crotty, 1998; MacIsaac, 1996; Ray, 1999). The three domains defined as technical, practical and emancipatory interests are regarded as complimentary to each other, not competing (Habermas, 1971; Kemmis, 2001). Technical knowledge is the realm of instrumental action involving the empirical/ analytical sciences governed by technical rules. This encompasses the scientific domains such as physics, chemistry and biology (MacIsaac, 1996; Ray, 1999). Practical knowledge identifies human interaction or communicative action within the phenomenological-hermeneutic disciplines, the intersubjective ways of knowing, the understanding of meaning though reflective interpretation. These include descriptive social science, history, aesthetics and ethnography (Crotty, 1998; MacIsaac, 1996). Emancipatory knowledge is regarded as the core of critical theory, whereby people are free from conscious or unconscious constraints to mutually negotiate social agreement and community life without coercion (Crotty, 1998; Ray, 1999). Emancipatory knowledge is gained though self-reflection and self awareness where one is able to recognise the controlling forces that shape and limit our lives but which have also been regarded as beyond human control (MacIsaac, 1996). It

is a result of the synthesis of technical and practical knowledge, "to focus on individual and collective self-reflection, enlightenment and rational, mutual understanding" (Browne, 2000, p.40). Benner (1984) describes technical knowledge the 'know-that', as knowledge formally acquired through education while practical knowledge, the 'know-how' is gained through experiences. It is the acknowledgment of the 'know-how' which has reaffirmed the importance of nursing practice. It is with the addition of the knowing of the self that brings this knowledge into the critical emancipatory paradigm (Dixon, 1996).

Another central assumption of CST is the rules, conventions, meanings and habits that individuals observe, that define and structure a society. Understanding the structural patterns and constancy of human activity enables one to recognise underlying meaning of the activity and its relationship with social structure or authority (Allen, Benner & Diekelmann, 1986). The uncovering of the hidden relationship of dominance and power underlying the structure and ideology of society is necessary for a social critique to be emancipatory (Browne, 2000; Fay, 1975). Therefore it was necessary for the nurse participants in this study to uncover and acknowledge the dominant relationships within the ICU and the institution that influences their practice. This critique included social, political, economic and also legal influences that coerce and also guide their decision making. By acknowledging these influences and considering what impact they have on the care decisions they make, the nurses are taking responsibility for their nursing practice. The framework of Habermas' Theory of Communicative Action will enable the nurse participants to collectively explore these influences, and collectively agree on areas which need developing.

The Theory of Communicative Action

In 1981 Habermas published his *Theory of Communicative Action, Volume One, Reason and the Rationalisation of Society,* followed by Volume Two, *Lifeworld and the System: A Critique of Functionalist Reason* in 1985. The Theory of Communicative Action is orientated to active emancipation and is intended as a framework for research (Ray, 1999; Crotty, 1998). Communicative action involves a framework for the common understandings in language, culture and traditions that constitute the lifeworld. In order to achieve emancipation through communicative action, the components of communicative competence; rationality, truth, autonomy and responsibility and also argumentation and discourse, are essential (Welch, 1999).

In the search for a comprehensive theory of rationality, Habermas (1999) drawing on Chomsky's model of linguistics, focused on linguistics and communicative competence as presupposing a background of consensus orientated to the idea of truth. This means shared understanding though rational discourse to achieve consensus without coercion (Bernstein, 1978). Consensus, an essential underlying component of communication involves four validity claims:

> that what individuals say is comprehensible, that it is true, that it is right (that is, governed by normative elements) and a sincere expression of the individuals beliefs (Swingewood, 2000, p. 205).

Consensus is achieved through argumentation, in a situation of ideal speech, where autonomy and responsibility are possible (Swingewood, 2000; Ray, 1999). Communicative action transpires when individuals use reason to convince others of the rightness of their arguments, on a basis of mutual understanding (Swingewood, 2000). Each nurse involved in this study had the responsibility to speak honestly and rationally about their practice and what governs it. Rational respectful discussion within the group situation enabled the nurses to reach a mutual understanding and agreement on what constitutes their values and beliefs on practice and also what governs and coerces their practice decisions.

The Theory of the System and Lifeworld

Habermas (1987a) further developed the Theory of Communicative Action to encompass that of the lifeworld and the system. He proposed that societies be simultaneously perceived as both systems and lifeworlds. He regarded the tensions and interconnections between the lifeworld and the system in a setting, as characteristics of the modern social world (Kemmis, 2001). The system is characterised by the organisational, institutional structures, the goal orientated functioning of economically driven or political-legal systems with measurement of performance and outcomes (Kemmis, 2001). The three structural components of a lifeworld; culture, society and person are "made possible by three enduring and interacting processes – cultural reproduction, social integration and socialisation" (Kemmis, 2001, p.94). Habermas (1987a, 1987b) maintained that the concept of the lifeworld is complementary to the concept of communicative action.

> The symbolic reproduction of the lifeworld takes place as a circular process. The structural nuclei of the lifeworld are 'made possible' by their correlative process of reproduction and these in turn are 'made possible' by contributions of communicative action (Habermas, 1987b, p.343).

In modern society, entire domains of social life are governed by the necessities for the function of the system, people just 'do the job' and do not question or reflect on the processes within the system. This in turn eventually induces crises in the lifeworld, putting strain on the domains of culture, society and personality. These crises are defined as: loss of meaning; breakdown of norms governing social action; unsettling of collective identity; psychopathologies; withdrawal of motivation and legitimation; alienation;crisis in orientation; and education and rupture in tradition (Habermas, 1987a; Kemmis, 2001).

Habermas (1987a) further expanded these crises to explore the 'uncoupling' of system and lifeworld and the 'colonisation' of the lifeworld. In the 'uncoupling' of system and lifeworld, Habermas describes the system mechanisms as becoming more and more detached from the social structures and social integration. These increasingly autonomous organisations are connected to each other via characteristics of economic and political-legal power and have become independent of their moral-political foundations. As the systemic mechanisms remain

anchored in the subsystem of the lifeworld, (which defines the pattern of the social system as a whole), then they have to be institutionalised (Habermas, 1987a). That is, they become an organised pattern of behaviour that is accepted as a fundamental part of a culture. New social structures take shape steered by processes of power and exchange; social relations are regulated by money and power and become second nature (Habermas, 1987a; Kemmis, 2001).

The 'colonisation' of the lifeworld explores how individuals and groups increasingly define themselves and their desires in systems terms, amid the differentiation or specialisation and relative autonomy of economic and political-legal systems (Kemmis, 2001). Colonisation of the lifeworld is said to be present when traditional life gives way to greatly differentiated, structural components (culture, society, personality) and exchanges between the lifeworld and subsystems are controlled by differentiated roles such as employment, consumer, client and participation in the legal system. The labour force and voters are tolerated by those affected as a trade off against social rewards (in terms of time and money). These rewards are financed through taxation of capitalist growth and are channelled "into those roles in which withdrawn from the world of work and the public sphere, privatised hopes for self actualisation and self determination are located namely in the roles of consumer and client" (Habermas, 1987a, p. 356).

The necessities of the economic and political-legal systems remove communicative action, which underpins the processes of the lifeworld, replacing it with language and ideologies based on the functioning of the systems. The collective and individual self understandings, relationships and practices are reshaped into the discourse of functional rationality (Kemmis, 2001). The systems have become impervious to the "imperatives of mutual understanding on which the solidarity and legitimacy of social orders depends" (Kemmis, 2001, p. 97).

Habermas (1987b) proposes 'the formation of autonomous, self-organised public spheres able to assert themselves against the power and money of the systems. Habermas defines public spheres as autonomous if they are not raised or reserved to create legitimation by a political system. Groups undertaking action research within the systems such as health and education institutions, are one example of 'autonomous, self-organised public spheres' striving to bring about change within the system (Kemmis, 2001). These groups gain strength from their lifeworld in response

to "threats to well defined collective identities" (Habermas, 1987b, p.365). However these lifeworlds are assimilated into the modern systems within which they exist and as such must work within that system rather then develop a more complex system by which to set it free. The nurses in this study, while gaining strength from their lifeworld, their collective identity which they feel is under threat, must also work within the system of the unit and the institution. The nursing lifeworld of the ICU and system of the ICU are mutually co-dependent and as such cannot be separated. Rather, the nurses need to identify and reclaim their values of nursing, to redefine their practice in terms of the nursing lifeworld rather than the terms of the medical lifeworld and institutional lifeworld. The initial step in this process is by first acknowledging and exploring the tensions and interconnections between the lifeworld and system within which they are situated.

Action Research as a Communicative Space

Habermas further developed the Theory of Communicative Action in *Between Facts and Norms* (1996) to include a third characteristic - that of creating a communicative social space. The creation of a communicative space provides the initial impetus for what has the potential to become a 'autonomous, self-organised public spheres' (Kemmis, 2001). Habermas (1996) maintains:

> The public sphere distinguishes itself through a communication structure related to a third feature of communicative action: it refers neither to the functions nor to the contents of everyday communication but to the social space generated in communicative action (p. 360).

People talking together in a situation with mutual interpretation of language and meaning, intersubjectively share communicative space which stands open for other participants who wish to join. This creation of a communicative space is the first step in the action research process, the reconnaissance stage. It provides the nurse participants with the opportunity, the social space, to come forward, and as a group define and discuss their practice in a commonly understood language. Reconnaissance is the crucial process of attaining mutual understanding and agreement

of their core values of nursing practice and defining where they are unable to meet these values in the reality of practice.

Background and Evolution of Action Research

Action research is not a specific method of research, rather it is a generic approach or orientation that shapes methodological practices towards participatory inquiry (Hoogwerf, 2002; Meyer, Spilsbury & Prieto, 1999; Morton-Cooper, 2000; O'Malley, 2001; Reason & McArdle, n.d). Blanchard (2006) maintains that there are consistent themes that guide the development of action research regardless of the interpretation. These themes "include knowing that action research is a collaborative inquiry with a participative intent that seeks to change a context or experience in a context" (p.31). Kemmis and McTaggart (1988a) offer this definition:

> Action research is a form of collective self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which the practices are carried out (p.5).

The origins of action research are often credited to Kurt Lewin, who in the 1940s made the assumption that theory can be directly expressed in action and thus conducted social experiments in field settings (Bellman, 2003; Gustavsen, 2001; Hoogwerf, 2002; O'Malley, 2001; Reason, 2001). Hoogwerf (2002) and Pasmore (2001) also credit John Collier, an American Commissioner of Indian Affairs from 1933 to 1945, as implementing collaborative research to improve race relations. He described his method as action research. However, Altrichter and Gstettner (1993) maintain Lewin was influenced by Moreno, who identified group dynamics and coined the terms, sociodrama and psychodrama. Moreno had already developed a view that action research was also activism, not just as method for practice and behavioural change. In the 1950s during a climate of anti-communism and the advocacy of positivist 'scientific' research, action research and social justice movements were de-emphasised in the United States (Kemmis, 1993; O'Malley, 2001).

Action research was revived in the 1970s as one solution to the increasing omnipotence of politico-legal and economically driven organisational structures. These have led to overwhelming structural crises and real life problems, which cannot be solved by academic aloofness and value-neutrality in research (Fals Borda, 2001). This view is congruent with the Habermas' (1987a) description of the uncoupling of the lifeworld and the system where the mechanisms of the system become more and more detached from the social structures and social integration. This in turn eventually induced crises in the lifeworld, putting strain on the domains of culture, society and personality.

The approaches (epistemological and ontological underpinnings) of action research are diverse, especially with regard to the theorisation of the relationship between research and social change. These distinct methodological approaches are influenced by the different kinds of reasoning that underpin the three knowledge-constitutive interests, (technical, practical and emancipatory) categorised by Habermas (1971; Kemmis, 1993; Kemmis & McTaggart, 2000; O'Malley, 2001). Some researchers see it as technical or instrumental, some as practical reasoning and others regard action research as critical.

Emancipatory or critical action research includes the technical goals of improving outcomes, the practical goals of achieving self knowledge along with the added goals of looking critically at the situation and context of the research. The practitioners look at themselves in this context and their relationship to others as well as the social, economic, legal and political issues which influence their practice (Kemmis, 2001). Emancipatory action research involves some form of social change or activism and is a political process (Kemmis, 1993; Marshall, 2001). The critical action research approach is congruent with the Theory of Communicative Action which involves a framework for shared understanding through rational discussion to reach consensus. This approach enabled the nurse participants in this study to acknowledge and explore their practice within the lifeworld of ICU nursing and its relationship with the system in which it is situated.

Action research process within the nursing paradigm

The participative, clinician focused aspect of action research has attracted a growing number of nurses to adopt this approach for their research inquiry (Bellman, 1999; Blanchard, 2006; Booth, 1997; Coyer, Courtney & O'Sullivan, 2007; Hoogwerf, 2002; Hope,1998; Meyer, Spilsbury & Prieto, 1999; Morton-Cooper, 2000; O'Malley, 2001). Blanchard (2006) conducted an action research project in an ICU developing the place and role of the family within the culture of critical care nursing. Booth (1997) used action research to explore the partnerships between nursing educators, practitioners and students to facilitate student learning during clinical experience. Hoogwerf (2002) brought about innovation and change in a rehabilitation unit for the elderly through action research while O'Malley (2001) used this approach with nurses to improve nursing care in an acute mental health in-patient service. Bellman (1999) conducted two critical action research projects in which nurses identified patient specific problems, challenged the status quo and systematically implemented an evidence based change process. Street (1991) maintains nursing is essentially an oral culture and I believe nurses communicate readily through storytelling especially in group situations. The action research approach is compatible with nurses' ability to work together, with a common goal of improving patient care. This approach brings research into the clinical area and enables nurses as a group, to actively participate in defining and improving their practice.

Kemmis and McTaggart (1988a, p.6) state, "Action research is a group activity", and that "group decision and commitment to improvement" were crucial aspects of Lewin's work. The education literature on action research in practice has enabled nurses to adapt the action research principles to reflect the health and nursing focus (Elliott, 1978; Kemmis & McTaggart, 1988a; 1988b; 2000; Whitehead & McNiff, 2006; Zeichner 2001). Moreton-Cooper (2000) adapted the key principles of action research from an educational model by McNiff et al (1992, cited in Morton-Cooper, 2000).

- Action research is practitioner-generated;
- workplace orientated;
- seeks to improve practice;
- starts with a problem shared and experienced by colleagues and/or patients;
- examines key assumptions held by researchers and challenges their validity;
- adopts a flexible trial and error approach;
- accepts there are no final answers; and
- aims to validate any claims it makes by rigorous justification processes (p. 19).

All types of research methods are compatible with action research, such as surveys, interviews, observation, focus groups and nominal group techniques. Morton-Cooper (2000) contends that the difference from other research is that in action research, the researcher participates in all aspects of the project, the participants are co-researchers and involved fully in the development and conduct of the research. Nolan and Grant (1993, p.307) maintain that it is crucial that the participants "establish a shared and explicit set of values which act as a reference point for all subsequent activity". In doing so it was necessary to differentiate between institutional, medical and nursing care philosophies, to ensure the participants are able to define what underpins nursing practice in the ICU. Participants looked critically at their own practice philosophies and values as well as how the practice of nursing in the ICU intersected and conflicted with the demands of the system.

The action research cycle

The cycle consists of reconnaissance, planning, action and evaluation. The first step in the process is reconnaissance, which through discussion and reflection identifies the aspect of practice which most needs improvement. The planning stage follows where an action or intervention is discussed with regard to feasibility and appropriateness as well as perceived barriers and problems. The plan or solution is then implemented into practice. This action is observed and evaluated and after a defined period of time, the process begins again. The success of the action is discussed and reflected upon; changes are then planned and then put into practice

again. This cycle may be a continual process or there may be an agreed endpoint at which time the success of the research is evaluated (Elliott, 1978; Kemmis & McTaggart, 1988a). Figure.1 shows a basic plan of the action research cycle.

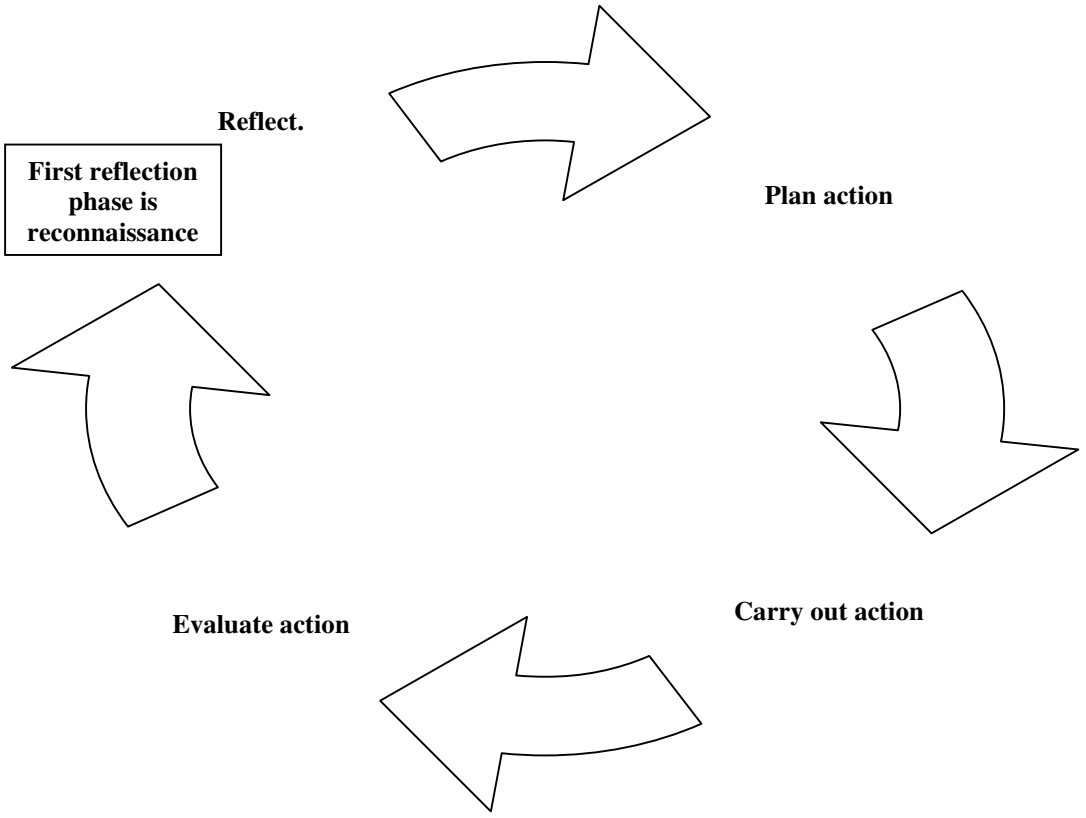

Fig. 1 Basic action research spiral

The reconnaissance phase in Figure.1 is depicted as a box outside but at the beginning of the first cycle. Other commonly used models of the action research also depict reconnaissance or fact finding as the least significant phase of the change process. This thesis centres on the reconnaissance phase of a future action research project. It is the foundation and reference point of all future action and as such needed to be conducted carefully and comprehensively to enable the nurses to define a shared set of core values. These core values are the ideals of practice and provide the guidance for optimum nursing care in the reality of everyday ICU practice. The second phase of the reconnaissance involved the nurses identifying where practice change is needed by defining where they cannot meet their core values of care. Successful future action is

aimed at bringing the reality of practice closer to the ideals of the core values (Hart & Bond 1995; Nolan & Grant 1993).

Critical action research within the context of an Intensive Care Unit

In the ICU nurses frequently raise concerns around issues and problems in their practice but often this is done in passing to other nurses, in bedside handover, staff room discussions or more social situations. Concerns raised at the nurses' staff meeting which is led by the Clinical Nurse Managers (CNMs) and/or manager, are often dealt with summarily as there is limited time for discussion or consensus. The meeting occurs monthly in the staff room around handover time from morning to afternoon shift. Therefore, most discussion is necessarily brief as there is an underlying awareness of the need to get back to the patients or to go home. There is a suggestion box which enables staff to anonymously submit ideas or criticisms and answers are distributed to staff in the form of general written handout. As these are anonymous the decisions are made by the management team (CNMs and/or consultants) as there is no opportunity for discussion with clinicians on the floor.

Caring for patients in this environment often seems (to me) like working in a maze, negotiating obstacles, barriers and dead-ends, all the while trying to care for your patient as a unique individual, in an institutionalised system. Nurses hear snatches of conversation, get glimpses of like minds also negotiating the maze but are unable to discuss their concerns in any constructive way. Hope (1998) uses the analogy of action research as being a bus ride; people get on the bus, which has a collective destination, but they also have the freedom to get off as well, demonstrating the fluidity of action research. The analogy of the bus as the project vehicle can be used as a way to negotiate the maze and collect the snatches of conversation and glimpses of like-minded nurses into a fluid but tangible group aiming for basically the same destination.

The action research group needs to be open and fluid to accommodate the varying contributions and commitment from each individual. Kemmis (2001) maintains that action research groups tend to be fluid and permit a range of roles within the communicative action process. This fluidity enables individuals to participate as they are able or desire within the constraints and reality of their own lives and does not preclude people who cannot attend every meeting or take

an active speaking role. This is important in the ICU where nurses usually work varying shifts and days making regular participation in the group difficult.

