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An exploration of the nurse's experience of nursing the outlier patient in the acute care setting: Using a hermeneutic phenomenological approach

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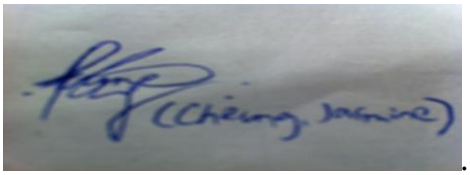
DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed: .....  . Date:.30th October 2013

ABSTRACT

The aim of this study was to explore the nurse's experience of nursing the outlier patient. Outlier patients are currently experienced by nurses nursing within acute care settings when patients end up in the "*wrong bed …in a ward inappropriate for their condition… (and they) are less likely to receive the specialist medical and nursing attention that their condition needs*" (Garling, 2008, p. 990). An example of the outlier patient would be a renal patient placed in a gynaecology ward.

Literature on nursing the outlier patient is scant. Available literature illustrates that the occurrence of outlier patients is a visible consequence of bed shortages within New South Wales (NSW), Australia. However, to many nurses an outlier patient is a patient they are required to nurse in a ward that is not suited or equipped to address the specific needs of the outlier patients, rather than the positioning of a patient as a consequence of political actions. The presence of outlier patients within the wards is having a direct but unacknowledged effect on the experience of nursing within the acute care setting. While some attention has been devoted to the occurrence of outlier patients, there is none that addresses the experience from the perspective of the nurses who are in the frontline.

Hermeneutic phenomenology highlighted a humanistic way of understanding the phenomenon of nursing the outlier patients. Eleven registered nurses who had been working in a public hospital in New South Wales within the last two years, and who had the experience of nursing **outlier patients** were recruited to participate in face-to-face in-depth interviews. The digitally recorded interviews were subsequently transcribed verbatim by the researcher for the purpose of analysis.

Analysis was conducted through a process of interpreting participant's interview transcripts initially word by word, then sentences and ideas until significant aspects of their experience were determined and clustered into themes. The themes were further organised and expressed using a "*phenomenological orientation*" as described by van Manen (2001, p. 97). Interpretation of participant's transcripts and the analysis process was also informed by

Heidegger's (1962) Being and Time, together with Merleau-Ponty's (2005) and van Manen's (2001) discussion on temporality and spatiality.

The study findings revealed that each nurse has her speciality construct developed from nursing in a specialised work environment. The nurse has normalised her experience of specialty nursing however, this normalised construct is disrupted as the nurse is nursing outlier patients. Some nurses were becoming less capable of 1) synchronising nursing rhythms, 2) practising with disease and/ or condition specific familiarity, 3) prioritising each nursing task, 4) predicting, and 5) practicing with inter-professional relationality as they were nursing the outlier patients when compared to nursing specialty-appropriate patients. While the nurse continued to nurse in the same work environment for both outlier patients and specialty-appropriate patients, her understanding of the work environment was altered by her experience of nursing outlier patients. Such disruptions disconnected the nurse from her sense of being an integrated part of the system and compounded the already-existing pressures that nurses experience in the current economic rationalist work environment.

GUIDE TO READING THIS THESIS

…Bolded and underlined… text is used for highlighting significant ideas, terms or issues that I (as the researcher) believe require special attention.

Bolded …text is used for highlighting important terms or issues that require special attention or further elaboration and clarification.

…Italic… text is used for my reflection and my voice as a nurse and as a researcher.

" …*Italic text* …" within double quotation marks is used for quoting literature.

Indented …Normal text... is used for quoting participant's excerpts.

An individual nurse will be presented as **she**, where she is to be read as he/ she throughout the thesis. This decision is based on the knowledge that nursing remains predominantly a female occupation, with only 9.6% of employed nurses in the year of 2009 in Australia being males (Australian Institute of Health and Welfare, 2012). In addition, where appropriate the pleural version has been used (them, they, their) to avoid the clumsy nature of he/she/ him/ her throughout the text of the thesis.

ABBREVIATIONS

Clinical Nurse Consultant	CNC
Clinical Nurse Educator	CNE
Clinical Nurse Specialist	CNS
Diagnosis Related Groups	DRGs
Echocardiogram	ECHO
Electrocardiogram	ECG
New South Wales	NSW
Peripherally Inserted Central Catheter	PICC

PREFACE

Marie's story — "It's very frustrating!"

"(An outlier patient is) anyone that is admitted under another specialty.

When you've got an outlier, you are not a specialist in their area. So you probably do fumble along a little bit. And then when you come up for air, you think I'd better try to get some information from the other specialty area. [You question] should I be doing something different with this patient? I think that's probably the experience. You do what you know, but sometimes you don't know what you don't know...

Me in particular I guess, [I] like to feel like they have done the best by the patients. And if there is a little bit of doubt that my knowledge might not be what it should be about a certain condition, you probably feel a bit dissatisfied at the end of the day because you think maybe I could have done a bit more for that patient that's not in my specialty. So there's a bit of probably being unsure about, your care of that patient which then leads you to feel a bit dissatisfied.

I think a lot of nursing time is wasted trying to get outlier patients reviewed or looked after properly... All this [interaction] takes time. You are not looking after your patient. So I think there is a lot of time wasted...you can see that all this nursing time takes them - number one away from the patient but the second thing is what you rang them [another nurse in the outlier's specialty] for you haven't had resolved then or either it just delays your care for that patient... This is a small example. But if you can imagine if that builds up overtime...

It's very frustrating !"

CONTENTS

LIST OF FIGURES

CHAPTER 1.

INTRODUCTION

The focus of this study is the nurse's experience of nursing the outlier patient. The study aims to gain a deep understanding of what it is like for nurses who are caring for outlier patients. Outlier patients are defined as patients who are admitted to a ward where the ward specialty mismatches the patient's disease and/ or illness condition. The Report of the Special Commission of Inquiry regarding acute care services in New South Wales (NSW) Public Hospitals refers to outlier patients as those who were "*not in a home ward*" and were being "*managed outside of the speciality"* (Garling, 2008, p. 991). Continuation of policy and organisational decisions permits patients to be admitted to wards that are not equipped for the patients' specific acute-care-needs. One major hospital in NSW reported that over one-sixth of the allocated "*sub-specialty ward beds*" are occupied by outlier patients (Sydney South West Area Health Service, 2006, p. 75). As a nurse nursing in NSW I was facing the emergence of outlier patients that I felt was a consequence of government and organisational policy decisions that had an impact on my nursing practice. This was the impetus for the study: the point at which I decided to find out how this phenomenon was experienced by other nurses. I had personally found the experience of nursing outlier patients to be frustrating.

In this study, I am writing from both the position of a researcher and that of a registered nurse in NSW. As a researcher, I inquire into and clarify my experience of nursing with the aid of current literature. In postmodern research, researchers are deemed to be valuable guides to inquiry (Lopez & Willis, 2004). Detached researchers in modernist research have been critiqued as having failed to capture the reality of nursing practice (Stevenson, 2005). Being a registered nurse and currently employed in a public hospital in NSW, I share many characteristics with the research participants and therefore I am not detached from the situation. Rather I consider myself as an attached researcher who is embedded in nursing in a public hospital in New South Wales similar as my research participants.

The purpose of this chapter is to provide background information on how the phenomenon of outlier patients has emerged leading to the need for nursing them and its subsequent effects on nursing practice.

1.1 Reflecting on my experience of nursing

I am a registered nurse who has been nursing in an acute care setting in a public hospital in NSW for five years. After completing a Bachelor of Nursing from the University of Sydney, I commenced a New Graduate Entry Program in a major teaching and country (rural) referral hospital in the Sydney Metropolitan area and began my nursing career in an acute care setting. During the New Graduate Entry program, I was rotated from one ward to another three times within a year. I gained nursing experience and knowledge of various clinical skills, including both general skills that were applicable across the three wards, and specific skills that were applicable to patients with particular clinical specialty conditions in a particular ward only. For instance, managing chest pain is an example of a general skill, whereas removal of vaginal packs in a gynaecology ward is an example of a specific skill applicable in the gynaecology ward only.

While reflecting on my experience and looking at the potential research question it became apparent that an understanding of what it means to be a nurse in NSW needed to be addressed here. Specifically 1) What is an acute care setting? and 2) What are generalised nursing and specialised nursing?

1.1.1 What is an acute care setting?

An acute care setting refers to a place where patients are nursed "*for a brief but severe episode of illness, for the sequelae of an accident or other trauma, or during recovery from surgery*" with the aid of "*complex and sophisticated technical equipment*" normally for a short time period (Anderson, Keith *et al.*, 2006).

In NSW, acute care services in the public hospitals are monitored by NSW Department of Health and the Guardianship Tribunal (Garling, 2008). These acute care settings fit within a complex set of health care services, including *"health promotion, disease and illness prevention, ambulatory care, acute care, tertiary*

care, home health care, long-term care, and hospice palliative care" (Finkelman & Kenner, 2012, p. 207). The acute care settings is one of the services within these ranges of services on the continuum of care.

A single patient may go through various services on the continuum of care, and therefore may be transferred from one ward to another ward within one acute care setting. For instance, a trauma patient will be initially admitted to the emergency ward, then to the intensive care unit for immediate treatment for life-threatening conditions, and to a medical ward or surgical ward for monitoring once patient's condition becomes more stabilized. Together these areas represent an array of hospital services within the acute care settings that are designed to address all the acute care needs of the NSW patient population (Finkelman & Kenner, 2012).

For the purpose of this study, **acute care setting** refers to any ward within an acute care hospital within the public healthcare sector in NSW. Historically, a hospital was a boundary-less place or structure where patients who were admitted with various conditions were grouped together anywhere under the same roof (Thompson & Goldin, 1975). The evolution of the hospital structure demanded the set-up of an administrative structure of the hospital. This administrative structure of the hospital, also known as the organisational structure, is responsible for lowering the risk of error and controlling hospital productivity (Jones, 2007; Roussel, 2012).

One way of enhancing hospital productivity is the emergence and adoption of the Classical Theory. The Classical theory suggests that division of work into tasks and repetition of the task improves the organisational design (Jones, 2007), in which an organisation defines tasks, rules and regulations in detail (Finkelman & Kenner, 2012). With the rapid development of scientific knowledge and evolving economic complexity, a hospital has changed from an open-ward-area to multiple wards that are organised to cater for a variety of new specialties along with the development (or creation) of new units (Chaboyer, Dunn *et al.*, 2000; Russell, 1990). Curtains and walls have signified a boundary for distinctive wards within the hospital.

Even though hospital wards are often referred to as "*nursing unit*" or *inpatient unit*" (Thompson & Goldin, 1975, p. xxvii), the division of hospital ward areas into multiple wards was based on a reductionist approach aligned with the medical organisation of care. From the medical point of view, systematic reductionist approach is a "*powerful tool*" for generalising and understanding complexities in the human body and disease process (Engel, 1989, p. 49) and its use has been widely reported in the literature (Beresford, 2010; Freud & McGuire, 1999; McCarthy & Rose, 2010). The human body as a whole can be systematically seen as parts using three types of reductionism; these are: 1) ontological reductionism, 2) methodological reductionism, and 3) epistemic reductionism (Beresford, 2010, p. 721). With ontological reductionism, the human body can be seen as molecular interactions, which is now particularly seen in genetic or hormonal actions of the body (Beresford, 2010; McCarthy & Rose, 2010). In terms of methodological reductionism the human body is described as a number of systems each consisting of different organs (Beresford, 2010; McCarthy & Rose, 2010), such as lungs and kidneys. Progressing to epistemic reductionism, the theory of one system is being seen as applicable across different systems in the body, such as the fight-or-flight stress responses that involves the sympathetic nervous system, hormonal system and muscular system (Beresford, 2010; McCarthy & Rose, 2010). Following the reductionist approach, the nurses' work environment is set up with reductively derived knowledge by the organisation rather than practical knowledge by the nurses (Lawler, 2006). Rather than nursing with a whole body focus in an open ward area, nurses are nursing a particular organ or body system within the organisation's imposed hospital ward division.

In summary, an acute care setting has been established as a work environment that consists of multiple wards, with each ward focusing on a particular disease or illness condition. Nurses are "*frontline workers*" in the acute care setting (Page, 2004, p. 29), where nurses are placed into the ward in relation to their assigned work tasks (Jones, 2007). The responsibilities of a nurse, from the organisational perspective, is to complete the work tasks as per the context of rules set by organisational requirements (Pearson, 2003). Given the hospital ward division (as seen in the NSW Health system), the nurse is expected to practice specialised

nursing in a particular ward, hence leading to the discussion of specialised nursing versus general nursing.

1.1.2 What is general nursing and specialised nursing?

In order to reach some understanding of the phenomenon of nursing the outlier patients the terms **general** and **specialised** nursing need to be explored. As a starting point, I traced back to the trend of establishing career structure in nursing. There are two major stages in the career structure and development in nursing leading to general nurse qualification, including 1) nursing training leading to general nursing certification in hospital nursing schools, and 2) nursing education in the tertiary education sector. Both stages in the education for nurses marked the preparation of qualified registered nurses as "*generalists*" (Russell, Gething *et al.*, 1997, p. 19)— where the nurse develops "*capacity and authority to practice competently" in all healthcare settings* (Affara, 2009, p. 6).

The first stage of establishing career structure in nursing involved the development of nursing training leading to general nursing certification in the hospital-based nursing schools. Traditionally, nurse training heavily relied on the medical professions, where practitioners provided basic training in nursing in hospital training schools (Nurses Registration Board, 1989; Purcal, 2008). Despite the Australasian Trained Nurses' Association being founded in Sydney in 1899, the nursing profession remained "*controlled*" by medical professionals for many years (NSW Nurses and Midwives' Association, 2009, p. 11).

In the year of 1923, the NSW Government took over "*the system of certification for trained nurses*" (Nurses Registration Board, 1989, p. 9) and established the requirement of general certification for nurses. It was not until 1924 that NSW Parliament passed the Nurses' Registration Act to provide legal registration and regulation of nurses (Nurses Registration Board, 1989). The Nurses Registration Board was set up with power to *"... appoint examiners, conduct examinations, issue certificates of registration, and keep a register of those nurses who have qualified for registration*" (NSW Legistlative Assembly, Hansard, 5th December, 1923, p.3048 cited in Nurses Registration Board, 1989, p. 2). The Nurses Registration Board of NSW granted the first registrations of nurses in the year of

1926, where nursing registration was categorised as general nurse, midwifery nurse, mental nurse and/or infant's nurse (Nurses Registration Board Minutes, 1926, vol.1, p.59 cited in Nurses Registration Board, 1989, p. 37). This outlines the emergence of the general certification for nurses in NSW.

The second stage of establishing the career structure in nursing saw the trend from general nursing training in hospital nursing schools towards nursing education in the tertiary sector, and continued the preparation of registered nurses as generalists. Since 1977 group and regional schools of nursing developed where the schools of nursing began its contractual arrangement with colleges of advanced education (McMillan & Dwyer, 1989). Throughout the 1980s, there was a shift in various states from hospital based training to the tertiary sector (Nurses Registration Board, 1989). Increasing literature pointed to the inadequacy of hospital-based general nurse training to meet the needs of the evolving health service (Appel, Malcolm *et al.*, 1996; Francis & Humphreys, 1999; Levett, 2005). A political controversy arose in NSW during 1976. The hospitals were having difficulties in recruiting and retaining nurses, and in ensuring the education standard was sufficient to meet the changing health-care needs (Greenwood, 2000; Russell, 1990). The Nurses Registration Act of NSW "*prohibited a registered nurse practising as a nurse in any capacity other than that in respect of which she is registered*" (Nurses Registration Board Minutes, 1976, vol.8, p.457 cited in Nurses Registration Board, 1989, p. 94). The NSW Deputy Premier and Minister for Health, the Hon. R.J. Mulock responded to the controversy by pointing to the employer's responsibility to *"…determine adequacy of nurses, qualifications and experience for the work to be performed*" (NSW Legislative Assembly, Hansard, 10th April, 1986, p.5765 cited in Nurses Registration Board, 1989, p. 1). Employer's responsibility, including the management of nursing personnel and the organisation of nursing work by management at the organisational level have led to "*superior-subordinate relationships*" between nurses and the hospitals (Creegan, Duffield *et al.*, 2003, p. 211). As a consequence of the apparenticeship system, the service needs of the hospital always took precedence over the learning needs of the nurses (Russell, 1990). Hospital trained nurses therefore were no longer adequately educated to perform the nursing roles developing in NSW

hospitals. There was a call for a change from hospital-based training to academic-based education. In 1981, the nursing training was moving to the tertiary education sector in NSW (Borbasi & Chaboyer, 2006). From 1985, all "*basic nursing education*" in "*hospital-based schools of nursing*" in NSW has transferred to "*colleges of advanced education*" (Nurses Registration Board, 1989, p. 105). The transfer of nursing education to the university sector was completed across Australia by the year of 1993 (Funnell, Koutoukidis *et al.*, 2009; Heath, National Review of Nursing Education (Australia) *et al.*, 2002; Nurses Registration Board, 1989; Russell, Gething *et al.*, 1997). Nursing education continued to evolve in line with this new position in the university sector.

Registered nurses become a generalist on completion of the pre-registration programs. Administration of the Register of Nursing in NSW changed from the seven registers: general, midwifery, psychiatric, infants, mothercraft, mental retardation and geriatric nurses; to one register with two divisions. Division A including the registers of general, psychiatric, and mental retardation nurses, and Division B including all nurses who had been trained at the basic/entry level in geriatric, infants and midwifery nursing (NSW Legislative Assembly, Hansard, 10th April, p.5765 cited in Nurses Registration Board, 1989, p. 107). Removal of practice restriction was applied across all nursing areas except for the practice of midwifery (NSW Legislative Assembly, Hansard, 10th April 1985, p.5765, cited in Nurses Registration Board, 1989, p. 107). Midwifery practice was distinguised from other nursing areas in the acute care settings as the skills required to "*provide pregnancy, labour, both and post natal care*" and the skills to "*prescribe scheduled medicines required for practice across that continuum of midwifery care*" are specific to midiwfery practice (Nursing and Midwifery Board of Australia, 2010). There was an assumption that all nursing areas in acute care settings, except midwifery practice, shared sufficient commonalities for coherent nursing education for preparation of a general nurse. In general, nurses learned the anatomy, physiology, pathophysiology and pharmacology that covered the whole human body through theoretical instruction and clinical placements (Australian Nursing & Midwifery Accreditation Council, 2012; Australian Nursing Federation, 2010; Hally, 2009).

The establishment of a nursing career structure in both phases emphasised a general nurse qualification while the study of nursing specialities was available only at post-registration level (Russell, Gething *et al.*, 1997). Nursing specialty, as defined by Russell, Gething *et al.* (1997, p. 11), referred to "*a defined area of nursing practice which requires application of specially focused knowledge and skills*". Nursing specialty expertise was awarded by higher education, in which the nurse obtained post-graduate certificate and diploma, masters and doctorate. Alternatively, nursing specialty expertise was also awarded by clinical experience, in which the nurse obtained post-graduate certificate and diploma offered by the health care sector (Russell, Gething *et al.*, 1997). Since nursing practice in the acute care setting takes place in the clinical environment, this concept of nursing specialty is also known as "*clinical specialty*" (Adams & Bond, 1997, p. 1159). Such concept of nursing specialty or clinical specialty will be termed as **specialty** for later discussion in this study.

Technological advancement has brought changes to the structuring of nursing work and created a drive towards nursing specialisation (Barnard, 1996; Fulton, Lyon *et al.*, 2010; Heath, National Review of Nursing Education (Australia) *et al.*, 2002; Sandelowski, 2000). Nursing specialisation refers to nurses nursing in a specialised ward as per the organisational construct of work environment that is normally biomedically determined according to disease classification or an anatomical systems approach. Therefore specialised merely describes the requirements of the work environment, rather than any recognisable changes in nurse's knowledge. For instance, a nurse working in a cardiac ward may perceive herself as a cardiac nurse (that is, a nurse nursing in a (named) specialised ward) despite her lacking any specific educational qualification as a specialist nurse or specialty nurse.

This apparent overlap in nomenclature has led to my inquiry as to current variations and the titles used by nurses. The confusion of language has led to three circumstances:

1. **A nurse nursing in a (named) specialised ward** (can) refer to any nurse who has fulfilled the Registered Nurse criteria and who is currently

employed as a nurse nursing in an acute care ward. All participants in this study were nursing in a specialised ward.

2. **Specialty nurse** refers to any nurse who has been nursing in the same specialised ward over a period of time, where she has gained specialised knowledge and skills based on her experience of nursing patients with similar illness conditions.

3. **Specialist nurse** refers to any nurse who has gained special knowledge and skills through their experience of nursing in the ward, **and** through formal education and professional development.

To avoid potential confusion between these terms as they are used later in the thesis they are further clarified below.

A nurse nursing in a (named) specialised ward refers to the nurse nursing in a ward constructed with the organisation's specialisation focus. A major driver of specialisation is that nurses are engaging with greater responsibilities in the use of medical technology while retaining the physical skills (Antonio, Baer *et al.*, 2007, p. 260). Despite nurses being the "*primary users*" of technology (Barnard, 2002, p. 19; Fulton, Lyon *et al.*, 2010, p. 286), technology continues to be seen as a scientific progress rather than as an evolution of nursing practice (Barnard, 1996). Technology is being referred to as "*machinery and equipment*" (Barnard & Gerber, 1999, pp. 159, 161), whereas the use of technology is often regarded as "*tasks devolved from doctors to nurses*" (Crocker & Timmons, 2009, p. 53). There is a concern that nursing skills may be replaced and overridden by technology. Sandelowski (1999, p. 201) points out that the notion of "*nursing as technology*" potentially dehumanises human care, and downgrades nursing as to "*work that extended the physician's hand*" (Sandelowski, 2000, p. 65). Barnard & Sandelowski (2001, p. 373) contend that the nursing organisation of care has moved from a human care approach to a "*constant interaction*" with technology.

Advancements in technology mean that nurses are operating equipment that is physical-condition-specific and ward-specific. While some technology is applicable for all patients across various wards, other technology is only applicable for patients in a particular specialised ward. Since the 1960s and 1970s,

technological changes have been associated with the organisation of hospital wards, for instance, cardiac monitors in cardiac wards, dialysis machines in renal wards (Rinard, 1996). An example of nursing specialisation is the operating of dialysis machines, in which the knowledge and skills involved in operating dialysis machines are only applicable in the renal ward.

The continued advancement in technology further influenced nursing specialisation in two ways: 1) raising the need for patient education and 2) leading to the trend of patient centred nursing, where patient is in the centre of care (Crameri, 2006). Person-centred care is a term being used interchangeably with patient-centred care in current literature, where the emphasis is on the person experiencing illness rather than on the disease and illness itself (Hobbs, 2009).

One important element of a patient or person-centred approach to nursing is empowering the individual patients to make informed decisions about their own care (Anderson & Funnell, 2009, p. 280). Therefore nursing with patient centeredness requires the nurse to have the ability to educate patients regarding their illness conditions and their self management activities that will promote their independence post discharge from the hospital. As the aim of nursing is to "*empower the individual to maintain personal integrity, identity, autonomy and self-esteem*" (NSW Nurses and Midwives' Association, 2007), it is questionable whether the education content for patients in one ward can be transferrable to educate patients with a different disease or illness condition in another ward. There is an inquiry as to whether education for general nursing is possible. A nurse nursing in (a named) specialised ward therefore is any 'generalist' practicing general nursing in a specialised work environment.

Specialty nurse refers to nursing "***in a defined area of nursing practice*** *which requires the nurse's application of specially focused knowledge and skills*" (Russell, Gething *et al.*, 1997, p. xiv). Specialty nurses obtain their knowledge and skills through "*various combinations of experience, formal and informal education programs, including* ***but not limited to*** *continuing education and professional development*" (National Nursing and Nursing Education Taskforce, 2006a, p. 4). For instance, a nurse nursing in a cardiac ward who has met the

qualification of a specialty nurse and is recognised by herself, her peers and social groups as a cardiac nurse. *Taking my experience as a Registered Nurse in the Coronary Care unit as an example, I need to fulfil the "purpose of position" requirements in order to make a claim for being a nurse nursing in Coronary Care Unit, where it stated that* "*It is expected that the Registered Nurse in the Coronary Care Unit will work towards and achieve their Advanced Life Support accreditation and other Coronary Care Unit competencies within 6 to 18 months of commencement*" (NSW Department of Health: Sydney Local Health District, 2011). Many of these competencies have devolved from medical tasks over time. For instance, the use of a cardiac monitor is "*technological object*" that is designed to show heart activity and it is traditionally "*conceived of as separate from human purposes*" (Sandelowski, 2000, p. 31). Gaining knowledge and skills that are required for nursing patients in the Coronary Care Unit is an example of experience that leads nurses to claim that they are a cardiac nurse. The nurse's claim as a cardiac nurse implies a claim to special(ist) knowledge.

Although it could be interpreted from the literature that the terms or reference to a nurse nursing in a (named) specialised ward and the term specialty nurse are one and the same (at least very similar) this is misleading because the latter involves education specifically for specialty nursing.

In terms of education, varieties of courses have become available for development of specialty nursing over the years. Specialty knowledge can be obtained through "*post graduate courses, professional development courses, on-the-job training experiences or variety of education programs*" (National Nursing and Nursing Education Taskforce, 2006a, p. 8). Following the shift from hospital based training to university pre-registration nursing programs in the 1990s, post registration education with post-registration specialty education programs have been developed (National Nursing and Nursing Education Taskforce, 2006b).

Compared to the general classification of medical and surgical wards in the nineteenth century (Watson, 1911, p. 114), International Council of Nurses reported that specialty preparation initially involved "*major fields of nursing — medical/surgical, maternal/child health, mental health/psychiatric, paediatric,*

geriatric, and public health/community nursing" (Affara, 2009, p. 5). In Australia, the National Nursing and Nursing Education Taskforce (2006a) has identified 66 areas of nursing practice and referred to them as specialties.

While nurses claim that nursing involves specialty areas of practice and is a profession in its own right, Street (1992) argued that some nurses have accepted the norms and values from the medical profession rather than generating nursing knowledge of their profession. Accepting that medical knowledge and nursing knowledge are both valuable, it is also clear that medical knowledge and nursing knowledge are different (Street, 1992). Medical knowledge focuses on scientism and Freud & McGuire (1999, p. 6) assert that patients' bodies are viewed as machines, on the other hand Rolfe & Watson (2008, p. 489) claim that the nursing model emphases the unique and individual inter-personal relationships.

Specialty nurse is an example of **horizontal career development** that is under-recognised. Horizontal career development refers to the nursing career development from a nurse generalist to a specialty nurse with emphasis on absorbing clinical experiences across a defined area of nursing practice, rather than relying on formal education. In NSW, registered nurses have the options of pursuing their career development through vertical or horizontal career development trend (The concept of vertical career development trend will be later discussed in terms of a specialist nurse on p.25).

Horizontal career development as a specialty nurse in nursing is "*positively perceived by nurses*" (Niebuhr & Biel, 2007, p. 181), yet arguably lacking a form of Government recognition. In NSW, it is arguable that the government fails to acknowledge horizontal nursing career development. Both the career development and salary system encourage nurses to be Clinical Nurse Specialist (CNS), not specialty nurses. Compared to a specialty nurse, CNS status is **more often** recognised by the management in terms of career development. The NSW government suggested that nurses who are "*thinking of specialising*" can consider the attainment of "*Graduate Certificate's in Specialty Nursing*" in order to "*develop as a specialist nurse*" (NSW Department of Health: Sydney Local Health Network, 2010). In terms of the salary system in NSW, in accordance with

the NSW Public Health System Nurses' and Midwives (State) Award, staff categories include CNS and Registered Nurse year one to year eight, but not specialty nurses (NSW Department of Health, 2012). Historically, the salary rate of Registered Nurses was paid in parallel with the years of experience rather than the attainment of formal postgraduate qualifications or informal experiences (NSW Department of Health: Public Service Commission, 2012). By contrast, more recent research conducted in Australia (Pelletier, 2005) and America (American Board of Nursing Specialties, 2006) suggests that "*increase(d) in salary*" is not necessarily the key motivation for nurses to attain post graduate certification. In Australia, "*seeking job satisfaction*" has been identified by nurses as the "*strongest motivating factor*" for postgraduate study in Pelletier's (2005, p. 41) study. Enhancing a "*feeling of personal accomplishment*" is another motivating factor for nurses to obtain the specialty nursing certification (American Board of Nursing Specialties, 2006, p. 7). Rather than exercising direct incentive in promoting the nurses' satisfaction and sense of personal accomplishment, the Government "*provides information on how to take responsibility for your (employees') work satisfaction...*" by outlining "*the process of making choices about work situation...*" (Spencer, 1996, p. 1). The Government claims that it is the employee's responsibility to develop work satisfaction and personal sense of accomplishment, rather than the government's responsibility in providing a work environment that promotes job satisfaction and encourages horizontal career development. In the absence of extrinsic rewards such as increased salary and direct measures to improve nurse's job satisfaction from the Government, the stimulation for nurses to pursue horizontal career development relies strongly on the nurse's personal initiatives and it is unrelated to ones eligibility for nurse registration.

Unlike specialty nurse, a **specialist nurse** is a **vertical career development** that requires the nurse to have both the experience of nursing in a ward and a formal education qualification. International Council of Nurses referred specialist nurse as "*a nurse prepared beyond the level of a generalist nurse and authorised to practice as a specialist with advanced expertise in a branch of the nursing field*." (Affara, 2009, p. 6).

Adding to the establishment of nursing career structure in both educational preparation for general nursing and specialised nursing as discussed earlier in this chapter the evolution of vertical career development in nursing can be traced back to 1943, where the Kelly Committee suggested the reorganisation of the nurses' training in order to increase the professional status of nursing (Nurses Registration Board, 1989). Following the Nurses Registration 1953 Act, five post-basic diplomas, including Ward Sister Diploma, Nursing Administration Diploma, Sister Tutor Diploma, Midwife Tutor Diploma, and Theatre Management and Teaching Diploma were issued by the College of Nursing, Australia in 1957 (Nurses Registration Board Minutes, 1957, vol.4, p.476 cited in Nurses Registration Board, 1989, p. 73). The focus of the vertical career development trend initially had a strong emphasis on educational or organisational career development rather than focusing on an area of clinical career development.

The importance of vertical career development in the clinical area has not been addressed until the much later recognition of the CNS status (NSW Nurses and Midwives' Association, 2008) . CNS refers to registered nurses who have gained relevant post-basic qualifications and work experience in a specific area of nursing. For instance, CNS is defined as a recognised and designated nurse role where nurses have "*relevant post-registration qualifications and at least 12 months experience working in the relevant clinical area of their post-registration qualification;* ***or*** *four years post-registration experience, including three years experience in the relevant specialist field*" (NSW Department of Health, 2008). Despite the position of CNS being a career option for Registered Nurses, the vertical career development towards a CNS requires a *"specialist post-basic (educational) qualifications*" additional to the qualification that led to eligibility to register as a nurse (Nurses Registration Board, 1989, p. 97). Nursing at the acute care setting only requires nurses to meet eligibility for registration. These nurses are being regarded as generalist registered nurse.

The availability of CNS position for qualified nurses is also questionable. In Australia, financial concern is a major factor leading to adjustment to skill-mix (Duffield, Forbes *et al.*, 2005). Skill mix refers to the "*balance or mix of various*

nursing classifications, skills and responsibilities required in particular specialty..." (NSW Nurses and Midwives' Association, 2010a, p. 5). The ratio specified in skill mix often includes positions of Registered Nurse in-general, but does not specify whether those positions should be nurse generalist or nurse specialist. *Reflecting on my own experience as a nurse,* w*hile skill mix models might comprise of all Registered Nurses, I have never encountered nursing in a skill mix model that comprised of all CNSs from my experience of nursing.* One possible reason for the shortage is that there may not be enough qualified specialist nurses available. However, it is reasonable to link the shortage to inadequate funding for the CNS Classification. My inquiry is addressed by Dubois & Singh (2009) who also reported the shortage of specialist nurses. The NSW Nurses and Midwives' Association (2010b) published a union investigation, in which the CNSs expressed job dissatisfaction due to their recurring experience of nursing with "*inappropriate staff ratio*" that comprised "*predominantly junior and agency staff*" in the ward. The number of positions for CNS in a ward is traditionally negotiated and set by the hospital management and government (State Government Victoria, 2001, p. 26). Hence the number of positions is potentially far fewer than the number of nurses eligible for CNS status.

In summary, nursing education has been and continues to be focused on the preparation of generalist nurses. The organisational construction of the work environment, technological advancement and the increasing care requirement from the patients has prompted nurses to develop the perception that they are **specialist** or **specialty** nurse nursing in a **specialised** ward. The preparation for practice has determined the nurse as generalist, whereas nursing practice has shaped the nurse as specialist or specialty nurse nursing in a specialised ward. My earlier reflection on my experience of nursing the outlier patients can be extended in light of this discussion of general nursing and specialist nursing.

During my New Graduate Entry program, I spent six months in the gynaecology ward in my first rotation. On completion of my new Graduate Entry program, I was employed in the gynaecology ward. I enjoyed working there and developed strong relationship ties that made moving to another ward a bit of a challenge. I

adopted the behaviour and work pattern of my colleagues and the medical team on the gynaecology ward. I felt comfortable in the gynaecology ward and over time I felt that I fulfilled what Malouf and West (2011, p. 490) described as "the desire to fit in", where secure social bonds with other staff members were established. I had built my home in nursing in the gynaecology ward, and subsequently, I considered gynaecology patients as being in my ***home ward.*** *I will use the term home ward in later discussion chapters of the thesis as I make reference to* ***patients-in-home-ward.*** *I referred to myself as a gynaecology nurse, by which I meant I was nursing gynaecology patients in a gynaecology ward. This became my perceived norm of nursing.*

My concern for nursing outlier patients did not begin until one busy afternoon, when I overheard my colleague's saying, "Why do they (the bed managers) send this outlier patient to us? This man (male patient) is not supposed to come to my ward and to stay with other female patients. He does not belong to my ward." I discovered that my colleague referred to patients who were not admitted with a gynaecology condition as an outlier patient. Compared to the gynaecology patients, the outlier patients have a different illness condition and treating medical team. This was the moment when I felt strange and wondered, "Why does my colleague call the patient an "outlier patient"? Maybe the term outlier patient actually means more than labelling a patient's condition? What does my colleague mean by saying the patient is not supposed to come to my ward? Isn't every ward the same? If the nurse believed that the patient does not belong to my ward, what will caring for these outlier patients be like?" Having encountered nursing for a number of so called outlier patients, I discovered that nursing the outlier patient tends to be more intense compared to nursing the gynaecology patients. Nevertheless, I believed (perhaps because of my novice registered nurse status) that nursing for the outlier patient should be similar to nursing for any other patients, for nurses 'should' attend to the patients' needs regardless of their conditions and the ward that they were in.

At this point, my belief was shaken as I encountered recurring episodes of nursing for the outlier patients. As I nurse the outlier patients, there is a strong voice in

my head saying that "Perhaps the outlier patients really are not supposed to be here in my ward? I am a gynaecology nurse. This is a gynaecology ward for gynaecology patients only. The outlier patient is different to my patients in my home ward". Despite these feelings I remained faithful to the delivery of optimal nursing for both outlier patients and gynaecology patients; I sometimes doubted whether I had addressed the needs of the outlier patient in the same way as those of the gynaecology patients in my ward. Every time I nursed the outlier patients, I had a feeling that their needs might be better addressed in another ward. This is in contrast to my previous belief where I viewed every ward as the same (pre socialisation and being immersed in the nursing culture). While I delivered nursing for both outlier patients and gynaecology patients in the ward, I found myself constantly comparing my way of dealing with outlier patients against my usual way of dealing with the gynaecology patients. The more I thought about my nursing for the outlier patients, the more I spiralled into stress and worries. This was the catalyst for the study as I am aware that my experience of nursing the outlier patients was likely not to be unique and I began to wonder how other nurses encountered/experienced nursing the outlier patients. This is when my research interest of nursing the outlier patients emerged.

Within the last century, the establishment of career structure and career development in nursing, together with evolution of the organisational structure as hospital ward division have established a **norm** in nursing, where it is typical for nurses to nurse in one specialised ward. The acute care setting exists within the society, where social issues are affecting **acute-care nursing** (Daniels, 2004). Social issues, such as the "*ageing population*", "*emergence of new, expensive technologies*" and "*demand for better quality health-care services*" are causing greater health care needs and costs in the acute care setting, and hence affecting the nurse's work environment (Mitchell, 2010). The nurse's knowledge, skills and experience develop in response to her work environment in the acute care setting. My experience of nursing patients-in-my-home-ward has promoted a successful attunement between my communication system and my emotional system, where I developed fittingness in nursing patients-in-a-home ward (Malouf & West, 2011). Fittingness allows me to learn about patient conditions and subsequent

nursing care which became secondary to successful attunement with nurses and the inter-profession team of the home ward (Malouf & West, 2011). Nursing gynaecology patients in a gynaecology ward therefore can become my norm of nursing as an individual nurse.

It is possible that each nurse has her individual norm of nursing based on her experience of nursing patients with specific disease and/or illness conditions in a matching specialty ward. These patients will be termed as **specialty-appropriate patients** for later discussion in this study.

Societal expectation of nursing forms part of the nurse's experience of nursing in acute-care-setting. The societal expectation of nursing changes overtime. For instance, historically nursing had an ideological image of vocation and being loving and kind (Bolton, 2000; White, 2002). Progressing to the 20th century, Staniszewska & Ahmed's (1999, p. 368) study identified some patients' expectation of the nurse, where the nurse should "*know about my [patient's progress]...provide proper care at all time...and always be there when needed [by patients]*". While these societal expectation of nursing do not define my norm in nursing, the societal expectation of nursing is part of each nurses' experience of nursing in the acute-care-setting. Conversely, while my norm in nursing is not defined by the societal expectation, there is a need to acknowledge the societal expectation of nursing as part of the nurses' experience of nursing in the acute-care-setting.

From my experience of nursing the outlier patients, I became curious about whether current literature described outlier patients and if so how did they describe them? Through investigating literature on outlier patients and uncovering the occurrence of outlier patients, my goal is to research and articulate the significance of nursing the outlier patients.

1.2 How does current literature describe the outlier patients?

Based on current hospital guidelines and reports in NSW, the occurrence of outlier patients have been defined as a misfit between a patient and a ward place. Garling (2008, p. 990) described outlier patients as patients in the "*wrong bed*"

and "*inappropriate ward"*, while Sydney South West Area Health Service (2006, pp. 12, 71) also referred to outlier patients as those who were affected by a "*lack of geographical localization*". Patients who were "*accommodated outside the specialty ward area*", in other words, a patient who "*was being treated in an area of health service that normally treats a different case mix*", might be known as a "*home ward outlier*" (Australian Council of Healthcare Standards, 2006). On the other hand, patients who are not specialty-appropriate patients, and who are being managed outside the specialty, are known as outlier patients. The distinction between specialty-appropriates patients, and "*home ward outlier*" indicates the mismatch between the patients' condition and ward specialty as defined by hospital guidelines in NSW. The specialty-appropriate patient is comparable to my discussion of my (gynecology) patients in my home ward (the gynecology ward) as a sense of fittingness developed through my experience of nursing in a gynecology ward, where this has become my norm of nursing, that is I am a gynecology nurse nursing gynecology patients in a gynecology ward. Outlier patients therefore are any patients who are not patients in the individual nurse's "*home ward*", and are out of the individual nurse's norm of nursing.

In current literature, the concept of nursing the outlier patient has not been clearly established. Over 800 literature references were found with a keyword search using the terms "outlier(s)" and "outlier patients" in the Cumulative Index to Nursing and Allied Health Literature/OVID database. However, the literature that was located emphasised the consequence of outlier patient using statistics rather than considering the nurse's experience of nursing the outlier patients. For instance, the idea of outlier patients has been confused with the concept of Diagnosis Related Groups (DRGs) in the hospital reimbursement scheme as a measuring standard for patients who are statistically more costly (Ahrens, 1999; Pirson, Dramaix *et al.*, 2006; Silberstein & Paulson, 2011) and more time consuming (Cots, Mercade *et al.*, 2004; Kjekshus, 2005; Lee, Gracey *et al.*, 2005). While Talerico & Diers (1988, p. 28) attempt to link length of stay with a nursing focus, their notion of "*total nursing time*" remains a statistical measurement for use by organisations to plan nursing work. DRGs and statistical outlier patients

should **not** be confused with the idea of outlier patients as previously discussed in this study because these groupings relate directly to funding, not nursing. Nursing the outlier patient is a phenomenon associated with the occurrence of outlier patients, where they are a construct of the economic rationalist healthcare system. Economic rationalist policies have remained the dominant policy paradigm since the late 1980s (Hancock, 1999; Wynne, 2004) and are still current within the NSW health care sector (Borbasi & Chaboyer, 2006; Forsyth & McKenzie, 2006; Heggen & Wellard, 2004; Willis, Willis *et al.*, 2008). Economic rationalism in healthcare reform, also known as neoliberalism or market liberal reform (Dryzek, 2009), refers to the government's attempts to control healthcare spending in order to maximize efficiency in the hospital system (Willis, Willis *et al.*, 2008). Willis, Willis *et al.* (2008) and Barraclough & Gardner (2008) state that implementation of healthcare policy is subject to economic, institutional and political constraints within an economic rationalist health system.

The NSW Clinical Excellence Commission (2005, p. 45) also describes the occurrence of "*outlier patients*" as a result of combining economic, institutional and political constraints. Institutionally, there is a traditional mismatch between bed capacity and the demands placed on them. The lack of flexibility in controlling the number of beds in each specialty in a hospital according to volume required by patient activity has caused the occurrence of "*outlier patients*" (NSW Clinical Excellence Commission, 2005, p. 45). The NSW Clinical Excellence Commission (2005, p. 45) suggests that unless bed occupancy rates are strictly controlled and reduced, the number and incidence of outlier patients will continue to increase as occupancy rates increase. Despite hospital occupancy rates having decreased slightly in the last decade, the current occupancy rate averaged at 89.1% in the NSW public hospital system (NSW Department of Health, 2011a, p. 215). This level was seen to be an alarming figure compared to the recommended 85% from the World Health Organisation and current medical perspective to reduce the high occupancy rates (Keegan, 2010; McKee, 2004). Reducing "*inappropriate admissions*" to "*make the provision of inpatient care more efficient*" is one of the strategies outlined by the World Health Organisation (McKee, 2004, p. 8). The

occurrence of outlier patients is arguably an *"inappropriate admission"* in an economic rationalist healthcare system in NSW (McKee, 2004, p. 8).

Taking an example from a Bed Management Policy in an acute care hospital in NSW, "*where a clinical specialty/ward has bed demands beyond their available beds, the (hospital) bed manager will advise if overflow into another specialty/ward is possible or if cancellation of elective surgery or delays to planned admission is required*" (Sydney South West Area Health Service, 2009). As the cancellation of planned surgery or hospital admission is not desirable for economical and political reasons, hospital bed management seeks other options. One of the options is to set up an "*acute medical unit*" to receive patients with acute medical illness for assessment and treatment for a designated period, "*typically between 24 and 72 hours*", prior to patient discharge or transfer to medical wards (Scott, Vaughan *et al.*, 2009, p. 398). For instance, St Vincent's Hospital in NSW opened a transit unit in the year of 2010 with the aim of assisting patient flow between emergency departments, operating theatres and in-patient wards/units (Swan, 2012). Nevertheless, a recent newspaper article reported an unpleasant experience of patients in the transit unit, where the patients described their experience as lying in "*a trolley in a corridor*" and lodged complaints, such as "*not enough nurses, overcrowding, poor hygiene, inadequate bathrooms, and a lack of privacy and patient confidentiality*" (Swan, 2012). As the option of establishing a transit unit is undesirable according to the patients' experience, current bed management continues to allow "*overflow into another specialty/ward*" and therefore gives permission for the occurrence of outlier patients (Sydney South West Area Health Service, 2009).

Despite much literature that outlines the **logic** of bed management and makes recommendations for managing patient overflow in hospitals (Fatovich, Geoff *et al.*, 2009; Gilligan & Quin, 2011; Walters & Dawson, 2009), hospital beds continue to be "*misused*" (Scott, 2010, p. 321). This logic refers to the application of an accounting logic of economic rationalism in hospital management (Broadbent & Laughlin, 2002), where quality and cost control remains a major concern in current health care delivery (Unruh, Hassmiller *et al.*, 2008). The

purpose of employing this accounting logic in hospital management is to quantify the outputs and to measure the "*price that is essential for[an] allocative mechanism to work*" (Broadbent & Laughlin, 2002, p. 101). Economic rationalism is an approach that informs this accounting logic. Economic rationalism attempts to understand economic life in abstract, deductive terms through the use of "*formal, rule-like models*" (Orchard, 1988, p. 22). While nursing is traditionally lead by the medical profession, nursing traditionally also follows the rules of the organisation in which it occurs, while the organisation follows the logic of economic rationalism. The rules of organisation emerged as managerialism began in 1980s, where "*the narrowing of the intellectual perspective for the management of public institutions*" requires the "*outputs, products, the measurable, and capacity for centralized control, authority and integration*" (Orchard, 1988, p. 23). Managerialism questions the effectiveness and efficiencies in nursing, for instance, Multi-skilling of nurses and the use of standardized charting is arguably bringing significant efficiencies into nursing from the managerial perspective (Choiniere, 2011). For the purpose of this study, nursing the outlier patient is a consequence of bed management. The more rapid the bed flow through Emergency Department, the higher the pressure on bed management to admit patients into inappropriate wards that mismatch their specialty illness condition. Consequently, the nurse experiences nursing patients who "*do require acute hospital care*" yet "*are receiving it inefficiently*" (Scott, 2010, p. 321). While I am aware of the literature available on different strategies adopted by bed management, such literature does not have specific relevance for my study. The purpose of introducing bed management literature is to point out the occurrence of outlier patients in NSW and to outline the scene for exploring the nurse's experience of nursing the outlier patient.