The creation of a communicative space enabled these nurses to be involved, when they were able, with the negotiation of a collective destination or goal rather than have the solution dictated to them by those who hold the power. Critical action research enabled the nurses to participate in defining and examining these issues and work together to find solutions. This research is the beginning of the negotiation of the maze, the beginning of the process of self and collective understanding of ICU nursing practice and its relationship with social, economic, legal and political aspects of healthcare

Chapter Four Research Design

In this chapter the research design and the process of introducing the research into the institution and the ICU are presented and discussed. Further, I discuss the ethical considerations of action research particularly with regard to the insider/outsider research, confidentiality and identifiability and also my own position within the unit structure. Rigour and reflexivity will be discussed along with Habermas' (1984) concept of validity in relation to the conduction of the research process and also on a personal basis with how I position myself within the research.

Invitation to participate

Preparing the ICU nurses for the research began over two years before the first focus groups were commenced in February 2005. In my Research Nurse role in the ICU I have a regular presence in the unit, either conducting unit research or discussing issues with the nurses. This thesis was not conceived in the isolation of my own experiences and assumptions; it was also developed in response to many conversations over the years. These conversations took place informally in the staff room and at the bedside and also in a more structured situation when I was teaching about patient sleep deprivation, sensory deprivation and sensory overload for the Critical Care Course students. Dissatisfaction with how nursing care was conducted and influenced was a constant thread running through these conversations, some of which were directly overt, others quiet but all the more compelling because of this (dis)quiet. These conversations led me to believe that this research, looking at practice on night shift, would not only be accepted but would be welcomed. I introduced the basic idea of this research during these conversations, saying I would be starting my Masters thesis in due course which would involve working with the nurses to look at these issues. This was met with either mild enthusiasm and interest in being a part of this, or interest in hearing about the research, after stating that they did not have time to be involved but it 'sounded good'. I sometimes was not sure if they were actually interested in the research or were showing interest because I was the person involved and they wished to show support on a personal as well as professional level. Some of these nurses had participated in a study previously in which night nurses were asked to take a homeopathic shift lag remedy compared with a placebo in a randomised crossover study. Although this study called for intrusive objective and subjective measures in the early hours of the morning the majority of these nurses found this to be a positive

experience which also increased their interest in nursing research (La Pine, 2004). The Clinical Nurse Managers (CNMs) were also informed that I was planning this research during casual conversation, both social and professional. They were aware I was studying so this was an opportunity to gradually introduce the basic concepts of the research. While everyone seemed supportive on the face of it, there were also some signs that there was passive opposition to the study. At this time I was in very isolated role, working autonomously, attempting to establish a research culture in the unit and encouraging nurses to become involved in research. However, this was meeting with little success as the expectation was that nurses were to do this in their own time, yet a measure of my 'success' in the role was how many nurses had conducted research. I was not expected to lead the research, but to teach, support and ensure the research was conducted correctly. Nurses may have felt this pressure to conduct research was also indicative of my stance on this expectation and resented my role in this. My actual standpoint was that we needed to develop research projects that all the nurses could become involved with during work time, also providing the opportunity for nurses to become more involved as they wished and were able. The situation is now different but at the time there seemed to be subtle indications some nurses were not supportive of my undertaking this research in the unit, in what may have been seen as my work time. This situation highlighted all the concerns about conducting critical action research in my own area of work and the dangers of undertaking what can be construed as political, subversive action (Kemmis, 1993; Marshall, 2001; Williamson & Prosser, 2002).

Requirements for institutional and ethical approval

During the planning period I had talked to the Clinical Director and Operations Manager of the ICU to ensure they knew the research was pending and to gain their support for this. Obtaining their support was crucial for the success of this study as I needed permission to conduct the study in the unit with the nurses and also to use unit resources. This was granted although with the stipulation that changes in practice would be discussed with them prior to commencement. When conducting research within a health related area it is necessary for the Clinical Director of the area to sign the regional ethics submission signifying approval for the research to be undertaken. Institutional approval was also sought and received from the Hospital Manager prior to submission to the Regional Health Ethics Committee. Most New Zealand health researchers are required to consult with local Maori to ensure Maori participants (indigenous people of New

Zealand) are protected, and a letter of approval is forwarded with the ethics submission (Appendix 1).

Researchers are offered the opportunity to present their submission in person to the Regional Ethics Committee which enables members to question the researcher if aspects of the research are unclear. This can expedite final approval without the need for clarifying correspondence to slow the approval process. I was able to attend the ethics meeting and fielded only one question, from a medical committee member, as to why doctors were excluded from the study. The committee was satisfied with my reply that it was because we would be looking at nursing problems, best solved by nurses and we would consult doctors as necessary. The last step in this process was presenting the letter of approval from the Regional Ethics Committee (Appendix 2) and Maori to the General Manager for final sign off and approval to conduct the research within the hospital.

A stipulation of the Clinical Director's approval was to present the study to the ICU management team. My supervisor also attended this meeting and it was apparent that this facilitated the acceptance of the research and enabled better clarification of the action research approach. The doctors' main concerns were that we would change something significant without consultation or evidence, but were reassured when I reiterated this would not be the case.

Consultation with Maori

Consultation with Maori as the indigenous people of New Zealand was undertaken during the formative stages of the research proposal (Appendix 1). This was undertaken with a member of the Kaumatua Kaunihera (Council of Elders) Research Subcommittee. In my thesis this was a formal ethical requirement to ensure participants identifying as Maori were protected with regard to the principles of the Treaty of Waitangi. This Treaty signed in 1840 by many Maori Chiefs and representatives of the Crown, is the founding document of New Zealand and guarantees Maori, partnership, participation and protection (Orange, 1989). In this research this meant Maori participants were regarded as equal partners, participation was encouraged and their rights were protected. To ensure Maori participants were offered equal voice within unequal power relations, it was agreed that it was appropriate to offer them individual interviews to ensure their voice was heard, in addition to their participation in the groups. We agreed that the consultant would be

contacted for assistance and guidance with any issues that arose with Maori nurses participating in this study.

Study design

The study design was written in the form of a protocol to act as a guide through the process of both the reconnaissance and the action stages of the study. Devising a protocol was one method of enhancing validity and rigour as it was used as a guide to ensure that the research followed the underlying principles of communicative action, regardless of the direction it took. This proved to be invaluable when the participants, in the imprecise nature of action research, broadened the focus of the path I had envisaged for the research. I was able to go back to the protocol and ensure that although the focus had broadened, the principles of communicative action still applied. When judging the quality of the research the philosophical aims informing the research must be taken into account (Fossey, Harvey, McDermott & Davidson, 2002). Frequent checks with the protocol ensured that however 'messy' the project became, the principles of communicative action, collaboration, argumentation and consensus were a continual thread throughout the research (Barrett, 2001). The protocol incorporated the study design, questions and aims as well as the process and initiated the development of a basic model of an action research project. As this research took shape it became obvious the planned model no longer reflected the process of this reconnaissance study so it is not included in thesis. Reflecting on the process of this thesis as a reconnaissance for future action also enabled me to realise that action and change had already begun with the first focus group. Creating the communicative space enabled the nurses to meet and for the first time discuss their practice and define the core values that underpin the care they give.

Reconnaissance as a change process

In many approaches to action research, reconnaissance is not regarded as part of the action process. However, increasing our awareness through discussion has an impact on how we now see these issues, thus increasing understanding and beginning the process of change (Morton-Cooper, 2000). This reflective process of sharing beliefs, values and insights into practice issues has the potential to improve relationships, procedures and power play within the institution (Taylor, 2000). Krueger (1994) maintains that the group dynamics of participants interacting and

influencing each other and also influencing the course of the discussion should be regarded as a limitation of focus groups. However, in action research and communicative action it is this group dynamics of interaction which enables the issues important to the participants to surface and become the focus of the discussion. While Krueger (1994) contends that the researcher needs to keep the discussion focused to prevent detours and irrelevant issues, it is the participants who determine the focus. The difficulty for the researcher is determining what information is irrelevant, further strengthening the need for the researcher to have insider knowledge. The reconnaissance phase in this thesis may be regarded as the core of the research rather than a peripheral starting point and it provides the basis of future growth and development.

The initial step in the reconnaissance process was to create the communicative space to enable the nurses to come together and discuss their practice. To understand and define how nurses care for patients and look at what influences this care, it was first important to acknowledge and clarify the values and beliefs nurses regard as fundamental to the care they give their patients in the ICU. The basis of action research is grounded in the shared and explicit values and culture, which in this research, is ICU nursing practice (Coghlan & Casey, 2001; Morton-Cooper, 2000; Somekh, 1995). Habermas (2001, p. 121-122) states "An action can only be justified with reference to norms that lay down that certain values ought to receive primary consideration in certain circumstances." Habermas (2001) defines norms as rules that have an intersubjective meaning and which governs the actions of the group for which that norm has meaning. A valid norm has a universal interest which has the consent of those affected by that norm, such as the rules of practice, which are universally agreed as true and correct. In situations where the rules are valid "everyone is justified in orientating herself towards certain values and to base her actions on the wants and needs interpreted in these values" (Habermas, 2001, p. 122). Situation specific or cultural values which are agreed on by the members of the group can become part of the requisite norms of practice. Therefore it was essential that the first step in this research was to ensure the members of the group, the participants, reached consensus on the norms and values that constitute ICU nursing practice. "Valid norms have the power to motivate actions because the values they embody…represent the standards according to which the wants and needs are interpreted…" (Habermas, 2001, p. 123). This values clarification set the standards which are the ideals of practice and by which the reality of practice can be evaluated and aspired to. It is only

through the recognition of these fundamental values that the issues arising from reflection on the reality of practice can be judged to be valid and true. Group consensus would define the validity of the claim within the context of the specific situation.

Research in action

When designing the study process it was difficult to envisage how the nurses would be able to meet as a group when most nurses worked shift work. In this unit, there are 5 CNMs, 2 Nurse Educators, and approximately 70 nurses who work a variety of 12 hour or 8 hours shifts either on rostered duties or permanent night shift. In addition to this the unit runs a transport team necessitating a nurse leaving the unit unexpectedly, a critical care course, requiring nurses to be on study days or clinical placements and when the unit is quiet, nurses are deployed to other wards. This made the planning of the focus group meetings very difficult and often needing to be cancelled at the last minute. The reconnaissance phase and philosophical principles of communicative action required collaborative collective discussion and I was concerned that this would be impossible or ineffectual if nurses were unable to meet in sufficient numbers. Hope's (1998) analogy of action research being like a bus ride, with a collective destination but people having the freedom the get on and off the bus as they wish, encouraged me to look at other ways the groups could work. Rather than try to get everyone in one big group, which was impossible, I decided on a flexible approach, with small groups as they were able. The reconnaissance process involved:

Stage 1) Values clarification focus groups using a modified nominal group process.
Stage 2) Reality focus groups.
Stage 3) Individual interviews.
Stage 4) Gaining consensus.

The values clarification process was achieved through a series of small focus groups whose participants comprised of interested registered nurses working in the ICU. The work of the first group provided the basis of the values of ICU nursing practice and each group subsequently debated and added to the work of the groups before it. This enabled the values to be built in a snowball fashion until no further values were identified. This enabled the nurses to develop

shared beliefs and mutual understanding from the basis of common understandings of the language, culture and tradition which constituted ICU nursing practice.

Nominal Group Process

One of the concerns I had for this process was how I would get the participants focused on their own values in a group discussion, especially as there would be a limited timeframe to achieve this. I decided to use a modified nominal group process, a type of brainstorming, using affinity diagrams (Booth, 1997; Kelley, 2000; Moon, 1999; Nelson, Jayanthi, Brittain, Epstein & Bursuck, 2002). The basis of the nominal group process is to ask participants to write down their answers on cards or post-it notes in silence with no conferring. This enables each person to concentrate and think of their own values of practice without anyone influencing them. This silent method also ensures each participant has an equal voice in defining the values of ICU practice, wherein the group process the most dominant voices often prevail, perhaps inhibiting some participants from speaking. This may mean that important aspects of ICU practice values are not revealed resulting in an incomplete portrayal of practice. This in turn would impact on what issues are revealed and agreed on, perhaps undermining the success of the project. Each participant has the responsibility to give their own opinion without coercion as the group will base its decisions on the best possible argument (Allen, Benner & Diekelmann, 1986). After each person has finished writing, they silently arrange them in related groupings which have an affinity with each other. An example of this was 'caring for the patient as an individual' had an affinity with 'not giving ritualised care'. All values with this similar affinity were then grouped under the core value of 'the patient comes first', when as a group the participants discussed the data and named each category as a core value.

A common strategy in the nominal group process is to then define, either as a group or vote silently, the degree of importance or priority each category has (Kelley, 2000; Moon, 1999; Nelson et al, 2002). However, in this research the purpose of the process was to get as complete a picture as possible of ICU practice values, rather than prioritising. Each value was important and there were no wrong answers as the participants were stating their own values and beliefs to establish a shared philosophy of ICU practice. The modified nominal group process was only used for the values clarification focus groups as the values generated from these groups would

serve as the starting point for the next stage. This process was again modified at the beginning of the first focus group as I realised asking the nurses to silently group their values was not feasible in the time and space allowed. In practice the nurses read out their values which I wrote on a white board. The nurses directed this process identifying which values had affinity with others. This demonstrated the flexibility of action research in being able to adapt the process as needed.

Reality focus group

The second stage of the research involved the participants reforming into the reality focus groups. They were often in different groups from the first stage of the study but were still guided by the values and beliefs of care defined in the values groups. In this stage they identified where in their own practice they were unable to meet these shared values and beliefs in the reality of clinical practice. In this way the groups were able to define the issues within their practice, reach consensus on the validity of the claims and determine the importance these issues have in their practice. Individual interviews were offered to participants who did not wish to talk in the open group or who were unable to get to a group meeting. This information was, with the participant's permission, incorporated into the overall data for analysis and if appropriate I introduced it anonymously into the group discussion.

Positioning myself within the unit and the research

Conducting a critical action research project in the area I work in has proved to be challenging, exhilarating and fraught with many difficulties and obstacles. Critical action research is an inherently political process involving social change (Kemmis, 1993; Marshall, 2001; Williamson & Prosser, 2002). It is enabling the participants to explore not only their own practice but also the governing ideology of the ICU and the institution, looking at the historical, economical, social and politico-legal influences of nursing practice. It is conducted with the ultimate goal of bringing about change in practice.

Conducting a research project in the institution and area the researcher works in raises ethical issues such as researcher bias and also in the hierarchical or professional relationship between the researcher and the participants (Bonner & Tolhurst, 2002; Coghlan & Casey, 2001; Hanson, 1994; Titchen & Binnie, 1993; Williamson & Prosser, 2002). When I first began planning my Masters thesis, I was advised by a colleague that doing research in my own unit would be

difficult as I was too familiar with the issues and it would be better to do the research in another unit. Another possibility would be to conduct the study in another unit as well as this one to reduce researcher bias and compare the issues. I explored this option for some time before deciding on the action research approach looking at nursing practice. I recognised that while I wished to do this research for the Masters thesis, I did not want to do the research purely for the qualification. It had to be of value to the nurses in the unit and something in which they had a vested interest.

In my role as researcher in ICU I had been involved with nursing research prior to this study and knowing the investment of time and energy required from the nurses, I wanted this research to be meaningful and actually bring about change in some aspect of practice. This resolve reinforced the 'rightness' of using Habermas's (1984,1987a) Theory of Communicative Action and the action research approach as it involved nurses talking and working collaboratively about their practice. However, conducting action research in my own workplace meant that I needed to carefully consider my position in the workplace and also within the research.

Insider-outsider model of action research

Titchen and Binnie (1993) identify two aspects of action research describing the insider and outsider roles. Insider refers to a researcher who has a clinical leadership role with authority to act as a change agent, whereas the outsider role refers to the researcher from outside the setting who has no authority to initiate or carry out change, but who has a supportive, diagnostic function. In my current role I do not have a clear cut 'fit' into either model.

A major part of my research role is talking to nurses about research and issues of practice in the ICU. Because of this I felt the introduction of my thesis research and my involvement as facilitator and participant was relatively easily accepted. I had worked as a staff nurse with many of the nurses, worked with most of them as a researcher and had participated in many discussions over the years on unit issues, such as staffing, noise, stress and visitors. I felt that I had a reasonable grasp of many of these issues and would certainly be able to understand and participate in the nurses' discussion within the context of ICU practice.

Gummesson (2000) refers to this knowledge, insight and experience as pre-understanding. Nurses know the jargon, what can and cannot be talked about, how nurses think, and what the critical events are and what meaning they have in the institution (Coghlan & Casey, 2001). The disadvantages to having this pre-understanding is that researchers may assume they know the issue and not probe further perhaps missing the opportunity to uncover deeper meanings. This was something I had to be constantly aware of during the discussions and interviews. Coghlan and Casey (2001) maintain that as a member of the unit it may be difficult to cross unit or hierarchical boundaries for further data. This is supported by Williamson and Prosser (2002) who maintain this is especially difficult as the research is exploring the "micropolitical climate, the policies of the organisation and personalities" (p.588). The political action of questioning institutional and individuals' beliefs and norms may be seen as subversive, even sabotage, by management. Uncovering these issues within the their own organisation may increase the researcher's and participant' personal risk, being seen potentially as " loose cannons rocking the boat" (Williamson & Prosser, 2002, p. 589).

This is an issue I have been very aware of in the planning of the research and also throughout the process. In my ICU research role I have access to both clinicians and managers although I am neither one nor the other. In the past 2 years that I have attended Management Team meetings which allows me a forum to introduce and discuss research activity as part of routine unit activity. Acceptance into this team has, to my mind, brought clinical research closer to clinical practice as it now seems to be regarded as part of unit activity rather than something I 'do' isolated from everyday practice. The isolation of my role prior to this put me in the position of outsider. Yet the clinical nurses were unaware of this isolation and regarded me as part of the Management Team as well as accepting my presence on the floor.

The discussion on insider-outsider (Bonner & Tolhurst, 2002; Allen, 2004; Titchen & Binnie, 1993) models of research highlights the benefits and difficulties of both aspects providing insights into how these issues were approached. However, the insider-outsider roles are not always as clear cut as in the action research by Titchen and Binnie, (1993). Williams (1995) states:

> Even an insider nurse who is facilitating other nurses may be an outsider in the sense that he or she has a close affiliation with…a management or educational setting than in the setting in which the change is being facilitated, such as a clinical setting (pg 52).

If I look at my position from an outsider point of view then the issues raised by Titchen and Binnie (1993) have direct relevance. One of the dangers of myself as an outsider researcher is that any change implemented could be seen as owned by me, not the nurse participants. For this change to be sustainable the principles of communicative action needed to be adhered to and the participants, myself included, reach consensus through communicative competence. Another identified tension is when the researcher enters the study focusing on a particular area and the participants take the study in a different direction (Titchen & Binnie, 1993). This actually happened in this research as I began the study focusing on night shift and the participants firmly placed the issues and need for change across all the shifts. This forced me to consider my own bias and assumptions from my experiences of night shift and adapt to the direction the participants wished to go.

Habermas (1984) addresses the possibility of researcher bias by maintaining that in order to understand what the participants are saying, the researcher has to be familiar with the validity or trustworthiness of the claims. The researcher cannot interpret expressions without taking a position on them, that is "without applying his own standards of judgment" (Habermas, 1984, p.116). Within the model of communicative action, the participant possesses equal interpretive competence with the researcher who becomes a participant in the research. Within the principles of communicative competence, the participants are equipped with the concepts of the three cognitive interests, technical, practical and emancipatory, and can apply them reflectively.

> The success of the communicative action depends…on a process of interpretation in which participants come to a common definition of the situation within the reference system of the three worlds (Habermas, 1984, p.119).

Equipping the participants with the same judgmental capabilities ensures that the researcher loses the privileged position and immunity of observer and exposes her interpretation to the same critique the participants do. The process this research followed enabled the nurse participants to define and explore practice issues and develop their understanding of these issues through self-reflection and collective reflection.

Rigour and Validity

The insider-outsider models of action research must also be considered with regard to issues of rigour and validity (Badger, 2000; Hanson, 1994; Turnock & Gibson, 2001). Rigour refers to how strictly the processes of the study have been followed, with clear evidence of meticulous attention to detail (Roberts & Taylor, 2002). Validity in this research refers not the positivist concept of generalisability and accuracy of measurement, but to Habermas' (1984) concept of validity which refers to the truth and rationality of communication. Rigour is determined by the four categories of credibility, fittingness, audibility and confirmability. Credibility refers to the extent the readers relate the research to their own experience. Fittingness means the findings of the research are applicable to others experiences while auditability refers to the decision trail of the research showing it has followed the correct methodological process. Confirmability is possible by the demonstration of the first three characteristics which are subjectively confirmed by the participants (Roberts & Taylor, 2002). These can also be related to Habermas's concept of validity where the participants, through discussion or argumentation confirm the truth and rationality of each idea as relevant to ICU nursing practice. The participants also ensure when the data is given back to them that this was a true and accurate record of their conversations in the focus groups without bias being introduced by the researcher.

Reflexivity

Rolfe (1996) introduces reflexivity into action research based on Schön's reflection-in-action. The situation is assessed, theory is constructed and change implemented, the effects of which are immediately assessed and practice modified accordingly. He claims reflexive action research is subjective, and the quality of the research should be judged by the researcher as the most qualified to interpret the findings. Finlay (1998) defines reflexivity as:

> Constantly reflecting on, questioning and evaluating the research process…to distinguish how subjective and inter-subjective elements have impinged on (and possibly transformed) both the data collection and the analysis (p.453).

Finlay maintains that subjective insider knowledge should be regarded as a resource to be exploited and to disregard this may undermine the validity of the research. While Waterman (1998) contends that the strength of action research lies in its validation process and this may be helped through a reflexive stance in which bias and prejudice are acknowledged and analysed so the researcher is able to understand what influence they have on the project. The researcher then is able to decide how appropriate this influence is and alter it if necessary. My knowledge of the unit, nursing practice and process and the language and jargon of ICU practice has enhanced the rigour and validity process in this research.

Finlay (1998) describes four subjective fundamentals as emotional/behavioural responses, expectations, assumptions and unconscious responses. While these refer mainly to personal reflexivity it is also necessary to reflect on the method of the study, methodological reflexivity. In this thesis there are dual levels of validity checks; the validity of the research process informed by Habermas's Theory of Communicative Action and communicative competence, and my own process of personal reflexivity. This process for me is not only in analysing and interpreting the data, but also in the focus groups during discussion and argumentation in which I was both facilitator and participant. I needed to be sure that what I heard was what was said, that it was true, appropriate and that my response was appropriate, true and did not introduce bias into the discussion. During the transcription of the taped discussions I had not originally intended to transcribe verbatim, but decided this was necessary as one way of checking how much influence I had during the discussion and if it was appropriate. This then enabled me to take more care during the next focus groups to ensure the data remained true. During this process, I also reflected on my emotional and also unconscious responses where I let go the facilitator role and became nurse participant in the discussion, drawing on my own experiences of the discussion subject. Koch and Harrington (1998) maintain that "reflexive research is characterised by ongoing self-critique and self appraisal…" (p. 882). During the thematic analysis I needed to ensure I was not concentrating on the parts of the discussion which supported my own

assumptions and expectations, but was staying true to the data. This involved frequent rereading of the data as a whole, as well as relistening to the tapes, to get the essence of the discussion and ensure I was not misinterpreting the information.

Issues of consent, confidentiality and identifiability

The uncertainty and evolving process during action research raises questions on the basic research requirements of informed consent, confidentiality and identifiability. Informed consent must take place prior to participants starting in the study. While it is correct to do this at the beginning of the project, one of the basic rights of being able to withdraw from the study at any time may be difficult if the change process has already begun and observation is a measurement tool (Badger, 2000). Nurses who have not been part of the study will be affected in some way by the change and this effect will become part of the evaluative cycle. Obtaining informed consent means that the participants have agreed to become part of the research, usually at the outset and with full knowledge of what the study involves and what is expected of them. This is cannot be the case for everyone affected by organisational change through action research. Meyer (1993) maintains that staff co-operation is always to some extent obligatory in action research, which contradicts the voluntary ethos. It is important to ensure the participants knew at the outset that I did not know which direction the project would take and the progress was largely dependent on the participants (Williams, 1995). This was achieved by not making explicit claims on what the research hoped to achieve giving more generalised aims for the study, i.e., to understand and define what we as nurses do on night shift. This enabled the nurses to know what the study was about but not be so prescriptive that the study lost its collaborative action research process. The direction the participants took with this research expanded the focus from night shift to all shifts. This did not detract from the original aims for the study but increased the depth and also made it more representative of what the issues actually are.

Confidentiality and identifiability are also basic requirements when conducting conventional research. In action research the collaborative and collective nature of the data collection, group discussion, makes this practically unachievable. As stated by Williams (1995) “confidentiality would be a matter of collective agreement on the part of all co-researchers (including the researcher) to respect the sensitivities of all” (p.55 The concepts of respect, non-judgmental

behaviour and confidentiality within the group were made explicit at the outset and in the information sheets and consent forms. Also included in this was an agreement by senior nurses that any information revealed in the group would have no adverse consequences for participants. The risk in undertaking critical action research to change practice can raise questions on safety of the participants in what may be construed as a political act. Williamson and Prosser (2002) respond to this dilemma by stressing the collaborative nature of action research in which the participants have equal ownership of the findings, and the ethical and professional responsibility to protect each other. Coghlan and Brannick (2005) however, maintain that the researcher as instigator of the study has a professional and personal responsibility to ensure the participants are protected from harm.

The study design allowed multiple focus groups to be formed to ensure as many nurses were able to participate as possible. The first phase involved values clarification of nursing practice in ICU. Due to the roster system and shift work, when the groups were reformed to look at the reality of practice, the participants were often in a different group from the one they were in during the values groups. This further lessened the possibility of anonymity and confidentiality between the groups. Information from individual interviews was anonymously introduced into the group process if relevant to the discussion at the time. If during the interview the participant asked for the tape to be turned off, this was done so and field notes were taken as appropriate. Permission was sought for specific quotes to be used in the analysis but the data was not introduced in the group discussion. To further ensure the participants in this research are protected, anonymity in this thesis and any publications will be ensured through pseudonyms and nurses will only be identified as senior or junior. Senior may mean members of the management team or a nurse who has been in the unit for many years. Medical staff will simply be referred to as doctors, not consultants or registrars. The next chapter describes the process of creating the communicative space with the commencement of the values and reality focus groups.

Chapter Five Research in Action: Values Clarification and Reality Groups

In this chapter I will discuss the process of creating the communicative space introduced in chapter 3. This social space, created in a situation where people talk together with mutual interpretation of language and meaning, is the third feature of communicative action (Habermas, 1996). Creating this space enabled the participants to meet to begin values identification and clarification. Collectively defining and clarifying their values and beliefs of practice ensured the participants had established a shared philosophy of ICU nursing practice. This provided a blueprint or a reference point for the study which guided the discussions, reflection and action. The values clarification is Part 1 of the reconnaissance phase. The groups will be briefly discussed and the ensuing values themes will be displayed in the form of a triangular model. Two individual interviews were also done for participants unable to attend a group meeting.

Part 2 of the study involved the reforming of the groups to discuss where they were unable to meet their values of practice. The challenges involved with reforming the groups necessitating flexible structuring and facilitation will be discussed.

Part 3 of the reconnaissance involved the individual interviews and one written response. These were provided for participants who were either unable to attend a group meeting or unwilling to speak in the group situation. I have assigned pseudonyms to each of the interviewed participants, choosing names which are not gender specific to further protect their privacy.

The 3 phases of data collection including dates and number of participants for each meeting are summarised in Table 2 (p. 56). The thematic analysis framework which guided the analysis of the data and the process of defining the major sub themes form the data will also be discussed in this chapter.

Table 2: The 3 phases of data collection for reconnaissance

Stage 1 - Values	**Date**	**Time**	**Number of participants**
Interview 1	23/2/05	1500	1
Group 1	24/2/05	1500	9
Group 2	2/3/05	2300	5
Group 3	8/3/05	1500	9
Group 4	10/3/05	2300	5
Group 5	16/3/05	1500	5
Interview 2	20/3/05	1300	1
Stage 2 - Reality			
Group 1	29/3/05	2300	6
Group 2	22/3/05	1500	5
Group 3	28/4/05	1500	4
Group 4	7/6/05	1500	6
Group 5	9/6/05	1500	3
Group 6	13/7/05	2300	3
Stage 3 Interviews			
Kerry	21/7/05	1400	1
Jordan	26/7/05	1100	1
Sam	28/7/05	2330	1
Brooke	28/7/05	0030	1
Rowan	26/8/05	1300	1
Joss	28/805	2330	1
Ashley	Written feedback		1

Creating the communicative space

Once formal permission was received from the General Manager of the institution I was able to formally introduce the study to the nurses in the unit. Announcement of the study was given verbally at handover time and also via a brief written overview of the study and invitation attached to each nurses pay sheet (Appendix 3). The Operations Manager gave me permission to use the protected education time at the end of the morning shift for the meetings. This protected education time occurred after the handover to the afternoon staff and prior to the morning shift leaving. This gave 30 minutes of paid time for education. Gaining permission to use this time for the focus groups was a pivotal factor in recruiting participants to the study.

One of the difficulties with conducting research with all nurses is being able to access the permanent night staff. As I worked permanent night shift prior to taking the Research Nurse role I had some idea of how isolated many night nurses feel socially and professionally, and how this can impact on opportunities for career development (Claffey, 2006). As at that time it was the permanent night nurses who would be most affected by the proposed research, it was crucial to have their involvement. The night coordinators and CNM were very supportive of the study and were excellent at organising time after handover by the afternoon staff for the participants to meet with me. I had worked with many of these nurses on night shift and this connection as well as the relationship I had fostered in my research capacity ensured a supportive environment for the study.

Stage 1- Values Focus Groups

I scheduled the first meeting on the 24/2/05 when many of the nurses who had consented were on either morning (AM) or afternoon (PM) shift. While handover was in progress, I set up the meeting room which is set back from the main corridor behind a little used store room, ensuring the meetings remained private. As I was only expecting 4-5 participants I was surprised when 9 nurses entered the room, some of who were expecting an education session. After I explained the research along with distributing information sheets they all expressed willingness to participate and signed the consent forms (Appendix 4). The consent form consisted of two parts, one to participate in the focus groups and the other to become a co-researcher in the future action group. I also explained that involvement in this study might contribute towards their hours of

professional development for the Professional Development Recognition Portfolio, which demonstrates their competency to practise.

The first step

I began by explaining the nominal group process and affinity diagrams and what I would like them to do. Originally I had thought to use the affinity diagrams with the silent process of each participant writing the values on post-it notes and then silently grouping them with others that had an affinity or similar meaning. I quickly realised this wasn't feasible due to time constraints and the number of participants. I combined the brainstorming aspect of the nominal group process where each participant reads out their values, with the affinity group process where the values are placed in affinity or similar groups. By writing them down first silently and individually it enabled each nurse to give their true values rather than being influenced by another's values. Initially there was some hesitation on what to write so I clarified the question in terms of;

a) What are your own values and beliefs in caring for patients in ICU?
b) What is your philosophy of nursing?
c) How would you care for your patient if there was no-one to tell you what to do and you did not have to consider anyone else but your patient?

Once everyone had finished writing the participants read out their values, which I then wrote on the white board. I placed similar values together as directed by the participants. Occasionally I would ask for clarification or more information and there was often some discussion on a stated value. In all cases agreement was reached which also validated my decision to modify the affinity diagram process. As the nurses read out their values, they often did so with explanatory statements which added clarity to their beliefs. This prevented any misconceptions which may have happened if they had been read in their initial form by someone other than themselves. At the end of this process, the group discussed each value in turn to ensure they were in similar categories or affinity groups. and then named each category as a core value. The core values are as follows:

- Patient comes first.
- Holistic framework for care.
- High professional standard of care.
- Working in partnership with doctors.

Once this was done I explained the process for the remainder of the values data collect and beginning of the reality groups. The meeting had continued past the nurses off duty time but when I apologised they said they were aware of the time but were enjoying being able to talk about their practice. Although some of the nurses had initially thought they were attending an education session they readily accepted the opportunity to become part of the groups defining their values of ICU nursing practice.

I commenced the next values group meeting on the night shift on 2/3/05 with 5 nurses. I began this with the same explanation and consent process as with the first group and used the same terminology with what I wished them to do. The values identified by the first group were already written on the whiteboard and the participants were invited to add to these already existing values and also identify additional values. In this way each subsequent group was aware of the other participants' values and beliefs and were able to agree they were core values for ICU practice. This group and the subsequent 2 groups on the 8/3/05 and 10/3/05 agreed with the previously identified core values of practice and each group added a new value. The new core values are:

- Making a difference.
- Humanising the experience.
- Altruism and motivation.

The final values group took place on the 16/3/05 at the of the morning shift. This group validated and added to the previous values but did not generate any new ones. The information from the 2 individual interviews was incorporated into the group values data. Both sets of data validated the values but did not generate anything new. As I had no further indications of interest in becoming involved in the study from other ICU nurses I decided to conclude this first stage of the

reconnaissance and began collating the data to define a philosophy of nursing for this intensive care. The complete core values as defined by the participants are:

- Patient comes first.
- Holistic framework for care.
- High professional standard of care.
- Working in partnership with doctors.
- Making a difference.
- Humanising the experience.
- Altruism and motivation.

The identified values and beliefs of the participants which enabled the definition of the core values underpinning ICU nursing practice will be explained under the heading of each core value.

Patients come first

The main thread through these group discussions was that the patient comes first. We as nurses wish to care for the patient as an individual, not giving ritualised care. The care we give should be based on the best possible evidence and with regard for the patient's autonomy. It is important to advocate for the patient, preserving the patient's dignity, and sense of self – physically, emotionally, spiritually and socially. The patient along with their family/whanau should be included in the care decisions as they are able, striving to maintain the patient's independence as much as is possible. It is important to listen to the patients if they are able to communicate and individualise their care as they wish.

Many nurses stated that they would nurse the patient as they would like themselves or their family/whanau to be nursed. This includes with dignity and respect, being non judgmental, regardful of colour, creed or religion, beliefs, age, gender and culture. It is important not to treat the patient as a body or disease in a bed and also to treat the unconscious or sedated person as if they are wide awake. It is essential to recognise that these patients are often totally dependent and

the ‘little things’ such as mouth care, keeping the patient clean and dry are as important as the ‘bigger’ more technical aspects of care.

Communication is essential, explaining the care and procedures we are giving to the patient, whether sedated or alert, respecting the patient’s privacy and dignity such as putting a gown on them and keeping them covered. It is also recognising that while life is precious, but everyone deserves a dignified death and it is essential that no person dies alone.

With any discussion about the patient, the needs of the family were interspersed throughout the conversation. Patient and family/whanau were synonymous although having very different needs. The importance of family/whanau to the patient was always recognised. While the nurses recognise the patient as an individual, he or she is also part of a family/whanau and community. We aspire to have a family centred focus with open visiting times and the number of visitors per patient depending on individual circumstances. Family presence during resuscitation should be encouraged.

The participants recognise that they are meeting the patient/family/whanau at only one specific vulnerable moment in their life and never think they care more for the patient than the family/whanau or friends. Nurses endeavour to advocate for families and allow time for them to express their fears and their need for answers. We would like to develop a rapport with the family/whanau, always treat them with kindness, empathy and ensure their comfort and safety.

Holistic framework for care

Holistic care is very closely aligned with patient focused care but was also identified as a theme. Nurses strive to care holistically for patients both physically and socially with regard for Te Whare Tapawha: Wairua (spiritual), hinengaro (mental), tinana (physical) and whanau (family). Family is extension of holistic care. We have regard for quality of life and respect for life but also recognise futility – not life at all costs. The aim of our practice is to help return the patient to a state of wellness or if unable, to support them in a peaceful death. Caring holistically must be also looked at within the ICU context in that nurses endeavour to provide comfort, safety, confidentiality and total nursing care.

High professional standard of care

As nurses we have autonomy of practice to uphold the patient's basic rights and advocate for them. We should be non-judgmental, protect patient confidentiality and privacy and support the patient's decisions. It is about rising to the challenge of treating and caring for complex, stressed patients and prioritising their care, using our own clinical judgement, knowledge and intuition. This care is based on good rationale, research and evidence. It is intervening when required, not unnecessarily, and having a high standard of care at all times (not just when being evaluated). It is about giving good basic cares and listening to our conscience.

Nurses need to acknowledge what we know and do not know, providing accountable, responsible expert care. It is having respect for colleagues and knowing what we are doing and asking when we don't. It is sharing this knowledge, looking outside our own space and helping colleagues without being asked. It is having consideration for future situations/needs such as restocking equipment as it is used, cleaning up our own mess. It is working as a team for better patient care and knowing that our skills, knowledge and clinical judgment are valued by all staff. Nurses are responsible for developing their skills both professionally and personally and have faith in the team. The participants agreed they have a professional responsibility to help each other and the maxim 'treat as like to be treated' should extend to other staff as well as the patient.

Working in partnership with doctors

Nurses believe in working parallel with the doctors, in partnership with the medical team. We want to know our skills, knowledge and clinical judgment are valued by all staff as part of the multidisciplinary team. Teamwork leads to better care and we regard ourselves as mediators and negotiators for patients and families, within this multidisciplinary team.

Making a difference

This means 'doing good' for the patient and family/whanau through offering help and support for the patient/family/whanau and caring for them as we would like to be cared for. It is keeping them well informed and looking to their cultural needs. It is forming relationships that make the difference, being aware of how and what we do impacts on the patient / family / whanau. This

also highlights the importance of 'little cares', such as mouth care or brushing hair, that ultimately can make a difference.

Humanising the experience

This is about breaking down the barriers, holding the patient's hand and offering comfort beyond the horror of the technology, pain, fear and isolation. It encompasses open communication providing a bridge between the doctors and the family/whanau and also offering care through non clinical touch.

Altruism and motivation

This looks at our reason for being a nurse, having a nurturing personality, doing something for someone else and being outward looking in life. Caring for patients is a privilege, giving holistic care as an individual without bias. It is knowing why we do things, looking at the underlying motivation, always questioning self and not being self serving.

My own values and beliefs

Revisiting and rewriting these values and beliefs as a philosophy of nursing practice in this ICU I realised that I had not been including myself and my own beliefs in this writing. I had been referring only to 'the nurses' or 'they' abstracting myself both from the data and from the nurses in the unit. The values and beliefs the nurses have voiced are also mine and I am part of this unit. Even though I do not care for patients as a clinical bedside nurse and do not have regular contact with family/whanau, I have a place in this unit. I had been thinking as an outsider, when in my heart I know I am an insider. I care for patients who are enrolled in research trials, I care for their family/whanau and I work side by side with the nurses and doctors. I had let the isolation of my Research Nurse role, and the knowledge that research is not yet part of everyday ICU practice, embraced by all, isolate me from the participants and as such, act merely as a facilitator. By acknowledging these core values as my own I am also acknowledging my place in this unit and situating myself alongside and with the nurses in this research. Each nurse in this ICU, whether we are staff nurse, CNM, Nurse Educator or Researcher, cares for the patient and their family/whanau. Our role is always centred on ensuring the patient receives optimal care, whether

it is through direct patient care, management of staff, education of staff or research with staff and patients.

This nursing philosophy of care is fundamental to nursing and focuses on the well being of the patient within the ICU context. Larson (1984, cited in Greenhalgh, Vanhanen, & Kyngas, 1998. p 928) defines caring as "intentional actions that convey physical care and emotional concern and promote a sense of security in another". This philosophy does not focus on the technology, measuring roles in terms of being technologically skilled, thus objectifying the patient. It is implicit that technology is simply part of the process of everyday caring in ICU (Walters 1994, 1995a, 1995b). Rather the emphasis is on developing a subjective caring relationship with the patient, family/whanau and also with colleagues (Barr & Bush, 1998; Greenhalgh, Vanhanen, & Kyngas, 1998; Tanner, Benner, Chesla & Gordon, 1993). Our collective stated values and beliefs are centred on ICU nursing, within a team, working together, caring for patient and family whanau.

Summary of values clarification

Gaining permission from the Operations Manager to conduct the focus groups in the nurses' work time was pivotal to the success of the groups. It enabled the creation of communicative space in which we as nurses were able to identify and discuss our values and beliefs for nursing in the ICU. This social space was solely focused on how we as nurses wish to care for our patients and enabled us to collectively define, clarify and validate a nursing philosophy of care for our ICU. It also provides the reference point for all future activity in this research. The next phase of reforming the groups will focus on how we as nurses are not always able to meet these defined values in the reality of practice in an intensive care unit.

Stage 2 – Reality focus groups

This next section will describe the process of reforming the focus groups to look at where the nurses had difficulty meeting their stated values and beliefs of practice. The groups will be presented generally rather than individually to ensure that the participants of any one group cannot be identified and key ideas in the discussion (Chapter 6) cannot be ascribed to a particular group or individual.

The themes collectively identified and agreed on by the participants from the values focus groups were collated and presented back to them at the start of the next round of focus groups. I had asked the participants at the end of the values meetings to think about these difficulties prior to the second round of focus groups. In this stage of the research the discussions each group had were not shared with the other groups. I did not begin each meeting with a summary of the previous groups' discussions as I had in the values groups. This was to ensure that the discussion was focused on where they were unable to meet their own values of practice and not be influenced by others concerns. This was also to encourage a wider range of discussion of the issues rather than continuing on the same thread as the other groups and so not have the opportunity to address issues which may have been important to them. These reality focus groups were about the clash between the ideals of care, as stated in the values groups, with the everyday care we give as nurses within a multidisciplinary functioning of the ICU. By revealing these clashes we could then determine aspects of practice which are of concern and need further exploration.

Difficulties encountered with reforming the groups

The process of reforming the focus groups was more complex than the values groups which had occurred with relative simplicity over the period of one month. The difficulty I had reforming these groups reflected the reality of ICU practice where the needs of the patient and unit are paramount. It was over five months before I was able to meet with all the participants. The makeup of these groups was not the same as the values groups to the differing shifts and rosters. The timing of the focus groups was very dependent on the workload and skill mix of the unit. The unexpectedness of ICU made forward planning for the meetings very difficult and I had many last minute cancellations for a variety of reasons. I would plan a meeting for the afternoon handover on a 'quiet' day to discover there were insufficient senior nurses on to cover the unit while the participants attended the meeting.

One afternoon shift while I was preparing the room for the participants there was a chest reopening for a cardiac surgery patient in the unit. This is an urgent life saving procedure involving multiple interdisciplinary staff for post operative cardiac surgery patients who have

cardiac tamponade or arrest. Although this was over before the meeting was due, the nurses were elated as this was a successful intervention, where many are not. I decided this was not the appropriate moment to discuss when the participants were not able to meet their ideals of practice. Saving a patient's life in these circumstances would rate as an ultimate ideal within the reality of ICU practice and it would be unfair (if not impossible) to ask the nurses to reflect on the more difficult aspects of practice at this time.