In reference to the healthcare system in NSW, current vagueness in bed management policy has led to the occurrence of outlier patients. There is a lack of coordination between nurses, patient-flow managers and medical staff in hospital bed management. Nurses are responsible for bed turnover yet not responsible for admission and discharge (Sydney South West Area Health Service, 2006). The patient-flow managers have responsibility for movement of patients into and out

of hospital beds, but have no authority to admit or discharge patients (Sydney South West Area Health Service, 2006). Medical staff have principal authority for admission and discharge, however they are not responsible for overall bed management (Sydney South West Area Health Service, 2006). While establishment of a patient flow management committee is arguably more effective in solving dilemmas in bed management (Sydney South West Area Health Service, 2006), the bed management pressures for outlier patients and the need to reshuffle outlier patients remain as "*obstacles*" in hospitals (Sydney South West Area Health Service, 2006, p. 85). The patient has become dehumanized as abed that flows within the hospital, rather than a person who requires nursing and medical attention.

A different approach to the problem of bed flow is that a single level of ideal occupancy does not reflect hospital efficiency and that the so-called "*desirable*" 85% bed occupancy rate is a myth (Bain, Taylor *et al.*, 2010, p. 42). In NSW, the relationship between the levels of risk and safety that accompany varying levels of bed occupancy within a hospital facility, has not been well-established (Garling, 2008, p. 994). Extending from the Garling's (2008) inquiry into a desirable level of occupancy in a hospital, the occurrence of outlier patients further questions how does the bed occupancy influence the nurse's experience of nursing.

Consider the hospital using a factory analogy, where patients are being fitted into beds on conveyor belts. As long as an empty bed is available for patients, the conveyor belt will continue to run. Initially, patients are being matched to a bed in a ward that is equipped for or suited to their specific needs. Since the conveyor belt only recognises the presence of an empty bed, the occurrence of outlier patients begins as the conveyor belt continues to run while a matching/appropriate bed is no longer available. Patients therefore end up in a bed in a ward that is not equipped or suited for their specific needs. The conveyor belt analogy is an example of how organisational structure has adopted an economic rationalist ideas of efficiency into practice, which Rankin and Campbell (2006, pp. 52-53) have described as "*the hospital's overriding concern about the excessive spare bed capacity*". As hospitals continue to accept admissions when bed demand is higher

than bed supply within a particular ward, patients of a particular condition will end up in a mismatching ward and become an outlier patient.

While the occurrence of outlier patients has been clearly established as a result of policy and organisation decisions, the experience of nursing the outlier patients has not been explored. Nursing the outlier patient is the phenomenon experienced by participants in this study and many other nurses in the public acute care hospital in NSW. This systematization of patient admission and bed management in acute care hospitals in NSW highlights the need to explore the nurse's experience of nursing outlier patients.

The research significance has been further amplified by the final report of the Special Commission of Inquiry into acute care services in NSW public hospitals released by Garling (2008). With the general acceptance from bed management, nurses, political and organisational policy makers of the emergence of outlier patients, the concept of outlier patients has been casually dismissed in some current reports and literature. A limited amount of literature describes the presence of outlier patients as a "*chaos*" (Parker, Giles *et al.*, 2009, p. 672) where they are associated with more "*medication omission[s]*" (Warne, Endacott *et al.*, 2010, p. 112), "*poorer outcome[s]*" (NSW Clinical Excellence Commission, 2005), and "*longer length[s] of stay*" (Johnson, Gaughwin *et al.*, 2005, p. 236; NSW Clinical Excellence Commission, 2005) than specialty-appropriate patients. Through criticising current bed management policy and identifying outlier patients as a "*problem*" in acute care settings in NSW, Garling (2008, p. 990) supports the notion that nursing the outlier patient is an important issue for investigation:.

> *"…An associated problem occurs where patients end up in the wrong bed, that is, in a ward inappropriate for their condition simply because of the unavailability of a more appropriate bed. These patients are called "outliers" and are less likely to receive the specialist medical and nursing attention that their condition needs.*" (Garling, 2008, p. 990).

This aspect of the report clearly establishes the outlier patient as an issue and provokes a contextual background to the nursing problem.

Unlike Garling's (2008) focus on reporting the consequences for the outlier patients, this study suggests that it is the nurses' experience of nursing outlier patients that corresponds to the occurrence of and underpins the associated effects on the outcome of nursing outlier patients. As discussed in this section, the concept of outlier patients has been casually dismissed as a problem. My experience of nursing the outlier patients has established for me the need for a humanistic way of understanding the phenomenon from the nurses' perspective. Current political initiatives of changing bed numbers have not, and will not actually eliminate the occurrence of outlier patients and consequently there will continue to be outlier patients requiring nursing care. This study acknowledges that nursing the outlier patient is a common experience for nurses and that this will continue because even though the problem is defined there is no quick solution to address the demand for hospital beds in the acute care setting.

The occurrence of outlier patients, as a result of hospital organisational decisions based on the principles of economic rationalism, has impacted nursing. In the contemporary nursing workforce, nurses' complaints overwhelmingly reflect their frustrations with the pervasive effects of policies of economic rationalism on their work practices, and the related lack of opportunity and support for the provision of comprehensive care (Forsyth & McKenzie, 2006). While nurses valued "*managing health services better*" through implementing frontline activities, nurses acknowledged that any reform agendas were often driven by financial and political concerns (Newman & Lawler, 2009, p. 425). Health policy experts voiced concern that current reforms focus on solving the political problem of public hospitals rather than initiating the wider reform that is needed (Sweet, 2008). Despite the efforts in attempting to change and initiate reforms, the occurrence of outlier patients continues. This concern echoes with Newman and Lawler's (2009, pp. 425-426) study in which a questionnaire response in their study stated that , "the *more we change [healthcare reform] the more we stay the same*". As a consequence of the dominance of economic rationalist discourse and

the subsequent systems of control introduced, the practice of nursing has been significantly influenced. The challenge for nurses and the nursing profession is to develop strategies to refuse to give in to the dominance of economic interests and instead to give more consideration to the need to prevent harm (Heggen & Wellard, 2004). I contend that developing a deeper understanding of the **nurse's experience of nursing outlier patients can actually inform both nursing and the broader community of what it means to be nursing outlier patients**, and potentially lead to better options for nursing these patients.

Rather than creating differences among nursing, organisational and political perspectives, this study suggests that historical nursing career structure, the changes in organisational structure and the current bed policies are all part of the "*socially shared realities*" leading to the emergence of outlier patients (Merton, 1972, p. 8). As an individual nurse "*socializes*" as part of a nurses' "*group*", nursing patients in a condition specific ward, that is a specialty ward; she engages in the nursing experience and follows the norm as an "*insider*" (Merton, 1972, pp. 8, 14). While this chapter has discussed the setting up of the norm of nursing, the actual nursing practice within the norm of nursing, particularly with that of nursing outlier patients has not been well understood. The **aim** of this study, therefore, is primarily **to develop an understanding of the nurse's experience of nursing outlier patients.**

1.3 Summary of the research aim and research problem

In summary, the phenomenon of this study is nursing outlier patients, where outlier patients refer to patients in the "*wrong*" ward. The overall aim of this study is to gain a deep understanding of the nurses' lived experience of nursing the outlier patient.

1.4 Organisation of the thesis

Chapter 1 has set up the research focus of "the nurse's experience of nursing the outlier patients". My experience as a registered nurse nursing the outlier patients was the stimulus for the inquiry of nursing in the acute care setting and the occurrence of outlier patients in NSW, Australia. I have reflected upon how my personal experience of nursing outlier patients has contributed to my

understanding and I have reflected on the phenomenon prior to engaging in interviews to gain a broader understanding of **nurses' experience of nursing the outlier patients in the acute care setting**. This chapter has concluded with a brief overview of the research aim and research problem, and an outline of the organisation of the thesis.

Chapter 2 addresses methodological and philosophical underpinnings of this study, that is, hermeneutic phenomenology. This chapter aims to demonstrate the appropriateness of the use of hermeneutic phenomenology in relation to the research aim. Six key concepts in phenomenology, particularly hermeneutic phenomenology are identified in this study as 1) Being-in-the-world; 2) social being; 3) The need to shift from ontological inquiry to sociological inquiry in exploring Being-in-the-world; 4) the four life-world existentials; 5) fusion of horizons and 6) hermeneutic circle. Each of these concepts will be explored in order to support the relevance of the hermeneutic phenomenology for this study.

In Chapter 3, the research method and context are discussed in reference to hermeneutic phenomenology. The process of obtaining ethics approval is outlined in this chapter. The data collection design of using a recursive model of interviewing, along with the profile of participants will be discussed. Data analysis method and the process undertaken and considered for ensuring research rigor are also addressed here.

Chapter 4 and Chapter 5 present an interpretation of the data as interwoven Findings and Discussion chapters of this study.

In Chapter 4, I introduce the structure of a straight ladder and a care ladder as a phenomenological orientation of the phenomenon. Despite the nurse is being frustrated with the organisational constraints, she is (being) capable of nursing with her care ladder. Chapter 4 serves as a foundation or basis for interpreting and articulating the participant's experience of nursing outlier patients that follows in Chapter 5.

Chapter 5 details the participants' experience of nursing the outlier patients by using the phenomenological orientation of a care ladder as introduced in Chapter

4. This chapter highlights the disruption to the personal norm of nursing- where the nurse's care ladder has disrupted ladder rungs, sides and legs. This has led to changes in the nurse's understanding of her work environment as characterised by the surface of anchorage of the nurse's care ladder. The nurse became less capable of what she used to be capable of as she nursed outlier patients with her disrupted care ladder.

The final chapter, Chapter 6 summarises my research findings by considering the nurse's specialty nursing as informed by the organisation's construct of specialisation in the work environment, in other words, the nurse's being-in-the-world. Nursing the outlier patient has disconnected the nurse from her specialty nursing practice. In order to minimize the disruption in nursing caused by the presence of outlier patients, such disconnection is therefore hinting a need for organisation to accommodate the nursing requirements, and for nurses to adjust the individual's construction of care ladder and specialty nursing. This chapter ends with a concluding statement that illuminates the phenomenon of the nurse’s experience of nursing the outlier patients in this study.

CHAPTER 2.

METHODOLOGICAL AND PHILOSOPHICAL UNDERPINNING

The distinctive use and applicability of hermeneutic phenomenology to address the nurse's experience of nursing the outlier patients will be discussed in this chapter. Informed by Heidegger's (1962) Being and Time, nursing the outlier patient is not an event occurring at any one point of time. As the nurse is nursing she experiences and perceives nursing; it is this perception of nursing that then serves as a basis for later interpretation of nurses' experience of nursing outlier patients. The use of hermeneutic phenomenology therefore allows the meanings of nursing the outlier patient to be explicated "*as I live them in my everyday existence*"(van Manen, 2001, p. 11).

2.1 Adopting qualitative approach

Given that the aim of this study is to explore the experience of the nurse who is nursing outlier patients, a person-centred or person-focused approach (Holloway, 2005) is appropriate for capturing rich descriptions that will inform this study (Denzin & Lincoln, 2011; Holloway & Wheeler, 2010). The data based on human experience is often more powerful and compelling in qualitative research when compared with quantitative research (Anderson, 2010). Using a qualitative approach allows me to challenge the appropriateness of knowledge development in relation to social sciences and to embed myself into human experiences in broader contexts in understanding how an individual comes up with her experience (Bailey, 1997; Elliott, Fischer *et al.*, 1999). The aim of using a qualitative approach in this study is to allow a deeper understanding of the nurses' experience of nursing the outlier patients as participants "*encounter, engage, and live through*" their experiences (Elliott, Fischer *et al.*, 1999, p. 216). I was seeking the individual's subjective description of the experience of nursing outlier patients so that ultimately I could identify and interpret the significant elements of the experience across the nurse participant's (individual) experiences.

2.2 Phenomenology as the methodology of choice

Phenomenology, is a qualitative approach that offers a way to understand human experience (Leininger, 1985, p. 94) and to make "*the study of lived experience*" (van Manen, 2001, p. 9). Phenomenology involves "*study[ing] the person in context*" and shaping and interpreting "*what a person values and finds significant [about the phenomena under consideration]*" (Leonard, 1989, p. 46). For the purpose of this study, the phenomenon under consideration is the *nurses' experience of nursing the outlier patients*.

2.2.1The phenomenological movement: from descriptive to interpretive

Phenomenology first appears in philosophical texts in the eighteenth century, although the idea of building knowledge by reflecting on the experience of others obviously existed in earlier times (Moran, 2000). One of the ways in understanding phenomenology is through the four stages of the movement, which are 1) realistic, 2) constitutive, 3) existential and 4) hermeneutic phenomenology (Embree, 1998). Although these stages follow a chronological development, each stage does not cancel the other stage(s) but can be seen as evolving or separate development in understanding and classifying the shift in thinking.

Realistic phenomenology which emphasised the metaphysical realism of universals and particulars (Embree, 1998). Today Realistic Phenomenologists are natural scientists who used phenomenology as a classificatory and descriptive branch of science (Phillipse, 2003). In contrast to the positivist's use of theory in addressing human concerns, realistic phenomenology involves careful consideration of phenomena such as the appearance of things (Cohen, 1987). The person as a subjective being is valued and their perception of experience is central to understanding as opposed to the positivist objectification of the person and their experience.

Constitutive phenomenology focuses on exploring the structure of consciousness and its relation to the objects experienced (Embree, 1998). Constitutive phenomenologists use phenomenology for epistemological clarification and logical investigation (Moran, 2000). One of the most influential protagonists of the constitutive phenomenological movement, Husserl who is also cited as

"*founder of phenomenology*"(Moran, 2000, pp. 60-89; Zahavi, 2003, p. 184), although he was not the first to use the term "*phenomenology*" (Husserl, 1962, p. 1), he claims that every phenomenon/experience is an object (Husserl, 1917). The realistic phenomenological phase, differs from the constitutive according to Husserl who argues that the relation between perception and its objects is active rather than passive (Denzin & Lincoln, 2011; Husserl, 1917). Consistent with Husserl's (1917) emphasis on capturing the empirical world through exploring the structure of consciousness, van Manen (2001, p. 9) states that "*consciousness is the only access human beings have to the world*". Merleau-Ponty (2005, p. 122) also describes consciousness as the "*being-towards-the-things through the intermediary of the body*". In other words, mind (and therefore experience) does not exist without consciousness through the human body. Husserl's discourse on consciousness is important in my study since without consciousness the immediate experience of nursing the outlier patient is inaccessible without consciousness. Despite Husserl's claim that consciousness is essential to experience, it is not an aim of my study to investigate the relationship between consciousness and the objective definition of outlier patients.

Husserlian constitutive phenomenology also highlights the use of phenomenological reduction which is also known as bracketing or the epoche (Husserl, 1917; Walters, 1995). Phenomenological reduction is an attempt to eliminate one's prejudice about the world from any consideration during the research (Howarth, 1998). According to Husserl (1917, pp. 3, 4), the purpose of phenomenology is to achieve "*the universal validity of theory*". Husserlian doctrine thus sees bracketing as essential in rigorous philosophical enquiry as it allows a focused understanding of the object under investigation (Walters, 1995).

Existential phenomenology is concerned with exploring the embodied being in the world (Moran, 2000) and uncovering the ontological meaning of lived experience (Annells, 1996; Crotty, 1996; Leonard, 1989; Walters, 1995). Compared to Husserl's epistemological focus, Heidegger (1962) contends that phenomenology neither targets the subjective nor objective experience. Heidegger considered the world as an essential part for understanding the meaning of being

(Converse, 2012). In other words, being does not exist independently without the world. It is the relatedness between the corporeal presence of humans and their experience that shapes the Being-in-the-world.

Hermeneutic phenomenology refers to the process of understanding and interpreting (van Manen, 2001). Through employing both methods of phenomenology and hermeneutics, hermeneutic phenomenology is "*descriptive and interpretive in nature*" (Hawley & Jensen, 2007, p. 664). The goal of hermeneutic phenomenology is to acknowledge the complexity of the life-world and to construct a full interpretive description of "*some*" aspect of the life-world (van Manen, 2001, p. 18). Through identifying and providing an understanding of the "*variety of constructions that exist about a phenomenon*" and bringing them into "*consensus*", hermeneutic phenomenology "*seeks understanding*" of the studied phenomenon (Annells, 1996, p. 708). Rather than revealing the essence of the phenomenon, the focus of hermeneutic phenomenology is to understand the phenomenon in relation to the researcher (Converse, 2012), where both researcher's interpretation and participant's experience fuse together and lead to a new understanding of the nurse's experience of nursing the outlier patients.

2.3 The choice of hermeneutic phenomenology for this study

While philosophers and researchers debate the distinctive uses and applicability of each form of phenomenology, I have adopted hermeneutic phenomenology as the best fit for the research aim of this study.

In determining the research approach for this study, I examined and critically considered each stage of the phenomenological movement. Realistic phenomenology did not seem to fit well since the research aim is to **explore the nurse's experience** rather than investigating what appears in the human mind. Constitutive phenomenology was not appropriate because rather than bracketing, this study aims to openly explore various possibilities of understanding the phenomenon and to make sense of the nurses' experience of nursing outlier patients. I have made clear my intention to include my own experience of nursing outlier patients and there is no attempt to bracket experience. Rather my own experience is acknowledged as contributing to the data and analysis. Both van

Manen (2002) and Gadamer (1977) believe that assumptions about the existence of an external world offer a different understanding towards the phenomenon. My pre-assumptions and potential for prejudice as a nurse and a researcher therefore is being seen as contributive rather than contaminative in this study.

I have included existential phenomenology in my initial consideration. It is what Spence (2001) describes as the "*situated, dynamic and intersubjective phenomenon*" that set up the scene for nurses to experience nursing outlier patients. While Heidegger's existential phenomenology informs part of my research process, it does not fulfil the purpose of my research. My purpose is not about providing a descriptive experience of the individual nurses as in Heidegger's existentialism. This is coherent with van Manen's (2001, p. 54) stated belief that the purpose of phenomenology is not just the provision of "*purely private autobiographical facticities of one's life*".

In summary, hermeneutic phenomenology is the distinctive and most applicable approach here. While the study **initially** focused on obtaining descriptions of the experience of nursing the outlier patient from nurses using an existential phenomenological approach, my deeper goal is to inquire into the nature of the phenomenon as an essential human experience. It is the exploration of the lived experience, which van Manen (2001, p. 36) describes as *"…the totality of life…the breathing of meaning*" that serves the purpose of my study.

Using a hermeneutic theoretical framework, my interpretation as a nurse and as a researcher will therefore not be seen as the absolute truth, but as a different way of understanding and making sense of the phenomenon (Patton, 2002, p. 114). The major focus of this study is on exploring how it is that the individual nurse experiences what she experienced, which is addressed through the hermeneutic phenomenological approach through my interpretation of the nurse's description of her experience of nursing the outlier patients. Given that the acts of "*gathering experiential material*" and "*analysing this material*" are inseparable and "*should be seen as part of the same process*"(van Manen, 2001, p. 63), using a hermeneutic phenomenological approach for this study takes the participants' description from the existential phenomenological stage to an interpretive level.

2.4 Key concepts of phenomenology/hermeneutic phenomenology

The purpose of this section is to highlight phenomenological concepts, particularly in hermeneutic phenomenology that informed the exploration of the nurse participant's lived experience of nursing outlier patients. The key concepts used in this initial description of my intended research process will then be explained in greater detail.

Existing as an embodied **Being-in-the-world**, the nurse interprets her meaning of nursing outlier patients through her **social being**. Through introducing the concept of being-in-the-world and that of social-being, I acknowledge that **a shift from ontological inquiry to sociological inquiry** will be necessary to make the participant's experience accessible for me as a researcher and for other readers. **The four life-world existentials** will also guide reflection in the research process. Probing every aspect of the participant's lived experience will then enhance the hermeneutic significance of this study. In this process I will actively engage (as the researcher) in the determination of the points of **fusion of horizons**. I will therefore consider my experience of nursing in interpreting participant's excerpts and fuse the vantage points provided from my experience, the participant's experience and the information gained from the literature review. Participants' descriptions will then be analysed in reference to the concept of the **hermeneutic circle**, where I will consider the parts and whole phenomenon in consolidating my interpretation of the data.

2.4.1 Being-in-the-world

The existential mode of being is known as the "*being-in-the-world*"(Heidegger, 1962, p. 156). In relation to this study, the nurse exists in a world that consists of external facts in the objective sense. These external facts can be considered two ways, simply as the external reality itself or as lived experiences. These external facts— the process, details and experience nursing patients are often taken-for-granted as the "*everyday existence*" and frequently attract little or no attention (Conroy, 2003). While Sartre (1969, p. 161) regards external reality as "*the necessary object for all reflection*", Merleau-Ponty (2005, p. 21) disagrees and contends that, *"…it is ridiculous to pretend that nature thus conceived is, even in*

intention merely, the primary object of my perception: it does in fact follow the experience of cultural objects, or rather it is one of them." The significance of lived experience is not merely the external reality, but is informed by the individual's context and meanings.

Being and the world do not exist in isolation from each other. An individual's life-world reflects her ways of being-in-the-world and the structure of meaningful relationships that she establishes and shares in the world (Conroy, 2003; Holroyd, 2007). Although the world is constituted of external facts, the world is not defined by the external facts themselves, but by the individual's being-in-the-world. Hence, through her experience of nursing a patient, the nurse develops her personal meaning of that experience. Her **experience** of nursing the patient is different to her being-in-the-world as reflected by her **lived experience**.

Experience on its own gives factual references/external realties to specific events at a particular point in time (van Manen, 2001). For instance, the nurse might check the patient's blood pressure at ten o'clock. The nurse puts the blood pressure cuff on the patient, takes the patient's blood pressure and documents patient's low blood pressure and gets a doctor to review the patient. Experience on its own is merely the nursing action and the nurse's interpretation of her actions for that particular patient at that particular point of time.

Comparatively, lived experience is pre-reflective experience that involves a temporal and a spatial nature. Lived experience revolves through various time and space horizons, where the lived experience is not being restricted to a particular time instant or place. For instance, the nurse checked the patient's blood pressure at ten o'clock. Reflecting on the nurse's past experience, a patients' blood pressure often drops two hours after having had antihypertensive medication in the morning. Thus, taking blood pressure at ten o'clock allows the nurse to monitor the patients' response to the earlier morning medication given and to plan for the future medication administration. If the patient's blood pressure is low, the nurse can withhold the next dose of antihypertensive medication and get the doctor to review the patient. The nurse also investigates the possible causes for patient's low blood pressure. Apart from considering the effect of the medication that was given

to the patient in the ward, the nurse also considers the patient's history. Thus, checking the patient's blood pressure is not an event at a particular point of time and has temporal and spatial meanings for the nurse. Lived experience therefore allows the nurse to interpret her current experience based on her past experience, and to use her current experience to inform future experience, and to consider her experience at different space. The nurse's lived experience therefore enhances a deeper understanding when compared to just her experience.

2.4.2 Social being

Based on their past experience of nursing patients, each nurse brings her social and cultural nursing context into the world of nursing the patients. The social being is not just part of the existential being but rather, the social being **is** the existential being. Nurses are therefore not empty beings who are completely disconnected or separated from their past experience, but social beings whose existence relates to their involvement in the world.

Lived experience is therefore both temporal and spatial in nature – for the lived experience is not shared through consciousness, but is shared through culture, history, practice and language (Laverty, 2003). While "*human conscious life*" is essentially "*already-in-the-world*", the lived experience is defined both by the person's cultural and personal past (McInerney, 1991, p. 131). "*To look at an object is to inhabit it, and from this habitation to grasp all things in terms of the aspect which they present to it...*" (Merleau-Ponty, 2005, p. 59). As the individual reflectively adds the lived experiences into her memory, her lived experiences accumulate and continue to feed into her social being, hence leading to her development of hermeneutic significance (McConnell-Henry, Chapman *et al.*, 2009; van Manen, 2001).

In relation to this study, the nurse participants' social-being-in-the-world involves their past exposure to nursing, such as their experience during their preregistration education and their experience of nursing in acute care wards as registered nurses. The nurse's experience of nursing the outlier patients, therefore does not merely mean an object among other objects (Merleau-Ponty, 2005), but the "*formative relations between who I am and who I may become, between how I think or feel*

and how I act…" (van Manen, 2001, p. 26). Taking my experience as a nurse as an example, I have carried forward what I have learnt from my past experience of nursing in general in shaping my social being. It is through my social being that I experience at (the) present. The social being continues to evolve as I continue to nurse different patients. What I have learnt from my current experience of nursing the outlier patients has now added into my perceived nursing culture and hence into my new (and ever evolving) social being. My new social being is *dynamic* and is constantly growing both from my past and current experience. The concept of social being is therefore one of a "*transcendent*" nature and which has a "*pedagogical consequence for professional and everyday practical life*" (van Manen, 2001, p. 26).

Social being is an interpretive basis for the being-in-the-world, and should not be taken for granted as the actual experience of self. From Heidegger's perspectives, all understanding, including the understanding of self, "*takes place within the horizon of shared norms, practices, rules and conventions that belong to the world*" (Crowell, 2001, p. 212). It is therefore important to address the temporal and spatial nature of the lived experience in understanding the social being.

In relation to this study, the nurse's social being is informed by the nurse's experience of nursing, together with the medical, organisational and political set-up of nurses' work and workplace. Reducing and conceptualising the meaning of social being as a physiological event, work event and/or political event risks depersonalisation of the nurse's experience (Holroyd, 2007). Gadamer, Weinsheimer *et al.* (1975, p. 271) stress that when constructing their social being an individual should not blindly adhere to fore meanings and neglect the openness of situating a meaning flexibly in relation to other meanings. The social being therefore serves as an interpretive basis for the being-in-the-world, but the social being is not equivalent to the being-in-the-world.

2.4.2.1 Shifting from ontological inquiry to sociological inquiry

Both personal meaning attached to the world, as well as the social meaning attached to the person, contributes to the existential being. Personal meaning is inconsequential unless it can be understood by others. Similarly, others can only

access an individual's personal meaning through the social meaning. From van Manen's (2001, p. xiii) perspectives, an individual's life-world consists of various experiential regions that "*border each other, partially overlap, and are nested within each other*". The shift from ontological inquiry to sociological inquiry is therefore crucial for one to make sense of the concept of being-in-the-world. Language is the medium for communicating the hermeneutic meaning within and among individuals (Gadamer, Weinsheimer *et al.*, 1975). Language is therefore essential for the exploration of experiential possibilities in the life-world (Deetz, 1973; Heidegger, 1962; van Manen, 2001).

Language, for the purpose of this study, refers to Heidegger's (1962, p. 210) "*philosophy of language"* which can be deconstructed through understanding of words (Heidegger, 1962, p. 210; Palmer, 2000, p. 382). Language is not merely "*abstract concepts"* and involves a "*more richly embodied notion of human rationality"* (van Manen, 2001, p. 1*7)*. Language brings the life-world to people and at the same time allows people to understand the life-world (Deetz, 1973; Gadamer, 1977; Gadamer, Weinsheimer *et al.*, 1975). Reinharz (1983) points out that the only way for the researcher to gain access to participant's experience is through the data obtained from individual participants. It is through language that as a researcher I can obtain the descriptions of lived experience from the participants and turn the individual participant's meaning into a meaning accessible by others. And it is through language that enables the shift from an ontological inquiry to a sociological inquiry.

2.4.3 The four life-world existentials

Phenomenological research always begins in the life-world. In van Manen's (2001, p. 101) view, life-world existentials refer to the fundamental structure of "*the lived world as experienced in everyday situations and relations*". van Manen (2001, pp. 101-106) proposes four existentials— corporeality, temporality, spatiality and relationality— that contribute to the existential structure of the nurses' being-in-the-world. The four life-world existentials are inseparable in informing the lived experience and they are all considered as components of the life-world and that one existential often demands the presence of another

existential in informing the individual's life-world (Merleau-Ponty, 2005; van Manen, 2001). In relation to this study, the nurse participants are experiencing nursing by living through the time, the space, the relational self and the physical self (body) that each has. The complexities of the nurse's experience, feeling and perception are captured through exploring these existentials of the nurse's life-world.

2.4.3.1Corporeality (lived body)

Corporeality, known as lived body, exists mutually inclusive with the life-world (Merleau-Ponty, 2005; van Manen, 2001). As Merleau-Ponty (2005, p. 92) explains I exist in the world through my "*phenomenal body*" rather than my "*objective (physical) body*". My phenomenal body as living mesh serves as the embodied space for experiences and allows emergence of understandings (Lawler, 1997) and it is my phenomenal bodily existence which allows me to develop my sense of the world (Maggs-Rapport, 2001). The phenomenal body is "*the vehicle of being-in-the-world*" that "*inhabits space and time*" (Merleau-Ponty, 2005, p. 89), corporeality is therefore one of the key concepts in informing us about how the individual nurses respond to the inquiry of this phenomenon as it is through the lived body that one experiences time, space and relationality.

2.4.3.2 Temporality (lived time)

Temporality, known as lived time, refers to subjective time (van Manen, 2001). Indeed, in my everyday life I often refer to time as objective clock time rather than as a temporal experience. Clock time has dominated the way in which nursing has been performed, evaluated and measured (Jones, 2001). Yet, clock time and lived time is not the same.

Clock time is a unit of measurement (Nowotny, 1994). Heidegger (1992, p. 4E) referred clock time as "*an identical duration that constantly repeats itself*" (Heidegger, 1992, p. 4E). Clock time revolves around the arbitrarily fixed point of now, for now represents a measurement of past and future (Heidegger, 1992). In other words, clock time is a linear representation of past, now/present and future. Now is not a part of time itself as it only lasts for an instant and has no duration on its own (Williams, 1992). The objective clock time is infinite as the clock

continues to run and produce a new reference point of now/present. The ticking of a clock provides a sense of measured sequence in everyday life (Gosden, 1994). Clock time is the time used when a particular duration of time is associated with an event (Jones, 2010). Clock time, as a physical time measurement therefore does not reflect the nurse's experience and has little meaning on its own (Jones, 2010). While my study is not about focusing on the actual now/present of nursing practice, clock time does provide us with a background understanding on how time contributes in various ways as participants reflected on their experience of nursing the outlier patients.

Heidegger (1992, p. 22E) moved beyond an ontological inquiry, such as "*what is time?*" , to express an interest in lived time and to suggest questioning whether *"are we [we are] ourselves time?*" instead. Lived time refers to the "*experience of the temporal features of conscious acts*" (McInerney, 1991, p. 121). Consistent with Merleau-Ponty (2005), van Manen (2001, p. 36) says that lived experience has a temporal structure and involves the "*totality of life*". Unlike the linear clock time of past, now/present and future; temporality is constituted of *three interchangeable horizons:* the *"horizon of the past, horizon of imminent and horizon of futurity*" (Merleau-Ponty, 2005, p. 60). Horizon of imminent does not merely refer to the time of now. Rather, the horizon of imminent is determined by retained elements of the past and anticipating future (Gosden, 1994, p. 2; McInerney, 1991, p. 14). A number of authors agree that temporality is defined by the connectedness among horizons (Annells, 1996; Gosden, 1994; Merleau-Ponty, 2005). The concept of temporality allows us to make sense of the "*notion of universe…a completed and explicit totality that exceeds beyond perceptual experiences*" (Merleau-Ponty, 2005, p. 61). For instance, the influence of time may change their (the nurses') perception of external reality or an event over time. What has happened has happened, but the interpretation of that can be altered over time as the social being of the nurse evolves.

In relation to this study, nurses nurse in clock time, yet experience lived time. While nurses know that time affects the way they feel, nurses do not ordinarily reflect on time, but their experience in time. Lived time is not limited to a specific

time period, but is a dynamic temporal dimension traversing the three interchangeable time horizons by means of the social being of each nurse.

2.4.3.3 Spatiality (lived space)

Spatiality, known as lived space is the "*felt space*" of the individuals (van Manen, 2001, p. 102). Lived space is different to space itself which generally refers to the differences between two places. For instance, Tilley (1994, p. 17) interprets the architectural space as "*the deliberate creation of space made tangible, visible and sensible*". While Tilley (1994) refers to space as the setting arrangement, Merleau-Ponty (2005, p. 218) argues that space is defined by its attached meaning and is the "*means whereby the position of things becomes possible*". One of the inclusion criteria for participants is experience in nursing outlier patients, that is patients in the "*wrong bed*" in an "*inappropriate*" ward for their conditions as defined by Garling (2008, p. 990). Since the recruitment information states that "*This study is being conducted to explore the nurse's experience of caring for patients who have ended up in the wrong bed*", it is unlikely that my nurse participants will agree with Tilley's definition of architectural space as a sensible space arrangement. Nevertheless, the concept of architectural space may help us to understand the logic underpinning the ward-based-design as a contributive factor to the nurses' experience of nursing outlier patients.

Despite Tilley (1994) and Merleau-Ponty (2005) having different ways of defining space, they both assert that there is no space without places or things. Williams (1992) further confirms that it is only the places or things in space that one can see and feel. Similar to the earlier discussion of lived time, individual's "*do not ordinarily reflect on*" space, yet "*know that the space in which we find ourselves affect the way we feel*" (van Manen, 2001, p. 102).

In relation to this study, nurses nurse patients in a ward, regardless of whether the patient is situated in a specialty-appropriate ward or an outlier patient. However, the outlier patient does not simply exist in an architectural space. An inquiry into nursing the outlier patient lies in the lived space, where individual nurse's experience a difference between nursing patients in the nurse's specialty or

designated ward in an appropriate space; and nursing the outlier patients in an inappropriate space for their condition/diagnosis.

2.4.3.4 Relationality (lived relation)

Relationality, known as lived other, refers to "*the lived relation I maintain with others in the interpersonal space that I share with them*" through my corporeal presence (van Manen, 2001, p. 104). Relationality is different when compared to relation. Relation involves interactions between two individuals and focuses on the content, the quality and the behavioural pattern that occurs in a space at a particular point of time (Hinde, 1976). Nurse-patient relationship is widely accepted as an important part of nursing (Vouzavali, Papathanassoglou *et al.*, 2011). In contrast, relationality informs us of the nurses' experience *in* relation to others and the world, rather than simply naming the relationship. Merleau-Ponty (2005, p. 93) stated that that "we *are literally what others think of us and what our world is*". The concept of relationality echoes with the inseparability between being and the world. In this study, nursing the outlier patient does not merely refer to the nurse-patient relationship, but the nurses' experience of nursing a patient through the corporeal presence in the temporal and spatial dimension of nursing.

2.4.4 Fusion of horizons

Gadamer and others introduced horizons as a personal concept comprising the individual's prejudice and historical understandings (Annells, 1996; Gadamer, 1977; Gadamer, Weinsheimer *et al.*, 1975; Maggs-Rapport, 2001). When a person describes their conscious experiences, there is a "*one-to-one*" relationship between each description and each possible experiential state (Overgaard, 2004, p. 366). At each time and space, individuals interpret their experience differently. For instance, for the same event, the person may have different interpretations or meanings attached to a particular experience at different horizons of time. The horizon of the present can only be formed from the horizon of past (Holroyd, 2007). According to Gadamer (1977, p. 398) the various horizons meld at a certain point that he identifies as the "*fusion of horizons*". He argues that this is necessary for interpretation of experience since the *"fusion of horizons*" facilitates new understanding of phenomena and allows language to be understood by both individual and others. Through using language in a phenomenological study,

"*fusion of horizons*" allows a diversity of vantage points joined together and therefore opens possibilities for new understandings of the dynamic phenomena (Gadamer, Weinsheimer *et al.*, 1975; Spence, 2001).

In relation to this study, my personal reflection as a nurse nursing outlier patients is a *horizon* that represents parts of the lived experience in the multiple-realities framework. During the "*fusion of horizons*", the variation among and between the individual realities shared by each participant will be explored and questioned (Wright, 2003) through the "*social, historical and temporal nature of life, and the role of language*" (Holroyd, 2007, p. 7). This enhances a depth understanding of both the participant's social being and hence the participant's being-in-the-world.

2.4.5 Hermeneutic circle

The Hermeneutic circle, which is also known as spirals, refers to the "*back-and-forth of studying of parts in relation to the whole and the whole in relation to parts*" of the analytical process (Denzin & Lincoln, 2011, p. 114; Patton, 2002, p. 329). Whitehead (2004, p. 517) emphasised on the importance of bringing in an "*awareness of changes in social, political and personal contexts*" in the data analysis process. My experience as a nurse and as a researcher, the individual participant's social being of nursing, their being of nursing the outlier patients, and their experiences of nursing the outlier patients are taken into consideration as parts and whole during the data analysis process, hence allowing an "*interplay of movement between tradition and interpretation*" within the hermeneutic circle (Holroyd, 2007, p. 4).

Chapter summary

The hermeneutic phenomenological approach therefore, is a distinctive qualitative approach appropriate for this study. Individual nurses experience nursing outlier patients through their being-in-the-world informed by their individual social being. The only way for individuals to experience is for them to live through the time, the space, the relation and the body that they have. The use of "*fusion of horizon*" and the "*hermeneutic circle*" will illuminate the interpretive understanding of nurse's experience of nursing outlier patients, hence allowing hermeneutic significance of the phenomenon of nursing the outlier patients to be unearthed in this study.

CHAPTER 3.

METHOD AND CONTEXT

While the previous chapter has discussed the methodological and philosophical underpinning that is applicable to this study, this chapter will now focus on research process related method and context. In outlining the research process, I carefully considered the research question, that is: What is the experience of the individual nurses as they provide care for outlier patients? I also ensured that the method and context would enhance the depth of understanding of the nurse's experience of nursing the outlier patients and would contribute to the hermeneutic significance of this study. The aim of this chapter is to set up the research process that "*investigate[s] experience as we [myself and the participants] lived it*" at different phases of the research (van Manen, 2001, p. 53).

3.1 Outlining the research process

The research process in this study is in the main informed by van Manen's (2001, p. 10) phenomenological philosophy, where he builds from the work of Husserl (1917) and Heidegger (1962). van Manen (2001, p. 10) states that, "*Phenomenology asks for the very nature of a phenomenon, for that which makes a some-"thing" what it is – and without which it could not be what it is*." The research process initially explores and opens the possibilities of understanding the phenomenon, with a later focus on grasping "*the very nature of a phenomenon* ". Initially, Husserl (1917, p. 4) distinguishes between phenomenology and science by exploring "*whatever is experienced*" rather than listing "*mere things— out—there*". While Husserl (1917, p. 5) places his emphasis on "*pure phenomenology*" and excludes all external experience, Merleau-Ponty (2005, p. xiii) later contends Husserl's pure phenomenology and points out "*the impossibility of complete reduction*". van Manen's (2001) phenomenological philosophy is influenced initially by Husserl's descriptive phenomenology that based on an individual's lived experience, and is later influenced by Heidegger's interpretive phenomenology seeking interpretations made based on descriptions of lived experience.

3.1.1 Prior data collection phase

3.1.1.1 Sampling: process and considerations

The process of sampling in this study utilises a non-probability sampling method because the researcher's subjective judgments were involved in the selection of the sample based on experience (Taylor, Kermode *et al.*, 2006). A non-probability sample is appropriate for this study as the aim of this study is not to generalise the results concerning the population from my findings about the sample, but to explode and explore a wider horizon of the nurses' experience in nursing the outlier patients (Taylor, Kermode *et al.*, 2006). The particular methods of non-probability sampling techniques used in this study were purposeful and snowball sampling.

Holloway and Wheeler (2010), Patton (2002) and Minichiello, Aroni, Timewell, & Alexander (1995) refer to purposeful sampling as a type of criterion-based sampling. In considering who would best be able to provide insights and understanding about the outlier patient it was clear that it would be the registered nurses who were managing the outlier patients at the coal face. Three inclusion criteria were deemed to be important and these were that that participant: 1) was a Registered Nurse, who 2) had two years experience of working in a public acute care hospital in NSW, and 3) had experience of nursing outlier patients.

The first inclusion criterion was that participants had to be a registered nurse and this refers to someone who is on the list of registered nurses in NSW, Australia. In the current definitive framework in Australia, nurses are trained or educated to "*promote, maintain and restore health and well-being*" (Australian Institute of Health and Welfare, 2009). All registered nurse are required to fulfil the registration standards from the Nursing and Midwifery Board of Australia (2012) under the National Registration and Accreditation Scheme (Nursing and Midwifery Board of Australia & Australian Health Practitioner Regulation Agency, 2011). A fuller summary of the "*Definition and qualification for registration as a nurse*" in reference to the registration standards listed by the Nursing and Midwifery Board of Australia by Meadley (2009, pp. 1-2) can be located in this thesis as Appendix A.

In terms of the second criterion, the decision to include only registered nurses with at least two years experience working in an acute care setting in a public hospital was based on my own experience and is also supported by the literature. (See further explanation below.)

Only registered nurses are included in this study because of the differences in the responsibility and accountability held between Registered Nurses and Enrolled Nurses. Australian Nursing and Midwifery Council (2007a, p. 3) stated that, "*It is the registered nurse or midwife's responsibility to provide direct or indirect supervision according to the nature of the delegated task.... The registered nurse or midwife who delegates an activity to another person is accountable, not only for their delegation decision, but also for monitoring the standard of performance of the activity by the other person, and for evaluating the outcomes of the delegation*". Enrolled nurses were excluded because they are responsible for providing support and comfort, assisting with activities of daily living to achieve an optimal level of independence, and providing for emotional needs of individuals while it is the registered nurse who takes a leadership role in the coordination of nursing and health care within and across different care contexts to facilitate optimal health outcomes. Enrolled nurses have been described as "*associate[s] to the registered nurse*", where an enrolled nurse is required to be supervised by a registered nurse (Heath, National Review of Nursing Education (Australia) *et al.*, 2002, p. 67). Considering that registered nurses and enrolled nurses have different caring responsibilities, limiting the inclusion criteria to registered nurses only focuses on the experience of nursing the outlier patients rather than shifting the emphasis to the varied experiences of nursing arising from different nursing populations (Australian Nursing and Midwifery Council, 2007a).

Outlier patients are only created within large public hospitals due to the organisation's imposed hospital ward division as discussed previously in Chapter 1, hence there is a need for participants to have experience of nursing in this particular work environment. In considering the length of the experience, I have reflected on my own experience as a new graduate nurse. Even though during the first year of my nursing career I had nursed outlier patients I felt that I was a

novice nurse and at that point I had not identified or perceived myself as a specialist or as having (or belonging to) a home ward. Based on my personal experience of nursing the outlier patients as a registered nurse, it is through ongoing nursing experience with nursing the outlier patient that I recognise the meaning of nursing the outlier patients. My experience of nursing the outlier patient was less apparent as a new graduate due to my lack of familiarity. Nursing literature has reported the new graduate nurse's anxiety and reality shock due to transition to a new role and a new clinical environment (Alhadeff, 1979; Malouf & West, 2011; Wangensteen, Johnansson *et al.*, 2008). With the study emphasis on the nurses' experience of nursing the outlier patients rather than on the new graduate nurse's experience, I have set the second inclusion criteria to include registered nurses who have at least two years experience of nursing.

The third inclusion criterion was that the registered nurse (participant) had experienced the phenomenon of interest of this study, in other words, they must have nursed outlier patients. This was essential for my study purpose (Salmon, 2012). It is only through the nurses' experience that they can explicate the meanings they lived as they lived them (van Manen, 2001), where their descriptions of their experiences are later interpreted by the researcher, allowing readers to develop a deeper understanding of the experience of nursing the outlier patients.

3.1.1.2 Sample size

In terms of the sample size, a small sample size was recruited for this study. This small sample size had always been envisaged as appropriate for this study. According to Starks & Trinidad (2007), the unit of analysis in a qualitative study is the concept or experience under study. Since an individual person can generate a wide range of concepts, small sample sizes are capable of generating rich data sets (Starks & Trinidad, 2007). While Saddler (2007, p. 315) recommend the sample size for a qualitative study is "*generally 30 individuals or less*", Starks and Trinidad (2007, p. 1375) report that the typical sample size for phenomenological studies "*range from 1 to 10 persons*". I designed and commenced this study with the view that many authors agree on and that is not to impose an absolute

predetermined number in determining or estimating the sample size (Carter, Ritchie *et al.*, 2009; Schneider, Elliott *et al.*, 2003).

3.1.1.3 Ethical considerations

It is important to consider ethical aspects in this study since this researcher may lead to psychological harms (National Health and Medical Research Council, Australian Research Council *et al.*, 2007). Participants may find the personal reflection involved in the interview process sensitive. For instance, the nurse may develop moral distress as she continuously reflects and rationing her experience of nursing outlier patients.

Inconvenience, such as "giving up time to participate a research" (National Health and Medical Research Council, Australian Research Council *et al.*, 2007, p. 16), is another ethical consideration. Participating interviews during work hours possibly distracts the nurse from nursing and potentially causes risks to patients.

Prior to commencement of this study, an application for ethics approval was lodged with the University of Sydney Human Research Ethics Committee and after clarification of the wording of the flyer for seeking participants, ethics approval was granted to conduct the study (see Appendix B).

The first contact with participants was made by telephone and prior to conducting the interview with them each participant was given a copy of the participants' information statement. This was to ensure that they understood the purpose and the procedures required for the project (see Appendix C). In addition, written informed consent was obtained from all participants prior to interviewing (see Appendix D) It was explained to the participants that the interview was completely voluntary and that they can withdrawn from the study at any time in an event of experiencing moral distress or inconvenience. In order to maintain confidentiality they would be referred to by a pseudonym in the writing up of the thesis.

3.1.2 Data collection phase

3.1.2.1 Participants recruitment

Participants were recruited through 1) an advertisement published in "The Lamp", the magazine of NSW Nurses' Association, 2) flyers posted within the premises of the Faculty of Nursing and Midwifery at the University of Sydney (see Appendix E), 3) brief announcements made by lecturers to registered nurse groups and distributions of flyers to potential participants, 4) snowball samples referred by participants.