Night shift groups were also difficult to arrange during this period as the meetings were held during the winter months. This meant there was a high patient occupancy due to patients with respiratory illnesses or nurses who were on sick leave due to influenza. While during the day there are often staff available to help, night shift usually exists on skeleton staff. If there are nurses spare in the ICU they are often redeployed to other wards. I also needed to plan these meetings around my work and personal commitments which made the process more complex.

Overview of the reality group process

Each reality group began with a reminder of the aims of the study, the rules of the group process followed by a recap of their identified values of nursing. Each participant was given a written copy of the themes and I asked them to think about where they could not meet these values in the reality of nursing in the ICU. I reminded them that the meeting was being taped and that they could ask for it to be turned off at any time.

The structure of the groups was informal and relaxed with myself as facilitator asking open ended questions to guide and prompt the participants with their reflections. Each nurse shared their thoughts and this led on to the next idea or there was some general discussion around the subject. There was an open atmosphere with often much laughter and joking but also some very honest reflections. This did not appear to be dissension and any disagreements were discussed and accepted as individual opinions.

The participants were willing to talk, sometimes after an initial hesitancy, but most were happy to talk in the group. Some of the senior nurses in particular were very forthcoming and it is almost as if years of frustration and anger were coming out and although it was very amicable

and light-hearted, the message was serious. The less experienced nurses usually had less to say but seemed to be part of the group regardless.

Reality Group Meetings

The reality group meetings commenced with the first meeting on the 29/3/05. Refer to Table 1 (p.70) for dates, times and numbers attending each group. For many of the nurses who worked certain shifts such as permanent night shift or mainly PM shifts, the discussion usually directly concerned issues for that shift. However, the majority of the participants worked rostered shifts, including nights so their conversation encompassed issues that were attributable to all shifts. Many of the participants were senior nurses whose confidence and experience was reflected in their honesty, depth of reflection and also in the sense of frustration that came through. However, it as a junior nurse who asked during a frank discussion, "If everyone feels the same, why has nothing been done?" The only answer I could give was that this study was the start of 'doing something'.

In some of the meetings the participants were more serious than others depending on their personalities rather than the level of seniority. But, regardless of the atmosphere the conversations were often remarkably similar with many issues recurring. The sense of frustration that came through was very often directed at themselves as well as others, as they struggled to meet the expectations they had set themselves. Occasionally there was some hesitation when they were about to say something contentious but continued when I assured them they would not be identifiable to anyone who was not present. I did not note any inhibition of the conversations with very senior nurses, although perhaps the nurses were more ready to agree with what the senior said. There did not seem to be any instances of senior nurses making statements or arguments and it was apparent the others didn't agree but did not speak out. I had made it clear that nurses who wished to speak to me privately as well as in the groups were welcome.

The ideas and issues in the discussion (Chapter 6) are presented as a whole although some groups focused more on particular issues than others did and vice versa. However, nearly all the issues presented were at least mentioned as a concern in all the groups.

Stage 3 - Individual Interviews

The individual interviews were conducted after the reality groups had finished to enable nurses who were unable to attend a group meeting or unwilling to speak in a group situation, to continue to participate. Four of these interviews were not taped, two at the request of the participants and two because they were impromptu and I did not have the recorder with me. The data was collected through field notes and during the two interviews which were recorded I also took notes. The more senior nurses were calm and confident during the interview process while the less senior were not as confident an displayed some anxiety as they talked about their practice. One participant became slightly distressed and asked for the recording to be stopped. The participant continued to talk about the unit but much of this was in confidence and the only data incorporated into the discussion was with the participant's specific permission.

Written Feedback

This nurse was unable to attend the reality focus groups but gave feedback to the values data in writing. The comments were brief but also were consistent with some of the data from other participants such as care being given routinely rather than when needed, being task orientated and also poor communication between nurses.

Reflection on Reality Data Collection

The knowledge and insight these meetings gave into ICU clinical practice is invaluable. Even though I am part of this unit I had not worked in a purely clinical situation for over five years. This had for me created a feeling of distance from the situations the participants discussed even though in the past I have been in many of the same situations. These conversations reinforced that many aspects of practice were as remembered but also that some of the issues were more pervasive than I had realised, when working clinically. As my position was a senior staff nurse role some of the situations discussed were not issues for me. Or perhaps of more importance, this may have been the first time these nurses were able to be together, within a communicative space, with the sole focus on discussing the reality of their practice.

The information is remarkably consistent in all groups and I tried not to prompt the group in a particular direction except to go back to the agreed values and beliefs of care and also to try to

focus on the night shift. The nurses readily discussed and reached consensus about the problems although not all nurses have problems in the same area. However, they acknowledged that everyone has different standards and issues.

One aspect of practice that stood out was the number of senior nurses who no longer adhere to the guidelines religiously. They think for themselves and make informed decisions. However, the guidelines have not actually been challenged, just ignored. The focus groups highlighted how good nurses are at stating a problem and then finding an instant solution. I guided the discussion away from instant solutions as this will be explored further during the ongoing process of the project.

I needed to be careful not seize upon any particular issue that may have had resonance for me as a clinical practitioner. There was so much richness of data and so many possibilities and questions that have emerged from these groups that I had to remind myself that the ensuing change will be decided by the action group by consensus. This included going immediately to the computer to do a literature search after an issue of practice I was not aware of was discussed in the group. It was necessary to refocus on the action research process rather than risk becoming side tracked with possibilities, which may have caused me to misinterpret the data.

Transcribing the tapes myself gave a better understanding of the issues, which I may not have been able to grasp so clearly simply by reading a transcript. Listening to the voices I could recall the meeting clearly, the feeling of the group, the attitudes and both the laughter and the frustration. I recognised the situations and attitudes these nurses were describing, many of which had been prevalent when I was a staff nurse.

The change in the study focus became apparent when night shift continued to be part of the conversations but was not the main focus of the issues under discussion. I felt I needed time to absorb this broadening of the focus by first stepping away from the study for a period of time and then re-immersing myself in the data, listening to the tapes and re-reading the transcripts. I also needed to do a step-by-step examination of the data in the form of a thematic analysis. This was to ensure that I did not make assumptions and conclusions based on my own knowledge,

experiences and familiarity with the ICU culture. I needed to determine what the issues actually were according to the data rather than risk focusing on an issue I was familiar with and felt strongly about. Fereday and Muir-Cochrane (2006, p. 4) describe thematic analysis as," a form of pattern recognition within the data where emerging themes become categories for analysis". They contend thematic analysis is also a way of demonstrating rigour in qualitative research.

Thematic Analysis

I began the thematic analysis using an adaptation of a Living and Learning in Practice Development framework for reading interview transcripts. This was used with permission from Associate Professor Cheryle Moss of Victoria University of Wellington Graduate School of Nursing, Midwifery and Health. The process involved several readings of each transcript, the first time to get 'a sense of the whole' and then the subsequent readings more carefully, recalling the participants and their voices, emotions and expressions. To gain a sense of the whole, I read all the transcripts in sequence rather than concentrating on only one at a time. The subsequent readings focused on each transcript until I was satisfied I had a clear picture of each meeting or interview. I then noted my impressions of the group including structure, format, processes and outcomes giving me an overview of the process as already described. The next step entailed systematically working through the transcript and noting areas of conversation. Each topic was annotated in the margin with brief descriptors and significant or relevant sentences were highlighted. For example, a discussion on the difficulties of trying to bring the family in to see the patient before the doctor needed to put an arterial line in was often described as seizing a 'window of opportunity'. This section was highlighted and 'window of opportunity –family' was noted in the margin.

Once annotation of all the transcripts was done I continued with the analysis of a single transcript at time, completing it before commencing the next one. I transcribed the highlighted annotated data into the thematic framework, identified by line and page number and topic. This was done sequentially from the transcript and not grouped into topics initially. When this was complete I summarised the key information and the insights that emerged for me from the data.

Once every transcript had been summarised I worked through the completed framework pulling out the ideas with the highlighted sentences and grouping them into clusters with similar ideas. These clusters indicated the emerging sub themes from the data. I reread the transcripts to ensure the voices in the data confirmed the validity of the sub themes. During this process I also worked reflexively, questioning my own assumptions and experiences, evaluating the process to ensure I was remaining true to the data. When analysing the data and identifying the emerging sub themes the principles of Communicative Action guided the analysis and the identified core values of practice also provided the reference point for pulling out the sub themes. It was the shared ideals and values discussed in a mutually understood specialised language that provided the framework for the nurses to identify and discuss the problems in the reality of practice. This mutual understanding of their practice enabled them to discuss and agree on the issues that pervaded their practice and also the underlying influences that both guided and coerced their practice. It also meant that all participants, myself included, were discussing these issues on an equal basis; there was no overt power play although some nurses were more vocal and forceful than others. However, there was agreement with the issues raised as the nurses recognized the rationality and veracity of the statements and there was little dissension. The issues of practice which became the sub themes from the data are:

- coercion of care-power relationships
- professional standards of care
- patients' dignity, privacy and prioritisation of care
- rituals, routines and tasks
- night shift, fatigue, patient's sleep
- advocacy-clash between doctors and patients needs
- patient care versus family communication and visiting
- staff stress, fear and safety.

As the core values identified in the values groups provided the basis for the reality group discussions and acted as the reference point for the ongoing study activity, these sub themes are closely aligned with the core values. These sub themes refer to aspects of practice where the participants are unable to meet their own values and beliefs of practice. To give feedback of the

data from the reality groups and interviews to the participants I summarised it in the form of a comparison between the core values and the reality sub themes. This brought the core values as the ideal of practice back into the minds of the participants and enabled them to reflect on the differences between the ideal and the reality as they read the comparison. Further analysis and the clarification of the sub themes into core themes is described in Chapter 6.

Chapter Six Identification and Discussion of Core Themes

This chapter will outline the process of giving the feedback and engaging the nurses in the reflective process. I will also discuss the change in process when re-engaging the nurses after time away from the project and how the sub themes were prioritised to mutually decide on an area of practice for development. This process of gaining consensus guided the analysis and the identification of the core themes categorising each one in terms of the relationships they embody, under an over arching theme which encompasses all nursing practice. The discussion of each of these themes will incorporate the data yielded by the participants and will be supported by the literature.

Redefining the research question and aims

As the participants had broadened the focus of this research from night shift to all shifts in the ICU, it was necessary to revisit the research question to more accurately reflect the direction the participants had taken. Therefore, the redefined research questions became:

How do ICU nurses wish to care for their patients and what are the tensions that exist between their stated values and beliefs and the reality of clinical practice within the context of the intensive care setting?
How can the nurses develop their practice to reduce these tensions and improve patient care?

The redefined aims of this research became:

To understand and define how nurses care for patients in the ICU and to understand and acknowledge what influences and guides the nursing care.
To understand the effect this care has on the patients.
To acknowledge and define where there is need for practice development.

Relationship between values and reality

The redefined questions and aims more accurately reflected the participants' stance that the issues and concerns of their ICU practice encompassed all shifts, not just night shift. These issues and concerns have been raised by first acknowledging the shared values and beliefs which guide their practice and comparing them with the reality of their everyday practice in the ICU. The mutually defined and agreed values and beliefs of nursing care in ICU have become the reference point for the reality groups and all future action in this project (Nolan & Grant, 1993). In the feedback given to the participants the sub themes were grouped in a loose correlation with the identified values. Feedback was given verbally, either in small groups or individually as opportunity presented itself. In addition to this, written feedback was given to each participant to enable them to read and reflect in their own time. Table 3 shows the reality sub themes as they were correlated with the core values and beliefs.

Table 3. Relationship of values to reality sub themes

Values	Reality
Patients come first	Patient's dignity, privacy and prioritisation of care
Holistic framework for care	Rituals, routines and tasks
High professional standards of care	Coercion of care-power relationships Professional standards of care
Working partnership with doctors	Advocacy clash between doctors and patients needs
Making a difference Humanising the experience Altruism and motivation	Night shift, fatigue, patient's sleep Patient care versus family communication and visiting Staff stress, fear and safety.

Feedback to the participants

Giving the feedback verbally to each nurse was a way of checking for any strong disagreement with the sub themes and content. Most nurses were quite strongly in agreement although some senior nurses expressed disappointment that many nurses felt as they did. I also gave the participants a reflective practice framework so they were able to work through the document in their own time (Appendix 5). This framework was adapted from a reflective practice framework devised by Caroline Allbon, Research Associate, Victoria University of Wellington. During the group work and interviews we all referred to what we did as 'we', 'they', 'you' and 'us'. Very rarely, myself included, was 'I' used in descriptions. I wanted them to look at the data and think of the situations they had been in and reflect on their actions and reactions to what was happening. The participants were not asked to give me their reflective writing but to use it as a way of ordering their thoughts.

Re-engaging the participants

After a nine month period I recommenced the study and as before, had difficulty in reassembling the focus groups. After ensuring the participants were agreeable an email group was established to re-engage the participants with the study and for ease of arranging further meetings. During the period of time between the reality groups and the recommencement of the study there were 21 of the original 34 participants in the reality groups still working in the unit. On the first group email contact I asked the nurses to decide which sub theme was most important for us as a group to look at, to give a rationale for their decision and to also rank the sub themes in order of importance. Each sub theme needed to be considered in relation to the other sub themes, how they interconnected and influenced each other. Three nurses replied they were unable to continue but wished me well with the study. Of the 12 participants who replied the majority thought a high professional standard of care was most important, with doctor - nurse relationship and patient centred care also very important. As some of this feedback was given anonymously individual quotations, in italics, will be identified by how they were received i.e. written feedback, verbal feedback or email response.

Rationale for prioritisation of themes

Several nurses decided patient/family focused care and patient's dignity was the most important aspect of care in the ICU. However, it was dependent on other relationships such as the nurse to doctor relationship.

> *I feel by focusing your care on the patient and family it assists you to perform better as a nurse…but empathy and ethic of care allow us to see the patients experience from another view and assist them through this stressful time in their life. This is something that nurses can do well and with little effort if the other themes such as nurse/doctor relationships are positive and open and holistic care is adhered to as much as possible.*
>
> *Written feedback*

One participant talked about the influence we have as 24/7 bedside nurses to ensure the patient's dignity and privacy in relation to other health personnel such as non ICU doctors or physiotherapists. Several participants also stated that holistic care – rituals routines and tasks - worked closely with patient and family focused care. One nurse maintained that with continual patient assessment and a good relationship with the family, the care will be patient focused. However, it was noted by another participant that when having a developed a rapport with the family, it was essential to maintain their confidence in the care by being supportive of the next nurse taking over.

The nurse/doctor relationship was said to be most important by 3 nurses although only one gave a rationale for this.

> *Nurses have responsibility of the patient and are in direct care of the patient often advising relatives and doctors about their patient yet many times they are not counted in decision making or shut out of decision making dependant on the medical personnel of the day. Doctors do not get education on e.g. nasogastric feeds, wound care, pressure area care in their training yet we let them dictate to us what we should do.*
>
> *Email response*

However, the main body of feedback was supportive of high professional standard of care as the most important aspect to develop. It was stated that everything flowed from this theme. For example:

> *Substandard handover sets up rest of shift, poor safety check, poor assessment, flows into everything. E.g. checking drug, patient dignity etc will be maintained with having a professional standard of care.*
> *If patient is assessed in the am, routines ritual tasks will be more patient wants and needs filled into requirements etc. You have assessed what is needed, so will be better able to work out plan for care and take ownership of own professional standards.*
>
> *Verbal feedback*

This participant also advocates the need for a teamwork approach to care and treating everyone as a professional regardless of who they are.

> *We need to work together more, talk to each other, better communication, bit more support for each other rather than moaning about what we didn't do. Have professional accountability for patient; take responsibility for profession and peers.*
>
> *Verbal feedback*

Another participant also agreed that professional standards of care incorporates all the is a place for routines and norms (of practice) which must be accepted as they ensure the work gets done when each nurse has their own standard of 'professionalism'. I have interpreted this statement as perhaps meaning that some routines and norms may be regarded as the minimum standard of care. It was also agreed by others that the nurse's own values and standards of care reflects back on all the sub themes and impacts on the care the patient receives (or does not receive). One nurse also stated that ICU was an environment with strong personalities and probably an area which suffered from 'horizontal violence' more than other areas.

If staff feel undervalued, know they are cited behind their backs or unsupported, they will not be giving the patient optimal care as they will be far too scared to ask for help when needed. So the patient will definitely suffer.

Written feedback

This nurse also contends that we are trying hard to maintain high standards in the ICU and we are underestimating this struggle.

It is a challenge to maintain professional identity as an ICU nurse by maintaining nursing standards, maintaining healthy relationship with other colleagues without violating professionalism and avoiding role ambiguity. Coercion of care is linked in having high standards of professional care and peoples' own interpretation of what that means.

Written feedback

A recurring idea in the reality of practice is that everyone has differing standards of care and each nurse interprets it differently.

Process of consensus

Although the individual replies indicated a high standard of professional care was most important it was still necessary to gain consensus. Majority vote does not mean consensus. This needs to be gained in a group situation through discussion and argumentation. This took place after the afternoon handover with 6 nurses and was agreed on the night shift with another 4 nurses. Each nurse stated which sub theme was a priority for them and gave a rationale for doing so. The ensuing discussion and argumentation enabled the nurses who considered a high standard of professional care the priority, to persuade the other nurses of the rightness and validity of their argument.

Habermas (1984) uses the term argumentation for the type of speech where participants attempt to vindicate or criticise contested validity of an expression or as in this research an agreed value of practice. The strength of the argument is measured through the soundness of the reasons and

also how the participants behave. A participant who is open to reason and either acknowledges the force of those reasons or is able to refute them is said to be rational, while the participant who dogmatically ignores opposing reasons is said to be irrational. Rational argument also enables mistakes to be identified and learnt from in a process of theoretical discourse, where controversial expressions or truth claims are discussed and consensus is reached. In this research through rational discussion the nurses identified which sub theme most underpinned their practice and on which all other values were based. Discussion was rational, uncoerced and the nurses reached consensus.

Once the sub theme had been agreed it was necessary to refine this further to define which aspect of the high standard of professional care, as defined in the values group, was most important to develop. It was agreed that the most important aspect of this, which was also supported by the reality data, was nurse to nurse communication and support.

Clarification and assignment of sub themes into themes

The process of prioritising the sub themes and reaching consensus guided further exploration of the acknowledged connections and relationships between each sub theme. These sub themes are all interconnected and each has an impact on the others. In the values data the first defined core value was the *patients come first*. It is this relationship which defines what we do as nurses. We care for critically ill patients. However, this is not in isolation. We interrelate with doctors, nurses and family/whanau in this situation of care. It is within these relationships in the reality of clinical practice, that concerns and issues have been identified. For example, the patient's privacy and dignity may be affected by prioritising care in an urgent situation, causing stress for the nurse who understands the need for urgent intervention, but who also knows the family/whanau are waiting to be with the patient and clashes with the doctor over bringing them in for a short visit. This may be further exacerbated by intervention by other nurses, fatigue on night shift or concern about handing over a messy patient at the end of the shift. As these situations are never discrete it was necessary to further analyse the data to discover what the common factor is in these occurrences. These interconnections then will be discussed in terms of relationships. Each situation or concern involves the nurse in a relationship with someone else, patient, doctor, family/whanau or colleague. Therefore, the themes that have been defined from the data are in

terms of relationships; *nurse to patient, nurse to family/whanau, nurse to doctor and nurse to nurse* (Figure.2). These relationships occur within the overarching theme of *professional standards of care.*

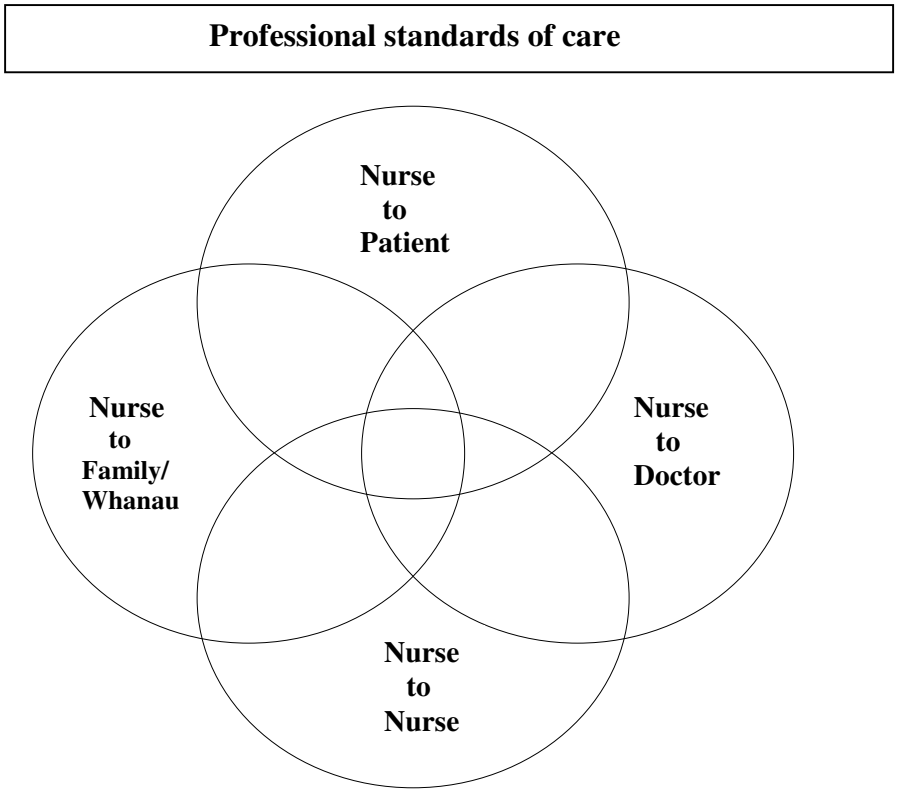

Fig. 2 Interconnecting relationships within the overarching theme of professional standards of care

Each sub theme emerging from the data will be discussed within the relationships the nurse has with the patient, family/whanau, doctors and each other. Professional standards of care have been identified as the overarching theme as each of these relationships is governed and guided by these standards, professionally, ethically and legally. Direct quotes are in italics and are referenced to the group the participant was in. Individual interview quotes are referenced by their non gender specific, assigned pseudonyms: Kerry, Jordan, Sam, Brooke, Rowan, Joss and Ashley.