Snowball sampling is appropriate for this study to enhance participant recruitment because there is no clear set of elements in identifying the nurses nursing the outlier patients (Minichiello, Aroni *et al.*, 1995). Snowball sampling is also known as network sampling (Nieswiadomy, 2008; Polit, Hungler *et al.*, 2009) and chain referral sampling (Biernacki & Waldorf, 1981). During the individual interview, extra flyers and participant information statements were given to participants in order to further recruit potential participants within their network. Following advertisement and flyer distribution, I contacted prospective participants directly through email or phone calls.

Eleven participants, including nine initial participants and two snowball participants, shared their experience of nursing the outlier patients. They participated in individual digitally recorded interviews that ranged from thirty minutes to one and a half hours. The eleven interviews were conducted from June 2009 through to January 2011. Interviews were conducted at various locations nominated by the participants as comfortable environments that also met the researcher safety requirements of the ethics protocol.

3.1.2.2 Using individual in-depth interviews

Data collection involved individual in-depth interview. Individual in-depth interview, refers to a direct face-to-face interview between researcher and participant (Minichiello, Aroni *et al.*, 1995). The purpose of conducting in-depth interviews was to grasp an understanding of the participants' perspectives on their lives, experiences or situations as expressed in their personal language (Minichiello, Aroni *et al.*, 1995). According to van Manen (2001), depth is

measured by the openness of participants and researcher in pursuing the rich meaning of lived experience. Consistent with the aim of this study, in-depth interviewing provides access to the knowledge of meanings that individuals give to their lives and events (Minichiello, Aroni *et al.*, 1995). For the in-depth interviews in this study, I adopted an unstructured format to allow for free discussion with the participants rather than following a set of predetermined questions or categories that may have restricted the responses from the participants (Minichiello, Aroni *et al.*, 1995; Turner, 2010). In order to allow maximum freedom for participants in reporting their experience, this study used a recursive model of interviewing (Minichiello, Aroni *et al.*, 1995). "Can you tell me about your experience of nursing outlier patients?" was the only question posed for participants at the beginning of the interview. The natural flow of conversation was then guided by the participants' responses. Probing questions were asked in order to clarify information or to enhance depth of a response (Minichiello, Aroni *et al.*, 1995). In relation to this study, I was not seeking a group response nor generalised agreement on my topic as in a focus group interview (Minichiello, Aroni *et al.*, 1995). I was interested in the multiple realities as demonstrated by individual participants.

3.1.2.3 Profile of participants

Eleven participants, comprising two males and nine females, were recruited for this study. Eight out of eleven participants were over fifty years of age, with six of them having over thirty years of nursing experience. The majority of participants worked in a ward of a particular specialty, except for two participants who had more than the required 2 years of working as an registered nurse in an acute hospital but they were currently working as a casual staff in rotating wards. The eleven participants profiles are presented below.

Rainbow

Rainbow is a registered nurse in her 50s. Rainbow believes that "I've never meant to be nursing in my life. I just happened to be nursing", however she has 12 years of nursing experience. She reports that she is being "classified as a senior" nurse in the coronary care unit. Rainbow believes that "quality of care" is "about

following the ward protocols" and to be "able to do the right things for the patient at the right time".

Agnes

Agnes, 52 years of age, is a registered nurse with 31 years of nursing experience. She regards herself as "an old dinosaur nurse" who may have a "totally different" view of nursing compared to the "new breed of nurses". Agnes has been nursing in a variety of settings, including public hospital, private hospital, hospices and community care. In this interview, Agnes shared her recent experience of nursing outlier patients in the Rehabilitation/Acute Stroke Unit in a public hospital outside the Sydney metropolitan area.

Ann

Ann, in her 60s, is a Clinical Nurse Consultant (CNC) with greater than 30 years of nursing experience. Her main role currently is discharge planning and liaising with families, team members, and outside agencies. Ann's role involves patient assessment, in which she encourages other nurses to "think" and to "look at why, question why" as they are nursing the patients. Ann is a snowball participant referred by Madeline.

John

John is a 54 year old registered nurse working in the respiratory ward in a large hospital outside the Sydney metropolitan area. He has 38 years of nursing experience. He is a snowball participant referred by Madeline. John believes that "optimal care" is care in which "everything revolves around the patients, rather than revolving around logistics or politics or budgets…"

Madeline

Madeline, age 43, has been nursing for 23 years. She started her nursing career as an Assistant in Nursing in a developmental disability hospital. At present, she is a Nurse Unit Manager in a ward covering four specialties, with respiratory being the primary specialty. Madeline describes herself as "assertive" in bed management as she views "good patient care, good outcomes, and even length of stay, are all linked to getting the right patient in the right ward".

Marie

Marie, in her late 30s, is a nurse unit manager in the cardiac unit. She had been nursing since 1994. Recalling her experience years ago, Marie used to be a registered nurse in a medical ward with mixed patient conditions. She considers that advancement in research, medication and technology, along with longer life expectancy, as the drivers towards specialisation of the wards and hence the increasing occurrence of outlier patients.

Peter

Peter, in his 50s, has worked full time as a registered nurse in NSW since the late 1970s. He has completed a Graduate Certificate in cardiology and Master degree specialising in cardiac nursing. He is currently working as both a Clinical Nurse Specialist (CNS) and Clinical Nurse Educator (CNE) in cardiac nursing. Peter sees nursing as "a lot more specialised" within "the last fifteen to twenty years" "in response to what the community needs". In Peter's view, nurses are specialised as "nurses have actually chosen a career pathway in a specialty". Peter regards his specialty as cardiology.

Claire

Claire is a 56 year old nurse who works as a CNS in a large teaching hospital in Sydney. Claire has been nursing for 34 years. She has 20 years of experience nursing in a gynaecology ward. Claire reports that the gynaecology ward has recently merged with the Extended Day Unit, where some patients are staying extended weeks and becoming outlier patients. In response to the occurrence of outlier patients, a best practice principle for the management of outlier patients is available in the hospital where Claire works.

Mary

Mary, a nurse who in her 30s, is a 7th year registered nurse. Mary has also been acting Nurse Unit Manager and educator. She considered her specialty as Transplant and Surgical. Mary also has experience of nursing in a Transplant ward.

Hope

Hope, in her early 50s, is a registered nurse with 32 years of nursing experience. Hope is currently working in the casual pool in a NSW metropolitan hospital. She usually works in emergency and intensive care units, and she has experienced nursing outlier patients in a neurology ward.

Kay

Kay is a 55 year old registered nurse with 38 years of nursing experience. Her nursing background includes long periods in paediatric and intensive nursing care. Apart from working as a nurse in the casual pool in a children hospital, Kay works as a clinical facilitator for nursing students undertaking pre-registration nursing courses in a number of public hospitals. Kay believes that once patients are in hospitals, they are inliers, not outliers. Kay claims that an "Outlier patient does not exist in public hospital". With further clarification and probing, Kay reports that she has been nursing children only in the children ward. Throughout the interview, Kay explains her definition of outlier patient (as outlying patient) and shares her view of nursing in general. While Kay's interview does not directly contribute to the exploration of the nurse's experience of nursing the outlier patient, Kay's interview has informed the way that the nurse's social being affects the nurse's experience of nursing. Kay's interview therefore highlights the importance of social being in the nurse's experience of nursing the outlier patients and serves as background information for interpretation of the phenomenon.

3.1.3 Data Analysis phase

3.1.3.1 Data Analysis method

The purpose of data analysis is to grasp the meaning of the nurse's experience of nursing the outlier patients through phenomenological themes. The structure of experience can be understood by the individuals and others (van Manen, 2001). The sufficiency of participants' response and researcher's interpretation is supported by the generation of audit trail. The audit trail of this study is demonstrated by 1) summary and reflection immediately after the interview, 2) reflection after conducting line-by-line analysis with the printed copy of transcription, 3) conducting thematic analysis with the use of NVivo, and 4) conducting thematic analysis with the use of Inspiration mind map, and 5)

conducting thematic analysis with the use of Scrivener software. Each phase of audit trail will be discussed in this section with the aid of figures and illustrations as shown in Appendix F.

Numerous interpretations were under taken as informed by the previous philosophical discussions in Chapter 2. Throughout the individual interview, as I was listening to participant's description of their experience of nursing the outlier patients, I developed my first interpretation of what it is that the participant told me. Immediately following each interview session, I wrote summaries of the interviews and my personal reflection. Each interview was transcribed verbatim. I used my "*personal experience as a starting point*" [for data interpretation] as described by van Manen (2001, p. 54). During the interviews, I formed immediate thoughts as I was listening to the participant's verbal description. At the same time I was interpreting and forming an initial understanding what participant(s) had said. After the interview, I wrote summaries and reflections of the interviews and recorded any immediate apparent concepts and themes from the interview (Minichiello, Aroni *et al.*, 1995).

During the conduct of line-by-line analysis with the interview transcripts, I referred to my summaries and reflections while seeking meaning and uncovering initial thematic aspects. I analysed each participant's description of experience in relation to that of other participants and my own experience as a nurse and as a researcher. I also enriched my own understanding of the phenomenon through analysing the participant's words. My analysis is embedded within a fusion of horizons, where different ideas fuse together to form a new concept. As the sub-themes emerged I discovered that there were commonalities and differences among them.

I utilised different techniques in my process of further analysing the sub-themes. Each technique allowed me to embed in the data analysis process and lead me closer in terms of understanding the phenomenon. Initially, I made use of NVivo (a commercially available software program) in the process of grouping common sub-themes. I collected sub-themes and grouped them into themes or nodes, which is shown in Figure A1 in Appendix F. According to Johnston (2006), using the

NVivo program allows the researcher to openly record their thoughts, questions and reflections through browsing data, reading memos and viewing nodes. However, as the analysis process proceeded, I realised that the use of NVivo had limited my free thinking (as one of my supervisors had suggested at the outset). Rather than simply letting the sub-themes emerge and probing for a deeper understanding of each sub-theme, I was following the program directions. Similar to the comments from Pope and Mays (2009, p. 738), I found myself "*getting quite a long way without having to make sense of what I have found*". I was categorising the nodes in a mechanical way and risked producing an "*overly descriptive*" analysis (Johnston, 2006, p. 383). While a number of researchers, such as Colaizzi (1978), Ricoeur (1981) and van Kaam (1959a) offer more prescriptive way of conducting a step-by-step data analysis, I attempted to move away from the prescription in order to let the data emerge naturalistically. I therefore sought other tools for assisting with the analysis process.

I then adopted Inspiration mind map software because this allowed the sub-themes to emerge more freely allowing me to create a picture, which is shown in Figure A2 in Appendix F. This process allowed me to further think about the commonalities and differences between sub-themes by looking at the picture as a whole. In the Inspiration mind map, I outlined the nurse's description of her experience of nursing the outlier patients with 1) bed manager, 2) government, 3) hospital organization, 4) other health care disciplines and 5) the nurse herself and other nurses. Through considering the nurse's experience as being influenced by and as influencing on her work environment, the Inspiration mind map allowed me to think of the phenomenon as a whole. I regard the nurse as the nurse nursing in a work environment, rather than the nurse as a separate entity from her work environment.

In order to further stimulate my data analysis process, I also used Scrivener (another commercially available software program), where I initially recorded all sub-themes as note cards on the cork-board electronically as shown in Figure A3 in Appendix F. The use of Scrivener software was an advantage in visualising changes or deleting the initial sub-themes from the phenomenon therefore

enabling determination of the essential themes. With Scrivener, I moved each of the note cards sharing commonalities — sub-themes in common — into a file. Each file represents one of the six themes of this study as shown in Figure A4 in Appendix F, which will later be discussed as rungs of the structure of a care ladder in Chapter 4. The thematic development phase demonstrated the possibility of the phenomenon as experienced by each participant, rather than a conceptual formulation that affirmed full understanding of the studied phenomenon (van Manen, 2001). Further probing of the themes through reflection on the interview transcripts, also led to the emergence of the **phenomenological orientation** for later phenomenological analysis.

The advantage of developing a phenomenological orientation is to enhance accessibility to the phenomenon through description of a familiar object from everyday life. The phenomenological orientation that arose from the analysis allowed me as a nurse and as a researcher to reflect on the conversations during the interview(s) and to develop a conversational relation with participant(s). Moving beyond a mere verbal chat, conversational relation refers to a personal relation involved in a conversation, where each individual becomes orientated to the conversation and a true conversation "*comes into being*" (van Manen, 2001, p. 98). Through constantly engaging with the transcript of the interviews with participants and subsequent analysis, this conversational relation allowed me to engage in the hermeneutic circle by continuously questioning myself, "Is *this what the experience is really like?"*, through bringing in participant's descriptions and through discussing my interpretation of the phenomenon and the essential themes (van Manen, 2001).

3.1.3.2 Issues of rigor

Kitto, Chesters, & Grbich (2008, pp. 243-244) uses the terms "*procedural rigor*" and "*interpretive rigor*" to describe the criteria for assessing qualitative research. A number of research articles highlight "procedural rigor" as one of the criteria to judge the quality of qualitative research (Milton, 2012; Thorne & Paterson, 1998; Wolf, 2003). Procedural rigor is one way of demonstrating the methodological congruence through applying the selected procedures for the study and recording the data accurately (Burns, 1989). Burns and Groves (2003, p. 391) refer to

"*procedural rigor*" as the "*openness, scrupulous adherence to a philosophical perspective, [and] thoroughness in collecting data*". Openness, as a part of procedural rigor, refers to the ability of the researcher to constantly explore and question the researcher's pre-judgment and preconceptions against the variance claimed by individual participants (de Witt & Ploeg, 2006; Wright, 2003). In the Introduction chapter, I outlined my position as a nurse and as a researcher. With my lived experience of nursing the outlier patients, I gained engagement with the phenomenon and this contributed and enhanced my ability to probe the participants' interviews in-depth (Armour, Rivaus *et al.*, 2009). I acknowledged my experience as a nurse and therefore I could identify with the participants as they shared their experience of nursing the outlier patients. While my immersion as a nurse had the potential to impact or influence the analytical distance required as a researcher and resulting in a risk to the credibility in this study (Baxter & Eyles, 1997), I see this involvement as important in informing my interpretation of the phenomenon (Lykkeslet & Gjengedal, 2007). Personal reflection and field notes were written after each interview in order to demonstrate reflexivity (Burhans & Alligood, 2010). Through reflecting on my experience, I recognised that my experience of nursing outlier patients is a part of the multiple realities (Porter, 2007; Sale, 2008). I would argue that my reflexivity enhances the reader's understanding of my own values and therefore adds credibility (Bradbury-Jones, 2007; Jootun, McGhee *et al.*, 2009). I have used the first person approach in disclosing my values and communicating my understanding of the phenomenon to assist the readers to grasp my interpretation and to consider possible alternatives (Elliott, Fischer *et al.*, 1999).

Procedural rigor is associated with the transparency of the audit trail (Kitto, Chesters *et al.*, 2008). In the introduction section, I have made links between my experience in nursing in NSW and my experience of nursing outlier patients. Through reflecting upon my experience of nursing in NSW, I have established concreteness of this study (de Witt & Ploeg, 2006). The phenomenon of nursing the outlier patients is not nursing activities that happened at a point of time, but the nurse's experience that cannot be considered without the historical concept of establishment of nursing career structure and further career development, and the

changes in the hospital organisation brought by dividing the hospital into multiple wards as listed in the Introduction section.

Interpretive rigor is achieved by checking relativity through the use of probing and recursive model of interviewing during data collection (Minichiello, Aroni *et al.*, 1995). The strength of data has been evaluated throughout the data analysis process to ensure relativity. Throughout the data analysis stage, I was aware of keeping a balanced integration through carefully articulating between the voice of my participants and my philosophical interpretation of their voice (de Witt & Ploeg, 2006). I addressed the trustworthiness through intertwining participants' excerpts and my philosophical interpretation to ensure a persuasive and coherent account of my findings, and to achieve trustworthiness (Rolfe, 2007). Sufficient data are presented in the data analysis chapter for the reader to assess whether my interpretation is supported by the participants' excerpts (Anderson, 2010, p. 148).

I have also made constant comparisons between my own analysis and the independent analysis conducted by my research supervisors (Elliott, Fischer *et al.*, 1999; Koch & Harington, 1998; Minichiello, Aroni *et al.*, 1995; Sandelowski, 1986). In addition, the second phase of data collection aimed to provide a deeper understanding to the first phase of data collection and to consolidate the relativity in the analytical process (Kitto, Chesters *et al.*, 2008). In summary, the issue of rigor in this study is best illustrated by van Manen (van Manen, 2001, p. 27), where he says that phenomenological description is "*validated by lived experience and it validates lived experience*". The section of future recommendations in the Findings and Discussion chapter further address the actualization (de Witt & Ploeg, 2006) and transferability (Baxter & Eyles, 1997) of this study, where the phenomenological interpretation continues to be interpreted by the readers in the future.

Chapter summary

This chapter outlined the research design, method and context in consideration of the methodological and philosophical underpinnings of this study, that is hermeneutic phenomenology. The nurse's experience of nursing the outlier patient was explored through interviews with registered nurses who have experienced this phenomenon. Their experiences were captured during an in-depth interview, which I digitally recorded and followed up with written summaries and reflections in response to each interview. This accumulated data was then analysis by me as a researcher and as a nurse, and in consultation with my supervisors to ensure rigour was maintained in the process. A phenomenological orientation was developed as the best way to understand the phenomenon in-depth.

CHAPTER 4.

ORIENTATION OF THE PHENOMENON OF NURSING THE OUTLIER PATIENTS

Chapter 4 orientates the phenomenon of nursing the outlier patient. As discussed previously in Chapter 1, the phenomenon of nursing the outlier patients has been protrayed by current literature as problematic. Therefore, the phenomenological orientation prevents the "*temptations to get side-tracked or... to settle for preconceived opinions and conceptions...* " (van Manen, 2002, p. 33) and guides the data analysis of this study. Phenomenological orientation allows the phenomenon to be explored in an open manner with human sense, and serves as a foundation for exploring the participant's experience of nursing the outlier patient.

FROM LADDER TO CARE LADDER: A PHENOMENOLOGICAL INTERPRETATION OF NURSING

This chapter orientates the phenomenon of nursing the outlier patients through a ladder. Using the simple straight ladder as depicted in Figure 1 Phenomenological Orientation: Structure of a simple straight ladder on p.75, I have described and interpreted what the participants have said about nursing care and caring for the outlier patient during their interviews. Later in the chapter the participants' experience is related to the simple straight ladder that is subsequently thematically named 'a care ladder'. During the interviews all of the participants described their individual nursing experience within specific contexts of nursing in the acute care setting.

Agnes described her experience of nursing using a ladder as a metaphor and she made the connection between a ladder and how for her it represents different levels of care. After immersing myself in the data I reached a point where the ladder seemed an appropriate object to use for interpretation of the phenomenon of caring for the outlier patient. Agnes said:

> I would say appropriate is one level up from adequate care. Adequate is just that.. you know you give enough …**on a ladder**… all different

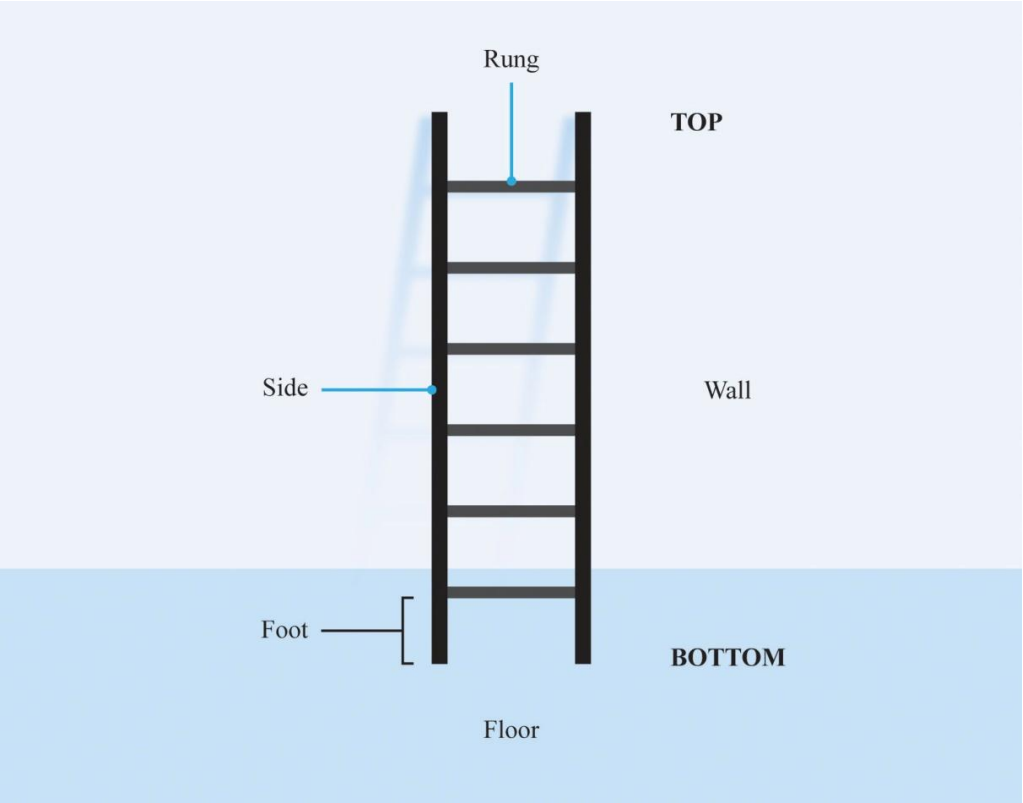
> levels. You would call basic is the basics… you just do the basics... Keep them alive. Hope that they don't get any worse. But that is just a minimum. Adequate level is already much better because it encompasses more. You have a much better picture of the whole person. Appropriate care would be really looking at all their needs where it goes to the really high level of nursing care, I would call that first class of nursing care... (Agnes 200-209)

Similar to Agnes' experience, other participants also reported or implied that they nurse with different levels of care in mind. Each participant's description of different levels of care varies. The combination of their comments, including each participant's experience of nursing at different levels of care, together with Agnes' experience of nursing "on a ladder", led me to orientate the phenomenon through visualising it using the structure of a simple straight ladder.

4.1 Understanding the simple straight ladder

Ladders can be conceptualised in various ways and they can have different forms of appearance and functions. For instance, "*career ladder*" has been used as a term for describing a hierarchical system of career progression in nursing (Barker, 2009, p. 18). Unlike the function of a "career ladder", the ladder that I will use to orientate the phenomenon is a structure that supports the individual participant's approach to nursing. I am referring to a **simple straight ladder** and its structure as demonstrated by Figure 1 Phenomenological Orientation: Structure of a simple straight ladder below.

Figure 1 Phenomenological Orientation: Structure of a simple straight ladder



Straight ladders of this type consist of two ladder feet, two sides and a variable number of rungs. The function of a simple straight ladder is to allow a person to climb onto the first rung and then move upwards on each rung above in succession until they reach a certain height or level. While a person needs to step upon a lower rung at the bottom part of the ladder prior to reaching the top or upper part of the ladder, the selection of rungs and the arrangement of rungs within each ladder can vary. The simple straight ladder rests on the floor and leans against the wall for support to allow standing and hence functioning. The simple straight ladder has an identifiable bottom and top part, although the top or upper part of the ladder is not qualitatively better than the bottom or lower part of the ladder. The best positioning on the ladder depends on the height (or place/location) that a person needs to reach. The simple straight ladder as an object is therefore not constructed or viewed as hierarchical.

4.2 Understanding a care ladder

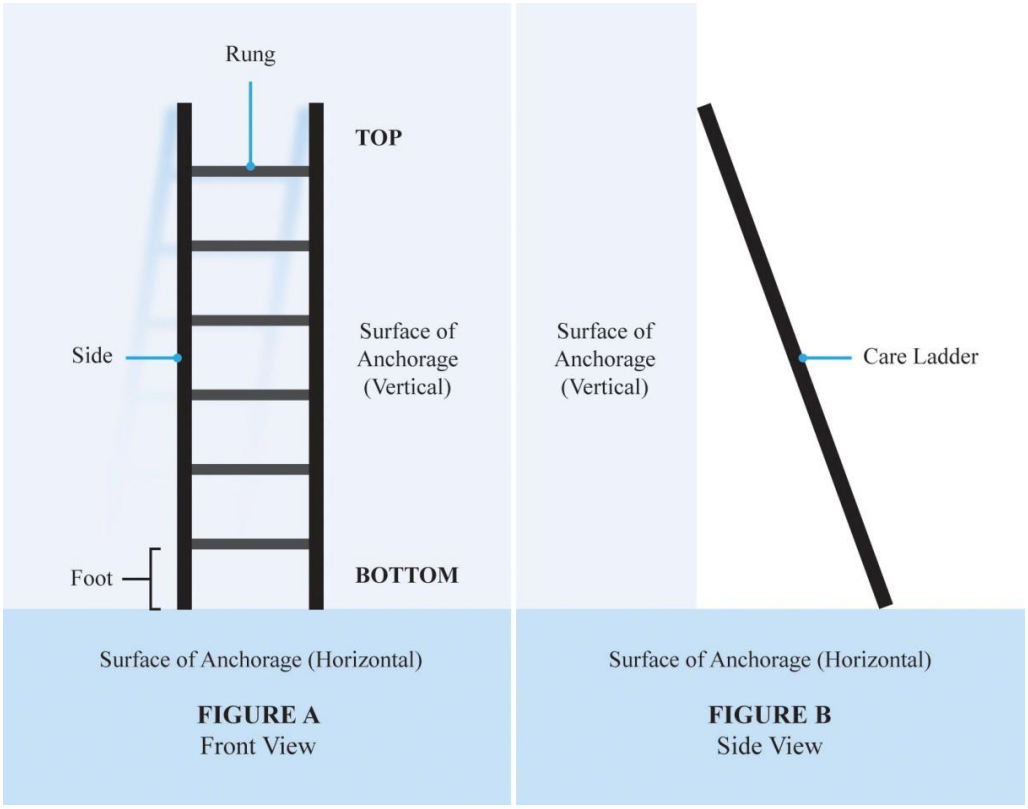
Similar to a simple straight ladder, a care ladder is not hierarchical. The best positioning on each care ladder depends on the nurse's determination of what is the best level of care and her capabilities for providing that care.

The nurse's **best level of care** firstly incorporates her current understanding of the patient's need for care which is based on her experience of nursing specialty-appropriate patients in an acute care ward. Secondly it is determined by her understanding of nursing itself, in which the nurse interprets her experience based on her individual social being.

The nurse's **capabilities of care** are determined by each nurse's capabilities in her work environment. DeBourgh & Prion (2012, p. 11) define capabilities as the "*abilities*" to 1) use knowledge and reasoning to nurse in both familiar and unfamiliar environments, 2) nurse effectively and appropriately, 3) think and explain rationale for actions, 4) demonstrate interpersonal skills, and 5) learn from own nursing experience. However, Higgs, Jones *et al.* (2008, p. 102) contend that capability is not "*a list of profession-specific technical skills and abilities*" and therefore cannot be defined precisely (Higgs, Jones *et al.*, 2008). For the purpose of this study, capabilities — in the context of nursing in acute care settings — refers to what Cairns (2000, p. 1) describes as "*having justified confidence in your [the nurse's] ability to take appropriate and effective action to formulate and solve problems...*". Capability therefore influences nursing practice and the nurse's actual level of care. Hence, capability serves as an important indicator for the height of the care ladder.

Care ladder serves as a phenomenological interpretation for this study. Care ladder is the experience of nursing as it is related to the structure of the ladder. The care ladder as a whole represents the nurse's world, her work environment, the managerial context and it serves as a relational object for understanding the construction of nursing. The structure of a care ladder is shown in Figure 2 below.

Figure 2 Phenomenological interpretation: Structure of a care ladder



There are similarities and differences when comparing the structure of a simple straight ladder and that of a care ladder. For example, both have ladder feet, sides, and rungs and both have identifiable top and bottom parts. In a simple straight ladder, the surfaces of the wall and floor are not part of the ladder, but are separated out as leaning surfaces for a ladder, thus differentiating the structure and function of a ladder. While the simple straight ladder requires wall and floor to operate, the structure of a care ladder as illuminated in Figure 2 (above) demands a stronger connection and relationality between the ladder and the surfaces.

The main difference between a care ladder and a simple straight ladder for the purpose of this orientation and interpretation is **the surface of anchorage**. Two surfaces of anchorage are required for a simple straight ladder to function, but is not necessary for defining its structure. A simple straight ladder is simply what it appears to be, and is merely an object consisting of ladder feet, sides and rungs. Comparatively, the care ladder does not exist without the surfaces of anchorage. As shown in both the front view (Figure A) and side view of the care ladder

(Figure B), the surfaces of anchorage form part of its structure (in terms of a conceptualisation of the care ladder), rather than existing as a separate object. Thus, the surfaces of anchorage are part of the whole experience contributing to a ladder structure that demonstrates interdependence of explanation and interpretation for exploring the studied phenomenon.

As illustrated by Figure 2 on p.77, the two surfaces of anchorage include the horizontal surface of anchorage and the vertical surface of anchorage. The horizontal surface of anchorage is similar to the floor where the feet of the ladder rests, whereas the vertical surface of anchorage is similar to a wall upon which the top part of the ladder leans. For the interpretation of the nurse's experience of outlier patients, the horizontal surface of anchorage refers to the organisational determinants of the work environment, while the vertical surface of anchorage refers to the nurse's social being. The horizontal and vertical surfaces are interchangeable. The focus is not about distinguishing between the horizontal and vertical surfaces of anchorage as such, rather it is to highlight the important role of both surfaces for understanding the function of a care ladder.

While reflecting on surfaces of anchorage as part of the care ladder, I was drawn to Heidegger's discussion of "*power and freedom*", where each nurse experienced "*power*" and "*freedom*" differently within the organisation (Heidegger, 1958, p. 27). Similar to the horizontal surface of anchorage, "*power*" refers to the "*background*" or "*structure*" of the experience as informed by the organisational determinants of work environment. The vertical surface of anchorage represents the "*freedom*", understood in this thesis as the nurse's social being, which is inseparable from her culture, history and tradition (Johnson, 2000, p. 141). Thus, the nurse experiences through the relationality of "*power*" and "*freedom*", rather than through experiencing either "*power*" or "*freedom*" separately. In parallel to this relationality of "*power*" and "*freedom*" as described by Heidegger (1958, p. 27), the surfaces of anchorage of the care ladder characterise the relationality between the nurse and the organisation of the work environment, where the nurse is nursing in the organisation's space.

I have referred to Heidegger's (1958, p. 27) discussion of "*power and freedom*" as **the mutuality between the nurse's existence and her embodiment.** Using a care ladder to nurse is an individual nurse's experience. Nurses as embodied beings perceive and understand their identity as a nurse through the corporeal presence of their bodies (Crocker, 2009; Sandelowski, 2002). As previously discussed in Chapter 2 on p.51, body is "*the vehicle of being-in-the-world*" that "*inhabits space and time*" (Merleau-Ponty, 2005, pp. 89, 124). At each point of time, the nurse experiences nursing in a particular space through her embodied being. While the nurse "*act(s) bodily within*" that particular space, the space also "*acts upon*" the nurse (Kupers, 2008). Embodiment takes account of space, where changes in the bodily experience modify the meaning of the space (Thomas, 2005). Thus, the nurse's embodied experience is unique at a particular time in that particular space. As stated by Merleau-Ponty (2005, p. 131), "*To be a body, is to be tied to a certain world, as I have seen, my body is not primarily* ***in*** *space: it is* ***of*** *it*". "*Nursing in*" suggests that the nurse is working in the acute care ward as dictated by the organisational design or structure: The nurse and the organisation are viewed as separate, rather than as a whole. "*Nursing of*" refers to the embodied experience that takes account of the meaning of place, where both the nurse and the place contribute to her experience of nursing: The nurse's world includes both her nursing space and the organisation's space. Thus, while a simple straight ladder may be visualised as an object separate from the wall and floor, in relation to the care ladder the surfaces of anchorage are inseparable from one another (see Figure 2 p.77).

Through the mutuality between the nurse's existence and her embodiment, her body and her spatial world are always changing and impacting upon one another (Carman, 2008; Merleau-Ponty, 2005; Moran, 2000). A nurse's experience of nursing can be understood as ever changing due to the dynamic relationality between her body and spatial world (Pollio, Henley *et al.*, 1997). I therefore contend that the experience of nursing varies according to three primary elements: 1) the nurse's individuality; 2) nursing for each individual patient; and 3) nursing in each different/individual ward. These three elements construct "***the world of relationships*****"**, where the nurse's social world involves both the nurse's

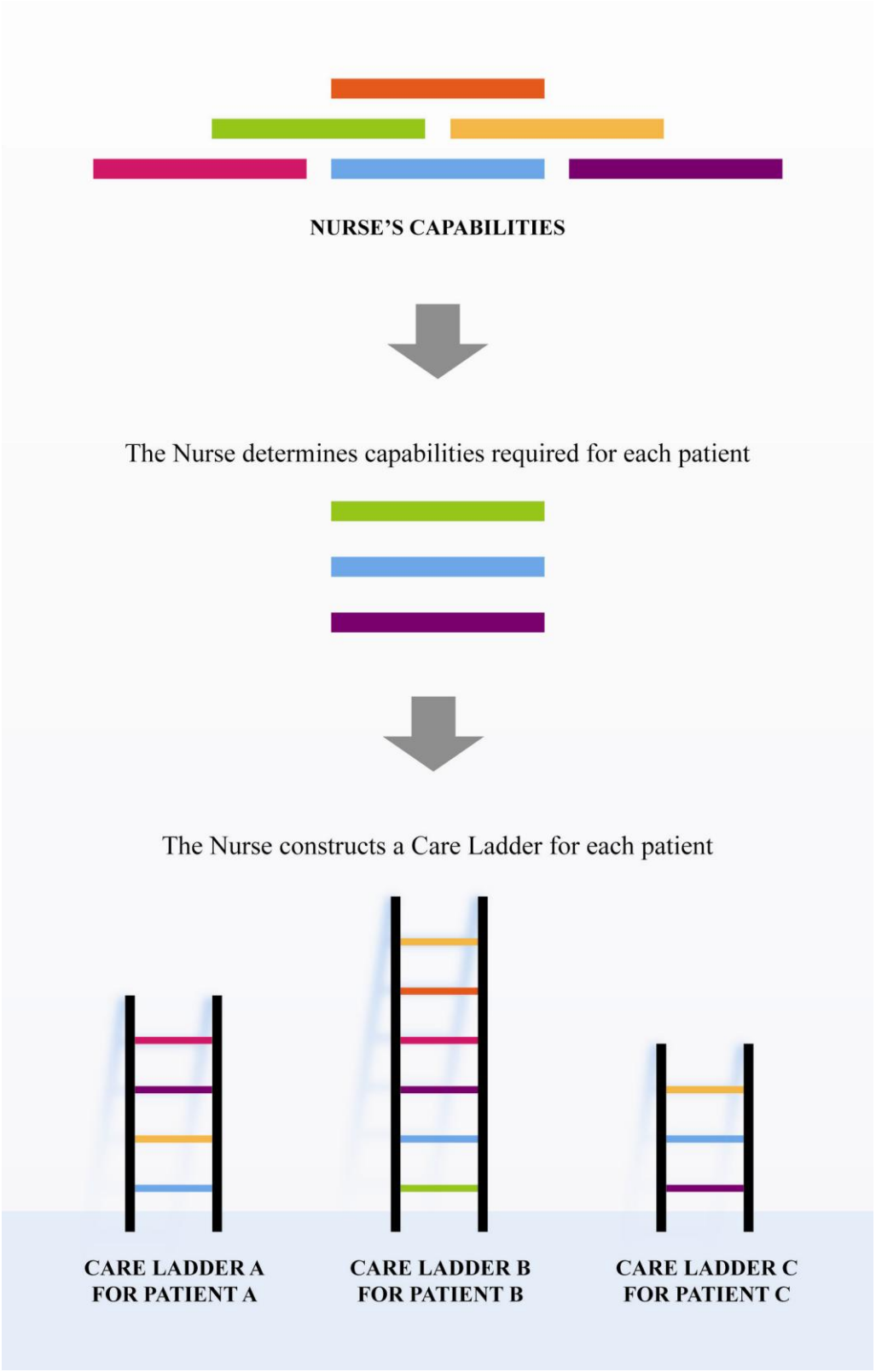
perception of the world and how others perceive the nurse in the world (Sadala & Adorno, 2002, p. 287). "*The world of relationships"* in the nurse's social world therefore serves as one of the anchorage points of a care ladder. A care ladder is not singular nor is it static. In other words, a change in any of the above three elements may lead to development of a new care ladder. In other words, nursing is an inter-subjective phenomenon, where each nurse constructs each of her care ladders in an "*already given world of relationships*" (Sadala & Adorno, 2002, p. 287).

4.3 The nurse's construction of a composite care ladder

As a consequence of nursing individual patients the individual nurse's repertoire alters and extends as she gains exposure to the different scenarios in her specialty nursing area. When nursing in this area, the nurse constructs her care ladder for each patient through building upon the composite care ladder, rather than constantly building a new care ladder from scratch. The composite care ladder is a **ready-to-hand** care ladder constructed by the nurse. Ready-to-hand is the nurse's engagement with (and for) her everyday nursing. As stated by Heidegger, "*ready-to-hand... even though actualised, it remains, as actual, something possible for doing something*" (Heidegger, 1962, p. 261). In her experience of everyday nursing, the nurse does not notice (be aware or conscious of) her use of a care ladder as such. The nurse's primary focus is the practical activity of nursing.

An example of how a nurse determines capabilities required for each patient and then constructs her care ladders from this ready-to-hand composite care ladder, is illustrated with the aid of Figure 3 below.

Figure 3 Distinctiveness of the nurse's care ladder

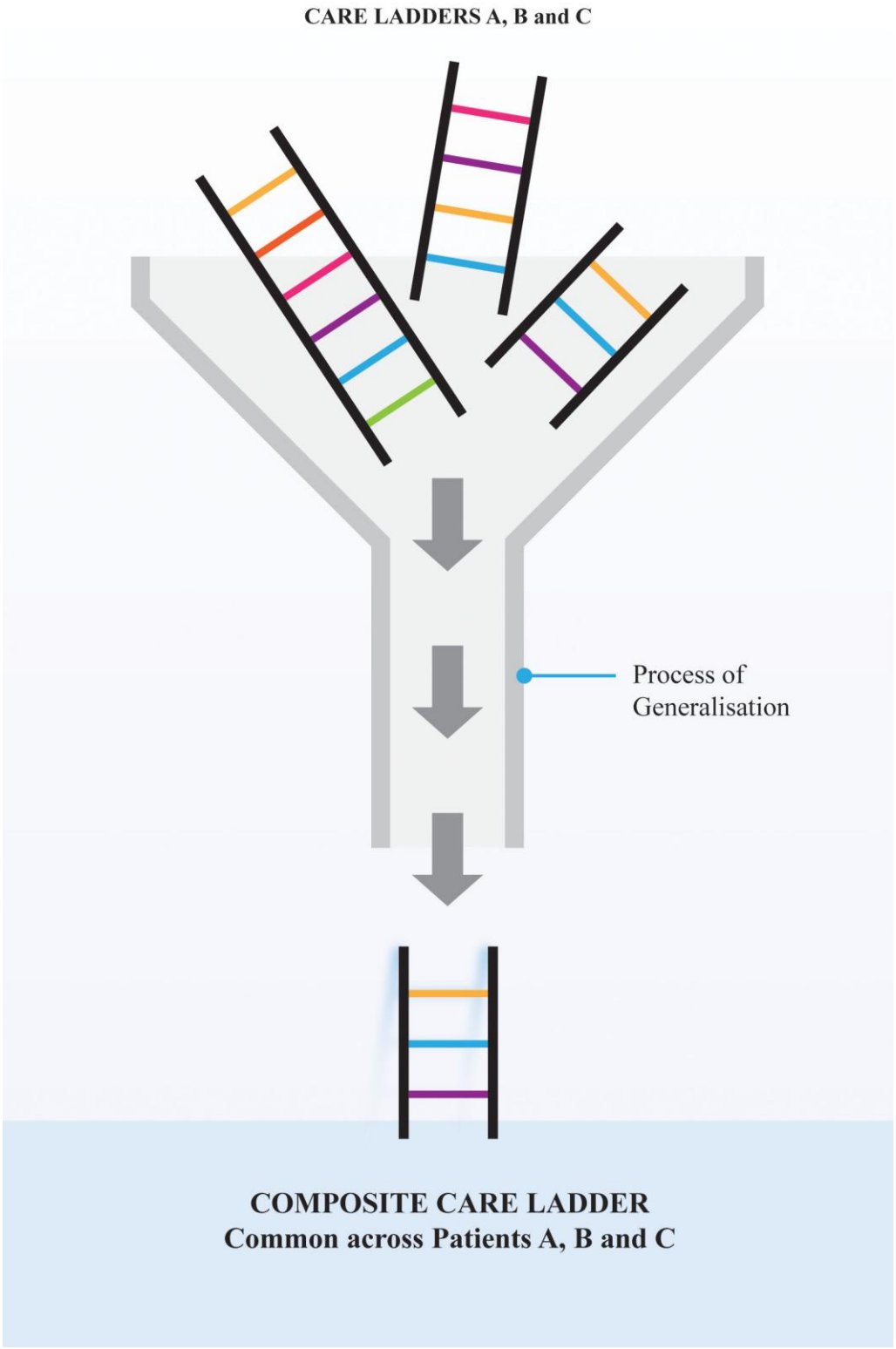


As seen from Figure 3 Distinctiveness of the nurse's care ladder above, while all care ladders are constructed with structures such as the foot, sides and rungs, each

care ladder consists of a different number of rungs depending on the nurse's assessment and understanding of the patient's need of care. The composition of the rungs on the care ladder relies on both the nurse's understanding or perception of what constitutes her best level of care as well as her capabilities of nursing. While patients in the same specialty ward have similar illness conditions, nursing practice generally emphasises patient-centeredness and each patient is considered as an individual who has unique needs in relation to care. The nurse's perception of her best level of care varies for each patient and therefore requires different rungs for nursing each patient to achieve her best level of care. The multiple care ladders vary in height because each ladder has a distinctive set of rungs for nursing each particular patient, however the structure of a care ladder is not to be interpreted as hierarchical. The purpose of nursing using multiple care ladders is not to compare the height of each care ladder but to tailor nursing to provide the patient-centred care required for each individual patient.

The nurse is grouping her nursing experience of using different care ladders to construct a composite care ladder, where this composite care ladder is applicable for nursing different patients and therefore acts as a base for building multiple care ladders. This can be understood or illustrated by different care ladders fused together leading to a new composite care ladder, in which the process of generalisation can be understood as what Gadamer (1977, p. 398) described as "*fusion of horizons*". The construction of a nurse's composite care ladder relies on the nurse's social being, where the nurse's experience of nursing with multiple care ladders has acted on the "*already given world of relationships*" and contributed to the development of a normative equilibrium (Sadala & Adorno, 2002, p. 287). As shown in the following Figure 4, care ladder A, care ladder B, and care ladder C has now become part of the nurse's social being. The nurse constructs her composite care ladder, that is, elements of care that are applicable for nursing patient A, B, and C. Figure 4 Construction of the composite care ladder from a multiplicity of care ladders below illustrates the nurse's construction of a composite care ladder from a multiplicity of care ladders.

Figure 4 Construction of the composite care ladder (D) from a multiplicity of care ladders



This construction of a composite care ladder is based on the nurse's social being, which is specific to the context of nursing patients with particular specialty illness conditions in a particular specialty ward. As the nurse continues to nurse, each nursing experience contributes to her evolving social being.

The nurse's assessment of the particular patient needs allows her to determine whether she has everything **ready-to-hand** from her composite care ladder. As a beginner nurse, each nurse constructs a new care ladder in relation to the nursing required for a particular patient. Each nurse assesses what knowledge(s) or skill(s) are required for nursing to fulfil a particular patient's need from her range of knowledge or skills learnt during her nursing education. Through continuously integrating knowledge gained during her pre-registration education, she develops and refines her knowledge and skills through practice (Schoessler & Waldo, 2006). As she nurses in a particular ward over a period of time, she is able to distil her experiences of nursing each of her patients using a distinct (individual) care ladder for each patient into a collective experience of nursing on a composite care ladder that addresses the nursing required for most of the patients in her ward. This collective experience which is based on the nurse's social being (Fell & Cumming, 1990), is what I refer to as the experience of ready-to-hand.