Nurse to Patient Relationship

One of the absolutes that came out of both the values and reality groups was that 'the patient comes first'. In the values group it was referred in terms of individualised care, recognising patient autonomy, preserving the patient's dignity and respecting their values. However, in the reality of practice it is referred to in terms of prioritisation, meaning the immediate needs of the patient and preserving life will take priority over privacy, dignity and individual needs. While the nurses are stressed because they have not been able to do the 'fluffy' things such as mouth care, they also knew they had saved the life of the critically ill patient.

> *Sometimes you cannot meet the needs of patient but have to prioritise, cannot do fluffy things, etc. but think we did a perfect job in that resus(citation) patient*
>
> *Participant - Group 3*

One of the most distressing aspects of nursing in ICU is trying to fit 'everything' into an 8 hour shift. The nurses acknowledged that it is 24 hour care and they know that it is okay to leave something for the next nurse, but there is still anxiety if they cannot fit it all in. They feel they have compromised their standards and 'failed'. All the nurses acknowledged that critically ill patients require the life saving measures as a priority and while the comfort cares are important, only if there is time. However they often feel distressed if they have not been able to achieve that during their shift as they acknowledge that the 'little things' make a difference.

In the values groups all nurses agreed that maintaining patients' dignity and privacy was very important, and caring holistically was desirable, within the ICU context. In the reality groups the nurses admitted that the ICU culture and context often overrode patient's individual rights under the guise of prioritisation. Attending to the patient's immediate needs and preserving life takes priority over privacy, dignity and individual needs. Patient safety also takes precedence over family needs and comfort. While this prioritisation is warranted it may sometimes be used as a reason to give dignity and privacy less regard. There is a difference between conscious and unconscious patients in that unconscious patients receive less privacy than conscious patients, are more likely to be nursed naked and while they are protected from other relatives' view, this does

not always extend to another health worker. Often a gown is put on the patient more for the sake of the relative's peace of mind rather than for the patient's dignity. As one senior nurse remarked,

> *We do not do dignity well. We say we want to protect the patient's dignity but do we really show that? Do we show respect? I think we use the ICU situation as an excuse to not do what we should.*
>
> *Participant - Group 2*

Nurses admit they could always be more professional, that a certain amount of patient information and personal discussions takes place within the unit environment and that care is not always taken to keep this separate from patients and families present.

Often there are visitors who wish to stay in the unit during patient turns and doctors' rounds and nurses find this particularly difficult, for reasons of patients' privacy. For consistency, most visitors are asked to leave during the turns except for those with paediatric or dying patients. These families are asked to stay with the patient and not move into the unit during this time. However, once visitors are gone this concern for privacy is not always followed through, curtains are not always drawn, or are only partially closed to protect patients from being exposed to other patients and hospital staff present in the ICU at the time. Conversation is sometimes personal and over the patient.

> *Sometimes we forget the patient is a person underneath all of that. We become task orientated and forget to communicate with the person receiving our care.*
>
> *Participant - Group 3*

Patients' privacy, control, respect and dignity are acknowledged basic rights (NZ Health & Disability Commissioner Act, 1994) and reduction in dignity may lead to poorer health outcomes (Walsh & Kowanko, 2002). This was evident in Russell's (1999) study of ICU patients' memories and experiences. One woman remembers the loss of dignity being so traumatic that even three years later she wished she was dead. She remembers being washed while lying naked in bed and staff joking about their social lives. In many ICUs, including our ICU, it is common

practice to nurse unconscious patients without gowns, covered by a sheet. This may be for ease of caring for invasive lines, temperature control or clearer observation While nurses try to preserve patients' dignity, factors such as caring for unconscious patients and the need to perform multiple tasks quickly to prevent a deterioration in the patients condition may impede this (Turnock & Kelleher, 2001).

> *Maintaining dignity can be very hard, very challenging. If patient is unconscious they are entitled to far less privacy right than conscious patients. It is much more token, you would cover them up so a relative next bed can't see but probably wouldn't cover up from another health worker.*
>
> *Participant-Group 2*

Also the proximity and very nature of the ICU patients' illnesses raises issues of privacy and dignity. The bed spaces are open, divided only by curtains in most cases and quite close together.

> *It is difficult to maintain this when a patient has frequent diarrhoea and the next patient and family are only 2 metres away.*
>
> *Participant – Group 3*

The need to prioritise also takes precedence over the desire to give holistic care and individualisation of care. In the ICU there are tasks that must be done, for example, changing the IV tubing to prevent infection or changing wound dressings. This does not mean the nurses disregard the patients individual needs, they simply recognise that certain routine cares must be done for the long term benefit of the patient.

> *We all want to be touchy feely etc but sometimes practicalities get in the way, tasks need to be done.*
>
> *Participant-Group 2*

The functioning of the ICU as a system comes before the individual needs of the patient and often the lack of staff and resources compound this. It was felt that to truly individualise care, all patients would need to be nursed in single rooms and huge numbers of staff would be required. However, few nurses like caring for patients in single rooms as they like to be in an area where others can help out and where they can socialise.

> *We are social creatures, we need social interaction.*
>
> *Participant –Group 4*

Insufficient staff means not being able to sit a patient out of bed when they wish as there is no one to help. It may mean washing an awake patient, not taking into account their wishes, because it is expected to be done when the attendants can assist. As one nurse stated,

> *We still have a lot of control when a patient is becoming well. We usually dictate what happens and when and may only give the patient limited choices.*
>
> *Ashley*

Waters and Easton (1999) looked at how the concept of individualised care was carried out in a medical ward, observing care delivery. It was observed that patients fitted into the routines of the ward and were not offered choices in their care. The nurses maintained they asked patients preferences but also stated they knew what was needed because of their training and experience. Individualised care cannot be achieved unless the patient's wishes are taken into account (Waters & Easton, 1999). Individualised care or patient centred care in the ICU is often thought of in the terms of one to one care i.e. one nurse to one patient. However, when the nurse is unable to develop a relationship with the patient, either due to sedation or confusion from the medication or illness, and ask the patients wishes or mutually plan their care, individualised care is usually not achievable (Christenson & Hewitt-Taylor, 2007; Kelleher , 2006).

Our ICU culture takes precedence over others. The 2 hourly system of turns and nursing cares is perpetuated by the attendants being available at those times to assist. It is difficult to turn the

patient at other times if assistance is needed as the attendants are busy throughout the rest of the hospital. This makes it difficult to nurse holistically or individualise care.

> *Which is more importance in practice, holistic care for culture or the culture of the unit? Professional culture, our culture wins every time. I am an ICU nurse not a holistic nurse as such, but believe in individualised care.*
>
> *Participant – Group 2*

The nurse while acknowledging the needs of the patient, often overrides them, recognising the need for prioritisation with life saving measures over comfort, and the needs and constraints of the organisation restricting patients' individual rights. In addition they are honest and open in the fact that ICU culture and their own priorities of care will often take precedence over the patient's priorities. Meijers and Gustafsson (2008) also noted this stance in their study of the ICU nurses perspective of patients' self determination. Self-determination was defined as being able to have influence on your surroundings and decisions which concern you as well as taking responsibility for your self. The nurses were asked to identify situations where they had or had not strengthened a patient's self-determination. The nurses regarded ICU patients as having restricted self-determination especially in what they determined were medical care situations. The goal was survival of the patient. A medical care situation where the patient's self-determination was restricted was termed as disconfirming nursing. Examples of where the patient's self-determination was not considered included following the routines of the unit, carrying out doctors' requirements or giving treatments, personal hygiene and saving lives. Confirming nursing was discussed in terms of listening to the patient, encouraging and motivating them to help themselves. It also involved advocating for the patient's wishes (Meijers & Gustafsson, 2008).

In this study the participants recognised that saving the patient's life must take priority, even though being unable to give them comfort cares during their shift was a source of stress. The issues of safety for the patient were used in conjunction with prioritisation of care. One-to-one nursing requires the patient to always be observed. This often meant the curtains were not pulled or only partially pulled when doing cares, if the nurse needed to observe the patient in the next bed while their nurse was away. Philpin (2007) maintains there is also a ritual element in the one-

to-one premise that the patient is vulnerable and safety is of paramount importance. Being able to see and safeguard the patient was also discussed in conjunction with night shift.

Rituals, routines and tasks were frequently discussed especially with regard to the patient washes, suctioning and turns usually on the night shift. Many of the nurses talked about the culture and routines of the unit which dictate the times of washes and turns. While they acknowledged that not all rituals are bad, if they evolve from an evidence base, the coercion of cares through unthinking routine without patient assessment is regarded as bad.

Many things we do on nights we fall in the trap of routine and ritual.

Participant- Group 1

A defined value is caring holistically for patients both physically and socially which was also described in the Maori concept of Te Whare Tapawha: wairua (spiritual), hinengaro (mental), tinana (physical) and whanau (family). In reality having regard for these may not always easy to achieve when nurses' care is often governed by the rituals, routines and tasks which make up much of the everyday work of ICU. Wikstrom and Larsson (2003) observed in their study that a large part of ICU care often involves benign situations or routine practices. However, this routine practice is often complex involving multiple actions within the care being given. Street (1991) maintains that nurses automatically revert to task orientated ritual and routine to cope with the rapidly changing and stressful practice of nursing. At times when the unit is extremely busy one nurse stated,

Sometimes it is just surviving from one end of the shift to the other.

Participant – Group 2

Carrying out routines and tasks can sometimes be a way of surviving the shift, knowing that nothing important will have been undone and the patient remains safe. This is supported by DeLuca (1995) who contends that rituals may give nurses time to stop, within the chaos, and promote a feeling of safety and security in response to unconscious needs. Within the stressful ICU environment it is often easier for nurses to concentrate on doing familiar clinical tasks which are perceived as more important for the patient's care and safety than cope with a stressed family or try to communicate with a confused or semi conscious patient. Many nurses agreed that

looking after a conscious patient was often far more stressful than caring for an unconscious patient.

> *It is easier to care for a sedated patient where I can do what I want when I want without having to ask the patient every step of the way. Caring for an awake patient with psychological needs is much more stressful, often due to communication issues when the patient is still tubed or is confused. Lip reading is very stressful, especially when you see the frustration on the patient's face. Writing is sometimes worse as you can't read it most of time. Sometimes you just need to prioritise and you cannot nurse holistically.*
>
> *Participant- Group 2*

Humanising the experience for the patient is regarded as breaking down the barriers, holding the patients hand, offering comfort beyond the horror of the technology and pain. This can make a huge difference for the patient as evidenced in Russell (1999) who cites a patient as saying she remembered very little except when momentarily feeling fear, a man patted her hand in sympathy, immediately giving comfort. This therapeutic touch and communication can also lessen the effects of sensory deprivation and sensory overload which can occur simultaneously in the ICU. Noise and overheard conversation from the clinical interactions and technology can be extremely distressing for patients and their family/whanau. Nurses have a vital role in reducing this stress and the possibility of long term consequences, through personal interaction, reassurance and comfort and careful repeated explanation of what the events are (Corrigan, Samuelson, Fridlund & Thomé, 2007; Morse, 1992; Russell, 1999).

The stated values of altruism and motivation look at the reason for being a nurse, having a nurturing personality, doing something for someone else and 'being outward looking in life.' Caring for patients is regarded as a privilege, giving holistic care as an individual without bias. It is knowing why we do things, looking at the underlying motivation, always questioning self and not being self serving. Fagermoen (1997) refers to altruism as the moral orientation of care and in her study which asked nurses what were the values underlying their professional identity, it was the overall guiding philosophy. Yam (2004) maintains that altruism is regarded as one of the

traits of a profession. The majority of nurses entered the profession for altruistic reasons (Whittock & Leonard, 2003); the standard answer to the question of "why do you want to be a nurse"? is "because I want to help people" (anecdotal).

During the night shift, this reason is sometimes harder to recall when feeling extreme fatigue. Nurses recognised the patients' need for sleep (Freedman & Schwab 2000; Honkus, 2003; Richards & Bairnsfather, 1988) but find this a complex struggle with issues of patient acuity, patient safety, nurse fatigue and a feeling of just surviving the shift as well as socialisation for night nurses (Claffey, 2006). They find it hard to balance the situation. When I was doing permanent night shift I also found this constant struggle. I would try to leave the patient as undisturbed as possible to minimise sleep disturbance but found it impossible to stay alert unless I paced continually.

It is often easier to protect patients' privacy on night shift as there is less staff and it is okay to draw the curtains around your patient's bed. However, some participants felt that some nurses are regarded as using night shift as an excuse for leaving nursing cares and tasks undone or for the day staff and there were many comments about ICU needing to be 24 hour care.

> *There is sometimes an attitude where you just let things be, chill and get though the shift and if you can get through the shift without the patient deteriorating you have achieved your role.*
>
> *Participant –Group 4*

Others say nights are more relaxed and nurses feel they can give better care and more individualised care without being 'watched' all the time. It is acceptable to continually disturb patients as this is regarded as a necessary part of staying alert and ensuring patient safety.

The patient washes usually done during the night shift around 3-4 o'clock in the morning are a constant source of debate and often stress. Historically, ICU patients were washed at this time as they were heavily sedated and paralysed and the mornings were regarded as too busy with doctors and multidisciplinary staff all requiring access to the patient. Therefore the needs of the

institution took precedence and little thought was given to the need of the patient to maintain a day/night sleep/wake cycle. Some nurses rationalise that the patient is awake due to noise from turns and orderlies talking so may as well turn the patient anyway. However, patients now tend to be less heavily sedated but we haven't changed our routines to keep abreast of these trends. This can relegates some routines into unthinking ritual. The nurse may often feel pressure to do so which further impedes individualised care of the patient as the following comments show.

> *There is a culture here that says the patient should have some form of wash each shift.*
>
> *Participant- Group 2*

> *Are you giving the wash because the patient needs it or because you don't want to be regarded as a lazy nurse?*
>
> *Participant-Group 2*

> *Personal routines of the patient are not taken into account such as order of shave wash etc. Nurses have their own routine, few consult the patient.*
>
> *Participant-Group 2*

Meijers and Gustafsson (2008) also commented on the washes being carried out in a routine fashion with one nurse stating, "It's an exaggeration to wash them twice a day from top to toe. And then if they say they don't want it, you do it anyway" (p. 229).

In this research it appears there is sometimes coercion of the patient and coercion of the nurse. This is in contrast to the participants' assertion that each patient should be assessed at the beginning of each shift and care planned according to that patient's individual needs.

Suctioning the intubated patient was also historically part of the 2 hourly routines. However, many nurses claimed they do not suction routinely now but only after assessment of patient need.

We have moved towards where we expect the nurse to assess whether the patient needs suction or not. It is up to professional integrity to assess the need.

Participant-Group 4

This is an area of practice where individual patient assessment guides care perhaps because this is an area of practice on which there is a significant body of research evidence (Almgren, Wickerts, Heinonen & Högman, 2004; Hagler & Traver, 1994; Riding, Martin & Bratton, 2003; Sole, Byars, Ludy & Ostrow, 2002; Spence, Gillies & Waterworth, 2003).

Night shift is constant struggle between recognising the patients need for sleep, the acuity of the ICU patients, patient safety, nurse fatigue, survival and socialisation. In Russell's (1999) study noise from machines, the radio, staff and distressed patients had an impact on patients' sleep and the ICU was equated to a factory or war zone. Noise in this ICU is also a much commented on issue but again there is the conflict between being quiet for the patients and the need for social interaction and staying awake and alert. The lights being dimmed to facilitate patient sleep conversely may affect safety as the nurse may be unable to detect patient deterioration. There is a struggle between the prioritisation of protecting the patient from life threatening events versus enabling the patient to have rest.

This is intensive care that is what it is. Mistakes happen if the lights are turned down too low, sick patients need bright lights for cares.

Participant-Group 1

Also there is often an overriding sense of fatigue and/or exhaustion which governs and influences the care given to the patient. Many find it easier to get through the night with the lights on and by keeping active. Constant intervention or activity around the patient is often used to keep the nurse alert and watchful, but has the disadvantage of disturbing the patients rest.

There are the lazy people who do not do a wash at night on a sedated patient and the others who keep themselves busy by washing an awake patient, continually, to keep awake.

Participant- Group 4

This was said humorously, but with an underlying seriousness. The inference is that sedated patients must be washed at night, with no consideration for individual assessments, individual decision making or accountability.

Nurses give you attitude; think you are a bad nurse for not giving ritualistic wash.

Participant- Group 3

However it can be seen as acceptable to continually disturb the patient as it is regarded as a necessary part of staying alert and therefore keeping the patient safe.

There are still individual needs of the persons looking after them (patients) and we have to take into account their needs(nurses) to enable them to maintain that vigil while maintaining that friendly banter while trying to keep their minds active.

Participant – Group 4

It is acknowledged by most participants that there is continual conflict between the enabling the patients to sleep or rest undisturbed and the need for the nurses to remain awake and alert to observe and give safe care to the critically ill patients.

Nurse to Family/Whanau Relationship

In the values data families/whanau are regarded as an extension of holistic care and nurses should develop a rapport with the family and act as their advocate. The family/whanau is important for the patient and the nurses wish to advocate for families and allow time for them to express their fears and their need for answers. Hupcey (1999) maintains that all the nurses in her study believed families play an important role and the nurse is responsible for helping them through the experience. This included encouraging the family to talk and touch the patient and watching out for them, encouraging them to take care of themselves. Gavaghan and Carroll (2002) contend that being able to help with the cares is one of the most important things for family members. However, in this research patient safety was always of concern often with regard to the family/whanau either with wanting to assist with caring for the patient or distracting the nurse's focus from the patient by asking questions. While most nurses wished to enable the relatives to assist in some way with the care, they were usually relegated to putting moisturiser on the patient's hands or massaging their feet. This ensured the family/whanau were feeling included but also kept them away from the invasive lines such as intravenous and arterial lines or vascaths (IV lines for haemodialysis).

For many nurses coping and communicating with families while caring for critically ill patients can be a constant source of stress and concern. Issues concerning patients' families were rated as a high source of stress in a study reporting on stressors and ways of coping in ICU nurses (Hays, All, Mannahan, Cuaderes & Wallace, 2006). Some nurses are very confident and are able to communicate to the family the difficulties they face when caring for the acute patient, with families needing to ask questions. The participants recognise the family/whanau's need for information, reassurance and support and know that they wish to be with the patient (Henneman & Cardin, 2002). However, many nurses find it frustrating when they are trying to do their best for both patient and family, when prioritising care means they cannot be distracted at the time.

> *We are often so focused on the patient we cannot focus on the family.*
>
> *Participant – Group 2*

When patients are newly admitted into ICU the workload is very complex and intense often requiring urgent intervention and care which needs the nurse's full concentration. Family are welcome but their presence also adds to the complexity of the situation.

> *It is quite skilful to make them feel welcome, answer their questions and put them at ease but sometimes it is quite difficult to concentrate particularly down the cardiac end when the patient is quite new and unstable and obviously you have to spend some time on that. I find that hard.*
>
> *Participant- Group 4*

Some nurses communicate with the family explaining the problem and ask them to be patient. Most report the families are happy with this as they know you are doing your best for their loved one and not ignoring them. Delegating the coordinator or doctor to talk to them when the nurse didn't have time was another way of dealing with the problem, not ignoring it or trying to cope with focusing on patient and family. Henneman and Cardin, (2002) also maintain that unit secretaries, housekeepers and aides can be extremely helpful with providing support for families.

> *It is ok to say to the family, give us time to sort the patient out, explain to them and allocate time to explain how important it is to care for the patient, consider the family, not ignore them.*
>
> *Participant- Group 2*

Some nurses also feel frustration when the families constantly try to talk to the patient, trying to get a response, when the patient is supposed to be sedated.

> *When the patient tries to respond, family do not see that as negative when the patient is supposed to be paralysed, but family often cannot see.*
>
> *Participant –Group 3*

These nurses have difficulty communicating with the family to ensure they know that the patient needs to be sedated and it is inappropriate and detrimental for the patient to constantly try to wake them.

> *Some families are far too touchy feely, I wish they would leave the patient and stand back a bit not ask them if they are all right all the time.*
>
> *Participant – Group 6*

Having visitors present all shift is often very stressful for nurses, especially if they constantly ask questions, challenging the care given or hover over the patient. Nurses sometimes deal with this by acting as gatekeepers and asking them to leave rather than trying to improve communication or asking for help.

> *Some families you just don't gel with, find excuses to get them out, some ask questions all the time.*
>
> *Participant - Group 2*

Many of the participants find it difficult to cope with families when the patient is very busy or very sick, and also find it difficult to focus on the family when their primary role is to focus on the patient (Gavaghan & Carroll, 2002). Hupcey (1999) also noted this and described the nurses as stating they needed to care for the patient first and if the family interfered with the care or the patient became agitated during the visits they maintained control by asking the family to leave. Many families want to be involved with the patients care, but nurses feel that in ICU there is a limit to how intimately they can get involved. Safety is an issue. However, other visitors are often afraid to touch the patient in case they cause harm or dislodge some equipment.