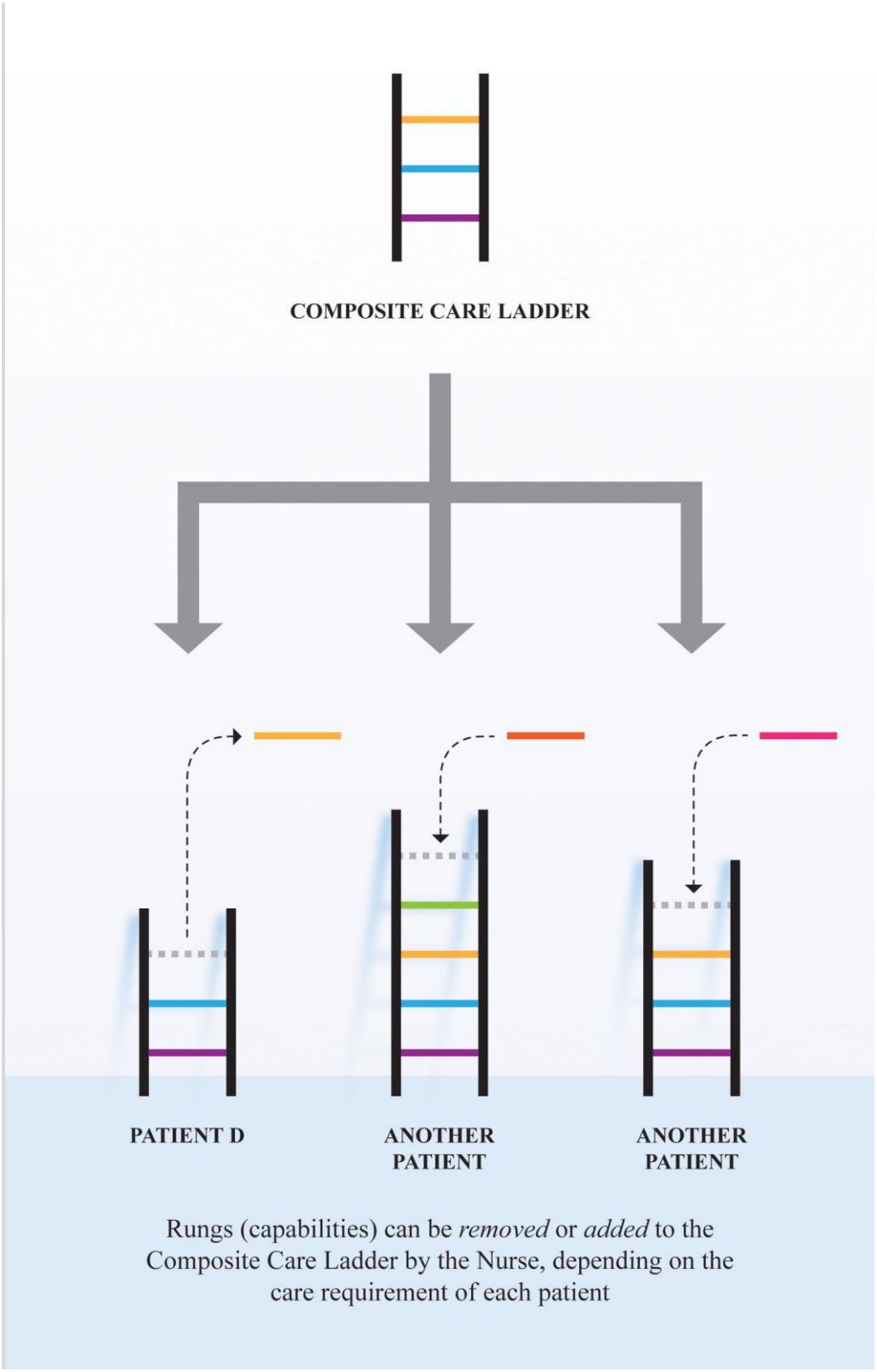
The nurse may use the same composite care ladder as a basis for constructing a new care ladder for all patients. As the nurse has developed her composite care ladder that is common across patient A, B and C, she takes it into account as she nurses a new patient D. In other words, the nurse now **builds on** the composite care ladder based on her social being of nursing patient A, patient B and patient C in her construction of a care ladder D.

The construction of composite care ladder often occurs within the specific specialty ward setting with patients being managed with conditions related to the specialty. As shown in Figure 5 below, the composite care ladder constructed, based on the nurse's social being of nursing patient A, patient B and patient C, is used as a foundation structure for the nurse to build a distinct care ladder for patient D and other patients. As the nurse is nursing another patient, she continues to take her experience of nursing patient A, patient B and patient C into account.

The nurse is using her familiar care ladder constructed from nursing patient A, B and C as she continues to nurse other patients. Regardless of who the patient is, the nurse may simply use the same composite care ladder as her basis of constructing a new care ladder specific to each patient.

Depending on the nurse's capabilities that may be required by each patient's condition, the nurse may add to or remove rungs from her composite care ladder. As shown in the Figure 4 above, patient D requires less rungs compared to the initial composite care ladder constructed from the nurse's experience of nursing patient A, patient B and patient C, where as the two other patients require more rungs compared to Patient D's composite care ladder. Figure 5 on p.86 below illustrates a composite care ladder (as it evolves).

Figure 5 Composite care ladder



The nurse's use of a composite care ladder is context specific to nursing specialty-appropriate patients. As specialty patients have specific clinical concerns and needs, there is no basic clinical care as such to meet the specific needs of patients from different specialties. Some participants described basic care as part of the individual's care ladder. However, most felt the emphasis is on specialised care, which is context specific to nursing specific needs of patients with a particular specialty illness condition. Reflecting on my experience as a nurse, a clinical example is the monitoring of ST elevation for myocardial infarct in cardiac patients. Referring to participant's experience, Peter asserted that a patient requires both generic care and specialised care in the following excerpt.

> "I love that word, "generic", because that's exactly what they get. This generic, they've got their bum washed, they get what's written on the medication sheet. (Peter 204-205)..."And at a basic level, we all give that generic care. But that extra step-up is the one that I think is responsible for the reduced length of stay and also the improved outcomes." (Peter 242-244)

Peter's description of generic care is the basic care that addresses the human needs of all patients, such as hygiene and administering medications. However the generic care is insufficient to address all aspects of specialty clinical care needs of the patient. **The specific clinical care required by all patients from different specialties is understood as specialised care.**

The continuous evolvement of a composite care ladder is an ongoing interpretive process of the nurse's experience. The nurse's experience of nursing specialty patients with specialty needs in a specialty ward requiring specialised care informs her construction of a composite care ladder that becomes part of her social being. As the nurse is nursing as an informed social being, she makes use of her initial composite care ladder in her experience of nursing. The nurse therefore is nursing with a circular hermeneutic experience, where her experience informs her social being, and vice versa. The nurse has normalised her experience of nursing with the composite care ladder. This normalisation process can be seen as the nurse's personal experiential meanings as she lives them in her everyday

existence (van Manen, 2001). While the nurse's use of composite care ladder demonstrates her capabilities, her capabilities also inform her experience of nursing and contributes to her positive social image as perceived by the organisation.

Nursing with a composite care ladder has advantages over developing a new care ladder from scratch. One advantage is that the composite care ladder fits nursing for the majority of patients with similar illness condition in the ward. Another advantage is that the composite care ladder allows the nurse to respond quickly when complications occur and hence improve patient outcomes. Gallagher & Gormley's (2009, p. 684) study reported that "*nurses felt less stress from the critical acuity of patients as years as a nurse increased*". As the nurse continues to use her composite (ready-to-hand) care ladder to construct a distinct care ladder for each of her patients, she becomes more familiar with the assessment and process of constructing each care ladder, hence saving her time and reducing her stress levels related to nursing care.

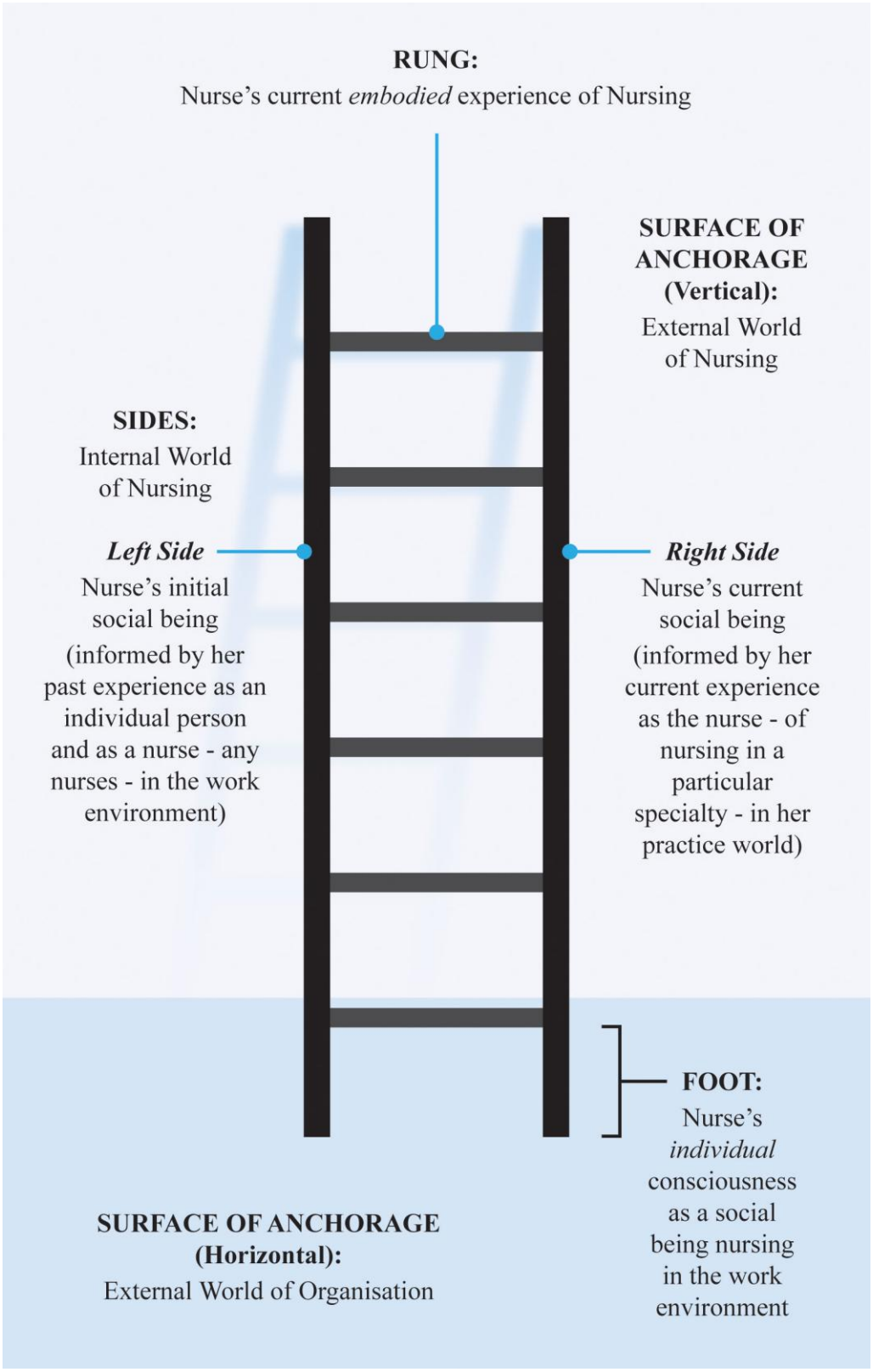
In summary, the nurse normalised her experience of nursing. The individual becomes an experienced nurse with specialty knowledge and skills. She is capable of constructing her composite care ladder for nursing patients with similar illness and/or disease conditions. This composite care ladder serves as a foundation for building a unique care ladder in meeting individual patient's needs in her experience of everyday nursing.

4.4 Interpreting the experience of nursing using a composite care ladder

The aim of this section is to explore the nurse's composite care ladder. Through a process of phenomenological analysis the nurse’s experience in relation to each of the components of her composite care ladder is interpreted: 1) surfaces of anchorage, 2) ladder feet, 3) ladder sides and 4) ladder rungs. Figure 6 Emergence of a composite care ladder below sets up and provides the basis for my phenomenological description, interpretation and explanation of the use of a composite care ladder where each component of a care ladder characterises the nurse's being-in-the-world. Each nurse's ready-to-hand composite care ladder serves as an important reference for further interpretive discussion of the nurse's

experience of nursing the outlier patient presented in the following chapter, that is Chapter 5.

Figure 6 Emergence of a composite care ladder



4.4.1 Surfaces of anchorage

The surfaces of anchorage represent the external world. The external world is where the nurse's "*practical involvement with the world*" begins and is "*fundamental for our [the nurse's] daily existence*" (Phillipse, 1999, pp. 12-13). In other words, it is through nursing within the external world that the nurse finds her experience meaningful.

The existentialist component, as defined by Conway (1998, p. 79), refers to the way that nurses use reflexive ability to link "*the world as presented by the patient*" to her nursing practice. The nurse establishes relationality from her experience of nursing the patients. For the purposes of this study, existentialist refers to individual nurse's involvement with the world, which is represented by the components of the surfaces of anchorage of the nurse's care ladder. The nurse's social being affects the way she interprets her involvement with the world and hence her experience. Her involvement with the world also adds to her personal context and leads to a continuous evolvement of her social being. This dynamicity between the nurse's involvement with the world and her social being has been termed by Watson (1985, p. 30) as "*environmental-personal interaction*", where the human care process between the nurse and patient transcends through temporality and spatiality and fits with the existentialist discourse in this study.

The surfaces of anchorage encompass both the horizontal and vertical surface of anchorage (see Figure 6 p.89). In the phenomenological orientation the horizontal surface of anchorage represents the external world of the health care organisation. The vertical surface of anchorage represents the external world of nursing. The following discussion of each of these surfaces of anchorage will explore the importance of the external world for the nurse and openly discusses the possibility of some conceptual confusion occurring as she nurses in the spaces between these surfaces of anchorage.

The horizontal surface of anchorage encompasses the organisational determinants of the work environment for nursing. One of the ways in which this impacts the nurse when she is caring for outlier patients is related to the differences between time as it is understood from a managerial (logic) perspective and the individual

participant's perspective of time does. The participants felt they were pressured. For instance, as Ann says,

> It's frustrating because we work...we work under constant pressure from the emergency department or ICU, they want to get somebody into that bed. It makes it difficult because they frequently say "Is that bed ready yet?" and we would say "No, it's not, because the patient is still in the bed". We do have a discharge lounge that we utilise for that. But there will be some patient who will not be suitable to go there. (Ann 169-173)

Here Ann is describing the organisational push for efficiency as a "constant pressure" which leaves her feeling frustrated. In Ann's example, the design of a discharge lounge, where patients can sit while waiting for a relative to pick them up or ambulance to transport them home, does suit the majority of patients. Yet, a minority do not fit into the admission criteria of the discharge lounge. And it is then up to the individual nurse to either take-on the bed manager's role and send the patient away somewhere else to create space for a new admission from the emergency department, or to upset the bed flow by allowing the patient to occupy the bed space while they wait for discharge.

For nurses the pressure to move patients through the system is constant because from a managerial perspective each bed space is viewed in terms of costs and occupancy. Ann's prime consideration is to provide comprehensive care while the manager's concern lies in cost efficiency (Forsyth & McKenzie, 2006). The discourse of economic rationalism and managerialism thus affects Ann's experience and perception of nursing. It can be seen that Ann and other participants are wary of becoming what Lawler (1999, p. 42) described as *"…functionaries, apparatchiks, instruments of the accounting system and extensions of management*". As the nurse no longer has "*what nurses know to be the value of their work and the value of their work as perceived by others*" in her experience of nursing, the nurse experiences "*enormous tension*" (Borbasi & Chaboyer, 2006, p. 112).

Reflecting on Fawcett and Russell's (2001) conceptual model of nursing and health policy, current bed management policy focuses on the efficiency of nursing practice delivery systems rather than the effectiveness of nursing practice processes for the health outcomes of patients. While the goal of bed management policy is to fit patients into a bed (frequently experienced by nurses as any patient into any bed), the goal of nurses is to provide nursing that fits with the patients' condition and needs. The ruling concern from the perspective of managerial logic is to clear the bed to allow admission of another patient (Rankin & Campbell, 2006). Ann's experience of nursing has been pressured by the phenomenon of "*110% utilization*" as described by Rankin & Campbell (2006, p. 52). This term is used to describe the managerial approach of reducing spare bed capacity and ensuring efficient utilization of resources generally through the use of admission, discharge and transfer software for efficient bed management (Rankin & Campbell, 2006, p. 45).

While the term "110% utilization" was coined within the Canadian health system, the approach is evident locally with the implementation of Bed Board, a bed management tool now used state-wide by NSW Health (Australian Resource Centre for Healthcare Innovations, 2010). In such bed-management processes patients from the emergency department are designated as occupying a "*textual space*" (Rankin & Campbell, 2006, p. 52) as they are queuing for a bed place that is actually filled by another patient at that point in time. Nurses are therefore required to take control of such situations on the basis of their nursing judgment, yet they are experiencing a situation that they perceive as either out-of-control or at best unsuitable for a particular patient for example, the discharge lounge being an unsafe alternative for some patients. In such circumstances individual nurses including the participants in this study are forced to decide between implementing bed management policy or defending their understanding(s) of the goals of nursing practice against the managerial logic that is organising the workplace.

Nursing with the managerial logic of efficiency, the participants in this study consistently described their experience of nursing in a workplace with inherent organisational complexity that they frequently saw as contrary to, or as potential barriers to, achieving their nursing goals. For instance, Agnes attends to lots of paperwork which is mainly for organisational and administrative purposes.

> Because you get bogged down. There is so many other things. I mean there is more, more and more paperwork, like putting patients file number... transfers of patients, [ensuring] that the patients have all their letters …all this sorting patients' notes. You know. All these things you know... half of the time I don't get to the bed or to the patient... (Agnes 280-293)

From Agnes' experience, the constraints of imposed managerial goals and standards of care that have been partially defined in terms of meeting organisational efficiency and effectiveness rather than reasonable and achievable outcomes for patients.

The vertical surface of anchorage encompasses a nurses' professional world, her requirements for registration as a nurse, her pre-registration and postgraduate nursing education and her ongoing accountability to the competencies and standards of nursing as defined by professional nursing bodies. This has been illustrated earlier in Chapter 1 on p.17 in the discussion of establishing career structure in nursing.

The current Australian National Competency Standards for Registered Nurses uses the terms effectiveness and efficiency within nursing standards to refer to the need for the nurse to provide their best level of care by using resources efficiently and effectively, to deliver effective care in a crisis situation through responding to unexpected or rapidly changing situations, and to ensure safe and accurate care through providing "*effective and timely direction and supervision*" (Australian Nursing and Midwifery Council, 2006, p. 10). Nursing standards of this type thus focus on the actual activities of nursing. Effective care in terms of nursing standards requires a combination of skill, knowledge, attitudes, values and

abilities in a professional area (Australian Nursing and Midwifery Council, 2006, p. 14). This professional perspective of nursing (that is the vertical surface of anchorage) is informed by the organisational perspective (that is, the horizontal surface of anchorage). As demonstrated in Figure 6 on p.89, the horizontal and vertical surfaces of anchorage intersect.

The nurse therefore attempts to connect these two surfaces of anchorage by positioning her care ladder within the intersected space between these two surfaces of anchorage. This space — the conceptual distance between managerial and nursing understandings of efficiency and effectiveness — is illustrated in the following examples of "tick box" care where such tick boxes are a task-orientated outcome measures (de Ruiter & Demma, 2011). The “tick box” approach is designed for efficiency and effectiveness for organisational and managerial purposes, whereas nursing purposes often differ although nurses will comply with the requirements of “tick boxes”. Both Agnes and Peter have nursed in workplaces organised by/through managerial tick-boxes and have come to recognise that the nurses' goals for a desired "level of care” cannot be fulfilled by simply ticking the boxes. Here Agnes explains her unwillingness to "tick boxes" on the basis of her desire to communicate with the patient.

> ... [What I want is] to be able to sit with the patient, to make a proper plan. Not this little tick boxes, you know, but to make a plan. I always come back to the word appropriate. But it’s just on the level of the patient, which they get something out of it. Not that we've just done the thing we needed to do. But that the patient actually has the feeling, he is heard and he’s definitely here to get better. (Agnes 192-196)

The “tick boxes” Agnes describes are formulated concrete listings of work tasks, the completion of which are to be indicated by ticking boxes. The organisational and managerial goal for using "tick boxes" is to establish the use of minimum-cost inputs to achieve the desired level of output – a process described as “*allocative efficiency*” (McGuigan, Moyer *et al.*, 2011, pp. 252-253). In managerial terms the effectiveness of the health care organisation’s performance is then measured by three factors: (i) patient/ family satisfaction with care, (ii) staff satisfaction with

work, rewards, professional development, career, personal and educational, and organisation, and (iii) management satisfaction with staff (Roussel, 2012, p. 280). Factors that are often only very loosely connected to the outcomes of care that nurses are striving to achieve with the result that many nurses question the applicability of "tick boxes" for measuring the complexity they encounter when nursing the variety of patients within any acute care ward environment.

Reflecting on my nursing experience, the **context-specific standardised care plan** is an example of a commonly encountered tick box approach to care. Here each "context-specific" care plan is specifically designed for patients of a particular illness group providing a standardized plan that has relevance for patients of a particular illness group only. The standardised care plan is therefore promoted as an efficient measure for incorporating the usual and expected outcome for patients of a particular illness group (Rosdahi & Kowaiski, 2008). The use of standardised care plans has the advantage of "allocative efficiency" and therefore is being seen as organisationally effective. However, such standardised care plans and their accompanying "tick boxes" always remain unsuitable or insufficient for a number of patients who for a variety of reasons (such as those pre-diagnosis or with multiple health problems whose outcome is therefore not predictable) do not fit or exhibit the usual or expected outcomes for patients of a particular illness group.

Alternatively, tick boxes in a standardised care plan can be interpreted as creating a "*space*" for nursing patients with a particular illness (Tilley, 1994, p. 10). Hence, all patients with a particular illness are eligible for a context-specific standardised care plan, where they share the same "*spaces*". Similar spaces will also be available to patients of another illness group. Cumulatively then these spaces account for the majority of patients. Yet, these plans and the accompanying tick boxes will be meaningless for an important minority of patients who have no standardised care plan because they do not fit and hence have no "*space*" to share. The managerial repositioning of quality of care as standardised care for the majority of patients has arguably violated the provision of "*equitable*" nursing as suggested by the Australian Nursing and Midwifery Council, Royal College of

Nursing Australia *et al.* (2008, pp. 7, 9). The managerial and nursing definitions of effectiveness and efficiency therefore vary.

Perhaps further illustrating the difficulties of working across two worlds that barely intersect, these "tick box(es)" generated by the external world of the organisation and largely ignored by the external world of nursing, have different meanings for the individual nurse's internal world of nursing. For example, while Agnes described tick boxes as merely a work task to be completed but not a nursing activity, Peter understood tick boxes as part of "care" and part of nursing activity but then he distinguishes between the levels of care provided thus demonstrating that for him too the tick box is not particularly useful in terms of provision of (good) care.

> And if you tick [the patient's] boxes on the form, it means that their care has been done. It doesn't matter to what level it [care] has been done." (Peter 415-417)… [Ticking boxes] on the form secures the basic requirement for that patient. It doesn't go anything beyond that." (Peter 423-424).

While all participants are nursing within a system of managerial logic, often in the absence of any managerial explanations, each participant experiences and interprets this managerial logic differently. Agnes and Peter experience and interpret "tick boxes" differently, yet both claim that the emphasis of nursing is to achieve a level of care that matches the patient's need, rather than fitting with the organisational design of work. For them, nursing goes beyond fulfilling the managerial logic of ticking the boxes, which they see as something needed by others but not directly effecting the care they provide to patients.

Nursing's managerial literature claims that adopting standardised nursing legitimises professional practice (Allen & Pilnick, 2005; Germov, 2005) and establishes "*clinically sound standards of care*" for patients of a particular illness group (Crisp & Taylor, 2008, p. 425). Other current nursing research has identified the replacement of critical nursing judgement with a "tick box" mentality as one of the risks of employing tick boxes to record nursing tasks

(Berkow, Virkstis *et al.*, 2011; Clark, 2007; Hughes & Clark, 2008; Rankin & Campbell, 2006; Rycroft-Malone, Fontenla *et al.*, 2008). In this study however it is evident that Agnes and Peter are more concerned with the disadvantages of using the "tick boxes", such as the not being able to "hear" the patient's voice and to "plan" nursing.

In summary, the surfaces of anchorage form essential components of the care ladder. For the purpose of this study, the horizontal surface of anchorage represents the external world of the organisation and the vertical surface of anchorage represents the external world of nursing. The examples of "tick boxes" — as constructed by the world of organisation — has different meaning when compared to the external world of nursing, and to the individual's world of nursing and thus gaps are created. The nurse therefore attempts to bridge these gaps by positioning her care ladder within the intersected space between these two surfaces of anchorage.

4.4.2 Ladder feet

Within the phenomenological orientation of the care ladder the ladder feet (the part of the ladder that is located below the bottom rung) represent the nurse's consciousness of being-a-nurse. Through the nurse's presence in the organisational construct and the determinants of the workplace, the nurse is conscious of where she is, and who she is as a nurse.

Because experience cannot exist without consciousness, the two ladder feet can be understood as providing the essential base of the care ladder.

The stability of the ladder depends on the way the bottom of the ladder (the ladder feet) is balanced, just as the level of care the nurse achieves may well depend on her consciousness of being-a-nurse.

Ladder feet exist in pairs and without being connected by a rung(s), an individual (single) ladder foot has little functional use or meaning. As being and the world are inseparable, the ladder rungs representing the nurse's experience of nursing are attached to each side of the ladder. The lowest rung is acting as a bridge spanning the space-between-the ladder feet, and stabilising the bottom of the care

ladder. In other words, the nurse's experience and her understanding of the nurse's world can only exist when stabilised by the nurse's consciousness of nursing.

It is through the nurse's consciousness of striving to be the best nurse she can be that she experiences providing the **best possible nursing care**: the **best possible positioning** of her care ladder. The importance nurses give to achieving the "best" possible nursing care is expressed in the following excerpts from several participants.

> Because a nurse is expected to provide quality of care for the patient. You just do your **best** when you have a patient." (Rainbow 196-197)
>
> …the need of the patient is good nursing care (Rainbow 407)
>
> Care is looking after the patient. Looking after his or her needs and addressing them as **best** I can. I can't solve everything obviously. But at least…his or her concern [is being] taken seriously and act to the point. (Agnes 146-148).
>
> We should hope that … everyone has the **best** interest of the patient at heart… (Ann 61-62)
>
> I think most nurses on the floor, would like to know at the end of the day, they have done the **best** by their patient. (Marie 52-54) ...in the end we all want what's best for the patient. (Marie 400)
>
> … that's expected of us… [Nursing with] High standards and protect the patients and the relatives as well. Protect the patients and do what is **best** for the patients. (Hope 519-522)

These exemplars can be seen to demonstrate how individual participants desire and aim to retain the core value of nursing of attempting to do the best for their patients (Maben, Latter *et al.*, 2007, p. 108). However when considered in context of other extracts (see Claire below) it could be interpreted that these data also represent compromised ideals where the participants "*could only partly implement*

their ideals" when nursing (Maben, Latter *et al.*, 2007, p. 107). For instance, Claire reflected on her nursing practice and she said "I think sometimes the care, the nursing care isn't as good as it could be." (Claire 142-144)

Each nurse develops her own core value of nursing based on her individual social being, that is, from her personal social and cultural nursing context and her past experience of nursing. As some nurses are sandwiched in-between the world of the organisation and the world of nursing, they appear to adapt their ideals by modifying their social being so that they can function within their work environment.

Each participant also experiences and understands what constitutes **best** possible nursing care, differently. When analysing the participants' descriptions, it became evident that some participants were nursing as nurse humanists with a commitment to human caring, and as specialist nurses and/or specialty nurses in delivering what they described as best possible care. The importance of the nurse's understanding of the patients' needs and demands has been aligned with being a nurse humanist (Burhans & Alligood, 2010; Traynor, 2009). Agnes and Hope, for example, were relating to the patient as a person and attaching personal meanings to their work (Wall, 2010) when they described their perceptions,

> …[caring for the patient as a whole] would give me the best satisfaction to provide that really high level of care where I really provided for the patient in a holistic way. Like the patient as the person again, you know. Where I have time to get to know the patients. And to look behind, not to just presenting problems now – but to look at the whole person. (Agnes 717-720)

> … giving the care the patient needs and not only in the physical sense. But at the same time try to be kind...on a human level …make the patient feel comfortable…give the patient attention and yes, also on the spiritual level too… being able to talk to the patient, or reassure the patient, or give the information to a patient the condition that they

> have or if they have worries, make the patient feel that they can ask questions. (Hope 368-375)

Both Agnes and Hope connected to the patient's situation as they were nursing. Reflecting on Watson's (1985) discussion of the nurse as humanist, Hope is demonstrating two senses of knowing: 1) knowing **from** the patient and 2) knowing **for** the patient. Hope's experience of "giving the care the patient needs" is an example of knowing from the patient, showing that Hope is using in her nursing what Watson (1985, p. 30) refers to as "*inter-subjective human responses*". Hope's experience of being able to "give the information to a patient" is an example of knowing *for* the person, where Hope uses what Watson (1985, p. 30) referred to as the "*knowledge of health illness environmental-personal interaction*" and the "*knowledge of nurse caring process*". Hope's experience of nursing as a humanist is characterised by the human bonding between the individual nurse and the patient as a person, rather than the completion of nurses' work/ technical tasks.

John can also be described as a nurse providing humanistic care as his strong need to use the patient as the central focus of his nursing illustrates.

> The optimal care is where the communications is high and everything revolves around the patients, rather than revolving around logistics or politics or budget or anything else. And then that's optimal care, that's what we all [nurses] want I guess. (John 131-134)

John is highlighting the different emphasis evident between the nurse's view of optimal care and how to achieve this for patients and the managerial perpective that involves a more political and/or economic focus. From John's perspective the patient and their needs must remain central. Whereas, from the managerial perspective, best possible care is that described in a best practice guideline, which is informed by the logic of standardisation and evidence-based medicine and/or nursing (Rankin & Campbell, 2006, p. 9) and not the needs of a particular patient.

For other participants, such as Peter, being-a-nurse involves working as a specialist in an environment that acknowledges the value of their specialised

knowledge and skills and is aware of the potential sequelae of the absence of such care.

> Every nurse gives a level of care which they will give regardless of what unit they are in. … But above and beyond that, I think it's where your specialisation comes in, and where the specialised knowledge and skills comes in. And if the patients are only getting that basic level of care, then it's going to impinge upon their length of stay. (Peter 234-238)

From Peter's perspective, specialisation means nursing with specialised knowledge and skills. However, these years of experience within such a specialised nursing area is frequently not distinguished from the concept of specialty nurse and specialist nurse as defined earlier (p. 20).

In this study it became clear that most participants identified their consciousness of being-a-nurse. At the foot of the care ladder, the nurse is nursing as either a nurse specialist or specialty nurse but not a generalist nurse. Whereas Conway (1998) regarded nurse specialists as having distinctive roles in a particular specialty area, this study suggests that the participants' understanding of nurse specialist, specialty nurse and a nurse nursing in a named specialised ward (who is potentially a generalist nurse) are three different concepts.

Hope believes that staying in one ward will lead to her being able to provide more specialised care because of her familiarity with that care and provides insight into the perspective of several participants when she says,

> It's good to have the general knowledge. But if you stay in one ward for a long time...I think eventually you becomes specialised because you do that work all the time, the same work all the time. (Hope 704-706).

From the perspective of the profession, a nurse is a specialty nurse when she gains knowledge through "*on-the-job training experience*" (National Nursing and Nursing Education Taskforce, 2006a, p. 8) and through exposure to nursing

specialty-appropriate patients (Watson, 1911). Blegen, Vaughn, & Goode's (2001) study showed that nurses with more experience provide better patient care than nurses with less experience.

Apart from the familiarity with care, formal education is another means of developing specialty and specialist care. For instance, Peter stated that he has been "…trained [educated] at postgraduate level" to "…give a specific level of care to a specific type of patient" (Peter 148-150).

Since each nurse has a different understanding of her nurse role; for example, as a humanist, a specialist or a combination of specialist and humanist, each nurse's construction of best level of care can be different.

Nursing with a care ladder is an individualised experience. in which each nurse uses a care ladder in nursing each patient. In Heidegger phenomenology is described as, the "*unit of analysis is a transaction between situation and the person*" (Laverty, 2003, p. 24). Since nursing "*requires (the nurse's) attentiveness to individual (patient's) experiences and to particular situations*" (Madjar & Walton, 1999, p. 5), exploration of each phenomena — the nurse's experience of nursing each outlier patient — as the nurses present themselves to consciousness, is therefore fundamental in understanding the phenomenon of nursing the outlier patients.

The nurse does not merely experience clinical situations as any nurse, but as an individual who has her life experience reflected in her nursing practice (Arbon, 2004, p. 150). In the world of nursing, the nurse nurses many patients in a ward. As she analyses her individual experience of using a care ladder to nurse each patient, she attempts to make sense of her experience of nursing each patient and nursing many patients in a ward. This intentional relation to the world — as the nurse uses multiple care ladders for many patients, has led to the nurse's construction of her **personal normative equilibrium**. This is a perception of her relationality with her patient in her work environment, as informed by the mediation between the nurse's "*self-relatedness*" in her social being, and her

"*world-relatedness*" as her experience emerged in her work environment (Zahavi, 2000, p. 262).

The nurse uses her personal normative equilibrium to bring in her multiple care ladders, for the purpose of ensuring that each care ladder meets her best level of care (her perception of optimal care). As the nurse gathers her "*lived-through meanings*" of nursing on multiple care ladders, she "*reshuffle[s] the elements of our (the nurse's personal normative) equilibrium*" (Merleau-Ponty, 2005, p. 177) to make sense of the phenomenon of nursing the outlier patients from her experience of nursing the outlier patient. The nurse uses each of her care ladders to deliver her optimal care in her nursing experience, and this ongoing experience of using multiple care ladders for nursing various patients therefore continues to inform and make the nurse's normative equilibrium achievable. Thus, she is capable of achieving her perceived optimal level of care, her relationality with her patient and hence her understanding of the phenomenon.

In summary, ladder feet represent the nurse's consciousness, in which most participants identified their consciousness of being a specialist nurse or specialty nurse. The nurse has the capability of achieving (her) normative equilibrium, in other words, a balanced state in which the nurse is comfortable in nursing at her best level of care. Some participants used the term "best" nursing when talking about their goals for the care they provide yet what is understood to be "best" care can vary widely. This probable variation is represented by the differing heights of the various care ladders as each care ladder is directed constructed and used by an individual nurse to meet her perception of optimal care. That is, the nurse has individualised her care ladder and achieved her personally constructed normative equilibrium for nursing each patient.

4.4.3 Ladder sides

For the purpose of interpretation in this study the ladder sides represent the nurse's internal world, (the world of the individual), which is situated within the external worlds. While all nursing takes place within a ward that is part of the external world, the experience of each nurse within her internal world may vary. In other

words, nurses can live in similar external worlds yet their embodied experience. Their internal world-view may be different.

In this interpretation the left side of the ladder therefore represents the nurse's initial social being, that which is informed by her past experience as an individual – both as a person (for example, an individual's exposure to mass media reports on nursing, television portrayals of nurses etc.) and as a nurse who has experienced working within nursing in particular nursing roles (for example, experience as a nursing student or nursing internationally). The right side of the ladder then represents the nurse's current social being, that which is informed by her accumulated experience of nursing to date and more specifically her experience gained from nursing within a particular specialty ward or area.

Using the rungs, the nurse makes connections between her initial social being: her "everyday existence" (left ladder side) and her current social being: she "lives the experience" (right ladder side) (van Manen, 2001, p. 11). Rather than simply understanding her workplace as it pertains to her initial social being i.e. as a **work environment** similar to any other provided by a health care organisation (left side of the ladder), when linked to the right side of the ladder the nurse now understands her work environment in connection with her current nursing experience and her embodied understanding of her work environment as her **practice world**.

Informed by his initial social being (left side of the ladder) John expresses his understanding of the work environment as a "system" that "revolve[s] around us [nurses and patients] and our needs." (John 134-135). Hence John's belief or perception is that his work environment **should** address the needs of both the nurses and the patients. This perception is based upon an **expectation** derived from both his initial social being, rather than a perception based on his current embodied experience.

Nowotny (1994, p. 48) refers to expectation as a dynamic "*horizon of expectation*", where the previous "*space of experience*" has been modified by the "*experiences of reality*" and has undergone "*changes in quick succession*".

Expectations change with experiences and thus have a "*transcendent nature*" that moves along with the transcendent nature of social being. In other words, expectation has both dynamic and a temporal nature. Unlike cognitive idealism that emphases the individual's internal process (Witcher, 1999), expectation takes account of both the person and the environment. The nurse's expectation is evolving continuously as the nurse's experience continues to add to and modify the nurse's existing social being. Taking John's example, both John's needs as a person and the needs of the "system" as his work environment inform his expectations. And it is through this relationality between the person and the environment that informs the individual's social being as represented by the ladder feet. While John's understanding of his work environment is based on his social being as a nurse, Peter expresses his understanding of the work environment based on his consideration of meeting organisational requirements and of "…trying to get systems in place for them [patients] to go out [discharge]". Peter's expectation of the work environment was for the nurse to fulfil the requirements of the organisation rather than the patient. Thus while both John and Peter both nurse in an acute care ward in NSW, their individual understanding(s) and expectation(s) of a health care work environment seem to vary considerably.

Claire's description of the "system" as practice world (right side of ladder) however, expresses her view of the "system" as a space associated with her nursing experience, where her experience of nursing in the "system" has made her feel quite stressed

> Because all the stress of the **system...** I suppose hospitals[s] are very busy places. And there isn't often enough staff to meet the demand of all the needs that people have…Looking back in my nursing life**... the nursing care isn't as good as it could be.** And that's because of the there isn't enough nurses. And there isn't enough time. ... Because there aren't enough people around, and maybe not people who are experienced as well…I think there are a lot of stresses. (Claire 138-152)

Claire's extract gives us an understanding of how she perceives nursing within a "system", where there is a lack of "time" and a lack of "staff" in the "system" resulting in "a lot of stresses" and directly impacting upon her experience of nursing. Claire's experience of the barriers to "good care" — as illustrated by her experience of stress — is a subjective phenomenon based on individual experience and perception (McVicar, 2003). This subjective phenomenon will now be explored.

In order to understand what Claire has referred to as a "system", I have considered Tilley's (1994, p. 17) description of relational space as a place "*created by social relations, natural and cultural objects*". Such relational space does not exist as a set of relations naturally occurring between things, but as a socially constructed space (Tilley, 1994). Therefore by adopting Tilley's concept of relational space in interpreting Claire's discussion of nursing in the "system", the "system" does not merely refer to the number of nursing hours and the number of staff at a workplace, but an architectural space built up by the organisation in facilitating the functioning of a hospital (Tilley, 1994). The nurse's initial social being is informed by her experience of nursing within this architectural space. Using the composite care ladder as a tool for phenomenological orientation, the nurse's experience of nursing within an organisationally determined structure of the work environment can therefore be represented by the left ladder side of the care ladder.

While I agree that Claire's "system" is a relational space, my interpretation of what comprises a "relational space" is different to that of Tilley (1994) as I have interpreted it to be an individual's experienced space rather than just a socially constructed space. As the nurse experiences nursing the outlier patients, her initial social being of nursing specialty-appropriate patients will inform her interpretation of her current social being of nursing the outlier patients. My construct of relational space therefore refers to a nurse's embodied experience of nursing, which is represented by the function of the ladder rungs in joining the left and right ladder sides together. In other words, the nurse's initial social being (as represented by the left ladder side) is linked to the nurse's current social being (as

represented by the right ladder side) through the nurse's experience (as represented by the ladder rungs).

Claire's embodied experience of nursing has also been affected by her experience of "time" and available "staff", which she perceived and described as nursing in the "system". It is this relationship between Claire's experience of "time" and available "staff" within the "system" and her experience of nursing that makes her space relational. Echoing the earlier discussion of the shift from ontological to sociological inquiry (See Chapter 2 p.50) where questioning both personal meaning and social meaning is crucial to understanding the concept of being-in-the-world, Claire establishes her "*relational space*" between her initial social being and current social being (Tilley, 1994, p. 17) by taking her experience of nursing within the system into account and interpreting/re-interpreting what "time" and available "staff" means in her experience of nursing. This relational space therefore is neither a personal space or a "*socially constucted space*" alone, but a space comprised of both a personal space and a socially constructed space (Tilley, 1994, p. 17), which is otherwise known as the nurse's embodied experience.

Similar to Claire's experience of lack of "time" in her practice world, Madeline and Hope also sensed time to be insufficient from their experience of nursing as evidenced in their words:

> [In order to] get all the basic things done and having the time for more. Having the time to actually be with the patient. To listen to them and communicate and give them education and things like that…There is never enough time. (Madeline 289-296)

> …in seven hours. I think I don't have the time to really read the notes of the patient. I don't have the time to talk to the doctor as much as I want…. (Hope 134-135)

Both Madeline and Hope commented that the lack of "time" has prevented them from nursing the way they wanted to nurse. Madeline's experience of "never [having] enough time" is similar to what Nowotny's (1994, p. 134) referred to as

the management's suffering from a "*chronic lack of time*" as a consequence of the frequent pushes for efficeincy and the attempts to "*constantly try to do too much*". Hope's time is being fixed into a "seven hour" time interval, where seven hours is a nursing shift as per the managerial determination of her work schedule. The work hours and the tools used to measure the work required and completed within them, such as nursing hours per patient per day and nurse-patient ratios, are managerial methods of measuring nursing workload (Twigg & Duffield, 2009). Organising themselves in the context of the managerial method of measuring nursing workload, Madeline and Hope assigned time to each work task. When the total of the time assigned (required) for each of the work tasks exceeds the total work hours of a nursing shift, these participants perceive that time is running out in that there is not enough time for all work tasks to be completed. Madeline and Hope's examples of getting everything done in a fixed time period represents task-orientated care, where they are trying to focus primarily on getting the assigned work as understood from the managerial perspective completed, and later if and when possible, they are attempting to complete nursing the patient by providing what they understand is required from their individual nurse's perspective (Maben, Latter *et al.,* 2007). Both Madeline and Hope primarily focus on using the "*functional care delivery model"* of nursing, where the priority of nursing is to complete tasks that are allocated according to judgement and technical knowledge required by each task. On completion of their "tasks", both Madeline and Hope then move to using a "*primary nursing care delivery model*" and nurse with one-to-one, patient-centred care if and when possible (Tiedeman & Lookinland, 2004, pp. 292, 295).

While Farrell, Bobrowski *et al.* (2006, p. 785) identify that "*not having enough time to complete work*" is a "*work load issue*" and conclude that such issues are a "*major distress factor*" for nurses, to some participants this lack of time is part of the nurses' experience of nursing rather than measurable factors. In this study, some participants (earlier described as humanists) attempt to fit within the managerial logic of task orientated care into their practice world (Maben, Latter *et al.*, 2007). It is likely therefore that the carefully measured workload of the nurse refers only to completion of the tasks required under this logic. Participants in this

study repeatedly discussed their experience of a relatively high work-load given the nursing time available, as illustrated by Agnes' description of her need to be watchful with her use of time while nursing.

> Because it [is] just [a matter] of sheer workload. And the way the work is organised because as a registered nurse, you are so busy dishing out the medications, organising the other staff, seeing that the observations are done. They are just the basics getting done. So that nobody dies on you with any luck. You know, or any terrible things don't happen, that you are lucky enough to see that somebody is going towards a heart attack or something else is happening that you can prevent. But it's all about just the maintenance, you know. Just to get it, you know. To get through another shift for sure. You know, it's not the individual nursing care. (Agnes 183-189*)*

Apart from securing time for getting the "basics" done, Agnes regarded any nursing activities outside of the "the basics" as opportunity costs. These workload issues and the lack of time as experienced by Agnes has shifted her focus of nursing towards adopting the priority of medical care (Kihlgren, Nilsson *et al.*, 2005). As discussed previously in Chapter 1 on p.21, many nursing competencies have devolved from medical tasks over time. Some nurses therefore possibly consider completing medical tasks as a sign of fulfilling nursing competencies. Despite "dishing out medications" and getting "observations" done being essential components of nursing, Agnes commented that such tasks are the organisation's construction of work and are only "the basics" and "just the maintenance" of nursing.

In addition to lack of "time", Clare also highlighted the lack of "staff" in her nurse's world. Similarly, Marie critiqued the current organisational strategy to address the lack of "staff" in the work environment. She said:

> Well, I mean it's a big picture. It is a big picture because the unions signed off on these things which are called a 'reasonable workload tool'. This tool is appropriate for some wards but not others. For most

> general medical wards, organisations abide by this reasonable workload tool which takes into consideration the nursing service rate. But it doesn't take into consideration things like skill mix. (Marie 349-353)

Adding to the staffing issues of nurse-patient ratios that Claire identified , Marie is demonstrating her concerns about "skill mix" based on her nursing experience. She is working in a nurse's world where a staff-centred care model that addresses changes in skill mix is absent (Chiarella & Lau, 2007). Skill mix refers to "*the balance or mix of the various nursing classifications, skills and responsibilities required in the particular specialty...*" (NSW Nurses and Midwives' Association, 2010a, p. 5). The theoretical construct of skill mix is driven by the organisation's financial considerations. As less skilled workers are functioning under the direction of a registered nurse in taking over more complex routine tasks, the registered nurses will have more time in direct care and are therefore less costly (Duffield, Forbes *et al.*, 2005). However, skill mix, according to the NSW Nurses' and Midwives' Association (2011) does not merely refer to the declining nursing numbers per patient, but also the declining proportion of Registered nurses in nursing that impacts on the quality of health care in NSW. In other words, inadequate staffing can influence the safe provision of care. Yet, the NSW Nurses and Midwives' Association (2010c) does not investigate staffing as a system issue, but as a nursing related issue. Nurse groups refer to staffing as the actions and decisions of an individual nurse, without addressing the underlying working conditions for the nurses in the system. It is up to the nurses to take their concerns and experience of inadequate staffing to a higher level of management (NSW Nurses and Midwives' Association, 2010d). In contrast, the Australian Nursing and Midwifery Council (2007b, p. 4) reported that it is the organisation's responsibility to ensure availability of sufficient resources for safe and competent care in the nurses' work environment. As per some participants in this study, skill mix means more than the nursing numbers per patient. The nurse's perception of skill mix, in both her initial social being and current social being, has influenced her experience of nursing, in which she is nursing with an actual (experienced)

lack of time and lack of staff in her internal world of nursing (as opposed to a perceived time and staffing issue).

In summary, the ladder sides represent the nurse's internal world. The left and right side of the ladder indicates a temporal difference of nursing. The left side of the ladder represents the nurse's initial social being, whereas the right side of the ladder represents the nurse's current social being. As reported by some participants, their social being is characterised by their experience of lack of "time" and lack of "staff". As the nurse is nursing specialty-appropriate patient, she is experienced in nursing with these resource constraints and a relatively high workload.

4.4.4 Ladder rungs

The ladder rungs are components of the care ladder that represent the nurse's experience, specifically the nurse's use of her capabilities in achieving her best level of care. The ladder rungs also provide a link between the nurse's initial social being and current social being with each informing the other in some ways.

Rungs connect the two ladder sides. On the left ladder side, the nurse develops "*analytical principle*" through formal university education. The nurse is able to perform actions with the aid of guidelines and achieves a level of competency (Benner, 1982, pp. 405-406). As the nurse repetitively uses these "analytical principle[s]" from her initial social being (as represented by the left ladder side), she gains "*experience*" of "*clinical practice*" by nursing patients with particular illness conditions and hence develops her capabilities (as represented by the rungs) around her specialty and informs her current social being (as represented by the right side of the ladder). For instance, the nurse who nurses cardiac patients in a cardiac ward develops her capabilities specifically in cardiac nursing (Benner, 1982, pp. 405-406). These capabilities specific to a particular specialty, are represented by the nurse's full set of ladder rungs, where the nurse continues to strengthen or develop new rungs within her specialty. The individual nurse’s full set of ladder rungs therefore becomes a ready-to-hand component for the construction of her care ladder where she selects rungs specific for each patient based on her assessment and interpretation of the patient's illness condition and

severity within her specialty. The nurse uses her selected capabilities (as represented by the rungs) in achieving her best level of care to nurse each patient. From the phenomenological interpretation of rungs connecting the left ladder side to the right ladder side, the nurse is able to understand her current social being and her experience of specialty nursing from the combination and accumulation of understanding of her initial social being, her experience of nursing in general and exposure to the specialty area. As she nurses patients of her specialty, the nurse uses her "experience" of "clinical practice" as one of her multiple realities to backup her formal education and to generate informal knowing.

The ladder rungs, as a representation of the nurse's experience of using her capabilities in nursing, also determine the energy and effort she requires to implement the care ladder to nurse individual patients within her care. Effort refers to a "*strenuous physical or mental exertion*"(Oxford Dictionaries, 2010) and can therefore be understood in this context as physical and mental strength used as the nurse metaphorically climbs the care ladder. I have termed this effort in the context of nursing in this study as **climbing effort**. Climbing the care ladder requires effort, for instance, the nurse's motion of taking off from the surface of anchorage stepping up on ladder rungs is an obvious transition, where the nurse enters her internal world of nursing from the external world. The effort required to reach the nurse's best level of care depends on her **capabilities** of nursing and her familiarity with the care ladder. The more capable she is, the less effort is required and the greater her exposure to patients with particular conditions or diagnoses the more familiar she will be with using her care ladder in the provision of care.

Comparatively, energy is defined by the dictionary as "*the strength and vitality required for sustained physical or mental activity*" (Oxford Dictionaries, 2010). The nurse expends energy in the effort to **maintain the upward direction** and to attain **the goal of reaching her personal best level of care**.

The degree of the nurse's energy required partly depends on her perceived best care for an individual patient. Depending on the acuity and severity of the patient's disease/illness condition as perceived by the nurse, the nurse's care ladder for each patient varies in height with some having more rungs than others. While a tall care

ladder compared to one that is shorter does not mean it is a better ladder than the short one, the height of a care ladder influences or effects the degree of energy required for climbing up a ladder, that is to reach the nurse's perceived best level of care. From my analysis of the data from these participants' experience, five significant ideas/issues became evident in the nurses effort to provide their best level of care and these have been labelled as the **capabilities of the nurse**. For the purpose of interpretation within this study each of these capabilities is represented by a ladder rung, however, the five rungs (capabilities) are not necessarily the only ones. It is possible that other rungs would emerge or become evident for each nurse or for nursing different patients.

In summary, ladder rungs represent the nurse's experience of nursing. As the nurse is nursing specialty-appropriate patients, she develops capabilities that enable her to provide her best level of care to her specialty-appropriate patients.

4.4.4.1 Being capable of synchronising the rhythms of nursing

The nurse is (being) capable of developing synchronised rhythms between the work environment and practice world as she is nursing in the internal world (as represented by the components of ladder sides and rungs of the composite care ladder) surrounded by the external world (as represented by the components of surfaces of anchorage of the composite care ladder). The nurse incorporates both rhythms from the world of organisation and from the world of nursing in her nursing practice in her internal world. She adapts to the organisational structure by using her past experiences and her accumulated nursing experience. The nurse develops a pattern of time and work that suits her experience of nursing within the organisation's construction of the work environment, where this can be seen to fit into a specific sequence of nursing practice that meets the managerial needs and ensures efficient functioning of the organisation.

For instance, John is experiencing both his nursing rhythm and the rhythm of the work environment as he nurses.

> Time management affects the routine like you necessarily have to do the shower at certain times, and medication... There is a certain

> amount of flexibility [for showering and administering medication] . But at the same time, there is a routine that the wards runs in. (John 57-61)

John recognises that the rhythm of the work environment has provided a rigid frame within which he accommodates his nursing rhythm by restructuring his scheduling of time and work. John's experience of doing showers and medications at certain times is an example of what Chia (2009, p. 196) described as a "*schedule-driven*" or "*activity-based*" approach in nursing, where the nurse exercises reactionary caring towards patients through following her routine. From John's experience, he is capable of developing and using synchronised rhythms for the majority of patients in the ward within his specialty, where most patients of his specialty are showered and receive medication at certain times. Being capable of developing synchronised rhythms promotes effectiveness and efficiency in nursing (Newman, 1999). Rather than questioning the organisation's routine of work, most nurses like John incorporate the organisation's work rhythm into their own nursing rhythm and nurse with an individual synchronised rhythm. As discussed in Chapter 1 on p.16, where nurses have shifted from nursing with a whole body focus in an open ward area to nursing a particular organ or body system within the organisation's imposed hospital ward division, the rhythm of nursing patients with **similar** illness conditions in a single ward is often "*repetitive, recognisable, and predictable*" (Newman, 1999, p. 228). As John nurses his specialty-appropriate patients in his work environment over time, he becomes familiar with and capable of synchronising the rhythm of nursing and that of the work environment.

John's goal of developing and using synchronised rhythms is to keep each of the nursing tasks flowing and to ensure completion of tasks, hence achieving a level of synchronicity where his nursing fits the managerial needs within the organisation. Synchronising the various rhythms in accordance with the work environment is how nurses develop what Newman (1999, p. 228) called the nursing "*pattern*", which "*...is a dynamic relatedness with one's environment, both human and nonhuman*". Being capable of developing and using synchrony is the

nurse's experience, where the rhythm required by the patient, and the organisation's rhythm are performing in synchrony, minimising the nurse's (climbing) effort. The nurse is capable of negotiating the possible barriers resulting from unsynchronised rhythms.

The idea of routine and rigid rhythms has been associated with nursing for a long time and it has been the basis of many of the historical approaches to nursing training. Prior to the 1950s, nursing training placed an emphasis on learning the technical and practical procedures related to the physical body (Bradshaw, 1995; Creighton & Lopez, 1982). Rather than empowering nurses to adapt knowledge to nurse the patients, nurses were being trained to follow the organisation's routines and rules (hierarchal), and to use experience as automatic behaviour systems (Creighton & Lopez, 1982).

Despite the trend of ongoing nursing education and career as discussed previously in chapter 1 on p.17, the historical practice/tradition of following an organisation's routine and rules remains prominent in nursing and has frequently been accepted without question as best practice in nursing. During the 1970s, the concept of advocacy was introduced in nursing to challenge the unquestioning loyalty of many nurses for organisational practice (Winslow, 1984). The assumption of nursing obedience to organisational policy continues to exist at present (Bail, Cook *et al.*, 2009), where the Code of Professional Conduct for nurses in Australia requires "*nurses [to] practise* ***in accordance with*** *the standards of the profession and broader health system*" (Australian Nursing and Midwifery Council, 2008, p. 3). Such policy provides a professional framework to practice and attempts to connect the external world of nursing in a unidirectional manner to nursing practice rather than seeing it as a two way connection. Elaborating from Newman's (2007, p. 227) discussion of a "*mutually satisfying rhythm*", the synchrony between the nurse's rhythm and the organisation's rhythm has led to the individual nurse gaining control of nursing and a feeling of closeness and unity. This capability is characterised by the relationality between nursing and work through nursing in a synchronised rhythm. The nurse's ability to provide this best

care is actually premised on this capability. The more capable the nurses are to enact, then the closer they can get to achieving their best care.

In summary, the nurse is capable of using the synchronised rhythms as she nurses her specialty-appropriate patients. This capability allows the nurse to keep nursing tasks flowing and enhances the nurse's ability to provide best care.

4.4.4.2 Being capable of practicing with disease and/or condition specific familiarity

The nurse develops her capability of practicing with disease and/or condition specific familiarity as she continues to apply and reflect on her personal knowing (Bonis, 2009). Nurses who work in the same specialty ward area over time accumulate experience and develop a familiar knowing about nursing patients with particular specialty illness conditions. In the following extracts Ann and Madeline describe their capability for practicing with disease and/or condition specific familiarity when they nurse specialty-appropriate patients:

> …people work in certain areas and develop skills in looking after patients with you know, certain diseases and conditions, and they become very good at that. So I think that the patient may want to ask questions about their disease process or if you have worked in that area for considerable time, you do develop those skills. So I think that's a great advantage. (Ann 220-224)

> When the patients in this ward are here, our specialty patients, the more and more they come in, the more familiar we are [with] what their conditions are, what their co-morbidities are. We often know the patients because they have been here before. (Madeline 50-52)

Both Ann and Madeline describe how they recognise that patients with particular illness conditions share particular signs and symptoms and how they develop knowledge of what Mishel (1988, p. 225) described as "*symptom pattern*". Over time when nurses encounter the same or similar nursing situations they begin to recognise and synthesize the typicality of their experience (Schutz & Embree,

2011, p. 126). Through exposure to "*many patients of similar type*" in her home (specialty) ward, the nurse develops her decision making processes based on her experience with similar patients (Cioffi, 2000, p. 111). Similarly, Mishel (1988, p. 225) referred this decision making process as the development of "*event familiarity*". Nurses working with specialty-appropriate patients are then able to extrapolate, at least to some extent, from this event familiarity to a pattern of care that nursing patients with a particular illness condition often follows. This pattern of care becomes ready-to-hand as the nurse continues to nurse patients with these particular illness conditions.

Both event familiarity and the expected pattern of care sometimes serve as a basis for nursing prediction, where nurses estimate that delivering certain care to patients with certain symptoms will result in certain patient outcome(s). When such nursing predictions are repetitively fulfilled in the nurses' experience, they further develop "*event congruence*" and become more confident in their pattern of care (Mishel, 1988, p. 225). The nurse evaluates her pattern of care and expresses her practical concerns in strengthening her capability to practice familiar nursing (Carper, 1978). The relevance of such capability to practice familiar nursing has been reported by Herbig, Bussing *et al.* (2001, p. 688) as having "*utmost importance for dealing with critical working situations*". Marie comments on her nursing experience by placing emphasis on the importance of articulating her familiar knowing to understand the rationale for implementing a specific nursing action for specialty-appropriate patients.

> … when patients come in with heart failure. We could give them information on why they are short of breath or why we need to check their weight every day. Why we keep them on a fluid restriction. So it's a constant… fairly set path on the treatment of those patients…if the doctor has ordered an echocardiogram (ECHO), we can explain to them what it's about and why they are doing that. And patients that come in with heart failure or chest pain have a sort of a set path on what they normally, what we normally do to help them to get out of the hospital. (Marie 272-278)

For Marie, nursing is not merely about accessing familiar knowing to complete a work task, rather it is to articulate the individual's familiar knowing to make sense of the her practice. Marie seeks to understand the rationale for particular treatment or pathway to recovery that are set for her specialty-appropriate patients.

The participants in this study obtained their empirical knowledge of general nursing through university-based pre-registration programs, post-graduate certification, and also through self-learning and professional development processes. The specialty nursing knowledge and knowing enables the nurse's capability of practicing with disease and/or condition specific familiarity. Peter recalls his use of this specialty nursing knowledge and knowing in his nursing practice,

> And you know, even something as simple as an electrocardiogram (ECG), a lot of the wards do not have a clue how to do them. And the ones that do them, do it so poorly anyway. And to the others, that's only an ECG. But in my book it's not only an ECG. It's a very important diagnostic tool. You know, and that's what comes with being specialised. You realise the importance of doing a test, diagnostic procedures, I mean, properly and for the right reasons. You just don't do an ECG because the doctor wants one. You do one because there is a good clinical indication or clinical need for it. And then it is important for you to be able to read the thing. (Peter 483-489)

Taking Peter's experience of undertaking an ECG, while it seems that he knows the theory in terms of ECG interpretation, it is through his experience of interpreting ECGs for many cardiac patients that he has come to know the clinical indication for them and to make sense of the theory. The nurse practices her familiar knowing by actualising and exercising her knowledge in nursing (Bonis, 2009; Carr, 1981; Ryle, 1945-1946). As the nurse is applying this familiar knowing in nursing, she often uses her personal judgement to reason her use of familiar knowing. As the nurse is nursing patients with a specific disease and/or condition, her capability to reason and transfer her familiar knowing from one

patient to another is enhanced (Garud, 1997, p. 85). The individual nurse is therefore capable of practicing with disease and/or condition specific familiarity.

This capability of practicing with disease and/or condition specific familiarity therefore represents another rung of the care ladder. This rung enables the nurse to use less energy to achieve her best level of care since she needs to give less attention to the reasoning process as she practises with familiarity and can more easily and quickly incorporate such familiar knowing as rationalised knowledge as she nurses within her specialty context.

In summary, the nurse is capable of practicing with disease and/or condition specific familiarity. As she nurses specialty-appropriate patients she gains familiar knowing – this ready to hand knowing therefore allows the nurse to respond in a timely manner.

4.4.4.3 Being capable of prioritising each nursing task

The nurse's capability of prioritising each nursing task refers to the nurse's experience of planning and managing her shift. In other beds, the nurse considers how best to use the time by assigning each task with a particular sequence and to be completed within a specific timeframe.

Agnes, in the following excerpt, described her rationale for prioritising each of her tasks so as to manage the time demanded by each of them.

> You know, because obviously you have to prioritise. The big thing is time management, to prioritise. If a patient is acutely ill, you have to look after that patient. Everything else comes second. If they are all breathing. It's fine. You have to look after the patient who is not breathing. You know, so that always gets priority, that the patient gets their tablet on time and gets the right tablet. You know, is other priority before…before if some patient has a psychological problem or anything that always comes last. You know even though it may be really important for that patient. But it still comes last on the list. Because first [priority] are the acute [physical] things. (Agnes 730-737)

According to Agnes, prioritising each nursing task involves recognising the needs of acutely ill patients as more urgent than the other patients' needs. In clinical practice, setting priorities involves identifying urgency and importance of the nursing problems in order to establish a preferential order for nursing actions (Hendry & Walker, 2004).

Being capable of prioritising each nursing task, as suggested by Lake, Moss, & Duke (2009), is necessary in nursing because it addresses the differences in the relative values of clinical criteria according to each clinical setting. From Agnes' description, her perceived patient need was relating to life-threatening situations in the acute care setting. She followed the National Competency Standard for the Registered Nurse which requires nurses to "*prioritise workload based on the individual's or group's needs, acuity and optimal time for intervention*" and to "*respond effectively to emergencies*" (Australian Nursing and Midwifery Council, 2006, p. 10).

Setting priorities is a strategy highlighted by some participants in this study as they perceived themselves as having insufficient time to do everything that they thought was necessary to provide good care. For instance, Rainbow's priority is to get all the tasks done in the finite amount of time. She reported the challenge of "hurry[ing] to get things done" while noticing that "there are other urgent things to be done" (Rainbow 68-70). She is in a "hurry" to get things done (67-68) as she perceives that time available within her shift is running out.

Being capable of prioritising each nursing task facilitates the nurse's time management for nursing in a work environment that nurses' frequently perceive as time-deficient. Similar to Rainbow's experience, Claire also perceives that she is nursing with a lack of a time or under time pressure in the following excerpts,

> ... the nursing care isn't as good as it could be. ... And there isn't enough time. Time is a big thing too. (Claire 144-145)

In Claire's experience, the amount of time available to her for nursing impacts the level of care she can provide. Without enough time she is unable to achieve her best level of care. Claire's description of time does not merely refer to clock time

that concerns the second, the minute and the hours scale/interval that informs the time functioning in her external world. For instance, the dressing will be done at 10.00 AM and will takes 15 minutes. Her description of time represents her construction of lived time. She lives in time and develops her understanding of time as she experiences nursing. Claire's experience of time indicates a "*hunger for time*" aroused by her perceived organisational "*expectation*" of having to do too much in a fixed time interval (Nowotny, 1994, pp. 133-134). As Claire perceives that there are too many tasks to be done at one fixed time interval when compared to her **expectation**, Claire experiences that there is "not enough time" as she is nursing.

In some nurses' expectation, the purpose of having a personal construction of time in nursing is to provide a personal reference to time in facilitating the flow of nursing and enhancing the nurse's experience in order to reach her best level of care. For instance, Madeline constructs her time by referencing to the patient's care requirement and she says,

> The difference between basic [nursing care] and ... better than that is having the time to actually talk to the patients...[and to be] able to concentrate on what you are doing with them. (Madeline 140-141)

Madeline further states,

> Proper care, is being able to provide all basic care and to... [have] time for the patients. And that includes giving time to provide them with education with what they [the patients] are here for, about their discharge and things like that. (Madeline 191-195)

From Madeline's expectation, her personal construction of time revolving around the patient's needs has an influence on her level of care. According to Australian Nursing and Midwifery Council (2006, p. 11), nurses are required to "*provide adequate time for discussion*" and to "*communicate effectively*" with patients in order to "*facilitate provision of care*". The adequateness of time in nursing is determined by the individual relationality developed between nurses and patients. The presence of the "*inherent trust*" between nurses and patients, and the

establishment of "*professional boundaries*" that facilitate therapeutic relationships are the two key indicators of using time adequately (Australian Nursing and Midwifery Council, 2006, pp. 7-8). The expectation of time therefore influences the nurse's perceived level of care and possibly contributes to the nurse's experience of lack of time.

Individual nurse's perception of lack of time in nursing arises as there is a finite amount of time in which to complete the nursing care required by patients. A finite amount of time also refers to physical time, which refers to the amount of time that the nurse has in the organisation. For instance, the organisation has structured the nurse's work hours. Each nursing shift at work is often set at an finite amount of time of eight hours. The nurse therefore needs to structure her timeline of nursing within these eight hours, in which the nurse subordinates her time to the organisation's construct of time. As represented by the surface of anchorage, the world of organisation measures time according to hours per shift. In reference to this organisation's construct of time, the nurse is being capable of prioritising each of her tasks according to her own perception of time. Each nurse determines her time-scale based on her initial social being (as represented by the left ladder side) and uses this time scale to inform her experience of nursing (as represented by the ladder rung) and adds to her current social being (as represented by the right ladder side).

Reflecting on my own experience as a nurse, I often hear my colleague's saying, "Nursing is 24 hours 7 days a week, go to your meal break now, you can come back and finish your work at any time, or handover to other colleagues...". From my work experience, some colleagues express that nurses have limited time at work; yet nursing is a continuous activity that takes an infinite amount of time. As a researcher, I question the nurse's experience of having a finite amount of time for completing an infinite amount of work that is supposed to take an infinite amount of time.

Hope, in the following description, discusses her strategy of nursing with a lack of time by skipping or postponing her meal-break.

> [My colleague said to me] “It’s time for a break now. Let’s go now, we’ve got to have handover now.” [Yet, Hope is thinking that] Because I really like to deal with the problem [the clinical tasks] ...And so I feel frustrated sometimes with my colleagues… [I] don’t really want to miss out on my break but if that [not going] means that the patient is comfortable, then I could have my break later... I suppose sometimes I am disappointed with my colleagues. And I know they all work very hard. But then you know that’s maybe an unfair comment. But yes, that’s what I feel and [I’m] frustrated with my colleagues, yes. (Hope 240-450)

Hope prioritises patient's comfort before her meal break. In the organisation's construction of nursing work and time, inpatient care must be delivered 24 hours a day, seven days a week (Penny, 2013). The organisation evaluates the nurse's performance by measuring the productive hours, which refer to "*the time that employee's are paid to carry out their work assignments*"(Penny, 2013, p. 84). When some nurses perceive that they are unable to nurse at their optimal care level within the organisation's construction of paid-hours, they makes a temporal reference by using their time from their unpaid-meal breaks as their perceived productive time. However, Hope's experience indicates that the organisation's construction of work time has gone out of synchrony with her temporal experiences of everyday nursing. While the nurse's experience of having lack of time (or time constraints) cannot be ignored in nursing, some refer to priority setting as part of their nurse's skills in coping with the time constraints (Madjar & Walton, 1999). However, Hope's priority setting is controversial when considering the Public Health System Nurse's and Midwives' (State) Award in NSW, in which it stated that “*Employees must not be required to work during meal breaks as a matter of routine practice unless mutually agreed at the local level. Provided that any time worked during such break shall count as working time*” (NSW Department of Health, 2011b, p. 11). Hope’s preference for skipping/postponing meal breaks indicates or can be interpreted as her preference for direct patient care activities such as pressure area care, over indirect activities such as attending handover. The decrease in direct patient care activities due to scarce resources in

the work environment — as illustrated by time as the scarce resource in Hope's example — has been reported in current literature (Jones, 2010; Myny, van Goubergen *et al.*, 2011).

Ann's strategy for dealing with nursing and the lack of time is evidenced or demonstrated by the way she alters her personal time perception. The nurse orientates each nursing task to a daily-time-scale as she prioritises and plans for each nursing task.

> ...every patient is supposed to have an estimated discharge date...somebody with airway disease...we will aim for them to go home in four days. So we have got the plan to work [towards attaining]. (Ann 109-116)

Ann orientates her clock on a **daily-time-scale** informed by the estimated date of discharge which is an organisation's construction of time, and is "*an essential part of care coordination to assist clinical teams to organise their work*" (NSW Department of Health, 2011c, p. 6). The estimated date of discharge allows nurses and the healthcare team to "*plan ahead*" and offers both nurses and patients "*a goal to aim for*" in preparation for discharge (Lees, 2010, pp. 356-357). By adopting the organisational construct of estimated date of discharge in her practice, Ann sets her (metaphorical) stopwatch at "four days" for her patient. Unless the patients' condition deteriorates, external bodies located within the surface of anchorage in the care ladder, such as government and the hospital management, stated that it is "*not appropriate*" for Ann and the healthcare team to change the estimated discharge date due to system delays, and commented that this action would lead to "*unnecessary waits*" for both patients and staff (NSW Department of Health, 2011c, pp. 2,5-6). Despite the possibility of changes to the estimated discharge date for a particular patient, a review of best practice confirms that estimated discharge date can be set accurately for the majority of patients (NSW Department of Health, 2011c, p. 4). This echoes the concerns of 'equitable' nursing from the managerial repositioning of quality of care as standardized care as discussed earlier on p.95 in this chapter. Ann therefore uses this estimated

discharge day to orientate the time available for patient care and prioritises and plans each of her nursing tasks accordingly.

The use of time scales as informed by the organisation's construction of time has also been reported by Hope. Compared to Ann, Hope's experience illustrates a smaller time scale of a daily time scale instead of an hourly time scale.

> Throughout my shift, ...the patient required hourly urine measures, hourly Blood Sugar Level's taking, and two hourly Patient Controlled Analgesia observations (Hope 37-38)

Hope uses an hourly time scale as her temporal orientation of time. Both Ann's and Hope's experience of nursing with time scales indicate that the organisation's regularity of time flow has dominated the nurse's experience of nursing. The organisation's regularity of time flow has ranged from the finite amount of time in the nurse's work to directing the nurse to work in various time scales. In other words, the organisation's construct of time has influenced the individual nurse's temporal framework and hence the temporal organisation of the nurse's work (Waterworth, 2003, p. 44). Hope is nursing with her temporal perception of the prescribed interval between patient observations. Rather than scheduling her nursing time according to a patient's care requirement, the nurse's temporal perception has been rigidly framed as a "*time-defining routine*" in her work environment (Brown & Brooks, 2002, p. 389). The nurse's orientation of time through using a time scale is a rhythmic knowledge of nursing around the temporal structure of their work environment, where time in nursing is organised into cycles such as per hour and per day and is characterized by a certain duration (Clandinin, 1989). The nurse's orientation of time influences the nurse's capability of prioritising, since the nurse sequences each of her nursing tasks within a different timeframe.

In summary, some nurses are capable of prioritising each work task. They organise their work in consideration of the organisation's construct of time. Such capability facilitates work flow and therefore facilitates the nurse’s goal of

providing her best level of care in the minimised timeframe with the same energy and climbing effort.

4.4.4.4 Being capable of predicting

Being capable of predicting refers to the nurse's ability to predict certain patterns or illness trajectories allowing them to be more proactive in their care. Nursing ahead of time refers therefore to the work involved in determining in advance what care needs the patient may have and planning potential nursing interventions to prevent (possible) patient deterioration. Predictability is a skill or capability that nurses can develop in circumstances such as having experience in a specialty ward and caring for patients with common illnesses and diagnoses. They build a repertoire of understanding — experiential knowledge/familiar knowing — that equips them to recognise a patients changing condition and to respond quickly. For instance, Rainbow, in the following excerpt, described her experience of nursing with predictability.

> You know how to prevent further...prevent adverse events after the complaint... And you can predict what's going to happen...there is an element of predictability. So you are really caring for the patient. Because you know what you are doing [when you are nursing a patient with a familiar illness/diagnosis]. (Rainbow 160-163)

Rainbow is nursing with the benefit of her experience with nursing patients with a familiar illness/diagnosis in her specialty ward. She can practice proactively and frequently "predict what will happen" and "act on meeting the patient's need". Rainbow uses predictability as a tool for future planning and this ability to predict is represented by one of the ladder rungs. Predictability when used in nursing can be a tool for manipulating and controlling future events (Polifroni & Welch, 1999; van der Zalm & Bergum, 2000) or as a guide to effective future planning (Kath, Stichler *et al.*, 2012; Marquis & Huston, 2009). While specific changes in the patient's condition and signs and symptoms might not be apparent at the time, some participants overcame the uncertainty of a patient's condition through identifying an underlying pattern to predict the likely evolution of the pattern for that patient (Newman, 1999). Nursing with predictability therefore is pro-active

care, rather than responsive or reactive care. Kath, Stichler *et al.* (2012) have argued that nursing with such predictability may be useful in reducing the negative effects of increased stress in nursing.

Rainbow (169-170) further reported that her "confidence" in nursing is associated with the fact that she feels there is an "element of predictability" in her nursing care. I interpreted Rainbow's "confidence" in nursing as a sense of control of nursing because of its temporal nature, where she can make use of the time at present to plan future tasks.

In summary, being capable of predicting links the nurse's social being in interpreting her future care planning, hence allowing the nurse to recognise changes in a patient and plan ahead.

4.4.4.5 Being capable of practicing with inter-professional relationality

Being able to practice with inter-professional relationality refers to the individual nurse's experience of developing understanding of the role of the profession of nursing and its relationships with the other health care professions (for example: medical, physiotherapy, occupational therapy and social work) comprising the healthcare team and with nurses in the home ward. The term "Profession" refers to a group of persons who share a knowledge set and are guided by the same system of rules as they then transform their knowledge into practice (Couturier, Gagnon *et al.*, 2008). Members of each profession are socialised into the professional culture and adopt certain attitudes and ways of conduct within their practice (Hammick, Freeth *et al.*, 2009). Comparatively, the term "Inter-professional" is not merely about involving various professions. There is an emphasis on collaboration among professions with the goal of working together more effectively to improve patient care (Goodman & Clemow, 2010). Currently, the World Health Organisation (2010, p. 37) claims that inter-professional collaboration is essential in the provision of best patient care, in which nurses and other health care professions can "*positively address current health challenges, strengthening the health system and improving health outcomes*".

In John’s experience, there is an overlapping between his world and the spaces of the other health care professions. In the following excerpt he considers how they “operate” and their “preferred ways of working” identifying how that influences his nursing.

> I was ... referring to the relationship that staff members are build[ing] up between each other and how that is reflected on the skill of caring. For example, as I was saying when nurses and doctors get to know each other, and how each other operates, and preferred ways of working, hopefully they build up a good working relationship that [means they] communicate well. That’s what I mean by culture. The more the culture [communication] the [better the] way that everyone reacts and is able to their job by supporting each other. (John 82-87)

Inter-profession relationality therefore enhances the health care profession’s communication and supports John in reaching his desired level of nursing for his patients.

Ann, in the following excerpt, reported that she attends a "daily meeting" with other healthcare team members.

> ...on this ward and most medical wards, we have a daily meeting, a quick fifteen minute meeting, that’s attended by my nurse unit manager, myself, members of the allied health team and the medical team. We briefly go through every patient. We identify patients that need referrals to allied health and we would usually nominate what the estimated discharge date for that patient is. (Ann 23-27)

Through the "daily meeting", the nurse and the other health care professions are collaborating with each other with a shared rhythm and establishing the inter-profession relationality. The nurse shares information regarding the patient's condition and collaborates with other health care professions to achieve a shared understanding of the patient's condition and care plan. The nurse, as a worker in the "*collaborative practice-ready workforce*" therefore has learned how to work in an inter-profession(al) team and to engage with each other (World Health

Organisation, 2010, p. 38). The nurse therefore becomes capable of practicing inter-professional relationality as she is nursing.

Reflecting on my own experience as a nurse, I interact with other health care professions in my everyday nursing practice. For instance, I meet with the team doctors everyday and discuss patient's progress as they come and review the patients in the morning. I refer patients who require physiotherapist, occupational therapist, dietician, and/or social worker consultation through the intranet network and communicate with them in person as they come and review the patient.

In summary, the different health care professions' worlds are bound together through having patients of a particular condition on a particular ward. The nurse's specialty is acting as a link between the nurse and different health care professional's space.

4.4.5 What does it mean to be nursing with a composite care ladder?

Nursing with a composite care ladder means that the nurse has normalised her experience of nursing specialty-appropriate patients. As the nurse uses her composite care ladder, she is abstracting/generalising her construction of a care ladder for nursing one patient from her experience of nursing with multiple care ladders for various patients with similar specialty disease/illness conditions. Rather than constructing an individual care ladder from scratch, the nurse has generalised her practice according to the patient's disease and/or illness conditions.

Nursing with a composite care ladder can be seen as the nurse's emergence in her work environment, where her internal world of nursing is bounded by the external world of nursing. As the nurse is nursing, she is not merely nursing in a specialised ward. The nurse is also engaging with specialty care. As stated by Peter,

> ...because the level of treatment now has specialised...you need to be a specialised nurse to look after them. The equipment, the drugs, the management regimes that are brought in to these patients are all very specialised. And you can’t expect a general nurse to be able to do that. (Peter 153-156)

The nurse's construction of specialty care is informed by her presence within both her external world of nursing, and that of the organisation. Within her external world of nursing, the nurse's construction of her care ladder has a strong reliance on the composite care ladder, in which the use of the composite care ladder as a care ladder fulfils the best level of care for nursing the majority of the specialty-appropriate patients and forms part of the nurse's social being. From the nurse's experience of nursing multiple patients, she identifies that patients with similar specialty disease/illness conditions have similar care requirements, and therefore by using the same composite care ladder as a base to build an individual care ladder for each of these patients, the minimal care requirement can be met. Nevertheless, this minimal care requirement is not what the participants described as optimal care. The nurse perceives that it is the care ladder as a whole, rather than the composite care ladder that informs and fulfils her normative equilibrium. The nurse's normative equilibrium of nursing is being set at a certain level, that is, an average level of the care requirement fulfilled as the nurse nurses on her multiple care ladders for patients having disease and/or illness conditions of the same specialty.

Within her external world of organisation, the nurse's experience of nursing is informed and influenced by the organisation's construction of workplace, work and time. Depending upon the individual's nurse's experience of nursing, each nurse is nursing within her construction of a spatial and temporal framework. While the nurse is frustrated as she nurses in a work environment with resource constraints, such as time and staff, she remains capable of nursing in her work environment and to deliver her perceived optimal care.

In summary, nursing with a composite care ladder represents the nurse's confidence regarding her capabilities of nursing specialty-appropriate patient gained from her social being; and the nurse's ability to incorporate the organisation's construct of work, time and workplace into her practice. Nursing with a composite care ladder ensures that a minimal level of specialty care is reached. This serves as a foundation for the nurse to build her care ladder and to position her care ladder within both surfaces of anchorage in a steady manner, and

hence allowing the nurse to achieve her perceived optimal care within her specialty.

Chapter Summary

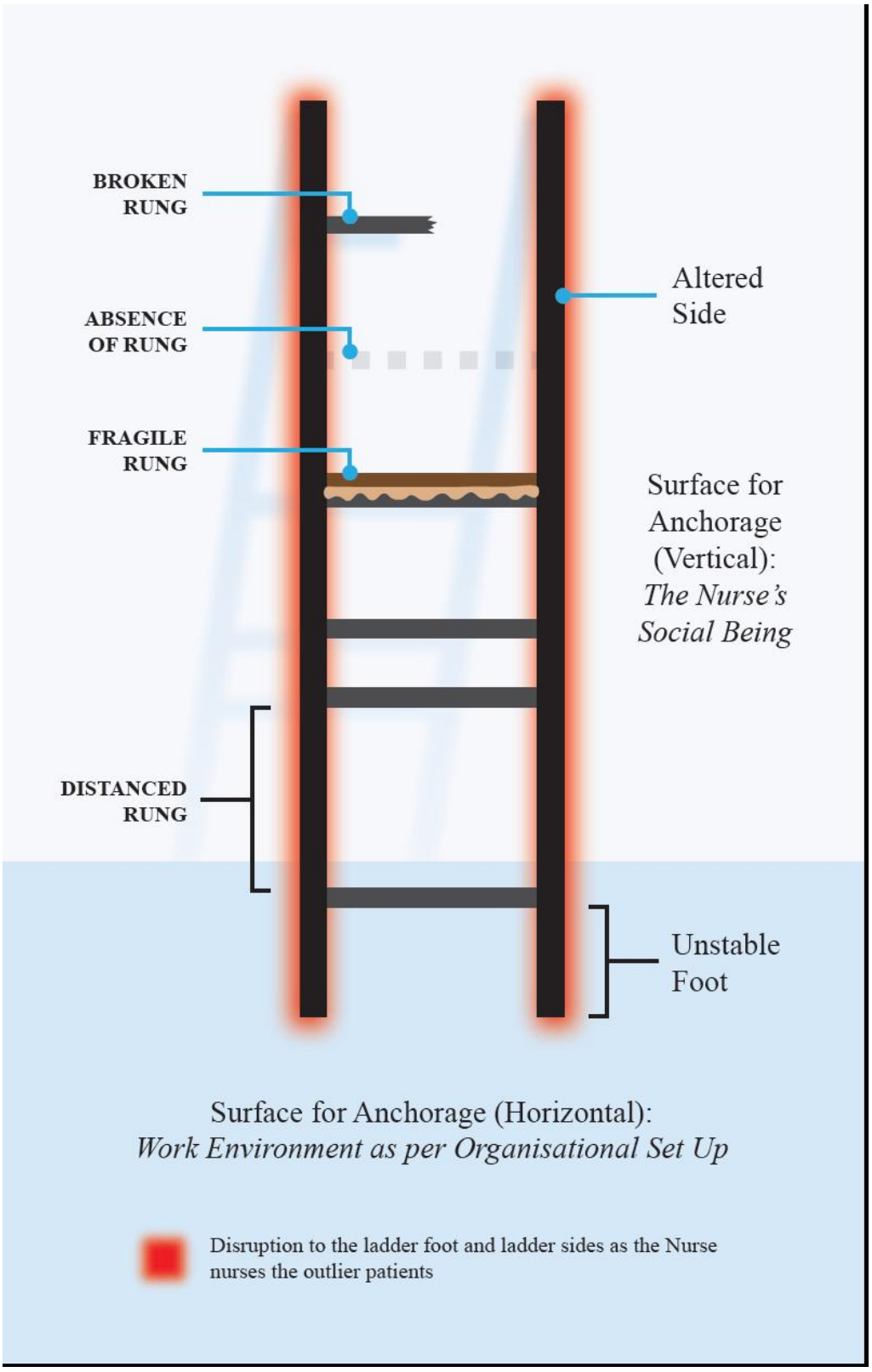
This chapter has presented a phenomenological interpretation of nursing by using the structure of a straight ladder to shed light on the phenomenon of care in the nursing context that I have named a care ladder. Each nurse uses her composite care ladder as the foundation for constructing a distinctive care ladder to meet an individual patient's care requirements. The nurse has normalised her experience of nursing with the composite care ladder, which is characterised by her experience of : 1) nursing with different efficiency and effectiveness concerns/constraints from both the world of organisation (the horizontal surface of anchorage) and the world of nursing (the vertical surface of anchorage); 2) being conscious about her best level of care that can vary among patients (ladder feet); 3) being frustrated as pressure from her external world has influenced/impacted her social being (ladder sides); and 4) being capable of nursing to meet patient's care requirement (ladder rungs). Despite constraints from the external world upon the nurse's experiences, she is (being) capable of nursing in her internal world of nursing.

CHAPTER 5.

EXPLORING THE PHENOMENON OF NURSING THE OUTLIER PATIENTS

This chapter aims to *"open up a deepened and more reflective understanding*" of the phenomenon of nursing the outlier patients (van Manen, 2001, p. 86). I will explore the phenomenon based on my interpretation of participants' excerpts from their experience of nursing the outlier patients along with current literature and hospital policy on outlier patients. This exploration, together with my interpretation as a nurse and as a researcher utilising the care ladder established from individual participant's experience of nursing specialty-appropriate patients explicated in Chapter 4, will inform the phenomenological analysis. The focus of this chapter is to demonstrate how nursing the outlier patient leads to disruption of the care ladder. As illustrated in Figure 7 below, the disruption begins at the ladder rungs which later affects other structures of the care ladder and hence influences an individual participant's experience of nursing outlier patients.

Figure 7 An example of a disrupted care ladder



One of the components of the care ladder, surfaces of anchorage, is not included in this figure since the structure of the surfaces of anchorage remains the same (as

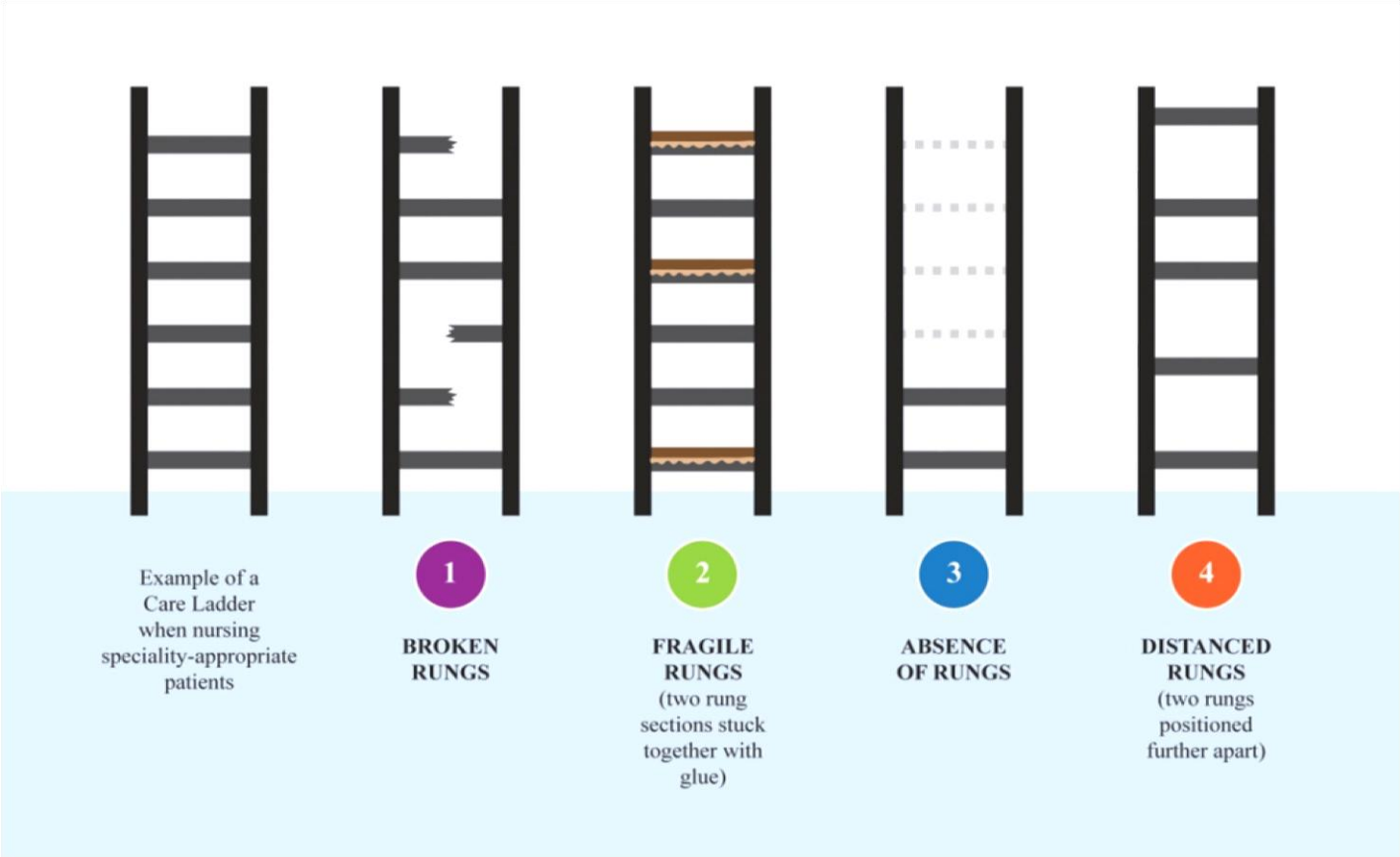
previously described) throughout the nurse's experience of nursing specialty-appropriate patients and nursing outlier patients. There is however a subsequent change in, or effect upon, the nurse's understanding of the surfaces of anchorage as an outcome of nursing outlier patients.

Compared to the structure of a composite care ladder as shown in Figure 2 in Chapter 4 on p.77, the disrupted ladder has an altered structure and therefore is less steady when compared to the composite care ladder. The disrupted ladder is the focus of this chapter.

5.1 Ladder rungs

Individual participants described themselves as being less capable of nursing the outlier patients than nursing their specialty-appropriate patients. This phenomenon is represented by the disrupted rungs of the care ladder in Figure 8 below. This figure demonstrates four potential rung disruptions that may be experienced by the individual participant’s as they nurse the outlier patients compared with an example of a care ladder when nursing specialty-appropriate patients.

Figure 8 Four potential rung disruptions as an outcome of nursing outlier patients compared with nursing specialty-appropriate patients



As shown in Figure 8 above, the example of the care ladder for nursing specialty-appropriate patients is one example of an individual nurse's care ladder that has six rungs for the purpose of demonstration. This example can be compared with four potential rung disruptions described by the individual participant's that represent their experience of nursing the outlier patients. These are identified as 1) Broken rung, 2) Fragile rung, 3) Absence of rung, and 4) Distanced rung.

Each of the six rungs developed in the ready-to-hand care ladder has been disrupted in one or more of the four ways shown in figure 8 above. Each individual nurse may be affected in various ways, so that a fragile rung for one participant may be broken or absent for another participant. A broken rung indicates that nursing the outlier patients has disturbed some components of the rung and caused partial disruption. Interpretation (i.e. examples) of what a broken rung represents are becoming less capable of using synchronised rhythms or becoming less capable of practicing with disease and/or condition specific familiarity. A fragile rung refers to two segments glued together, in which one segment is a thinner/incomplete rung on its own. Compared to the rung as a whole, the extra glue used to stick the two segments together requires the nurse's effort. Depending on the gluing effect, the strength and stability of the rung may be reduced compared to the rung as a whole. Interpretation (an example) of what a fragile rung refers to or represents is being less capable of using synchronised rhythms. The absence of rungs is a representation of the nurse's lack of experience in nursing the outlier patient compared to her familiar specialty-appropriate patients. As the nurse's social being is context specific to the nurse's specialty, the nurse becomes less capable of practicing with disease and/or condition specific familiarity, of predicting, and of practicing inter-professional relationality when nursing patients of a different specialty; that is the outlier in this case. The nurse is unable to associate or make the connections between her social being of nursing specialty-appropriate patients to nursing the outlier patients. Distanced rungs represent the increased effort, energy and time that is required for the nurse to establish what has been present to hand for nursing specialty-appropriate patients but absent or

inaccessible when nursing the outlier patient. Interpretation of what distanced rungs represent include the nurse being less capable of prioritising and practicing with inter- professional relationality.

All four ways of rung disruption mean that nurses are using more effort and energy, and with a prolonged timeframe to reach the nurse's best level of care, hence impacting her experience of nursing the outlier patients. Individual participants reported a number of feelings as they reflected on their experience of nursing the outlier patients, such as “fear”, “failure”, “frustrated”, “unfamiliar”, ‘not easy”, “hard”, “difficult”, “bad”, “not welcoming”, “dislike”, “odd”, “different”, “not confident”, “less certain”, “in doubt”, “unsure”, “devastating”, “dissatisfied”, “worry”, “stressed”, “disappointed”, and “limited”. Each individual participant is therefore being left without stable rungs as she uses her care ladder to nurse the outlier patient. The disruption in the rungs, combined with participant’s feelings arising from the experience of nursing the outlier patient have a snowball effect with or when the (existing) individual participant’s frustration in nursing specialty-appropriate patients is compounded by the frustration of nursing the outlier patients.

While the nurse maintains some underlying capabilities for nursing all patients, she loses her capabilities developed around her specialty when she nurses patients of a different specialty. As some nurses normalise the experience of nursing specialty-appropriate patients in the individual’s social being, their experience of nursing outlier patients becomes nursing out of space and out of time.