> *There are little things they can do such as mouth care but they are too scared to touch them or do much.*
>
> *Participant-Group 6*

While some families want to be at the head of the bed, this area is off limits as having a person in that space could prevent the nurse from protecting the airway in an emergency or reaching vital medication when needed. Nurses often limit family to small interventions such as giving the patient mouth swabs or moisturising their hands and feet. This allows the nurse free access to the patient, keeps families away from essential IV lines or endotracheal tubes but also includes them in the care.

Making a difference means doing good for the patient and or family. This is offering help, support, keeping them well informed and looking to their cultural needs. It is forming the relationships that make the difference, being aware of how and what we do impacts on the patient/family. One issue that was raised was the desire to bring families in when the patient needed resuscitation as the nurses were aware that this may be the last time they would see them alive. There was also concern that there were many difficulties with this as it was only possible if there was a staff member to care for them. Usually the ICU does not have spare nurses to do this especially at night. Again it comes down to patient safety over caring for family.

> *Comforting a relative who is crying and assisting the patients breathing then I have to prioritise that is part of my role, I am going to be bagging (artificially breathing for the patient via an ambu bag) rather than rubbing someone's shoulder.*
>
> *Participant – Group 4*

For family/whanau humanising the experience is open communication, alleviating the relatives fear, providing comfort and also providing a bridge between the doctors and the family/whanau (Hupcey, 1999; Russell, 1999). Sometimes the reality is that families can be very intimidating for staff. This may be in the form of constant questioning, watching every movement the nurse makes, to actual threats of harm. This impacts on how the nurse cares for the patient especially when the nursing intervention or assessment may be interpreted as uncomfortable to the patient (Livesay, Mokracek, Sebastian & Hickey, 2005). This can cause nurses stress and fear and makes it difficult to care for the patient and the family who are often traumatised and stressed themselves.

In an environment such as an ICU where visitor access must be controlled for patient privacy and safety there are often incidents where visitors can be angry and aggressive for a variety of reasons. This may be due the family/whanau not being able to see the patient when they want or because they are untrusting of the care or angry at how they perceive they have been treated.

> *Verbal and physical intimidation from visitors impacts on the job no matter how hard you try. Nurses are afraid to speak out for fear of recrimination and it affects how you work.*
>
> *Participant – Group 1*

There have been a number of incidents where nurses have felt very unsafe in their environment and have felt unsupported by management. It is only in the past few years that this unit has had security doors which are locked after hours and controlled by intercom. Prior to that it was very difficult to control access when there was no reception staff on duty. Nurses find it extremely difficult and very stressful to try to give good care when aggressive family/whanau are present.

Another source of stress is when a patient is newly admitted and the nurse is conscious there are distressed family/whanau waiting to see the patient often for the first time since the accident or illness which necessitated their ICU admission. In Bourne and Mitchell's (2002) study of relatives experiences of waiting in the ICU, the participants described this waiting as "brutal, stressful and frustrating…unsure of what is happening, feeling intimidated, expecting something terrible…being exhausted…" (p.61). Many nurse participants are constantly aware of this and they talked of seizing the 'window of opportunity' to bring the family/whanau into see the patient even if it was only for a moment. However, this can sometimes cause conflict with the doctors who often like a clear uninterrupted time to carry out procedures such as putting in IV lines.

Nurse to Doctor Relationship

Nurses see themselves advocates for patients and families sometimes against the doctors. This is often in relation to nurses wanting to bring the family in for a new admission and the doctor wanting to put lines in and refusing or being annoyed when bringing family in to see patient who was 'bloody'. This type of situation was a source of frustration as nurses had often already prepared the family. El-Masri and Fox-Wasylyshyn (2007) claimed that the nurse's years of experience and corresponding level of confidence impacted on how well they prepared families for their first visit into the ICU. The participants talked about advocating to get family in when they can.

> *…nurses seized the opportunity to get the family and told the doctor washing the patient wasn't a priority, family had a right to come in and had had the state (of the patient) explained to them prior to coming in.*
>
> *Participant – Group 3*

The doctor's annoyance denied the relationship the nurse had already developed with the family through communicating the situation to them. The nurses also felt some doctors do not realise that the distress of the family is compounded by not being able to see their critically ill relative as soon as possible.

> *With a new admission, family in family room for 4 hours, hadn't seen patient and the nurse asked to bring family during break and doctor said no as wanted to put in lines at some stage.*
>
> *Participate- Group 2*

The participants talked about advocating for the family and the patient but also said this could be stressful.

Advocating for patients is challenging and confrontational because if you are advocating for someone you are bumping against something. That is why advocating, confronting someone who is quite senior is very hard.

Participant - Group 2

One nurse stated that you need to be confident to advocate and not be subservient or downtrodden by the registrar who is only in the unit for 6 months. But to be assertive you need to have the knowledge to support your decisions. Nurses from different cultures are often coping with a huge culture shift, may be more subservient and will not challenge the doctor. Challenging a doctor tends to be the domain of more senior nurses who feel confident enough to give their input, especially during family meetings.

Family meetings, nurses should have more input. More senior nurses will actually say something in meetings.

Participant – Group 3

Even if nurses do challenge, their knowledge and or suggestions may be disregarded. This often has the effect of de-motivating the nurses who will either give up or simply not follow the instructions especially if they regard it as a nursing issue. The comment was;

This is because it came from a nurse, as per usual.

Participants –Group 2

Some nurses maintain they welcome open and equal discussion and are willing to discuss an issue with the doctors. However, the doctors must also be willing to have an open an equal discussion in return and accept nurses can challenge their decisions.

I don't mind docs challenging as long as they give a very good rationale for why they want something done. But they must accept challenge if it is not a good enough rationale. Sometimes it is an order, it is under them and we must do it.

Participant – Group 3

Many doctors do not listen to what the nurse says and go ahead with their own ideas about the patient. Doctors have the last say and may not agree with the nurse.

Ashley

Bucknall and Thomas, (1997) in their study of ICU nurses' problems associated with decision making discuss the nurses conflict with doctors in regard to these decisions. A particular source of dissatisfaction was their relationship with junior doctors. This was often in terms of the doctors who had less familiarity with the equipment and patients not listening to the nurses when making decisions. One nurse stated "the Dr-Nurse game is always a problem in the ICU at the beginning of their rotation" (p.234). Stein, (1976) and Manias and Street, (2001) talk about the doctor-nurse game, a complex word game where the nurse suggests a treatment in such a convoluted way that the doctor gives the order without conceding it was a direct request. While I have observed that this still occurs, (and remember doing it myself) the participants who discussed the nurse doctor issue were more forthright. They are frustrated with being told how to care for their patients and regard the as the unit as being a medical domain. This is supported by Fairman, (1992) who contends the development of intensive care as a medical specialty means that the doctors now define who needs intensive nursing care. Intensive care units were established by doctors and in the early years the doctors dictated the standards for nursing care. However, the majority of nurses in this ICU have completed a Critical Care Course and have many years experience.

Nurses have confidence in what we know and also knowing what our practice is, what is nursing.

Participant –Group 3

The Critical Care Nurses Section (CCNS) of the New Zealand Nurses Organisation (NZNO) have defined *Philosophy and Standards for Nursing Practice in Critical Care* (2002) which also states the majority of nurses should have a post registration critical care qualification. Manias and Street (2001) maintain that nurses draw on varied forms of knowledge when deciding a patients

care yet this knowledge is often dominated by the "more professional and socially prestigious medical knowledge" (p.132).

The participants see the ideal as nurses and doctors working in partnership, as a team with each discipline having its own domain of practice. Casanova et al (2007) concede that on the surface teamwork is seen as important for doctors and nurses, but the advantage of collaboration is not adequately emphasised in medical education or practice. They contend doctors think collaboration can undermine their authority and that working in parallel is more feasible than partnership. Doctors and nurses have very different perceptions of their own and each others roles. This dissatisfaction is more pronounced when doctors trespass on what nurses regard as their domain. Although the ICU is regarded by management as a multidisciplinary unit, nurses feel that it is all a medical domain.

> *We have always been told how to care for our patients, turns, cares etc. taping eyes etc. Doctors seem to want to tell us what to do. Medical staff, it is all their domain, there is no separate practice, but in ICU there is some intertwining of practice.*
>
> *Participant – Group 3*

While this perception may have been very relevant in the early days of the unit when the nursing guidelines were written by doctors, the ICU nursing domain is now more defined. For example the ICU nursing guidelines for practice are written and updated by nurses and supported by research and evidence based practice. Quality assurance and health and safety teams are comprised mainly of nurses and are nurse lead. The Critical Care Course is lead by nurse educators and many senior nurses lecture on the course which is now taught at a postgraduate university level. However, in many aspects of everyday care nurses are still not included in the discussion and decisions regarding their patients. One of the defined values of practice was the desire to work in partnership with the doctors. Nurses who feel confident in their nursing practice, wish to be able to nurse their patients without feeling that doctors were overseeing every aspect of this care. They are happy to discuss the care and treatment with the doctors but often feel that they are disregarded. Improving nurse to nurse communication and support will give provide them with a strong basis with which to initiate communication with doctors. This belief

is supported by the consensus group and also by comments from some participants in the reality groups.

> *It could be very powerful in a good way, if nurses as a group say we will do it this way who is going to stop us?*
>
> *Participant – Group 3*

Nurse to Nurse Relationship

The participants' ideal is that they should have autonomy of practice and advocate for the patient. It is rising to the challenge of treating and caring for complex, stressed patients and prioritising their care, using their own clinical judgement, knowledge and intuition. It is intervening when required, not unnecessarily, and having a high standard of care at all times. Respect for colleagues is valuing each others knowledge, sharing your own knowledge and helping without needing to be asked. It is also having the responsibility to ask for help when you are unsure. It is working as a team for better patient care and knowing that your skills, knowledge and clinical judgment are valued by all staff. It is being responsible for developing skills both professionally and personally.

The reality is that nurses set high expectations for themselves, as they are orientated into the cares, tasks and routines for optimum care of the ICU patient and to ensure the smooth running of the unit. Whenever possible these nurses are orientated on stable patients who require routine ICU care. When the nurse is faced with an acute or unstable patient requiring many procedures and urgent interventions they are thrown off the path they learnt on and for the first time must cope, without a preceptor, with a very busy patient, leaving no time for the 'fluffy' cares. They feel anxiety and stress when they can not do everything they have been taught and feel that they have failed their own and the unit standards. Reising (2002) reports new critical care nurses as feeling very uncomfortable and disappointed with themselves, especially when they had higher expectations of their capability. This supports the comment by one of the participants in this study.

Some nurses want to touch, be at the patients all the time, can't sit them down at end of bed and say it is ok not to touch your patient. We all went through this, scared we will miss something. Takes practice before we are comfortable and able to leave them alone. And monitor etc.

Participant- Group 3

While senior nurses are more experienced, better able to cope with 'fitting' things in and know it is okay to leave some things undone, they also often feel stressed and guilty if they have not been able to do the 'fluffy things'.

Sometimes chasing your tail all day, sometimes cannot meet the needs of the patient but have to prioritise, cannot do the fluffy things etc but think we did a perfect job in resuscitating the patient, had rapid infuser going, sengstaken, cared for everything but to 'fluff' such as mouth, eye care etc would have interfered with care.

Participant- Group 3

The nurses know that they do a good job, saving critically ill patients' lives but still feel guilt at not being able to do everything the patient needs. There is still a feeling of failure; of being a bad nurse if they have not managed to do all the things they have been taught. They have not met their own standards that they have set for themselves or have had set for them during their orientation, when they are taught routines. These routines and expectations are perpetuated by the culture and ideology of the unit, and although often unrealistic with the high acuity of ICU patients, are often set as the 'gold standard' to be achieved. This failure is usually in the eyes of the nurse themselves, where they have failed to meet their own standards, not necessarily in the eyes of the other nurses, who have seen they have worked very hard.

However, these standards and the unit expectations also guide their perceptions of each other's practice. Nurses are happy to continue tasks, if they think the previous nurse has been busy and not left cares or tasks undone unnecessarily or without good rationale.

Prioritising of care is important and handing over a live but messy patient is ok if you know the patient has been busy or the patient next door has. It is not ok if the patient is quiet and work hasn't been done.

Jordan

Hays et al (2006) maintain that 'apathetic incompetent' nursing staff rated as one of the four highest stressors in ICU nurses. A participant in this research stated that, "Everyone has their own standards and they hold other nurses to their standards." Often it may be a matter of perception such as the differing observations and perceptions of care on night shift. El-Masri and Fox-Wasylyshyn (2007) give an example of nurses' differing perceptions in when nurses are asked about caring for family. Each nurse believed they were performing family focused interactions more often that other nurses.

Many participants state nurses must make their own decisions and need to support others to do so - but are also aware that there are often constraints put on this and not all nurses are supported or enabled to make their own decisions.

Senior staff will treat as a guideline but a lot of staff do not have the authority to make that judgment call, seniors have the standing others may be bullied and rebuked.

Participant – Group 2

Coercion of care and power relationships was a recurring topic in the data, where nurses felt they had breached their own standards of care and felt coerced to carry out interventions or cares because as a senior nurse said "some nurses get on other nurses backs". This seemed to be a cause of stress and guilt, because they are being coerced into doing something or not doing something they disagreed with and because they knew they have a responsibility and accountability for the care of their own patient. This suggests coercive expectations of care have become embedded in ICU nursing culture when tasks and routines are taught to junior nurses as essentials of care. Power is exercised through subtle or sometimes overt indications that the

nurses have not met these expectations and then may be giving less than optimal care (Foucault, 1979; Kuokkanen & Leino-Kilpi, 2000, Street, 1991).

> *We do it because some nurses get on other nurses' backs if cares not done, they hassle other staff to do what we perceive is ritualistic care as that is the way it should be done. We are told to something because that particular nurse feels that it should be done, it is in "protocol" and you might give very good rationale why not to do it but they insist.*
>
> *Participant –Group 1*

The nurse may persuade an unsedated patient to have a wash, for example, because the nurse is worried about what the next nurse will say. If a nurse suspects another nurse is not caring for their patient adequately they may suggest the wash as a way of ensuring the nurse looks at the patient. One senior nurse admitted to this.

> *I can remember saying to a nurse "you should wash your patient". There was a poor assessment at beginning of shift, have handed the nurse a bowl to ensure they will wash and assess skin the at same time.*
>
> *Participant –Group 3*

Even though acknowledging that the intervention or care may be ritualised or from 'the old days' the nurses often admitted to still succumbing to pressure and giving what they regard as unnecessary interventions. There were comments on the nurses who use this '24 hour care' as an excuse to 'sit down all shift'. They are happy to take over and continue with tasks such as dressings and line changes if the nurse has genuinely been busy but not if they perceive the nurse is being lazy.

> *There are certain nurses that come on night shift because it s perceived as a more relaxed environment and less work and a chance to sit and read a good book and one of the frustrations I have found is that people aren't giving 24hr care to patients.*
>
> *Participant –Group 4*

They talk of prioritising care, leaving the 'fluffy' things when the patient's condition necessitates immediate interventions but make a judgment on whether this has been the case when the patient is handed over to them for the next shift. All nurses acknowledge that critically ill patients require the life saving measures as a priority and while the comfort cares are important, only if there is time. Nurses seem to differentiate between nurses who are seen to work hard by being in constant motion and those who they perceive as being lazy because they seem to be sitting at the end of the bed. It is not acceptable to leave the 'fluffy bits' unless they see it is for a good reason. They maintain nurses must take responsibility for their own work, be prepared to make decisions and support others to do so. But it would seem that these decisions and actions are judged by other nurse's standards of care, with little regard for the rationale for the decision or even asking if there was one.

Everyone has their own standards and they hold other nurses to these standards.

Participant – Group 3

However, other nurses recognise that their own standards may be different from other as people have different backgrounds and personalities which guide their practice. This does not necessarily mean the care that is given is poor.

Recognising that standards of care alter and mines not wrong compared to someone else's, it may be different so standards differ between personalities it doesn't mean to say the care is any less.

Participant – Group 6

In respecting that each nurse has their own standards of practice there is also the responsibility for nurses to make their care decisions and be responsible for their practice.

We still have to have people prepared to accept that they can make a decision and we also have to people in authority such as a CNM, coordinator and senior nurse allow people to do so.

Participant – Group 5

The participants maintained that nurses must make their own decisions and senior nurses must support them with this but paradoxically it is also acknowledged that junior nurses do not have the same authority to be flexible with their decision making, and if they do so, may be challenged. They admitted that junior nurses can be rebuked or bullied if they make a decision the senior nurse thinks is more suited to their own expertise and knowledge. This is supported by Bowler and Mallik (1998), who noted in their study that senior nurses acted as gatekeepers preventing junior nurses from performing the more technical roles ceded to nursing by medical staff. Marshall (2007) also contends that many nurses are overprotective and block novice nurses from caring for very sick patients because they feel they lack the skills to care for them safely. This effectively prevents nurses developing problem solving and critical thinking skills as well as advanced clinical skills. In this research the participants stated nurses must have a good rationale for their decisions but nurses of all seniority suggested that some of their decisions and cares are coerced by proponents of ritualistic and routine practice. There is also frustration when nurses make these decisions but are unable to give a good rationale for doing so.

> *Nurses do things without a good reason such as turning up propofol (sedation) so nurses can have an easier shift or restraining the patient, so they can sit down.*
>
> *Participant- Group 5*

There was no mention of how senior these nurses were or whether they were challenged. One nurse commented "we are not good at policing our peers" which implies that nurses do not challenge each other, especially if they are both senior and control is exerted on others through exercising of unequal power relationships. There was a comment that

> *Rules are made for the newest person in the group to ensure there was safe care given and that these tick boxes and guidelines offer a measure of safety for new and junior nurses*
>
> *Participant – Group 3*

Yet it was also maintained that all nurses have the responsibility for assessing their patient at the beginning of the shift and planning their care. It is stated that this is often not done or done well. One nurse was adamant that new graduates should not be in ICU and nurses take 6-7 years to learn the basics first. She stated,

> *I am comfortable as a nurse managing care and not being neurotic. Junior nurses cannot advocate for the patient and do not know what to ask for as they do not know what they are doing.*
>
> *Joss*

When do junior nurses learn to do all this if they are not supported with decision making and there is a culture of bullying and blame when they do not follow set guidelines? It was stated by senior nurses that they needed to be approachable and supportive and needed to teach more junior nurses. Gardner and Pierce (2002) also commented on this in their study on the feelings and values of ICU nurses relating to their work environment. While the nurses stated they valued each other, they also said that they were quick to tell a new nurse when they did something wrong and rarely gave them praise. A junior nurse in their study stated that "…you hear that you could have done better and if that's all you hear, it makes you lose confidence" (p.107).

The terms bullying and horizontal violence have been used by participants in the focus groups and individual interviews. Woelfle and McCaffrey (2007) define horizontal violence as "aggressive and destructive behavior of nurses against each other" (p. 123).

This behaviour may be verbal with rude, humiliating or abusive comments or be more subtle conveying disapproval with silence or lack of support (Alexy & Hutchins, 2006). Nursing may still be regarded as an oppressed group and thus exhibits a subtle self hatred and dislike for other nurses evident in the divisiveness and lack of cohesion seen in nursing groups (McCall, 1996; Roberts, 1983). While many studies have been focused on new graduates or students others have shown as, is it is evident in this thesis that nurses of all seniority have at some stage been subjected to bullying either through verbal abuse or more subtle coercion of practice (Randle, 2003; Sheridan-Leos, 2008; Sunderland & Hunt, 2001; Woelfle & McCaffrey, 2007). As Woelfle and McCaffrey (2007) state "Horizontal violence seems ironic in a discipline that has caring for others as its main focus" (p. 130). The participants in both Woelfe and McCaffrey's study and

this research identified that support for nurses must come from each other, not from the hospital. This support must include enabling more junior nurses to learn to care for sicker patients and develop their critical thinking and problems solving skills (Marshall, 2007). ICU nursing may perhaps be said to be a process of continual decision making when caring for a critically ill patient. If these care decisions are coerced or influenced by other nurses standards or the routines and needs of the system, the registered nurse is still responsible for the decisions he or she makes, whether there is a good rationale or not.

Male nurses in particular felt pressure to be extra diligent with washes and the 'basic cares' to avoid being labelled a 'boy' and regarded as not having as high standards as female nurses. One nurse recounted of being told by a senior male nurse when he first started,

> *Make sure you do all the small things as all the women will be watching*
>
> *Participant- Group 2*

Another male nurse agreed stating,

> *They are the self appointed gestapo of hygiene. You partially wash the patient se its necessary for hygiene and partially because of expectation of peers. Sometimes I know patient doesn't want to be washed even if a bit grubby but they just don't want you near them doing all the scrubbing etc and it makes me feel quite stressed.*
>
> *Participant – Group 2*

This gender bias was initially brought up by a female participant, which indicated this is part of ICU culture, and also something I was not aware of. This attitude highlights the concepts of females as nurturers and carers, attributes which historically relegated nursing as woman's work. However, Whittock and Leonard (2003) contend males have a long tradition in nursing dating back to the 1300s in the monastic orders. Male orderlies cared for the wounded but were often required to fight leaving the way for Florence Nightingale to introduce females into public nursing. In their study of the motivations and experiences of male nurses, the participants all stressed that males can be as caring as female nurses and many had experienced caring for a

relative motivating them to become a nurse. There is research stating there is little difference in the concept of caring between male and female nurses (Heskins, 1997; Milligan, 2001; Whittock & Leonard, 2003) and I have been unable to find any evidence that male nurses give poorer hygiene nursing care than females. The male participants in this research agreed that this attitude did exist and warned new male nurses to the unit to take care.