From the phenomenological interpretation of rungs connecting the right ladder side to the left ladder side, the nurse probes her initial social being and her experience of nursing in general by questioning her current social being and her experience of specialty nursing. As the nurse nurses patients who have illness conditions outside her specialty, the nurse can only partly connect her current social being with her initial social being, since some rungs. Many or most components of her ready-to-hand care ladder are context specific to nursing patients of her defined specialty. The occurrence of outlier patients

therefore has disrupted the individual participant's capabilities where she can no longer associate her experience with her work environment and she may become 'lost' in her practice world.

In summary, nursing the outlier patient has partially/completely disabled the nurse's capabilities as represented by ladder rungs in the phenomenological interpretation. The nurse consequently became less capable of 1) developing synchronised rhythms between the work environment and practice world, 2) practicing with disease and/or condition specific familiarity, 3) prioritising each nursing task, 4) predicting care requirements, and 5) practicing with inter-professional relationality as she is confronted/challenged with nursing the outlier patients. The nurse's experience of nursing with each of these capabilities will further be explored.

5.1.1 Becoming less capable of synchronising the nursing rhythms

When nursing specialty-appropriate patients, specialty nurses synchronise the various rhythms of nursing to facilitate their ability to effectively nurse this known group of patients (as discussed previously in Chapter 4 on p.113). The presence of an outlier patient means however, that the nurses' capability of either developing or maintaining synchrony of the various organisational and personal rhythms involved in nursing the outlier patient is considerably diminished. The following explanation from John illustrates this situation of how his rhythms were destabilised by the need to include the rhythm of the healthcare team caring for the outlier patient who is from an unfamiliar specialty.

> If that [outlier patient's specialty] team of doctors used to do their round at 10am [at the team doctor's specialty ward] because this suits the rest of their day, they will come to see the outliers at two o'clock, for example. Now you are trying to feed the patients. The doctors now want to see the patient or whatever. So it can affect the nurses' routine as well. It has to affect the patients...might affect showering, may affect the feeding, may affect the medications, may affect the dressings, it may affect the treatment times because

> doctors are coming on a different routine to see outliers as they come in as a normal [specialty] ward. So that now the nursing routine, everything to do with patient care [is disrupted]… (John 44-54)

As John explains, the outlier patient's healthcare team operates with a different rhythm to the healthcare team of the specialty-appropriate patients. For example, the healthcare team of the specialty-appropriate patients review patients at 10am, whereas the healthcare team from the specialty of outlier patient reviews the outlier patient at 2pm (after attending to the patients in their specialty-appropriate area). Therefore, while John is using the synchronised rhythms normally associated with his nursing specialty-appropriate patients he now also needs to incorporate further rhythms resulting from the presence of the outlier patients: the likely result of which is disruption of all of John's rhythms for the shift.

The de-synchronisation of nurses' rhythms as a consequence of the presence of outlier patients adds considerable complexity to the clinical work of nurses. Faced with the additional rhythms of outlier patients, John's capability is diminished as he attempts to fit the rhythm of the outlier patient within his already established rhythm, as considerable amount of energy and effort are required for John to negotiate and establish a shared rhythm with the healthcare team specific for outlier patients.

For instance, John is nursing an outlier patient whose meal time has been disrupted. The meal time and kitchen food services are determined by the organisation. While John is capable of fitting either the organisation-scheduled mealtime or the consultation time from the healthcare team specific for the outlier patients into his nursing schedule, John becomes less capable of fixing the conflict between the two in his nursing schedule. Since the organisation-scheduled mealtime has overlapped with the consultation time from the healthcare team specific for the outlier patients. John's experience of nursing with de-synchronised rhythms indicates a conflict between efficiency and care, where task completion and maintaining work rhythm takes precedence over the

needs of individual patients. However, John accepts the de-synchronised rhythms and works to complete all the tasks by nursing with de-synchronised rhythms. John's experience of nursing specialty-appropriate patient with synchronised rhythms has been distanced by his experience of nursing outlier patients with de-synchronised rhythms. John's experience of nursing the outlier patients with de-synchronised rhythms "*may affect the treatment times*", leading to an increased timeframe for the nurse to reach her best level of care for the outlier patients when compared to that for her specialty-appropriate patients, hence further complicating and adding to the de-synchronisation of John' rhythms.

Alternatively, the nurse's rhythm can be de-synchronised as the nurse attempts to apply the already-established synchronised rhythm intermittently. Rainbow experiences asynchronous rhythms associated with the presence of outlier patients, which she described as nursing with "two nursing routines" when she contacts nurses from another specialty to review the outlier patient.

> … by the time you got to contact them, there is a delay because you always do that [call the CNE or CNC] once you finish with the routine, like giving medications and up to showers or doing other things...and then by the time the CNE or CNC comes, they may be in a meeting, so...they cannot come on time... sometimes they are in the middle of [doing] something too, so they can't [come on time]. (Rainbow 145-150)

When Rainbow is not able to complete a dressing without contacting the CNE or CNC from the specialty of the outlier patient, this is when Rainbow's synchronised rhythms are hindered. Rainbow discards her already-established synchronised rhythm when this rhythm is no longer applicable to meet the patient's care requirement. As the nurse intermittently disengages with her synchronised rhythm for all patients, withdrawing from the use of synchronised rhythm leads to a reduction of care for all patients and adds to the nurse's frustrations.

Compared to John's experience of becoming less capable of immediately synchronising the organisation's rhythm and the rhythm from the healthcare team of the outlier patients together in his nursing rhythm, the CNE/CNC from the specialty of the outlier patient has no set rhythm in relation to the outlier patient. Both Rainbow and the CNE/CNC postpone the nursing activities specific for the outlier patients until after completion of other nursing activities required by all patients. The already established synchronised rhythms of Rainbow and that specific for the outlier patient are unlikely to be synchronised with each other. The rhythms becomes entangled when Rainbow requires support from the CNE/CNC from the other specialty while the CNE/CNC is busy or when Rainbow is occupied when the CNE/CNC is available. Dealing with this situation takes more time and energy, the outcome of which is a time delay in reaching the nurse's best level of care as she uses her (disrupted) care ladder to nurse the outlier patients.

In summary, the nurse becomes less capable of using the synchronised rhythms developed from nursing specialty-appropriate patients or less capable of developing synchronised rhythms specific for nursing outlier patients. This is represented by an absent rung on the care ladder. In situations where the rhythm of nursing the outlier patient and the rhythm of nursing specialty-appropriate patient are completely out of synchrony the care ladder rung will be broken. However, the rung may appear fragile if the nurse attempts to piece together the rhythm of nursing specialty-appropriate patients and that of the outlier patients. Since the two segments cannot be completely aligned the caring for both specialty-appropriate patients and outlier patients are impacted/affected.

5.1.2 Becoming less capable of practicing with disease and/or condition specific familiarity

Nursing an outlier patient can directly affect the nurse’s capability for practicing with disease/or condition specific familiarity. The capability(ies) each nurse accumulates for (and when) practicing with disease or condition specific familiarity depends on their experience and this has a subsequent effect on their experience of nursing the outlier patient.

Marie is nursing the outlier patient yet recognising the possible limits of her familiar knowing. Marie commented on her lack of or decreased (cap)ability to educate outlier patients regarding the disease and/or condition due to her lack of familiarity of nursing the outlier patient,

> I think I have done everything for this [outlier] patient but I haven't been able to educate them as much as I normally would if it is a cardiac condition... It's just that maybe I could [have] done a bit better. (Marie 57-60)

Marie described how she feels less capable of accomplishing some non-cardiac related clinical tasks such as educating the outlier patient on disease related issues that she does not consider part of her usual specialty specific work. Her capability is related to cardiac specialty. Marie's familiar knowing, as termed by Ryle (1945-1946, pp. 4-5) as "*knowing-how*", is context-specific to cardiac nursing since she has been nursing patients with cardiac disease and/or illness conditions for some considerable time. As have many acute care nurses, Marie has self-defined her area of specialty knowledge and it could perhaps be argued that is a fairly narrow definition, nevertheless the nurses' understanding of their capabilities as being narrowly defined in this manner is something that has provided some challenges for the current management and organisation of acute care hospitals. Consequently, in direct contrast to Marie's (arguably) rather narrow self-defined area of familiar knowing the "*National Specialisation Framework for Nursing and Midwifery*" attempts to link knowledge and knowing across different specialties. These linkage areas have been described as "*skill domains*" and refer to the sharing of common skills and attributes across related **specialty groups** regardless of the variable knowledge bases of each specialty (National Nursing and Nursing Education Taskforce, 2006c, pp. 11-12). For instance, the specialty of "*Nephrology*" and the specialty of "*Urology*" are in the same specialties group of "*Renal Care*" within the National Nursing and Midwifery Specialisation Framework (National Nursing and Nursing Education Taskforce, 2006c, p. 14) and shares the common skill set of "*Acute and Supportive Care*" and concerns with a nursing goal of

"*maintenance or a return to independent function*"(National Nursing and Nursing Education Taskforce, 2006c, p. 15). Marie's experience where she is unable to use her cardiac-related knowledge and knowing to educate outlier patients indicates that the knowledge and knowing between the two different specialities may only be minimally linked. The "*skill domains*", as developed for National Nursing and Midwifery Specialisation Framework, is therefore an example of a theoretical framework in which complexity has not been addressed by the current organisational approach to patient-bed allocation within acute care hospitals (National Nursing and Nursing Education Taskforce, 2006c, p. 14).

Rainbow is stuck at practicing her familiar knowing only and she describes some of the technical challenges resulting from the need to nurse outlier patients without her usual level of familiarity.

> If it [the outlier patient] is surgical there is a lot of...drains that you know really little about. And if something goes wrong with any of those drains it's not easy (Rainbow 61-63)

> ...there is a lot of this tubing and ...containers and drains...and you don't even know the names of them. Like they are saying Bello vac. There are different [unfamiliar] names. (Rainbow 80-82)

While Rainbow develops familiarity from experience with pericardial drains as a cardiac nurse, she does not know how to operate the Bello vac drain. Bello vac drain is a drain with not only a "different name" but also located in a different part of the body with unknown conditions of use and potential risks. Her familiarity in specialty cardiac nursing has not been transferrable to nursing the patients from other specialities. She is unable to exercise "*inter-task learning*" and transfer knowledge and skills for tasks of nursing outlier patients (Lindbeck & Snower, 2000, p. 5). Such diminished capability is not merely due to the important and time-costly immediate absence of technology and equipment specific for the outlier patients in the ward space, but the absence of "*values, norms and practice*" as experienced by the nurse due to her

lack of familiar knowing about how to nurse the outlier patients (Sandelowski, 2000, p. 11).

As identified by both Madeline and Marie, the consequence of diminished familiarity is uncertainty.

> So if it is an outlier, the person might have a condition, for example, a renal condition or a cardiac condition that we may know about or may look after before. But because it is not something that we look after regularly, …we know less about it... [we are nursing with] the lack of familiar knowing... (Madeline 52-55)

> You don't know what you don't know really. (Marie 292-293)

Many other participants also reported that while they possess physiological understanding of various illness conditions, they claimed that they "don't know…", "know very little about", "(are) not good at…", "would not have a clue…", "would be unfamiliar…" with the specifics of the technologies used when nursing outlier patients. As some nurses considered an outlier patient as one who "is under another specialty", individual participants have drawn a boundary between knowing "my specialty" and not knowing outside of "my specialty". Esthetic knowing is the nurse's deep appreciation of the meaning of a situation is absent in the nurse. She becomes less capable of *"perceiving and grasping the nature of a clinical situation*" as she nurses the outlier patient (Johns, 1995, p. 228), hence preventing "*comprehension of the depth of these perceptions*" to occur and to develop new knowledge and knowing specific for nursing the outlier patients (Chin & Watson, 1994, p. 225).

Marie further describes her experience of nursing an outlier patient while simultaneously being concerned that she may be missing something due to her diminished familiarity. Yet, Marie is not aware of the significance of which or what is missing.

> You might think you travel along with somebody, but you know you might be missing a whole heap of things. (Marie 293-294)

Marie is using the idea of "travel along" to explain how she nurses an outlier patient by using her tacit knowing from other experiences but without the full comprehension that familiarity brings. Tacit knowing is often learnt from close observation, verbally passed on skills, and trial and error practice without necessarily support by empirical knowledge (Holste & Fields, 2010). The nurse practicing on the basis of tacit knowing is often unable to demonstrate the "*logical relation*" between her previous experience and current experience (Polanyi, 1966, p. 9). While Marie uses her established pattern of care which is based on her familiarity with patients related to her specialty while nursing the outlier patients and "travels along" with her tacit knowing, she "might be missing a whole heap of things" since she cannot associate nursing actions and her reasoning for nursing the outlier patients. Importantly also, tacit knowing as a form of personal knowledge that cannot be "*described or experienced*" and can only be "*actualized*" (Carper, 1978, p. 18). There is therefore less motivation for Marie to advance her tacit knowing since as she said "[I] don't [do not] know what I don't know" and is unlikely to reflect and build on her tacit knowing particularly as this might challenge her currently established familiarity with her specialty related patients.

Relying heavily on tacit knowing in nursing is also a source of discomfort for some nurses. Peter finds that his familiar knowing is largely irrelevant in nursing the outlier patient and therefore claims that the nurse's capabilities for nursing patients of a particular specialty is being undervalued in the following extracts. He describes the frustration that arises as a result of having to care for outlier patients.

> I think it goes beyond undervalued. I think it goes to a stage where you feel …anything that you have done as a specialist person is being totally ignored. I think when they give me a patient to look after who is not one of my specialty patients. Then I think: why did I train, why did I become a cardiac specialist? Why is this unit [hospital ward] paying me as a cardiac nurse to look after all these other patients which I can't give that [specialised] level of care

> to? ... I am committed to giving that level of care or specialised [care] to the cardiac patients. And imagine the frustration I feel when I get patients admitted to my unit that I can't give that level of care to. (Peter 733-740)

Peter is a recognised CNS in cardiac nursing having completed a Master in Cardiac nursing and he has more than 30 years of experience in this area of specialty. As a cardiac specialist, Peter commits to provide a specialised level of care in cardiac nursing and perhaps somewhat unrealistically feels that he should be able to provide a similarly high level of care for the outlier patient in the absence of his familiar knowing.

Similarly, Marie reports experiencing dissatisfaction when she nurses the outlier patients,

> Most nurses like to feel like they have done the best by the patients. And if there is a little bit of doubt that my knowledge might not be what it should be about a certain condition, you probably feel a bit dissatisfied ...maybe I could have done a bit more for that patient that's not my specialty. (Marie 47-51)

Marie's awareness that nursing the outlier patient who is by definition "not" from her "specialty" demonstrates again the effect of diminished familiarity about the care she has been able to provide and the resultant sense of dissatisfaction.

Importantly also, when nursing the outlier patient the nurse is not able to establish the level of "mental and emotional preparedness" she may need to nurse this patient effectively. As described by Rainbow in the following extract,

> ...there's no mental and emotional preparedness for what may happen in the event of adverse...You just feel...you...you are not able to care for the patients...it's a lot to do, but you know you can't....so you feel...guilty not being able to do what you need to do. Because there is a lot of things that you don't know, that you think

> the patient may need. So, one is not really providing quality of care to this patient. I suppose everyone knows it. (Rainbow 179-185)

There is no basis (foundational experience) to develop the nurse's familiarity for nursing the outlier patient. Unlike nursing the specialty-appropriate patient, there has not been the opportunity for repeated experiences or the variation on experience that the nurse can use. There is no familiarity when she is faced with nursing the outlier patient. The lack of familiarity affects the nurse's level of satisfaction with the level of care she can provide to the outlier patient and diminishes her preparedness to meet and deal with any adverse events that may occur. The lack of familiarity is experienced by nurses as a lack of recognition of her embodied social being. While the nurse is nursing the outlier patients, she believes that she is nursing outside her specialty and therefore unable to deliver the care required by the outlier patients. The lack of familiarity, therefore, is experienced by the nurse as she nurses outside her construction of specialty as informed by her work environment.

In summary, some participants described becoming less capable when they do not have disease and/or condition specific familiarity when nursing the outlier patients. The infrequent use of clinical skills specific for nursing the outlier patient and the opportunity to advance their tacit knowing is lacking. This absence of familiarity in the nurse's practice of nursing the outlier patients is represented by the absence of a rung on the care ladder , a component that normally would assist the nurse to achieve her best level of care in a timely manner. This is despite maximising her climbing effort and energy.

5.1.3 Becoming less capable of prioritising each nursing task

Nursing the outlier patient leads to nurses “fumbling” along with some nurses only going with the flow and not being able to prioritise nursing care requirements or be decisive about appropriate care implementation. This is evidenced in Marie's comment,

> When you’ve got an outlier, you are not a specialist in their [the outlier patient's specialty] area. So, you probably do fumble along a little bit. (Marie 27-28)

Fumbling along indicates that the nurse is nursing in a "*passive learning role*" and by "*just picking things up*", "*trial and error*" and/or "*cope[ing] without assistance*" rather than actively prioritising each nursing task (Gerrish, 2000, p. 478). Marie acknowledges her limitation that she is not a specialty nurse for the outlier patient and this results in her experience of "fumble[ing] along". The nurse's capability of prioritising each nursing task for her specialty patient for whom she has disease and/or condition specific familiarity is no longer possible when she is faced with nursing the outlier patient. This "*knowledge and experience*" of being familiar with a particular illness/disease has been identified by Baumann & Bourbonnais (1982, pp. 435, 441) as "*the most important factors*" influencing rapid decision making.

The participants experienced frustration at the perceived additional amount of time that outlier patients consumed in their busy schedule compared to nursing their specialty-appropriate patients. According to Hope, nursing the outlier patient has taken her time away from nursing specialty-appropriate patients so that all of the patients in her care are affected by the one outlier patient.

> So I had the added stress of not being able to look after the other patients as well as I should have done...I think everybody was missing out. I was stressed. But the patient who was in the wrong ward, he [the outlier patient] really suffers more because he was in the wrong ward. And the other patient [specialty-appropriate patients] didn't get the care and the attention they needed. So it was very stressful and dissatisfy[ing]. (Hope 76-80)

Hope continues to share her experience of making multiple phone calls for the outlier patient who she previously describes as being "in the wrong ward".

> When I mentioned that to the doctor, can we not get this patient to HDU? Do you think he should be in a different ward. Of course he totally agreed. When I said, will you do something about it, he just sort of shook his shoulder and left. And when I mentioned that to the team leader she fully agreed and also did nothing. So, I mention

> it a few times to her. I mentioned it to the evening shift who took over from me. So yes, I don't know, maybe I should have done more. Maybe I should have found the nursing supervisor myself, yes. Which again, there is not enough time for sitting on the phone and I really have to look after the patients. So that's another part of being very dissatisfied and frustrated after days like that. (Hope 335-344)

From Hope's experience each nursing task for the outlier patient means sacrificing to some extent each nursing task for the other patients. Hope describes "sitting on the phone [for the outlier patients]" and while she is doing this she is not able to really "look after the patients". Hope has become frustrated by the additional time she has to spend making telephone calls to establish contact with different personnel who do not normally have patients in her ward and to locate necessary equipment that is outside her specialty ward.

With more indirect care activities involved in nursing the outlier patients, the nurse is less capable of prioritising and this adds to the time constraints she is already experiencing. Consequently in her experience there is insufficient time to complete all the tasks necessary for reaching best possible care. Rainbow and Madeline comment on their experience of this extra time constraint,

> …it is a patient outside the ward, it is not happening at the ...the right things are not happening at the right time, there is a delay in attending to the needs of the [outlier] patient. (Rainbow 115-117)

> So I found that in general their [the outlier patient] care lags behind at least a day, but several days sometimes, just because they are not on *their* [specialty-appropriate] ward. (Madeline 21-23)

Ann and Claire further express concerns regarding this added delay in nursing the outlier patients.

> …the care can be compromised. (Ann 41).

> But for outlier patient, they might not get the care that they really should get. (Claire 342-343).

A delay in nursing the outlier patients potentially resulted in what Kalisch & Williams (2009, p. 211) termed as "missed nursing care", where the loss of timeliness potentially led to an increased and untimely patient mortality (Jones, Hoffman *et al.*, 2010, p. 519).

In summary, nursing the outlier patients adds extra indirect nursing activities and requires additional time, and therefore the nurse becomes less capable of prioritising each nursing task. These added work and time constraints is represented by the distanced rungs, where more climbing effort and energy is required for overcoming the indirect care for nursing the outlier patients.

5.1.4 Becoming less capable of predicting

The participant's composite care ladder is a fore structure of understanding, where I interpret their experience of nursing outlier patients based on their descriptions of practical familiarity or background practice from their world of nursing (Hollywood, 2011; Wojnar & Swanson, 2007). However, nursing the outlier patient has an impact on the nurses' perceived (cap)ability of predicting nursing care needs and the patient's condition. For example, the outlier challenges Rainbow's capability with respect to clinical reasoning,

> You don't feel confident doing it [nursing the outlier patients] and there is no element of predictability, you cannot determine what is going to happen next. You can't look forward. You are only looking at what [is happening now]. (Rainbow 161-171).

The nurse's incapability of predicting means that she can no longer recognise and act upon on early signs and symptoms and initiate the nursing interventions on time (Jones, Hoffman *et al.*, 2010, p. 518). Unlike nursing the specialty-appropriate patients where the nurse is capable of predicting future events, of being proactive and planning care ahead, Rainbow reported a lack of confidence with caring for the outlier with the same capability. The nurse loses her well honed capability to predict, assess, manipulate and/or control future

events as she nurses an outlier patient (Polifroni & Welch, 1999; van der Zalm & Bergum, 2000).

Rainbow's experience of uncertainty involves a temporal nature where her current experience of uncertainty is affected by her past experiences. Due to this uncertainty, Rainbow reported challenges in relating to forecasts of the future. Penrod (2001) demonstrated that predictability offers control as a perception of being able to influence the outcome. As Rainbow perceives that she is unable to handle the uncertain event without "predictability", she is "not" feeling "confident". Her experience also reflects a relationship between uncertainty and confidence as discussed by Penrod (2001), who points out that the experience of uncertainty is mediated by the feelings of confidence.

A further link is described by Chia (2009) between anticipatory caring and a sense of accomplishment in the nurse's work. Rainbow's experience of nursing the outlier patient with "no element of predictability" has made anticipatory caring impossible and therefore leading to Rainbow's lack of confidence and a lack of a sense of accomplishment in nursing the outlier patients. Rainbow's experience of uncertainty and her lack of confidence mark the variation in her decision-making and the level of complexity in decision-making tasks brought about through the presence of the outlier patients (Cranley, Doran *et al.*, 2009). Rainbow's experience demonstrates that she normalises her level of "predictability" of nursing specialty-appropriate patients as she nurses the outlier patients.

Compared to Rainbow's experience of seeking certainty when faced with uncertainty in nursing the outlier patients, Claire responded differently to her experience of being uncertain in nursing the outlier patients.

> Well, I suppose, maybe because he had to go and have a laparotomy, maybe if we could have prevented that. I don't know if we could have. May be, may not but anyway. But it makes you feel like you think Oh, you didn't do all you could have. I mean even

> though we did and then it leaves you the sense of unease I think. (Claire 132-135)

Rather than seeking certainty, Claire acknowledged that she is nursing with uncertainty since through her clinical reasoning she accepted that she "may be, may not [be able to]" "prevent" the patient's deterioration. Claire's "sense of unease" is potentially a stimuli for positive outcomes in life experience and enhances the nurses' recognition of information needs and information seeking behaviour (Cranley, Doran *et al.*, 2009, p. 13).

Kay is the only participant in this study who reported that nursing the outlier patient "does not worry me because I have got very good skills" (Kay 235). Kay's experience suggests that uncertainty in nursing may be overcome by developing stronger or different rungs, such as "skills" and as the development of enormous updated knowledge has opened the possibilities of changing the future and resulted in more uncertainties (Mullavey-O' Byrne & West, 2001), Kay has updated her "skills".

Claire comments on her experience of raised anxiety and stress as she loses her (cap)ability of predicting as she nurses the outlier patients.

> Well, you feel a bit anxious and stressed… what if something happens...I might not [have] recognised or there might be something wrong …What if I don't know the drugs [for this unfamiliar condition/diagnosis], if I am not sure? Because we are used to knowing everything [about our regular/familiar patients]. (Claire 705-709)

When Claire nurses the outlier patients, she recalls from her previous experience of nursing specialty-appropriate patients, where she was "used to knowing everything". As the nurse experiences "*presentness at hand*", she "*attempts in routine praxis to domesticate, to make familiar and to master, what at heart one understands to be strange…*" (Fell & Cumming, 1990, p. 38). In other words, when Claire is nursing the outlier patient, she no longer knows everything. For instance, she may not know the drugs for the outlier patients.

As she is nursing outlier patients, she attempt to overcome or to live through this lack of knowledge by referring to her experience of nursing specialty-appropriate patients, that is, to her composite care ladder.

Claire's reflection on being "used to knowing everything", according to Fell & Cumming (1990, pp. 28, 38), is "*an original anxious disclosure of contingent and unmeaning nature*" as she is experiencing a situation that is "*stripped of their ordinary familiarity*" in nursing the outlier patients. The nurse has the capability to predict as she nurses patients with a particular familiar illness conditions. The nurse's capability of predicting becomes a fore structure of understanding, where she interprets her experience of nursing the outlier patients based on her practical familiarity or background practice from her world of nursing the specialty-appropriate patients (Hollywood, 2011; Wojnar & Swanson, 2007). For Claire, becoming less capable of predicting what she used to be capable of predicting has lead to her experience of increased anxiety and stress.

In summary, nursing outlier patients can result in some nurses becoming less capable of predicting and facing more uncertainty. The nurse is unable to engage in future care planning for outlier patients. The nurse's incapability of predicting is represented by the absence of rungs in the phenomenological analysis, where the nurse is unable to grasp the temporal nature of her experience and to stretch herself to future planning for patient care — hence rendering the nurse's best level of care unreachable or distanced on the care ladder — and that requires more climbing effort and energy from the nurse.

5.1.5 Becoming less capable of practicing with inter-professional relationality

The presence of the outlier patients act to fragment the different health care professional's world. This contrast with the shared understanding established when caring for specialty-appropriate patients. As Madeline and Claire have identified as a reason for their experience of diminished rapport with other health care professions.

> If it is a [other]specialty areas, for example, renal or cardiology, you are not seeing these people [allied health care members or

> doctors of the outlier patient's team] everyday every week...you don't establish the same sort of rapport. (Madeline 104-105)
>
> I suppose is that not having a rapport is because you don't know them. You know you don't know the teams, the doctors. (Claire 445-446)

Madeline and Claire voice that they are nursing the outlier patients in an isolated space, where they have limited or no interaction with the other health care professionals compared to that which occurs with specialty-appropriate patients. Without interacting in the same place and at the same time, there is a lack of shared (common) space and shared time for the development of rapport. Rapport, as a component of the nurse's silent space, refers to her experience of being "*welcome, affiliative [attached], safe and cooperative*" as she interacts with other health care team members (Gurland & Grolnick, 2008, p. 227). While Madeline acknowledges that the rapport developed in nursing specialty-appropriate patients and nursing the outlier patient is different, Claire comments that there is an absence of rapport in nursing outlier patients. While some nurses may be able to develop some level of rapport in their experience of nursing outlier patients, others are nursing in a distanced space, that is, distanced from the other health care professionals and thus requiring more energy to reach the space of another profession.

The absence of rapport is complicated by the absence of face-to-face interactions. For instance, Madeline normalises her experience with the health care professionals of her specialty-appropriate patients, in which she often sees them in the ward and develops more face-to-face interactions. As Madeline is nursing outlier patients, her personal normalised construct of inter-professional relationality has been disrupted. She reported that she is not seeing the health care professionals of the outlier patients. Madeline can no longer link her space and the space of the health care professionals of the outlier patient in this absence of face-to-face interactions, hence deepening the absence of rapport.

According to Gittell, Fairfield *et al.'s* (2000, p. 817) concept of "*relationship coordination*", shared goals, shared knowledge and mutual respect facilitates patients' outcome. Thus, Claire's experience of nursing with a missing rung means that there is no shared space, no shared knowledge in reference to familiar knowing of patients' conditions, and hence no shared goals and mutual understanding that is foundational for building a relationship between Claire and other health care professionals.

For nurses, the space of nursing a specialty-appropriate patient is frequently a silent space due to the lack of communication and connection with the other health professionals relating to the outlier patient's condition. Her inter-professional collaboration has been taken for granted as part of her being capable of practicing inter-professional relationality and has consequently contributed to the silent space, in which the nurse has already developed and embedded her capability of practicing with inter-professional relationality into practice.

This silent space has particularly been illustrated by the absence of the discussion of practicing inter-professional relationality with nurses in the home ward when compared to that with other health care professions. One possible explanation is that the nurse and nurses in the home ward are nursing within the same work environment, where they meet and interact with each other more frequently when compared to that with other health care professions. The nurse has comfortably normalised her experience of practicing inter-professional relationality with other nurses.

Claire also points out the possibility of establishing rapport with the health care team from the specialty of the outlier patient,

> Well, you know your own team, you see. And we have good rapport and you know. And I am sure with the other team it would be the same...because...you don't know them, so you have to explain who you are and where you are and what's happening and

> you know, that sort of thing, you [have] to let them know all of the details. (Claire 420-423)

Rather than nursing in an isolated space from the professionals from the specialty of outlier patients, Claire believes that good rapport between her and the health care team can be established with communication and explanation. There is potentially overlapping space and overlapping knowledge between the nurse of one specialty and the inter-professionals of another specialty that is currently absent and awaiting to be discovered. The extra time, effort and energy in establishing this rapport therefore is represented by two rungs distanced from each other.

Agnes and Ann further discuss the importance of establishing rapport in the work environment,

> It's that patients know where to go, what to do and what to expect. Like he doesn't have to deal with different people all the time who do little bits and then there is no communication between them. So you get to tell all the story again and again and again. Everybody asks the same questions again and again and again. (Agnes 579-58)

> So when we have outliers, we don't know what those plans are because we are not there with that treating team. Similarly when we have outliers in the other wards, we are really not sure what's going on. So I see the main disadvantage is the lack of continuity. (Ann 27-30)

Both Agnes and Ann point to a lack of sharing in understanding of the outlier patient's need for care with health care professionals of the outlier patients, which is also reflected by the experience of becoming less capable as discussed in previous rungs). This sharing in understanding, which Ann refers to as "continuity" is the linkage between the nurse's space and the spaces of the other health care team, and is absent according to some participant's experience of nursing outlier patients. The lack of "continuity" indicates a lack of structural support for developing the inter-professional relationality, and consequentially

affect the transmission of knowledge, customs and attitudes between the nurse and the other health care professions (Missen, Jacob *et al.*, 2012, p. 194). Hence, this lack of "continuity" creates difficulties for a fuller engagement with inter-professional learning and sharing knowledge and experience. The nurse is not sharing understanding of what care is required by outlier patients and how to care for outlier patients with other health care professionals – in other words, the nurse is not part of the group that share understanding of the particular outlier patient and the speciality to which they belong.

In summary, some participants become less capable of practicing with inter-professional relationality within the profession of nursing and with other health care professions as they nurse the outlier patient. The nurse's normalised construct of space, with one component being the rapport between the nurse and other health care professions, becomes silent and absent as the nurse nurses the outlier patients. The nurse is unable to develop sharing in understanding of the patient's condition with other health care professionals in an isolated space, where the nurse is nursing **out of space** and **out of time** as she nurses outlier patients.

5.2 Ladder side

Within the phenomenological interpretation of the care ladder the rungs are the ladder components that connect the right side of the ladder to the left side, as the nurse probes her initial social being and her experience of nursing in general and specialty nursing in particular to construct her current social being. However, when she nurses outlier patients the nurse can only partly connect her current social being with her initial social being, since some of the rungs of her ready-to-hand care ladder are specifically contextualised to nursing patients of her defined specialty area. The occurrence of outlier patients therefore has disrupted the individual nurse’s capabilities for nursing specialty-appropriate patients by altering the context within which she is nursing; sometimes to the point where she can no longer associate her experience with her work environment and becomes lost in her practice world.

The experience of nursing outlier patients does not provide a sufficient link between the nurse's initial social being and her current social being as the former [represented by the left ladder side] is no longer being informed by her experience of nursing specialty-appropriate patients. Similarly, her current social being [as represented by the right ladder side] is not being fully informed by any experience she may have of nursing outlier patients as the rungs of her care ladder may have been disrupted in multiple and various ways each time she has nursed an outlier patient. The eventual consequence of which is the disassociation of the nurses' initial and current social beings (the left and right sides of the ladder) as illustrated by Hope as she shares her experience of the "stressors" of searching in other wards for equipment needed by an outlier patient.

> …he (the outlier patient) has specific drains for gastro, for after the operation, but that was not on [our] ward. So that means you have to get that from the other ward, the gastro surgical ward, which is not a big job to get it, but it all added little stressors to getting the job done and looking after the patient. (Hope 156-159)

Nursing the outlier patient often requires specific equipment from another ward since the work environment is designed for patients with specific illness conditions. Hope normalises her experience of nursing specialty-appropriate patients, in which the nursing equipment is almost always readily available in the ward. When Hope nurses the outlier patient, she finds herself stretching her work environment from one ward space to another ward space to look for the equipment. Hope uses extra energy to locate as well as use the unfamiliar equipment for that particular outlier patient.

Similarly, John reports that more time is involved in getting equipment from a ward of a different specialty.

> You know all wards... [are in a] very specialised world now...the departments are completely separate, particularly true for departments of medicine and administration and budget and

> everything. They wouldn't necessarily supply equipment from their budget ... (John 29-33)
>
> When it [goes beyond] our quota of equipment [when our ward does not have that particular equipment in-stock], it takes longer. Sometimes your mate [nurses in other ward] refuses [to provide] it [for you], so then you go to find another avenue [ward] to get the equipment. And if you are looking for an equipment,[it is] not for fun, it's part of patient care. So its costs, kind of affects the patients. He may be waiting for that longer, when he needed that straight away. (John 217-220)

John understands that he works in a hospital (work environment) that has been split into different specialty wards and that each ward also has its own resources and budgeting. When another ward refuses to share the equipment needed to nurse an outlier patient, John needs to use even more time as he stretches himself from one ward space to another until he finds one that is willing to lend/supply the equipment. John points out that searching for equipment from another ward "affects" the timeliness of nursing; he perceives that he is not only distanced from the equipment in the other ward, but is also distanced from providing the "appropriate care" for the outlier patient.

Hope's and John's experiences, clearly describe how indirect patient care activities are increased when nursing outlier patients. Nurses are increasingly involved with indirect patient care activities in everyday nursing (Westbrook, Duffield *et al.*, 2011). However, the influence of indirect care in nursing outlier patients, such as the coordination of care needed in getting the equipment for the outlier patient, has not been widely acknowledged by either nurses or the organisation. As suggested by current competency standards in nursing, nurses are generally silent in reporting to the "*relevant persons when level of resources risk compromising the quality of care*"(Australian Nursing and Midwifery Council, 2006, p. 10). Hope and John's experience of nursing the outlier patient is interpreted as their attempted movement from the nurse's current social being as informed by her current experience as she is nursing in a

particular specialty in her practice world; to the nurse's initial social being as informed by her past experience as an individual person and as a nurse in the work environment, that is from the right ladder side to the left as shown previously in Figure 6 on p.89. The difficulties encountered in doing this are demonstrated by their awareness of the risk of compromised care resulting from their perception of extra workload and the added stressors involved when nursing outlier patients

Alternatively, the phenomenon can also be interpreted as the nurses' attempt to move across the ladder from the nurse's initial social being as informed by her past experience as an individual person and as a nurse in the work environment to her current social being as informed by her current experience as she is nursing in a particular specialty in her practice world, that is from the left ladder side to the right as shown previously in Figure 6 on p.89. Hope re-interprets her experience of nursing the outlier patients in her context of nursing specialty-appropriate patients.

> He [the outlier patient] really didn't get the care. I try as much as I can. But in another ward [of the specialty of the outlier patient], which look more appropriate to me, [the outlier patient] would have got much better care. (Hope 69-70)

In Hope's reflection, she perceives that she is unable to reach her best level of care as she nurses the outlier patient. Using the care ladder for phenomenological analysis, this perception represents her current social being from the right ladder side. She evaluates her experience of nursing the outlier patients by stating, "I try as much as I can". Her reflection and evaluation adds to her later re-interpretation of her initial social being, where opportunities of nursing specialty-appropriate patients is understood as meaning providing "much better care": where the nurse is able to reach or get closer to providing her best level of care.

The interactions between the right and left sides of the ladder are dynamic and cannot occur without the presence of the rungs. The ladder sides represent the

nurse's perception and understanding of her work environment based on her experience all of which is contributing to her social being. As she normalises her workload, timeliness and her best level of care from her experience of nursing specialty-appropriate patients, she perceives the difference between nursing specialty-appropriate patient and nursing outlier patients, where she understands her work environment as being one which now has an "extra" or "added" workload, requiring "longer time" in an already-stressed system and one in which it is unlikely that the outlier patient is going to be provided with the best level of care.

In summary, as the nurse is nursing outlier patients, the ladder sides have been disrupted. Nursing outlier patients increases indirect care activities, hence compounded the existing resources constraints as experienced by the nurses.

5.3 Ladder feet

The nurse's experience of nursing the outlier patient challenges the nurse's consciousness of being “a specialty nurse” who nurses specialty-appropriate patients. Rainbow describes the experience:

> …emotionally I am a bit drained, mentally I am challenged, and physically there is something I would like to do but I can’t do... we don’t always get outlier patients. When we have one, that’s how I feel. (Rainbow 440-443)

Rainbow is conscious of the difference in the level of care she delivers to the outlier patient, when she compares it to the care she provides for specialty-appropriate patients and expresses her frustration at being "emotionally drained", "mentally challenged" and "physically" unable to do what she would like to do when nursing the outlier patient.

As described in Chapter 4 (p.101) when nursing specialty-appropriate patients each nurse develops her (individual) normative equilibrium for her best level of care. When nursing outlier patients, she feels "there is something I [she] would like to do but I [she] can't do" since it is likely that her capabilities have been decreased or limited by the presence of the outlier patient (as illustrated by the

disrupted rungs). Consequently, her expectation of achieving her best level of care as previously determined by her normative equilibrium for her best level of care for a specialty-appropriate patient needs to be lowered when nursing an outlier patient.

The work environment demands an acceptance of her nursing at less than what the nurse considers to be her usual level of "best care" for the outlier patient. Therefore the effort and energy the nurse has been using to nurse at her "best" level of care for her specialty-appropriate patients has become seriously undervalued. All of the participants who described feeling that they were not able to provide the "best" level of care for outlier patients also described their dissatisfaction with this outcome and the frustration they were experiencing because of this. As seen from Agnes' description of outlier patients,

> It seems like they (the outlier patients) just got shuffled around. It's no respectfulness for the people again... (Agnes 567-568)

> ...you don't know who you get. It could be anybody. You could get anybody that they [the bed management] just want to shuffle off. (Agnes 611-612)

From Agnes' experience, she interprets that the bed management has focused on outlining a normative definition of outlier patients, rather than acknowledging the nurse's personal normative equilibrium as informed by her nursing experience. Normative definition of outlier patients places emphasis on hospital bed management, where outlier patient refers to any patients who are in a specialty ward that does not match with their particular specialty disease or illness condition. The outlier patient as an individual has been taken for granted as any patients. This consequently influences the nurse's experience of nursing. As Agnes reports, she is experiencing,

> Again the frustration. Because I know I could have done better... I feel sorry for them [the outlier patients] as well. Because they are just little points in the big gang. (Agnes 569-572)

Agnes perceives that she is not nursing at her optimal level as she is caring for outlier patients. The nurse's personal normative equilibrium constructed from her experience of nursing specialty-appropriate patients is less/not attainable, hence resulting in a lower level as she nurses outlier patients. In other words, what is considered as "best care" for nursing outlier patients is of a lower level compared to that of nursing specialty-appropriate patients. Despite trying her best in nursing both outlier patients and specialty-appropriate patients, she perceives that the level of care received by both patient groups are not the same. This relationality between the nurse and the particular situation of nursing each outlier patient is generally understood as the nurse's "*adjustment*" to her work environment, rather than a "*normative paradigm*" in which the individual nurse and her work environment are "*mutually influencing one another*" (Zahavi, 2000, p. 284). Consequently, this nurse dissatisfaction is the individual nurse's experience of feeling a dissonance or incongruence with their internal rhythms and external interactions with outlier patients (Hagerty, Lynch-Sauer *et al.*, 1993). The nurse's normalised level of care is being disrupted.

In summary, nursing the outlier patient has altered the structure of ladder feet . While some nurses may remain conscious of being a specialist nurse or specialty nurse, they may not be aware that nursing the outlier patient has led to a disruption of their identification as specialist nurse. The nurse's capability in achieving her normative equilibrium is lost or weakened. The nurse lowers her "best" level of care for nursing the outlier patients when compared to nursing specialty-appropriate patients.

5.4 Surfaces of anchorage

While the presence of an outlier patient within a ward does not change either the external world of the organisation or the external world of nursing, the outlier patient has impacted on the nurse's experience. In other words, the surfaces of anchorage do not undergo changes/disruption when the nurse is asked to nurse an outlier patient but her experience of nursing. Her care ladder is disrupted. The nurse continues nursing the outlier patient in the space between the surfaces of anchorage, that is, the space between the world of

organisation (as represented by the horizontal surface of anchorage) and the world of nursing (as represented by the vertical surface of anchorage). While the nurse nurses both specialty-appropriate patients and outlier patients in the same external world of nursing, each surface of anchorage has its distinct goal of efficiency and effectiveness. This definition/understanding of the surfaces of anchorage is not sufficient to inform/describe/represent/illustrate the nurse's external world of nursing the outlier patient.

For instance, effectiveness and efficiency are two terms that are commonly used when describing or defining performance measures or key indicators in nursing. There is however an assumption of shared understanding of such terms between healthcare administrators and the nurses. For instance, nurses understanding of nursing effectiveness and nursing efficiency have a strong reliance on framings involving nursing or patient outcomes. Nursing effectiveness therefore, is commonly understood as "*the achievement of one's goals*" as determined by "*staff performance appraisal and quality management of patient outcome*"(Barbum & Kerfoot, 1995). On the other hand, nursing efficiency often refers to the timeliness of nursing. For instance, Thompson, Johnston *et al.*'s (2009, p. 444) study uses "*a reduction in the amount of time spent on activities that are not part of direct patient care*" as a measurement of nursing efficiency. Consequently, while organisation and management emphasises achieving efficient and effective outcomes for the organisation, individual nurses focus on achieving a certain level of care through delivering and managing care efficiently and effectively but within the constraints they see as being generated by the need for care of individual patients (Rankin & Campbell, 2006). Thus, rather than exploring the nurse's experience of nursing in the external world of nursing or that in the external world of organisation alone, this section aims to explore the nurse's experience of nursing within the space between the two surfaces of anchorage as she nurses outlier patients. In other words, it is important to take both the external world of nursing and that of organisation into consideration in exploring the nurse's experiences.

In summary, the nurse continues to position her care ladder within the intersected space between the two surfaces of anchorage as she nurses the outlier patients. However, as the structure of other parts of care ladder, that is the ladder rungs, sides and feet have been disrupted, the surfaces of anchorage on their own can be interpreted as insufficient to inform the nurse's experience of nursing the outlier patient.

5.4.1 Nursing the outlier: creating additional workload

Nursing the outlier patient creates additional workload in the nurse's experience of nursing in an "already stressed system". For instance, Marie reports that she is nursing the outlier patient with inadequate staffing in her work environment.

> Yes, I mean the reasonable workload tool is about staffing…But in a way, it's just another negative impact, potentially negative impact for the outlier patients if there is not enough nurses on the ward that they are [the hospital management] in to look after them (Marie 365-368)

Marie further emphasises that,

> … Outlier patients are not [being] considered enough at all when they [the organisation and management] are looking at staffing the ward. (Marie 376-377)

Marie referred to staffing in terms of the "reasonable workload tool" and the need for this tool to include specific consideration of nursing outlier patients, inferring that the workload involved in nursing an outlier patient is different to that of nursing a specialty-appropriate patient and that a different "staff-patient ratio" may be needed to reflect this. As discussed previously when being asked to nurse the outlier patient without the practice base provided by the knowledge and knowing specifically related to that patient, Marie perceived that there was "not enough nurses" to do this effectively and that this would "impact" upon and potentially compromise the care of outlier patients. Nursing outlier patients therefore has altered the nurse's understanding of her work environment in that

she experiences her work environment when it involves nursing outlier patients as associated with a greater workload and being increasingly short of staff.

Agnes comments on her experience of compounding workload as she nurses the outlier patient,

> …it's [nursing the outlier patient is] extra workload. Because it's not it's not resourced. You know, it's just something, in other words, an additional workload we have to carry (Agnes 864-865)

Agnes is experiencing nursing the outlier patient as a workload that is "extra" and "additional" to the workload of her nursing specialty-appropriate patients. While she is nursing her specialty-appropriate patient with insufficient staff and time, Agnes perceives that the outlier patient is being nursed with inappropriate resources. Inappropriate does not only mean a mismatching between the specialty of the ward and the specialty of the patient's disease or illness conditions as described by Garling (2008, p. 990), but a disharmony between the nurse's being and her world. The nurse constructed (self-identifies) herself as a nurse nursing specialty-appropriate patients. However, her world has been constructed by the organisation as a generalised space that ignores the nurse's capabilities in nursing specialty-appropriate patient.

5.4.2 Nursing with a policy on outlier patients

Within the external world of the organisation, some hospital management processes have developed and implemented a formal policy for nursing outlier patients. (I was informed by a participant whose pseudonym has not been used in order to maintain confidentiality). He/she reports that the hospital in which he/she is working has a policy entitled "Management of Outlying Patients" for nurses. The development of this policy was directed by the organisation and did involve discussion with some nurses. According to the policy statement (provided by the participant) nurses should explain to the outlier patients on admission that they will be transferred to their specialty area if the need arises or a bed becomes available. However, there is no guidance as to what it means or who should be responsible for assessing the needs of the patients. It could be argued therefore that the policy statement is more of a policy for nurses to

convince and reassure the outlier patients that they will continue to receive the 'optimum' patient care regardless of where the patients are rather than a guide for nursing the outlier patient.

While some nurses may indeed follow the “Management of Outlying Patients” policy when nursing an outlier patient, even the existence of such a policy is somewhat controversial given that the presence of an outlier patient has been identified (now almost 5 years ago) as an indicator of poorer patient outcomes within the NSW health system (Garling, 2008). In this study, only one participant mentioned the existence of a policy designed specifically for outlier patients. This raises questions about why this is the case. Perhaps it is failure to acknowledge outlier patients or a desire to play down management strategies. While hospitals may have a policy for managing outlier patients the nurse at the coal face may be unaware of the existence of such policy.

The “Management of Outlying Patients” policy serves as a managerial strategy to reduce the patient's perception of not receiving effective care through being located in an inappropriate ward but it is also controversial. The nurse, as a worker within the organisation, explains and reassures the outlier patients by diminishing the negatives of being in an inappropriate ward and offering more positive solutions that enhance the patient's experience of being in what to them is a “transit” ward as they wait for a bed in a specialty-appropriate ward. The nurse, as a frontline worker, faces the possible discontent from the patients and possible discomfort in masking the fact that the outlier patient is in an inappropriate ward, and they are not happy with this either. For instance, Ann said,

> Patients are [being] moved from one ward to another. This makes the continuity even worse. It’s not good for the patients having so many moves. Particularly, the average age is probably 80s, lots of patients were sick, large proportion of those would have some cognitive impairment. The constant move is not good. Families are finding it difficult. You are disadvantaging the patient because

> you've then got different allied health, you've got to tell their stories again and they don't like that. (Ann 31-36)

Ann perceives that transferring the outlier patient from one ward to another is undesirable for the patients. The so-called-solution of managing the outlier patients through transferring patients to the ward of their specialty, to Ann, has potential complications. *Reflecting on my experience of nursing the outlier patients, some never get transferred to the ward of their specialty during their hospital stay. Some outlier patients get moved to different wards before arriving on the ward of their specialty. The policy of "Management of Outlying Patients" is not convincing to me as a nurse, since the inappropriateness of the ward is masked by the idea of it being a temporary or transit ward.*

Furthermore, even when there is an overt organisational policy for managing the nursing of outlier patients, some nurses report difficulties in following the policy. The policy statement for "Management of Outlying Patients" further stated that follow-up from the CNC from the specialty covering the outlier patient is required in developing treatment strategies and providing patient education. The current policy for "Management of Outlying Patients" relies on the presence of CNCs in addressing nursing concerns when nursing the outlier patients. However, another participant, Peter comments on his challenging experience of getting support and follow-up from the CNC afterhours in the following excerpt.

> I feel very bad, basically because quite often we have specialists like CNCs, but they work Monday to Friday. And they work from eight till four thirty p.m. But that only represents thirty-eight hours a week. But I think there is about a hundred and forty and a hundred or fifty hours a week. [Actually one hundred and sixty-eight hours a week.] There is no resource available for those patients other than going to the ward to the nurses that are looking after them. (Peter 428-432)

> And that specialty, I can ring up and said, "we've got a patient in the coronary care that is one of your outliers and we would like to know..." Now it's four-thirty in the afternoon [so] I can forget about any opportunity to do that because they are not going to be there. And weekends, they [CNCs] are not going to be there. Public holidays, they are not going to be there. So where do you go?...You just hope that a medical event does not occur. (Peter 438-444)

When the CNC is unavailable, it is up to Peter to contact nurses from the other specialist (for the outlier) ward. Peter's description of this delay in achieving appropriate nursing for the outlier patient indicates a level of frustration and anxiety while he "just hope[s] that a medical event does not occur (for the outlier patient)". Peter's example demonstrates that the difficulties nurses experience when nursing the outlier patients remains unacknowledged even when there has been some organisational administrative recognition.

Both the external world of organisation and the external world of nursing have a role in providing ways of managing the outlier patient - however, some participants continue to experience difficulty in managing them and report the difficulties in following the policies. The meaning of nursing for the individual nurse has therefore been altered by her experience of nursing outlier patients. When the nurse is nursing specialty-appropriate patients, she is nursing with her composite care ladder. Comparatively, as the nurse is nursing the outlier patients, she is nursing with a disrupted care ladder.

Meeting the organisational standard has been prioritised in some nurse's experience of nursing. Rather than attempting to nurse the outlier patients on a disrupted care ladder, some nurses turn to managing them as per the organisational standard. The nurse as a being-in-the-world in nursing specialty-appropriate patients has become merely a labourer managing the outlier patient. There is no longer a clear distinction between nursing outlier patients and managing outlier patients. This is illustrated by Figure 9 as shown on p.172 below.

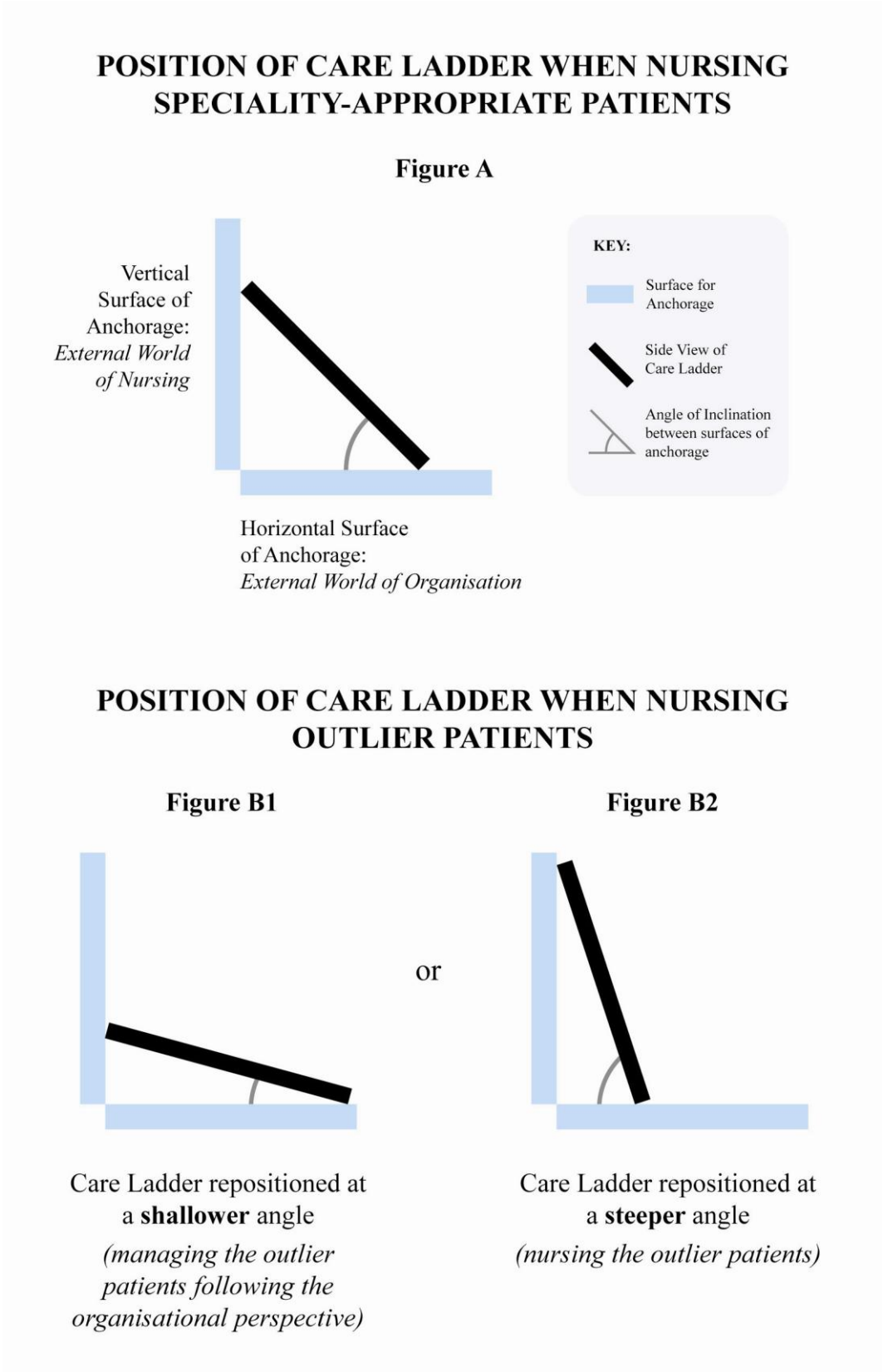
Figure A demonstrates an example of the position of the care ladder as the nurse nurses the specialty-appropriate patient. Using Figure A as a reference, Figure B1 and Figure B2 represent the position of the care ladder as the nurse nurses the outlier patient.

In Figure B1, as the nurse repositions her care ladder towards the horizontal surface for anchorage, the nurse is relying on her external world of organisation in informing her experience of nursing the outlier patients. The nurse therefore puts her consideration of workload first in her experience of managing.

In Figure B2, as the care ladder is leaning towards the vertical surface for anchorage, the nurse is relying on her external world of nursing in informing her experience of nursing the outlier patients. The nurse therefore puts patient first in her experience of nursing. The nurse's social being, in other words, her experience of nursing specialty-appropriate patients is not applicable in informing her experience of nursing outlier patients. The nurse's social being is informed by the organisation's construction of the work environment. However, nursing the outlier patient has challenged the nurse's understanding of her work environment as informed by her social being. The nurse experiences nursing the outlier patients in her practice world, where this practice world is informed by her experience of nursing specialty-appropriate patients. Through nursing in a particular specialty ward, the nurse connects to her experience of nursing through identifying her specialty and constructing her care ladder within her specialty.

Both surfaces of anchorage are interchangeable as previously discussed in Chapter 4 on p.78. Thus regardless of the nurse's preference towards her world of organisation or her world of nursing, the nurse may use extra effort to maintain a positive physical and mental strength for a nurse to position her care ladder either at a steeper or shallower angle. The nurse may use extra energy to fix and refurbish or reconstruct her disrupted care ladder into a new care ladder that is congruent for nursing outlier patients.

Figure 9 Position of care ladder



5.5 What does it mean to be nursing with a disrupted care ladder?

The care ladder that the nurse has been relying on as she nurses the specialty-appropriate patients has now become unreliable/inadequate/insufficient/inappropriate for nursing the outlier patients. The outlier patient has disrupted the nurse's care ladder, and the outcome is that the nurse experiences compounding frustration.

Hope has referred to her compounded frustration of nursing the outlier patients as a disconnected nursing experience. Hope says,

> ...because often the equipment may not be there, the nursing care may not be there. Not knowing exactly who to phone. Having to ask always first, like who is looking after this, who is the doctor, who is this, who is that, yes. And working with the fact that you know, you walk into the patients' room and knowing that he shouldn't be there. (Hope 622-625)

Hope refers to the outlier patient as a patient who "shouldn't be there". She has difficulties in relating to her experience of nursing the outlier patients. Applying Hagerty *et.al.*'s (1993, p. 293) four stages of relatedness: 1) connectedness, 2) disconnectedness, 3) enmeshment and 4) parallelism into the nurses' experience, Kay is the only nurse participant who reported that she is in a state of connectedness and claimed that she is actively involved with the outlier patients,

> you wouldn't have an outlier patient in a public hospital… when they are in hospital; you just see them as inpatients." (Kay 119-126) and that "they are here in the hospital, so you look after them. You look after them to your best ability. (Kay 44-45).

With the exception of Kay, all nurse participants, with disrupted rungs on their care ladder, are intermittently nursing in a state of disconnectedness, where they have not been "*actively involved*" with the outlier patients as they are nursing out of space and nursing out of time (Hagerty, Lynch-Sauer *et al.*, 1993, p. 293). Most nurses in this study possibly demonstrate minimal social

competencies in establishing and promoting relatedness. Two social competencies, "*the sense of belonging*" and "*synchrony*" as stated by Hagerty, Lynch-Sauer *et al.*(1993, p. 294) have been lost in time and space. As individual participants distinguish between "my ward…my patients" (Peter 482) and outlier patients, they do not consider themselves as an integral part of the system. According to Hill (2006, pp. 212, 214), a sense of belonging refers to the "*connectedness [that] occurs through the dynamics of relationships between everything in the creation/universe*" and is a "*dynamic phenomenon of social significance*". Focusing upon the participant's experience of nursing outlier patients, the lack of relationality between them indicates an absence in the individual participant's sense of belonging, where she is unable to relate her experience of nursing the outlier patient to her practice world. As the individual's sense of belonging influences interpersonal relationships and her experience of nursing, this lack of relationality, as informed by the nurse's experience, possibly suggests that nursing the outlier patient is a phenomenon lacking in social significance in some nurse's perception.

Some participants acknowledge that they are nursing in "a system" that is currently suffering from a funding deficit, understaffing and a lot of other issues. While economic rationalism has been adopted by the organisation and management to address the "already-stressed" system, participants' experience of nursing outlier patients indicates that they have intermittently disengaged from nursing in the system. For instance, the nurse's "*adaptability"* has been outlined by Sydney South West Area Health Service as the organisation's standard of "*performance indicators*". Nurses are expected by the organisation to "*demonstrate ability to support change and apply knowledge/ skill to accommodate service needs at the organisational level*" (Sydney South West Area Health Service, 2010a). The organisation's use of "*adaptability*" as a "*performance indicator*" was derived from the Australian Nursing and Midwifery Council elements, where a nurse is "*a person licensed to practice under an Australian State or Territory Nurse Act or Health Professional Nurse Act*" and to "*respond effectively to unexpected or rapidly changing situations*" (Australian Nursing and Midwifery Council, 2006, p. 8) also to "*revise*

expected outcomes" and to set "*interventions and priorities with any change in… situational variations*" (Australian Nursing and Midwifery Council, 2006, p. 11).

While the organisation expects nurses to nurse with "*adaptability"* by "*assist(ing) or support(ing) the implementation of change within the department*" (Sydney South West Area Health Service, 2010a), most participants in this study have delineated individual nursing experience from working in the department. For instance, most participants demonstrated reluctance to acquire or retain new knowledge necessary for nursing the outlier patients. This suggests the possibility that some nurses are not accepting the occurrence of outlier patients from the bed management's decision, and shows a lack of recognition of what the organisation described as "*changes within the department*" (Sydney South West Area Health Service, 2010a). Most participants were nursing in the personal space and keeping a distance from the organisation's space. The nurse is nursing in her internal world largely without making reference to her external world. Some nurse's experience of nursing out of space is an argument of the nurse's understanding of being a specialist with a somewhat narrow focus of being a nurse for familiar patients or patients with a particular (familiar) illness condition.

Another possibility is that these nurses are exercising customer deviance in protecting patients from being in a risky environment of "compromised care" as described by one of the participants. Most participants view nursing outlier patients as nursing **against** the performance indicators of "*customer service*" in the organisation's Registered Nurse Guide (Donavan, Brown *et al.*, 2004) and "*demonstrate(d) appropriate and respectful attitude towards clients and customers in the provision of care and service delivery*" (Sydney South West Area Health Service, 2010a). The lack of customer orientation influences job satisfaction and commitment, hence affecting the motivational well-being of the service worker (Donavan, Brown *et al.*, 2004). This has been demonstrated by the participant's experience of compounding frustration of nursing with the

phenomenological analysis of nursing with a disrupted care ladder. For instance, Hope says,

> …the right care is just not there [in Hope's experience of nursing outlier patients]. And the nurses are not specialised in their field. They don't have the knowledge. And the nurses are not to [be] blamed… that's their (the nurses') field of expertise. And they can't know everything about the gastric [outlier] patient. So, yes, the poor patient is not to be blamed. … actually I shouldn't say that. Yes. I feel I have to blame. Yes because the system is not a machine. The system is made of people. Well, there is a bed manager, of course. And we should have sent him [the outlier patient] to the appropriate ward (Hope 286-294).

Hope refers to the "system" as the offender to "right care", where the "bed manager" should have sent the outlier patient "to the appropriate ward" at the first instance. While the outlier patient is not an offender in Hope's experience, nursing the outlier patient has led to disruption in Hope's experience. The aim of this study was not about finding the source to blame, but to highlight the nurse's experience of nursing. The disjunction between the nurse's internal world and external world of nursing has contributed to the nurse's experience of nursing out of space. This has consequently lead to a cycle of poor nursing morale, nursing burnout and nurses quitting, and impacting on the nurse's experience of nursing and hence the patient's outcome. For instance, Darby & Daniel (1999) referred to job satisfaction and customer orientation as factors affecting nursing practice. These factors serve as background information informing the nurse's external world of nursing and external world of organisation, which is where the nurse positions her care ladder in her experience of nursing.

Chapter summary

Nursing outlier patients leads to a disruption of the individual nurses' phenomenological care ladder. Individual participants experienced compounding frustration as they were nursing the outlier patient. The outlier patients caused disruption of the ladder rungs, sides and feet. These disruptions results in an increase in the difficulty or making it impossible for the nurse to reach her best level of care. Despite the surfaces of anchorage not changing in their structure as the nurse nurses the outlier patients, she understood her experience of nursing in the intersected space between the vertical and horizontal surface of anchorage differently. The nurse is managing a perceived/experienced extra workload and some have to deal with policy specific for nursing outlier patients. The nurse perceives that her normalised self-belief of being a nurse nursing specialty-appropriate patients has been disrupted and gets lost in space as she is nursing outlier patients.

CHAPTER 6.

CONCLUSION TO THE STUDY

Nursing outlier patients is a phenomenon experienced everyday by many acute care nurses. Consequently, everyday they are required to nurse in a ward that is not suited to or equipped to address an outlier patients' specific needs. Rather than focusing on investigating the already-known consequences of this for the outlier patients (see Garling's (2008) description of the outcomes for outlier patients), this study explored the nurse's experience of nursing outlier patients, which is currently an under-researched phenomenon. The initial aim of this study was therefore to develop an understanding of this phenomenon and its influences and/or impacts upon nurses' experiences of nursing.

The use of hermeneutic phenomenology as the methodological underpinnings for the study has facilitated the exploration of participants' responses through individual in-depth interviews. Using my personal experience as a nurse as a starting point, my ongoing reflection upon, and interpretation of the interview transcripts and my experience as a nurse researcher facilitated the development of an object for phenomenological orientation. A straight ladder was used firstly to address and explore the nurse's experience of nursing specialty-appropriate patients. This straight ladder is used as the basis of my description and interpretation of the phenomenon under study and subsequently thematically named a care ladder. When nurses are caring for their specialty-appropriate patients they do this by constructing their composite care ladder as they accumulate and normalise their experience of nursing this patient group. Using this ready-to-hand composite care ladder as a template they adapt or further develop it as they nurse each new specialty-appropriate patient. However, when allocated an outlier patient the nurse discovers that her ready-to-hand composite care ladder is only useful in nursing specialty-appropriate patients and is not sufficient for the nursing required by the outlier patient. Thus suggesting, that the composite care ladder has been narrowly framed and does not fit well for a broader patient group. Using the phenomenological orientation of the care ladder thus uncovered a notion of "specialty" that the

nurse participants were using to frame their experience of nursing their normalised patient group: the patients they expected to nurse within the 'specialty' acute care ward in which they were employed.

This personal construct of nursing which has been created as she nurses specialty-appropriate patients is also informed by her experience in a temporal and spatial context. Consequently, the experience of nursing the outlier patient, which disrupts her normalised construct of specialty nursing, is for the nurse a temporal experience in which she attempts to use her established social being of nursing specialty-appropriate patients to inform her experience of nursing the outlier patient and hence her current social being. The nurse's established social being is therefore framed by her understanding of specialty and is also informed by both her experience in the world of the organisation and her world of nursing. Both of these worlds serve as an external world for her ready-to hand care ladder and as surfaces for this ladder to anchor upon (see figure 6 p.89) when nursing specialty-appropriate patients. When nursing an outlier patient however, these surfaces may now be sources of disruption.

The external world of the organisation is therefore creating both the reason for the existence of the outlier patients and the challenge to the nurse's construct of specialty, which is frequently, at least in part, derived from the organisation's approach to structuring the acute care hospital. In the world of the organisation, economic rationalism and technological advancement has driven the move from hospitals comprising a small number of open areas or wards servicing a broad range of medical disciplines to the current structure of multiple smaller specialised wards each focussed on a narrow range of health care services (Barnard, 2002; Sandelowski, 2000). The logic of management has more recently instituted the process of bed management to achieve more efficient management and resource use (Scott, 2010). While each specialised ward has specific technological equipment for nursing patients with specific disease/ illness conditions and is staffed by nurses who are employed to nurse within these specialised wards (specialty nurses) and specialist nurses with relevant advanced knowledge and expertise, the bed management process does not

appear to value such specialty-specific nursing during the bed allocation process. The goal of bed management is to enhance the bed occupancy rate, which as Garling (2008) identified has been operationally defined as a "*measure of the utilisation of hospital resources*" (Garling, 2008, p. 988). In the world of the organisation, "*the number of beds in each specialty in a hospital is usually historically determined rather than related to the volume required by patient acuity*" (NSW Clinical Excellence Commission, 2005, p. 46). Consequently, when "*a bed is not available in the home ward*", bed management "*accommodate[s] urgent and elective admissions*" by following two guidelines:

1) by accommodating patients as outlier patients in "*the most suitable wards*", and

2) by prioritising the "*transfer*" of outlier patients to their home ward "*when a bed becomes available and if medically appropriate*" (Sydney South West Area Health Service, 2010b).

Although prioritising the return of the outlier patients to their specialty-appropriate (home) ward is a positive step, the incidence of patient transfers between wards is increasing within the hospital system in Australia and other developed countries (Blay, Duffield *et al.*, 2012).

While the occurrence of outlier patients has added to this increasing incidence of patient transfers, the increased patient transfers associated with the outlier patients specifically are impacting nurses' experiences and workload. As Claire reports these bed movement activities are not having a positive impact on the workload of nurses in either ward. She said:

> ... (when) you got an outlier patient in your bed, ... in transfer to another ward ... That could take a while too with that getting on to the ward and giving the handover and making sure they (the other ward) had a bed. They (the nurse on the other ward) are going to go and get an orderly (a ward person to transfer the) patient (to) take them (the outlier patient) to the other ward. You know, it's lot of time. It's lot of frustration and time. (Claire 491-495)

While bed transfers are determined by the bed manager, nursing work is required for the actual patient transfer including as Clare describes the additional workload of handover to the other ward, contacting the ward person, and escorting the outlier patient. This additional workload of transferring the outlier patient thus further challenges the nurse's ability to fit more tasks into her nursing schedule, possibly further disturbing her synchronised rhythm of nursing (as discussed previously in Chapter 4).

In recent years as bed occupancy rates have increased the incidence of outlier patients has also increased. Consequently, more nurses are experiencing this currently unacknowledged phenomenon of nursing the outlier patient. The increase in outlier patients has occurred as a result of a combination of economic, institutional and political constraints in the world of the organisation. The nurse however, has continued to nurse in a specialised ward. A specialised ward is initially constructed by the organisation with the expectation of nursing patients of specific illness conditions and constructing her idea of specialty. The specialisation focus of the organisation also prompts the nurse as a worker to move in depth in a particular specialty (Peplau, 2003, p. 4). The continual evolvement of the nurse's social being thus defines her specialty context, within which she has developed her composite care ladder for nursing patients with specialty conditions in a specialty ward. Over time she begins to regard herself as a specialty nurse who may at times progress through further study to the role of specialist nurse who is now further encouraged through specialty relevant education to focus her work within a defined specialty area.

6.1 Specialty Nurses and Specialty-appropriate Wards

In the external world of nursing nurses were trained as generalist rather than specialist nurses. Nursing education was largely medically orientated and nurses were seen as performing a series of work tasks commonly required for the care of any patient (Nurses Registration Board, 1989; Purcal, 2008). Employers therefore saw such generalist nurses as capable of working in any area of what was then known as a general hospital. While some specialty-related knowledge was learnt through exposure when practicing, the nurse who

practiced clinical nursing in hospital wards largely remained a "*generalist*" nurse (Russell, Gething *et al.*, 1997, p. 19). The career development available for nurses at this time generally emphasised vertical knowledge (that is, knowledge associated with vertical career development, a concept that has been discussed previously in Chapter 1) and mainly involved education for educator and administrator roles. The horizontal knowledge of nursing's clinical work and practice was of less value. For the "generalist" nurse there were few educational opportunities and no financial incentives or rewards other than 'years of service' payments, which were awarded on the basis of time served not expertise developed (NSW Department of Health, 2012). Therefore the specialty related expertise developed by these 'generalist' nurses as they worked within hospital wards was seriously under-valued and only rarely formally acknowledged.

Following completion of the transfer of nursing education to the tertiary education sector Australia wide in the year of 1993 (Funnell, Koutoukidis *et al.*, 2009; Nurses Registration Board, 1989; Russell, Gething *et al.*, 1997) and the subsequent extensive development of specialty-focussed postgraduate specialty education in nursing, and the advent of a clinical career structure there has been increasing acknowledgement of the expertise and value of expertise in clinical nursing. However, this acknowledgement has also been accompanied by considerable confusion amongst the various titles, roles, job descriptions and personal constructs of specialty and specialist nursing within acute care settings. This confusion impacts and influences the nurse's embodied being.

While a consistent meaning for the terms specialised, specialty and specialist has been used within this thesis, there is considerable conceptual confusion or perhaps mis-interpretation evident within the data and with many nurses using the term nurse-specialist to describe themselves as nurses nursing in a specialised ward. Such self-identification as a nurse specialist influences the nurse's experience of nursing and her perception and understanding of herself as a specialist adding to her frustration when nursing outlier patients. Conversely, the actions of the bed management processes of the organisation

portrays ‘specialty’ as a label with little value and certainly one that does not require much consideration when attempting to locate beds for patients. Consequently, there is a lack of consideration of the specialty or indeed specialist related knowledge, expertise and resource requirements of nurses working within specialised wards when bed managers are attempting to meet the organisational requirements dictated by waiting lists and predetermined time lines for emergency care.

From the nurse's perspective, specialty is being understood as a concept that arises from her social being both informing and defining her specific area of nursing practice that contributes to both her confidence and self-worth. A nurses understanding of specialty might be organisationally or educationally constructed, but for each individual nurse her understanding of her specialty is also her individual informal recognition of her clinically based expertise that has developed from and continues to inform her ongoing nursing experience. This study has made visible the disjunction between personal and organisational expectations that surround the claims of specialty and the self-labelling of specialist nurses. The nurses self- labelling can however also be seen as a consequence of the vaguely defined “specialty nurse” and confusion of nomenclature within current literature where the three distinct concepts of nursing in a specialised ward, specialist nurse and specialty nurse are jumbled or indeed used interchangeably. (See for example, Hanks' (2010, p. 99) discussion of medical-surgical nursing as "the largest specialty in acute care settings" and their subsequent sample recruitment as involving "*the identification of a registered nurse's specialty is performed by the registered nurse indicating his/her own specialty, such as medical-surgical nursing, without demonstrating expertise or credentials to support the specialty claim*".)

Internationally, the definitions of specialisation and the regulatory requirements for specialty nurses "*differ markedly*" between the United Kingdom, the United States of America and Canada (King, Ogle *et al.*, 2010, p. 333). Specialisation in the United Kingdom was determined by the "*nursing roles*" as informed by the nurse's "*knowledge and skills*", whereas

specialisation in the United States of America was accredited with the "*discrete areas of nursing practice*" (King, Ogle *et al.*, 2010, p. 333). In Canada, specialisation was attributed to the "*nurse's competence in a particular nominated area of practice*"(King, Ogle *et al.*, 2010, p. 333). While defining specialty nurse according to the areas of practice demonstrates the organisational construct of a specialty work environment, defining specialty nurse based on the nurse's knowledge and skills returns the definitional basis to the nurse's personal construct of specialty nursing thus providing further basis for continuing confusion. The inconsistencies of defining specialty according to an organisational construct of specialty work environment and that to the nurse's personal construct of specialty indicates a disconnection between the nurse and her work environment, which later influences her experience of nursing the outlier patient.

While at the commencement of this study (in the year of 2008) the phenomenon experienced by nurses in NSW, Australia and labeled by them as "nursing the outlier patient" was not evident in the literature, it is clear that this phenomenon although unacknowledged was or is now being experienced by nurses internationally. In 2009 when talking with nursing doctoral candidates from Brazil, Canada, Finland and Spain at the International Nursing PhD Collaboration Summer School (Universitat de les Illes Balears in Spain) it became clear that while the phenomenon resonated with them the term used to describe it in Australia was not familiar to them. This lack of a shared understanding in relation to naming of the complexity and difficulty caused by current approaches to bed management and organisation of patient admissions has added to nursing workload and caused frustration for many nurses working in acute care settings not only locally but also internationally. More recently and certainly since I commenced my study in 2008, the importance of the phenomenon and use of the term "outlier" has been acknowledged. One recent study uses the term "outlier patients" to demonstrate the consequences/effects of nursing the outlier patients (Goulding, 2011). Goulding (2011, pp. 140-145) uses the term outlier patients in her thesis conducted in United Kingdom linking the presence of outlier patients to bed pressures such as "*winter bed*

pressures, lack of beds, internal transfers, ward closures, repatriation and delayed discharge". Goulding, Adamson *et al.* (2012, p. 218) further identified outlier patients as patients "*who are [being] placed on a hospital ward that would not normally treat their illness*". This thesis therefore contributes to a process of acknowledgment of a phenomenon that is being experienced internationally but is currently hidden through the lack of a commonly shared terminology.

This thesis also acknowledges the value of nurse's knowledge and clinical experience, which has been somewhat buried by the confusion in the perspectives evident in current literature. The nursing literature has for some time presented a mix of nurses' experiences of nursing, and organisational and managerial perspectives on nursing. As the nurse is a being-in-the-world, these organisational and managerial perspectives on nursing rarely inform or even speak to the nurse's experience of nursing. Failure of the current nursing literature (practice, managerial, organisational and other) to address issues of relevance for nurses from the nurses' perspective represents an undervaluing of the nurse's experience of nursing; a situation that mirrors to some extent the situation of patients before research focusing on the (patient's) experience of illness was developed. The nurse's experience, the organisational perspective and the managerial perspective on nursing are not synonymous, but could potentially inform one another. Such recognition of the nurse (her experience) as a being-in-the-world would both value nurses' experience and provide opportunity to acknowledge nurses frustrations with organisational and managerial practices that directly impact the nurses' world.

The complexity and difficulty nurses are experiencing as an outcome of organisational/managerial practices are illustrated by the multiple ways that the nurses' composite care ladder is disrupted by the presence of the outlier patient. As the nurse constructs her ready-to-hand-composite care ladder from her experience of nursing specialty-appropriate patients, she also constructs her framing of specialty within the specialised work environment and develops her clinical confidence. However, the nurse's ready-to-hand-composite care ladder is disrupted whenever she nurses outlier patients and experiences a

disconnection between her framing of specialty and the organisational construction of a specialised ward. Such disconnections impact upon and cause changes in the nurse's understanding of her work environment, her role as a nurse and her patient(s).

Lindbeck & Snower's (2000, p. 3) discussion of "*capital deepening*" and "*capital widening*" aid interpretation of such changes in the nurse's work environment. When nursing an outlier patient the nurses' experience changes from that of nursing a specialty-appropriate patient in a capital deepening work environment to nursing within a capital widening work environment that now includes outlier patients. The organisational construction of an acute care ward is generally conceptualised as involving a capital deepening work environment (Lindbeck & Snower, 2000, p. 3), where nurses as workers are implicitly or explicitly directed towards improving their performance of **particular skills** for patients with **particular illness** in a **particular ward**. Such a capital deepening construction of the work environment therefore forms the nurse's external world of nursing as is clear from discussion with the participants all of whom were practicing in wards designed for patients with particular illnesses and had developed familiarity/familiar knowing in nursing these specialty-appropriate patients.

In a capital widening work environment nurses would be required (expected) to acquire and maintain a wide variety of skills in nursing patients with a wide variety of illnesses. As the acute care hospital is constructed as a series of specialty-focussed wards to acquire such a breadth of knowledge and skills to the level required to work in a variety of specialty areas would require the nurse to regularly rotate through different wards in a process similar to that followed by many New Graduate Nurse programs. (See for example my earlier reflection on my own New Graduate Nurse experience p.14). From a capital widening perspective, the organisation is expecting the nurse to accumulate her nursing capabilities as she nurses over time within a variety of wards and is therefore valuing the nurse as a generalist with the ability to nurse across multiple specialties rather than as a specialist nurse with specialty-related knowledge and skills. This change in focus would also mean that over a period

of time the nurse would become incapable or less capable of delivering the specialty/specialist care, the aspects of her practice from which she is currently deriving her clinical confidence and self-belief.

Although such changes in the way nurses work is valued within a modern acute care work environment they have not been discussed with, or communicated to, the nurses working in acute care areas, (as this study demonstrates) nurses are becoming aware of the undervaluing of their specialist skills that appear to be the consequence of such changes. For instance, Peter describes his understanding of the concept of nursing used by the organisation in general and within bed management in particular as something that "...any nurses can give to any patients" (Peter 399). An understanding substantiated by Sleutel (2000) who describes the bed management process as considering nurses to be people who are consistent in "*behaviour, experience, orientation, feelings, reactions"* and "*job attitudes*". Perhaps not surprisingly then many participants in this study reported experiencing a feeling of being undervalued by management in terms of their own normalised understanding of 'being a specialty nurse' who nurses patients with particular specialty illnesses or conditions. .

6.2 Bed Implications for patients and care of patients

Nursing outlier patients has also changed the nurse's understanding of her patient. While the organisation's bed management processes attempt to improve patient-bed flow by standardising the care of patients, as a by-product of this standardisation process where a patient's care cannot be standardised the patient is categorised as exhibiting **possible variance** and becomes a person exhibiting a variation in the expected clinical course.

Acute care hospitals often use standardised clinical pathways. Clinical pathways, also known as critical pathways, are case management tools designed for managing and sequencing care processes for various surgical and medical procedures (Marja, Leino-Kilpi *et al.*, 2002; Rankin & Campbell, 2006; Scott, 1995). Standardisation of the treatment for each particular disease is a necessary pre-requisite for developing its clinical pathway (Takegami, Kawaguchi *et al.*, 2003). These tools also contain the implicit organisational

assumption that each clinical pathways has been designed for the generic hospital work environment, that is that the pathway will work in any acute care ward. Any cases (patients) that do not follow the standard pathway and fail to meet anticipated outcomes within the foreseeable timeframe determined by the clinical pathway are therefore categorised as a variance (Scott, 1995; Takegami, Kawaguchi *et al.*, 2003).

The organisation uses clinical pathways to predict care outcomes for the target population. Similarly, bed managers anticipate that patients who follow the prescribed clinical pathway will achieve the outlined goals within an appropriate length of stay and require a predicted amount of resource utilisation (Scott, 1995). Similar to the use of many other standardised managerial tools, the implementation of a clinical pathway without accurate nursing assessment of the patient's illness and specialty related condition has been described as frequently dangerous (Craven & Hirnle, 2006; Faulkner, 2000). Nevertheless, if every patient has a unique variance analysis attached to their clinical pathway, it is no longer an efficient standardised tool but becomes a time consuming individualised care plan (Craven & Hirnle, 2006). The efficiency and effectiveness of clinical pathways is however dependent on it being used in wards that are designed to provide the specialty-appropriate care that the pathway anticipates. On the basis of the assumptions underlying the processes of standardised care, if the patient is nursed in a different ward that is not specialty-appropriate, the outcome is that they become an outlier patient and consequently they must be designated as a variance.

The disconnection between the nurse and her environment that results from the inconsistent definitions of specialty is intensified by current hospital bed management processes that further disconnect the nurse and her work environment. While hospital bed managers/management do attempt to match a patient's specialty disease and/or illness condition to the specialty of a particular ward, the primary focus of bed management is the facilitation of efficient hospital bed flow and therefore patients frequently become outliers when specialty-appropriate beds are not available. Despite the current use of

Hospital Dashboard (a software package) that provides a summarised management view of "*all elements of the Patient Flow Portal*" such as "*ward occupancy*" and number of "*empty beds available*", the phenomenon of nursing the outlier patient remains present (Australian Resource Centre for Healthcare Innovations, 2013). In achieving their bed flow goals though it seems that bed managers allocate beds without sufficiently acknowledging the specialty-related differences between patient's diseases or illness conditions and frequently act as if there is no problem of "fit" between the patient's diagnosis and the ward specialty.

Not surprisingly, bed management uses of bed allocation pathways are designed specifically to meet hospital goals of efficient bed utilisation, in doing so however, this process is largely failing to meet or perhaps even consider the consequences for the nurses and nursing. Identifying a clinical pathway for the outlier patient is not a major concern of the bed manage(er)ment. For nursing however, when the outlier patient is admitted without a clinical pathway, this newly admitted patient (whose clinical pathway must not be one of the standardised clinical pathways associated with the admitting ward for the patient to be categorised as an outlier patient) rapidly becomes an outlier patient who cannot be documented as a variance to a clinical pathway as there is no standardised pathway to be varied for this patient.

Bed management's desire to allocate a bed, that is any bed, for the patient has created a work environment that disconnects the nurse from her specialty-related understanding of her nursing. Such disconnections can also be understood as disrupting each nurse's care ladder in ways that frequently require more time and effort from nurses. For example, as identified by Rainbow and John nursing an outlier patient is not the same as nursing other patients, as the outlier patient involves "extra" work in nursing.

> I think, all human beings have the same basic needs. But I think they [the outlier patients] have different needs, adding needs, extra needs... for example, you know, the rest of patient in this ward might not necessarily have the Peripherally Inserted Central

> Catheter (PICC), so the extra need of the outlier patient is the PICC. (John 151-152)

> It's just that [you are] out of routine [when you have an outlier]. And it just delays all your nursing tasks, it just delays all the other work that you have to do. Because you are doing extra work with this [outlier] patient. And there is no added nursing staff when you have this patient. (Rainbow 264-267)

John's and Rainbow's excerpts demonstrate how nursing outlier patients involves nursing care requirements that are different from "the rest of the patients in this ward" and how the nurse is nursing "out of routine". The findings of this study show how the care of outlier patient, as experienced by participants in this study, are completely at odds with their familiar standardised pathway, rather than simply a variance of it. An outlier patient is an outsider within a specialised ward and it is a more complicated event that is taking place in the absence of and not just a variance to a standardised clinical pathway.

The nurse, her use of the organisationally constructed standardised clinical pathway and her work environment are inseparable when nursing. However, as the nurse nurses the outlier patients without a standardised pathway or attempts to adapt one designed for another ward (that is, a different work environment as compared to the nurse's practice world), the nurse is nursing out of space and is becoming disconnected from her work environment and her care ladder is therefore being disrupted. Once her care ladder has been disrupted there is a need to reactivate/redefine the nurse's personal framing of her specialty in light of the organisation's apparent expectation of her role as being that of a nurse generalist. Generalist nurses can be expected to nurse patients of various illness and/or disease conditions and hence effectively provide care for the outlier patient as constructed by the bed management process. Working within a modern acute care hospital where wards are organised on the basis of a specialty, nurses are expected to provide more specialised care as they progress in their career. As such they move beyond being a generalist registered nurse as

they continue to modify their social being as they gain more specialty knowledge and skills and/or become qualified as a nurse specialists. It is the organisation's construction of specialised wards or work environments that has contributed to the nurse's perception of herself as a nurse specialist who works within a designated specialty area. The nurse's perceived embodied being as a specialist nurse as informed by the organisation's construction of work environment is now in conflict with the embodied being of a general nurse as conceptualised by bed managers and it is the presence of the outlier patient that is making such conflict visible for her. While the majority of this study's participants reported that they are providing the best possible nursing care and that outlier patient should get the "the same care as everybody else [in the ward]" (John 130-131) this study also revealed that the participants often perceive the best possible nursing provided for outlier patients as being of a lower standard than that provided for specialty-appropriate patients. It is apparent therefore that nurses nursing outlier patients do consider there is some risk of outlier patients receiving "compromised care" despite nurses attempts at providing "the same care as everybody else [in the ward]" (130-131). While the nurse generalist may have greater breadth of skills and exposure to a variety of patient conditions and illnesses, the depth of knowledge provided by the nurse specialist is also needed if high quality care is to be provided in the complex acute care work environment. In short, neither is sufficient for meeting the nursing demands of organisations that are both organised into specialties but also wish to ignore this structure when they consider it expedient to do so.

6.3 Suggestions and/or considerations for future practice

This study has provided an interpretation of nurses' experience of caring for outlier patients in the acute care setting. Taking this a step further I have considered how this difficult and challenging situation for nurses (those at the frontline of care delivery) might be addressed. Reflecting on the career structure and development in nursing as discussed in Chapter 1, nurses have been educated as nurse generalists yet, in the main, they are practicing as nurses nursing in a specialised ward. The nurses are operating with equipment

that is physical-condition-specific and ward-specific as their experience consists of nursing in one specialised ward. In other words, the nurse nursing in a specialty ward becomes familiar with nursing patients with a particular disease or illness condition. Given that undergraduate nursing education for registration as a nurse in Australia is currently a three year degree program, specific knowledge and skills required to nurse the outlier patients further complicates "*the growing knowledge and skills content that is required to comprehensively prepare nurses for practice*" (McAillster, Madsen *et al.*, 2010, p. 373). Taken nursing the outlier patient into consideration when designing nursing curriculum therefore risks overloading an already full curriculum.

This thesis demonstrates that the lack of acknowledgement of the nurse's social being in relation to nursing education needs to be addressed. There is little evidence from this research that fostering a nursing workforce is a consideration or that individual nurse's voice is important in determining the organisation of their work. The value of skills and knowledge and experience gained in nursing in the specialty wards ought to be strengthened and acknowledged. Designing an education program that best prepare novice nurses for the "real world" — that of the contemporary workforce — is therefore another important future research/education implication.

At present, nursing curricula has not taken nursing the outlier patient into consideration. Nursing the outlier patient is being considered as a situation in which communication skills are required, but the skills and knowledge specific for nursing the outlier patients has not attracted much attention. Despite the Garling report highlighting the risks associated with being an outlier patient (Garling, 2008), there is no mention of nursing the outlier patient in the current Safety and Quality Health Service Standards (Australian Comission on Safety and Quality in Healthcare, 2012).

Future research might address the question of "What are the most sensitive measures that might be developed to study the impact of patients' health outcomes when they are admitted as outlier patients?".

Being incapable or less capable of delivering the specialty/specialist care to outlier patients has simply been portrayed as a communication problem that

nurses should handle. This thesis has emphasised the individual nurse's experience as her being-in-the-world. The meaning of care is not just patient care, organisational care or nursing care, but about the co-existence of this through a dynamic continuum of time. Apart from the nurse, the health service human resource managers are also part of the picture in managing nursing the outlier patients. How do health service human resource managers make informed decisions about the appropriate skill mix for the breadth of specialty units constituting tertiary care facilities therefore is another future consideration.

As an alternative to the consideration of skill mix, I have also considered the possibility of developing the disease and/or condition specific familiarity. I reflected on ways of broadening the nurses' construct of specialty in both the horizontal and vertical dimensions, while organisations and their bed managers determine possible specialty groupings where the commonalities of care would facilitate better quality care for outlier patients. The National Nursing and Midwifery Specialisation Framework (National Nursing and Nursing Education Taskforce, 2006c) uses the term "*Practice Strand*" to identify and group the specialty areas that share some common skills and attributes and consideration of these could also assist with broadening the nurse's self-perceived constructs of specialty. For example, the cardiac and cardiothoracic nursing specialties are considered to be part of the same practice strand on the basis of prioritising the skills domain of "*time critical care*" (National Nursing and Nursing Education Taskforce, 2006c, p. 12) whereas, cardiac and urology nursing exemplify different practice strands on the basis of their different skill domains priorities with Urology emphasizing "*active and supportive care*" (National Nursing and Nursing Education Taskforce, 2006c, p. 14) as they work to promote patient independence rather than the "*time critical care*" required within cardiac nursing.

A supportive work environment is required for nurses to put the concept of "practice strand" into practice. Despite the fact that nurses may possess some broader knowledge across various specialty areas, as Rainbow and Hope point out that they have not nursed outlier patients in their daily practice within a

specialty related ward. This absence of rehearsal for nursing the outlier patients has disengaged the nurse from her experience as a generalist nurse and thus limited her ability to nurse the outlier patient. As stated by Rainbow and Hope,

> As a nurse, I don't feel confident. I feel inadequate looking after the [outlier] patient. Ill-prepared to look after the [outlier] patient. (Rainbow 388-389)

> You don't always see them. You just don't know what to do with them. (Rainbow 167)

> We can nurse the patient and care for the patient... we will bring them to their best possible health. Yes. And we can't do that if the nurses are not trained to look after him. Maybe they have trained to, but they have not looked after patients like that for a long time. (Hope 696-699)

Apart from not matching a patient's illness to the specialty ward, current area health reports, for instance, Sydney South West Area Health Service (2010b) suggests that there is currently no established grouping of specialty related wards on the basis of shared nursing commonalities to assist the process of bed allocation. While outlier patients should be accommodated in "*the most suitable wards*" according to current guideline for bed management (Sydney South West Area Health Service, 2010b, p. 4), "*the most suitable wards*" or the best work environment for nursing the outlier patients, have not been clearly defined, which therefore compounds the nurse's frustration of nursing with a less suitable/unsuitable work environment. Given that the current concept of "*practice strands*" have not been considered during bed allocation, the nurse's opportunity to develop her capability for nursing outlier patients has not been, and may never be fully developed. The nurse is unable to utilise her capability of practicing with disease and/or condition specific familiarity for nursing patients from a specialty that shares few nursing commonalities with her specialty.