Handover was regarded as quite stressful for some, with the oncoming nurse acting as a 'drill sergeant' and some nurses' felt they are often dictated to and watched. While it is each nurse's professional responsibility to check the emergency equipment, infusions and patient orders when taking over a patient, there is often tension and anxiety during the handover phase. The nurse handing over may feel anxious that s/he may not have been able to meet their personal and unit expectations of care and there is tension when the oncoming nurse needs to know everything about the patient.

> *I get nervous with handover coming up knowing (thinking) that as soon as I walk out the door mouths will start flapping, they will talk about nurses' practice behind their backs.*
>
> *Kerry*

Philpin (2006) that nurses, especially juniors, sometimes felt anxious at handover, but this was usually met with empathy and understanding from the oncoming nurse. Manias and Street (2000) however, called the handover the examination, scrutinising nurses and their care. The same attitudes and behaviours as in this thesis were reported, the nurse handing over feeling anxious and defensive at the implied criticism. The oncoming nurse in Manias and Street's (2000) study also made a judgment saying you can tell if it has been a busy shift, without asking. The participants in this research talked of feeling let down when as the oncoming nurse they perceived their expectations of care had not been met. Rowe (2001) in her study of handover in medical ward talks of being human. Not every nurse gets on with everyone else and she noted that while it was obvious that some nurses felt uncomfortable handing over to others in no way did this affect the information given. However, there was little socialising at the end of handover. The ICU handover can be quite intense and there is little time for socialising as the oncoming nurse is concentrating on taking over care of the patient and they are usually thinking about the oncoming shift.

There is also a comment of feeling dictated to and watched constantly especially on the day shift. Cheek and Gibson (1996) who refer to this monitoring as the 'nursing gaze' maintain that this has the effect of developing conformity in nurses. There sometimes seemed to be a lack of care for each other, with nurses working as individuals rather than as a team. They talked of needing to trust each nurse to fulfil their obligations and duties to ensure the unit is safe for the patient and each other especially in an emergency situation.

> *It is that working as a team and sometimes there will be situations where you feel let down because someone hasn't fulfilled what you believe is part of their role in the team.*
>
> *Participant –Group 4*

However, professional responsibility and individual accountability also demands that you do not work on trust alone, there is always human error and you need to protect yourself by doing your own checks. This trust does not absolve you from your own professional obligations.

> *There is a trust but you can't just go on trust you still have to check.*
>
> *Participant –Group 4*

As part of the team it is expected when you have a busy patient to do as much as possible and considering the next nurse coming on.

> *And every little bit helps you can't do everything but you can do some things like you can't get 5 dressings done but you can do 2 and it helps the next person out.*
>
> *Participant –Group 4*

The expectation is that everyone works together as a team for good care of the patient but also every nurse has a professional and legal responsibility to be accountable for the care they give their patients and the decision they make for that care. However, there seemed to be a lack of professional openness and discussion of issues and nurses were reluctant to challenge each other. In the teamwork study by Kalisch, Curley and Stefanov (2007), communication was regarded as a vital component of the project which involved the whole unit, supported by management.

However, in this project communication was in the form of tools conveying information around teamwork to the staff, not so much nurse to nurse communication.

The participants in this research felt there is a need to support each other, with better communication and sharing of knowledge. This support was for all nurses, not just junior staff, as senior nurses also had difficulty controlling their own practice within the patient bed space. One senior nurse told of a situation when she received a cardiac surgery patient from theatre.

> *I was listening to the handover from the anaesthetist while I was also connecting the patient to the monitor etc when about 4 nurses swooped in to help. I didn't need help and was content to do everything at my own pace, but with everyone helping I got confused and then when they all left I wasn't sure what needed to be done.*
>
> *Consensus group participant*

It was agreed that this situation is not uncommon especially when the unit is quiet or the patient was critical and all agreed that help should be offered if needed but the primary nurse should be in charge regardless of seniority.

Many participants talked of their care being influenced and felt they should work together more as a team. Kalisch and Begeny (2005) state research has shown that teams that are regarded as high performing have a common purpose and destiny. In their study they maintained that while nurses regard themselves as having the common purpose of providing good care it was only for their patient on that shift. Common destiny is described as every team member equally sharing in the successes and failures of practice, which they maintain is not possible for a nursing situation. However, in this research there is strong evidence that the nurses do care about all the patients on a 24 hour basis, not just for their own shift. All the issues raised are all directly concerned with optimum care of the patients and I suggest that the successes and failures are felt by every nurse in the unit. This evidence indicates that the nurses in this study have the capacity and desire to truly work together with a common purpose and common destiny as a high performing team.

Responsibility of the Researcher

I needed to constantly remind myself when writing this that I had asked them where they could not meet their ideals of practice. This meant that they were only talking of the difficulties in their practice and the successes and caring behaviours were not discussed. However, when talking about these issues in a group such as this, it is accepted that the 'good' is understood, it is also part of our ICU nursing culture. As an ICU nurse I know the reality of nursing in this context and even though the nurses are critical of themselves I know there is an underlying reason why they could not give care the way they wished to. It is also being able to understand the language used, e.g. what a sengstaken tube is, why it is used, why the rapid infuser is used, and I can see the situation as it is. No further explanation is needed.

I asked a group if they would be have been so open with another researcher. The answer was an emphatic 'No'. It is because I am part of this unit that the participants were willing to talk openly, trusting me with this information. With this openness and trust, comes the responsibility, for me as the researcher, to analyse, interpret and write this thesis with great care, acknowledging the successes as well as the difficulties. As evidenced by the defined core values of ICU nursing practice these nurses wish to care for their patients to the best of their ability, with compassion and acknowledgement of the patient as a person. Throughout the reality data this concern for the patients well being comes though clearly and the acknowledgement of the difficulties is always with the patients' well being as a focus. The discussion in the reality groups is a critique of how this care is given, it was critical of self and of others and of how it impacts on the patient. It is also important to remember that this care is situated in the ICU and as such must be looked with the context of caring for often critically ill patients and their family/whanau. Walters (1994) describes 'focusing' as "empathising concern with for the critically ill patient and his/her family amid the high technology of the intensive care unit" (p. 23). This concern for the patient and family/whanau was an underlying thread through all the group meetings and interviews.

There are always circumstances beyond the nurse's control which will dictate the care given, whether it is deterioration in the patient's condition, demands from members of the multidisciplinary team or institution, or extreme fatigue on night shift. The nurse wishes to give the most appropriate and best care that is possible in the circumstances. The challenge was to be

able to confront and change the issues that are within the nurses' control and within the domain of nursing. The consensus group identified nurse to nurse communication and support as the most essential issue impacting on the way they care for their patients. This issue sits within the domain of nursing and only the nurses themselves will be able to bring about change in this area.

Chapter Seven Reflections and Conclusion

I will begin this final chapter reflecting on the overarching theme, high standards of professional care which guides the relationships ICU nurses work with in their everyday practice. This overarching theme which encompasses the values and beliefs of nursing also provides the reference point by which nurses must conduct their ICU practice, from a professional, ethical and legal standpoint. Nurse to nurse communication and support is discussed in relation to Habermas' Theory of Communicative Action and ideas for bringing about this change will be posited.

The study and processes will be revisited with discussion on its contribution to nursing in ICU and for future action research and development of practice. This will also be discussed in relation to participatory action research and its concept of community critical and political action and power in relationships. The notion of reconnaissance as change will also be considered highlighting its importance in the action research process and as a change process in its own right. The New Zealand koru as the new growth and new beginning of the ponga fern has been used to illustrate the importance of the reconnaissance phase as the core of the action research process and the foundation for future projects.

High professional standards of care

The components which define high professional standards of care in the values data relate to all aspects of nursing care in the ICU. These include the nurse advocating for the patient, being non judgmental, protecting their privacy and confidentiality and also guiding the family/whanau through the ICU experience. It was supporting the patient's decisions and basics rights, intervening only when necessary, basing practice on research as well as using our own clinical judgment, knowledge and intuition. A major component of high professional standards of care related to communication and support of each other as well as other members of the team. Teamwork included wanting to know our skills, knowledge and clinical judgment were valued by all staff and having faith in the team.

The Critical Care Nurses Section (CCNS) of the New Zealand Nurses Organization (NZNO) has developed a *Philosophy and Standards for Nursing Practice in Critical Care* (2002). The 5 standards are as follows:

- Nurses are accountable for their practice.
- Within their scope of practice, nurses are responsible for the safety and well being of their client group.
- Nurses are responsible for entering into and maintaining a partnership with clients, community, colleagues and employers.
- Nurses are committed to nursing professional development.
- Nurses manage resources efficiently and effectively to meet client health care needs.

Within each standard there are defining factors which essentially encompass all the standards identified as core values of practice. Nurses being accountable for their own practice and maintaining a partnership with colleagues is congruent with nurse to nurse communication and support, further supporting the need for developing this in practice. The HPCA Act (2003) which governs health professional practice in New Zealand also requires that registered nurses are accountable and responsible for their practice. If the nurse makes a decision of care that they are uncomfortable with, in that they feel pressured to do so, then the nurse must be aware that they are still professionally, ethically and legally responsible for the care decision. Senior nurses admit they need to enable nurses to make their own decisions and they need to support them in this process while also ensuring the patients and nurses remain safe. The nurse must also be prepared to take on this decision making role and in doing so be prepared to ask for and receive guidance from more experienced nurses when it is needed. This guidance should also include supporting the nurse to manage the relationships that constitute the ICU environment.

Nursing in the ICU is a complex process of juggling the relationships or partnerships with the patient, family/whanau and doctors as well as colleagues while striving to maintain a high standard of professional care within the reality of ICU (Figure. 3).

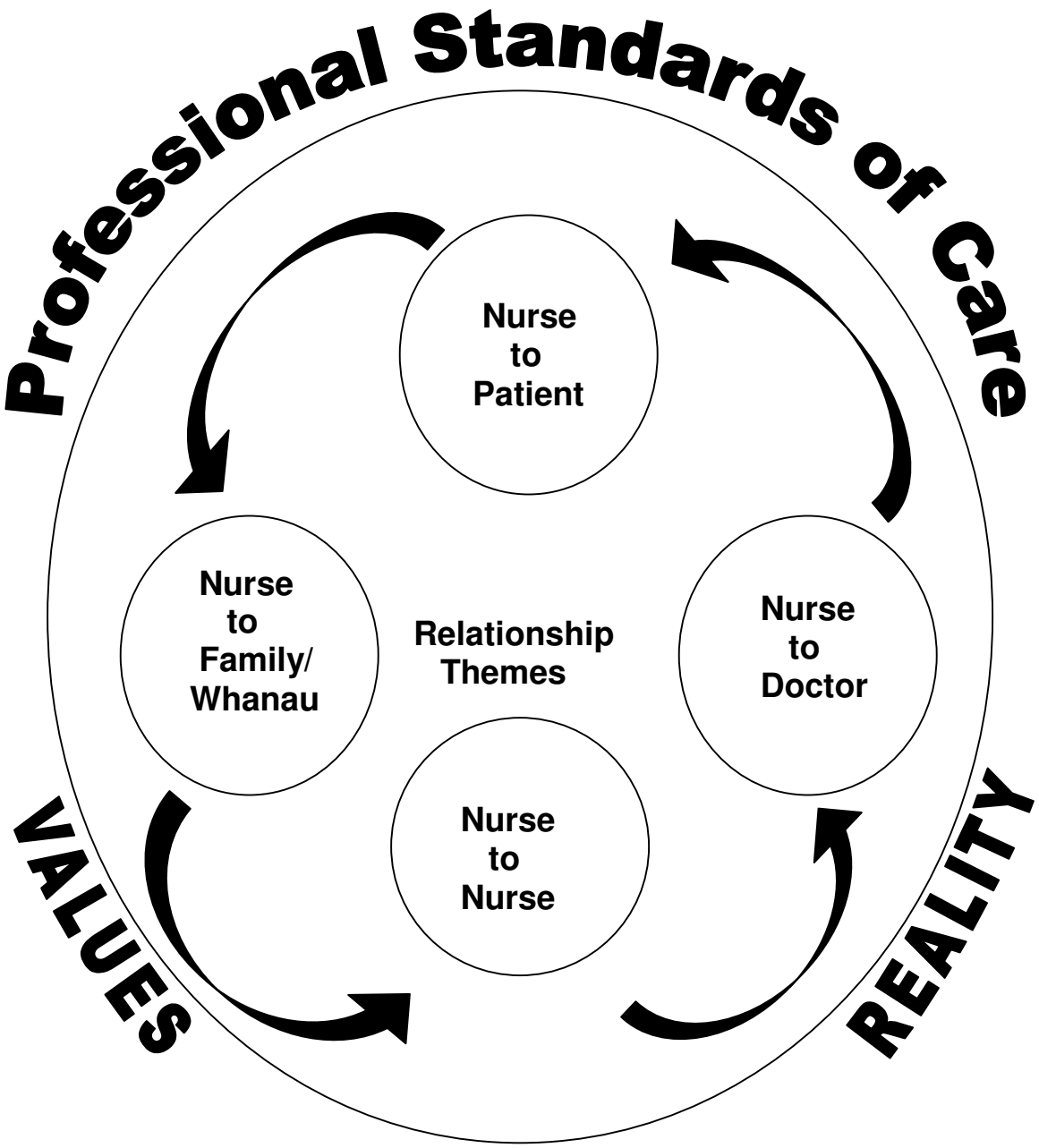

Fig.3 Complexity of managing each relationship while striving to achieve high professional standards of care in the reality of ICU.

Perceptions of Care

The complex nurse to nurse relationship often seemed to be governed by perceptions, with little open communication and support. Whether their care was being coerced or they felt they have been let down by nurses not doing cares, the participants often seemed mired in the issues and unable to find a way forward. The challenge was to guide and support them through an individual and collective reflective process enabling them to recognise how these issues affected them, the patients and the unit and how they may devise new ways of interacting and reacting.

The participants admitted that each nurse has their own standards and they will often judge others by those standards. There seems to be a very fine line between prioritising care and interventions and being regarded as lazy and not giving 24 hour care. It is these perceptions and assumptions and the attitudes that stem from these that appear to be a significant cause of stress. The stress that these nurses feel is due to fear about what the other nurse(s) say or perhaps appear to be thinking and also because they feel they have failed. They acknowledge it is all right to leave 'stuff' undone and for the next nurse but still are anxious about what the oncoming nurse will say or think. The oncoming nurse admits to feeling let down or angry that work has been left but will often make a judgment on how busy the patient has been, without asking. Nurses talk about night shift being a more relaxed time, where they can allow their patient to sleep but also commented on others who are perceived as being lazy and not giving good care. They also stated that they must always be able to validate the decisions they make.

However, what seems to be missing in many of these situations is that the nurses are not asked for validation; the oncoming or observing nurse makes a judgment according to their own perceptions and standards of practice. Nurses who like to be continually busy may perceive other nurses as lazy if they are not continually busy while more relaxed nurses may perceive these nurses as either judging others or perhaps lacking in confidence. There is little communication between the nurses which may prevent these misconceptions.

Distorted communication

Many of the issues described by the nurses in this thesis are ascribed to a lack of communication or miscommunication. Habermas (2001) explains the universal presuppositions of communicative action as being accountable and being ready and willing to reach mutual understanding. By this he means,

> that the participants mutually consider each other to be accountable. That is, they must presume one another to have overcome childish egocentrism and be able to distinguish between the intersubjectivity of language, the objectivity of external nature, the subjectivity of inner nature, and the normativity of society (p. 147).

Ready and willing to reach mutual understanding refers to mutually supposing each other to act on or reach a consensus about the four validity claims of speech. These are intelligibility (mutual language) in this study of ICU nursing culture, the truth of the discussion content (regarding ICU situations), the rightness of the discussion with reference to ICU norms and the sincerity of the speaker regarding the expressed intentions. Habermas (2001, p. 149) also states that "it is not possible to want to communicate *and* to express oneself unintelligibly or misleadingly". This also applies to the other validity claims of sincerity and normative rightness. If the speaker is not sincere then their intention is not to achieve mutual understanding. If the participants disagree about the normative background (the accepted norms of ICU nursing culture), then there is a split in communication. If the conversation continues presuming there is communicative action this split in communication occurs, which doubles it into a public and private process. This systemically distorted communication continues along "the thread of action orientated to mutual understanding" (p. 155), and then this may become part of the culture. The misunderstandings or assumptions which have not been clarified and resolved at the time of the original conversation and caused the split in communication continue to cause conflict and stress. These conflicts may then smoulder on distorting communication, unable to be openly carried out or resolved. Within the context of ICU this distortion of communication may occur during any interaction where the nurses are insincere, there is conflict or perceived different values and standards of practice or in a situation where there is unequal power and there is not mutual accountability for practice.

Contribution to ICU nursing practice

This study has enabled the participants to uncover and acknowledge the aspects of their practice which highlight the situations of distorted communication. The first part of the study process involved the collective defining and clarification of their values and beliefs which guide the nursing practice in this ICU. This allowed the participants to gain a mutual understanding of the core values and norms by which every nurse in the study wished to conduct their nursing practice. This practice is defined in the terms of relationships; with the patients, the family/whanau, the doctors and with each other. Discussing their practice honestly and freely has given them a greater knowledge and understanding of the underlying influences which guide and coerce their practice. With this knowledge they have then been able to mutually agree, through discussion, which aspect of this practice is the most important to change. By agreeing nurse to nurse communication and support is the essential component which has most impact on their practice, they are taking the first step in the process of correcting the split in communication which is imbued in the ICU nursing culture. With the acceptance of a mutually defined philosophy of nursing the false perceptions of differing values of care that helped create the miscommunication can no longer be sustained. However, heightened knowledge and understanding cannot correct this distortion on its own. In order for communicative action to take place the nurse to nurse interaction must be mutual and sincere. Habermas' assertion that the speakers must regard each other as mutually accountable and overcome childish egocentrism requires each nurse to speak to other on an equal basis as a professional nurse.

Transactional analysis developed by Eric Berne (1961) may be one method of communication which will enable the participants to achieve communication as adults with a mutual understanding of their practice and their own accountability. Transactional analysis is a model based on the notion of the 3 ego-states of our personality. These ego-states are parent, adult and child which according to Berne govern communications and where there is crossed transaction or communication between two different ego-states then there is conflict. These crossed transactions support Habermas' concept of accountability and childish egocentrism. An example of crossed transaction in the ICU may be at handover when the oncoming nurse may seem or is critical (parent ego state), the other nurse may become defensive or upset (child ego state). This in turn

may cause the oncoming nurse to act more like the parent perpetuating the crossed transaction or communication. However, if both nurses act as adults the oncoming nurse may inquire how the shift was rather than assuming and the outgoing nurse will be accountable for the decisions and actions on their shift and give a rational description of the problems that occurred.

It must be noted that the issues under discussion relate only to nurse to nurse communication and support. Performance issues are another matter entirely and must be dealt with appropriately through the correct channels. Regardless of the problem or performance issue each nurse is still accountable for their decisions and care.

Contribution to the ICU context

The lifeworld of nursing practice in ICU mutually exists within the demand and needs of the system which is driven by economic and legal expectations and successes. This is beyond the realm of nurses to bring about significant change. The requirements of the institution which impact on the lifeworld of the ICU including the 2 hourly attendant services, the needs of other health personnel, also functioning within the system, and the economic constraints of staffing, resources and physical layout are inviolable. Therefore the nurses must learn to work within this system to minimise the tensions that impact on the care they give their patients. Comments from the participants about the ICU being all a medical domain indicates that many nurses feel powerless and still see nurses in terms of being the subordinate group dominated by medicine. Nurses must acknowledge the importance of their work and also the control and autonomy they have over their practice. This is evidenced in ICU with nurses writing their guidelines for practice, leading the Quality Assurance and Health and Safety teams, Senior Nurses on the management team and nurses conducting their own research, supported by management. The process of the focus groups has enabled them to begin talking about their practice with the collective goal of optimum patient care and to also acknowledge the constraints which influence this care. Continuing this process by improving communication and supporting each through teamwork will enable them to minimise the impact of the external influences and together provide optimum care for their patients.

Contribution to the ICU nurses

Consensus was reached on nurse to nurse support and communication being the most important aspect of practice which needed development. Discussion amongst the nurses included agreement that nurses needed to be able to make their own decisions for care and it was important to provide support to ensure that happened. This support was for all nurses, not just junior staff, as senior nurses also had difficulty controlling their own practice within the patient bed space. This is evident with the senior nurse who talked of the situation when receiving the cardiac surgery patient from theatre and a group of nurses 'swooped' in to help resulting in the nurse being left confused and uncertain of what still needed to be done. It was agreed that this situation is not uncommon especially when the unit is quiet or the patient was critical and all agreed that help should be offered if needed but the primary nurse should be in charge regardless of seniority. While the excerpt may have been regarded as teamwork, this fails if the primary nurse who is ultimately responsible for the patient is derailed and left confused or demoralised. Junior nurses needed to be supported, kept safe, given education if needed and the patient needed to be safe. There was sometimes a fine line between nurse autonomy and patient safety and the coordinator and senior nurses needed to take care with this. Working and communicating as a team will encourage nurses who are struggling to cope with family/whanau to ask for help while other nurses will notice this situation and support the nurse. While much of the literature is around nurse/doctor teamwork, collaborative decision making and communication, the consensus group and I believe it is more important to look at nurse to nurse communication and teamwork first (Kalisch, Curley & Stefanov, 2007). Enabling nurses to communicate and be cohesive will provide them with a strong basis with which to initiate communication with doctors. This belief is supported by the consensus group and also by some participants in the reality groups.