6.4 Engaging with a final reflection on the phenomenon

Through exploring the nurse's experience of nursing the outlier patient, this study has established that the presence of outlier patients is not merely a bed management mismatch of patient numbers, patient types and beds, but is an indication of inappropriate care since the nurse is nursing on a disrupted ladder. The outcome is that most participants became less capable of practicing as a specialist nurse, and hence lost the connection with their individual embodied being as a specialist nurse when they nurse outlier patients. Most participants experienced stress and frustration as they nurse outlier patients, those outside their specialty nursing context, that is nursing patients with specialty illness conditions in a specialty-appropriate ward. The synchronised rhythm established by the individual nurse, between or among nurses, the other healthcare teams within the same specialty, and the organisation has been disrupted by the pattern of time and work specific for nursing outlier patients. The nurse becomes less capable of nursing with a synchronized rhythm while nursing the outlier patients. The nurse's experience of nursing the outlier patient is further compounded by the inapplicability of her practice-base of knowledge and knowing, her familiar knowing, her schedule, her ability to predict and her inter-professional relationality. All of which are context specific to her specialty.

This research has explored and articulated what it is like for nurses to care for outlier patients hence achieving the aim of the study. Acknowledging that the phenomenological approach does not seek solutions to questions or problems, I will share some ideas to address the issues that have emerged as a result of my reflection on the participant’s experiences. Through identifying the nurse's construction of specialty from her experience of nursing within the organisation's construction of the work environment, nurse's experience of nursing the outlier patients can be improved by developing an understanding of and considering practice strands in both bed allocation and nursing practice. As the nurse identifies commonalities between nursing specialty-appropriate patients and nursing outlier patients within the same practice strand, she can use part of her ready-to-hand composite care ladder as a foundation for

building new care ladder(s) for the outlier patient(s). Nursing the outlier patient could then become a new horizon in nursing joining the various horizons in the nurse's social being to re-interpret a new care ladder for nursing the outlier patients providing more certainty and control over the uncertainty associated with the phenomenon. Thus potentially, outlier patients who are of the same practice strand as the specialty-appropriate patients will be much less seen as "*patients... in a ward inappropriate for their condition ..."* (Garling, 2008, p. 990) and more likely to be seen as patients whose illnesses/disease conditions are within a range of the nurse's normalised specialty construct. In this way both the nurse's construct of specialty and the organisation's notions of generalisation/specialisation will no longer be limited to or bounded by specific diseases and/or illness conditions. Instead, a broader patient population will be constructed/identifiable within practice strands and the outlier patient will be nursed within a specialised ward that shares some commonalities with their home ward.

In conclusion, this study has explored the phenomenon of nursing the outlier patient and identified ways to broaden both nurses current constructs of self-identified areas of specialty practice and the organisation's construct of specialty related wards. Extending from Marie's understanding,"... a bed is a bed from the bed manager's point of view" (Marie 19), the phenomenon of nursing the outlier patient is the lived experience involving the nurse's experience, the patient, and the organisational determination of the nurse's work environment.

In the experience of acute care nurses:

A bed is not just a bed

A patient is not just a patient, and

A nurse is not just any nurse.

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APPENDICES

Appendix A- "Definition and qualification for registration as a nurse"

In reference to the registration standards as listed by the Nursing and Midwifery Board of Australia by Meadley (de Bleser, Depreitere *et al.*, 2006), the definition and qualification for registration as a nurse is as follows,

> *" The entry requirement for a registered nurse is a bachelor degree or higher qualification. Registration or licensing is required. Any person who satisfies the NSW Nurses and Midwives Board that he or she is of good character is, on making an application in writing to the Board for the purpose and on paying to the Board the prescribed fee, entitled to be registered as a nurse and to be issued with a certificate of that registration if:*
>
> *a) the person satisfies the Board that he or she has completed a course of training as a nurse at an institution in Australia, being a course of training that is recognised by the Board as entitling the person to registration as a nurse, and is the holder of a degree, diploma, certificate or other qualification to the effect that the person has successfully completed that course; or*
>
> *b) the person satisfies the Board that he or she would, but for the commencement of*
>
> *Schedule 2 (3) to the Nurses Registration (Amendment) Act 1985, have been entitled to be registered under the Nurses Registration Act 1953 as a general nurse, a mental retardation nurse or a psychiatric nurse; or*
>
> *c) the person satisfies the Board that he or she:*
>
> - *has undergone a course of training as a nurse in any place outside Australia in which a law providing for the registration of nurses is in force, and*

- *is the holder of a degree, diploma, certificate or other qualification to the effect that the person has successfully completed the course of training, and*
- *is registered as a nurse under that law, and the Board is of the opinion that the standards of that training and of the examinations leading to that degree,*
  diploma, certificate or other qualification are not lower than the standards provided for by or under this Act for the registration of nurses; or
  d) the person satisfies the Board that he or she:
- *has undergone a course of training as a nurse, and*
- *is the holder of a degree, diploma, certificate or other qualification approved by the Board from an institution, person or body in any place (in or outside Australia)*
- *to the effect that the person has successfully completed the course of training,*
- *and the person has passed such examinations, and has successfully completed such additional training, as the Board may in the particular case require, and the Board is satisfied that the qualifications of the person are adequate for the purposes of registration as a nurse; or*
  e) the person was previously registered as a nurse under this Act or the Nurses
  Registration Act 1953, being registration properly granted on the basis of
  qualifications actually possessed by the person at the time of that previous
  registration."

Appendix B- Ethics Approval letter

The University of Sydney

Gail Briody

Manager

Office of Ethics Administration

Marietta Coutinho

Deputy Manager

Human Research Ethics Administration

Ref: PB/PE

10 March 2009

Associate Professor Maureen Boughton

Faculty of Nursing and Midwifery

Dear Professor Boughton,

Thank you for your letter dated 26 February 2009 addressing comments made to you by the Human Research Ethics Committee (HREC). After considering the additional information, the Executive Committee at its meeting on **3 March 2009** approved your protocol entitled ***"An exploration of the nurses' experience of "outlier" patients in the acute care setting: a hermeneutic phenomenological study"***.

Details of the approval are as follows:

Ref No.: ***03-2009/11602***

Approval Period: ***March 2009 to March 2010***

Authorised Personnel: Associate Professor Maureen Boughton
Associate Professor Sandra West

Miss Jasmine Cheung

The HREC is a fully constituted Ethics Committee in accordance with the *National Statement on Ethical Conduct in Research Involving Humans-March 2007* under *Section 5.1.29*

The approval of this project is **conditional** upon your continuing compliance with the *National Statement on Ethical Conduct in Research Involving Humans.* We draw to your attention the requirement that a report on this research must be submitted every 12 months from the date of the approval or on completion of the project, whichever occurs first. Failure to submit reports will result in withdrawal of consent for the project to proceed.

Chief Investigator / Supervisor's responsibilities to ensure that:

(1) All serious and unexpected adverse events should be reported to the HREC as soon as possible.

(2) All unforeseen events that might affect continued ethical acceptability of the project should be reported to the HREC as soon as possible.

(3) The HREC must be notified as soon as possible of any changes to the protocol. All changes must be approved by the HREC before continuation of the research project. These include:-

- If any of the investigators change or leave the University.
- Any changes to the Participant Information Statement and/or Consent Form.

(4) All research participants are to be provided with a Participant Information Statement and Consent Form, unless otherwise agreed by the Committee. The Participant Information Statement and Consent Form are to be on University of Sydney letterhead and include the full title of the research project and telephone contacts for the researchers, unless otherwise agreed by the Committee and the following statement must appear on the bottom of the Participant Information Statement. *Any person with concerns or complaints about the conduct of a research study can contact the Manager, Ethics Administration, University of Sydney, on (02) 8627 8175 (Telephone); (02) 8627 8180 (Facsimile) or gbriody@usyd.edu.au (Email).*

(5) Copies of all signed Consent Forms must be retained and made available to the HREC on request.

(6) It is your responsibility to provide a copy of this letter to any internal/external granting agencies if requested.

(7) The HREC approval is valid for four (4) years from the Approval Period stated in this letter. Investigators are requested to submit a progress report annually.

(8) A report and a copy of any published material should be provided at the completion of the Project.

Yours sincerely

Associate Professor Philip Beale

Chairman

Human Research Ethics Committee

Copy: Miss Jasmine Cheung
Jche9913@mail.usyd.edu.au

Encl. Approved Participant Information Statement

Approved Advertising Flyer

Approved Advertisement

Approved Participant Consent Form

Appendix C- Participant information statement

CHIEF INVESTIGATOR'S / SUPERVISOR'S NAME

Associate Professor Maureen Boughton (Supervisor)

Associate Professor Sandra West (Associate supervisor)

Miss Jasmine Cheung (PhD student)

PARTICIPANT INFORMATION STATEMENT

Research Project

Title:

An exploration of the nurses' experience of caring for "outlier patients" in the acute care setting: a hermeneutic phenomenological study

(1) What is the study about?

This study is about the nurses' experience of caring for "outlier patients". The term "outlier patient" has been widely used in hospital bed management and in current nursing literature. The New South Wales Clinical Excellence Commissions (2005) has defined outliers as "patients who are being nursed on a speciality ward that is not aligned to the condition for which they are primarily receiving treatment" who often "have poorer outcomes and longer length of stay". Therefore, the aim of this study is to develop a broader understanding of the nurses' perspectives in caring for an outlier patient.

(2) Who is carrying out the study?

The study is being conducted by Jasmine Cheung [PhD student], and will form the basis for the degree of Doctor of Philosophy at The University of Sydney under the

supervision of Associate Professor Maureen Boughton and Associate Professor Sandra West in the Faculty of Nursing and Midwifery.

(3) What does the study involve?

This study involves face-to-face, audio-recorded interviews with nurses. The interviews will be unstructured and some follow up phone calls may be necessary to clarify issues raised during the interviews. Some demographic information will be collected including age, gender and years of nursing experience.

(4) How much time will the study take?

The study will be conducted from March 2009 to December 2011. The researcher will conduct unstructured interviews with individual eligible participant. Each individual interview session will require **approximately 30 to 90minutes.**

(5) Can I withdraw from the study?

Being in this study is completely voluntary - you are not under any obligation to consent and - if you do consent - you can withdraw at any time without affecting your relationship with the University of Sydney.

You may stop the interview at any time if you do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

(6) Will anyone else know the results?

All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information that could link participants with the transcripts; therefore protecting the individual's identity. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

(7) Will the study benefit me?

By participating in this study you will be contributing to the generation of knowledge around, and understanding of, what it is like to care for the "outlier patients". Your contribution will also provide important information that will potentially benefit future policy directives that serves to improve the nurses' and patients' experience in the acute care setting. **But the study will not be of any direct benefit to you**. Reimbursement for travel expenses will NOT be available.

(8) Can I tell other people about the study?

You are free to discuss this study with anyone else you please.

(9) What if I require further information?

When you have read this information, Miss Jasmine Cheung *(PhD student)* will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her on *93510760 (telephone) or jche9913@mail.usyd.edu.au (Email)*

(10) What if I have a complaint or concerns?

Any person with concerns or complaints about the conduct of a research study can contact the Manager, Ethics Administration, University of Sydney on (02) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or gbriody@usyd.edu.au (Email).

This information sheet is for you to keep

Appendix D- Consent form

PARTICIPANT CONSENT FORM

I, ...[PRINT NAME], give consent to my participation in the research project

TITLE: Exploration of the nurses' concept of "outlier patient" at the acute care setting: using a hermeneutics phenomenological approach

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.

3. *I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) or the University of Sydney now or in the future.*

4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.

5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.

6. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

7. I consent to:

i) Digital audio-recording YES ☐
NO ☐

ii) Receiving Feedback YES ☐
NO ☐

If you answered YES to the "Receiving Feedback Question (ii)", please provide your details i.e. mailing address, email address.

Feedback Option

Address: _____

_____

Email: _____

Signed: .....

Name: .....

Date: .....

Appendix E- Flyer/Advertisement as shown in The Lamp (June 2009 p.50)

The University of Sydney — Faculty of Nursing and Midwifery

Attention Registered Nurses!

Have you ever thought you are caring for patients in the:

WRONG BED or WRONG WARD…
*i.e. **INAPPROPRIATE** for their conditions*

According to the special commission of inquiry into acute care services in NSW public hospitals, currently existing clinical barriers were demonstrated by mismatch between patient's conditions and ward specialty (Garling, 2008).

Poorer patient outcomes have been reported to relate to patients being admitted to "inappropriate" wards for their condition – subsequently labelled as "**outlier patients**".

This study is being conducted to **explore nurses' experience of caring for "outlier patients"** who have "ended up in the wrong bed".

If you are a **registered nurse** who has been working in a **public hospital in NSW** within the last **two years**, please contact Jasmine Cheung (PhD student) to **share your experience of nursing "outlier patients"**.

PhD student: Jasmine Cheung
T: 61 2 9351 0760 Email: jche9913@mail.usyd.edu.au

Supervisors: Associate Professors M. Boughton & S. West

Appendix F- Data analysis audit rail

1. Summary and Reflection immediately after the interview : An example from Agnes' interview

Despite Agnes described the nursing care experience for outlier patient as "inevitable" and "inappropriate" at the beginning of the interview, and used a lot of "ideally…" throughout the interview, Agnes believed that there will be a "solution" for eliminating the outlier patients by increasing the budget "the money". Rainbow also described the current "pressure for public hospital to fill in the beds" is a "cheap option" for bed managers. Nevertheless, Rainbow later described bed managers actually faced a "different level of pressure". It is the "policy" and lack of "money" that resulted in these pressure.

For Agnes, caring for outlier patients is "inevitable" because she felt that there was "pressure for public hospital to fill in the beds". These outlier patients were often described by doctors and managers as patients who require "babysitting for overnight". However, Agnes described the outlier patients sometimes as "acutely medical ill" patients with "increased morbidity" who were "**not** easy playing out rehab patients".

Agnes feel "frustrated" as they did "NOT have doctor on the ward", particularly during night shift. And that the "normal rehab doctor" is a "junior" medical doctor. Other frustration, such as lack of "resources" and "staffing" - for example, lack of chute, and only 2 wards men are available for the whole hospital at night time, the lack of support from supervisor, for example, when psychiatric patient cried out at night and disturb others, Rainbow has no other options but to lock patient in the room. Rainbow have immediately called supervisor, however supervisor did not offer help and claimed that "it's your responsibility" in locking patients in the room. Rainbow lodged complaint letter. Caring for outlier patients finally became a "small reason" why Rainbow "quit" the hospital.

Agnes also feel "frustrated" as the outlier patients, which Agnes described as "frequent flyers" and "cry wolf" who "cannot cope at home" and like "to be looking after". For instance, Rainbow felt that she "need to do an ECG" for

patients who she believed that “99%” there is no chest pain. She also felt she is always “going out of window”. While Rainbow believed that hospital is a “Place” for filling the patients, Rainbow is interested in finding out why these “frequent flyers” prefer to stay in hospital rather than own home -“comfortable place”. Rainbow believed that the “frequent flyers” may be social “minority” that require further investigation.

During the interview, Agnes has also use “ladder” as a description for different levels of care. “
“Basic care” is the lowest in the ladder and involves “tick boxes” and “maintenance” only. “Appropriate care” is at a lower level than “Adequate care”. “And that the “continuity of care” is situating above all kind of care mentioned. Rainbow believed that she reached the level of “appropriate care” when she is “lucky and when all goes well”. To Rainbow, care involves human element. Rainbow see many new nurses as “robot” nurses, where she initially defined as nurses not within the care ladder, but later explained that “robot nurses” may involve in basic care. “Expert” to Rainbow means a person with “resourceful information” in caring for the outlier patients.

“Time” has frequently mentioned by Rainbow throughout the interview. There is a lack of time for Rainbow in “getting to know the patients”. Rainbow “prioritize” time by putting life threatening physical task on top, however, she believed that emotional care for the patient is also “valuable”.

2. Reflection after conducting line- by -line Analysis with the printed copy of transcription : An example from Agnes' interview

I found that this interview has revealed something scary- our hospital system is actually placing acute medical outlier patients in rehabilitation ward with inadequate level of resources and support.

Unlike Rainbow cases, Agnes does ventilate her frustration to her supervisor. However, the response she got is “it’s your responsibility”? It is our responsibility even we are not being provided with a fair workload or fair resources to work with (of course, what is/who to determine what is fair is another issue to be look at).

And when Agnes mentioned about a case where the psychiatric outliers started yelling at night and there seems to be no other solution but to lock the patient in the room. This reminds me about my experience. I am not sure whether this is an outlier problem or is it really a co-morbidity issue. I used to have a patient who is of our ward specialty but also suffered from dementia. This patient has been constantly yelling and disturbing other patients. This patient also has a non-English speaking background. I have been spending time to get in touch with the interpreter to find out what this patient want and hope that patient would settle. However, this is really time consuming and the patient get settled for 15 minutes and then started yelling for other things again. I am very busy that night and my colleague advice me to ignore the yelling patients since her observations are fine. However, I feel very difficult. What if the patient actually yelled for chest pain or life threatening issues? But then do I just ignore her yelling, go and have a quick look at her and walk away -or maybe as suggested my colleague, if she can yell that loud, she probably is ok? Or do I spend another 15 mins trying to find an interpreter again? Some colleague also advice me that calling an interpreter at night time is very expensive? What is my priority? In my philosophy, patient is our ward is quite sick because we are a critical ward. When the advice I got is "Use your clinical judgement", based on what principle do I judge? And what if I judge wrong? I cannot just say sorry and walk away. It is someone's life. I understand my colleague is trying to be realistic and provide the best possible care and be fair to other patients. However, how much risk am I taking in here? My friend said that I worry too much, but why shouldn't I? Why me? Why not? I can understand the frustration that Agnes has had. And when Agnes 31 years of nursing experience does not help to stop the frustration (similar to Rainbow case), then no wonder me as a 2nd year nurses is feeling it the same way. I begin to wonder is this frustration part of the nurses' job process? Or is that something we can do about it? I also think my experience is parallel to Agnes' description of "cry wolf".

And when Agnes mentioned about the "ladder" where care is being described as having different levels. I wonder whether Agnes perception of the "ladder of

care" is something parallel to the literature re: "models of care" that I have read? Maybe the similarity is that

1) Low level of ladder, that is the basic care/tick box is parallel to standardize care as described in the literature
2) High level of ladder, that is the human element involved is parallel to individualised/ holistic care model as described in literature

In terms of Agnes' description of "frequent flyer", I feel that there is a component of nursing obligation again (similar to Rainbow case). Tick box, basic care....is that mean best possible care? In terms of the care ladder that Agnes described, I believed I have been aiming for the basic care. I feel I was a bad nurse because deep down in my heart, I know I should be providing adequate care and continuity of care. However, I also need to set realistic goals. Just like setting job priority, I feel that low priority task is also important for the patients. But with our best possible care, we usually only perform high priority task without going back to fulfil the low priority task. I am not sure whether I can think of it this way. Using hermeneutic circle, to look at the whole you need to look at the parts. To understand the parts you need to going back to the whole. I feel in terms of caring for outlier patients is more like, "I look at the whole, these are the problems, I fix the whole in a superficial way without getting enough time and details to look at what parts of the problems involved (in other words, I just fix immediate apparent problems without investigating or understanding the root cause or details of the patient needs)." Priority to me means task to be done in an accordingly order, rather than task that should be done and is okay and if it's not being done. And in my clinical experience, when nurse said, "Jasmine, you got to handover. Nursing is 24 hour job, you need to set your priority and just have to handover the task that you have not done". I always doubted. If I think something is a low priority task, will the nurse in the next shift set it as a high priority task and get that done?

I know this sound terrible, but imagine patients who are bed bounded, how often do they get their hair wash? Hair wash...well, not a priority, will not kill

the patient, they are not that dirty since they are only lying in bed....is that true????? And if I handover to the afternoon staff...sorry I am really busy but I think Mrs. A need a hair wash in bed??? I really doubted how many people would actually go and do it? And often we just assume maybe patient is that sick and they prefer not to be moved and rest in peace? I remember that I used to have an NFR patient whose hair obviously has not been washed for many days. And she looked really sick and we are guessing that she will pass away within a few days due to her physical signs. It is this really busy morning time where all the meds are due and all the buzzers begin to ring, and that one of the enrolled nurses ask the patient "would you like a hair wash?". The patient said yes, smile after having a hair wash, and that afternoon she also passed away. To the dying patient, hair wash is not life threatening but is a dying with dignity issue. What is priority? I guess this is something to deal with clinical judgement AGAIN?

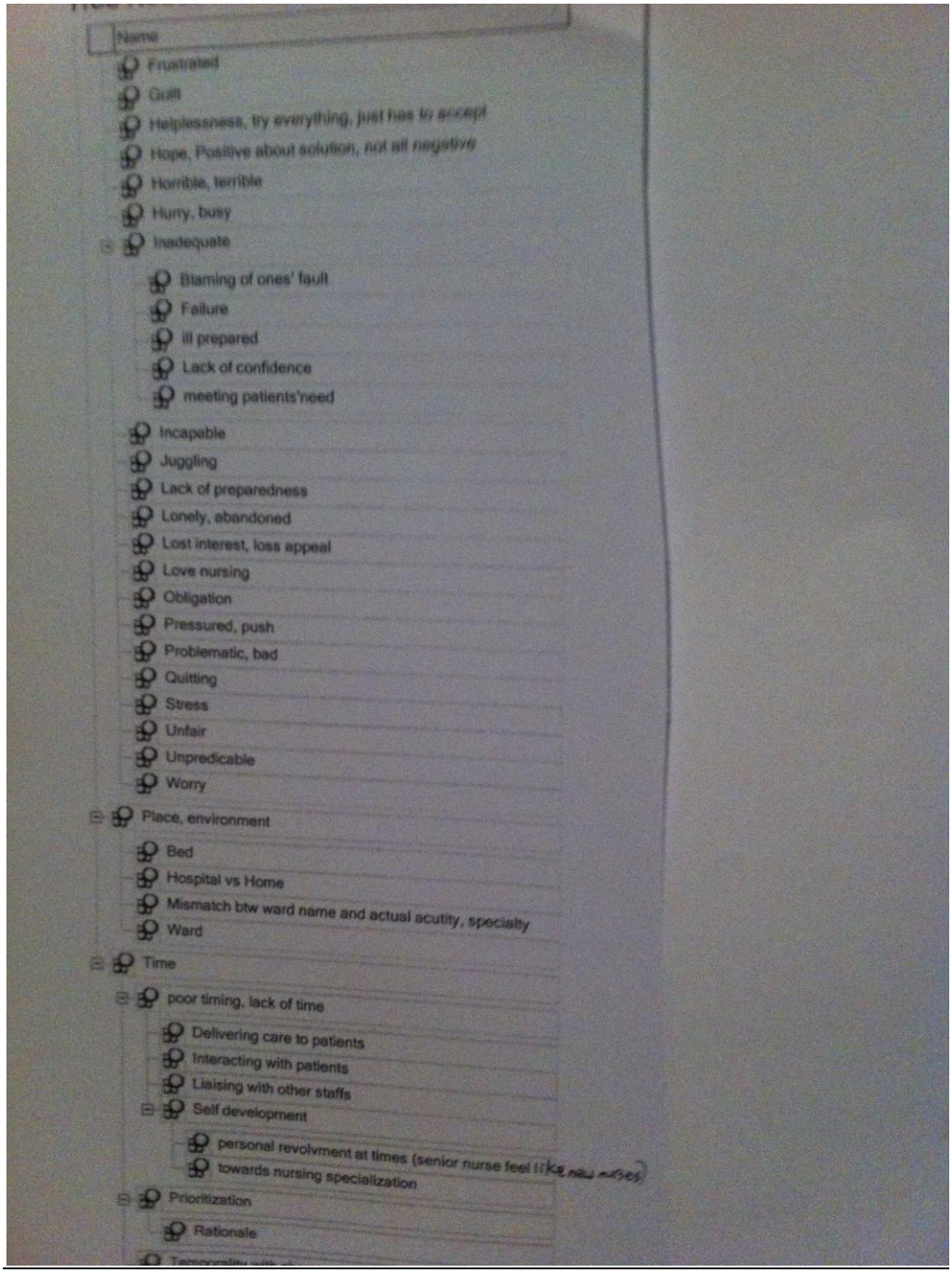
Agreeing with Agnes, I also believed that having more funding in healthcare will alleviate the outlier problems. However, I think it is not a realistic thought because there always going to be a budget limit. Where do we go from here? Towards the end of the interview, Agnes mentioned the occurrence of outlier patients as a "cheap option" for policy makers. Maybe this cheap option is just a way of trying to invisible the outlier problem but not actually eliminating the outlier problems? And maybe the fact that bed manager think bed allocation as fitting patients into beds should involve more careful considerations of resources allocation and nurses and patients' experience?

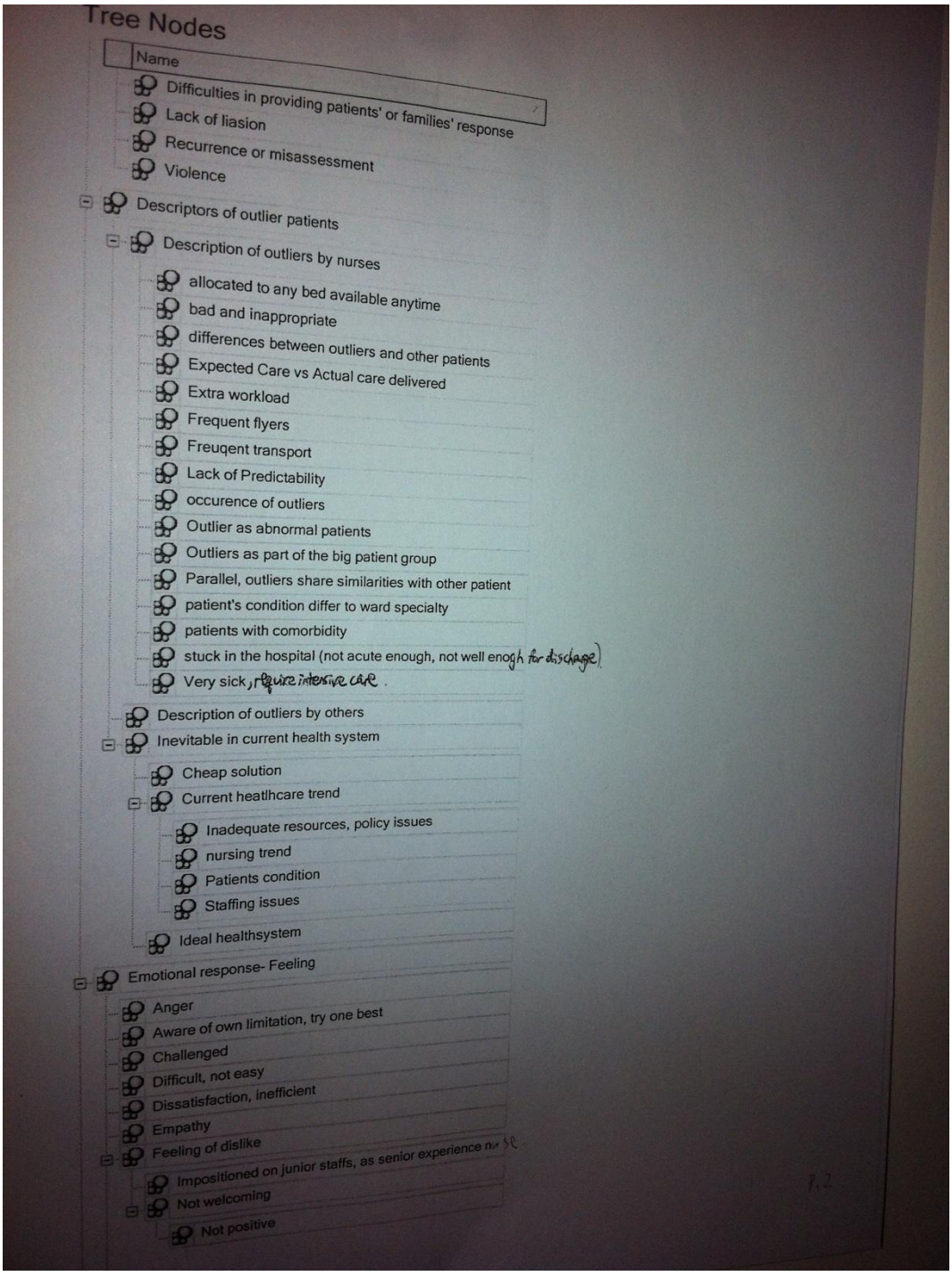
And why there is also a time constraint for nurses? Nightingale..from my memory, have mentioned in her ten commandments that "not to hurry"....but we are always rushing with the time??? Nursing is no longer a merely loving and caring figure, and involve clinical judgement, and involve resources and seem to be involved in a lot of political issues (eg. similar to 1st interview, Rainbow, Agnes has also talked about time constraint, quality of care and problem with staffing issues.). Hospital is not a place where a lot of things can be "ideally" by the nurses due to various factors, and is not an "utopia" for

caring for outlier patients. Where outlier patients are not the same as “normal patients” (of own specialty) but is a norm (frequent occurring) in the current hospital setting.

3. Conducting initial thematic analysis with the use of NVivo on Agnes' interview and on Rainbow's interview

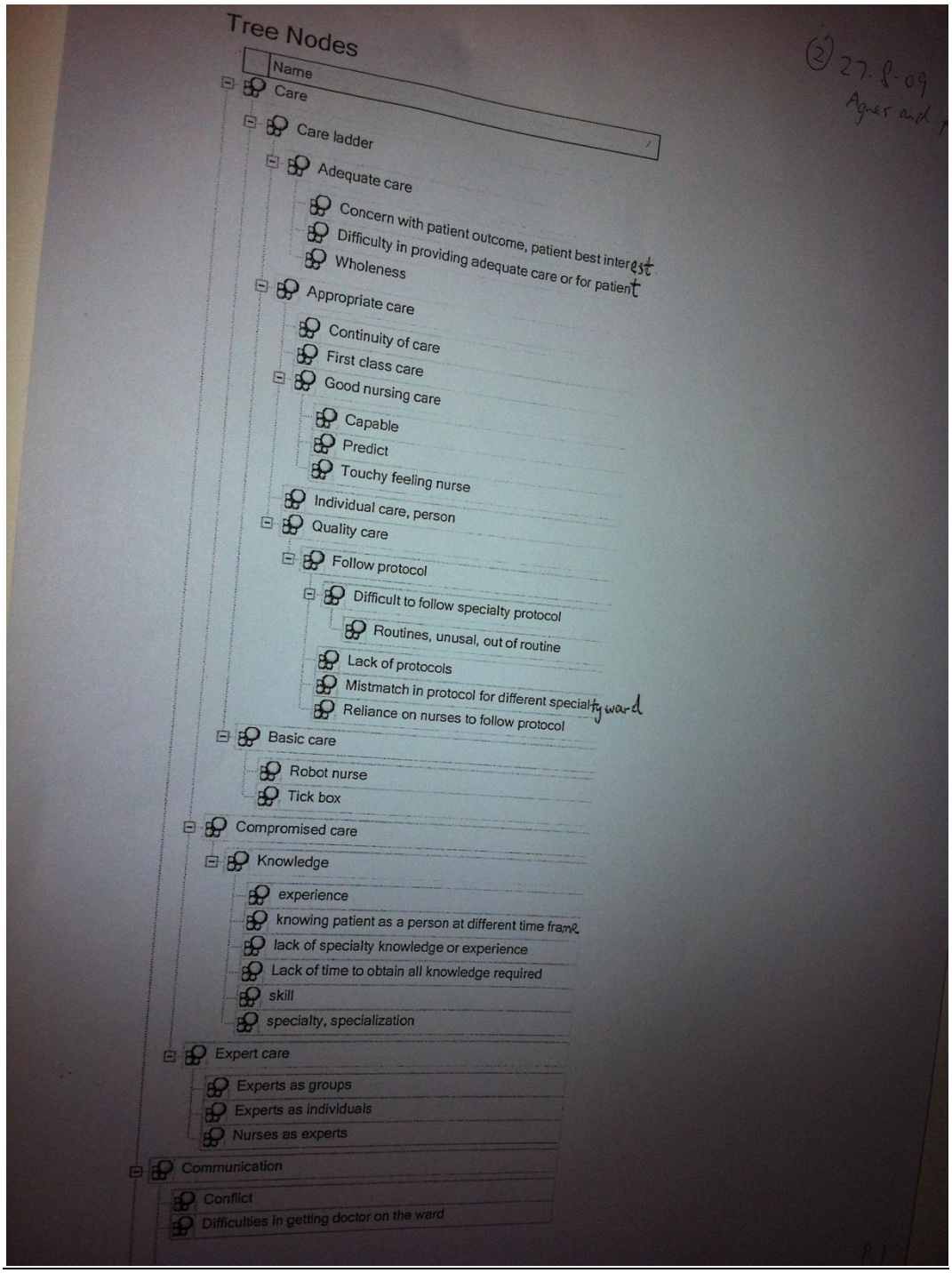
Figure A1 Conducting initial thematic analysis with the use of NVivo on Agnes' interview and on Rainbow's interview




Tree Nodes

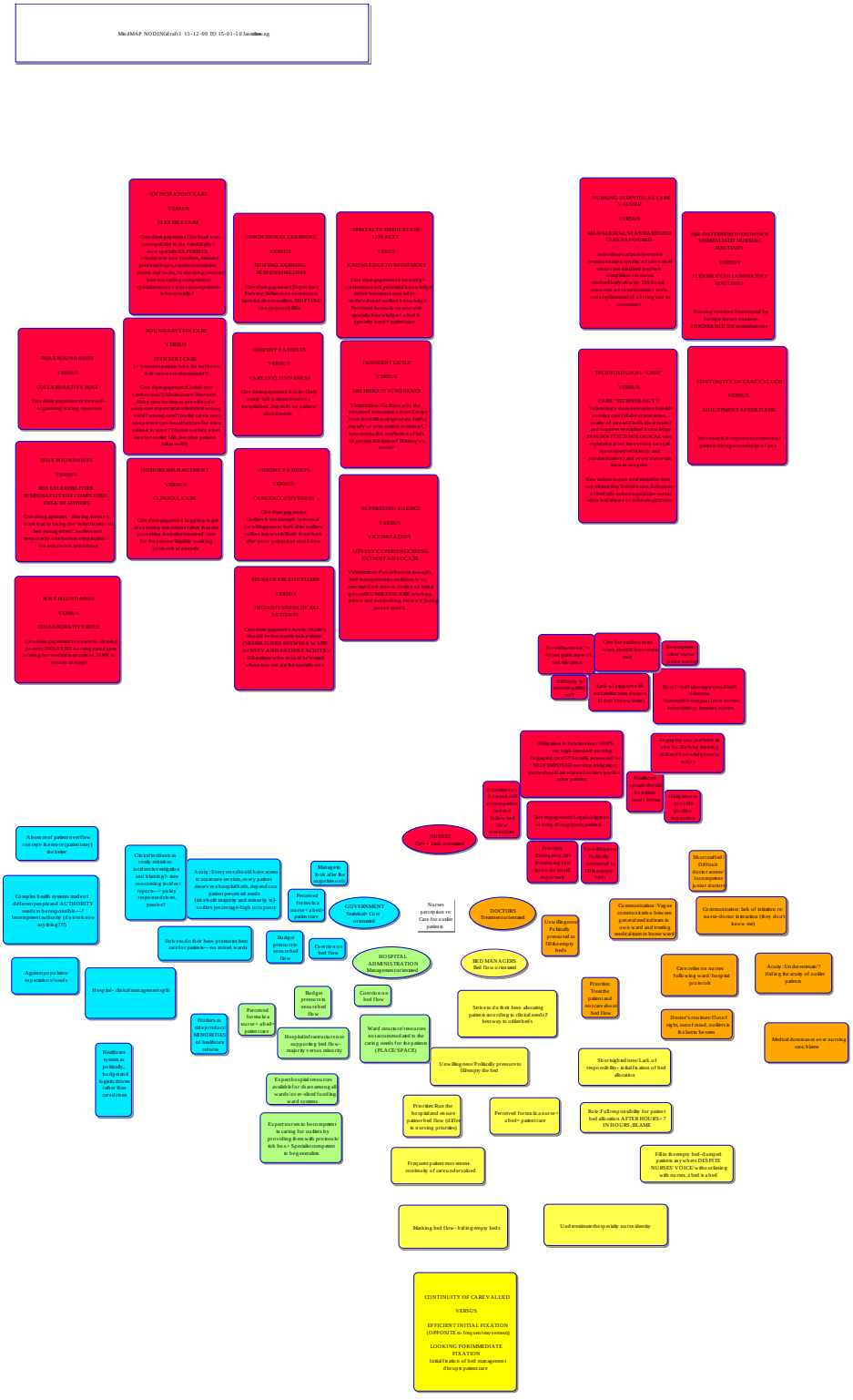
Name

- Difficulties in providing patients' or families' response
- Lack of liasion
- Recurrence or misassessment
- Violence
- Descriptors of outlier patients
  - Description of outliers by nurses
    - allocated to any bed available anytime
    - bad and inappropriate
    - differences between outliers and other patients
    - Expected Care vs Actual care delivered
    - Extra workload
    - Frequent flyers
    - Freuqent transport
    - Lack of Predictability
    - occurence of outliers
    - Outlier as abnormal patients
    - Outliers as part of the big patient group
    - Parallel, outliers share similarities with other patient
    - patient's condition differ to ward specialty
    - patients with comorbidity
    - stuck in the hospital (not acute enough, not well enough for discharge)
    - Very sick, require intensive care .
  - Description of outliers by others
  - Inevitable in current health system
    - Cheap solution
    - Current heatlhcare trend
      - Inadequate resources, policy issues
      - nursing trend
      - Patients condition
      - Staffing issues
    - Ideal healthsystem
- Emotional response- Feeling
  - Anger
  - Aware of own limitation, try one best
  - Challenged
  - Difficult, not easy
  - Dissatisfaction, inefficient
  - Empathy
  - Feeling of dislike
    - Impositioned on junior staffs, as senior experience n
    - Not welcoming
      - Not positive


Tree Nodes
Name
Care
Care ladder
Adequate care
Concern with patient outcome, patient best interest
Difficulty in providing adequate care or for patient
Wholeness
Appropriate care
Continuity of care
First class care
Good nursing care
Capable
Predict
Touchy feeling nurse
Individual care, person
Quality care
Follow protocol
Difficult to follow specialty protocol
Routines, unusal, out of routine
Lack of protocols
Mistmatch in protocol for different specialty ward
Reliance on nurses to follow protocol
Basic care
Robot nurse
Tick box
Compromised care
Knowledge
experience
knowing patient as a person at different time frame
lack of specialty knowledge or experience
Lack of time to obtain all knowledge required
skill
specialty, specialization
Expert care
Experts as groups
Experts as individuals
Nurses as experts
Communication
Conflict
Difficulties in getting doctor on the ward

4. Conducting initial thematic analysis with the use of Inspiration mind map

Figure A2 Conducting initial thematic analysis with the use of Inspiration mind map



As shown in the above mind map, the five colours representing the nurse's description of her experience of nursing the outlier patients with 1) bed manager, 2) government, 3) hospital organization, 4) other health care disciplines and 5) the nurse herself and other nurses. Through considering the nurse's experience as being influenced by and as influencing on her work environment, the Inspiration mind map allows me to think of the phenomenon as a whole- that is, the nurse nursing in a work environment, rather than the nurse as a separate entity from her work environment.

5. Conducting initial thematic analysis with the use of Scrivener software

Figure A3 Conducting initial thematic analysis with the use of Scrivener software

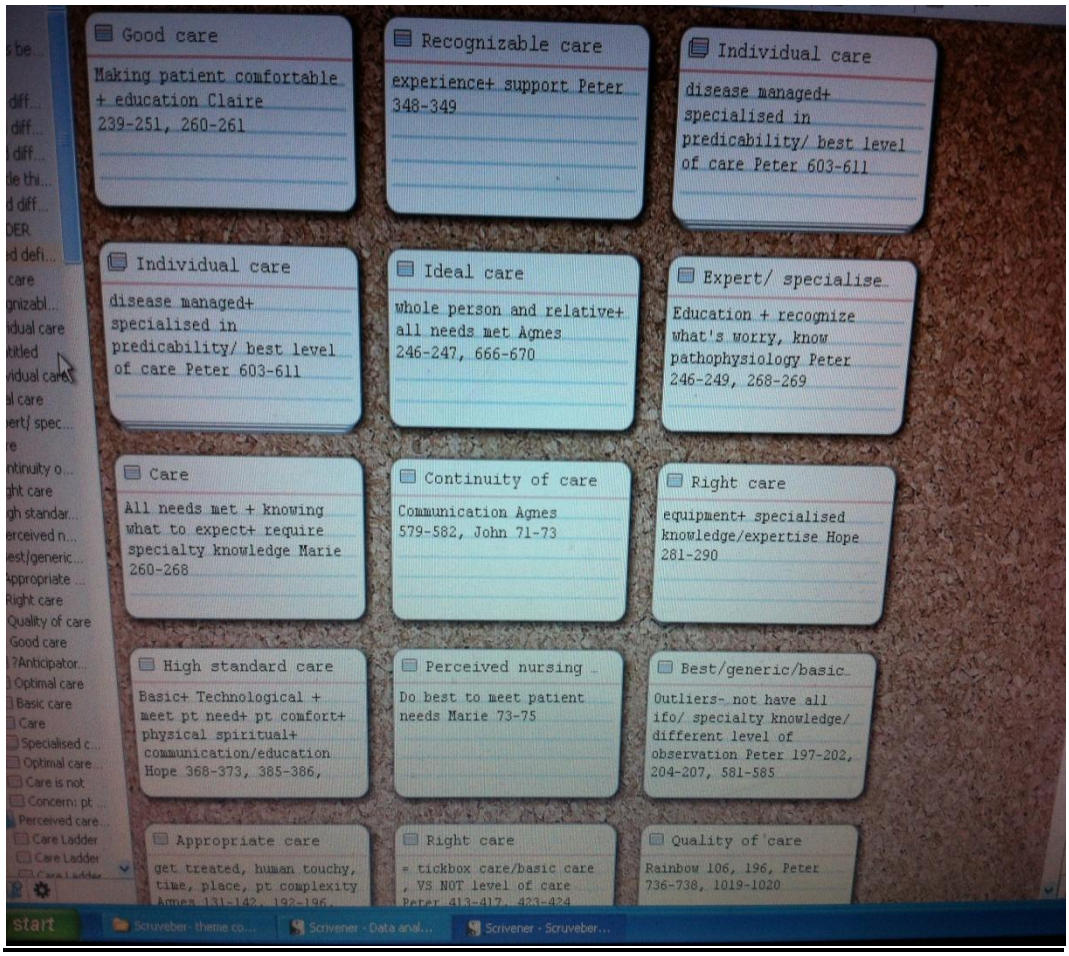


Figure A4 Interpretation of themes and sub-themes with the use of Scrivener software

Themes	Initial sub-themes
1. Nurse's reported feeling from experience of nursing the outlier patients	In Doubt re: knowledge; Belittled; Hesitate; Fearful; Dissatisfied; (Learnt) Helplessness; In Doubt; Devastating; Acceptance/ Indifference; Uncertainty; Frustrated re: pt care/outcome; Frustrated re: Uncertainty; Frustrated re: pressure; Frustrated re: lack of support/ uncaring attitude; Being ignored; Frustrated re: staff and resources; Stress re: Lack of support; Frustrated; Not confident; Abuse; Stress re: intense workload; Not prepared; Guilt; Difficult; Bad; Unfamiliar; Feeling stress; Limited; Failure; Feeling hard; Not easy; Tense inside; Not welcoming/ Don't like/ lack of interest; Not positive; Odd/ Different; Stress: patient not getting care; Worry; Frustrated; Inadequate; Inappropriate; Anger re: uncaring attitude; Painful; Awful; Disappointed/ unhappy; Unease
2. Perceived care ladder	Basic-Optimal; Basic-Human; Basic-Continuity; Something missing; Basic-Comprehensive; Generic- Specialised; Basic-Adequate-Appropriate
3. Perceived care of outliers	Minimal care; Missing in care; Not basic care; Inappropriate care/ inadequate; Compromised care; Best possible nursing; No predictability; not good nursing care/ only basics; Not continuity of care; Not just babysitting/ require intensive look after
4. Nurse's experience of nursing	taking away time from patient; lack of time; Time delay in attending to pt needs; Predictable time; Knowledge-clinical; Knowledge- gaps; Knowledge- brain switching for different patient; Knowledge-know the person; Barrier to rapport; Rapport; Workload (extra work); Workload (Inappropriate); Knowing- depend on what you frequently dealt with; Knowing-pathway; Knowing: technology advancement; Knowing (Experience); Knowing (specialty experience); Knowing- experience takes time

5. Perceived definition of care	Good care; Recognisable care; Individual care; Ideal care; Expert/ specialised care; Continuity of care; Right care; High standard care; Best/generic/basic care; Appropriate care; Right care; Quality of care; Good care; Anticipatory care; Optimal care; Basic care; Specialised care; Nurses are NOT trained to look after outliers; Too specialised; Optimal care= best possible care
6. Nurses' perception	Hospital as a specialised unit; Outlier patient have extra needs; Perceived nursing standard; Perceived difference between bed management and nurse re: specialty; Perceived difference between routine(nurse and doctor); Perceived difference between management and nurses re: specialised care; Perceived difference between management and nurses re: specialised or generalised nurse; Perceived difference between Nursing concern and management concern; Perceived community expectation; Perceived difference between bed management and Nurses re: bed allocation; Perceived difference with government; Concern: Patient needs not met/ not individualised/specialised care; All this little things / barrier to adequate care