What was of interest during these focus groups was that despite the issues being discussed, the nurse participants illustrated through their interactions with each other that they were actually more cohesive than the discussion indicated. They were respectful and supportive of each other regardless of which nurses were in each group, were willing to concede that everyone worked differently and that they should be more thoughtful and supportive of each other in practice.

There was a sense of unity, a shared purpose as ICU nurses looking together at the issues in their practice.

Relevance of action research approach

The process and results of this thesis endorses and validates the action research approach as relevant to nursing as whole and also for working with groups such as ICU nurses. Participatory or critical action research, while not an easy process for the researcher, is able to engage nurses in the research process enabling them to define their own problems and issues of practice. The flexibility of action research allowed for multiple focus groups with myself as the facilitator and link between the groups. The snowball fashion of the values groups made it possible for the participants to define a collective philosophy of care to act as a reference point for the rest of the study and also on which to strive for improved care of their patients. This reference point enabled the reformation of the reality groups with the participants being in different groups from the values phase.

The action research approach enabled the nurses to get to the 'grass roots' of their practice by first collectively defining their values and beliefs of practice - their philosophy of ICU nursing. The creation of the social or communicative space brought together a seemingly disparate group of nurses and through mutually agreed values and understanding of their practice began the process to becoming a supportive cohesive group. Carr and Kemmis (1986), state that "in emancipatory action research, the practitioner group takes responsibility for its own emancipation from the dictates of irrationality, injustice, alienation and unfulfillment" (p.204). Working together as a self-reflective community the nurses were able to critically explore their practice highlighting where there were issues for change. The collaborative approach enabled nurses to act as leaders in the social conscience of the community and critically argue for nurse to nurse communication and support as the most important aspect of their practice to develop (Carr & Kemmis, 1986; Friere, 1972).

The nurse participants changed the focus from the original question and aims thereby confirming the action research approach as being appropriate for nursing clinicians to determine their own problems and solutions. The participants broadened the focus from looking at practice on night

shift to encompass nursing practice issues across all three shifts. Following the principles of Communicative Action and achieving communicative competence they were able to explore the issues in their practice that most concerned them with the collective core values as their reference point. The impetus for this process and the collective purpose is to be able to provide optimum care for the critically ill patients in ICU.

Perhaps one of the limitations of this research was that the research did not involve all the nurses in the unit which may make it harder to bring about overall change and there were less junior nurses involved than seniors. However, this may be minimised due to the fact that the juniors involved are now relatively senior and are now preceptoring new nurses into the unit. Although not all nurses participated, many of the senior nurses involved would be regarded as key people in the unit and their support will be crucial for the continuation of the study. Kritik (2001, p. 336) states "giving voice to nursing concerns itself becomes a call to excellence and those unwilling to change are best excluded". She maintains only nurses can articulate the changes needed for good nursing care and the "collective silencing" (p. 336) must be challenged if this is to change. Dracup and Bryan-Brown (2006) maintain that low expectations have evolved in many hospitals where people come to expect and accept the prevailing culture such as high workload, poor communication and interdisciplinary collaboration. They talk of creating a new tipping point in intensive care, citing Gladwell's (2000) book *The Tipping Point* where large scale change can come from seemingly small or inconsequential forces. Critically resisting the status quo by speaking out and together, the nurses have the potential to create their own tipping point and change the culture of the unit to an environment of collegial support and effective communication with each other (McEldowney, 2003). Beginning this process of seeking change by creating the communicative space gives voice to the concerns participants have for their nursing care and breaks this collective silence.

Reconnaissance as a change process

As described in the introduction of this thesis, reconnaissance is the crucial developmental stage of action research which sets up the possibilities for action and change to take place. Within this process of reconnaissance, transformation began to take place as participants together defined the core values which underpin their nursing care. The second stage of this research enabled the nurses to discuss and reach agreement on fundamental issues of their practice, thus highlighting areas for change (Morton-Cooper, 2000, Nolan & Grant, 1993). The reconnaissance phase of the traditional action research project in the literature often seems to be written as the preliminary of the main event which is the action phase. The importance of defining of the core values does not receive the same attention as the actual process of the action change event. Kemmis and McTaggart (1988a) define reconnaissance as discussion and reflection in the group situation which reconstructs meaning of the situation giving the basis or reference point for further planning. They state:

> Reflection is descriptive, it allows reconnaissance building a more vivid picture of life and work in the situation, constraints on action and more importantly, of what might now be possible, for the group and for its individual members as actors committed to group goals (p.13-14).

What needs to be emphasised is that in this research change began with the first group meeting, with the creation of the communicative space. With each new voice, breaking their silence and giving a true account of their practice and what guides and constrains it, the participants discovered more about each other and themselves. Parse (1995) in the Theory of Human Becoming talks about transformation through humans forging "unique paths with shifting perspectives as a different light is cast on the familiar" (p.7). By looking at their work in a new light the participants' perspective shifted and they began to look at their practice and their work situation differently, more aware of what was happening around them and also of how they themselves react to each other. By collectively defining the values and beliefs which guide their

practice they were united with a common purpose of giving the best possible nursing care for their patients.

In the many discussions with the nurses when describing the action research process it was depicted as a spiral shaped model. This spiral model led on to the adoption of the New Zealand koru as the model to depict the reconnaissance phase of the action research process in this research. The use of this koru is also consistent with other nursing projects in the ICU. The koru which begins new life as a tightly furled frond develops into a ponga fern (Figure. 4). The illuminated area of the koru represents the reconnaissance phase as a part of a future ongoing action research project.

Fig.4 The illuminated koru as the reconnaissance phase of the action research spiral.

(Note: photograph gifted by N. Rowe ©)

The koru is the centre of the fern and represents the unfolding of new life, rebirth and continuance. It represents renewal and hope for the future. as the koru is the beginning of new life, new growth, this research as the reconnaissance stage of a future action research project is

the foundation and heart which defines, guides and supports all future action. The multiple fronds within the koru may also reflect the complexity of nursing in the ICU and the nurses' relationships with each other, the patients, the patients' family/whanau and the doctors. As the koru begins to unfurl the new leaves appear. These leaves or fronds represent the ideas and possibilities for future action research projects, while still embedded in the reconnaissance but reaching towards new beginnings and change (Figure 5).

Fig. 5 The possibilities for action research emerging from the reconnaissance.

The thesis focused on the reconnaissance phase of the project as this was the first time these nurses had come together through the creation of a communicative space to talk about their practice. It was starting at the 'grass roots' learning how to come together as a group and define what is important in their practice of ICU nursing. It was crucial to take time to get this right as this reconnaissance will now provide the foundation for future action and practice development. The processes of reflection and gaining consensus will be repeated for future projects to ensure the foundation provided by the initial reconnaissance remains robust and relevant.

Final reflection

The revised questions for this research were: How do ICU nurses wish to care for their patients and what are the tensions that exist between their stated values and beliefs and the reality of clinical practice within the context of the intensive care setting?
How can the nurses develop their practice to reduce these tensions and improve patient care?

The openness and honesty of the nurse participants in this project has afforded a deeper understanding of the care they give their patients in the ICU and also what influences and guides their nursing care. By defining their collective core values of ICU nursing practice they have been able to identify the tensions that exist in the reality of practice. By critically reflecting on these tensions with the core values as a reference point they were able to reach consensus on where there is a need for practice development.

Conducting this study with the nurses in ICU has not only given me a deeper understanding of ICU nursing practice, but also a deeper understanding of myself and where I 'fit' in the ICU. My role as research nurse had caused me to feel removed from ICU, isolated from everyday practice and also from the nurses. This isolation was due to several factors; no longer wearing a uniform, having an office away from the floor, no longer taking a clinical load, being neither clinical nor management and also the nurses not really understanding what my role entailed. Not long after I commenced the role, I was asked now that I was doing research, was I still going to be doing any nursing? On another occasion my presence in the unit was explained to a patient's relative that I used to be a senior nurse, now I was just doing research. These two incidents dismayed me. It had never occurred to me that I might no longer be regarded as a nurse. Two purposes of my role were to foster a research environment in the unit and to get nurses interested in research. I made a concentrated effort to have a presence on the floor and encouraged nurses to question their practice whenever the opportunity presented itself. Facilitating this study with the nurses and writing and reflecting has allowed me to reclaim myself as an ICU nurse and feel part of this unit once more. During the data collection and analysis it was easy to become immersed in the context

and it was not until I began writing this thesis that I could see the value of what has occurred. This thesis is not the end of the study, it is the beginning. It has enabled us as nurses to define our practice, and rather than be entrenched in the impossible, to look ahead at what might now be possible.

Appendices

Iwi Affiliations:
Tainui te Waka
Raukawa, Waikato, Maniapoto te Iwi

Hapu
Ngati Whakatere,
Ngati Apakura.

Member:
Kaumatua Kaunihera

Date: 21st July 2004

Administrator
Ethics Committee

Tena Koe

Re: Short Project Title: Nurse Action in the Intensive Care Unit.
Disruption to patients sleep.
Practice change through action research.

I have received a request from researcher Mary La Pine for a further letter of support for the above project.

I am happy to acknowledge support for this project from a Maori perspective within the [redacted] area.

No reira

Noho ora mai
Na

22 July 2004

Waikato Ethics Committee

PO Box 1031
HAMILTON
Delivery Address:
C/- Ministry of Health
Level 3, BNZ Building
354 Victoria Street, Hamilton

Telephone (07) 858 7021
Facsimile (07) 858 7070
Email juliana_smithells@moh.govt.nz

Waikato Ethics Ref No: WAI/04/07/062
Please include the reference number and study title in all correspondence

Mary La Pine
C/- Intensive Care Unit
Waikato Hospital
Private Bag 3200
HAMILTON

Dear Mary

Night shift - the domain of nursing: developing practice through action research.

Investigator:	**Mary La Pine (student MA (nursing)**
Supervisor:	**Dr Ken Walsh**
Reference:	**WAI/04/07/062**

Thank you for submitting this proposal for ethical review. It was considered by the Waikato Ethics Committee at its meeting on 21 July 2004. The Committee appreciated you being present at the meeting to answer questions about the study.

The above study has been given ethical approval by the Waikato Ethics Committee.

Approved Documents
- Information Sheet; June 2004
- Consent Form; June 2004
- Transcriber confidentiality agreement
- Independent observer confidentiality agreement

Certification
The Committee is satisfied that this study is not being conducted principally for the benefit of a manufacturer or distributor of a medicine or item in respect of which the trial is being carried out. This certification is for the purposes of the Injury Prevention, Rehabilitation and Compensation Act 2001.

Accreditation
This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Progress Reports
The study is approved for its duration (12 months). An annual progress report is due in July 2005. A final report is required upon completion of the study. Please note that failure to complete and return this form may result in the withdrawal of ethical approval. A report form is available for this purpose and is enclosed with this letter. A Word document version is also available should you prefer to complete it in this way.

Amendments
All amendments to the study must be advised to and approved by the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

Further use of data
Please note that if the data collected in this study is to be used in another study at some time in the future, then further ethics approval must be obtained for that study at that stage.

General
It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your study.

Yours sincerely

Peter D Allan
Chairperson

cc Dr Ken Walsh

Dear colleague

I am inviting you to participate in a study, which will be looking at night shift in our ICU.

Night shift is often regarded as a difficult shift, which can be as busy, noisy and demanding as during the day. It is also the one shift where we, as nurses, can care for our patients with less interruption from other health professionals. Night shift is essentially a nursing domain.

The research will involve two phases.
Phase one will involve a series of focus groups which will enable us to define what we do as nurses on nights, why we do it and what effect it has on our patients.

Phase two will involve the formation of an action group, to define areas for developing our nursing practice. This will involve devising and implementing action plans. This will be a cyclical process of action, observation, evaluation and review.

Please contact me for further information.

Mary La Pine

Work - ph: xxxxxxxxxxxxx Home – ph: xxxxxxxxx

INFORMATION SHEET

NIGHT SHIFT – THE DOMAIN OF NURSING:

DEVELOPING PRACTICE THROUGH ACTION RESEARCH

RESEARCH FACILITATOR: Mary La Pine, MA (Nursing)
Candidate, Graduate School of
Nursing and Midwifery, Victoria
University of Wellington.

Wk Ph: xxxxxxx
Hm xxxxxxxx

SUPERVISORS: Professor Ken Walsh
Ph: xxxxxxxxxx
Dr Rose McEldowney,
Ph: xxxxxxxxxxxx
Graduate School of Nursing and
Midwifery, Victoria University of
Wellington.

REASON FOR RESEARCH

Night shift in the Intensive Care Unit can often be as busy, noisy and demanding as during the day. However, during the night there is less intervention and intrusion by outside personnel and we, as nurses, are predominately responsible for provision of patient care. Night shift is essentially a nursing domain. This research proposes to enable nurses to join together, through the process of critical action research, to define and examine our practice on night shift. It proposes to develop nursing practice within the paradigm of nursing philosophy of care, with the optimal care of our patients, always as a focus. The group process will enable nurses to work together, through discussion and mutual agreement, on the issues that govern and define our nursing practice on night shift.

The purpose of this study is:
To understand and define what we do as nurses on night shift.
To understand why we do it.
To understand the effect it has on the patients.

To acknowledge and define where there is need for practice development.
To define barriers to the proposed development.
To form strategies – methods which will facilitate the practice development.
To action, observe, evaluate the development, replan etc. This is a cyclical process of continual practice development and evaluation.

This research is being undertaken as a four-paper thesis to fulfill the requirements of the MA in Nursing at Victoria University, Wellington. This research has no connection with my role as Research Nurse in the ICU and is for my own personal study.

DESIGN AND PROCESS

Participation in this study is entirely voluntary and you may withdraw at any time. If you wish to participate in this study you will be required to sign a consent form.

PHASE ONE of the study will consist of a series of focus group meetings open to all registered nurses in the ICU. These will be loosely categorised into approximately groups comprising of permanent night staff, rostered day / night staff, and CNLs / coordinators. There will some overlap of roles but the purpose of the groups is to ensure all nurses have the opportunity to participate. Participants in the focus groups will be asked to define what we do as nurses on night shift, why we do it and what effect it has on the patients in our care. This will be done as a step by step process and the issues that emerge from each group will be grouped into themes. Information will be given by each nurse on individual written cards which will then be pooled together into similar themes for further discussion as a group. xxxxxxxxxxxx, as an independent observer, may be present during the meetings taking notes. She is not involved in the study and no longer working in the ICU. This is to ensure that all information is recorded in the event of tape failure or poor sound quality.

PHASE TWO will begin with the formation of the action group. This will be comprised of members from each group who are willing to work together to define from the focus group themes, where there is a need to for practice development. The group will develop strategies towards this proposed change and implement it into practice. The change will be observed, and evaluated with further discussion, reflection and decision-making at the next meeting. In addition to group meetings, the study participants will also have informal, reflective, individual discussion/interviews with me.

The group meetings will be audiotaped. The tapes will be transcribed either by myself, or an independent typist who will be required to sign a form of confidentiality. The tapes will be erased after 10 years but the transcripts will be kept indefinitely. xxxxxxxxxx will also sign a form of confidentiality.

Informal reflective discussion documented in the form of field notes will be written as soon as possible after the discussion. With your permission these discussions will also be audiotaped to ensure the field notes are accurate. The individual interview tapes will not be transcribed word for word. The field notes will be available for you to verify and/or edit. The individual reflective discussions are for you to reflect upon your personal situation and development. These will be confidential between you and myself. However, you may also use this as an opportunity to provide information for the group discussion, if you do not feel confident or safe to speak within the group situation. I will introduce the relevant information into the group process, maintaining your anonymity.

Confidentiality will be preserved through the use of pseudonyms when necessary and you will not be identifiable in any reports of the study. All raw data will be kept in a locked filing cabinet. The meetings will take place in a location agreed on by the group. Participants will agree that the meetings will be a safe, non-judgmental forum where no-ones ideas or opinions are more important than any one else's, regardless of hierarchical status. Participants who have senior roles within the ICU will agree that information revealed in the group will have no adverse consequences for the participants involved and their future career will not be threatened in any way. Confidential information revealed in the group process will not be discussed outside the group.

Participating in this research will have no negative impact on your professional work life. I have no clinical or managerial role within the ICU and therefore have no influence on your present or future career.

This study has been approved by the xxxxxxx Ethics Committee.

Please feel free to contact me with any queries or concerns you may have about this study.

Mary La Pine

CONSENT FORM

NIGHT SHIFT – THE DOMAIN OF NURSING:

DEVELOPING PRACTICE THROUGH ACTION RESEARCH

I …….consent to be a co-researcher/participant in this study. I am aware that this study is a requirement for the MA in Nursing, four paper thesis being undertaken by Mary La Pine. I am aware that this study has no connection with any other research being conducted by Mary La Pine in her role as ICU Research Nurse and that participating in this study will in no way affect my working conditions in the Intensive Care Unit.

I am aware the meetings will be audiotaped and the tapes will be kept for a period of ten years. I am aware that informal reflective discussion will be documented through field notes and I may be asked for verbal permission for the conversation to be taped. I am aware that the tapes will not be transcribed word for word but will be used to ensure accuracy of the field notes. I am aware that if I do not feel confident or safe talking in the group, I may give Mary information that I wish to be incorporated into the group discussion, without revealing my identity. I agree not to disclose any confidential information revealed and discussed during the meetings.

I am aware that my participation in this study is entirely voluntary and I may withdraw from the study at any time with no negative consequences. I agree that information revealed in the group will have no negative consequences for the participants involved and their future career will not be threatened in any way. Any personal information I give will be confidential and I will be unable to be identified in any reports of the study. I am aware that confidentiality and anonymity will be preserved though the use of pseudonyms and all raw data will be stored in a locked filing cabinet. I am aware that the group meetings may be documented by xxxxxxxxxx as an independent observer and who has signed a form of confidentiality.

I consent to the taped information from the group meetings being transcribed by Mary La Pine or an independent typist who will be required to sign a form of confidentiality.

I have received an information sheet about the study and am satisfied with the explanations I have been given. I have had a chance to discuss it with other people if I so wished. I know whom to contact if I have any queries or concerns about the study.

I consent to participate in the focus group only. Yes No (please circle)

I consent to participate in the focus group and action group. Yes No

I consent to take part in the action group only. Yes No

Participant's Signature……

Participant's Printed Name…….

Date…….

Researcher's Signature……

Researcher's Printed Name…….

NIGHT SHIFT – THE DOMAIN OF NURSING:

DEVELOPING PRACTICE THROUGH ACTION RESEARCH

Transcriber Confidentiality Agreement

I…….agree that all information I hear when transcribing the tapes from the above study, will remain confidential and private. All data files will be copied to disk for the researcher and deleted from my computer. I will not reveal any information to any person other than the researcher, Mary La Pine.

Typist's Signature……

Typist's Printed Name…….

Date…….

Researcher's Signature……

Researcher's Printed Name…….

NIGHT SHIFT – THE DOMAIN OF NURSING:

DEVELOPING PRACTICE THROUGH ACTION RESEARCH

Independent Observer Confidentiality Agreement

I…….agree that all information I hear when documenting the focus group and action group meetings during the above study, will remain confidential and private. All data files will be copied to disk for the researcher and deleted from my computer. I will not reveal any information to any person other than the researcher, Mary La Pine.

Observer's Signature……

Observer's Printed Name…….

Date…….

Researcher's Signature……

Researcher's Printed Name…….

I.C.U ACTION RESEARCH PROJECT

REFLECTIVE PRACTICE

Thank you all for your participation in the values and reality focus groups looking at our nursing practice in ICU.

The identified themes in both groups have been presented back to you and will form the basis of the next phase of the project. This is a composite document of each participant's thoughts and feelings of practice in ICU and of where the reality doesn't meet the ideal. The themes have been identified and developed from the group discussions and individual interviews.
It is important for each participant to be able to situate her/himself in the data. We have talked about the We, Us and They. We now need to be more self-reflective and look at the 'I' in practice. Where am I in these themes, how do I relate to these situations and relate and react to others?

It is important to examine these themes and experiences of our everyday practice, which is underlying or taken for granted.
The difference between ***what we do*** (theories-in-use) and ***what we say we do*** (espoused theories) is not always the same and therefore not always open to conscious scrutiny. Reflective practice can enable us to become aware of our theories-in-use, ***what we do***.

Types of reflective practice

Schon (1991) has identified two types of reflection:

Reflection-in-action occurs while practicing and affects the decisions you make and the care you give.

Reflection-on-action occurs after the event and adds to the development of your skills in practice.

How to reflect

One of the best ways to reflect is to look at the experience/s and describe it in writing.
You may like to consider questions such as:

What was I trying to do?

What were my values and beliefs that underpin the way I acted?

Did my beliefs match my actions?

What internal and external factors were affecting my behaviour?

How did my behaviour affect others?

How did my behaviour affect me?

How do I feel about what happened?

How do I know if my behaviour was effective or not?

What meaning do I make of this experience?

Could I have done things differently?

What worked well and what would I like to do more of?

What would I do differently next time?

What has changed as a result of my reflection?

Please use the following pages for your thoughts. I will be away from October 14th until November 20th. I look forward to catching up with you on my return and continuing the next phase of the study.
Regards
Mary

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